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Massachusetts Joins Growing Number of States to Prohibit Mandatory Overtime For Nurses, as Well as Ban Use of Government Funds in Unionization Efforts



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Effective Nov. 5, Massachusetts law prohibits hospitals from requiring nurses to work mandatory overtime and imposes restrictions on the length of shifts a nurse may work.

These new restrictions are buried in a lengthy piece of legislation enacted in August and intended to control escalating health care costs. While the cost containment strategies are unique, there is nothing unique about the ban on mandatory overtime. With this legislation, Massachusetts joined a growing number of states that have enacted regulations governing mandatory overtime.

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The law also prohibits Massachusetts hospitals from using government funds to persuade employees to support or oppose unionization. Similar legislation has been passed in other states, including California, whose law was struck as unconstitutional,[1] and New York.

History of Health Care Reform in Massachusetts

In 2006, Massachusetts became the first and, to date, the only state to require that all residents purchase health insurance or face penalties.[2] To assist residents in obtaining health insurance, the legislation provided state-sponsored private insurance plans. The Massachusetts health care legislation has received increasing attention in the midst of the national dialogue over President Obama's 2010 health care legislation.[3].

As a second phase to the 2006 landmark legislation, on Aug. 6, Massachusetts Gov. Deval Patrick signed into law ''An Act Improving the Quality of Healthcare and Reducing Costs through Increased Transparency, Efficiency and Innovation'' (the act).[4] Frequently referred to as the cost containment bill, Patrick touted the act as ''the next big step forward on health care re-

[1] See discussion below.

[2] MASS. GEN. LAWS ch. 111M, §§ 1-5 (http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111m).

[3] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, to be codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C.

[4] An Act Improving the Quality of Healthcare and Reducing Costs through Increased Transparency, Efficiency and Innovation, S.B. 2400 (2012) (enacted).

form,'' projecting that the act will result in $200 billion in cost savings over the next 15 years.[5]

Buried within the text of the 349-page act are two provisions seemingly unrelated to the goal of controlling health care costs that regulate hospitals as employers rather than as health care providers. The first provision prohibits mandatory overtime and imposes maximum shift lengths for nurses. The second provision bans hospitals from using government funds to pay individuals to persuade employees to support or oppose unionization. While the cost containment provisions have received significant national attention, to date little attention has been paid to the mandatory overtime and union spending provisions of the act.

Ban on Mandatory Overtime

The act prohibits hospitals from requiring nurses to work ''mandatory overtime,'' defined as ''any hours . . . beyond the predetermined and regularly scheduled number of hours that the hospital and nurse have agreed that the employee shall work.'' The law does not prohibit or place limits on voluntary overtime and hospitals remain free to offer overtime to nurses.

Hospitals are not completely banned from requiring nurses to work overtime hours. An exception is provided for ''emergency situations'' where ''the safety of a patient requires its use and when there is no reasonable alternative.'' It is important to note though, that the emergency situation exception is not absolute. Even in the event of an emergency, hospitals must make a good faith effort to cover the overtime on a voluntary basis before mandating overtime.

The act does not define what constitutes an ''emergency situation.'' Instead, the act creates a Health Policy Commission tasked with issuing regulations and interpretative guidance after holding public hearings. One of the most anticipated guidelines will be a definition of what constitutes an ''emergency situation.'' It is unclear when members of the Health Policy Commission will be appointed, much less when public hearings will be held. Until such regulations are adopted, hospitals will need to determine for themselves what constitutes an ''emergency situation.''

The act does not provide specific penalties for hospitals that mandate overtime in nonemergency situations. Hospitals, however, will be required to report all instances of mandatory overtime to the Department of Public Health. These records will be made available to the public. It remains to be seen what the Department of Public Health will do with such information or if the regulations from the new Health Policy Commission will provide any guidance on the impact these reports may have on a hospital.

Maximum Shift Lengths

The act sets maximum shift lengths for nurses. Hospitals are prohibited from regularly scheduling a nurse to work more than 12 hours in a 24-hour period. Hospitals further are prohibited from permitting a nurse to work more than 16 consecutive hours in a 24-hour period. In the event a nurse works 16 consecutive hours, the hospital must provide that nurse with at least eight hours of consecutive off-duty time immediately following the 16-hour shift.

The act also includes an anti-retaliation measure, which prohibits hospitals from discriminating against or terminating nurses who refuse to accept a work assignment in excess of the specified limitations. Again, however, the act does not provide any penalties nor does it expressly create a private right of action for a nurse against a hospital, including those hospitals that mandate overtime in nonemergency situations.

Mandatory Overtime Restriction and Collective Bargaining Agreements

It is unclear how the act will impact overtime provisions contained in collective bargaining agreements. Many Massachusetts hospitals are parties to collective bargaining agreements that include clauses expressly permitting the assignment of overtime and providing procedures for such assignments. The act specifically states that it does not ''limit, alter or modify the terms, conditions or provisions of a collective bargaining agreement entered into by a hospital and a labor organization.'' As such, this language may permit hospitals with nurses covered by a collective bargaining agreement that includes mandatory overtime provisions to argue they are exempt from the act's requirements. Labor organizations, however, undoubtedly will vigorously oppose such an interpretation and continue to assert that hospitals only may require their members to work mandatory overtime if it falls within the act's emergency situation exception.

Mandatory Overtime Bans in Other Jurisdictions

While Massachusetts remains the first and only state to mandate universal health care coverage, the ban on mandatory overtime for nurses is not unique. By adopting these restrictions, Massachusetts joined 17 states with similar restrictions on overtime.

Maine, Oregon, and California began the push against mandatory overtime in 2001. Since that time, other states have adopted similar bans, including Alaska, Connecticut, Illinois, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Texas, Washington, and West Virginia.

Like the Massachusetts law, states banning mandatory overtime for nurses commonly have exceptions for either emergency situations or exigent circumstances. These exceptions to the law commonly are defined as an unforeseeable medical emergency and afford wide latitude in permitting hospitals to declare when, in the patients' best interests, an event can be considered an ''emergency situation.'' The New Hampshire law for instance specifically excludes from its overtime prohibition nurses participating in surgery for the duration of the operation.[6] That being said, however, many states still require hospitals to attempt other arrangements before requiring mandatory overtime. In New York, for example, a hospital must create a ''Nurse Coverage Plan'' that plans for patient care emergencies, taking into account typical patterns of absenteeism due to ill-

[5] Press release, Massachusetts Gov. Deval Patrick, Implementation Website for Health Care Cost Containment Launched (Sept. 27, 2012), *available at* http://www.mass.gov/governor/pressoffice/pressreleases/2012/2012927-health-care-website.html.

[6] N.H. REV. STAT. § 275:67 (2011) (http://law.justia.com/codes/new-hampshire/2010/titlexxiii/chapter275/section275-67/).

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ness, leave, and similar factors.[7] Moreover, Maryland law takes into consideration an individual nurse's critical expertise or skills when determining if overtime may be required.[8]

States have taken a divergent approach on how a hospital may be penalized for requiring mandatory overtime. While nearly all laws, including those of Massachusetts, contain a specific provision banning retaliation against an employee who reports a mandatory overtime violation, states are divided on whether hospitals can be financially liable for requiring overtime. In Pennsylvania, for example, a health care facility can face administrative fines from $100 to $1,000 for each violation.[9] The law even provides an administrative hearing and judicial review process for such assessments. Rhode Island similarly imposes a fine of up to $300 for each violation.[10] New York's statute does not have its own penalty provision. Violations would be punishable under the general New York labor law penalty provisions that impose fines ranging from $1,000 to $5,000 depending on the number of prior violations. In addition, violations of New York labor law may be prosecuted as misdemeanors. The Massachusetts law does not provide for penalties.

Moreover, states have taken contrasting views on how the mandatory overtime prohibitions interact with collective bargaining agreements. As mentioned previously, many of the overtime restrictions have come at the behest of labor organizations. That being said, not all states have prevented employers and unions from collectively bargaining around statutory overtime restrictions. For example, in New Hampshire a collective bargaining agreement between the hospital and its nurses can exempt a hospital from the mandatory overtime prohibitions.[11] In contrast, under New York law, collective bargaining agreements only can provide *additional* protections against the use of mandatory overtime.[12]

Ban on Use of Government Funds to Oppose Unionization

Along with the union-endorsed ban on mandatory overtime, included in the legislation is a prohibition against using government funds to persuade employees to support or oppose unionization. In its entirety, this section reads:

> No hospital shall receive reimbursement or payment from any governmental unit for amounts paid to employees, as salary, or to consultants or other firms, as fees, where the primary responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for services rendered in dealing directly with a union, in advising hospital management of its responsibilities under the National Labor Relations Act, or for services at an administrative agency or court or for services by an attorney in preparation for the agency or in court proceeding shall not be support or opposition to unionization.

It is unclear what type of real-world impact this provision will have on hospitals operating in Massachusetts. Many hospitals may be completely unaware of the new restriction as the language is buried within a lengthy section of the act discussing rates paid by governmental units for health care services and is out of context with the remainder of the bill. Read on its face, the provision seems fairly limited. It appears only to prohibit hospitals from seeking reimbursement or payment from the government for monies paid to an individual whose primary responsibility is persuading employees to *oppose* unionization (as it seems unlikely a hospital would pay someone to persuade employees to support unionization). The real question is whether this prohibition will be read more broadly and prevent any hospital that receives government funds from hiring a persuader (commonly referred to as a labor consultant) when faced with a union organizing drive. Such an interpretation could seriously limit how hospitals internally educate, train, and advise members of their management team in response to a unionization effort.

A similar law passed by California in 2000 may offer the best guidance for how the Department of Public Health may interpret this provision. The California law prohibited any entity from using state funds to ''assist, promote, or deter union organizing.'' Businesses around the state immediately protested, arguing the law created an over-burdensome accounting task of separating state-provided funds from other funds in order to counter union organizing attempts. The U.S. Chamber of Commerce challenged the law and ultimately prevailed in the U.S. Supreme Court in 2008.[13] The Supreme Court held the law infringed on an employer's free speech right to oppose unionization. The Massachusetts law, if interpreted to include a similar prohibition, may face the same fate if challenged.

What to Do Now

The act became effective Nov. 5. If they have not done so already, hospital administrators should review their policies and practices, as well as any collective bargaining provisions related to overtime and scheduling to ensure they are in compliance with the act. Specifically, hospitals should adopt procedures to cover patient care needs without requiring nurses to work man-

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[7] N.Y. COMP. CODES R. & REGS. RESTRICTIONS ON CONSECUTIVE HOURS OF WORK FOR NURSES tit. 12, § 177.4 (2011) (http://www.labor.ny.gov/legal/mandatory-nurse-overtime.shtm).

[8] MD. CODE LAB. & EMPL. § 3-421 (2011) (http://law.justia.com/codes/maryland/2010/labor-and-employment/title-3/subtitle-4/3-421/).

[9] 43 PA. CONS. STAT. § 932.6 (2011) (http://www.portal.state.pa.us/portal/server.pt?open=514&objID=614503&mode=2).

[10] R.I. GEN. LAWS § 23-17.20-4 (2011) (http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.20/INDEX.HTM).

[11] N.H. REV. STAT. § 275:67 (2011) (http://law.justia.com/codes/new-hampshire/2010/titlexxiii/chapter275/section275-67/).

[12] N.Y. COMP. CODES R. & REGS. RESTRICTIONS ON CONSECUTIVE HOURS OF WORK FOR NURSES tit. 12, § 177.6 (2011) (http://www.labor.ny.gov/legal/mandatory-nurse-overtime.shtm).

[13] *Chamber of Commerce of the United States v. Brown*, 554 U.S. 60 (2008); *see also* John Kloosterman and Jennifer Mora, *U.S. Supreme Court Overturns California's Limitation on Employer Free Speech Rights to Resist Union Organizing*, Littler ASAP (June 26, 2008), *available at* http://www.littler.com/publication-press/publication/us-supreme-court-overturns-californias-limitation-employer-free-speech.

datory overtime. Examples include utilizing per diem staff or agency nurses, floating nurses from other units, and seeking volunteers. Hospitals should consider whether they must negotiate over any new procedures or over the effect of those procedures on represented nurses, as well as whether and how those procedures might impact existing collective bargaining contracts. Hospitals must train managers about the requirements of the new law and about the need to seek alternatives prior to requiring mandatory overtime and the need to document the circumstances requiring the use of such overtime and the steps taken by them to seek other alternatives prior to requiring overtime. Hospitals also should consider adopting internal mechanisms that facilitate managers' compliance with the requirements and their documentation of compliance. This information ultimately will need to be reported to the Department of Public Health.

As mentioned above, the newly created Health Policy Commission will be issuing a number of regulations in reference to the act's restrictions, including when hospitals still may require mandatory overtime and how hospitals should report its occurrence. As a result, hospitals in Massachusetts should keep an eye out for proposed regulations and consider what involvement, if any, they may want to have in future public hearings on these issues.

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