

Benefit Insights

Avoiding Common COBRA Mistakes Is the Best Way to Manage Costs

With high COBRA costs and steep penalties for noncompliance, employers have plenty of incentive to make sure that they—and their administrators—are doing all that is necessary to administer COBRA exactly according to the law. Yet, errors frequently occur, due in large part to the complexity of the COBRA law and its regulations, but also sometimes to misunderstandings and miscommunications that occur between the employer and administrator as to who is responsible for what aspects of COBRA compliance.

Just how costly is COBRA for employers? According to an annual survey from Spencer's Benefits Reports, in 2006, the average annual cost for employers per COBRA enrollee was 45% more than the average annual health care cost for an active employee, or \$9,914 compared with \$6,831. And when a plan encounters administrative problems, noncompliance penalties can add significantly to COBRA's costs: an excise tax penalty from the Internal Revenue Service of \$100 per day (\$200 if multiple qualified beneficiaries are involved), an ERISA penalty of \$110 per day, and potential court costs, legal fees, and even medical claims costs if an individual is not properly covered by the health plan due to COBRA noncompliance.

With all this at stake, it's worth taking a look at some of the common and most frequent COBRA errors—

- Failing to provide the initial or general COBRA notice. This is the notice that must be provided to all employees, and spouses, which tells them about the COBRA law and their responsibility to notify the employer if they experience certain qualified events. If this notice is part of the health plan summary plan description (SPD), and the SPD is only distributed on-site to employees, the notice-to-spouse requirement will not be satisfied.
- COBRA notices that do not contain language as required by the most recent COBRA regulations.

- Poor documentation that the required notices have been provided. If challenged that a required COBRA notice actually was provided, an employer will need to show that its methods for meeting the notice requirement are reasonably calculated to result in receipt by employees. This requires established procedures and proof that those responsible actually are adhering to these procedures.
- Not offering COBRA for coverages besides the core medical coverage, such as dental, vision, and the flexible spending account.
- Not holding qualified beneficiaries to coverage election deadlines by accepting COBRA elections late. What may seem like a nice gesture can cost a company significant dollars, given the data cited above concerning average claims costs incurred by COBRA beneficiaries.
- Keeping COBRA beneficiaries on the coverage rolls for longer than necessary (not terminating coverage when required premium payments are missed or are received beyond the grace period; not terminating coverage at the end of the 18- or 36-month coverage period, plus the disability or multiple qualifying event extension, if applicable; not terminating coverage when a COBRA beneficiary becomes entitled to Medicare or becomes covered under another plan).
- Assuming the health plan insurer is providing COBRA notifications, though it has not been specifically contracted to do so. COBRA is an employer law, and though employers can allocate contract specific COBRA responsibilities to other parties, don't assume that the insurer is providing notices simply because it pays any claims under the plan.

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Welcome to Our Newsletter!

It is with great satisfaction that we bring this newsletter to you. In this issue and in coming months, we will discuss pertinent employee benefit topics which may affect your organization. We sincerely hope that you will find this newsletter informative and please do not hesitate to contact us at advisor@21stcenturybenefit.com or 781-416-1043 should you have any questions or needs.





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 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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- Trying to save a few dollars by self-administering rather than hiring a qualified COBRA administrator. Remember the dollar signs cited at the beginning of this article. Proper administration will help you to avoid penalties, and also to keep your COBRA costs as low as legally possible.

Though you can charge COBRA beneficiaries 102% of the "cost of coverage for similarly situated employees,"

most employers will find that the individuals who elect COBRA under their plan will incur costs well beyond this amount. Precise compliance is your best chance to keep your COBRA costs as low as legally possible.



Voluntary Benefits Provide Value in Tough Economy

Tough economic times can take a toll on all aspects of a company's operations, including the employee benefits department. As companies look for ways to keep a cap on employee benefits costs—while still offering an attractive, competitive benefits package—consider the value of voluntary benefits.

Voluntary benefits can help meet individual employee needs and fill gaps in the regular employee benefits program, at little or no cost to the employer. Employees pay



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for voluntary benefits with their own money, but at a sometimes substantial savings of both time and money: group discounts generally are available; marketing is brought into the workplace, instead of employees having to shop for these products on their own; and payment can be conveniently made through payroll deduction. Furthermore, employees may have access to products that would not be available to them on an individual basis, as underwriting may be relaxed when the product is offered to a group.

When considering voluntary benefits, it's important to offer those products that are most likely to be well-received by your

employee group. Therefore, have a strategic plan for implementation, just as you do with your core benefits program. Consider first what coverage gaps employees may have. For example, if your core program lacks dental or vision options, these are ideal voluntary benefits offerings. If you limit life insurance coverage to a set multiple of salary, supplemental life or life insurance options with a cash accumulation feature could be offered. If your workforce includes part-time employees who are not eligible for the core plan, voluntary benefits offerings could include limited medical, along with dental and vision. And if your benefit plan is comprehensive, and has few gaps, bring in options that give employees alternatives to purchasing insurance products in the individual market—long-term care, group home and auto, cancer and/or critical illness insurance, legal services plans, even pet insurance.

In addition to coverage gaps, examine employee demographics to determine which voluntary benefits offerings would be appropriate. Employee focus groups and surveys also can be useful information-gathering tools in selecting voluntary benefits products that are likely to be well-received by your workers.

In addition to expanding your employee benefits options, voluntary benefits can enhance your communications opportunities with employees. Choose a vendor that is armed with communications vehicles that ensure program success: a combination of paper, online and in-person outreach designed to promote the opportunities of the voluntary benefits offerings, but without the kind of hard sell that can turn employees off.

Today's technologies make the administration of voluntary benefits programs easier than ever. Online enrollment and claims inquiries/processing direct to the vendor can, in many cases, limit the burden on the employer's human resources and benefits staff to the set-up of payroll deduction. This is a small investment when the return is a more comprehensive benefits program at little or no additional cost, and employees who are more satisfied with their employee benefits package.

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the cancer patient's workload. One study published in the Journal of Clinical Oncology, and specific to breast cancer, found that a company's willingness to accommodate workers' breast cancer and treatment was an important factor in the studied women's decision to return to work after treatment. In that study, 82% of the cancer patients had returned to work within one year after their diagnosis, with 87% perceiving their employers as being accommodating to their cancer and treatment needs.

Your company makes a huge investment in recruiting and training qualified employees. While your support and

that of co-workers means the world to a cancer patient, it also makes good business sense for your company. A willingness to implement flexible work policies for employees struggling with this disease, coupled with a sensitivity to each individual's specific needs, can engender the kind of loyalty that can motivate these temporarily disabled workers to return to work, with renewed commitment to your company, once they've officially joined the ranks of "cancer survivor."



Cancer Tops List of Disability Claims - Keep These Workers on Board with Your Workplace Policies

For the seventh year in a row, cancer ranks as the leading cause of long-term disability claims, according to an annual review of claims by disability insurer Unum. With nearly 1.5 million new cancer diagnoses expected in 2008, according to the American Cancer Society, and survival rates increasing, cancer-related disabilities are sure to continue to rise, making it imperative that employers implement policies that encourage workforce participation by employees with the disease.

The American Cancer Society reports that the five-year relative survival rate for all cancers diagnosed between 1996 and 2003 was 66%, up from the 50% rate seen during part of the 1970s. Screenings that detect various types of cancers at earlier, more treatable stages, and improvements in treatments account for this gain. Higher survival rates mean that a cancer diagnosis does not necessarily carry the meaning it once did. Unum characterizes cancer survival rates as more similar to levels seen with serious chronic conditions, rather than those associated with a terminal illness.

Consequently, more and more individuals diagnosed with cancer are benefiting from treatment options and staying connected to the workforce, albeit sometimes with periods of time off work while undergoing treatment. This is seen in statistics reported by Unum: Between 2001 and 2005, the insurer saw a 16% increase in cancer disability claims, and

in 2007 12.2% of its long-term disability claims were cancer-related (followed by 12.1% for pregnancy complications, 11% for back injuries and 9.3% for other injuries).

Though its cancer disability rates have increased, Unum also reports significant increases in the rate at which those temporarily disabled by cancer return to work: Between 2001 and 2005, the disability insurer saw a 77% overall increase in return-to-work rates in cases of short-term cancer disability, and a 24% overall increase in return-to-work rates in cases of long-term cancer disability.

Various studies demonstrate that the support shown by an employer and co-workers influences cancer patients' return to work. Factors that positively influence a return to work during and after cancer treatment include a company's and co-workers' attitude toward the cancer patient, a willingness to work out a flexible work schedule, and a willingness to negotiate

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