

LEGAL & COMPLIANCE

REPORTING HEALTH CARE COVERAGE COSTS ON FORM W-2

On March 29, 2011, the Internal Revenue Service (IRS) issued Notice 2011-28 to offer guidance on how to report health care coverage costs on Form W-2. This follows the IRS Notice 2010-69, issued in October 2010, which made reporting of health care coverage costs voluntary for calendar year 2011 (W-2s issued in January 2012).

The Patient Protection and Affordable Care Act (PPACA) added a new section to the Internal Revenue Code, Section 6051(a)(14), which requires employers to include the aggregate cost of health care coverage on Form W-2 starting in 2011 – right alongside reporting of wages, 401(k) contributions, withholding taxes and other information. Some employers may report costs in 2011, even though it is voluntary; perhaps where:

- Necessary data is already being accumulated in payroll systems
- Payroll software is updated to include the appropriate controls and capability in time for the January 2012 distribution of 2011 W-2s

Shortly after PPACA was enacted, there were rumors that the W-2 reporting was a precursor for changes in the favorable tax treatment of health coverage. The IRS' notice once again confirmed that the reporting to employees is for informational purposes only.

Coverage that will NOT be counted and reported on the W-2 in box DD includes:

- Health coverage that is not subject to COBRA requirements (i.e., church plans)
- Dental or vision options if they are not integrated into health coverage
- Contributions to Archer Medical Savings Accounts or Health Savings Accounts
- Worker contributions to Health Care Flexible Spending Accounts



LEGAL & COMPLIANCE

Reporting Health Care Coverage Costs on Form W-2 1

DOL Advises on Use of Demutualization Proceeds 2

DOL Releases FAQs on Grandfather Rules 3

Agencies Extend Regulatory Grace Period for Some New Internal Claim Processing Requirements 5

Class Acts FAQ 6

Since You Asked 6

HR CORNER

New ADA Regs Bring More Clarity 8

New Guidance on Break Time for Nursing Mothers 9

WELLNESS

The Cost of Sleep 12

WEBCASTS 13

CONTACTS 14

- Cost of Health Reimbursement Arrangement coverage
- Supplemental accident, specified disease or illness, hospital indemnity or fixed indemnity insurance
- Long-term care coverage
- Disability income insurance and workers' compensation
- Liability insurance, automobile insurance, credit-only insurance and other similar coverage, where medical benefits are secondary or incidental to the coverage

Reportable costs will be calculated using COBRA methods – including both employee and company contributions, without the 2%. Or, the employer may report actual premium charged. Different methods can be used for different plans but the same method must be used for each employee covered under a particular plan. Importantly, the monthly reportable cost must reflect any mid-year changes in coverage (adding or dropping coverage, changes in the tier of coverage, etc.).

Finally, the IRS also announced that reporting will be further delayed for employers who have fewer than 250 Form W-2s in 2011, where relief from reporting will continue until further guidance is issued.

DOL ADVISES ON USE OF DEMUTUALIZATION PROCEEDS

A recent Department of Labor (DOL) opinion letter, Advisory Opinion 2011-05A, provides guidance on the use of demutualization proceeds under a plan where only some of the current participants contributed to premium payments. In the letter, the DOL advised that, absent plan terms to the contrary, welfare plan fiduciaries may use demutualization proceeds that are plan assets for the benefit of all current participants and beneficiaries, rather than only for those who actually contributed to the premium payments for the insurance policies. The DOL also noted that “ERISA does not require plan fiduciaries to consider the interests of individuals who are no longer covered under the plan in deciding how to use such demutualization proceeds.” Demutualization occurs when an insurance company converts from a mutual insurance company to a stock insurance company.

BACKGROUND

In September 2001, the J.B. Hunt Transport Services, Inc. Benefit Plan Trust received approximately \$800,000 of Prudential Financial, Inc. common stock as demutualization proceeds in connection with Prudential's mutual-to-stock conversion. The demutualization proceeds were attributable to a group insurance policy that provided voluntary term life and driver disability insurance under the company employee benefits plan. While the policy was funded entirely by participant contributions, very few of the employees who contributed to the premium payments for the policy (giving rise to the demutualization proceeds) were participants in the plan at the time it received the proceeds.

J.B. Hunt chose to amend its plan and use the proceeds to provide for a wellness program to enhance the health care benefits available to current plan participants. When the demutualization benefits were exhausted, the terms of the plan provided that J.B. Hunt would be liable for the cost of the program. J.B. Hunt sought the advisory opinion because it was concerned about the permissibility of using the demutualization proceeds to provide the wellness program to current employees rather than for the benefit of only those current and former plan participants who actually contributed the monies to the insurance policy that generated the demutualization proceeds.

APPLICABLE LEGAL OBLIGATIONS

Any distribution made in connection with an insurance policy that provides benefits under an ERISA plan is an asset of that plan and must be handled in accordance with ERISA requirements. In general, ERISA requires employers to ensure that plan assets are held in a plan trust or by a state-licensed insurance company and applied exclusively for the benefit of plan participants or for defraying the reasonable costs of plan administration. ERISA does not necessarily require that proceeds of the distribution be paid to participants.

While J.B. Hunt used the demutualization proceeds to provide additional benefits to plan participants and to pay related administrative expenses, the funds could also have been used in other ways without violating ERISA. For example, a contributory plan might provide for a “premium holiday” or a non-contributory plan could apply the proceeds to pay future premiums.

Opinion letters do not have the force of law and do not change regulations that have been adopted. They are, instead, letters addressing a particular fact situation that has been presented by an employer. The letters are binding on the employer asking for the opinion, but opinion letters are valuable for other parties since the letters reflect the analysis that the DOL would likely engage in for other similar issues. A copy of Advisory Opinion 2011-05A can be found [here](#).

DOL RELEASES FAQs ON GRANDFATHER RULES

The Department of Labor (DOL) recently added its sixth set of **FAQs** regarding the Patient Protection and Affordable Care Act (PPACA) to its website. These new FAQs, which were prepared jointly by the Departments of Health and Human Services, Labor and Treasury, clarify certain elements of the grandfather rules.

The first FAQ explains what is considered a “bona fide employment-based reason” for purposes of employees who are being transferred from one plan to another. Under the interim final regulations, transferring groups of employees among plans may cause a loss of grandfathered status. Specifically, if a group of employees is transferred to a grandfathered health plan from the plan under which it was covered on March 23, 2010, the receiving plan will lose grandfathered plan status if both of the following are true:

- The transfer results in changes that, if made by changing the plan under which the employees had coverage on March 23, 2010 (instead of by transferring the employees to the new plan), would cause loss of grandfathered status
- There is no bona fide employment-based reason for the transfer

The regulations provided that closing a location is a bona fide employment-based reason for transferring employees to another plan but termination of a plan that has become too expensive is not. The following examples from the FAQs further illustrate what the Departments would consider to be “bona fide employment-based reasons.”

- When a benefits package is being eliminated because the issuer is exiting the market
- When a benefits package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer’s minimum participation requirement)
- When low or declining participation by plan participants in the benefits package makes it impractical for the plan sponsor to continue to offer the benefits package
- When a benefits package is eliminated from a multi-employer plan as agreed upon as part of the collective bargaining process
- When a benefits package is eliminated for any reason and multiple benefits packages covering a significant portion of other employees remain available to the employees being transferred

The Departments are clear that the examples provided above are not intended to be an exhaustive list of circumstances deemed to satisfy the bona fide employment-based reason condition.

FAQs TOPICS

#1 explains what is considered a “bona fide employment-based reason” for purposes of employees who are being transferred from one plan to another.

#2 involves a plan that bases the level of cost sharing for brand-name prescription drugs on whether or not the brand-name drugs have generic alternatives.

#3 has a group health plan making similar preventive services available at an in-network ambulatory surgery center and an in-network outpatient hospital setting.

#4 and #5 address at what point an amendment to a plan (that causes the plan to relinquish grandfather status) will cause the plan to lose grandfather status.

#6 addresses how to determine whether an employer’s contributions toward the cost of coverage have decreased below the threshold allowed under the grandfather rules when the employer makes contributions to retiree coverage based on a formula.

The second FAQ involves a plan that bases the level of cost sharing for brand-name prescription drugs on whether or not the brand-name drugs have generic alternatives. The classification of a brand-name drug that previously had no generic alternatives will change when a generic alternative for it becomes available and is added to the formulary. This results in an increase in the cost-sharing level for the brand-name drug. The Departments indicate, however, that the movement of a brand name drug into a higher cost-sharing tier due to a generic equivalent of the drug coming into the market does not cause the plan to relinquish its grandfather status.

In the third FAQ, a group health plan makes similar preventive services available at an in-network ambulatory surgery center and an in-network outpatient hospital setting. However, it currently does not impose a copayment for these services in either setting. The plan wishes to adopt a Value-Based Insurance Design (VBID) approach by imposing a \$250 copayment for these preventive services only when performed in the in-network outpatient hospital setting (i.e., not when performed in an in-network ambulatory surgery center) and waiving the copayment for any individuals for whom it would be medically inappropriate to have these preventive services provided in the ambulatory setting. The FAQ clarifies that the increase in the copayment for the preventive services solely in the in-network outpatient hospital setting (subject to the waiver arrangement described above) without any change in the copayment in the in-network ambulatory surgery center setting would not cause the plan to lose grandfather status.

The fourth and fifth FAQs address at what point an amendment to a plan (that causes the plan to relinquish grandfather status) will cause the plan to lose grandfather status. The

FAQs make it clear that a loss of grandfathered plan status will occur when the plan provisions that cause the plan to relinquish grandfather status are effective (regardless of when the changes are actually adopted). For example, if a calendar year plan is amended so that it is no longer grandfathered, and the amendment is effective July 1, 2011, then the plan will lose grandfather status on July 1, 2011. The FAQs make it clear that if the plan sponsor wishes to avoid a loss of grandfathered plan status mid-year, it should make sure that any amendments to the plan that would cause such a loss are not effective until the first day of the plan year (e.g., January 1, 2012).

The sixth FAQ addresses how to determine whether an employer's contributions toward the cost of coverage have decreased below the threshold allowed under the grandfather rules when the employer makes contributions to retiree coverage based on a formula. The FAQ involves a plan that covers both retirees and active employees (and is therefore subject to the health care reform law's insurance mandates). The employer contributes, for retirees, \$300 per year multiplied by the individual's years of service for the employer, capped at \$10,000 per year. Since the employer is making contributions based on a formula, the plan will cease to be a grandfathered health plan if the employer decreases its contribution rate toward the cost of coverage by more than 5% below the contribution rate on March 23, 2010. If the formula does not change, the employer is not considered to have reduced its contribution rate, regardless of any increase in the total cost of coverage. However, if the dollar amount that is multiplied by years of service decreases by more than 5% (or if the \$10,000 maximum employer contribution cap decreases by more than 5%), the plan will cease to be a grandfathered health plan.

CONCLUSION

Similar to the other FAQs released by the Departments, the new FAQs help to answer employers' questions regarding compliance with PPACA. The Departments will likely continue to issue responses to questions and other guidance related to the implementation of PPACA. The other FAQs (**Part I**, **Part II**, **Part III**, **Part IV** and **Part V**) can be found on the DOL's website.

For additional information about the grandfathered plan rules, please see Willis Human Capital Practice *Alerts*, Vol. 3, No. 12, "**Regulations on Grandfathered Plans**" and Vol. 3, No. 17, "**Agencies Amend Grandfather Regulations.**"

AGENCIES EXTEND REGULATORY GRACE PERIOD FOR SOME NEW INTERNAL CLAIM PROCESSING REQUIREMENTS

A regulatory grace period related to internal claim procedures has been extended so that full compliance will not be required until the plan year starting on or after January 1, 2012. The grace period previously ended on July 1, 2011. The provisions affected by the grace period are also changed as explained below.

BACKGROUND

The health care reform law included requirements relating to internal claim and appeals procedures, as well as external independent review procedures for denied claims.

IMPORTANT: The new internal claim and appeals requirements and the external review requirements **APPLY TO NON-GRANDFATHERED PLANS ONLY.**

For most plans, the new internal claim and appeals requirements add seven new requirements to the Department of Labor's (DOL) existing requirements for internal claim and appeals procedures.

- Notifying a claimant of an initial decision on an urgent pre-service claim within 24 hours after the receipt of the claim (as opposed to 72 hours, required under current rules)
- Providing notices in an alternate language as provided in the regulations
- Strictly adhering to all the requirements of the interim final regulations regarding internal claim and appeals procedures
- Including additional information in certain notices to claimants:
 - a. Identifying information, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
 - b. The denial code for an adverse benefit determination and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim and, in some cases, a discussion of the decision
 - c. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal

- d. The availability of, and contact information for, an applicable state office of health insurance consumer assistance or ombudsman

- Treating rescission of coverage as a claim subject to the plan's claim and appeals procedures
- Providing the claimant (automatically, as soon as possible, free of charge, and sufficiently in advance to allow response) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial
- Making decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as a claim adjudicator or medical expert) without regard to the likelihood that the individual will support a denial of benefits

Last September, the agencies issued a **temporary non-enforcement policy** with respect to the first four of these new requirements. Under that policy, until July 1, 2011, the agencies would not enforce those new requirements against a plan "working in good faith to implement such additional standards." (The last three additional requirements continued to apply to NON-GRANDFATHERED plans with respect to plan years starting on or after September 23, 2010.)

GRACE PERIOD EXTENDED AND MODIFIED

The agencies have now extended, with a few modifications, the enforcement grace period until plan years beginning on or after January 1, 2012. In addition, the agencies eliminated the "good faith efforts" condition. Plans need not be working in good faith to implement the requirements subject to the grace period in order for the grace period to apply. For the first three of the new requirements listed above, that is the entire effect of the announcement: the grace period is extended and the good faith efforts condition removed.

For the fourth new requirement listed above – relating to content and specificity of notices

to claimants – the picture is more complicated. The guidance first carves out the requirement that notices to claimants include the diagnosis and treatment codes and their corresponding meanings and makes that requirement subject to the same extended regulatory grace period that applies to the first three new requirements listed above. For the other additional information requirements, the grace period is modified so that it applies until the beginning of the first plan year starting on or after July 1, 2011 (January 1, 2012 for calendar year plans). Employers will want to be sure that claim payers prepare to provide the following information in notices to claimants by the deadline:

- a. Sufficient details to identify a claim (other than the diagnosis and treatment codes and their meanings)
- b. The reasons for an adverse benefit determination
- c. A description of available internal appeals and external review processes (for information on the required processes, see Willis Human Capital Practice *Alert*, **Vol. 3, No. 16**)
- d. For plans and issuers in states in which an office of health consumer assistance program or ombudsman is operational, the disclosure of the availability of, and contact information for, such program (the agencies provided a listing of such consumer assistance programs in an appendix to the **announcement of the grace period extension**)

Willis' National Legal & Research Group will continue to monitor and communicate developments regarding the health care reform law.

CLASS ACT FAQs

The Department of Health and Human Services' (HHS) Administration on Aging recently released a set of Frequently Asked Questions (FAQ) regarding the Community Living Assistance Services and Supports (CLASS) Act program. The CLASS Act, which was created under the Patient Protection and Affordable Care Act (PPACA), establishes a new, voluntary long-term care insurance program for workers. According to the FAQs, the Secretary of HHS has until October 1, 2012 to designate the CLASS benefit plan. The FAQs also clarify that employers are not required to participate in the CLASS program's automatic enrollment process for their employees and that employers should not yet start withholding premiums for CLASS coverage from their employees' pay. The FAQ makes it clear that enrollment in the CLASS program will not take place before the plan is announced, and no one will pay premiums until after they enroll.

The FAQs can be found **by clicking here**.

SINCE YOU ASKED:

WHAT HAPPENS IF AN EMPLOYEE DOESN'T ENROLL IN MEDICARE PART B WHEN FIRST ELIGIBLE?

Willis' National Legal & Research Group (NLRG) often fields questions about Medicare. NLRG recently received a question about an employee who was participating in the employer's group health plan and eligible for (but not enrolled in) Medicare Part B. Upon his retirement, he elected to continue coverage under the employer-sponsored plan through COBRA; he did not enroll in Medicare Part B. When his COBRA ended, he contacted Medicare to enroll in Medicare Part B. At that time, he was told that he would have to wait until Medicare's General Enrollment Period (January 1 – March 31) to enroll and that his coverage would not be effective until the following July 1. He was also informed that he would have to pay a higher Part B premium. NLRG was specifically asked why.



Please note that NLRG's general recommendation for questions involving Medicare is that, given the complexity of plan choices, enrollment deadlines and potential late enrollment penalties, employers should refrain from offering advice to employees. Instead, the individual should always be directed to contact Medicare about his or her specific situation. The following is a general discussion of the applicable rules for enrolling in Medicare Parts A and B. For information about Medicare Part D prescription drug coverage, please see Chapter 12 of Willis' online *Compliance Manual*.

MEDICARE ENROLLMENT PERIODS

The Medicare program contains three enrollment periods during which individuals can sign up for benefits under Part A (hospital insurance) and Part B (medical insurance). They are the Initial Enrollment, Special Enrollment and General Enrollment Periods.

INITIAL ENROLLMENT PERIOD

As the name implies, this is the enrollment period when the individual is first eligible for Medicare. The Initial Enrollment Period (IEP) is a seven-month period that encompasses the three-month period prior to the month in which the person reaches age 65, the month in which the person's 65th birthday occurs and the three-month period after the month in which the person turned 65. For example, if a person's 65th birthday is June 7, 2011, the IEP runs from March 1, 2011 through September 30, 2011.

However, if the person is receiving benefits from Social Security or the Railroad Retirement Board, Medicare will automatically enroll the person in Part A and Part B starting the first day of the month in which the individual turns age 65. The Medicare card and information is sent about three months prior to the individual's 65th birthday. Since there is a Part B premium, however, individuals can opt out of Part B by following the directions that come with the card.

For those individuals who are not receiving benefits from Social Security or the Railroad Retirement Board, they must submit an application to enroll in Medicare during their seven-month IEP. If the person delays enrollment (in Part A or Part B, or both) and does not qualify for the special enrollment period (SEP), the person has to wait until the next General Enrollment Period (GEP) to enroll. In addition, if an employee does not enroll in Medicare Part B during his or her IEP, he or she may have to pay a higher Part B premium. The Part B premium may increase by 10% for each 12-month period that an individual could have signed up for Medicare Part B but did not, *except* if the individual is entitled to a SEP. The individual pays the extra cost for as long as the person has Part B insurance.

SPECIAL ENROLLMENT PERIOD

This period is available to an eligible person who did not sign up for Medicare Part B previously because the individual or the individual's spouse was working and had group health coverage through an

employer or union plan. The higher Part B premium for delayed enrollment does not apply if the individual in this situation signs up for Part B:

- a. Any time while still covered by the group health plan available through the person or spouse's employment, or
- b. During the eight months following the month that the employer or group health plan coverage ends, or when employment ends (whichever is first)

A person can also add Part A at this time if they did not enroll previously. If the individual does not enroll by the end of the eight-month SEP, he or she will not be entitled to another SEP and will have to wait until the next GEP to enroll.

GENERAL ENROLLMENT PERIOD

If an individual did not sign up when first eligible or, if applicable, during the SEP, the person can still enroll in Part B (and Part A if not previously enrolled) during the GEP which runs from January 1 through March 31 each year. However, coverage for Part B (and Part A, if not previously enrolled) does not start until the following July 1 and the higher Part B premium discussed above will apply.

CONCLUSION

The employee who waited until his COBRA coverage was ending to enroll in Medicare Part B was not entitled to a SEP. The SEP for Medicare enrollment ends eight months following the month in which employment ended, but the employee waited 18 months (the maximum period for COBRA coverage due to a termination of employment) before attempting to enroll in Medicare Part B. Exhausting COBRA coverage does not give rise to another SEP. As such, the employee had to wait until Medicare's GEP to enroll and was subject to the higher Part B premium. It is important for those individuals who are terminating employment and eligible to elect COBRA continuation coverage to keep this SEP in mind when deciding whether or not to enroll in Medicare Parts A and B or to elect COBRA.

HR CORNER

NEW ADA REGS BRING MORE CLARITY

The ADA Amendments Act, or ADAAA, was passed by Congress in 2008 and became effective in January 2009. And, it took the Equal Employment Opportunity Commission until March 24, 2011, to issue final regulations interpreting the revisions to the law. To be fair, the commission issued proposed regulations in September 2009, but it was inundated with public comments and questions.

It goes back to the beginning. Responding to and integrating all those comments took the commission considerable time. We asked Legal Editor Joan Farrell, J.D. to explain some of the more important revisions. “Legislators and EEOC say they intended to reset the law back to what Congress envisioned when it passed the ADA in 1990. So the revised regulations actually reverse two U.S. Supreme Court rulings that legislators felt had narrowed the law, especially the meaning of disability.”

And, Congress went back to testimony from 1990 to discern what legislators meant at that time. In 1999, justices ruled, in *Sutton v. United Air Lines*, that the benefits of medication or corrective devices used to mitigate an impairment had to be taken into consideration when deciding whether that impairment rose to the level of disability. If drugs or hearing aids or some other device mean that the impairment no longer “substantially limits” the individual in “a major life activity,” the ruling said, then the person doesn’t have a disability.

The new final regs provide that, for the most part, such mitigating measures should not be taken into account in defining a disability. The only exception is eyeglasses or contact lenses. Ironically, the Sutton plaintiffs were twin sisters who wore strong eyeglasses—and United Air Lines wouldn’t hire them as pilots because of their poor vision.

The other Supreme Court ruling, in 2002, that Congress felt cut back too far on ADA’s protections was *Toyota Motors v. Williams*. There, the plaintiff had injured her back and could no longer do the physically demanding job she held. But justices said that, because she could do all the activities basic to a normal life, such as cooking and bathing herself, she couldn’t invoke ADA protection. They set what they called “a demanding standard for qualifying as disabled.”

There may be lots more plaintiffs. The new regs now include many more conditions as disabilities. “For example,” says Farrell, “such episodic illnesses as cancer and epilepsy, even if they are in remission or under control, are now seen as disabilities, as they were when they were active. And to ‘major life activities’ the regs added ‘major bodily functions,’ such as the brain, immune system, and neurological and endocrine functions.”

Many discrimination cases brought under ADA since the two court rulings focused mostly on whether someone did or did not have a disability under the strict definition. That will no longer be emphasized in litigation. Instead, plaintiffs will show how an employer treated them.

BLR Legal Editor Joan Farrell, J.D. urges employers to skip to the very end of the regulations where the *Interpretive Guidance*, an appendix, is full of good information about what they should and shouldn't do. One change she noted is that when a plaintiff charges that he or she was "regarded as" disabled by the employer, the focus in court will shift away from what the employer did or did not believe to how the person was treated—similar to the focus shift away from the definition of disability to how the employee was treated.

Employers that raised questions about the proposed regs are pleased that many of the them have been answered: EEOC listed impairments that are "automatic disabilities," explained how it will analyze "working" as a major life activity; how condition, manner, and duration may be relevant to whether an impairment is a disability, and the length of time a condition must last to be a protected disability.

Automatic disabilities include deafness, blindness, missing limbs, cancer, diabetes, HIV, multiple sclerosis, and a number of others. Whether other conditions are or are not disabilities must be determined through an individual assessment.

The definition of "working," as it did under ADA covers a "class or broad range of jobs." But, says Farrell, there are some provisions of the regs "that could give employers pause. For example, a 'transitory or minor' condition is transitory if it lasts less than six months, but minor isn't defined. So there really isn't a clear limit on duration. Those are questions that may need to be sorted out in court." If a plaintiff has not asked for a reasonable accommodation, or fails to make that request

part of his or her lawsuit, courts will analyze the case under the "regarded as disabled" prong of the law.

In determining whether an employee is substantially limited in a major life activity, employers should compare the person to "most people in the general population" in the following ways: the condition under which they perform the activity; how they do so; how long it takes them to perform it and how long they can do so; the difficulty, effort, or time it takes them to do so; the pain they experience; and the adverse effects, if any, of prosthetics, other aids, or medications. Take note: The regs become effective on May 24, 2011.

You can access the regulations at www.regulations.gov. (There are also some helpful frequently asked questions about the regs at www.eeoc.gov.)

This article provided by BLR.

NEW GUIDANCE ON BREAK TIME FOR NURSING MOTHERS

The Patient Protection and Affordable Care Act (PPACA) amended the Fair Labor Standards Act (FLSA) (29 USC §207) to require employers to provide rest breaks and space for employees who are nursing mothers to express breast milk.

As a result, the FLSA now requires covered employers to provide rest breaks to mothers who wish to express breast milk and to provide an appropriate space, other than a bathroom, for mothers to express milk.

All employers covered by the FLSA and that employ 50 or more employees are required to comply with the amendment. Employers with

fewer than 50 employees are not required to provide the breaks if such requirements would impose an undue hardship.

CLEARING UP A FEW THINGS

When the FLSA was first amended, many questions were raised regarding the scope of the new leave requirements. In response, DOL issued a fact sheet that further clarified employers' responsibilities and nursing mothers' rights under the new law.

DOL's "Fact Sheet #73: Break Time for Nursing Mothers under the FLSA" provides general information on the break time requirement for nursing mothers in the PPACA, including general requirements, time and location of breaks, and coverage and compensation during break time.

REQUEST FOR COMMENTS COMES WITH GUIDANCE

Most recently, in December 2010, DOL announced that it was asking for comments on the nursing break requirements of FLSA. No new regulations would be issued, said DOL, but the call for comments would help the DOL "...develop guidance for employers that will assist them in complying with this new law and [will] support women who choose to continue nursing once they return to work," according to Secretary of Labor Hilda L. Solis.

KEY POINTS: DOL CALL FOR COMMENTS

In its request for comments, DOL reveals some key information that further clarifies the new break time rule for nursing mothers and their employers:

Unpaid break time. Although the law does not require the employer to compensate covered employees, DOL's call for comments states that if the employer already provides compensated breaks to employees, the covered employees must be paid for that portion of time expressing milk equal to the time paid other employees during breaks. The employer does not have to compensate for time that exceeds the paid break time. The WHD encourages employers to permit nursing employees to make up unpaid break time.

Reasonable break time. DOL's call for comments states that "the frequency of breaks needed to express breast milk varies depending on factors such as the age of the baby, the number of breastfeedings in the baby's normal daily schedule, whether the baby is eating solid food, and other factors." Therefore, "The Department expects that nursing mothers typically will need breaks to express milk 2 to 3 times during an 8-hour shift. Longer shifts will require additional breaks to express milk."

Employers are encouraged to take into consideration the frequency and number of breaks a nursing mother "might need and the length of time she will need to express breast milk." The analysis of reasonable time will also include the time it takes to get to the lactation site and the time it takes to gather, set up, and clean a breast pump or other supplies and to secure and store the milk.

Room for expressing milk. The break time for nursing mothers provision requires that covered employers provide "a place, other than a bathroom, that is shielded from view and free from intrusion from co-workers and the public, which may be used by an employee to express breast milk." DOL's initial interpretation of the requirement that the space be "shielded from view and free from

intrusion” is that it requires employers, where practicable, to make a room (either private or with partitions for use by multiple nursing employees) available for use by employees taking breaks to express milk.

Where it is not practicable for an employer to provide a room, DOL says the requirement can be met by creating a space with partitions or curtains. Any windows in the designated room or space should be covered to ensure the space is “shielded from view.” With any space provided for expressing milk, the employer must ensure the employee’s privacy through means such as signs that designate when the space is in use or a lock on the door. The employer is not obligated, says DOL, to maintain a permanent, dedicated space for nursing mothers. A space temporarily created or converted into a space for expressing milk or made available when needed by a nursing mother is sufficient provided that the space is shielded from view and, free from intrusion from co-workers and the public.

What needs to be in the space? In order to be a functional space, DOL says the room must contain, at a minimum, a place for the nursing mother to sit, and a flat surface, other than the floor, on which to place the pump. Ideally, the space will have access to electricity, so that a nursing mother can plug in an electric pump rather than use a pump with battery power.

DOL recognizes that there is a range of additional features that some employers have included when providing spaces for their employees to use to express breast milk, such as sinks within or nearby the room, for washing hands and cleaning pump attachments, and refrigerators within or near the room for storing expressed milk. While such additional features are not required, says DOL, their provision may decrease the amount of break time needed by nursing employees to express milk.

Employers are not required to provide refrigeration options for nursing mothers for the purpose of storing expressed milk; however, they must allow a nursing mother to bring a pump and insulated food container to work for expressing and storing the milk and make certain there is a place where she can store the pump and insulated food container while she is at work.

Coordination with the FMLA. DOL states that breaks for expressing breast milk would not properly be considered FMLA or counted against the FMLA leave entitlement.

Enforcement. Complaints will be received and handled by the DOL Wage and Hour Division (WHD), which can seek injunctive relief. Termination of an employee protected by the statute for exercising her rights under the law could result in litigation by the WHD to obtain reinstatement and reimbursement of lost wages.

To see the complete set of guidance in DOL’s call for comments, go to *Federal Register*, Vol. 75, No. 244, page 80073 (December 21, 2010).

This article provide by BLR.

WELLNESS

THE HIGH COST OF POOR SLEEP

Employers are paying a high price for their employees' lack of or poor sleep. Sleep deprivation costs businesses in the U.S. an estimated \$150 billion annually in absenteeism and lost productivity. Poor quality sleep reveals itself in the workplace as irritability and decreased productivity, including lessened attention to detail and poor communication. A recent study in the *Journal of Occupational and Environmental Medicine* outlined the impact of sleep disturbances on work performance and productivity. Employees at four corporations were surveyed about their sleep patterns and completed the Work Limitations Questionnaire. Participants were classified into four groups: insomnia, insufficient sleep syndrome, at risk and good sleep. Results showed that the insomnia and sleep syndrome groups had significantly worse productivity, performance and safety outcomes. The group with the highest use of sleep medication use was the insomnia group. Fatigue-related productivity losses in this study were estimated to cost nearly \$2,000 per employee annually.

According to the *American Journal of Respiratory and Critical Care Medicine*, the economic costs of poor sleep will continue to rise. For example:

- Fatigue and sleep disordered breathing are associated with a 10-20% increase in health care utilization.
- Employees diagnosed with insomnia were twice as likely to seek treatment for emotional problems, have double the number of physician visits and twice as many hospitalizations.
- 80-90% of obstructive sleep apnea (OSA) cases remain undiagnosed. Testing and treatment costs for every American with OSA would be more than \$20 billion.

What can employers do?

- Promote better sleep through an employee communication campaign focused on healthy sleep habits
- Promote Better Sleep Month in May, www.bettersleep.org
- Consider dedicated space for a quiet room
- Consider including treatment for sleep apnea in the health plan benefits

For assistance with other health-related issues in the workplace, contact your Willis Client Advocate®.



WEBCASTS

9TH ANNUAL METLIFE EMPLOYEE BENEFITS TREND STUDY FINDINGS

MAY 17, 2011
2:00PM EASTERN

Presented by:
DR. RON LEOPOLD

MetLife is proud to give you a first look at its much anticipated 9th Annual MetLife Study of Employee Benefits Trends. For the 9th consecutive year MetLife has surveyed employers and employees to develop a current and comprehensive look at the state of the U.S. employee benefits industry. This year's study examines employee/ employer relations on the cusp of economic recovery and reveals unexpected challenges for companies as the economy rebounds; over a third of employees hope to be working somewhere else in 2011. Balancing retention goals with the other key benefits objectives of cost control, and maintaining recession-generated employee productivity gains is a skillful juggling act, especially in the light of health care reform. But the Study findings suggest a new benefits blueprint for guiding this effort – especially when it comes to health and financial security benefits.

Join Dr. Ron Leopold as he shares the latest findings and insights that can help as you work with your clients to identify opportunities to modify or improve upon current benefit strategies – ensuring that they realize the full potential of their benefits programs and continue to maximize the return on their investment.

The annual Study reflects MetLife's long-standing commitment to providing executives, benefits professionals, brokers, and consultants with the latest knowledge and insights to maximize the effectiveness of employee benefit plans.

Participant Access

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

FMLA GETTING BACK TO THE BASICS

JUNE 21, 2011
2:00PM 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.

KEY CONTACTS

US BENEFITS 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

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Reston, VA
703 435 7078

Richmond, VA
804 527 2343

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301 692 3025

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904 355 4600

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770 425 6700

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305 421 6208

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251 544 0212

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Grand Rapids, MI

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Milwaukee, WI

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414 259 8837

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763 302 7209

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