



NEW/REVISED LAWS FOR 2009

Congress was very active prior to the election in November. President George Bush signed most of the Acts passed and some of those affect welfare benefit plans. For discussion purposes, this article will highlight some of the new laws and their effective dates.

AMERICANS WITH DISABILITIES ACT AMENDMENT (ADAA)

While this Act (ADAA) has the most impact on employment law and company practices, there are some aspects which may affect benefit plans that contain disability based limitations or exclusions. The ADAA has re-defined "disability" as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." It further expands the term "major life activities" by adding bending, eating, sleeping, reading, communicating and the operation of bodily functions, such as the immune system, normal cell growth, digestive, bowel, bladder, brain, neurological, respiratory, circulatory, endocrine, and reproductive systems to the original listings in the earlier ADA. Although this Act goes into effect on January 1, 2009, how the regulators view necessary plan changes will not be known until the Department of Labor (DOL) issues regulations, which will most likely occur later in 2009.

Some of the plan limitations or exclusions that should be reviewed in light of the revised definition of "disability" include, but are not limited to, the following: infertility, sexual dysfunction, learning disabilities and developmental delay, growth hormones, etc. Mental Health and Addiction are addressed in their own Act.

FAMILY AND MEDICAL LEAVE (FMLA)

In November 2008, the DOL published its final rules that implement the first amendments to the original FMLA written 15 years ago. This Amendment updates the regulations and includes the new military family leave entitlement signed in to law in January 2008. This amendment extended FMLA to certain events relating to

military personnel:

- ◆ Eligible employees who are family members of a covered service-member will be able to take up to 26 work weeks of leave in a 12-month period to care for the covered service-member with a serious illness or injury incurred in the line of active duty.
- ◆ Exigency Leave for the family members of the covered service-member in order to help manage their affairs when the covered service-member is called up to active service, generally on short notice. "Exigency Leave" is a broad term including, but not limited to, short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest/recuperation, post-deployment activities and any other activities agreed to between the employee and employer.

This Amendment does not apply to the individual who is called up to active service, only to family members who may need to quickly make arrangements to cover activities that the service-member was performing.

The final rules were published in the Federal Register dated Monday, November 17, 2008. This included revised forms that can be used to document leave as well as a new poster that should be placed where employees have ready access. These forms and the poster are available at the DOL/EBSA website: <http://www.dol.gov>.

These regulations, including the use of the new forms and the poster, became effective on January 16, 2009.



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MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This Act expands the existing Mental Health Parity Act to include both mental health and substance abuse conditions. While it does not require plans to cover these conditions, plans that do provide benefits are required to provide coverage that is not more restrictive than the benefits generally provided for medical/surgical conditions. This Act is effective for plans renewing on/after October 3, 2009.

There is some concern regarding the definition of “addiction” as included in the Act. The DOL will issue regulations which will hopefully provide a complete description of what is intended by this wording.

MICHELLE’S LAW

This Act is effective for plan years beginning on/after October 9, 2009. It prohibits a plan that requires dependent children to be full-time students from terminating coverage when the child ceases being a full-time student due to a medically necessary leave of absence. It grants the child additional coverage for a period of up to the earlier of 12 months or the date the child would otherwise terminate. The child to be eligible for this extension must be a full-time student prior to becoming disabled so as to not be able to attend school. This Act will not affect those states who have removed the requirement for full-time student status in the dependent definition for fully-insured contracts. Regulations on this Act have not yet been published.

NEWBORN’S AND MOTHER’S HEALTH PROTECTION ACT – FINAL REGULATIONS

Final Regulations for this Act were issued in the Federal Register for October 20, 2008. The Final Regulations do not make any significant changes to the original interim Regulations for this Act passed in 1996. Generally this Act requires plans to provide hospital stays of up to 48 hours for a normal delivery and up to 96 hours for cesarean section. The Act requires plans to issue a Statement of Rights under this Act that includes the following language:

Under federal law, group health plans and

health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require a physician or other health care provider to obtain authorization for prescribing a length of stay up to 48 hours or 96 hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

This Notice can be included in some form in the Summary Plan Description for the plan or it can be issued independently.

GENERAL NOTICE

Most federal laws defer to state laws where those state laws provide better benefits than those required under the federal versions. Only fully-insured plans and those for governmental subdivisions (cities, counties, etc.) are subject to those state laws. Each of the laws indicated above may also have been addressed at the state level. If your contract is fully-insured, your contract and carrier should be compliant with the applicable state laws as your plans renew.

4 SIMPLE SELF-PROMISES FOR BETTER COMMUNICATION

Quick Summary: Devising progressive, creative ways to deliver your health-related messages is admirable, but consider those methods your icing. You should start with the cake—mastering basic concepts that can serve as the foundation of your communication goals.

Although communication is one of the most basic human activities, its importance in the workplace is often underestimated. Effective health communication doesn't begin and end with the ability to relay correct information. It also includes the ability to listen, ask questions, understand specific needs, and customize messages to different sectors of your audience.

“The act of communicating is so basic and so fundamental that most people don't think much about the fundamentals,” says business-leadership trainer and communication expert Suzanne Updegraff. “But while communication mediums have become increasingly faster and more convenient, the fundamental goals of communication haven't changed. This is particularly true in business.”

Effective Workplace Communication...

- Empowers employees to make more informed decisions.
- Increases clarity of health-related topics.
- Engages employees, making it more likely that they'll participate.

Important workplace messages about health care, wellness, and benefits often fall on deaf ears because communicators neglect one or more of these essentials:

“I PROMISE TO BE MORE CLEAR.”

Clarity is the essential component of effective communication. If your messages aren't obvious and plain, they can't be understood. In fact, they might not even be heard. This is especially true when a topic is critical but complex (examples of complex topics

include choosing a health care plan or understanding a health savings account).

Chances are, you know more about the topic than your employees do. Putting your communication in “plain language” doesn't mean you're “dumbing down” messages. It means you understand the importance of having employees *receive* them.

In written communication, be direct and simple. Eschew professional-sounding words like *eschew* (which means “to avoid using”), as well as jargon and corporate-speak. Include charts and graphs, when appropriate, to help employees think visually.

“I PROMISE TO ENCOURAGE FEEDBACK.”

Communication is often unclear and ineffective because of a simple lack of information: HR leaders and benefits managers often neglect to ask employees what they want to know more about, and employees often neglect to share questions and ideas.

“For many people, asking questions is perceived to be a sign of ignorance or stupidity, so they hesitate to ask questions due to fear of embarrassment,” Updegraff points out. “Lack of questioning leaves some matters unclear, and assumptions are made to compensate for lack of knowledge.”

“I PROMISE TO ASK FOR INVOLVEMENT”

Communication is a two-way street. Don't just talk “at” employees; talk “with” them by encouraging their involvement in your company's health promotion programs. (Find someone to add a personal anecdote to your next newsletter story. Tape a video testimonial about the impact of your last wellness event.) The unintentional problem of poor listening often undermines workplace communication, experts say.

“I PROMISE TO ADD AT LEAST ONE NEW COMMUNICATION METHOD”

Employees have different ways of absorbing messages and retaining information, so effective employee communication involves a mix of media. Are you relying too heavily on one source? Incorporate a sense of newness into your messaging strategy. Possibilities include a lunch Q&A session, posters, an intranet, and a community event.

SELF PROMISES (cont.)

NEXT STEPS

- ◆ Realize that employees respond best when communication is targeted to their needs, interests, and lifestyles. Analyze your audience: Is it diverse in age and experience? Then you're more likely to need to use a variety of methods to get your message across. Is it technology savvy? Then read here about tools such as intranets, podcasts, social network sites, and wikis.
- ◆ Plan ahead to avoid last-minute communicating. Take your calendar to planning meetings and jot down a schedule for refreshing or distributing health, wellness, and benefits messages.

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WHO, WHAT, WHEN...

As a new person to Human Relations and getting to know our employee benefits, I am confused between what constitutes the plan itself and the Summary Plan Description (SPD). Please explain the difference between the plan and the SPD?

The Employee Retirement Income Security Act (ERISA) feels that employee benefit plans should have two separate documents--a plan document and a summary plan description (SPD).

ERISA requires that every plan be "established and maintained pursuant to a written instrument." This means that when an employer provides benefits subject to ERISA, there must be a written document, which is called the plan document. This document details the rights of participants and beneficiaries. Such as who is eligible, how benefits are paid, how the

plan is funded, who is the named fiduciary, what are the plan's amendment procedures, and what are the procedures for allocating plan responsibilities are included. A participant or beneficiary may make a written request for this document. The plan administrator may be charged up to \$110 per day if the plan document is not provided within 30 days after such a request.

ERISA also requires employee benefit plans to have an SPD summarizing certain critical information about the plan document. It should be written so that it can be understood by the average plan participant. The plan administrator must automatically furnish the SPD at specific times to "participants" who are "covered under the plan." One of these requirements is that the plan administrator must automatically provide an SPD within 90 days after a participant first becomes covered under a plan. The SPD must include required items, such as plan-identifying and eligibility information, a description of plan benefits and circumstances causing loss or denial of plan benefits, claims procedures, and a statement of ERISA rights. The SPD must be furnished in response to a participant's or beneficiary's written request. And a plan administrator may be charged up to \$110 per day for failing to provide an SPD within 30 days after such a request.

Some health and welfare plans have one document that serves as both the formal plan document and the SPD. If the document complies with both the written plan document and the SPD format and content rules, the document would appear to satisfy both ERISA requirements. Nevertheless, some sources argue that a combined plan document and SPD may not meet the requirements since it is not possible for a document to summarize itself.



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