EMPLOYEE BENEFITS

Willis HRH

HRFocus

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WELLNESS WORKS

GOOD HEALTH IS GOOD BUSINESS

Imagine you are an employer who has just learned that one in every five of your staff will develop sight impairments while working for you, but you don't know when it will happen or to whom. What do you do? Chances are you would investigate multiple options, including screening tests for early identification, treatment options and workplace accommodations that would make it possible for that employee to remain a fully contributing member of your team. Such steps would benefit your staff and the organization as a whole.

What if you were told that one in every five of your staff would develop a mental health disorder in the next year? This is not a fanciful scenario – the odds are it will happen. What would you do? How might your approach differ from that of the sight impairment example above? Certainly both the diagnosis and treatment of mental disorders differ from that associated with physical impairments, but the impact mental illness can have on the individual and your workplace environment make this worth thinking about.

According to the U.S. Surgeon General, one in five adults (20%) will experience a diagnosable mental disorder in a given year. Contrary to popular belief, most individuals with mental disorders work. Among those of working age, it is estimated that the prevalence of mental illness and/or substance abuse in any given year approaches 25%. In fact, the *Employee Benefits Journal* reports more workers are absent from work because of stress and anxiety than because of physical illness or injury.

While we might be able to recognize vision impairment in a co-worker, the signs and symptoms of mental health disorders are not always so obvious. Mental illness has many faces and can be found just as easily in the CEO's office as on the shop floor. An equal opportunity disease, mental illness afflicts people of all ages, races, backgrounds, occupations and income levels.

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The current economic environment has contributed to increasing levels of stress and anxiety in the workforce. Mental Health Parity is forcing employers to rethink the way they cover treatment for mental health disorders; but now, more than ever, it makes sense for every employer to have a comprehensive strategy to address, not only the physical health of their workforce, but also the mental health of their most valuable resource – their human capital. Strategy ideas:

Calculate the cost of depression and substance use disorders in your workplace. For free online calculators that can help, **click here.**

If you don't already have an EAP, consider adding one. Employee Assistance Programs have developed well beyond their roots in treatment of substance abuse. Quality EAPs can assist you with assessment of the workforce, implementing appropriate policies and procedures and linking affected employees to appropriate care. A critical function of EAPs is to train your managers and supervisors in effective identification and referral techniques. Ongoing coaching can be available to assist managers with sensitive situations.

Offer education and awareness programs to employees. Stigma will likely discourage attendance at a seminar titled "Dealing with Depression," but seminars offering tips for managing finances, positive parenting or providing support to a co-worker or friend with a serious illness may be better attended. Education and information about mental health is often part of a stress management lecture or program. Share information in a variety of ways, including newsletters, emails and bulletin boards.

Make mental health an important part of your overall wellness program. You can de-stigmatize the issue by helping employees understand that today depression can be screened in the same way high blood pressure is screened, and that we facilitate referral and treatment for mental health conditions the same as we do for physical health issues.

Good health is good business, and that includes good mental health. For more detailed information, we invite you to register for our **webcast** on September 8.

HR CORNER

STATE INVESTS MILLIONS IN JOB TRAINING, EMPLOYMENT SERVICES

Under the Massachusetts Recovery Plan, Governor Deval Patrick has invested more than $67 million of funds from the American Recovery and Reinvestment Act (ARRA) in job training and employment services for Massachusetts workers. Much of the funding will support 37 One-Stop career centers located throughout the state.

Governor Patrick allocated more than $4.9 million to the Boston Private Industry Council and job training centers in the city of Boston; $1.9 million to the Cape and islands; $1.79 million to Northampton and surrounding communities; $2.59 million to the North Shore area; $4.3 million to central Massachusetts; and $4.6 million to the Fall River area. Patrick also dedicated more than $21 million to programs targeting workers between 14 and 24 years of age.

"During this difficult economic time, workforce training dollars will go a long way to help unemployed workers prepare for the jobs that Massachusetts organizations and businesses have to offer," Lieutenant Governor Timothy Murray said.

Nationally, employee layoffs reached a historic high of 558,909 for the first quarter of 2009, more than double the total for the first quarter of 2008, the U.S. Bureau of Labor Statistics reported. The layoffs set records across 12 industry sectors, affecting businesses of every size and workers at all skill levels.

The state's One-Stop career centers offer a broad range of services to help employers navigate the recession and prepare for recovery, including recruiting and hiring assistance, workforce partnerships, seminars, and information on tax credits and grants. The Executive Office of Labor and Workforce Development also offers programs such as WorkSharing, which provides alternative strategies for businesses contemplating layoffs, and Rapid Response, which helps businesses in transition. For more information, **click here.**

This article provided by BLR.

NEWS

COMING SOON! FINAL CAFETERIA PLAN REGULATIONS

Informal comments from the U.S. Treasury's Office of Benefits Tax Counsel indicate that the final cafeteria plan regulations are a high priority for the 2009 tax guidance calendar, and Treasury hopes to issue the much anticipated final regulations as early as mid-summer. (For background information about the cafeteria plan regulations proposed by the IRS, please see **Willis HRH EB *Alert* #116**.

When the proposed rules were issued, final rules were anticipated within a short period of time and would have applied to plans starting January 1, 2009. However, with the intervening delays in issuing the final regulations, the implementation date has been pushed back, and there is a possibility that, even if the final rules are issued in the near future, the Treasury Department may further delay the effective date. Without a delay in the effective date, the earliest that the final regulations will apply to plans is January 1, 2010. (Some industry experts suggest that the IRS might even delay regulations until January 1, 2011.)

In Congressional discussions of health care reform, all options are on the table, including the serious consideration of eliminating the tax-free treatment of health benefits. If this idea becomes law, then employers may not be able to justify offering a cafeteria plan, whose prime reason for existence is tax-free treatment.

What the final cafeteria plan regulations will address is open to speculation, but some of the following points will likely be included:

- Cafeteria plans are the exclusive governing body for employee choices between taxable and non-taxable benefits except in certain delineated circumstances. There is concern that this rule could be used by the Treasury to tax all plan participants on the benefits that they could have received if not for the existence of the cafeteria plan.
- The Treasury may provide sanctions for limited violations of the cafeteria plan rules in order to avoid whole plans being disqualified.
- Cafeteria plan nondiscrimination rules will be further defined by examples, and mechanisms will likely be in place to resolve any existing discrimination issues.

NEW HHS REPORT: "HIDDEN COSTS OF HEALTH CARE"

The Department of Health and Human Services (HHS) has released a new report: "Hidden Costs of Health Care: Why Americans are Paying More but Getting Less." The report, available by **clicking here,** documents the rising cost of deductibles, co-payments and out-of-pocket expenses that are making it more difficult for families with insurance to receive the health care they need. According to HHS, out-of-pocket expenses for Americans with employer-based coverage hit an average $3,700 per year in 2008.

The report also notes a person with employer-based coverage paid an average of $1,522 for health care (not including premiums) in 2006 compared with $1,260 in 2001. When including the added burden of higher premiums, out-of-pocket costs rose even more sharply, with a 30% increase from an average $2,827 in 2001 to $3,744 in 2006.

Employer-sponsored health insurance premiums have nearly doubled since 2000, a rate three times faster than that of wages. In 2008, the average premium for a family plan purchased through an employer was $12,680 – nearly equal to the annual earnings of a full-time minimum-wage job.

For preferred provider organization (PPO) plans purchased through an employer, the average family deductible increased 30% in just two years, from $1,034 to $1,344. The increase is even more pronounced for PPOs offered by small firms, where PPO deductibles increased from $1,439 to $2,367 – a rise of 64%.

In 2004, only one in five people with health insurance through an employer had a co-payment of more than $25, but by 2008 the number jumped to one in three.

Although the report is intended to spur Congress into enacting proposed health care reform legislation, there is no mention of problems associated with runaway health care costs as the central factor for increased out-of-pocket costs. Willis HRH has always maintained that meaningful health care reform must incorporate cost containment strategies. The HHS report is one of a series of reports on the current health care system that are available online (**click here**).

LEGAL & COMPLIANCE

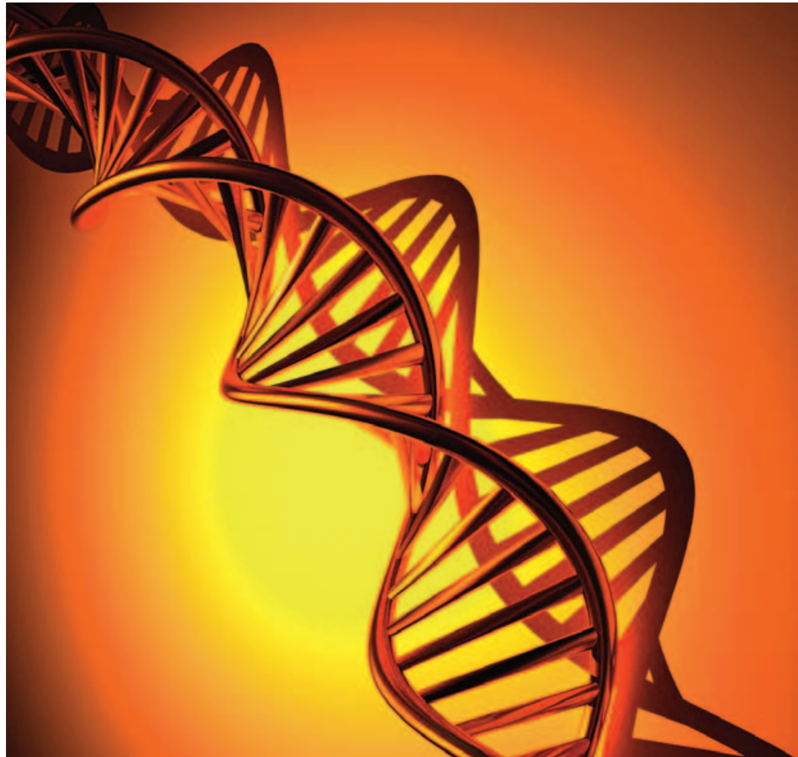
EEOC AND GINA REGULATIONS

President Bush signed the Genetic Information Nondiscrimination Act (GINA) into law last year. GINA generally bars health insurers and employers from discriminating based on genetic information. The law amends ERISA, the Public Health Service Act, and the Internal Revenue Code and covers employers with 15 or more employees. The DOL will also be issuing regulations under GINA that generally center on the areas where GINA applies to group health plans. (**Click here** for additional details.)

GINA also prohibits the use of genetic information in employment, prohibits the intentional acquisition of genetic information about applicants and employees, and imposes strict confidentiality requirements on employers. Earlier this year the EEOC published proposed rules implementing GINA requirements that are slated to become effective on November 21, 2009. (Additional information is available by clicking here for the **EEOC web page**).

Genetic information is often used to measure someone's predisposition for developing a particular disease. Genetic testing can show if an individual is at a higher risk for an occurrence of a specific disease – even though they may never actually manifest the condition. Congress took steps to ensure that as science advanced to identify and screen for diseases, individuals would not be unfairly barred from health coverage or be targets of other forms of discrimination on the basis of test results.

Employers should reevaluate their discrimination and harassment policies, medical and Family and Medical Leave Act (FMLA) certification forms, and other relevant policies and procedures to ensure GINA compliance. Employers should also be aware of the prohibitions and requirements found in provisions of the law concerning health insurance, which (as noted above) will fall under DOL regulatory control.



PENNSYLVANIA EXPANDS DEPENDENT AGE

In recent years, state legislatures around the country have been busy working on a variety of proposals intended to reduce their numbers of uninsured. One particular approach has been the passage of insurance laws requiring the extension of coverage for dependent children. (For details about this phenomenon, including insight about how ERISA preemption generally protects self-funded plans from application of such laws, please see **Willis EB *Alert #71.***)

Although most health insurance plans already provide dependent coverage up to age 19 (typically with an available three-to-five-year eligibility extension for full-time students), these new laws are now beginning to require coverage for even older dependents. In some instances, the new laws mandate longer periods of coverage contingent upon the dependent's student status or financial dependency. Other state proposals have tied the extension to particular circumstances – such as taking a medical leave of absence from school or for full-time students whose studies are interrupted by National Guard or armed forces reserve duty.

Most recently the Commonwealth of Pennsylvania adopted a rule extending dependent eligibility age. Specifically, Governor Edward

Rendell (D) signed legislation that expands health insurance coverage for dependent children, providing that adult children can be covered up to age 30 under the health insurance policies of their parents if the children:

- Are unmarried
- Have no dependents
- Are residents of Pennsylvania or enrolled as full-time students at institutions of higher education
- Are not provided private insurance or enrolled in or eligible for government benefits

As this is insurance legislation, it does not affect self-insured plans. It is also important to note that this expansion is at the discretion of the policyholder, which for a group insurance plan would be the employer. The insurer must allow for the expanded coverage if the employer requests it, but the employer is not required to offer it in their plans.

The law applies to new health contracts and policy renewals occurring 180 days after June 10, 2009 (January 1, 2010 for a calendar year renewal).

NEW JERSEY PAID LEAVE REMINDER

Beginning July 1, 2009, New Jersey employees may take up to six weeks of paid family leave under the state's temporary disability insurance program. Benefits are funded entirely by employees through payroll deductions that began January 1, 2009.

Employers subject to the New Jersey paid family leave requirement and the employees who may become entitled to the paid leave are the same as those affected by New Jersey's Temporary Disability Benefits Law (TDBL). All employers subject to New Jersey's state unemployment insurance law are subject to the TDBL. Generally, this includes any employer that has paid $1,000 or more in either the current or preceding year to an individual working in New Jersey.

Employers may provide benefits through the state or through an approved private plan. The leave will be available to employees to care for a family member with a serious health condition or to bond with a child during the first 12 months following the child's birth or adoption. For an employee who receives paid family leave benefits for a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) or the New Jersey Family Leave Act (NJFLA), the new law will not extend the amount of leave that the employee has available. In these situations, leave taken under the new mandate generally will run concurrently with leave taken under the other laws.

The paid family leave mandate also does not include any job protections for employees. Such protections are provided by FMLA and NJFLA. A copy of the employees' rights notice that employers are required to post as well as additional information about the mandate can be found at the New Jersey Department of Labor and Workforce Development **website**.

SINCE YOU ASKED:

COMMUNICATING WITH NON-ENGLISH SPEAKING EMPLOYEES

An employer has a workforce with 35% to 40% of its employees not literate in English (they speak Spanish). We were recently asked if the employer must provide a summary plan description (SPD) and other plan documents in Spanish.

The best practice would be to offer the materials in Spanish. The materials are meant to provide information to employees, and the letter and spirit of ERISA is to communicate with employees. Moreover, common sense dictates providing the information in a language that is understandable. In addition, there may be other reasons to consider sharing plan materials in foreign languages. For example, Executive Order No. 13166, ("Improving Access to Services for Persons with Limited English Proficiency") promotes employing non-English languages where appropriate.

There is no legal obligation under ERISA to provide the information to the employee in the employees' native tongue. In some circumstances there IS an obligation to provide assistance (and to communicate that availability) in their native language. The requirement arises if an employer has fewer than 100 employees, 25% of whom are literate only in the same language (other than English) or if an employer has 100 or more employees and the lesser of 500 or 10% of them are literate only in the same, non-English, language. In that case, the SPD can still be provided in English – but with a notice in their native language telling participants how they can obtain assistance in their native language.

EXAMPLE

ABC Company maintains a pension plan which covers 1000 participants. At the beginning of a plan year, five hundred of ABC Company's covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in English. Compliance could be achieved by preparing and distributing SPDs in each applicable language.

An alternate approach is also acceptable. Each of the 1000 employees receives a summary plan description in English containing a prominently displayed "assistance notice" in both Spanish and Vietnamese stating:

"This booklet contains a summary in English of your plan rights and benefits under Employer A Pension Plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main St., Anywhere City, State, 20001. Office hours are from 8:30 AM to 5:00 PM Monday through Friday. You may also call the plan administrator's office at (555) 555-5555 for assistance."

When considering this alternative, be sure to compare the cost of translation and printing to the potential risks incurred by requiring employees to operate with less-than-readily available information.

WEBCASTS & EVENTS

FMLA ADMINISTRATION AND UPDATES

August 11, 2009
2:00 PM EASTERN TIME

PRESENTED BY: HR Partner National Practice Team: Jennifer Barton, Debbi Davidson, Cheryl Rhodes

Workers are becoming increasingly aware of FMLA protections and, as a result, are asserting 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 daunting, especially with the new regulations released by the Department of Labor that took effect on January 16, 2009. 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 RSVP is required to participate in this call; **click here** to register.

MENTAL HEALTH IN THE WORKPLACE

SEPTEMBER 8, 2009
2:00 PM EASTERN TIME

Presented by Cheryl Mealey, Wellness Practice Leader and Dennis Fiszer, National Legal and Research Group Attorney

Last year Congress enacted the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The new law expands the Mental Health Parity Act of 1996 (MHP). Rates of mental health disorders such as depression and anxiety are increasing in workplaces everywhere. Depression is a common co-morbid condition with many serious and costly physical illnesses. Employers can benefits from a proactive approach to managing mental health issues in the workplace and through benefit plan design.

This legislation is effective for plan years beginning after October 3, 2009. Join us for this webcast where we will discuss the full range of Mental Health Parity compliance issues including:

- Specific requirements of the Mental Health Parity and Addiction Equity Act
- The link between mental and physical health
- Elements of a healthy workplace
- Proactive strategies to address the mental health of your workforce
- Rules governing plan documentation and disclosure requirements
- Anticipated cost impact of these new requirements
- Practical plan design elements some employers are considering in light of the current economic climate

Participant Access:
Advance RSVP is required to participate in this call; **click here** to register.

PITFALLS IN PLAN ADMINISTRATION

SEPTEMBER 22, 2009
2:00 PM EASTERN TIME

Presented by Frances Horn, Co-Practice Leader of the National Legal and Research Group

The scope of an ERISA plan is defined by the official plan documents and the summary plan description. ERISA benefit plans must be administered strictly in accordance with the documents and instruments governing the plan. Furthermore, it is known that failure to act in accordance with the documents governing the plan is presumptively a breach of a fiduciary duty. This session will discuss some of the common administrative errors that plague plan administrators. The following topics will be covered during this webcast:

- Identifying whether a plan subject to ERISA exists
- Conflicts in plan and summary language
- Business relationships with service providers
- Document interpretation versus administering outside the terms of the plan

Participant Access:
Advance RSVP is required to participate in this call; **click here** to register.

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 557 7517

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Philadelphia, PA
610 260 4351

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

Atlanta, GA
404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
352 378 2511

Raleigh, NC
704 344 4856

Savannah, GA
912 239 9047

Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

Appleton, WI
414 259 8837

Chicago, IL
312 527 6482
312 621 4843
312 621 4704

Cleveland, OH
216 357 5921

Columbus, OH
614 326 4788

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI
414 259 8837

Milwaukee, WI
414 203 5248
414 259 8837

Minneapolis, MN
763 302 7131
763 302 7209

Moline, IL
309 764 9666

Pittsburgh, PA
412 645 8537
412 586 3524

Schaumburg, IL
847 517 3469

SOUTH CENTRAL

Amarillo, TX
806 376 4761

Austin, TX
512 651 1660

Dallas, TX
972 715 2194
972 715 6272

Denver, CO
303 765 1564
303 773 1373

Houston, TX
281 584 1672
281 584 1676
713 625 1017

McAllen, TX
956 682 9423

Mills, WY
307 266 6568

New Orleans, LA
504 581 6151

Oklahoma City, OK
405 232 0651

Overland Park, KS
913 498 4423
913 339 0800, ext. 108

San Antonio, TX
210 979 7470

Wichita, KS
316 263 3211

WESTERN

Aliso Viejo, CA
949 461 3996

Fresno, CA
559 256 6212

Las Vegas, NV
602 787 6235
602 787 6078

Los Angeles, CA
213 607 6300

Novato, CA
415 493 5210

Phoenix, AZ
602 787 6235
602 787 6078

Portland, OR
503 274 6224

Rancho/Irvine, CA
562 435 2259

San Diego, CA
858 535 1800
858 678 2130

San Francisco, CA
415 291 1567

San Jose, CA
408 436 7000

Seattle, WA
800 456 1415

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