

## WELLNESS

### LUNCH AND LEARNS A BUSINESS CLASSIC SUPPORTS WELLNESS

Lunch and Learns, a classic format for imparting information and honing employee skills in a low key setting that is usually brief – and often fun – is also an ideal format to engage your employees in your company wellness program.

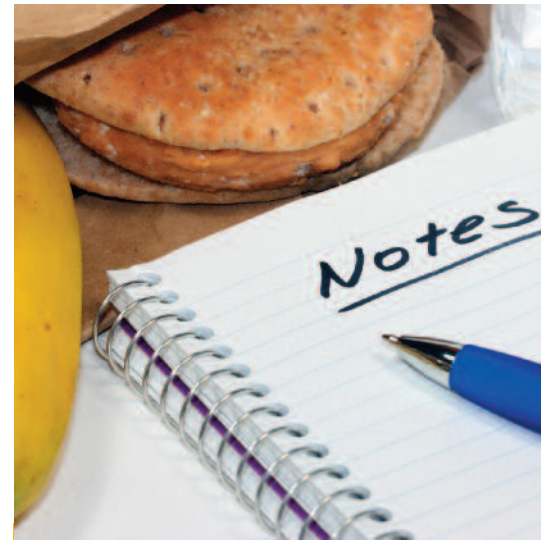
Popular wellness Lunch and Learn topics include:

- **NUTRITION** Healthy holiday eating, healthy snacks, weight loss or maintenance, vitamin and mineral supplementation, quick and easy meal preparation, etc.
- **PHYSICAL ACTIVITY** Strength training, stretching basics, yoga, Zumba, Pilates, how to maximize your work-out, etc.
- **STRESS MANAGEMENT** Relaxation techniques, defusing the stressors in your life, Stress Management 101, etc.
- **FINANCIAL WELLNESS** Saving for retirement, managing your budget, Investing 101, how to reduce credit card debt, etc.

Interested in starting a Lunch and Learn program? Here are a few tips.

- **TOPICS** Consider conducting a short, employee-interest survey with a list of potential Lunch and Learn topics.
- **RECRUITING SPEAKERS** Invite local and internal resources to conduct the sessions. Contact a local health care provider to see what they offer onsite. If your employer has an employee assistance program, ask if they can provide speakers. Ask fellow employees if they are willing to present – you never know, you may be sitting next to a subject matter expert!
- **LOCATIONS** Remember to pick a place in the building that supports eating and learning. (Lunch rooms are not usually the best place to hold a session because often they can be too noisy to facilitate learning anything.) And, don't forget to reserve the room!

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# HR CORNER

## HEAT'S BEEN TURNED UP ON EMPLOYER COMPLIANCE

Federal legislation has been enacted to expand the compliance efforts of federal agencies in 2010 and beyond. The Equal Employment Opportunity Commission (EEOC), for example, received an additional \$23 million for its budget with an appropriation passed in December 2009, according to Reid Bowman, Esq., general counsel for ELT.

During a recent webinar, Bowman explained that EEOC's case backlog was about 70,000 and that over 200 new investigators will help to trim that backlog while producing stronger enforcement of regulations going forward.

"From the EEOC charges, we see that [some] employers are only addressing sexual harassment or workplace compliance and might be overlooking overall EEOC compliance," said Bowman. "Are employers talking about disability accommodation or religious accommodation? Do compliance programs include age and national origin discrimination? These are all topics that we're seeing in terms of EEOC charges.

With the current infusion of dollars into its budget, EEOC "is more energized" with investigations and has "a renewed focus on systemic issues, such as increased scrutiny on company background screening processes, for example, since they may have an adverse impact on certain population groups," commented Bowman.

### RETALIATION CLAIMS

Margaret Hart Edwards, Esq., shareholder of Littler Mendelson ([www.littler.com](http://www.littler.com)), added that retaliation claims are also in the forefront of EEOC investigators' and juries' minds. "Juries really believe in retaliation and as a consequence, retaliation verdicts tend to run much larger [monetarily] than verdicts for ordinary discrimination," she says.

She shared the broad definition of retaliation that is followed by EEOC. "It is any time you take action against someone because they're engaged in a protected activity, which includes making an informal complaint internally or a formal complaint in a lawsuit, and it includes participating in any investigation. The employee doesn't have to be right – just operating in good faith." Edwards cited a U.S. Supreme Court decision in 2009 (*Crawford v. Metropolitan Government of Nashville & Davidson County, Tennessee* (No. 06-1595)).

"Retaliatory conduct is any conduct that would discourage a reasonable person from engaging in opposition to unlawful conduct," commented Edwards. She explained that what is prohibited conduct has been broadened through the *Crawford* case and through *Burlington Northern & Santa Fe Railway Co. v. White* decided by the Supreme Court in 2006 (No. 05-259). "Retaliation can reach beyond the workplace," too she explained. Some specific areas include "fling false criminal claims; filing a false report with an unemployment compensation office; and false references to damage job prospects."

Another area that employers should be watching is sexual orientation and gender identification discrimination issues, noted Edwards. The Employment Non-Discrimination Act (ENDA), most recently passed by the House of Representatives in November 2007, without gender identify included,

was introduced again in June 2009 in Congress with gender identity back in the bill (HR 3017). In September 2009, hearings were held before the House Education and Labor Committee and in November 2009, the Senate Health, Education, Labor, and Pensions Committee held hearings on ENDA as well, explained Edwards.

Edwards cited a quote from the White House [website](#): “President Obama also continues to support the ENDA and believes that our antidiscrimination employment laws should be expanded to include sexual orientation and gender identity.” She notes that Obama signed the Hate Crimes Prevention Act in October 2009, which “expanded existing federal hate crime law to include crimes motivated by a victim’s actual or perceived gender, sexual orientation, gender identity or disability and dropped the prerequisite that the victim be engaging in a federally protected activity.”

Edwards’ take on ENDA is this: why wait until this federal legislation is passed, (which she believes will occur this year or next year) – start preparing now. “ENDA wouldn’t create any exceptions to sexual harassment prohibition, but would make any sexual harassment policies applicable to all, regardless of perceived sexual orientation or gender identity. It would also include special provisions regarding what to do with shared showers, restrooms, etc., and special provisions regarding dressing and grooming standards.”

## POLICY AND TRAINING REVIEW

HR executives should do a thorough review of policies and practices if they haven’t within the past 12 months, in light of already enacted legislation and in preparation for the legislation that is ahead, suggests Edwards. Once that is done, they should turn a critical eye toward their training and revamp it where needed in order to prevent potential EEOC claims.

*This article provided by BLR.*

*(Wellness—continued from page 1)*

- **LUNCH** Employees usually bring their own lunch, but for a special event or kick-off of a Lunch and Learn series, the employer may, if the company budget will support it, want to provide a healthy lunch or a beverage. Doing so generally helps increase attendance.
- **PROMOTION** Plan enough lead time (at least four weeks prior) to announce the Lunch and Learn date and to promote the event up to the scheduled date. Promotion methods should include print, email, newsletters, etc. to highlight upcoming topics and featured speakers. Consider offering the session more than once on the same day. For example, offer an 11:30 AM session and then repeat it at noon. Another option is to record or videotape the presentation for employees who are unable to attend, those who work other shifts or who work remotely.
- **EVALUATION** Consider incorporating a pre-test and post-test as part of the session to evaluate learning, as well as a participant sign-in sheet to track attendees and an end-of-session survey to assess participant satisfaction.
- **INCENTIVES** You may also want to have a small incentive to reward attendance. For example, if you are having a series of Lunch and Learns on one topic, such as weight management, participants who attend three out of the five sessions would be eligible for a raffle.

A Lunch and Learn is typically an informal educational presentation, video or demonstration, offered to employees while they have lunch. These sessions are generally 20 to 30 minutes, but can last longer.

# LEGAL & COMPLIANCE

## GRANDFATHER RULES: MEDICAL INFLATION TRACKING TOOL

Since enactment of the health care reform law, employers have strongly expressed concern about preserving grandfather status for their group health plans. Grandfather status seems to represent one of the few tangible provisions Congress wove into the law to encourage the maintenance of employer plans, and understandably, most employers did not want to casually lose those protections.

Willis has received a wave of requests for insight about what employers can and cannot do to their group medical plans, while retaining their grandfathered status. Unfortunately, the issuance of grandfather regulations by the IRS, DOL and HHS on June 14, 2010 only serves to support the idea that the government is intent on eliminating grandfather status wherever possible.

### MAINTAINING GRANDFATHER STATUS

The regulations state that plans will lose grandfathered status if they:

- **SIGNIFICANTLY CUT OR REDUCE BENEFITS** This rule applies to even a single benefit for the treatment or diagnosis of a single condition. For example, if a plan stops covering care for people with diabetes or a mental illness.
- **RAISE CO-INSURANCE CHARGES** Grandfathered plans cannot increase any coinsurance percentage.
- **SIGNIFICANTLY RAISE COPAYMENT CHARGES** Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.
- **SIGNIFICANTLY RAISE DEDUCTIBLES** Compared with the deductible required as of March 23, 2010, *grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points*. In recent years, medical costs have jumped an average of 4 to 5%, so this formula would allow deductibles to go up by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean that if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- **SIGNIFICANTLY LOWER EMPLOYER CONTRIBUTIONS** Grandfathered plans cannot decrease the percent of premiums the employer pays by more than five percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- **ADD OR TIGHTEN AN ANNUAL LIMIT ON WHAT THE INSURER PAYS** In order to retain grandfather plan status, plan sponsors cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an



annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).

As described above, although applicable regulations make it difficult to retain grandfather status, the rules do permit operational cost adjustments within prescribed limits without losing grandfather status. These permitted corridor limitations generally depend on accurately measuring medical inflation.

## WILLIS HEALTH CARE REFORM CALCULATOR

Employers seeking to measure medical inflation can now tap Willis for assistance in obtaining precise information about the governing medical inflation rate and how it will impact their particular group health plan. More specifically, Willis' new health care reform planning calculator allows employers to measure a variety of health care reform related-costs. From examining the corridor of medical inflation available vis-à-vis grandfather status, to issues related to pay or play, even to the potential impact of the "Cadillac" tax assessment (not scheduled to go into effect until 2018) – Willis maintains cutting-edge tools perfectly calibrated to give employers important strategic advantages. We invite you to contact your Willis representative to set up a meeting.

For additional details about the grandfather rules, [click here](#).

## REQUIREMENTS FOR INTERNAL AND EXTERNAL CLAIM REVIEW PROCESSES

The federal agencies responsible for implementation of the insurance reform provisions of the health care reform law have issued interim final regulations under the provision that requires group health plans, among others, to maintain processes that meet certain standards for reviewing denied claims. Both internal and external review processes are required. This requirement is described in Willis' Human Capital Practice *Alert*, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011," which can be accessed by [clicking here](#).

Highlights from the new regulations include:

- The required internal review process is largely identical to the claim review process that medical plans subject to ERISA are already required to have in place. The new regulations add a few requirements, however. For example, the review process will apply to coverage rescissions in addition to adverse benefits determinations and new requirements to provide information during the review process will apply.
- The regulations confirm that a group health plan must continue coverage and, in some cases, payment of benefits, pending the outcome of an appeal.
- Group health plans and insurers currently subject to a state external review process will continue to be subject to that process during a transition period. Subsequently, a state external review process must meet certain standards. For group health plans and insurers that are not subject to a state external review process, a federal external review process will apply. The new regulations do not define that process, and additional guidance will be issued on it in the "near future."

## REGULATORY LANDSCAPE

Employers have now been living with the various iterations of the health care reform legislation for about four months. Since the law's enactment, questions and concerns continue to be addressed by various commentators and technical experts, including Willis. Part of the confusion surrounds the fact that health care reform legislation contains numerous instances where, rather than offer detail about how the law should work, Congress simply says that "the Secretary of Health and Human Services is charged with providing guidance through the issuance of regulations or other formal explanation of certain requirements." Some sources cite those references to be as high as 1,400 instances!

The external claim-review regulations described above now represent at least the seventh set of key health care reform-related guidance issued since the law was enacted on March 23, 2010. While the statute was itself only 2700 pages long, the regulations, once they are completely issued, will likely present many times that number of pages in new federal rules and requirements.

Published guidance so far includes:

- IRS guidance explaining the tax implications of health coverage upon the parent(s) of an adult child who receives employer group health plan coverage
- Guidance implementing the "Early Retiree Reinsurance Program" (ERRP)
- Adult child health coverage mandate
- Regulations implementing grandfather status
- Regulations implementing pre-existing exclusion rules/lifetime and annual limits/health coverage rescission/patient protections
- Regulations implementing preventive care rules
- Regulations implementing internal and external claim review processes

## HHS SOLICITS COMMENTS ABOUT FORTHCOMING EXCHANGES

Although the insurance "exchanges" as envisioned under the health care reform statute do not go into effect until January 1, 2014, an agency of the Department of Health and Human Services is already seeking public comment on issues related to those state exchanges.

HHS' Office of Consumer Information and Insurance Oversight recently published an announcement in the *Federal Register* inviting public input in advance of rulemaking. The announcement notes that comments will only be collected through October 4, 2010.

Regulators have communicated that the exchanges are being developed with the goal of functioning as easily navigable, fully internet-based, "one-stop shop" information centers for consumers to compare and purchase health insurance

coverage. The government is therefore seeking input on a wide array of insurance exchange-related concerns, including factors that states will evaluate when determining whether to build an insurance exchange or use an alternate federal solution. Insight is also being solicited about implementation timeframes and feedback about which aspects of exchange functions should be uniform across the states.

Suffice it to say that employers that plan to interact with state-level health exchanges under PPACA will have much at stake when regulations are finally published. Organizations interested in sharing feedback may therefore wish to [click here](#) to deliver their perspective.

# PREVENTIVE CARE RULES ISSUED

As part of last spring's enactment of the health care reform law, non-grandfathered plans are required to provide preventive care (such as mammograms, colonoscopies and immunizations) without cost-sharing. Now the IRS, DOL and the HHS have issued regulations implementing those preventive care service requirements. (*Note:* Grandfathered plans can avoid the preventive care service mandate. For information about grandfather status, please [click here](#) to access our Human Capital Practice *Alert*, Vol. 3, No 12, "Regulations on Grandfathered Plans."

## EFFECTIVE DATE

As with the health care reform law's generally phased-in effective date, the regulations become effective with the first plan year after September 23, 2010 (January 1, 2011 for calendar-year plans).

## ITEMS AND SERVICES

Under the new rules group health plans must provide coverage for the items and services listed below. In addition, plans may not impose any cost-sharing requirements (such as a copayment, coinsurance or deductible) with respect to those items or services.

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the **United States Preventive Services Task Force** with respect to the individual involved
- Routine immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the **Centers for Disease Control and Prevention** with respect to the individual involved
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the **Health Resources and Services Administration**
- With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the **Health Resources and Services Administration**

## OFFICE VISITS - SPECIAL RULES

- If an *item or service is billed separately from an office visit*, then a plan may impose cost-sharing requirements with respect to the office visit.
- If an *item or service is NOT billed separately* from an office visit, and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may NOT impose cost-sharing requirements with respect to the office visit.



- If an item or service described is *NOT billed separately* from an office visit and the *primary purpose of the office visit is NOT the delivery of such an item or service*, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

## OUT-OF-NETWORK PROVIDERS

Unlike the emergency-services rule, nothing in the new regulations requires a plan that has a network of providers to provide preventive benefits or services that are delivered by an out-of-network provider. Moreover, nothing precludes a plan that has a network of providers from imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

## REASONABLE MEDICAL MANAGEMENT

To the extent that the appropriate guideline for an item or service fails to specify, a plan can use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive services.

## SERVICES NOT DESCRIBED

The regulations do not preclude a plan from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines.

## CHANGES IN RECOMMENDATIONS OR GUIDELINE

A plan is not required to provide coverage for any items and services specified in any recommendation or guideline after the recommendation or guideline is no longer recommended by the appropriate group or agency.

## CONCLUSION

As compared to other recently issued health care reform-related regulations, the preventive care regulations appear relatively straightforward. Happily the regulations appear to extend plans a bit of leeway to require co-pays or other cost-sharing for preventive care – as long as the particular treatments are not identified as covered under the appropriate agency requirements or are from an out-of-network provider. Even where non-grandfathered plans are entirely precluded from using cost-sharing tactics, items or services where cost sharing can be used should be easy to identify and, therefore, easier to administer. Finally, most commentators do not expect the cost of this mandate to be particularly onerous as measured against most other health care reform mandates.

# 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 [click here](#) to access 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 that apply to substantially all medical/surgical (M/S) benefits.

Plans often have different cost-sharing arrangements (e.g., copayments 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 drug 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 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 struggling with 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., copayments and co-insurance) for outpatient benefits, given the trouble such employers were having passing the “substantially all” prong of the parity test.

# HEALTH CARE COSTS POISED TO JUMP?

When federal health care was being debated in Congress last year, proponents strongly endorsed the “Massachusetts model” as the ideal for the rest of the country to emulate. Given the Bay State’s budgetary red ink, continuing health care cost escalation and only modest improvement in coverage for residents – it’s very tough to characterize the Massachusetts model as a success story.

As we have regularly emphasized in prior health care reform articles, a serious concern about health care reforms initiated at the federal level is that, while health coverage was promoted – virtually nothing was done to curb skyrocketing medical costs. This time we highlight the startling findings of a new study examining health care reform activities in Massachusetts. The study underscores concerns about unchecked health care costs and confirms our worst fears about landmark federal legislation enacted last March.

Stanford and Columbia University researchers recently concluded an in-depth study examining health care reform in Massachusetts. That study revealed serious problems in Massachusetts that should raise alarm bells in Washington about the direction of the country’s recent health care reform initiative, as so much of the recently enacted legislation has been modeled on the Massachusetts program.

The study, “The Effect of Massachusetts’ Health Reform on Employer Sponsored Insurance Premium,” is fully detailed in the academic journal, *Forum for Health Economics & Policy* and was recently also covered in the industry publication *Risk & Insurance*. The study authors note, “Because the plan’s main components are the same as those of the new health reform law, *the effects of the plan provide a window into the country’s future.*” [Emphasis added.]



- Single-coverage premiums among all private-sector employers in Massachusetts rose by 8.7% between 2006 and 2008 (representing a differential of 2.2 percentage points more than the nation as a whole).
- Single-coverage private-sector premiums in Boston rose 11.9% in 2006 through 2008, far outpacing the 5.2% growth demonstrated when measured before health care reform (as compared to the period 2004 through 2006).
- Researchers found an average 21.7% premium growth for employer-sponsored, family health care coverage for private-sector employees since health care reform was passed in Massachusetts in 2006.
- Businesses in Massachusetts with fewer than 50 employees saw their health insurance premiums grow by 14.7% between 2006 and 2008 – a rate more than double the pre-reform rate of 7.1% between 2004 and 2006.



## HHS: PROPOSED REGULATIONS AFFECTING HIPAA/HITECH

The Department of Health and Human Services (HHS) released **new proposed regulations** that will affect employer plans and the implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act that applies to the HIPAA privacy, security and enforcement requirements.

Under HIPAA, employer plans were required to maintain certain protected health information (PHI) pursuant to increased levels of privacy protection. The HIPAA Privacy Rule protects individuals' medical records and other individually identifiable health information (PHI) created or received by or on behalf of covered entities. The Privacy Rule protects individuals' health information by regulating the circumstances under which covered entities may use and disclose PHI and by requiring covered entities to have safeguards in place to protect the privacy of the information. As part of these protections, covered entities are required to have contracts or other arrangements in place with business associates that perform functions for or provide services to the covered entity and that require access to PHI to ensure that these business associates likewise protect the privacy of the information.

The HITECH Act included additional requirements for employer plans regarding broader requirements for maintaining business associate agreements with vendors and other service providers who may come into contact with protected health information in the course of their work on behalf of a HIPAA-protected plan.

Although the effective date of the HITECH requirements is February 18, 2010, the agency recognized the difficulty of compliance with that effective date and stated that "[i]n light of these considerations, we intend to provide covered entities and business associates with 180 days beyond the effective date of the final rule to come into compliance with most of the rule's provisions." The effective date will be tied to the date the rules are published in the *Federal Register*.

Future Willis Human Capital publications will include more detailed discussion of the new rules after they are published in the *Federal Register*.

# 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 represent 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 must 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 under \$1,000 from filing duties. Another clarification showcases 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 “free-standing” HRA coverage (i.e., coverage that is 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.



# WEBCASTS

## 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.

## WELLNESS: BEST PRACTICES IN WORKSITE WELLNESS

OCTOBER 19, 2010  
2:00 PM EASTERN TIME

Presented by Cheryl A. Mealey, CHES  
National Practice Leader  
Wellness Consulting,  
Human Capital Practice

What are the secrets to success in worksite health promotion programs? What common elements turn up time and time again in programs we consider to be "Best in Class?" This presentation will cover the essential elements you need to know to maximize the results of your worksite wellness program and will feature representatives from client organizations with award winning programs who will share their secrets of success with you.

### PARTICIPANT ACCESS

Advance reservations are required to participate. [Click here](#) to RSVP for this call.

# KEY CONTACTS

## U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

### NEW ENGLAND

**Auburn, ME**  
207 783 2211

**Bangor, ME**  
207 942 4671

**Boston, MA**  
617 437 6900

**Burlington, VT**  
802 264 9536

**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

**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**  
312 288 7700  
312 621 4843  
312 348 7678

**Cleveland, OH**  
216 357 5921

**Columbus, OH**  
614 326 4722

**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**

713 625 1017

713 625 1082

**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**

913 339 0800

**San Antonio, TX**

210 979 7470

**Wichita, KS**

316 263 3211

**WESTERN****Fresno, CA**

559 256 6212

**Irvine, CA**

949 885 1200

**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**

858 678 2000

858 678 2132

**San Francisco, CA**

415 291 1567

**San Jose, CA**

408 436 7000

**Seattle, WA**

800 456 1415

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