

HR CORNER

FMLA - THE HEADACHE THAT WON'T GO AWAY

The Family and Medical Leave Act (FMLA) affects employees on a personal level more than any other regulation or rule. And yet, after almost two decades since its enactment, it continues to confound attorneys and human resource professionals alike.

In today's workplace, human capital drives business success. However, as more and more employees are using FMLA than ever before, it is important for companies to ensure that they are compliant with their FMLA administration practices to avoid serious legal and financial implications. Research by the Employment Policy Foundation indicated that compliance with FMLA costs employers in excess of \$21 billion in terms of lost productivity, continued health benefits and labor replacement. Furthermore, according to the Department of Labor Wage & Hour Statistics, more than \$1.54 million of back wages were paid as a result of FMLA violations in 2009.

We have seen five recurring themes, across organizations, which contribute to leave administration problems and could give occasion for compliance issues.

- Lack of detailed policies which leads to inconsistent practices
- Challenges with administering intermittent leave
- Lack of proper tracking systems
- General lack of knowledge regarding FMLA dos and don'ts by managers and/or HR professionals
- When to terminate employees after FMLA is exhausted

POLICY VS. PRACTICES

With the growing use of FMLA by employees and the emergence of state-specific FMLA regulations, ensuring compliance can be challenging. Therefore, it is extremely important for companies to have detailed policies which clearly outline company and employee requirements pertaining to FMLA and applicable state-specific leaves. It is also critical for actual practices to match company policy and for leave to be administered consistently throughout the organization.

To ensure compliance, the following core elements should be addressed in your company's FMLA policy:



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- Leave entitlement and eligibility
- Reasons for leave
- Amount of leave allowed
- Clear statement regarding how the company defines its 12-month period (best practice is to use the rolling backward method); without this statement, the courts will apply the most liberal interpretation, which would be the calendar year method
- Employee notification/application for leave (best practice is to require leave to be requested in writing)
- Notice from the company
- Certification requirements (including the right to first and second opinions and recertifications)
- Same employer limitations
- Intermittent or reduced schedule leave (including scheduling of leave, transfer or reassignment, and whether the employee can take intermittent leave for baby-bonding)
- Substitution of paid leave (whether required or allowed), as well as how holidays are handled
- Coordination with other leaves (inclusive of vacation, sick, PTO, STD, WC, state leaves, etc.)
- Treatment of benefits while on leave
- Employee reporting requirements while on leave
- Return to work, including fitness for duty and right to reinstatement
- Administrative separation clause

In addition to the items listed above, some of the optional provisions to include in your FMLA policies from a best practice standpoint include discussions around variable work schedules, a provision that prohibits employees from working for another employer while on FMLA leave and exemption for highly compensated executives. It is also important to incorporate into your policies and/or practices any state-specific leave requirements that would impact your workforce, ensuring that your policy provides for state and federal leave laws to run concurrently, where applicable.

INTERMITTENT LEAVE

Intermittent leave under FMLA is usually the top contributor to HR's headaches. This is due to the fact that when employees are on intermittent or reduced schedule leave, only the amount of leave actually taken can be counted towards the 12 weeks of leave. As such, it is important that you have sound tracking systems in place to properly account for intermittent leave, as intermittent FMLA leave must be accounted for in increments no greater than one hour or the smallest increment allowed by the employee's payroll system.

NOTE: Exempt employees who are taking leave on an intermittent or reduced-schedule basis can be treated like hourly employees during an approved FMLA leave of absence without impacting their FLSA exemption status. Companies should exercise their rights to deduct hours not worked by exempt employees during FMLA leave.

LACK OF PROPER TRACKING SYSTEMS

To ensure that FMLA is being properly accounted for, organizations must decide whether they have adequate internal systems and resources to track FMLA or whether FMLA should be outsourced to a third-party vendor. FMLA is not something you want to track haphazardly. According to Careworks USA, recent studies have shown that it can take four to six hours to process an initial FMLA claim request, exclusive of claim follow-up or recertification.

One of the top contributing factors to non-compliance with FMLA is the failure of front-line managers to respond to FMLA requests properly. This is usually due to a lack of understanding of the requirements of the law in general and/or company policy and why their role is important. With rising EEOC claims, as well as increased violations for FMLA non-compliance, it is critical for organizations to invest the adequate resources in the proper training of front-line managers to respond to FMLA requests.

With increased employee knowledge and usage of FMLA and ever changing regulations, more and more firms are exploring outsourcing the administration of all leaves to organizations that specialize in complete absence management. Outsourcing not only alleviates the administrative burden and strain on internal resources, but also helps ensure compliance and eliminates possible discrimination in your leave practices.

TRAINING

One of the top contributing factors to non-compliance with FMLA is the failure of front-line managers to respond to FMLA requests properly. This is usually due to a lack of understanding of the requirements of the law in general and/or company policy and why their role is important. With rising EEOC claims, as well as increased violations for FMLA non-compliance, it is critical for organizations to invest the adequate resources in the proper training of front-line managers to respond to FMLA requests.

As the first point of contact for employees, the front-line managers can make or break an organization when it comes to FMLA compliance and consistency in application, because notice to the manager is deemed notice to the company. When managers fail to act on the notification by the employee, it opens the door for legal exposure. Legal exposure for non-compliance does not stop at the company level. Any employee – top management, HR, front-line managers – who is involved in the FMLA process can be held personally liable for FMLA violations.

TERMINATION

We often receive the question, “When can I terminate an employee who has exhausted FMLA?” Simple question, right? Well, the answer depends on several factors, including your company’s internal policies/practices, any additional protections provided by state leave laws, whether ADA will play a role and past precedent.

Within your FMLA policy, it is important to clearly outline when the company would terminate an employee who failed to or could not return from FMLA leave, taking into consideration any state leave requirements as well as allowing for reasonable accommodations in accordance with ADA requirements. Next, you must consider any company-specific personal leave of absence policies which grant leave time for employees who are ineligible for FMLA (inclusive of those who have exhausted FMLA leave). Lastly, you will need to consider past precedent in order to ensure consistency and not open doors for discrimination.

As a best practice, companies should terminate employees as soon as FMLA (and any state-specific leave) is exhausted, unless a reasonable accommodation must be made. According to our research, the maximum duration that most companies allowed

employees to remain employed after FMLA was exhausted was three months.

You can see, just in the five areas we have highlighted, that a web of complexities surround the administering of family and medical leaves. Is it any wonder that managers, HR professionals, attorneys and the courts alike continue to struggle with interpreting and ensuring compliance with FMLA?

HOW TO MANAGE INTERMITTENT LEAVE

Jeffrey Wortman, a partner at the Los Angeles law firm of Seyfarth Shaw, emphasizes that an employer’s approach to FMLA should be a positive one. Don’t approach it as “This is an incredible pain (although it may be) and I know you’re trying to game the system (although the employee may be). Go at it from the positive end,” Wortman says. “This is a great law. We value our employees and we want to comply with what the law requires. At the same time, we need our employees to comply with what the law requires of them.” Then you ask for the certification forms, he says.

CERTS ARE YOUR BEST TOOL

Certification forms are your best tool for managing intermittent leave, Wortman says. You have the right to request certification, and doing so helps you to gain some control over the situation most of the time. Of course, Wortman says, not all the time, because “you never know what doctors will certify.”

The cert forms establish some responsibility on the employee’s part, and they also help with morale, he says. Fellow workers want to know that they won’t be overburdened by having to do the work of an employee who is gaming the system.

A few things to remember about intermittent leave:

- **EMPLOYEES MUST ASK** Employees must ask for intermittent leave (as opposed to block of time leave).
- **MUST BE MEDICALLY NECESSARY** The medical certification must establish that intermittent leave is medically necessary.
- **CAN'T REQUIRE PROOF OF TREATMENT** You can't require that employees prove they had the medical treatment unless your request is for other reasons like sick pay.
- **ABSENCE PROTOCOL** Establish an absence protocol for managers' use so they have something to rely on in dealing with employees requesting leave.
- **RECERT FOR PATTERN ABSENCES** Request a recertification when you find pattern absences (e.g., every Friday and Monday). Send absence information to the health care provider. Ask, is this the pattern of absences you would expect? (Don't jump to conclusions about pattern absences, though. Maybe the person gets chemo on Friday and needs the weekend to recover.)

CALCULATING INTERMITTENT LEAVE

What's an Hour? The first step in dealing with reduced and intermittent leave under the FMLA is to calculate how many "hours" of leave an employee is entitled to. This calculation is based on an employee's regular workweek. For example, an employee who regularly works a 5-day week and 8 hours a day, is entitled to 480 hours of leave: (5 days x 12 weeks) x 8 hours. Similarly, an employee who works a 3-day week and 8 hours each day is entitled to 288 hours of leave: (3 days x 8 hours x 12 weeks).

Establishing the number of hours worked each week for exempt employees may be difficult where the employer does not maintain such records, especially since it is not unusual for exempt employees to work more than 40 hours each week.

In these cases the burden of proof is on the employer to disprove the employee's record of the number of hours worked by the employee. Employers may wish to obtain a statement from exempt employees before an intermittent or

reduced leave, setting forth their regular workweek and hours for the preceding 12 weeks.

Variable Schedules. If an employee's schedule varies from week to week to such an extent that an employer is unable to determine with any certainty how many hours the employee would otherwise have worked (but for the taking of FMLA leave), a weekly average of the hours scheduled over the 12 weeks prior to the beginning of the leave period (including any hours for which the employee took leave of any type) would normally be used for calculating the employee's leave entitlement.

SPECIAL ISSUES: INTERMITTENT LEAVE

Face the fact that employees on intermittent leave often do not ever reach 12 weeks in 12 months because they are using such small amounts of leave, Wortman says.

An employee requesting intermittent leave must confer with the employer so as to not disrupt the employer's operations.

The employer may assign an employee to an alternative position with equivalent pay and benefits so as to better accommodate the intermittent leave.

FINAL TIPS

Wortman says that if nothing else, employers should be sure that they are:

- Requiring employees to use paid leave concurrently with FMLA leave. (Otherwise, employees may be able to take 12 weeks of FMLA, then vacation, then sick leave or PTO.)
- Calculating FMLA leave on a rolling 12-month basis. This insures that employees cannot take back-to-back leaves (12 weeks at the end of one year and then 12 weeks at the beginning of the next year) as they can under a calendar year system.

This article provided by BLR.

LEGAL & COMPLIANCE

HEALTH CARE REFORM'S 1099 REPORTING AND FREE CHOICE VOUCHER REQUIREMENTS REPEALED

Congress has enacted legislation that repeals two mandates under the health care reform law: the expanded Form 1099 information reporting requirements and free choice vouchers. Although neither mandate was currently in effect, given the administrative and financial burden these requirements would have imposed, their repeal is welcome news to businesses.

FORM 1099 REPORTING

On April 14, 2011, President Obama signed H.R. 4, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011. This legislation repeals the expanded Form 1099 information reporting requirements mandated under the Patient Protection and Affordable Care Act (PPACA). It also repeals a 1099 reporting requirement imposed on taxpayers who receive rental income.

Congress had included an expansion of the 1099 reporting obligation in PPACA as a means of raising revenue to pay for health care reform. As enacted, the provision would have required all businesses that make payments in excess of \$600 for goods and services to “persons engaged in a trade or business” to report those amounts on Forms 1099. Prior to the enactment of PPACA, purchases made from corporate vendors were excluded from the reporting requirements. Concerned that some corporations were evading their tax liabilities, Congress expanded the 1099 reporting obligation in order to capture that “lost” tax revenue. The reporting requirement would have been applicable to any payments made after December 31, 2011.

According to the **Joint Committee on Taxation**, repealing the expanded 1099 information reporting requirements reduces tax revenue by approximately \$24.7 billion over 10 years. To make up for that loss, the legislation increases the amounts that must be repaid on advance premium assistance tax credits for health insurance.

FREE CHOICE VOUCHERS

On April 15, 2011, President Obama signed the fiscal year 2011 budget bill that allows the government to continue operating through September 30, 2011. H.R. 1473, the Department of Defense and Full-Year Continuing Appropriations Act, 2011, trims \$38 billion from the federal budget. Of importance to employers, however, is a provision in the legislation, Section 1858, that repeals PPACA’s free choice voucher provisions.

PPACA would have required employers, beginning January 1, 2014, to provide vouchers for certain employees whose employer-provided health insurance premiums exceeded certain cost thresholds. Specifically, employers that offer coverage to employees and contribute to the cost of coverage would have been required to offer “free choice vouchers” to employees with household incomes below 400% of the federal poverty level (for a family of the size involved) whose required contribution under the employer’s plan was between 8 and 9.5% of their household income. The amount of the free choice voucher would have been equal to the employer’s cost of providing health insurance coverage to eligible employees under the plan for which the employer pays the largest portion of an employee’s premium. The vouchers could then have been used to purchase coverage in the state exchanges.



COURT RULES ON INCENTIVES FOR COMPLETING HEALTH QUESTIONNAIRES

The U.S. District Court for the Southern District of Florida recently ruled in favor of the employer in a case regarding wellness program surcharges (*Seff v. Broward County*). The court considered whether an employer violated the Americans with Disabilities Act (ADA) by charging a \$20 bi-weekly surcharge to health plan participants who failed to complete a biometric screening and health risk questionnaire. The participants who brought the lawsuit claimed that the arrangement violated the ADA prohibition against medical examinations and disability-related inquiries.

The court ruled that there was no ADA violation.

THE EMPLOYER'S WELLNESS PROGRAM

Many employers have wellness programs that are very similar to the wellness program that was challenged in this case. Individuals enrolling in the employer's health plan were asked to complete a health risk questionnaire and undergo a biometric screening. Those individuals who did not comply with the request were required to pay an additional amount for their health plan coverage (\$20 every two weeks). As with most wellness programs, the information collected under this wellness program went to a third party and the employer received only de-identified aggregate data. Unlike many employers' wellness programs, the insurer providing coverage under the plan arranged for and provided the wellness program as part of the coverage it provided.

NO ADA VIOLATION

The court concluded that the employer had not violated the ADA by maintaining its wellness program. The court relied on an exception to the ADA's prohibitions that allows "establishing, sponsoring, observing or administering the terms of a bona fide benefits plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law" and are not used as a subterfuge to evade the purposes of the ADA.

Typically, this safe harbor provision has been construed as allowing collection of health information for underwriting (e.g., when a life insurance plan requires evidence of insurability to increase a coverage amount or a health insurer requires health statements from all participants in order to determine whether it will issue a group policy). It generally was not thought that this provision would apply to medical examinations or disability-related inquiries for purposes other than determining eligibility and premiums. The court read this provision much more broadly, however, ultimately finding that the wellness program was part of a bona fide benefits plan and that the employer was engaged in administering its terms based on underwriting, classifying or administering risks that are based on or not inconsistent with state law.

The court first found that the wellness program was a term of the employer's group health plan, noting that:

- The insurer paid for and administered the program under the terms of its insurance contract with the employer
- Only health plan participants were eligible for the wellness program
- Materials describing the benefits plans included references to the wellness program

The court then determined that the wellness program was a term based on underwriting, classifying or administering risks “because it is designed to develop and administer present and future benefits plans using accepted principles of risk assessment.” The court was persuaded that the employer would use de-identified aggregate information it received from the wellness program to design benefits plans that address the risks reflected in that information. “Though [the employer] is not underwriting or classifying risks on an individual basis, it is underwriting and classifying risks on a macroscopic level so it may form economically sound benefits plans for the future.”

Near the end of its opinion, the court noted that the other conditions for the safe harbor to apply were met: “Plaintiff can point to no Florida law that is inconsistent with the program, nor does the complaint allege any sort of subterfuge to evade the purpose of the Act.”

COURT’S ANALYSIS AVOIDS DIFFICULT QUESTIONS

By finding that the safe harbor could apply to a wellness program, the court avoided the typical analysis of wellness programs under the ADA. That analysis assumes that the safe harbor used by the court does not apply, focusing instead on the voluntary wellness program exception to the ADA prohibition of disability-related inquiries and medical examinations. The voluntary wellness program analysis is problematic because EEOC guidance states that a program is not voluntary if employees who choose not to participate are penalized. The EEOC has not further defined what constitutes penalizing nonparticipants, leaving open the possibility that applying any incentive will make the program involuntary. The court did not comment on the voluntary wellness program analysis other than to say that “the Court need not address [whether] the wellness program is permissible under the Act as a voluntary wellness program.”

CONCLUSION

The result in this case is welcome, but it remains to be seen whether other courts are persuaded by the reasoning of the decision. The court’s analysis in this case is particularly attractive for employers because it removes the ADA as a concern when implementing a wellness program as part of a health plan. By the court’s reasoning, the ADA does not prohibit even the types of programs that the EEOC has condemned in informal statements (e.g., a program that excludes anyone who does not complete a health risk questionnaire), so long as they are part of a health plan. Additional information on wellness programs and the ADA can be found in Chapter 9 of the Compliance Manual and in Willis’ Human Capital Practice *Alert*, No. 80, “**Wellness Plans: HIPAA, the ADA and the EEOC.**”

DFVC PROGRAM CHANGES MAILING ADDRESS

The Department of Labor’s Employee Benefits Security Administration has changed the mailing address for the Delinquent Filer Voluntary Compliance (DFVC) Program for the payment of penalties for delinquent Forms 5500. Effective March 29, 2011, the address for the DFVC Program lockbox changed to: DFVC DOL, PO Box 71361, Philadelphia, PA 19176-1361. There is no longer an overnight delivery address.

Note that penalty submissions to the DFVC Program also can be done electronically. To do so, follow the DFVC Program penalty calculator instructions for online payment. You may access the calculator by [clicking here](#).

The court concluded that the employer had not violated the ADA by maintaining its wellness program. The court relied on an exception to the ADA’s prohibitions that allows “establishing, sponsoring, observing or administering the terms of a bona fide benefits plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law” and are not used as a subterfuge to evade the purposes of the ADA.



Filing overdue 5500s using the DFVC Program is a two-part process. Plan administrators must both file their delinquent 5500s online through the EFAST2 system and also apply for the DFVC Program and pay the required penalties. The penalty payment can be made either by mailing check(s) and copies of the 5500s to the address noted above or by using the online penalty calculator to pay by electronic transfer from a bank account or by credit card.

The following link will access the DOL's Frequently Asked Questions about the DFVC program:

http://www.dol.gov/ebsa/FAQs/faq_DFVC.html.

HHS MODIFIES NATIONAL MEDICAL SUPPORT NOTICE

The Department of Health and Human Services' (HHS) Office of Child Support Enforcement recently released an updated version of Part A of the National Medical Support Notice (NMSN). An NMSN is a standardized medical child support order used by state child support enforcement agencies to obtain group health coverage for children.

NMSNs consist of a Part A and a Part B. Part A is sent to employers to complete and the employer sends Part B to the plan administrator to complete. HHS made several changes to Part A of the notice but many are minor in nature. The HHS Action Transmittal (AT-11-03) sent to state agencies administering child support enforcement plans provides detailed information about the revisions. A copy of the Action Transmittal can be found [here](#). While no changes were made to Part B at this time, HHS has indicated that the Department of Labor is expected to update Part B shortly.

As state agencies will need time to make programming changes in order to begin using the updated form, HHS asks that the prior version be honored until the new one can be implemented. Qualified medical child support orders (QMCSO) are legal orders by which health care coverage is secured for children. The Employee Retirement Income Security Act (ERISA) requires group health plans to provide benefits in accordance with the applicable

requirements of a QMCSO. A properly completed NMSN is deemed to be a QMCSO. For additional information about NMSNs and QMCSOs, please see Chapter 7 of the *Willis Online Compliance Manual*.

OPT-OUT ELECTION MATERIALS FOR SELF-FUNDED, NON-FEDERAL GOVERNMENTAL PLANS POSTED

The Department of Health and Human Services (HHS) has posted new materials that self-funded, non-federal governmental plans may use to opt out of certain federal mandates. These new materials reflect the changes made to the opt-out provisions by the health care reform law. Those changes are explained in Willis' *HR Focus*, Issue 41, **“HHS Announces Changes to Opt-Out Election for Self-Funded Nonfederal Governmental Plans.”** The following is a brief summary:

- The opt-out is no longer available for many federal provisions that it used to cover, most notably, the Health Insurance Portability and Accountability Act (HIPAA) portability (rules limiting preexisting condition exclusions, requiring special enrollment opportunities, and prohibiting discrimination based on health factors).

- The opt-out remains available with respect to four federal mandates: Newborns’ and Mothers’ Health Protection Act, Mental Health Parity and Addiction Equity Act, Women’s Health and Cancer Rights Act, and Michelle’s Law. It is worth noting that the opt-out has never been available with respect to the Genetic Information Nondiscrimination Act, HIPAA’s privacy and security provisions, or the health care reform law (e.g., prohibition of lifetime maximums and no cost-sharing for certain preventive care).
- While the change generally is effective for plan years beginning on or after September 23, 2010, some transition rules apply for collectively bargained plans that previously opted out and an HHS non-enforcement policy applies to plan years that began before April 1, 2011. The effective date, transition rules and non-enforcement policy are not affected by a plan’s grandfathered status.

HHS has posted an **explanation of these changes** along with the new forms, as well as **procedures and requirements** for making the election. These materials include reminders that the opt-out generally is available for plan years for which the required election has been filed and the required notice provided to plan enrollees. That is, most plans must file annually for the opt-out to remain available. The procedures and requirements also provide links to the **model election form** and a **model notice to enrollees**. Although the materials no longer relate to HIPAA provisions, the materials continue to refer to the opt-out as the “HIPAA Exemption Election.”

SINCE YOU ASKED:

WHO IS ELIGIBLE FOR TAX-FREE HSA REIMBURSEMENTS?

The National Legal & Research Group (NLRG) is frequently asked questions about who is eligible to receive tax-free reimbursements from a Health Savings Account (HSA). The questions usually originate from an employee whose spouse and/or dependent(s) are not covered by a high deductible health plan (HDHP) and/or receive health coverage from another source (e.g., Medicare). In analyzing this question, it is important to remember that the requirements for a tax-free distribution from an HSA are different than the requirements for a tax-free contribution.

In order to make a tax-deductible *contribution* to an HSA, an individual must be an “eligible individual.” A person is an eligible individual, with respect to any month, if the person is:

- Covered by a plan that qualifies as a HDHP
- Not covered at the same time by any other plan which is not an HDHP, but which covers the same benefits as the HDHP (other health plans include general purpose health Flexible Spending Accounts)
- Not claimed as a dependent on another person’s tax return (a spouse is not considered to be a tax dependent under either Internal Revenue Code (IRC) §151 or §152, even though a taxpayer may claim an exemption for the spouse)
- Not enrolled (not just eligible, but actually enrolled) in Medicare Part A or B (eligible employees age 65 or over may contribute to



an HSA, including the catch-up contribution, as long as they are not enrolled in Medicare)

The ability to make tax-free distributions, however, is not limited to individuals covered by a HDHP. Distributions from an HSA are excluded from the account holder’s gross income to the extent that they offset otherwise unreimbursed qualified medical expenses (incurred after the HSA is established). A qualified medical expense generally is an expenditure for medical care, as defined in IRC §213(d), for the account holder and his or her spouse or tax dependents, to the extent that such amounts are not reimbursed by insurance or otherwise.

Even if the employee, spouse or tax dependent is covered by a medical plan that is not an HDHP, distributions from the HSA may still be used to pay for his/her qualified medical expenses. Coverage under another health plan may impact the ability to make a tax-deductible HSA contribution, but it does not affect the reimbursement of expenses except to the extent that the reimbursement would result in double-dipping (which is not permitted). The HSA may not reimburse expenses covered by the other plan, but it may reimburse, for example, co-payments and deductibles not paid from another source.

As noted, an HSA may be used to pay for qualified medical expenses of an account holder's tax dependent. IRC §105 and §106 were amended by the Patient Protection and Affordable Care Act (PPACA) to allow medical care and medical reimbursement provided to an "adult child" to be excludable from the employee's gross income. An adult child is defined as an employee's child who has not attained the age of 27 by the end of a tax year (December 31). An HSA, however, is governed by IRC §223. When an individual is seeking tax-free reimbursement from an HSA, §223 only permits the reimbursement of qualified medical expenses for spouses and tax dependents. A tax dependent is a "qualifying child" or a "qualifying relative" under IRC §152. PPACA did not amend the tax code to allow tax-free reimbursements for an

"adult child" from an HSA (although this was probably an oversight by the legislative bodies, it is how the law is written and subsequently now regulated.) As such, an employee may be able to have an "adult child" covered under an employer-sponsored, HSA-qualified HDHP, but qualified medical expenses for that same adult child may not be necessarily reimbursable from the HSA (on a tax-preferred basis) if the child does not also meet the §152 definition of a qualifying child or a qualifying relative.

For additional information about the changes PPACA made to the IRC regarding adult child coverage, please see Willis Human Capital Practice Alert, Vol. 3, No. 6, "**IRS Guidance Regarding Tax-Free Health Coverage for Adult Children.**" Information about HSAs can be found in Chapter 12 of the *Willis Online Compliance Manual*.

WELLNESS

NO TIME, NO MONEY: NO PROBLEM

CREATIVE SOLUTIONS FOR COMMON CHALLENGES WITH WORKSITE WELLNESS PROGRAMS

Starting a worksite wellness program often gets postponed or grounded altogether due to potential barriers perceived to be insurmountable by those in charge of the project. The good news is that, while many organizations do have certain nuances to their employee population, in general there are commonalities to these barriers that have been identified and successfully overcome to provide robust and effective wellness programs of benefit to employees and employer.

In recent months, financial difficulties have been a key issue for many organizations and continue to be exacerbated by the sluggish economy. Based on findings from the Willis 2010 Annual Health and Productivity Survey, 60% of respondents cited budget constraints as the primary barrier to implementing a worksite wellness program. Many other surveys have stated similar findings. Another key issue commonly reported is the lack of manpower or human resources available to help plan, implement and evaluate programs. While adequate resources – financial and human – are important components of successful programs, they are not the sole determinants.

We know based on Best Practice standards that there are multiple variables that determine success with worksite wellness programs. Strong and visible leadership backing for the program, a supportive environment, interesting and multiple communication channels and meaningful incentives are all critical elements as well.

There are many thriving wellness programs that were started with a "grassroots" effort, piecing together free resources as time allowed and, with persistence, grew over time.



The trick is to identify creative solutions that clearly demonstrate to program planners that, despite barriers, a worksite wellness program is still possible.

Solutions include:

- **TAP INTO YOUR EMPLOYEES** Organizations often employ a diverse workforce and find that many of their own employees are knowledgeable and have a personal interest in health and wellness. Survey your employees to determine if you have peer leaders to help plan or deliver the program.
- **COMPELLING COMMUNICATIONS** Communicating the program in a fun and compelling manner can have a great impact. Consider including a creative element as well as multiple avenues of delivery to keep things interesting. Get your leaders involved, at the very least, with the communication efforts.
- **CREATIVE INCENTIVES** Get creative about providing different types of incentives that are meaningful and will encourage employee engagement. Recognition and special privileges can go a long way and typically cost nothing.
- **SEEK PARTNERSHIPS** Check into the feasibility of partnering with community resources, such as hospitals, teaching institutions or universities, fitness centers, and healthy restaurants or grocers. Often partnerships can benefit both parties – those needing services and those seeking increased exposure.
- **LOOK FOR LOW COST/NO COST RESOURCES** Contact local chapters of organizations that promote health, such as the American Heart Association, American Cancer Society and American Diabetes Association, to explore the wealth of information, tools and resources that are available and consumer-ready.
- **DESIGN A HEALTHY WORK ENVIRONMENT** Look around the physical work environment to identify areas to promote health. Stairwells and break rooms are often a good place to start.

To learn more about the array of Willis value-added wellness solutions or more creative ideas for tackling worksite wellness challenges, contact your local Willis Associate.



WEBCASTS

FMLA GETTING BACK TO THE BASICS

JUNE 21, 2011
2:00 PM EASTERN TIME

Presented by:
CHERYL RHODES
HR PARTNER SENIOR CONSULTANT

FMLA affects your employees on a personal level more than any other regulation, act or rule. Is there any wonder that FMLA disputes are among the top 5 issues that land companies in the courtroom? More than a dozen years since its enactment, the FMLA continues to confound attorneys and human resource professionals alike. Practitioners know that the relatively straightforward requirements of FMLA are not as simple as they appear and mistakes can cost organizations a lot of money. While some practitioners opt to stick their heads in the sand and hope for the best, others endure sleepless nights and worry constantly because they know the stakes are extremely high and the opportunities for error practically endless.

Please join us for an informative webcast in which we will be “Getting Back to the Basics” with a general discussion around the most frequently asked questions on this topic.

Clients who RSVP by May 20 will have the opportunity to submit a general FMLA question for inclusion in the webcast. **Click here to email** a question.

PARTICIPANT ACCESS

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

HEALTH CARE REFORM: WHAT NOW AND WHAT'S COMING?

JULY 19, 2011
2:00 PM EASTERN TIME

Presented by:
JACK TOWARNICKY, JD, MBA, BBA, CEBS FELLOW
EMPLOYEE BENEFITS ATTORNEY
NATIONAL LEGAL AND RESEARCH GROUP

Please join the Willis Human Capital Practice for a review of 2011 legislative and regulatory changes as well as an examination of the pending changes through 2014.

We will start with a review of the Patient Protection and Affordable Care Act (PPACA) timeline – 2011 through 2014 – with updates on recent legislation and regulatory actions that removed certain provisions or delayed implementation of various features.

This webcast will also focus on opportunities where you may want to consider communications that go beyond simple reporting and disclosure when it comes to compliance with the W-2 informational mandate and the Uniform Explanation of Coverage mandate – options that may highlight the superior coverage value you may already offer your employees.

The presentation will end with an overview of distant but looming issues to consider in any health coverage strategy update, providing a heads-up for your CFO on the potential for new costs and challenges from the next wave of health reform:

- Massachusetts Health Reform as a precursor
- Higher cost from higher enrollment – migration due to the pay or play mandates, taxpayer-subsidized state-based exchanges and automatic enrollment
- Higher cost from new rounds of cost-shifting, provider response to increased Medicaid and exchange enrollment, new Medicare limits and/or new PPACA taxes
- Why delay may not be an effective strategy – the potential “death spiral” from the 2018 excise tax

PARTICIPANT ACCESS

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

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