

Benefit Insights

Is Your Company Doing Enough to Deter FMLA Fraud?

The Family and Medical Leave Act (FMLA) requires covered employers to grant eligible employees up to 12 weeks of unpaid leave during a 12-month period for specified family- and medical-related reasons. While administration of FMLA leave associated with the need to care for a newborn or newly adopted child can be quite straightforward, handling leave requests based on an employee's own serious medical condition, or the need to care for an immediate family member with a serious medical condition, can be more complicated, when questions about the authenticity of the medical reason present themselves.

In any company, most employees will respect the rules and only request FMLA leave when they need and are legally entitled to it. But as any employer knows, there always seem to be a few employees who try to bend the rules and play the system. What can employers legally do to minimize abuse of FMLA leave requested for medical reasons?

A first step in dissuading attempts at fraudulent FMLA medical-based leave is to require that employees document the need for leave with medical certification. An employer may require that, for any leave taken due to a serious health condition, the employee provide a medical certification confirming that a serious health condition exists. Certification may be requested whether the stated reason for the leave request is the medical condition of the employee or of an immediate family member. The employee must be allowed at least 15 calendar days to submit the certification.

When the employee supplies the certification, examine it to determine whether it does in fact document a serious medical condition, and whether it is complete and authentic. If the certification is incomplete, require that the employee correct it. If you have any suspicions about the authenticity of the stated reason—for example, if you suspect that the health care provider may be exaggerating the seriousness of the medical

condition at the request of the employee—the law allows you to require the employee to submit a second certification. This is at company expense, and you can choose the provider for the second opinion. If the opinions conflict, the employer can require a third—and final—certification.

Of course, certifications that do support the employee's or immediate family member's serious medical condition should result in leave approval, just as those that do not document this should result in the leave request being denied.

An area that can cause particular frustration for employers involves requests for intermittent leave. FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule when medically necessary to care for a seriously ill family member, or because of the employee's serious health condition. To get a handle on whether any employee might be abusing this FMLA leave provision, look for patterns in employees' FMLA leave requests. Does the employee's medical condition always seem to flare up on Mondays, Fridays, or days preceding and following holidays? Do intermittent leave requests always coincide with school holidays, or certain weeks in the summer? Employees who require or desire time off work during such times should not be looking to FMLA to provide it. Employees who do legitimately need intermittent leave for foreseeable medical reasons should work with their employer to schedule leave so as to not unduly disrupt the employer's operations.

While implementing strategies to combat FMLA fraud, it's also important that your business doesn't suffer when employees are out on FMLA leave, whether legitimately or not. If your business has a pattern of FMLA-based absences at noticeable times, schedule workers accordingly.

Correct administration of FMLA leave is an important compliance issue for employers. Lengthy final regulations were

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Welcome to Our Newsletter!

The **AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (ARRA)** was signed by the President in February 2009. ARRA includes 65% COBRA premium assistance for eligible individuals, effective March 1, 2009.

This appears to be based on what the QB is actually charged, not the maximum COBRA premium. An eligible individual is any Qualified Beneficiary with adjusted gross income to \$250,000 (joint return) or \$125,000 (all others), phased out for AGI of \$290,000/\$145,000. Employers are not required to determine if a QB meets the AGI eligibility; it is the QB's responsibility to notify the employer/insurer if they are not eligible. The assistance applies for all QBs who elected COBRA coverage between September 1, 2008 and December 31, 2009 and only caused by Involuntary Termination. QBs who were eligible for COBRA during that time period (due to involuntary termination), but did not elect COBRA will need to revisit this decision to elect COBRA on a prospective basis (from March 1, 2009), with the maximum coverage period measured from the earliest date that COBRA could have been elected. Call our Benefits Department with your questions, 317-844-7759.

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Consumer-Directed Health Plan Enrollment Continues to Grow

Enrollment in consumer-directed health care plans is low, but growing, and employees participating in these plans seem as satisfied as participants in traditional plans on some, but not all, measures of health care and health plan quality, according to a survey from the Employee Benefit Research Institute (EBRI).

The fourth annual Consumer Engagement in Health Care Survey presents data on high deductible health plans (HDHPs), HDHPs paired with a health savings account (HSA) or health reimbursement account (terming such a pairing a consumer-directed health plan, or CDHP), and traditional comprehensive health care plans. According to the survey, in 2008, 3% of the insured population was enrolled in a CDHP (4.2 million individuals, up from 2% in 2007), and 11% of the insured population was enrolled in a HDHP (13.4 million individuals, steady from 2007). Of the HDHP enrollees, 42% were eligible to contribute to an HSA, but chose not to do so. Reasons for not enrolling in an HSA included:

- 28% did not have the money to fund an HSA.
- 22% said the tax benefits weren't attractive enough.
- 17% thought it was too much trouble to open and/or manage the account.
- 10% said HSAs were too complicated or they did not understand the HSA option.

Among individuals who did enroll in a CDHP, the two primary reasons for doing so were to have the lower premium associated with the HDHP component of the plan (48%) and to have the opportunity to save money through the HSA component of the plan (47%). Two-thirds of the CDHP enrollees said their employer contributed to the account.

Overall, 63% of participants in traditional plans reported they were extremely or very satisfied with their plans, compared with 49% of CDHP enrollees and 40% of HDHP enrollees. According to the survey report, differences in out-of-pocket costs may explain much of this satisfaction gap, because on other specific measures of health plan satisfaction the gap is not so wide, or is nonexistent. For example, when asked about the quality of care they received through their plan, 71% of CDHP enrollees said they were extremely or very satisfied, only two percentage points shy of the 73% of traditional plan participants who expressed this level of

satisfaction. (Among HDHP enrollees, however, a smaller percentage, 63%, said they were extremely or very satisfied with the quality of care.) On choice of doctors available through their plan, the same proportion in each type of plan, 75%, said they were extremely or very satisfied. However, as noted above, a gap remains on satisfaction with out-of-pocket costs, with 45% of traditional plan participants being extremely or very satisfied, compared with 23% of CDHP enrollees and 17% of HDHP participants.

Although consumer-directed health plans are supposed to be designed in ways to motivate members to become informed about cost and quality issues, overall, participants in traditional plans were more likely to say that their plans provided this type of information than were CDHP or HDHP enrollees. For example, when asked whether their health plan

provided information to help choose a doctor, pharmacy, lab or hospital, 67% of traditional plan participants said the plan did, compared with 61% of CDHP enrollees and 57% of HDHP enrollees. Furthermore, one-third of traditional plan participants said their plan provided quality information on physicians, compared with a quarter of CDHP and HDHP enrollees. As far as information on health care costs, 26% of traditional plan enrollees said they could get this from their plan, compared with 20% of

CDHP enrollees and 19% of HDHP enrollees.

CDHP and HDHP enrollees did say that, regardless of where cost information was obtained, they were more likely to consider cost and more likely to have checked whether their plan would cover a health care expenditure ahead of time, than participants in traditional plans. Nearly 70% of CDHP enrollees and 61% of HDHP enrollees strongly or somewhat agreed that the terms of their plan made them consider cost when deciding whether to see a physician or fill a prescription, while about half of traditional plan participants felt this way. CDHP and HDHP enrollees also were more likely than traditional plan participants to ask their doctor to recommend a less costly prescription drug and, while few of the surveyed individuals participated in a wellness program, CDHP enrollees were the most likely to say that they do.

The full survey report appears in EBRI Issue Brief No. 323, available through the organization's Web site, www.ebri.org.



Motivate Employees to Make Health and Lifestyle Changes

We live in a culture of immediate gratification. “On-demand” cable television services, pre-prepared foods from the grocery store, fast-food carryout, and diet programs that claim you will shed pounds “without trying” all are signs that Americans have lost sight of the fact that not everything can be obtained without waiting. And when it comes to changing behaviors to eliminate unhealthy habits and adopt healthy ones—such as giving up cigarettes, losing weight, exercising more and effectively managing stress—hard work and sustained personal effort also are required. In order to succeed, workplace wellness programs need to recognize this and include elements that engage employees over time.

Suppose you host a brown-bag lunch in your company cafeteria with a presentation on the health benefits of eating right and leading an active lifestyle. You may find that this seminar is well-attended, but observe that few employees actually seem to make the recommended changes, and that even fewer are doing so after a few months. This experience is all too common, and reflects the reality that more individuals are well-intentioned than are self-motivated. Your wellness initiatives, therefore, need to provide the motivation. Here are a few ways to do this—

- Personalize the experience by offering health risk assessments that show each employee, on an individual basis, their current health risks and the steps they should take to address them.

- Tie any offered health risk assessment incentives—such as reduced health plan premiums—not only to taking the assessment, but also to completing any recommended follow-up actions.
- Focus on helping employees want to make the sought-after lifestyle changes, because behavior change is more likely when an individual is ready to make it. This can involve offering incentives as discussed above, but also thinking of ways that would help employees see the risks of not changing (such as posting clear statistics on differences in lifespan for smokers versus non-smokers, individuals with normal blood pressure versus those with hypertension, individuals who maintain a healthy weight versus those who are overweight or obese, etc).
- Provide motivation in the form of support systems. This could involve initiatives such as Weight Watchers at Work, lunchtime walking clubs, articles in company newsletters on employee success stories, providing lists of local gyms and a small company subsidy for joining, sponsoring a “biggest loser” competition, and the like.

Most of us find any change difficult, and lifestyle changes can be daunting. Remember this facet of human nature when implementing wellness programs, and you may find employees more engaged in them, over the long run.

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issued by the Department of Labor in late 2008, and were effective January 16, 2009. These regulations include provisions on establishing a “serious health condition” and clarifying

administration of intermittent and reduced schedule leave, and on what employers can do regarding inadequate medical certifications.

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Looking back at the employee misconceptions about LTC, overcoming them indicates several key communications components:

- The cost of long-term care services. According to a 2007 study from Genworth Financial, the national average for a private room in a nursing home runs almost \$205/day or almost \$75,000/year; a stay in an assisted living facility costs more than \$2,700/month; and hourly rates charged by certified home health agencies average more than \$32.
- The funding sources for long-term care services. As noted above, many people think that, once they hit age 65, Medicare will pay for any long-term care needs that may arise. However, Medicare does not cover extended long-term care stays.
- The chances that long-term care services will be needed in one’s lifetime. According to figures from the govern-

ment, currently, about 9 million people over the age of 65 need assistance with their long-term care needs. By 2020, this figure will likely rise to 12 million. According to one government study, individuals who reach age 65 have a 40% chance of entering a nursing home, and about 10% of people who do enter a nursing home will stay there for five or more years.

- The advantages of purchasing coverage through a voluntary workplace-based offering.
- The EBRI study cites surveys showing that communication is the most important determinant of participation in a long-term care program; one survey noted found that 38% of employers making LTC coverage available wished, in retrospect, that they had communicated the plan more effectively. Thus, when contemplating an LTC offering—or when looking at an existing program—do not underestimate the importance communication and education will play in the program’s success.

Facts Needed to Overcome Long-Term Care Misconceptions

Long-term care (LTC) insurance is a benefit that seems ripe for the needs of today's workforce. Yet, when employers offer employees the chance to purchase long-term care coverage through the workplace, the participation is usually low. (Typically, LTC insurance is offered as a voluntary benefit, for which an employee pays the entire premium.) A May 2000 study contracted by the U.S. Department of Health and Human Services (HHS) found that, while purchase rates varied considerably among the group of surveyed employers, 40% saw participation rates below 2%. A separate study published in May 2000 by the Employee Benefit Research Institute (EBRI) found employee participation rates for LTC insurance averaged less than 10%.

As with any voluntary benefit, there are advantages to purchasing LTC through the workplace: premiums are typically lower due to the power of group purchasing; underwriting may be less stringent; marketing comes to the employee, who does not have to take the time to seek out information; enrollment will be easy and payment convenient through payroll deduction. Given these advantages, why don't more employees opt to enroll when offered the chance?

A 2006 study from AARP indicates misconceptions among Americans about long-term care needs, costs and services, and this may be one factor contributing to the low number of individuals who decide to purchase LTC insurance coverage. According to this survey, "Americans age 45-plus know less

about long-term care than they think they do." Some specifics from the survey indicate a sobering lack of knowledge about issues involving long-term care—

- Only 8% of respondents correctly estimated the monthly cost of a nursing home within 20% of the national average cost, and only 23% made a similarly correct estimate for the monthly cost of an assisted living facility.
- Close to a quarter didn't know the cost of an in-home visit from a skilled nurse or an aide.
- A majority (59%) thought Medicare pays for extended nursing home stays, and 52% thought Medicare covers assisted living costs.
- Almost 30% said that they have purchased LTC insurance, a figure considerably higher than industry estimates about the number of policies that have been sold.

Clearly, more work needs to be done to educate individuals about the issues involving long-term care. Employers that make LTC coverage available agree with this assessment. The HHS study cited above reveals that employers found educating employees about the LTC benefit to be very important, but also very challenging. When asked what they would have improved about their LTC offering, most named education and communication during the initial offering period.

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