

# Benefit Insights

## ***COBRA Subsidy Program Extended through February 2010***

In late December 2009, President Obama signed into law changes to the COBRA premium subsidy law that was previously set to expire on December 31, 2009. The extension brings added compliance obligations for employers, as the program has been extended two months through Feb. 28, 2010, the subsidy period is expanded by 6 months to 15 months total and separate notice requirements apply.

The American Recovery and Reinvestment Act of 2009 previously established a law under which "assistance-eligible individuals" (AEIs) could receive a 65-percent COBRA premium subsidy for up to nine months from their continuation effective date. Under the original legislation, an AEI was defined as any COBRA qualified beneficiary who elected COBRA coverage and: (1) lost group health coverage as a result of an involuntary employment termination; and (2) had a qualifying event between Sept. 1, 2008, and Dec. 31, 2009. The Act included various new administrative requirements for employers, many of which were required within a short time period after ARRA was enacted.

Here are the key provisions of the new COBRA subsidy extension:

1. The maximum subsidy period increases from 9 to 15 months.
2. The subsidy eligibility period is extended to February 28, 2010 (previously Dec. 31, 2009).
3. AEIs who had previously reached the end of their original premium reduction period before the extension was passed will have additional time to pay their premiums to continue coverage. They must pay the 35 percent of total premium costs by the later of February 17, 2010, 30 days after notice is provided by their plan administrator, or the

end of the otherwise applicable payment grace period.

4. AEIs who paid the full COBRA premium after their original subsidy period expired are eligible for reimbursement or crediting of excess premiums paid.
5. Plan administrators must provide notice of the subsidy extension by February 17, 2010 to those individuals who were AEIs on or after October 31, 2009.
6. Additional notices must also be provided to AEIs who are eligible to make retroactive premium payments at the subsidized rate and those entitled to premium reimbursement.



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## **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. 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.



## **EAPs Promote Good Health and Boost Employee Morale**

In today's complicated workplace, where many employees are primary caregivers of children under 18 or elderly relatives, workers may need assistance in resolving family-related events. Other employees could be facing marital problems, substance abuse issues, or even depression. Companies and group insurance policies can help provide a resolution by offering participants an Employee Assistance Program, or an EAP. Created for the purpose of promoting and maintaining good health as well as offering a variety of mental health counseling services, EAPs are strictly confidential and are generally offered to employees at little or no expense.

Most EAPs offer referrals and/or treatment for a variety of situations, including but not limited to:

- Health and Wellness
- Dependent Care (including child care and elder care)
- Diet and Nutrition Consultation
- Depression
- Anxiety
- Stress Management
- Marital Conflict
- Parent-Child Issues
- Financial Planning
- Legal Concerns
- Substance Abuse
- Career Planning

Insurers offer EAPs to employees with a goal of promoting overall employee health and well-being. Based on the idea that healthy, well-balanced employees are more productive, have less absenteeism, are less likely to become injured, file fewer workers' compensation and general health claims, and even demonstrate a lower turnover rate, EAPs provide a very valuable service for employees, and employers alike.

EAPs help to alleviate stresses and problems that may negatively affect an employee's attitude or performance by providing necessary professional assistance to the employee and/or their family members.

Likewise, employees perceive EAPs as an extra benefit, which boosts employee morale, and demonstrates that employees are cared about, and even cared for.

EAP counseling and consultations are conducted by qualified professionals and typically take place away from home or work. Discussions, consultation, and counseling offered through EAPs are highly confidential. None of the information provided in counseling sessions, including employee name, can be released without the employee's written consent. The only exceptions are those required by law, such as the mandated reporting of child or elder abuse, or if an employee presents a threat to himself or others. The EAP gives employees, even those not on corporate health insurance, the safety net they need when they reach out for necessary assistance.

## **Let an Umbrella Policy Be Your Safety Net**

There comes a certain point in your life when you can look back with a sense of pride at what you have been able to accomplish. Your hard work has paid off and you now are the proud owner of a nice house, a great vacation home, a luxury car and all the other amenities associated with the good life.

If you have reached this stage of your life, you are now wealthy enough to be vulnerable to lawsuits. Incidents can occur in your day-to-day activities that could potentially cost you. For example, the elm tree in front of your home could fall onto a neighbor's house, and in the process, pull down electrical wires that start a fire, burning the neighbors house to the ground. Depending on the neighborhood, replacement costs for the house could be several million.

Or perhaps you have just been named to the board of your favorite non-profit. The organization is being sued for personal injuries that occurred during their annual bazaar. As a board member you are also liable and can be sued.

If you're like most people, you feel confident that your homeowner's and car insurance will protect you if you fall victim to a claim arising from normal activities. What you should be aware of is that while these policies do include liability coverage, the amount of coverage usually tops out at \$300,000.

To protect assets, people need to increase their coverage with an umbrella policy. Umbrella policies take over after the liability insurance in your homeowner's and auto policy stops. The umbrella policy will pay claims above the liability limits you currently have, up to the limit you have selected.

Since the major portion of the risk is assumed under the primary auto or homeowner's policy, personal liability umbrella insurance is inexpensive. You can buy a \$1 million or larger umbrella policy for about \$200 a year.

Many carriers prefer to sell umbrella policies to clients who have both their auto and homeowner's insurance coverage with them. Your insurance company may also require that your primary liability limits be a certain amount. Umbrella policies are generally sold with a deductible ranging from \$250 to \$1,000. Your carrier covers you if your actions cause bodily injury, property damage, or personal injury to someone else.

The broadest coverage under an umbrella policy is probably the personal injury coverage because it includes coverage against false arrest, false imprisonment, malicious prosecution, defamation, invasion of privacy, wrongful entry, or eviction. Your homeowner's and car insurance policies cover bodily injury and property damage, but not personal injury. You can also buy umbrella policies that include coverage if you are held liable in the course of serving on the board of a nonprofit organization.

Another important aspect of this type of coverage is it not only pays damages, but also lawyer's fees and defense costs should you be the defendant in a lawsuit. Even if a lawsuit is obviously a nuisance suit, you still have to pay the costs for mounting a defense. In this age of rising litigation expense, it is reassuring to know that you are well equipped to handle it before the need arises.

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## Save on Workers' Comp with a Creative Return to Work Program

The National Safety Council has estimated that employers annually lose 80 million work days to illnesses or injuries suffered on the job. The federal Bureau of Labor Statistics reported that, in a recent year, 1.2 million workers missed an average of seven days of work due to occupational health problems. The resulting cost in lost productivity, disability benefits, and workers' compensation premiums is enormous. However, these are costs that employers can reduce with a little creativity. Often, treating physicians will release an injured worker for return to some work duties after a relatively short period of time. While the worker may not yet be ready to resume his former duties, he can still perform some work for the employer. To enable this to happen, the employer needs a return to work program and policy.

The idea behind return to work programs is to provide temporary jobs that (ideally) take into account an injured worker's physical capabilities, skills and interests. A good program encompasses several objectives:

- Addressing factors - physical, environmental, emotional, knowledge - that prevent the employee from returning to work full-time.
- Focusing on what the employee can do rather than what he cannot do.
- Easing the transition from temporary work assignments to full-time regular work.
- Maintaining productivity by decreasing the number of lost work days.
- Improving the employee's morale and increasing incentives for him to return to work and stay there.

The benefits to employers from return to work programs are many.

- They make it easier to retain valued employees and to obtain some production from those recovering from injuries.
- Because they help retain employees, they reduce recruiting, hiring and training costs.
- They show the employer's concern for the welfare of injured employees.
- They reduce the duration of disability payments to injured workers and may also reduce associated medical costs.

- They facilitate communications between the employer, the employee and the health care provider.
- They make it more difficult for unmotivated employees to stay out of work.
- Over the long term, they reduce an employer's workers' compensation claim costs, making the employer more attractive to insurance companies and inviting competitive pricing.

Return to work programs also accelerate an employee's recovery process. According to the California State Compensation Insurance Fund, half of all employees who stay out of work for six months or more never return to their former jobs. Those who are out for more than a year have only a ten percent chance of returning. Most workers want to feel like they are productive and contributing. Getting an injured employee back to work early heightens those feelings of accomplishment and increase the chances that he will eventually return to his old job. It also helps him maintain his job skills and reduces the adverse impact of the injury on his family.

The return to work policy should include the following elements:

- Employee eligibility criteria.
- Provisions requiring assignment of meaningful tasks to the employee, not busy work such as "counting paperclips."
- Descriptions of the types of duties to which an injured employee may be assigned.
- Stated parameters for the length of time a temporary assignment will last and conditions for extension.
- Provisions covering situations where an employee returns to work and subsequently has to take additional medical leave.
- Provisions for alternative work arrangements acceptable to the employer, such as telecommuting.

Workers' compensation is a major part of personnel costs for any employer. Well-executed return to work programs can help employers reduce those costs, recover productivity that would have been lost, and keep good employees happy. That's a good outcome for everyone.



**Intermountain Business Insurance**  
1124 W. South Jordan Pkwy. #C  
South Jordan, UT 84095

Phone (801) 304-9949  
Email: [info@ibibenefits.com](mailto:info@ibibenefits.com)  
Website: [www.ibibenefits.com](http://www.ibibenefits.com)