

Benefit Insights

Use FMLA Medical Leave Certification to Minimize Abuse of Leave Entitlement

The Family and Medical Leave Act (FMLA) allows employees to take up to 12 weeks of job-protected unpaid leave for certain specified reasons, including to care for their own or a family member's serious health condition. To avoid abuse of this provision, you as an employer are entitled to request a medical certification from the employee's physician. FMLA regulations outline the information that may be required as part of the certification, and the process for obtaining it.

What types of medical issues amount to a "serious health condition" as contemplated by FMLA? The regulations require that the illness or injury involve either inpatient care (meaning an overnight stay), or continuing treatment by a health care provider that includes one or more of the following:

1. Incapacity of more than three consecutive full days, along with treatment; the treatment must occur on two or more occasions within 30 days of the first day of incapacity (unless extenuating circumstances exist), or an initial treatment must result in a regimen of continuing treatment (for example, medication, physical therapy).
2. Pregnancy or prenatal care.
3. A chronic condition that requires periodic treatment and continues over an extended period of time (but may include conditions that are episodic rather than continuous, such as asthma or epilepsy).
4. A permanent or long-term condition for which treatment may not be effective; the patient must be under continuing medical supervision, but need not be receiving active treatment (examples include Alzheimer's, stroke, or the terminal stages of a disease).
5. Conditions requiring multiple treatments, such as restorative surgery following an accident, chemotherapy/radiation for cancer, physical therapy or dialysis for kidney disease.

To verify the presence of a serious medical condition, you may require a medical certification from the employee's or family member's medical provider. Employers can use Department of Labor Form WH-380-E, "Certification of Health Care Provider for Employee's Serious Health Condition," or may devise their own form, but in that case cannot require the employee to provide more information than that requested on the model certification form. You should notify the employee that certification of the medical condition will be required, either at the time leave is requested or within five business days of that date. If the leave was unforeseen, notice that certification will be required should be given within five business days after the leave has commenced. The employee then has 15 days to provide the certification.

If the certification is incomplete, vague, nonresponsive or ambiguous, you can request in writing that the employee correct the deficiency, specifying what additional information is required to make the certification complete. The employee has seven days to correct the deficiency. You may also contact the medical provider directly for authentication or clarification of the information on the certification, but the individual from your organization who makes this contact cannot be the employee's direct supervisor.

If the employee fails to provide a sufficient medical certification you can deny the FMLA leave request. The employee should be advised of this potential consequence at the time you first request the certification.

If the employee's need for leave lasts longer than a year, certification may be required on an annual basis. You also may require certification at a later date if you have reason to question the appropriateness of the leave, or its duration. If the employee's medical condition may also be a disability within

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Please be advised new legislation (H.R. 3326) passed December 19, 2009, which extended the COBRA subsidy's eligibility period for two months (that was enacted under the American Recovery and Reinvestment Act, ARRA) and extends the maximum duration of the federal assistance from nine months to 15 months. The legislation also provides additional notification requirements. **Please contact us to obtain the Fact Sheet from the Department of Labor (DOL) that provides a concise overview of the new changes and new requirements as deadlines quickly approach.** ARRA provides for a federal subsidy of 65 percent of the COBRA continuation coverage premiums for qualified beneficiaries receiving COBRA continuation coverage due to involuntary termination of employment between September 1, 2008, and December 31, 2009.

What Has Changed

1. The end date of eligibility for the ARRA subsidy changes from December 31, 2009, to February 28, 2010 (extended two months) for those who are involuntarily terminated. Previously, employees who were involuntarily terminated after December 31, 2009, would have been ineligible for the subsidy.
2. The ARRA premium subsidy period expands to 15 months, increased from previous nine months.

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Dependent Eligibility Audits Emerge as Health Plan Cost Cutting Tool

As employers search for ways to contain employee benefit plan costs, many are undertaking dependent eligibility audits. The logic and potential cost savings is compelling. Why pay for something in this case, coverage for someone not entitled to it under the terms of a benefit plan when you don't have to?

According to the results of client dependent eligibility audits conducted by HRAdvance, a third-party provider of audit services, the percentage of ineligible dependents detected in such audits ranges from 7% to 19%. And, with each employee dependent covered under a health plan running about \$3,400 annually (with this amount varying considerably company to company, according to figures from Aon Consulting), the potential cost savings can be dramatic, even for a small company. Aon cites the potential return on investment from dependent eligibility audits as high as 40 to 1. Savings should be considerable, when you consider that each removed ineligible dependent represents dollars saved year after year.

Though the cost savings are compelling, they're not the only reason to conduct a dependent eligibility audit. ERISA mandates that benefit plans be maintained for the "exclusive benefit" of employees, and employers as plan fiduciaries are required to operate plans accordingly. Arguably, covering ineligible individuals, which can create additional plan costs for all employees, runs afoul of these requirements.

The purpose of a dependent eligibility audit is to verify that individuals listed by employees as eligible for coverage under the plan—primarily spouses and dependent children—indeed meet the plan requirements for eligibility. A simple employee certification or affidavit of dependent eligibility does not provide proof of this, and therefore an audit requires employees to submit documents that substantiate eligibility. An audit will be a significant undertaking. Consider that you will need to:

- Review health plan documents (and the documents for any other plans for which the audit is being conducted) to determine the definitions for all possible eligible dependents.
- Determine the documentation you will require for substantiating eligibility. For example, in the case of a spouse, this may be not only a marriage license or certificate, but also a recently filed joint income tax return to show that the marriage continues to the present day.
- Establish a time line for informing employees about the audit and a deadline for submitting the required documentation, and develop communications materials accordingly.
- Determine the process by which employees can submit their documentation, and set up a mechanism to receive materials.

- Review submitted documentation to determine whether they meet the requirements for establishing eligibility, and establish a notification and grace period process for employees who fail to submit materials properly and/or on time. Inform employees of the audit results.
- Since these audits generate a large amount of paper, arrange for secure storage and/or disposal of the materials employees have submitted.
- Since the audit will likely generate questions from employees, a knowledgeable person or persons must be assigned to field employee inquiries.

Some companies choose to outsource dependent eligibility audits instead of conducting them in-house. Audit service providers cite the potential cost savings that can be achieved and the amount of work involved in a thorough, well-designed audit to argue that contracting for such services delivers a good return on investment. If you decide to use an outside resource, you'll likely have a choice of vendors with more and more employers conducting dependent eligibility audits, an industry specializing in this particular employee benefit plan service has developed.

Other design considerations can impact the workload an audit generates. For example, in order to make the process more manageable, some companies audit only a particular dependent group, or a single company division or location at a time, instead of requiring all employees enrolling dependents to submit dependent documentation. If considering honing in on particular dependent groups, data from HRAdvance's client audit shows the distribution of ineligible dependents to be 43% children under age 19, 29% children over age 19, and 28% spouses. Another consideration that can impact the manageability of the audit is whether to conduct it retrospectively (and try to recover claims that shouldn't have been paid) or on a forward-looking basis only. Many employers also choose to precede the audit with an amnesty period during which employees can voluntarily remove dependents from the plan with no penalty.

Since most companies have traditionally run on an honor system when covering dependents—basically taking an employee's word for it that those dependents enrolled for coverage indeed meet a definition of eligible dependent—advance communications to alert employees of the audit, and the reasons for it, are critical to employee cooperation and, ultimately, how successful the audit will be. Use all available media, and stress that removing individuals who are not eligible for coverage will benefit not only the company, but all employees who are paying to have themselves, and family members, covered by the plan.

Make No Mistake - Obesity is Expensive

Two critical tasks in managing any business are to control costs and maximize productivity. Many business owners feel confident that they're doing all they can in both of these areas. However, if employers aren't considering the shape their employees are in, they are missing a huge piece of the puzzle that may be adversely affecting both costs and productivity.

According to a study by the Centers for Disease Control and Prevention, 26.1% of American adults were obese in 2008, compared to 25.6% in 2007. If we count Americans who are either overweight or obese, a staggering 2 out of three fit the bill. These statistics become of even more concern for business owners when you add the findings of the Department of Health and Human Services (DHHS) survey entitled "Prevention Makes Common Cents: Estimated Economic Costs of Obesity to U.S. Business." DHHS discovered that the total cost of obesity to U.S. companies is estimated at \$13 billion per year. Health insurance costs related to obesity comprise the largest percentage of the total coming in at a whopping \$8 billion.

Of course, increased insurance costs aren't the only story here. The ballooning American waistline is the cause of 39 million lost work days; 239 million restricted activity days; 90 million bed days; and 63 million physician visits; numbers which add up to an immense drain on productivity.

What can employers do to combat this growing problem? Start with some suggestions offered by the American College of Occupational and Environmental Medicine:

1. Offer healthy choices in cafeterias and/or vending machines.
2. Provide nutritional information for cafeteria selections.

3. Provide healthier snacks at meetings and other employee events. For example, serve fruit, popcorn, and low-fat yogurt, rather than doughnuts or pastries.
4. Provide bottled water in the vending areas or cafeteria.
5. Institute a workplace wellness program that provides mechanisms to aid employees in adopting healthy lifestyles.
6. Provide educational material on the health risks of being overweight and how to eat healthier.
7. Encourage the use of stairways instead of elevators by placing signs near the elevator and stairs highlighting the health benefits of stair use. Ensure that stairways are accessible and are properly lighted.
8. Discourage employees from eating at their desks. Even a short walk to the cafeteria/lunch room can be helpful.
9. Support physical activity breaks during the workday.
10. Allow employees enough time for lunch so that they can walk or use the gym.

Although there may be an initial cost associated with implementing these provisions, the ROI will prove that the expense was well worth it when employers begin to see the improvements in productivity and the decline in obesity-related health claims. Even more important than those two benefits are the residual benefits received from implementing these changes. When employees see that their employers care enough to provide not just a safe workplace, but also a healthy workplace, these gestures encourage a real sense of loyalty that will ultimately translate into a healthy boost to everyone's bottom line.

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the meaning of the Americans with Disabilities Act (ADA), information obtained through ADA procedures may be used in the FMLA leave determination.

Though FMLA leave is an entitlement for qualifying employees, employers have tools to control the risk that this

entitlement is abused. Make use of the procedures allowed to ensure that only truly qualifying employees in your organization go out on FMLA leave.

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Thus, for employers that conduct dependent eligibility audits-a growing trend as employers look for ways to manage health care costs-the Michelle's Law mandate will impact audit communications.

What should employers be doing now in response to this new law becoming effective? Given the lack of specificity for some aspects of compliance-such as the time frame under which to require physician certification of a serious illness or injury-consult with your legal counsel or benefits professional to determine how you will handle any pending

regulatory clarification. Also, review plan documents and summary plan descriptions and update them as needed to reflect Michelle's Law provisions. Additionally, make sure any human resources or benefits staff members are apprised of the requirements so that they can respond to employee inquiries appropriately.

Some states have laws similar to the federal law. If any of these apply to your organization, make sure your plan and procedures are also in compliance with provisions that may be additional to or more specific than the federal law.

Michelle's Law Extends Health Care Coverage for Ill or Injured College Students Who Lose Full-Time Student Status

On October 9, 2009, a new federal law impacting eligibility for coverage under employer-sponsored group health plans became effective. "Michelle's Law" requires continued eligibility for seriously ill college students covered under a parent's plan, who lose their full-time student status due to reducing their hours or taking a leave as a result of their medical condition. For calendar year plans, the law's provisions will apply for plan years beginning January 1, 2010. Michelle's Law applies to both insured and self-insured plans.

The impetus behind the law was the case of New Hampshire college student Michelle Morse. Diagnosed with colon cancer and undergoing treatment, she was advised by her doctors to cut back on her course load or take time off from school. If she did this, however, she would lose full-time college student status, and with it coverage under her parents' health plan. Though she could then elect COBRA, that coverage was too expensive. Consequently, she continued as a full-time student while undergoing chemotherapy. After her death, her parents worked to have a law passed in New Hampshire that would have allowed her to continue coverage as an eligible dependent while taking a leave or reducing her school schedule. This state law served as the model for the federal law.

The federal law mandates continued eligibility as a dependent for 12 months for post-secondary school students with a serious illness or injury, even if the student loses full-time student status. The individual must be covered as a full-time student under the plan immediately before taking the leave or reducing the school schedule. A physician must certify in writing that the student has a serious illness or injury and that a leave of absence from school or change in enrollment status is medically necessary. The law does not specify a time frame for providing this certification.

During the 12-month period of continued coverage, the regular plan premium will apply. If during those 12 months something happens that would cause coverage to end for reasons not pertaining to loss of full-time student status—such as the termination of employment for the parent working for the company sponsoring the plan, or the student reaching an age that exceeds the plan limit—then coverage can be terminated for these reasons.

For employers that require employees to certify full-time student status for college-age dependents, the law says that notice of the 12-month Michelle's Law extension must be included in communications requesting such certification.

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