HUMAN CAPITAL PRACTICE

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LEGAL & COMPLIANCE

MORE GUIDANCE: LOOMING 2011 HEALTH CARE REFORM OBLIGATIONS

Is keeping grandfather status worth it? Since enactment of the Patient Protection and Affordable Care Act (PPACA) many organizations have understandably expressed an interest in preserving grandfather status for their group health plans. However, as the federal agencies (the IRS, DOL and HHS) charged with interpreting the health care reform law continue publishing regulations implementing PPACA rules, the limited value of grandfather status becomes increasingly apparent. This point is underscored again as federal agencies have issued new rules governing pre-existing condition exclusions, lifetime/annual limits and rescission.

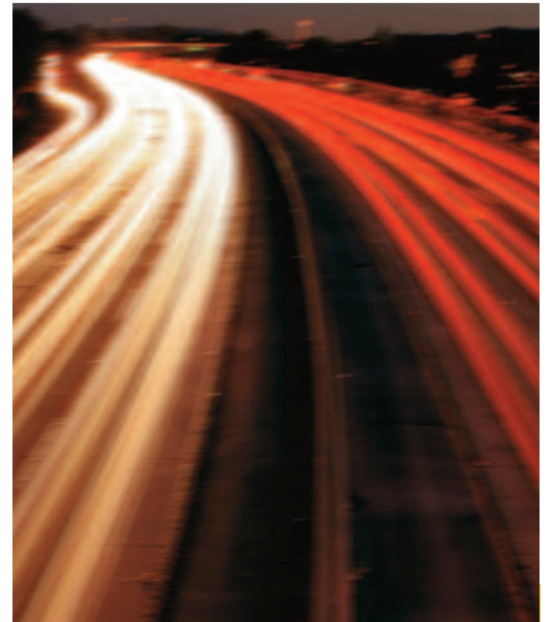
EFFECTIVE DATE

As with the PPACA itself, the regulations are applicable to all plans starting the first plan year that begins after September 23, 2010 (or January 1, 2011 for most plans).

PREEXISTING CONDITION EXCLUSION

The regulations prohibit group health plans from imposing preexisting condition exclusions for ALL participants effective for plan years beginning on or after January 1, 2014. However, starting the first plan year after September 23, 2010 participants under age 19 will enjoy protections under that rule. Specifically, application of preexisting condition exclusions are barred for any participant who has not yet attained age 19.

Of course, HIPAA portability rules already limit application of preexisting condition exclusions by measuring "creditable coverage" and mandating reduction of the exclusion where a significant break in coverage has not occurred. Therefore, it is unlikely that this will have a large financial impact on most plans. Those protective HIPAA rules continue to apply; at least until the PPACA's preexisting condition exclusion requirement is comprehensively implemented in 2014.



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LIFETIME AND ANNUAL LIMIT PROHIBITION

Group health plans are generally prohibited from imposing lifetime and annual limits on the dollar value of essential health benefits. While essential health benefits are no more fully defined in the regulations than the list in PPACA, the regulations do provide that a good faith effort to comply with a reasonable interpretation will be taken into account.

EXCEPTIONS The preamble states that the annual limit does not apply to *health* flexible spending arrangements, medical savings accounts (MSAs) or health savings accounts (HSAs). **Note:** Although the annual limit rule does not directly apply to health FSAs, PPACA imposes a different rule that subjects such accounts to a $2,500 limit beginning in 2013. Also, the PPACA does not affect *dependent care* FSAs (sometimes referred to as DCAPs) in any way.

Health reimbursement arrangements (HRAs) are not subject to the annual limit when they are integrated with other coverage as part of a group health plan that otherwise complies with lifetime and annual dollar limits. Retiree-only HRAs are also not subject to the annual limits. The agencies have requested comments regarding application of the annual limits to "stand-alone" HRAs.

"PHASED-IN" ANNUAL LIMITS

The regulation permits "restricted annual limits" with respect to "essential health benefits" as defined by the statute up to 2014, and a plan may impose annual or lifetime dollar limits on covered benefits that are not essential health benefits.

The phased-in limits are:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012
- $2 million for plan years beginning on or after September 23, 2012, but before September 23, 2014

Plans can also include higher annual limits, or impose no limits.

The minimum annual limits for plan years beginning before 2014 apply on an individual-by-individual basis. This means that any overall annual dollar limit for families may not operate to deny a covered individual the minimum annual benefits for the plan year.

PPACA ESSENTIAL HEALTH BENEFITS LIST

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder treatment (including behavioral health treatment, prescription drugs, rehabilitative services and devices)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services (including oral and vision care)

"LIMITED MEDICAL PLANS" NOT FULLY CLARIFIED

What about "limited medical plans" (often also called "mini-med" programs)? According to the preamble, the restricted annual limits are designed to make certain that individuals have access to needed services with a minimal impact on premiums. To ensure that individuals with limited medical benefits plans are not denied access to needed services or experience more than a minimal impact on premiums, the regulation permits the Secretary of HHS to establish a program under which the requirements related to restricted annual limits may be waived if compliance with the regulations would result in a significant decrease in access to benefits or a significant increase in premiums.

The preamble states that guidance from the HHS Secretary regarding the scope and process for applying for a waiver is expected to be issued in the "near future."

CONCLUSION

The federal government continues publishing PPACA guidance at a feverish pace. Almost uniformly, the guidance is far more restrictive than employer plans have seen in the past, and we expect the overall impact on the plans to be an ongoing issue for years to come. Additional details about these requirements may be found in documents **posted at this link**.

CMS GUIDANCE ADDRESSES HRAS AND MEDICARE SECONDARY PAYER

The Centers for Medicare and Medicaid Services (CMS) recently published employer guidance in the form of an agency alert addressing Medicare Secondary Payer reporting duties in the context of health reimbursement accounts (HRAs). The CMS alert is available by **clicking here**.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

Loosely defined, HRAs are 100% employer-funded accounts (e.g., not a penny of employee money is allowed to be included) established for reimbursement of health care expenses. HRA accounts share obvious similarities with health savings accounts (HSAs) and health flexible savings accounts (health FSAs), but are generally treated as stand-alone self-funded medical plans. For details about these accounts, please see the CDHP chapter of the Willis online *Compliance Manual* by **clicking here**.

CMS ALERT

Although the MSP reporting rules principally target insurers and TPAs, CMS has provided updated information about reporting health reimbursement arrangements (HRAs) in its Medicare Secondary Payer (MSP) Mandatory Reporting User Guide for group health plans.

As noted above, HRAs are generally considered self-funded medical plans. Not surprisingly, the guidance confirms such programs are subject to the MSP rules and therefore required to comply with the mandatory reporting requirements. In the alert, CMS directs Responsible Reporting Entities (RREs) to deliver the federal government key information revealing circumstances in which an employer-sponsored group health plan is primary to Medicare. The alert also builds on earlier guidance defining HRAs for purposes of the MSP reporting rules.

A special rule exempts HRAs with annual benefits less than $1,000 from filing duties. Another clarifies that HRA termination dates are only to be submitted when an individual loses or cancels coverage, as opposed to when a specific annual benefit threshold is reached.

Perhaps most significantly, the guidance notes that RREs must report stand-alone HRA coverage (HRA reimbursement eligibility not linked with other group health plan coverage) for the first time during the fourth quarter of 2010 for HRA effective dates beginning October 1, 2010, and during the first quarter of 2011 for HRA effective dates beginning January 1, 2011.

DOL: MHPAEA "SAFE HARBOR" FOR OUTPATIENT BENEFITS

The Department of Labor (DOL) has released guidance on its **website** (in the form of an FAQ) that will provide some relief to plan sponsors trying to comply with the Mental Health Parity and Addiction Equity Act

(MHPAEA) and the new interim final regulations that were released earlier this year. For detailed information about the interim final regulations for the MHPAEA, please see Willis' **Human Capital Practice *Alert*, Vol. 3, No. 11, "Parity Redefined."**

BACKGROUND

The MHPAEA generally prohibits the application of financial requirements (e.g., copayments and deductibles) or treatment limitations (e.g., annual limits on outpatient visits or hospital days) to mental health/substance use disorder (MH/SD) benefits unless those requirements and limitations are no more restrictive than the predominant ones applying to substantially all medical/surgical (M/S) benefits.

Plans often have different cost-sharing arrangements (e.g., co-payments or co-insurance) based on certain classifications, such as whether care is provided on an inpatient or outpatient basis, or whether care is provided in-network or out-of-network. The interim final regulations allow the benefits included in a benefits package to be divided into six different classifications and for each classification to be considered separately when comparisons are made for measuring parity.

Essentially, the parity regulations preclude group health plans from applying a financial requirement or treatment limitation to MH/SD benefits in a classification that is more restrictive than the "predominant" financial requirement or treatment limitation of that type applied to substantially all M/S benefits in the same classification.

The regulations generally define "substantially all" to mean at least two-thirds of the benefits in a classification. The permitted classifications are:

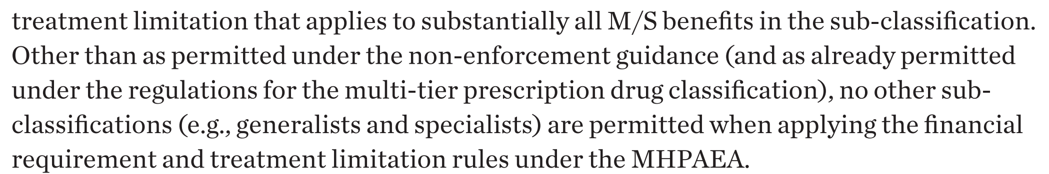
- Inpatient, in-network
- Inpatient, out-of network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

Special rules apply for the parity analysis of the prescription drug classification if different levels of financial requirements apply to different tiers of prescription drugs benefits. If the tiers are based on reasonable factors (e.g., cost, generic versus brand name, mail order versus in-store pickup), without regard to whether the drug is prescribed with respect to M/S conditions or MH/SD conditions, the parity requirements will be satisfied with respect to the financial requirements applied to MH/SD benefits in the prescription drug classification.

NEW FAQ

In a bit of welcome news for plan sponsors, the DOL's newly published FAQ provides that, until final MHPAEA regulations are issued (remember, the regulations released earlier this year are only considered "interim" guidance), the agencies (the DOL, Health and Human Services and the Treasury) will not take enforcement action against a plan that divides its outpatient benefits into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under the MHPAEA: (1) office visits and (2) all other outpatient items and services.

This means that when determining parity, the plan may not impose any financial requirement or treatment limitation on MH/SD benefits in either of the permitted sub-classifications that is more restrictive than the predominant financial requirement or



treatment limitation that applies to substantially all M/S benefits in the sub-classification. Other than as permitted under the non-enforcement guidance (and as already permitted under the regulations for the multi-tier prescription drug classification), no other sub-classifications (e.g., generalists and specialists) are permitted when applying the financial requirement and treatment limitation rules under the MHPAEA.

IMPLICATIONS

For employers already beleaguered by health care reform implementation, this "non-enforcement" action should offer a bit of useful compliance relief as the non-enforcement announcement extends some much needed flexibility in complying with the MHPAEA requirements. The announcement is probably especially meaningful for organizations that used more than one type of financial requirement (e.g., co-payments and co-insurance) for outpatient benefits, given the trouble such employers were having passing the "substantially all" prong of the parity test.

HHS OPENS ERRP APPLICATION PROCESS

The Department of Health and Human Services' (HHS) Office of Consumer Information and Insurance Oversight (OCIIO) recently announced that it is now accepting applications for the Early Retiree Reinsurance Program (ERRP).

BACKGROUND

ERRP was established by the Patient Protection and Affordable Care Act (PPACA) with dedicated funding of $5 billion. Although technical details governing the program exceed the scope of this article, in a nutshell, ERRP provides employment-based plans that offer health benefits to early retirees (including their spouses, surviving spouses and dependents) access to a temporary reimbursement program. Under this program qualifying organizations may receive a tax-free reimbursement for the costs of certain health benefits incurred on behalf of such individuals.

In order to qualify for the ERRP, plan sponsors must submit a completed application to HHS. The $5 billion set aside for the ERRP will likely be exhausted quickly and eligibility will be determined on a "first come, first served" basis. Although HHS issued interim final regulations describing the application process and conditions for participation in the ERRP on May 5, 2010 (for details, see Willis Human Capital Practice ***Alert*: Health Care Reform Bill, Vol. 3, No. 7, "It's a Start: Guidance On The Early Retiree Reinsurance Program"**), the ERRP application has remained pending until now. Once HHS reviews and analyzes the information on a plan sponsor's application, notification will be sent to the plan sponsor about its eligibility to participate in the program. After eligibility has been established, a plan sponsor must submit documentation of actual costs for early-retiree health care benefits in order to receive reimbursement from the ERRP.

UPDATED WEBSITE MATERIALS

Following the OCIIO's announcement, it changed the materials accessible through its webpage to reflect the opening of the ERRP application process. The posted material includes an updated fact sheet, which provides the following information:

Access To Reinsurance: What Employers Need To Do

- Employers with self-funded and insured plans can apply; this includes private companies, state and local governments, nonprofits, religious organizations, unions operating employee benefits plans, and other employers.

- Applications are now available online at **www.hhs.gov/ociio** along with extensive application assistance materials and information on where to send the applications. Applicants are being accepted as of June 29.

- To participate in the program, employers must have their applications officially accepted by the government. Once that acceptance is obtained employers must then satisfy other requirements, including obligations to thoroughly document submitted claims, and implement programs and procedures that have or have the potential to generate cost savings for participants with chronic and high-cost conditions.

- Employers participating in the program will be subject to audits of their health benefits plans to ensure fiscal integrity.

The **application form** now includes information on where to send the applications (which apparently must still be submitted in paper form). The newly posted items include a list of **application "dos and don'ts"** that employers may find helpful. The OCIIO notes in its announcement that additional application assistance, including a webinar, will soon be available.

FEDS PUBLISH MODEL PPACA NOTICES

Along with the Department of Labor's (DOL) Employee Benefits Security Administration (EBSA) posting of regulations for preexisting conditions, annual and lifetime limits, rescissions and patient protections (see related article in this edition of *HR FOCUS*), the federal agencies have also released the following model notices for compliance with the health care reform law's notification requirements.

ADULT CHILD COVERAGE

The health care reform law included a provision requiring employer-sponsored group health plans that provide coverage for employees' children to make that coverage available until age 26, regardless of an adult child's marital or student status. When the three federal agencies responsible for implementing this provision issued interim final regulations interpreting this requirement, they included an open enrollment requirement for certain adult children. (For details of this requirement, see Willis Human Capital Practice ***Alert:*** **Health Care Reform Bill, Vol. 3, No. 8, "Adult Children Health Coverage Extension: Regulations Published."**) Plans that have had limiting ages lower than 26 or have had student status requirements are required to allow an opportunity for employees to enroll their adult children who are under age 26 if they were never eligible, or lost coverage, due to the more restrictive dependent eligibility provision.

The regulations require plans to provide notice of the enrollment opportunity and specify the options that must be made available to those who qualify. The agencies have now released a model notice for this purpose, which is available by **clicking here**.

ELIMINATION OF LIFETIME LIMITS ON COVERAGE

The health care reform law includes a provision requiring employer-sponsored group health plans to eliminate any lifetime limit on the dollar value of all benefits available under a plan. (For additional information on this requirement, see Willis Human Capital Practice ***Alert:*** **Health Care Reform Bill, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011."**)

When the three federal agencies responsible for implementing this provision issued interim final regulations interpreting this requirement, they included an open enrollment requirement for certain individuals. Plans are required to offer enrollment to an individual who previously reached a lifetime limit and who is not enrolled in the plan at all (or who is eligible for a different benefits package than the one in which the individual is currently enrolled). The regulations require plans to provide notice of this enrollment opportunity and also to notify any individual who previously reached the plan's lifetime limit and who is still covered, that the lifetime limit no longer applies, so the individual is once again eligible for benefits under the plan.

The agencies have now released a model notice for this purpose, which is available by **clicking here.**

PATIENT PROTECTION

The health care reform law includes provisions requiring employer-sponsored group health plans to provide certain patient protections. (For additional information on this requirement, see Willis Human Capital Practice ***Alert:*** **Health Care Reform Bill, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011."**) When the three federal agencies responsible for implementing these provisions released interim final regulations regarding them, they included a model disclosure, which is now available by **clicking here**.

GRANDFATHERED PLAN STATUS

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include (in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage) a statement that the plan or coverage believes it is a grandfathered health plan within the meaning of §1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints. (For additional information on grandfathered plans, see Willis Human Capital Practice ***Alert:*** **Health Care Reform Bill, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011."**)

When the three federal agencies responsible for implementing the grandfather provisions released interim final regulations regarding this provision, they included a model disclosure, which is now available by **clicking here**.

SAN FRANCISCO HCSO LEGAL BATTLE ENDS

The United States Supreme Court has rejected the appeal of the Golden Gate Restaurant Association (GGRA) regarding San Francisco's Health Care Security Ordinance (HCSO). This means that the legal challenge against the employer spending requirement is now officially over, and the Ninth Circuit Court of Appeal's ruling, that ERISA does not preempt the employer mandate, stands (at least inside the Ninth Circuit). As such, covered employers must continue to comply with the HCSO and its requirements.

BACKGROUND

In July 2006, San Francisco adopted the HCSO, creating the Healthy San Francisco program, which is intended to help give San Francisco residents access to affordable health care. The HCSO also required that medium and large businesses make certain minimum contributions toward employees' health care. Days before the HCSO's January 1, 2008 effective date, a federal district court held that ERISA preempts the HCSO's minimum employer contribution requirement. However, the Ninth Circuit Court of Appeals subsequently ruled that that the city's ordinance mandating specific employer responsibilities in providing health care coverage was not preempted by ERISA, and San Francisco could enforce the employer contribution requirement. (The case is *Golden Gate Restaurant Association v. City and County of San Francisco*.)

For additional information about the controversial San Francisco Ordinance, please see Willis **EB *Alert* #112 Willis EB *Alert* #125**.

On June 8, 2009 the Golden Gate Restaurant Association (GGRA) filed a petition with the U.S. Supreme Court regarding the legality of the employer spending requirement. In response, the Court asked the Solicitor General (the entity responsible for supervising and conducting government litigation in the U.S. Supreme Court) to file an opinion on the federal government's views on the case. On May 28, 2010, the Solicitor General filed its brief recommending *against* the Court hearing the case. (The brief represents a complete reversal of an earlier recommendation in favor of Supreme Court review during the Bush Administration. The new recommendation justified the reversal by explaining that newly enacted health care reform legislation was a driving force behind this opinion). Given the Solicitor General's new position on this case, it was not surprising that the Supreme Court chose not to hear the appeal.

Although this ruling has little effect on those employers already complying with the HCSO, the Court's decision to not hear the appeal further weakens the ERISA preemption argument. The ruling could therefore be the impetus state and local regulators need to enact similar mandates which would prevent employers that operate in multiple states and municipalities from providing uniform nationwide health care coverage for their employees.

The Ninth Circuit includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington, Guam and the Northern Mariana Islands.

DOL EXTENDS FMLA TO EMPLOYEES WITH NO BIOLOGICAL RELATIONSHIP TO CHILD

The Department of Labor recently issued guidance that clarifies the definition of son or daughter in the Family and Medical Leave Act (FMLA) (DOL Interpretation # 2010-3). The guidance generally enlarges the definition to apply to workers who stand *in loco parentis* (in the place of the parent) with a child. This important distinction effectively expands applicable FMLA protections to now reach individuals who have no biological or legal relationship with the child. For example, this could apply to situations where a grandparent, aunt or uncle might step in to raise the child – even if the child is never actually adopted by the worker.

DOL ANALYSIS

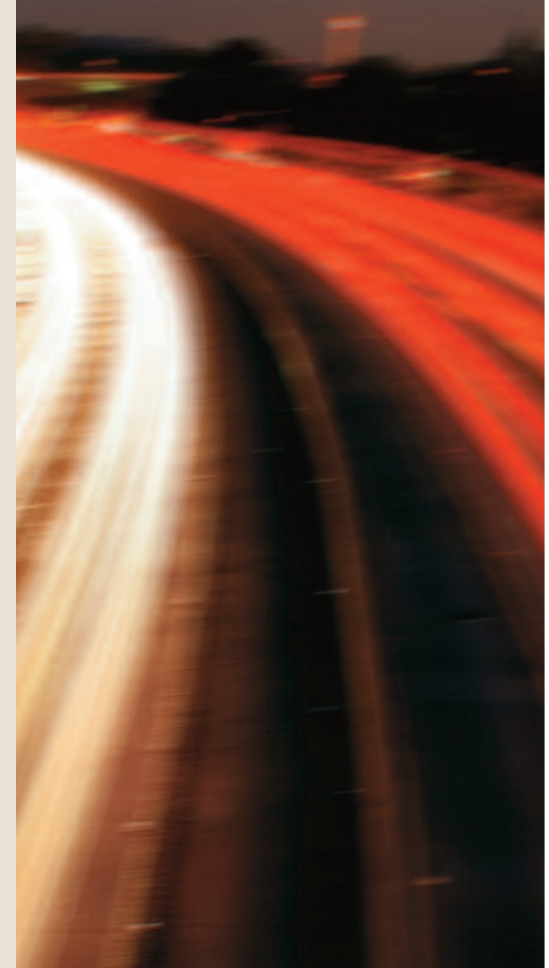
The guidance explains that the DOL believes FMLA law and regulations should be interpreted broadly to apply to situations where the employee, despite lacking a biological (or legal) relationship with the child, maintains "day-to-day care or financial support...where the employee intends to assume the responsibilities of a parent with regard to the child." In other words, an eligible FMLA user could be entitled to protected leave if they provide reasonable documentation demonstrating intent to assume parental responsibilities for the child.

The guidance also acknowledges that local facts and circumstances are still ultimately relevant to evaluating the appropriateness of FMLA. Although this likely means that the employer could insist on reasonable assurances and proper documentation that a genuine *in loco parentis* relationship exists, many employers will probably find it easier to modify leave procedures to accommodate such leave requests and simply deduct time off for eligible workers in accord with FMLA requirements.

The new DOL interpretation is available by **clicking here**.

SINCE YOU ASKED:

RE-ENROLLING AFTER WAIVING HEALTH COVERAGE



An *HR FOCUS* reader recently contacted us with a question we believe may be on the minds of other employers as well. The question concerns rules that control the type of health coverage that must be offered at an annual open enrollment.

Last year one particular organization adopted a company policy that encouraged workers to join their spouses' health insurance plans by offering cash to waive out of the company health plan. (The cash incentive is offered in conjunction with the client's cafeteria plan.) The company recognized that federal law (under HIPAA) specifically mandates that it allow employees to return to their employer plan following a loss of the spouses' coverage. Although the employer understands its HIPAA special enrollment duty, the company asked us whether workers could be denied the opportunity to rejoin the plan at a future open enrollment simply because the person changed his mind concerning coverage.

There is nothing in federal law that prevents a plan from establishing an open enrollment period that excludes participants who have waived coverage because they have spousal coverage. In fact, as long as the HIPAA requirements are satisfied, no federal law precludes an employer from permanently restricting eligibility after initial eligibility is declined, absent a HIPAA special enrollment event, (e.g., in all instances of HIPAA special enrollment [marriage, children, etc.], the plan would have to allow enrollment regardless of its open enrollment policies.)

In order for an employer to adopt the restrictive plan design it wishes to use, it is critically important that any provision for allowing or denying open enrollment must become part of the written plan document, must be accurately communicated to employees in an SPD, and (since this was a self-funded plan) must comply with general nondiscrimination rules regarding highly compensated employees. (**Note**: In the future insured plans may also need to consider these nondiscrimination rules as well since the new health care reform law contains provisions that would extend previously inapplicable discrimination testing rules to insured plans. For details about health care reform duties and compliance strategies, please **click here** to access Willis materials on this topic.

HR CORNER

WORKPLACE FLEXIBILITY ADDRESSES EMPLOYEES' CAREGIVING NEEDS

When employees have problems managing their elder care and/or childcare responsibilities, their stress levels are likely to rise and their effectiveness at work is likely to drop, says Ellen Galinsky, president and co-founder

of the Families and Work Institute. That's why many employers implement programs aimed at addressing employees' caregiving needs.

INCREASED DEMANDS

Even if your employees do not currently provide elder care, they might be doing so in the future. In fact, 19% of surveyed employees—both men and women—provide special care for an elderly relative or in-law, 43% have had that responsibility within the past 5 years, and 51% expect to within the next 5, Galinsky explained in a presentation at the first annual Care Summit sponsored by Care.com this spring.

In addition, "41% of the workforce has children," she says. In a 2008 study, the Families and Work Institute (www.familiesandwork.org) found that 59% of fathers experience work-life conflict (up from 35% in 1977), compared to 45% of mothers (a slight increase from 41%).

"Women have become more prominent in the workforce, and dual earning couples have increased, so there are families [that] often have no one at home to care for children and aging family members as they did in the past," says Galinsky.

PRACTICAL SOLUTIONS

Onsite child care may not be economically feasible for every employer, but there are more affordable ways that employers can support employees' caregiving needs and help them maintain work-life balance. "Time flexibility is what most employees want," says Galinsky.

According to the Families and Work Institute, 79% of employers permit employees to change their starting and quitting times within a certain range of hours; 77% allow some employees to gradually return to work after childbirth and adoption leaves, while 73% let employees take paid time off to attend to important family and personal needs.

There is a compelling business case for offering flexible work options to employees. Galinsky points to higher employee engagement, job satisfaction, and retention, as well as reduced stress and better mental health.
In terms of childcare assistance, 46% of survey respondents provide dependent care assistance plans, and 35% offer childcare resources and referrals.

Also, 75% of surveyed employers give employees time off (paid or unpaid) to provide elder care without jeopardizing their jobs, while 31% provide information about elder care services.

WHAT TO DO

"There is no one-size-fits-all solution" to addressing employees' caregiving needs, Galinsky says. So, before you implement programs to help employees with their caregiving responsibilities, you should identify their needs. "I think you can't really solve the problem until you know what the problem is."

She recommends asking employees about their caregiving needs and listening to their responses. "You can't give them everything that they come up with," but this process will help you identify needs so that you can then determine how these needs relate to your business challenges.

"You have to know what challenges your employees are facing and look for common ground where you can make work 'work' better for your organization and your employees," she states.

This article provided by BLR.

WELLNESS

ERGONOMICS AND WORKSITE WELLNESS = A GOOD FIT

Expanding your worksite wellness program to address ergonomics may seem unnecessary or involve departments beyond your own, but it is a worthwhile consideration. According to the U.S. Occupational Safety & Health Administration (OSHA), ergonomics is the "science of fitting workplace conditions and job demands to the capabilities of the working population." In a broader definition, ergonomics looks at what kind of work is being done, the tools being used and the entire work environment. Incorporating ergonomic principles in the worksite can increase productivity, help avoid the risks of costly illness and injury and increase satisfaction among the workforce. Sound more appealing?

Examples of ergonomic changes to address in the workplace include:

- Adjusting the heights of desk chairs to ensure that employees' feet are comfortably resting flat on the floor
- Positioning computer monitors to avoid eye strain and enable people of various heights to maintain correct posture
- Arranging a computer keyboard to minimize wrist strain
- Training employees on proper lifting techniques to prevent back injuries
- Incorporating core strengthening information and practice into a physical activity program to help prevent back strains
- Sharing ergonomic workstation set-up tips from your Wellness Committee as reminders to current employees and to welcome new employees

NUMBERS DON'T LIE

According to the CDC, workplace musculoskeletal disorders account for:

- One-third of all lost workday injuries
- Nearly 70 million physician office visits in the U.S. annually
- An estimated 130 million total health care encounters (including outpatient, hospital and emergency room visits)

The Institute of Medicine estimates of the economic burden of worksite musculoskeletal disorders, as measured by compensation costs, lost wages and lost productivity, are between $45 and $54 billion annually. A costly issue, and chances are that some of the leading causes of worksite injuries in your organization are the same ones impacting your overall medical costs. But what can be done to foster prevention and education in the workplace? Meet with your risk management team and find out how they are approaching injury prevention and safety.

FAR-REACHING BENEFITS

Some organizations already have a strong safety and injury prevention program due to the nature of the work being done; for example, in a manufacturing or hands-on labor environment. Most jobs in most organizations today require one or more of the following: repetitive use of the hands (e.g., typing or data entry), frequent or heavy lifting, pushing, pulling or carrying of heavy objects. Other departments may already focus on areas of employee safety and injury prevention, and integrating their programs (or creating new campaigns) into your worksite wellness program can be in everyone's interests and could lead to risk reduction and cost savings.

Consider your organization's various departments and locations and how you will handle setting up work stations. Conducting train-the-trainer work groups can provide help beyond a one-time event and allow the trained employees to then continue the ergonomic programs in their own locations or departments. Your Wellness Committee might consider bringing in a fitness or ergonomic professional to conduct stretching refreshers or ergonomic training for employee groups throughout the year. Reach out to your workers' compensation carrier for support in providing training, job safety analyses and other preventative services, which can help workers work safer, smarter and avert injury. (Keep in mind that an employee who learns how to do something the right way, the safe way, will take that knowledge with them out the door and is more likely to be safer at home and everywhere else.) Partner with senior staff and supervisor teams to recognize and reward work groups who are thriving with safety and injury prevention.

Safety and wellbeing go hand in hand. No matter what types of jobs you have in your organization, incorporating ergonomics into your overall worksite wellness program can only enhance the value of each and will also help employees connect health and safety in the workplace with your interest in their health and safety at home as well. To learn more, contact your Willis Client Advocate®.

WEBCASTS

THE SELF-FUNDED VS. FULLY-INSURED PROPOSITION – WHAT IS BEST FOR YOUR MEDICAL PLAN

August 17, 2010
2:00 PM EASTERN TIME

Presented by Roland Birkner, National Underwriting Practice Leader

Fully-insured? Partially self-funded? Minimum premium? What is the best funding arrangement for your medical plan? Which type of funding arrangement would give your plan the best opportunity to succeed both financially as well as with employee satisfaction? Which are more important to your company and your plan:

- Premium stability?
- Ability for financial gains in good claim years?
- Choice of networks and vendors?
- Unbundling?
- Plan design flexibility?

In this session we will discuss the advantages and disadvantages of self-funded and fully-insured medical programs. We will explain self-funding concepts, including stop-loss protection. We will discuss the differences between funding arrangements relative to plan design, financial forecasting and renewal calculation, administrative efforts and fiduciary responsibility. We will also talk about the merits of bundling or un-bundling the components of a self-insured program (claim administration, prescription drug plan, stop loss, utilization review, disease management and wellness). At the end of the session, you should have an understanding of whether or not self-funding is appropriate for your plan.

PARTICIPANT ACCESS

Advance reservations are required to participate. **Click here** to RSVP for this call.

FMLA ADMINISTRATION AND UPDATES

SEPTEMBER 21, 2010
2:00 PM EASTERN TIME

Presented by Cheryl Rhodes, SPHR, MBA, HR Partner, Senior Consultant

Workers are becoming increasingly aware of FMLA protections and, as a result, are enforcing their rights through the courts. As a matter of fact, FMLA disputes are among the top five issues that land companies in the courtroom.

Understanding all of the intricacies of the Family Medical Leave Act can be a daunting task, especially with the new regulations released by the Department of Labor that took effect last year. Whether you are new to HR or are an experienced professional, this webcast is designed to provide the latest information on FMLA compliance.

During this webcast we will explore:

- The latest developments in FMLA
- Practical knowledge to ensure your policies and procedures are in compliance
- The proper usage of FMLA and documenting absences

PARTICIPANT ACCESS

Advance reservations are required to participate. **Click here** to RSVP for this call.

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