

WELLNESS

STAND UP FOR BETTER HEALTH

If you are reading this sitting down, you may want to stand up! According to a Vanderbilt University study published in 2008, the average American spends 55% of their waking time or 7.7 hours a day sitting. Recent research from The American Institute for Cancer Research states that as many as 49,000 cases of breast cancer and 43,000 cases of colon cancer each year are linked to a lack of physical activity. Additional research suggests that even those who *are physically active* but have a sedentary job, are at increased cancer risk due to prolonged periods of sitting.

How does this happen? Prolonged periods of sitting inhibit the circulation of a fat absorbing enzyme called lipase. Conversely, while standing, the fat is processed and distributed throughout the body instead of being deposited into vital arteries and ultimately causing disease.

Encourage your employees to do more than just park further away from the building or take the stairs instead of the elevator. Below are a few tips to get employees more physically active during the day.

1. Encourage employees to get up on the hour and take a short walk. If they have trouble remembering to do so, suggest they use a timer. 3 to 5 minutes an hour of standing alone is adequate.
2. Encourage employees to discuss business matters in person versus sending an e-mail.
3. Encourage employees to stand up and walk around while on a conference call.
4. If your building has several floors, encourage employees to use a bathroom on a different floor.
5. Explore piloting standing workstations.

Take a stand in your organization for better health. To learn more about the resources and tools available to help get you started, contact your Willis service team.



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HR CORNER

DON'T GET CLOCKED BY TIMESHEET CONFLICTS

Employees who keep private records of time worked are nothing new. What is new is that the DOL has launched its new “DOL Timesheet App” and a similar paper version called the “Work Hours Calendar,” which encourage employees to maintain their own time records. While the DOL has been careful to say that it neither encourages nor discourages legal action, it’s taking measures that could alter the balance in favor of litigation.

Most companies that employ hourly workers have timekeeping mechanisms in place and generally are informed on the FLSA regulations that govern what time is considered compensable “work” and what time isn’t. If an employee keeps his own timesheet and a difference arises between his records and the employer’s, incongruities can create disagreement.

Managers should have written policies that instruct employees to advise management immediately if their records disagree with the employer’s, so that discrepancies can be reviewed before ever reaching the point of litigation. After the inconsistencies have been addressed, the company should secure the employee’s written acknowledgement that the issue was discussed and resolved.

Wage and hour actions against businesses likely will be an increasing concern for the foreseeable future. In addition to the recommendations above, employers should audit their hours-worked practices and periodically review their exemption classifications to err on the side of self-protection.

This article provided by Gregory Ballew, Fisher & Phillips.

IN PRAISE OF . . . ORIENTATION?

While consideration of a process to optimally introduce new employees to the company may be swimming upstream just a little, consideration of a carefully-crafted orientation program is not at all out of place. For one thing, it’s easier to think about this subject when new employees are not flowing through the doors in large numbers. For another, orientation programs which communicate to new employees the values, beliefs, culture and history of the employer are and will be more important than ever as expectations increase, as they must, in the “new economy” in which employers as well as employees are going to have to achieve more with fewer resources.

A thoughtful introduction to the company is essential if you believe there is any correlation between employee commitment and company performance. We strongly believe that there

is a very high correlation between employee involvement and company achievement. We also believe that a well-structured orientation program is an effective and very necessary first step in taking your company out of the low-hanging-fruit category for union organizers, in a rapidly changing environment where management will very likely have much less time to oppose union marketing efforts than it had in the past.

STARTING ON THE RIGHT FOOT

It's true that employee orientation does not have any slick, new-age moniker which makes it sound like it's a new idea or somehow smarter and more relevant than it was in the past. It's also true that the concept has been around for a long time and is not particularly helpful to consultant marketing or branding initiatives. But if you think about it, a careful introduction to your company just makes sense.

In almost every case, new employees know very little about the company – they probably know next to nothing about the company's history or its key accomplishments. They have no idea about their co-workers, about their supervisors, about top management, about their job responsibilities, your expectations, how you measure contribution, or what is really important to the company. Orientation is your chance to tell them what you really, really want them to know and understand about the company. There will never be a better opportunity to shape impressions and expectations than you have at the beginning of employment. In our experience too many employers don't even recognize the opportunities that are slipping through their fingers because they are too busy focusing on the tyranny of the schedule and the everyday grind.

There is one additional and inevitable benefit in addition to all those mentioned above: The fact that you take the time to inform the new employee about the company sends an inescapable message to that new employee. "YOU'RE IMPORTANT." This is never a bad message to send to anyone, whether a new or a long-term employee.

Alternatively, management can opt not to take the time to communicate its pride in the company and its accomplishments, it can save the time and let someone else conduct the orientation. And don't fool yourself, new employees **will** receive an orientation, whether you provide one or not. They will and must form impressions about the company. When you abdicate your responsibility for a careful introduction, you just can't be sure what the orientation will be. If you don't provide it, a disgruntled employee who has no use for the company or its objectives or culture may fill in the void. Or if a disgruntled employee doesn't "assist" in the orientation, you may leave the employees on their own to make uninformed guesses about what is important to know about the company. So you must decide what kind of orientation your new employees will receive.

SOME FUNDAMENTAL CONCEPTS

If you accept our claim that new employee orientation programs are truly important, here are some elements a well-designed program should include.

Initially we think orientation should extend over more than one day. Saying this does not imply that orientation needs to be an interminable slog which must be entirely completed before an employee starts to do any productive work. We do believe that orientation

activities should be intermixed with all of the other necessary elements of someone starting at ground zero and progressing to reasonable productivity.

Periodic questionnaires or mini-surveys during the first weeks of the orientation should also be considered to provide feedback about each new employee's view of the effectiveness of the orientation. Responses to these questions will also provide the opportunity to reinforce points which may not have been effectively communicated the first time.

Typically, employers have a secretary, payroll clerk or the junior human resources person sit down with the new employee(s) and get all the necessary paperwork signed which includes W-4s, insurance forms, etc., and put the employee to work. If this is your orientation program, it is neither adequate or effective. While the orientation period should last more than one day, and will necessarily involve the completion of all required paperwork, it needs to include much more.

We believe that an effective orientation program should, among other items, include the opportunity for the new employee to be exposed to managers at all levels of the organization, as well as provide an explanation of company expectations, opportunities for advancement, introductions to co-workers and to the operations both in front and behind the employee's work department so the new employee understands how the job interacts with those both up and down stream. A thorough safety briefing is also essential. Obviously it is in the company's interest that all employees work safely and go home at the end of the day in the same condition as they came to work in the morning. Additionally a safety mentality sends the message to the new as well as to old employees that the company really cares about them, which is never a bad impression to leave with an employee.

Some employers with unionized workforces don't bother communicating the company's strengths because all of the employees are covered by a collective bargaining agreement and the employer is obligated to deal with the union. An excellent introduction to the company is useful in *every* case because union-represented workers are not automatons. It is not violation of any labor law if they choose to work productively and use their brains as well as their physical skills to accomplish the company's goals. No provision of the National Labor Relations Act mandates that an employer abdicate its responsibilities to effectively manage, inspire and motivate union-represented employees as well as those who are not represented by a union. There will be no excuse or slack for the employer who does not maximize each and every resource available to her in the new global economy.

We believe so strongly in the importance of an employer's communicating what makes each company unique, that we do not advise limiting employee-orientation efforts only to new employees. Messages about the company's history, why it believes in itself, its culture and value systems should be communicated regularly to employees, even those who are no longer new to the company; and this is particularly so if there has been no prior effective orientation program in effect. So, effective employee orientation need not necessarily be restricted to employees who first walk in the door, although it should always be used for each of them from this point forward.

This article provided by John McLachlan, Fisher & Phillips.

LEGAL & COMPLIANCE

DOL ANNOUNCES DELAY OF SUMMARY OF BENEFITS & COVERAGE REQUIREMENTS

The Department of Labor (DOL) has posted new FAQs on its website that include good news for health plan sponsors: the Summary of Benefits and Coverage (SBC) requirements are delayed pending regulations. The requirement was thought to become effective on March 23, 2012, which caused considerable anxiety among those responsible for health plan communications, given the long lead time often needed to produce such materials. It appears that the DOL focused on the statute's requirement that the SBC is to be provided pursuant to standards developed by the responsible federal agencies. The agencies have proposed such standards, but those are subject to comments and revisions before they are finalized. (See Willis Human Capital Practice *Alert*, October 2011, "**Proposed Regulations for Summary of Benefits and Coverage Released.**")

In its FAQ, the DOL stated that "until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act § 2715." The DOL's reference to § 2715 in this quote is significant. In addition to requiring the SBC, § 2715 requires grandfathered and non-grandfathered health plans to provide at least 60 days' advance notice of "material modifications" that are not reflected in the most recent SBC. It appears, therefore, that the 60-day advance notice requirement also is delayed. (A previous DOL FAQ noted that the advance notice requirement would not be enforced until the requirement to provide the SBC became effective.) The DOL "anticipate[s] that the Department's final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply."

The new FAQs are posted [here](#).



The screenshot shows the top navigation bar of the United States Department of Labor website, including the logo, "Subscribe to E-mail Updates", and search options. Below the navigation is the "Employee Benefits Security Administration" header and a breadcrumb trail: "DOL > EBSA > Frequently Asked Questions". The main heading is "FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation", with a link to a "Printer Friendly Version". The text below explains that these FAQs address implementation of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008. A key section, "Summary of Benefits and Coverage", contains a Q1: "On August 22, 2011, the Departments issued proposed regulations and proposed templates in connection with implementation of the Summary of Benefits and Coverage and Uniform Glossary requirements of PHS Act § 2715. An applicability date 'beginning March 23, 2012' was proposed. At the same time, the Departments invited comments generally, as well as on a range of discrete issues, including the timing of the application of the SBC requirement."

BACKGROUND

The health care reform law expanded the disclosure obligations of both grandfathered and non-grandfathered group health plans, requiring distribution of SBCs according to standards developed by responsible agencies. Notably, any group health plan that willfully fails to provide or update the SBC as required may be fined up to \$1,000 per enrollee who is not provided the required information. The health care reform law specified that, by March 23, 2011, the Department of Health and Human Services (HHS) was to have provided "standards" for creating and providing the SBC as required. It was not until August 17, 2011, however, that the agencies released proposed

regulations. Along with that proposal, the agencies issued requests for public comments on many issues, including the feasibility of meeting the March 23, 2012 compliance date.

For group health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), the SBC will be required in addition to the summary plan description (SPD) and other disclosures required by ERISA. The delay of the SBC and 60-day advance notice requirements does not relieve employers of ERISA obligations to provide SPDs and summaries of material modifications.



CMS CREDITABLE PRESCRIPTION DRUG COVERAGE: FILING REMINDER

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires all plan sponsors – even those who did not provide retiree prescription drug benefits – to distribute notices to Part D-eligible individuals explaining the creditable coverage status of their prescription drug benefits. This notice tells recipients whether or not the plan’s prescription drug coverage is considered “creditable” as measured against Medicare’s Part D standard prescription drug benefit. Creditable status is important since a Part D-eligible individual will be assessed a Part D late enrollment fee if he or she initially waives enrollment in Medicare’s prescription drug benefit and later enrolls after a break in creditable coverage of 63 days or longer. Details of this notice obligation are available in Chapter 12 of the on-line *Willis Compliance Manual*. (Please check with your Willis representative to obtain access to the manual.)

ADDITIONAL REPORTING DUTY TO CMS

A second and perhaps more easily overlooked disclosure requirement is that group health plan sponsors providing prescription drug coverage to Medicare Part D-eligible individuals *must also report creditable status directly to CMS*. Specifically, the group health plan must communicate whether its prescription drug coverage qualifies as creditable or non-creditable. The government needs this information to effectively coordinate Medicare Part D enrollment.

All plan sponsors providing prescription drug coverage are required to make this disclosure – even if they do not make coverage available to retirees. Reporting to CMS about the plan’s creditable status is due within 60 days after the first day of the new plan year. Calendar-year plans must submit the disclosure to CMS by March 1, 2012. Additional information about the CMS reporting duty is also contained in the *Willis Compliance Manual*.

IRS CONTEMPLATES PROPOSING NEW DEFINITION OF “GOVERNMENTAL PLAN”

Recently, the Internal Revenue Service (IRS) issued two notices describing some rules for defining governmental plans for purposes of the federal tax code. The notices explain that the IRS contemplates issuing those rules in proposed form but wants to receive public comments on them before doing so. The rules being considered by the IRS are provided as attachments to the notices.

The first of the two notices describes a set of rules that would define the term “governmental plan” generally and is available by [clicking here](#). The second notice describes rules providing guidance on whether a plan of an Indian tribal government may qualify as a governmental plan. That notice is available by [clicking here](#).



BACKGROUND

Various federal laws regulating employee benefits plans apply differently when the plans are sponsored by governmental entities for their employees. For example, the COBRA provisions included in ERISA and the federal tax code do not apply to governmental plans, but the COBRA provisions included in the Public Health Service Act (PHSA) do apply to state and local governmental plans. Generally, the significance of this is that the penalties and liabilities that may apply to governmental plans for COBRA violations are different from those that apply to other plans.

Section 414(d) defines governmental plans for various benefits purposes under the federal tax code. The § 414(d) definition is primarily relevant for retirement plans that need to meet various federal tax code requirements in order to be qualified plans. Even so, the § 414(d) definition also is relevant for health plans and other welfare benefits plans. In some cases, tax code provisions affecting welfare benefits directly refer to § 414(d)'s definition of governmental plan. Interpretations of the § 414(d) definition also are relevant to welfare plans because ERISA's definition of a governmental plan (i.e., a plan exempt from ERISA) is substantially identical to the § 414(d) definition. Currently, there are no regulations interpreting § 414(d).

DEFINITION OF GOVERNMENTAL PLAN

Even though identifying governmental entities seems straightforward, in some cases, it can be difficult to determine whether a specific plan meets the definition of a governmental plan. This is particularly true in the case of a plan maintained by an Indian tribal government.

As stated in § 414(d), governmental plans include “a plan established and maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.” The rules under consideration by the IRS interpret this definition.

The IRS notes that guidance is needed on the meaning of certain terms used in the definition, including:

- Established and maintained
- Political subdivision
- Agency
- Instrumentality
- State

According to the IRS, “[t]he anticipated proposed regulations would include numerous factors for determining whether an entity is an agency or instrumentality of a State or a political subdivision of a State.” Rules relating to plans sponsored by Indian tribal governments would primarily focus on the extent to which employees covered by the plan are engaged in commercial or governmental activities.

The IRS consulted the Department of Labor (DOL, the agency that interprets ERISA) in connection with the rules being considered. According to the IRS, the DOL agrees that it would be a good idea to have “coordinated criteria for determining whether a plan is a governmental plan.”

Comments on these “proposals to propose” are to be submitted by February 6, 2012. Among other things, the IRS is requesting comments on “the clarity of the proposed rules and how they can be made easier to understand.” Willis, through the American Benefits Council, will be commenting on behalf of its clients.

HEALTH CARE TAX CREDIT: NEW LEGISLATION EXTENDS AND MODIFIES PREVIOUS PROVISIONS

President Obama recently signed the Trade Adjustment Assistance Extension Act of 2011. Among other things, the law modifies the Health Coverage Tax Credit (HCTC). The HCTC is a refundable tax credit available to certain individuals to help them pay for health insurance. The HCTC occasionally affects employers because it can be used to purchase COBRA. (It can also be used to purchase a number of other types of coverage.) In addition, availability of the HCTC can alter COBRA administration in some cases. For details of when the HCTC applies and exactly how it affects employers, see Chapter 2 of the on-line *Willis Compliance Manual*. (Please check with your Willis representative to obtain access to the manual.)

IMPORTANT: The HCTC is NOT the COBRA subsidy that was available to many (if not most) individuals who suffered involuntary termination of employment at various times in 2008, 2009 and 2010. Most employers will recall that they were required to provide the COBRA subsidy to qualifying individuals and allowed to recover it in most cases through reduced payments of payroll taxes. After August 2011, the vast majority of COBRA subsidy recipients have exhausted their eligibility, and the program has not been extended or renewed for later periods.

The HCTC is a completely different program. It is available to certain individuals receiving federal trade adjustment assistance benefits due to job loss (or reduced hours and wages) resulting from increased imports. It is also available to certain individuals receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). In comparison to the COBRA subsidy, the HCTC applies to very few former employees. Although the HCTC can be used to pay for COBRA coverage and can sometimes affect COBRA administration, it affects very few employers because employers do not administer or provide the HCTC. Individuals claim the HCTC on their tax returns as a refundable tax credit. In some cases, eligible recipients can obtain the HCTC through an advance payment program administered by the IRS.



HCTC CHANGES

The recently adopted modifications to the HCTC include:

- A sunset date: The HCTC will not be available for any month of coverage beginning after December 31, 2013.
- An increase: The HCTC is increased from 65% to 72.5% of eligible premiums, retroactive to the first coverage month beginning after February 12, 2011. Previous legislation had temporarily increased the HCTC to 80%, but it reverted to its prior 65% level starting with the first coverage month after February 12, 2011. Because this latest increase is retroactive, the 65% level that has applied since last February is now 72.5%. The IRS is in the process of determining how it will implement the retroactive increase in the HCTC. Information is available [here](#).

COBRA AND HIPAA PORTABILITY CHANGES

In addition to changing the HCTC, the legislation modifies some COBRA and HIPAA portability provisions to match the HCTC modifications.

Previous legislation included provisions allowing certain HCTC recipients to keep their COBRA coverage beyond the time it would normally end but provided that any extension of the COBRA period under those amendments would end no later than February 12, 2011. That end date is now January 1, 2014.

- Under one of these extension provisions, if a qualifying HCTC recipient is still receiving certain government benefits when the normal maximum COBRA period runs out (usually 18 months after termination of employment), the plan is required to allow an additional period of continuation until the earlier of January 1, 2014 or cessation of the government benefits.
- The other extension provision, in certain very limited situations, requires that COBRA coverage remain available until January 1, 2014, unless the end of the normal maximum COBRA period is later.

These provisions have a confusing effective date. They do not extend any period of COBRA coverage that, under the rules then in effect, ended before November 20, 2011. They only apply to situations in which, without the extension provided by the new provisions, the HCTC recipient's COBRA coverage would end on or after November 20, 2011.

The new legislation also extends a previous modification of the way that the HIPAA portability rules apply to individuals who qualify for the HCTC so that it is effective for plan years starting before January 1, 2014. These rules prevent certain HCTC recipients from being subject to a preexisting condition exclusion as a result of not having health coverage during certain periods. The relevant periods for purposes of this rule start with an HCTC recipient's trade-related job loss and end on one of three dates, as applicable:

- For an HCTC recipient who elects COBRA coverage, the period ends when COBRA coverage becomes effective
- For an HCTC recipient who lost active employee coverage under an employer's plan on or after February 13, 2011 and on or before November 20, 2011, the period ends November 20, 2011
- For other HCTC recipients, the date is until seven days after the DOL issues a certification of eligibility for the HCTC (it is likely that this rule will apply instead of the rule in the previous bullet if that would be more beneficial to the HCTC recipient)

The new legislation provides that application of these HIPAA modifications does not require any plan to modify a benefits determination made on or after February 13, 2011 and on or before November 20, 2011. It appears that this refers to the possibility that, before becoming an HCTC recipient, an individual might obtain coverage that applies a preexisting condition exclusion. If benefits determinations during such a period were made on or after February 13, 2011 and on or before November 20, 2011, expenses excluded due to a plan's preexisting condition exclusion need not be redetermined after application of the new rules.

SCARY STOP-LOSS STORY

A recent court case serves as a cautionary tale about what happens when an employer administers COBRA incorrectly. The plan involved in the case was self-insured and the claim involved was the employer's claim for reimbursement under its stop-loss policy.

BACKGROUND

The employer agreed as part of a severance package to provide a retiree with “extended COBRA” coverage (i.e., coverage that would continue following retirement for much longer than the normal 18-month maximum COBRA coverage period that usually follows a termination of employment qualifying event) and then incurred claims that normally would have triggered reimbursement under the stop-loss policy. The stop-loss carrier denied the employer’s claim for reimbursement because the claims were incurred after the retiree had received all of the continuation coverage required by COBRA. The employer argued that, under COBRA, it was entitled to provide a longer COBRA continuation period than required by the law and therefore, the stop-loss carrier should provide reimbursement for the retiree’s claims, just as it did for other COBRA claims.

The court that decided this case agreed that the employer was free to provide a longer COBRA continuation period under its plan than the minimum required by the law. The court concluded, however, that the employer had not adopted a plan provision to that effect. The plan documentation apparently provided for coverage to continue for the period required by the COBRA statute but not for the longer period that the employer extended to the retiree. Therefore, according to the terms of the plan, the retiree should not have been covered at the time the disputed claims were incurred and those claims should not have been paid by the plan.

The employer argued that its severance agreement with the retiree amended the plan to make COBRA coverage available under the terms of the plan for a longer period and therefore bound the stop-loss carrier to provide coverage. Even if the severance agreement amended the plan’s terms, however, the court concluded that the stop-loss carrier still would not be obligated to provide reimbursement for the retiree’s claims. The stop-loss policy specified that it covered COBRA claims only if incurred under coverage provided according to COBRA regulations. As a result, even if the plan had provided for a longer COBRA continuation period than required by law, the stop-loss carrier would not pay claims incurred after the period specified in COBRA regulations had ended.

LESSON TO BE LEARNED

Many insurance policies – including stop-loss policies – have these types of provisions. In addition to precluding coverage when the employer provides COBRA beyond what is required by law, these provisions also can preclude insurance coverage when the employer is obligated to provide COBRA. For example, an employer that fails to offer COBRA when required generally still has a COBRA obligation and should offer COBRA as soon as the omission is discovered. Because COBRA was not offered according to the COBRA regulations, however, an insurer with this type of provision might refuse coverage of claims incurred by someone electing pursuant to that late offering of coverage. This is why the Willis National Legal & Research Group often recommends that, when a COBRA situation is anything out of the ordinary, the employer should determine with the carrier what coverage will be provided if COBRA is elected. A carrier’s refusal to provide coverage does not excuse the employer from complying with COBRA, but the employer should be aware of the coverage that will be available before offering COBRA.



SAN FRANCISCO HEALTH CARE ORDINANCE AMENDED

San Francisco Mayor Edwin Lee (D) recently signed legislation that amends the Health Care Security Ordinance (HCSO). The legislation makes several changes to the HCSO. Most importantly, it redefines qualifying health care expenditures so that only amounts actually paid or irrevocably committed to pay for providing health care services to employees would satisfy the HCSO's employer expenditure requirements. This could significantly affect the way health reimbursement arrangements (HRA) can be used to satisfy the rules. These changes are effective January 1, 2012.

The legislation makes the following changes:

- Expenditures must remain available to the employee for a minimum of 24 consecutive months from the date of the expenditure
- Expenditures must remain available to terminated employees for 90 days after termination and employers must provide a written notice of the employee's account balance no later than three business days after the employee's separation
- As a condition of using an HRA in 2012, employers must carry over any account balance as of December 31, 2011 to January 1, 2012
- Employers imposing surcharges on customers (such as a restaurant who imposes a "health care surcharge" on diners) must report the amount collected to the Office of Labor Standards Enforcement (OLSE) and, if the amount collected from a surcharge for health care is greater than the amount spent on employee health care, the employer must pay or designate an amount equal to the difference for employees' health care expenditures
- Employers using reimbursement accounts must provide a written account summary (e.g., account balance, applicable forfeiture rules, etc.) to employees 15 days after each quarterly contribution
- Employers using reimbursement accounts must report to OLSE the terms of the accounts, including what costs are eligible for reimbursement
- Employers must post, annually, a notice addressing employee rights and employer obligations under the HCSO (OLSE shall make available, by December 1 of each year, a notice suitable for posting)

Employers using HRAs to meet their obligation under the law will be most affected by the revised ordinance. An employer will want to review its HRA's current terms and make any necessary changes to ensure continued compliance with the HCSO. An employer will also want to be sure the third-party administrator it may use to administer its HRA will be able to handle the changes. Given the law's January 1, 2012 effective date and the requirement to carry over balances remaining at the end of 2011, employers will not want to waste any time addressing this issue.

BACKGROUND

San Francisco's HCSO requires that medium and large businesses make certain minimum contributions toward their San Francisco employees' health care. Under this mandate, an employer may either contribute at least the minimum amount to a medical plan or other health benefits or pay that amount into the publicly available program established by the HCSO. (See Willis Human Capital Practice *Alert*, Issue 112, "**San Francisco Delays Health Care Security Ordinance Effective Date**" for additional information about the HCSO.)

HIPAA PRIVACY AND SECURITY AUDITS

In 2011 it seems the buzzword for employers has been “audit.” The Department of Labor (DOL) publicized a \$12 million increase in its budget in order to hire 90 new investigators. A joint Treasury-Labor initiative ramped up its auditing of employers as it scrutinizes misclassifications of employees as independent contractors.

The momentum for performing audits will continue to be strong in 2012. The Employee Benefits Security Administration (EBSA) recently indicated that its group health plan audits will include investigations of employer compliance with the Patient Protection and Affordable Care Act of 2010 (PPACA). Now, the Office of Civil Rights (OCR), the enforcement arm for the Department of Health and Human Services (HHS) has announced a pilot program to perform up to 150 audits of covered entities to assess compliance with the HIPAA privacy and security rules and breach notification requirements.

The momentum for performing audits will continue to be strong in 2012. The Employee Benefits Security Administration (EBSA) recently indicated that its group health plan audits will include investigations of employer compliance with the Patient Protection and Affordable Care Act of 2010 (PPACA). Now, the Office of Civil Rights (OCR), the enforcement arm for the Department of Health and Human Services (HHS) has announced a pilot program to perform up to 150 audits of covered entities to assess compliance with the HIPAA privacy and security rules and breach notification requirements.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA), greatly expanded and broadened HIPAA's privacy and security provisions. One provision of HITECH requires HHS to perform periodic audits to ensure compliance by covered entities. The OCR pilot program is the start to complying with the audit mandate.

The program will begin in November 2011 and will continue through 2012. Initially developed as a three-step process, that pilot process is outlined below:

- Development of the audit protocols
- Initial wave of audits to test the protocols (throughout November 2011) and revise the process as needed
 - Conducting full range audits pursuant to any revised protocols

The covered entities that are subject to the HIPAA privacy and security rules are group health plans, health care providers and health care clearinghouses. As to the pilot program, OCR will attempt to include as wide a range as possible for the audits, taking size and functions of the entity into consideration. Thus, any covered entity will be considered for an audit. Although HITECH provides that business associates are also subject to being audited, business associates are not included in this pilot program.

As to the actual audit, general audit mechanisms will be employed. Generally, this includes:

- Covered entity informed of audit selection
- Request for documentation of privacy and security compliance efforts
- Site visit (at least during the pilot phase)
- Audit report (at least during the pilot phase)

The site visit of the audit will include key personnel interviews and observation of process and operations. A preliminary audit report will describe how the audit was conducted, audit findings and actions required due to those findings. A final report will incorporate any corrective actions taken by the covered entity as well as any best practices.

OCR has established a tight timeline for the audits:

- Written notification to the selected covered entity between 30 and 90 days prior to the onsite visit
- Onsite visit between 3 and 10 business days
- Draft of final report
- Covered entity has 10 business days to review and respond to draft
- Final audit provided within 30 business days after covered entity's response

In summary, the OCR has established a pilot audit program primarily for the purpose of compliance improvement activity. Results of the audits are expected to help OCR better understand the compliance efforts by covered entities and to share best practices. An OCR audit does not protect a covered entity from further compliance review, which could result in monetary settlements or civil money penalties. Thus, covered entities and business associates should review their HIPAA privacy and security compliance efforts for workforce training, policies and procedures and security risk assessments.

PHILADELPHIA PASSES PAID SICK LEAVE ORDINANCE

The Philadelphia City Council has passed a new ordinance that will require, effective July 1, 2012, certain employers in Philadelphia to provide employees with paid sick leave. The ordinance, which became law without Philadelphia Mayor Michael Nutter's (D) signature, was approved by the council in a 15-2 vote. Earlier this year Mayor Nutter had vetoed a similar bill that would have required all businesses in the City of Philadelphia with more than five employees to provide a minimum number of paid sick days.

The paid sick leave ordinance amends Philadelphia's 21st Century Minimum Wage and Benefits Ordinance, which requires certain employers to pay employees at least 150% of the federal minimum wage and provide certain health care benefits. The ordinance considers "covered employers" to be:

- The City of Philadelphia, including all its agencies, departments, and offices
- For-profit service contractors that receive or are subcontractors on contract(s) with the city for \$10,000 or more of goods/services in a 12-month period, with annual gross receipts of more than \$1 million
- Nonprofit service contractors that receive or are subcontractors on contract(s) from the city for \$100,000 or more of goods/services in a 12-month period
- Recipients of city leases, concessions or franchises, or subcontractors thereof, that employ more than 25 employees
- City financial aid recipients, for which compliance is required for a period of five years following receipt of aid
- Public agencies that receive contract(s) from the city for \$10,000 or more of goods/services in a 12-month period

The new sick leave ordinance states that covered employers must provide each full-time, non-temporary, non-seasonal covered employee with at least one hour of paid sick leave for every 40 hours worked. Employees working for employers with more than five but fewer than 11 employees can accrue up to a maximum of 32 hours per year. For employers with 11 or more employees, up to 56 hours per year can be accrued.

Those employers covered by the ordinance should review their current sick leave policies and make any necessary amendments to ensure compliance by the law's July 1, 2012 effective date.

WASHINGTON PAID FAMILY LEAVE UPDATE

In 2007, Washington enacted legislation that provides paid family leave to employees. Payments under the new law were to become available on October 1, 2009, but due to budgetary reasons this was delayed until October 1, 2012. Earlier this year Governor Chris Gregoire (D) signed legislation that further delays the law's effective date until October 1, 2015.

BACKGROUND

The law created a family leave insurance program that pays Washington employees up to \$250 per week for five weeks so that they can bond with and care for a newborn or newly-placed child. The law only applies to an employer with more than 25 employees. The law requires jobs to be held open for workers on leave and calls for unpaid federal leave and paid Washington state leave to be taken concurrently.

WEBCASTS

FEDERAL AGENCIES ON THE PROWL: BEST PRACTICES FOR DEALING WITH INCREASED FEDERAL AUDIT ACTIVITY

JANUARY 17, 2012
2:00 PM EASTERN TIME

PRESENTED BY
Jay Kirschbaum, Willis National Legal & Research Group

The agencies with the responsibility to enforce the rules regarding benefits, tax and employment at the Department of Labor and Treasury have gotten approval and funding for more enforcement activity. This session will provide information, insight, tips and suggestions for employers to anticipate and be ready for the dreaded audit. We will share best practices to follow even if you are not prepared and how to respond in the event the letter from the agency arrives before you're ready.

PARTICIPANT ACCESS

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

EMPLOYEE MOBILITY

FEBRUARY 21, 2012
2:00 PM EASTERN TIME

PRESENTED BY
Chris Burns, Chief Executive Officer, Willis Global Employee Benefits Practice

As business goes global, more and more companies are finding they must station employees overseas. Providing benefits in an international environment opens up new but crucial challenges, including a host of issues that complicate benefits, such as health care management and compliance for employers and expatriates. Benefits programs need to reflect the realities of the world into which expatriates are sent. By knowing what the challenges are, as well as best practice solutions, employers can better understand what expatriates will need. Join Willis for an informational webcast, in which we will cover:

- Health Care – What are the real risks?
- International insurance issues and important considerations
- Traveler support
- Expatriate facts and concerns
- Overview of health care challenges
- Typical benefits and plan design
- Meeting expatriate health care needs

PARTICIPANT ACCESS

Advance reservations are required to participate. [Click here](#) to register 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
407 562 2493

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
800 236 3311

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 861 9100

Columbus, OH
614 326 4722

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

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 8506

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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