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Information Every Business Needs to Know

HR & Benefits Advisor

September 2010

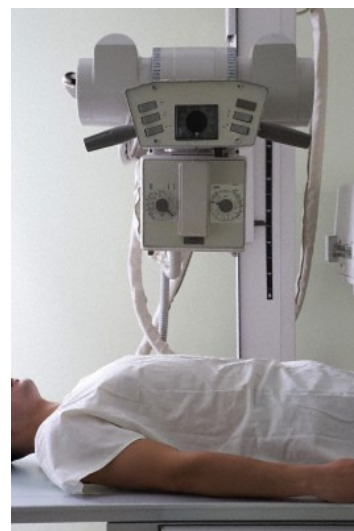
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Key Changes to Group Health Plans As Early as September

Sponsors of group health plans should pay attention to a number of significant reforms to group health coverage that start as early as this month. The Patient Protection and Affordable Care Act ('Affordable Care Act') mandates certain consumer protections in health plans, effective for plan years that start on or after September 23, 2010, which is six months from enactment of the Affordable Care Act. For calendar year plans, these changes are effective January 1, 2011.

The following features some of the most important changes to all group health plans - for plan years starting on or after September 23, 2010. These reforms also apply to 'grandfathered' plans, which are plans that existed on March 23, 2010.



IRS Invites Public Comment on Expanded Business Reporting Requirement



The IRS has invited [public comment](#) on how to most effectively carry out a law change that, starting in 2012, will require businesses to report a wider range of payments to contractors, vendors and others, usually on Form 1099. These comments will help the IRS issue guidance that

Extend Dependent Coverage Up to Age 26

For plan years starting on or after September 23, 2010, the Affordable Care Act requires group health plans (including grandfathered plans) that cover dependents to continue to make dependent coverage available until age 26. However, for plan years beginning before Jan. 1, 2014, grandfathered group health plans offering dependent coverage will not need to make this coverage available if the adult child is eligible to enroll in another employer-sponsored health plan.

Prohibit Lifetime Limits

For plan years starting on or after September 23, 2010, group health plans (including grandfathered plans) may not impose lifetime limits on coverage for 'essential health benefits.' Essential health benefits will be further defined by the U.S. Department of Health and Human Services.

Restrict Annual Limits

For plan years starting on or after September 23, 2010, group health plans (including grandfathered plans) are prohibited from imposing annual limits other than on 'restricted' annual limits to be set by HHS. Effective Jan 1, 2014, group health plans may not set any annual limits on essential benefits coverage.

implements this provision in a manner that minimizes burden and avoids duplicate reporting.

The Internal Revenue Code generally requires information returns to be made by every person engaged in a trade or business who makes payments, aggregating \$600 or more in any taxable year to another person in the course of the payer's trade or business. The information returns must be filed with the IRS and corresponding statements must be sent to each payee.

The change, enacted in March but not effective until 2012, expanded existing reporting requirements to include a business's payments related to goods and other property, and payments to most corporations. With some exceptions, payments to corporations are currently exempt from this requirement. The change in law adds to the reporting requirement payments of 'amounts in consideration for property' and 'gross proceeds' to the list of payments subject to reporting. Some exceptions include most interest, dividends, royalties, and securities and broker transactions. Under a proposed regulation, many business purchases made with credit or debit cards would also be exempt from the new reporting requirement because they are already reported by banks and other payment processors. The IRS seeks comments on additional circumstances in which duplicate reporting might otherwise occur and on rules that would prevent such duplicate reporting.

The IRS advises that there are three ways to submit comments:

- [E-mail comments](#) to include 'Notice 2010-51' in the subject line.
- Mail to: Internal Revenue Service, CC:PA:LPD:PR (Notice 2010-51), Room 5203, P.O. Box 7604, Ben

Drop Pre-Existing Condition Exclusions for Children

For plan years starting on or after September 23, 2010, group health plans (including grandfathered plans) must not exclude children under age 19 on the basis of pre-existing conditions. Effective Jan. 1, 2014, group health plans may not impose pre-existing condition exclusions on adults or children.

No Rescission of Coverage

For plan years starting on or after September 23, 2010, group health plans (including grandfathered plans) are prohibited from rescinding a participant's coverage, absent fraud or an intentional misrepresentation of material fact.

Required Changes As Early As September for Non-Grandfathered Plans

The following changes are effective for plan years starting on or after September 23, 2010, for non-grandfathered plans. For more on grandfathered plans, including rules on maintaining grandfathered status, please [click here](#).

Preventive Services without Cost Sharing

For plan years starting on or after September 23, 2010, group health plans that are not considered grandfathered must provide without cost-sharing (deductibles, copays or coinsurance) certain preventive services recommended by the United States Preventive Services Task Force (USPSTF) when delivered in-network. You can view the chart of covered services by [clicking here](#). You can also view a list of covered services for adults, women (including pregnancy) and children by [clicking here](#). The interim final regulations on preventive services under the Affordable Care Act are [available here](#).

Internal Appeals

Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.

External Review

New rules require plans to provide external reviews that meet standards set by the National Association of Insurance Commissioners. These standards include:

- External review of plan decisions to deny coverage for care base on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Clear information for consumers about their right to both internal and external appeals - both in the standard plan materials, and at the time the company denies a claim.
- Expedited access to external review in some cases - including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- Health plans must pay the cost of the external appeal under State

Franklin Station,
Washington, DC 20044.

- Hand deliver to:
CC:PA:LPD:PR (Notice 2010-51), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW, Washington, DC, between 8 a.m. and 4 p.m., Monday through Friday.

The deadline is Sept. 29, 2010. Further details are in [Notice 2010-51](#), posted July 1, 2010, on [IRS.gov](#).

New Procedures and Notices for Claims and Appeals and External Reviews under the Affordable Care Act



The U.S. Departments of Labor (DOL), Treasury and Health and Human Services (HHS) have released interim procedures and related Model Notices for claims, appeals and reviews under the Affordable Care Act. The Affordable Care Act sets standards for plans and issuers regarding both internal claims and appeals and external review. Plans and issuers in States without an applicable external review process are required to implement an effective external review process that meets certain minimum standards. An interim safe harbor provided by [Technical Release 2010-01](#) applies to non-grandfathered, self-insured group health plans not subject to a state external review process. The standards include a number of notice requirements for internal appeals and external reviews.

law, and States may not require consumers to pay more than a nominal fee.

- Review by an independent body assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- Emergency processes for urgent claims, and a process for experimental or investigational treatment.
- Final decisions must be binding so, if the consumer wins, the health plan is expected

The Department of Labor has released Model Notices, along with other guidance jointly released by the DOL, Treasury and Health and Human Services Departments. For more on these, see '[New Procedures and Notices for Claims and Appeals and External Reviews under the Affordable Care Act](#)'. For more on the Affordable Care Act, visit the *HR & Benefits Essentials* [Health Care Reform Section](#).

New Employee Orientation/On-Boarding

New employee orientation (also called on-boarding) is the process employers have created to introduce new employees to management, staff and their new workplace environment. The goal is to familiarize your new employee with your company and create a positive first impression. Employee orientation is also designed for employees who are promoted within your company and need a similar type of program.



Be sure that your employee orientation process treats employees fairly and avoids any statements or actions that could constitute illegal discrimination under federal or state law. If you have questions regarding your orientation program and discrimination issues, contact an employment law attorney who knows your state laws.

Benefits of Employee Orientation

The following are major benefits of a good orientation program:

- Increases staff retention - an effective orientation program can increase the likelihood that new employees will stay with the company.
- Enhances productivity - a proper orientation will allow new employees to be more productive at a faster pace.
- Helps new employees understand the processes and procedures that help your company run smoothly- and what is expected of them.
- Provides an opportunity for the new hire to ask questions, get help and even offer constructive suggestions as to how to improve your company.
- Reinforces the qualities you conveyed about your company and the position during the recruitment process.

New Employee Orientation Checklist

Your orientation process should begin with planning ahead for your new employee's arrival. The following checklist will help things move smoothly for your new employee:

- Notify everyone in the employee's department that a new person is starting.
- Assign one of your employees to show your new hire the new workplace environment, make introductions and respond to any

Model notices that can be used to satisfy the disclosure requirements of the interim final regulations are being posted on the Department of Labor's website at

<http://www.dol.gov/ebsa> and the Department of HHS/Office of Consumer Information and Insurance Oversight website at <http://www.hhs.gov/ociio/>. They include:

- Model Notice of [Adverse Benefit Determination](#)
- Model Notice of [Final Internal Adverse Benefit Determination](#)
- Model Notice of [Final External Review Decision](#)

For more on new claims, appeals, and review process requirements under the Affordable Care Act, please view a Fact Sheet by [clicking here](#). You can also view the [technical release](#) from the U.S. Department of Labor and [notice](#) from the Departments of Labor, Treasury and Health and Human Services. For more on the Affordable Care Act, you can visit the HR & Benefits Essentials Health Care Reform Section, or visit the DOL's Employee Benefits Security Administration (EBSA) website by [clicking here](#).

questions. This is a great way to put your new employee at ease.

- Encourage the team to welcome and support the new employee.
- Create a great first impression by making the employee's work location neat, clean and organized.
- Be sure that access to the company's network or intranet, email and phone extension are set up for your new employee.
- If necessary, arrange for a building pass, IDs and parking pass.
- If you will be providing an employee handbook, make sure it is ready to be distributed, along with all necessary benefits plan information, including a general COBRA notice if you are a covered employer (20+ employees).
- Develop a training plan to ensure that the new employee's first few months go smoothly.
- Organize a list of key people, i.e., team and management your new employee should meet to get a better understanding of everyone's roles.

Workplace Safety Tips for New and Existing Employees

As an employer, it is important to make sure you have the safety standards and training in place that protects your new and existing employees. Federal law requires employers in general to provide a workplace that is free from recognized hazards that cause or are likely to cause death or serious physical harm to employees. The following are tips and guidelines to enhance your safety procedures:

- Be sure all employees receive relevant protective equipment and instructions on how to use it properly.
- Make sure you provide safety training and supervise all new employees to make sure they can competently handle all tasks assigned to them.
- Don't assume that your new employees are familiar with safety procedures even if they have worked in similar jobs. Now that they are working for you, be sure they fully understand your safety program.

For more on workplace health and safety responsibilities, including standards for certain industries, please visit the Department of Labor's Occupational Safety and Health Administration by [clicking here](#).

Recordkeeping Requirements under the Fair Labor Standards Act (FLSA)

Every employer covered by the FLSA must keep certain records for each [covered, nonexempt](#) worker. Employers must keep records on wages, hours, and other information as set forth in the Department of Labor's regulations. Most of this data is the type that employers generally maintain in ordinary business practice.

There is no required form for the records. However, the records must include accurate information about the employee and data about the hours worked and the wages earned. The Act does require that the records include certain identifying information about the employee and data about the hours worked and the wages earned. The law requires this information to be accurate. The following is a listing of the basic records that an employer must maintain:



1. Employee's full name and social security number.
2. Address, including zip code.
3. Birth date, if younger than 19.
4. Sex and occupation.
5. Time and day of week when employee's workweek begins.
6. Hours worked each day.
7. Total hours worked each workweek.
8. Basis on which employee's wages are paid (e.g., '\$9 per hour', '\$440 a week', 'piecework')
9. Regular hourly pay rate.
10. Total daily or weekly straight-time earnings.
11. Total overtime earnings for the workweek.
12. All additions to or deductions from the employee's wages.
13. Total wages paid each pay period.
14. Date of payment and the pay period covered by the payment.

How Long Should Records Be Retained?

Employers are required to preserve payroll records for at least three (3) years, as well as collective bargaining agreements, sales and purchase records.

Records on which wage computations are based should be retained for two years (2), i.e., time cards and piece work tickets, wage rate tables, work and time schedules, and records of additions to or deductions from wages. These records must be open for inspection by the Division's representatives, who may ask the employer to make extensions, computations, or transcriptions. The records may be kept at the place of employment or in a central records office.

What About Timekeeping?

Employers may use any timekeeping method they choose. For example, they may use a time clock, have a timekeeper keep track of employee's work hours, or tell their workers to write their own times on the records. Any timekeeping plan is acceptable as long as it is complete and accurate.

Where to Obtain Additional Information

For additional information, visit our Wage and Hour Division Website: <http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-487-9243.

DOL Releases Fact Sheet on Break Time Requirement for Nursing Mothers

The U.S. Department of Labor (DOL) has released a [Fact Sheet](#) on the new break time requirement for nursing mothers under the Fair Labor Standards Act (FLSA). Effective since March 23, 2010, the date the Affordable Care Act was signed into law, employers are required to provide reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk, according to the Fact Sheet.



State Laws with Greater Protections Still Apply

The FLSA requirement of break time for nursing mothers to express breast milk does not preempt State laws that provide greater protections to employees, according to the Fact Sheet. Examples of greater state protections include providing compensated break time, providing break time for exempt employees, or providing break time beyond 1 year after the child's birth.

The DOL Fact Sheet also covers Time and Location of Breaks, Coverage and Compensation, and Where to Obtain Additional Information. To view the Fact Sheet, please [click here](#). To visit the HR & Benefits Essentials Health Care Reform Section, please [click here](#).

Newsletter provided by:
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