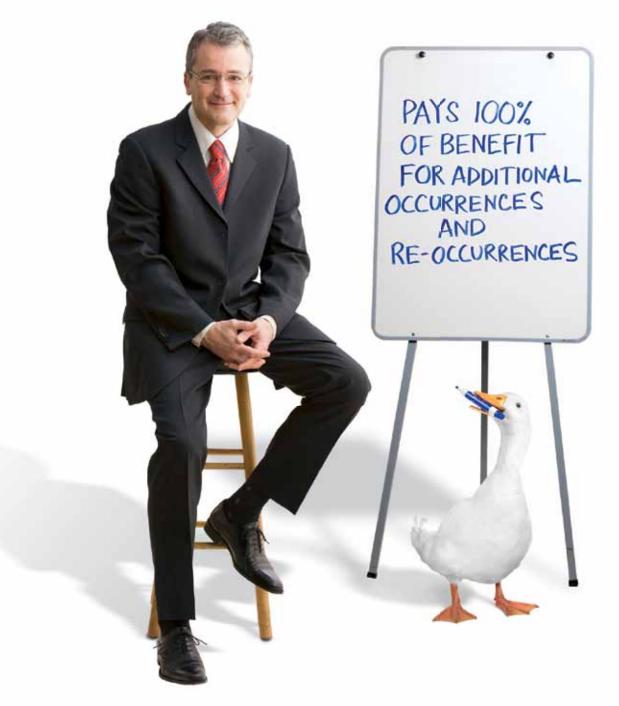
DENEFICATIONE DENEFICIONES DE LA COMPANION DE NOVEMBER 2011 **Improve Your ROI** With a Wellness **Diagnostic** Page 19 Recruiting, Retaining & Rejuvenating **Employees:** Incentive Top Talent with Voluntary Benefits Page 28 **Educating Consumers about Healthcare Price Transparency is the Best Solution** to Controlling Costs Page 54

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EDITOR'S LETTER



late Edith

Jonathan Edelheit President, Editor-In-Chief Employer Healthcare Congress

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The Reward in Risky Business

As I reflect on the excitement and growth of the 3rd Annual Employer Healthcare Congress, I think of a quote from one of our Keynote speakers, Bill Rancic, who said, "Keep your options open. And remember, where there is no risk, there is no reward."

One of many inspirational and motivational quotes from Bill Rancic, these words make a powerful statement. The advice to never close any doors but to walk through them boldly and willing to take risk, resonates with the challenges our industry is facing.

From unsustainable rising healthcare and health insurance costs, healthcare reform, and what seems to be a never ending economic recession, these challenges are a true to test of our ability to try new business practices, get creative, and collaborate with colleagues in efforts to reinvigorate each other and open up new ideas and concepts. The risk; carefully evaluating budgets and bottom lines, and making the best assessment of investing time and effort, will be a result of the ultimate reward; succeeding in your business.

With this in mind as we headed to Chicago for the recent Employer Healthcare Congress, October 26-28, 2011, our goal was to help you meet these challenges through our speakers, educational content, and exhibitor showcases. We took our risks this year, heavily investing in bringing some of the best keynote speakers to press upon the cutting edge issues.

Our success comes from the feeling of knowing our attendees had access to some of the best keynote speakers not seen at other healthcare and insurance conferences before; Susan Voss, President of the National Association of Insurance Commissioners, Cecil Wilson, President of the American Medical Association, Mitch Joel, Social Media Guru and Best-Selling Author of *Six Pixels of Separation*, John Casey, Director of International Benefits at Google, and of course, Bill Rancic, Entrepreneur and Season 1 Winner of NBC's *The Apprentice*.

The reward we receive is the fulfillment in providing the 2011 Employer Healthcare Congress participants with the knowledge to assess the four critical areas of our industry. We passionately dedicated our time to research these areas and give participants the crucial educational content. The power this information holds, in giving our attendees the confidence to move forward with the changing industry, is truly invaluable.

Employer Healthcare Congress speakers dissected healthcare reform; from changing the name of the game, understanding it and complying with it. Our experts in the industry touched on utilizing Voluntary Benefits as a protective cushion for employees during these tough economic times, the advantages of Self Funding Healthcare, and how to engage employees with sustainable corporate wellness programs.

Our team at the Employer Healthcare Congress is already gearing up and planning for 2012 in South Florida, October 24-26th. We are "keeping our options open" and thinking outside the box to continue our precedent of cutting edge speakers and relevant educational content. Most importantly, we are taking risks because our reward is preparing you for whatever the future has in store.

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Written By
Kaye Kennedy
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Beware of Your Chair

If you are one of the millions of American workers who rush to work every morning just to sit down for 8 to 10 hours you might not want to "sit this one out." In fact, the latest research suggests that you would be better off reading this standing up. Research from the American College of Cardiology proposes that sitting for long stretches may be just as bad for your cardiovascular health as smoking. Sitting for extended periods of time has been linked to the very conditions that company based Wellness programs are trying to combat. Namely, conditions like heart disease, obesity, diabetes, cancer and premature death.

"But my employees use our company fitness facility," you might say. While that is good it's not good enough. Epidemiologists are beginning to doubt whether a daily exercise routine does enough to counteract the effects of too much sitting on the job. Inactivity researchers explain that even if a person exercises 30 minutes most days a week and gets 8 hours of sleep each night there are still 15 plus hours of inactivity that could be wreaking

havoc on their health. Those 15 plus hours are making employees fat, weak and for some it may even be a death wish, according to doctors.

Working at a desk requires minimal muscle activity. In fact, the large muscle groups of our legs and back are essentially taking a nap when we sit. When we sit at a desk for an extended period, the three curves of the spine (cervical, thoracic, and lumbar) can round or compress. Chronic low back pain has increased significantly over the last 10 years. No doubt because sitting all day causes hip flexors and hamstrings to shorten and tighten, while the muscles that support the spine become weak and stiff.

While our employee's productivity may be going up while they are at their desks, the inactivity of their muscles is creating a world of hurt. When employees are on conference calls, at meetings, returning phone calls, sending emails and doing all of those necessary things that keep the company moving forward their bodies are



going into shutdown mode. Think of it like your computer screen. After a few minutes of inactivity the computer goes to sleep requiring you to enter a password or touch the key board to wake it up again.

Keep in mind we were not made to sit at a desk all day. We have evolved into desk dwelling creatures. Inactivity researchers point out that when we sit for prolonged periods of time electrical activity in the muscles plummets. This extreme state of inactivity leads to an avalanche of negative metabolic effects. The rate at which we burn calories takes a drastic drop. Insulin effectiveness plunges within 24 hours causing the risk of type 2 diabetes to increase. The risk of obesity rises while the levels of HDL (happy cholesterol) fall because the enzymes necessary for ridding our blood stream of fat fall dramatically. The metabolism slows to a crawl.

The work that our employees do is very important as is their health while doing it. So, the question for employers is how can we create a more mindful work environment? That is, an environment wherein employees are not only mindful about what they are doing but how they are doing it. Whether your company is up and running with a Wellness program or still trying to figure out how to start one, creating a culture of movement is really easier than you might think. The work place is dynamic in its own right. Adding physical activity to an already vital office, factory or store environment can be accomplished through subtle cultural shifts, as well as, the introduction of programs that encourage movement.

The quickest way to address the sitting epidemic is to stand up! Move! Many of the California based companies I work with have instituted walking meetings. They take their meetings outside

and walk the campus while discussing business objectives. Employees are still being productive but they are moving while doing it. The change in environment also provides a much needed mental clarity break for employees. One employee told me that "It's like taking a vacation from your desk. Just doing what I do every day in a different setting for a few minutes makes a huge difference in my mood."

In many of my corporate accounts I am introducing basic stretching programs. Employees are trained on how to do some basic stretches while at their desk. Consider It Done (Southern California legal support firm) employees engage in a stretch break at 10am and 2pm regularly. Everything stops for 10 minutes while employees stretch wherever they might be. Even the president stops what he is doing to do shoulder rolls and enjoy a few ujjayi breaths. We also instituted a Green Room for employees. The Green Room is a Zen and peaceful space where employees can go to meditate and do additional stretching on their own at any time during the course of the day.

Any time employees can get their blood pumping the organs will be fired up to do things that are good for the body. Encourage them to interrupt sitting whenever they can with activities like walking and marching in place. Suggesting employees take calls standing, rely a little less on email and speak to each other face to face are subtle cultural shifts. One of my friends recently purchased a stability ball to use as his desk chair. It took a few weeks to get used to it. He started off by using it a couple of hours a day until his core strength improved. Just 3 months later he believes it is the best thing he could have done for his low back.

We all know that there is powerful medicine in our walking



shoes. Re-visit your worksite walking programs. If you have given employees pedometers hold them accountable by encouraging so many steps by lunch or the end of the day. We recently implemented a walking program at a small engineering firm in Oakland, CA. With only 50 employees there were fewer obstacles to employee engagement. It also helped that the CEO walked Lake Merritt every day. We used this as a platform for starting their walking program. Groups were formed. Walking dates were made via a community board in the cafeteria. The Wellness committee also established a rainy day plan, wherein, employees were encouraged to put in enough steps to log a half a mile within the office. Every time an employee was successful in reaching the half mile goal they earned Wellness points to be cashed in at the end of the quarter.

Almost all of the companies I work with are offering their employees some form of Yoga during the work day. The benefits of a basic Yoga practice are endless and are ideal in a work environment. What employee couldn't benefit from from mental clarity, stress reduction, increased circulation and an energy boost? In a recent Mindful Mood Management seminar, I started my presentation with some basic yoga stretches and breathing techniques. It was short, simple and functional done right there in the company's board room. One of the participants asked "did we just do a little Board Room Yoga? Nice!" People were pleasantly surprised at the mental and physical charge they got from a few sun salutations and deep breaths.

Be sure to address ergonomics in your office. OSHA offers some excellent on-line tools to help employees make small tweaks that translate to huge relief for those trouble spots like the eyes, wrists, back, and neck. The use of easily adjustable furniture, for example, allows workers to frequently change seated postures, which allows different muscle groups to provide support while others rest. Some basic education on things like substituting keystrokes for mousing tasks, such as Ctrl+S to save, Ctrl+P to print can prove quite helpful to your employees.

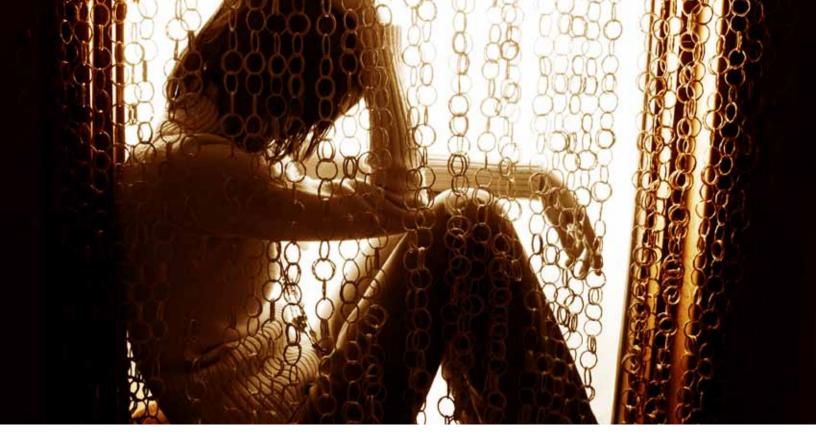
The goal of any Wellness program should be to spur employees on to a healthier lifestyle. Even if employees are gym goers and week-end warriors, they are still glued to the chair for a large portion of the day. An employee Wellness program has to figure out how to incorporate non-exercise, simple movements, to counteract all the sitting that employees do. Maybe an office full of fidgeting employees taking a few micro-breaks a day wouldn't be so bad after all.

About the Author

Kaye Kennedy is certified in group exercise, personal training and Pilates. She is the Director of Corporate Wellness for MBS Wellness, a company that specializes in creating and implementing employee wellness programs. The company provides cutting-edge, hands on consulting to assist companies in achieving the maximum results from a wellness program. To learn more about starting a wellness program for your employees or enhancing an existing program, visit www. MBSWellness-SF.com, email Kaye at Kaye@MBSWellness-SF.com or call 888.957.9940.

Defeating Depression with Resilience





Written By Gail Wagnild

RN, PhD is the Director of the Resilience Center and author of the Resilience Scale™

Written By Rose K. Gantner

EdD is Senior Director of Health Promotion, Consumer Education, Training and Innovation for UPMC Health Plan in Pittsburgh, PA A good way to reduce health care costs and increase vitality and productivity in your organization is to increase resilience to prevent or eliminate depression.

The Business Case for Reducing Depression in the Workplace

The cost of depression for businesses is huge:

- Depression is estimated to cost employers between \$17 and \$51 billion each year, with 200 million workdays lost to the disease.
- Depression leads to more absenteeism than almost any other physical disorder.
- In a three-month period, people with depression miss an average of five workdays, and are significantly less productive for twelve additional workdays.
- Eighty percent of people with depression do not function well in their daily activities and one-third report serious difficulties in work and home life.
- Current research indicates that for every dollar spent on effective wellness programs medical costs in the U.S. decrease by \$3.27 and absenteeism falls by \$2.73.

About Depression

Almost everyone is affected by people who have some degree of depression. Even if you are not depressed yourself, you almost certainly know someone who is. According to the National Institutes of Mental Health.

depression affects approximately 20 million American adults 18 years and older, almost one in ten. Furthermore, depression is a growing problem. The World Health Organization says that by 2030, depression will be the largest cause of early death or disability.

Depression affects you physically, not just mentally. Depression increases the risk of coronary heart disease, and is a significant predictor of the annual number of deaths in a given age group. Depression related to stress can lead to high blood pressure and a weakened immune system, and makes women almost a third likelier to have a stroke.

Depression can also cause poor health behavior, such as failing to take diabetes medication. Other negative health habits often associated with depression include smoking, excessive alcohol consumption, poor exercise, poor diet, and underdeveloped or nonexistent social support. If that is not enough, when depression occurs in combination with other serious illnesses such as cancer or HIV, people tend to have more severe symptoms of the medical illness, with the associated higher medical costs.

What leads to depression? From time to time, everyone experiences events that leave them feeling helpless, useless, not appreciated, or a failure, and as a result, a person might feel depressed for a while. Serious depression, however, often results from more long-term, strategic causes, such as chronic overwork, job insecurity, deadlines that can't be met, gossip, no hope of a promotion, the feeling that every move is being monitored, harassment, ongoing

What is Depression?

The World Health Organization defines depression as a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday activities.

Signs of Depression

- Inability to experience pleasure
- Lack of interest in activities you used to enjoy
- Insomnia or sleeping too much
- Loss of appetite or significant weight gain
- Lack of energy
- Very low self-worth
- · Inability to concentrate
- Suicidal thoughts

(Source: American Psychological Association)

Resilient People:

- Exercise more
- Practice better nutrition
- Use stress management techniques such as meditation
- Seek out interpersonal support
- Are less lonely
- Feel less hopelessness
- Experience less anxiety
- Report better overall health
- · Perceive less stress
- Are more forgiving

conflict with co-workers or supervisor, and lack of social support.

Resilience is a Powerful Antidote to Depression

While there is more and more information about the connections between job stress and depression, less is known about ways to prevent depression. Fortunately, new research indicates that it may be possible to prevent depression from occurring in the first place by strengthening resilience. This may be the most effective way to deal with depression, because after all "an ounce of prevention is worth a pound of cure."

Resilience is the ability to recover, learn, and grow stronger from adversity. Most people are able to do this to some degree, though clearly some do this better than others. Those with strong resilience are able to handle change and adversity exceedingly well, oftentimes without missing a beat. Even though they experience the same setbacks that others do, their response is different and they emerge challenged and optimistic rather than threatened and defeated. They are therefore less likely to become depressed.

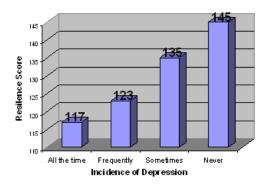
The Science of Resilience and Measuring Resilience with the Resilience Scale™

While there are many interventions and programs that offer resilience programs, not all are evidence-based. We have been conducting research since 1987 to understand why some adults do better in life than others, adapting successfully to adversity. We have conducted surveys and studies to learn more about this human ability that we have come to call "resilience." Our research has identified five characteristics that are strongly present in all people who have adapted well to adversity, which we call "the five core characteristics of resilience."

Early in our research, we constructed a tool to measure resilience. We took the five core characteristics and, using verbatim statements from people we knew to be resilient, constructed an instrument called "The Resilience Scale" (RS), which is now in use worldwide. Over the past 25 years, the scale has proven to be a reliable and valid measure of resilience (See www.resiliencescale.com). We have tested it on thousands of people and the results have proven conclusively that it measures individual strengths that are potentially preventive for depression.

We have learned in numerous studies with thousands of people that as resilience scores go up, depression

scores go down. We have also learned that other behaviors known to protect against depression increase along with resilience scores.



The Five Core Components of Resilience

It is clear that increasing a person's resilience will prevent depression, but how do you help someone become more resilient? What is the process? It sounds challenging, if not impossible. The key is not to try to "become resilient" all at once, but rather to work on one aspect of resilience at a time. This should happen in discrete, orderly steps. Like the saying goes, you have to eat an elephant "one bite at a time."

This is where the five core components of resilience come in. We have found that the most effective way to increase employee resilience is to focus on each component, one at a time, strengthening each. This will create a more resilient employee. The five core competencies of resilience are:

- A sense of purpose and meaning in life. If people can learn what they were born to do (their purpose), it gives them passion and creates meaning for them in life. They will begin to experience what Csikszentmihalyi refers to as "flow." When a person is deeply immersed in work, focused and engaged, there is little opportunity for depression to take root. Within the organization, this means that an employee's life direction, talents, and abilities must be consistent with the organization's purpose. Thus, choosing employees who fit the organization is essential. Providing encouragement and opportunities to do work that fits with their abilities and desires is very important, and will reap tremendous rewards.
- A balanced outlook on life. Although change, adversity, and demands in the workplace are here to stay, feeling negative, threatened, defeated, hopeless, or helpless is not. People can learn to have a balanced perspective, and

to respond to difficulties on the job in healthy ways. Two thousand years ago, Marcus Aurelius said, "You have power over your mind...not outside events. Realize this, and you will find strength."

- The ability to persevere, no matter how difficult things become. Resilient people rarely give up. They recognize that it takes time and effort to achieve success. Perseverance is a habit that can be acquired like any other. Because perseverance without purpose is pointless, the first step is to know what your purpose is. Then, although you may experience rejection, fear, discouragement, and doubts, giving up will no longer be the likely outcome.
- The ability to depend on yourself. When people begin to understand that they are capable and competent, that they can depend on themselves, their self confidence and self-esteem grow. Self-reliance is not easy to achieve, however, and takes a lot of practice. People with self-reliance are self-starters, dependable, and resourceful. They are able to focus and prioritize more effectively. This, too, contributes to 'flow' and leaves little room for depression. Within the organization, employees can become self-reliant if given the encouragement, time, training, and support to do so.
- Self-acceptance. Resilience and self-acceptance go hand in hand. Resilient people do not judge themselves harshly. They don't reject themselves. Resilient people have the courage of their convictions and aren't riddled with self-doubt. Depressed people often are dissatisfied with themselves and are very critical of what they see as flaws; resilient people recognize their self-worth and grow to appreciate how unique they are. This realization sets them apart and allows them to be truly themselves and comfortable in the world.

How resilience cancels depression

The five core characteristics of resilience in every case "cancel out" vulnerability to depression, as shown in the table below.

Resilient	Depressed
Sense of purpose	Feelings of
	worthlessness; nothing
	to look forward to
Balanced view and	Feelings of
optimistic	hopelessness
Perseverance	Can't see the point in
_ <u></u>	continuing
Self-reliant	Helpless and low self
	esteem
Self acceptance,	Dislikes self
"warts and all"	

The Supporting Players

We also identified four "supporting players" that strengthen resilience. While they are not essential to resilience, it is difficult to have a strong resilience without them. These four supports are:

- Taking care of yourself through exercise, nutrition, and stress reduction.
- Seeking support when needed, and giving support as well.
- Balancing rest, responsibility, and recreation.
- Engaging fully in life; not retreating from it.

With this fundamental understanding of the basis of resilience in hand, we have found ways to measure it and even to increase it in individuals and organizations.

Strategies for Strengthening Resilience in the Members of Your Organization

Employee education interventions integrated into your health promotion program are a good place to start improving the resilience of the members of the organization. These interventions can take many forms:

- Online or web-based resilience strengthening modules.
- · Face-to-face or phone coaching.
- Group classes organized around the resilience core.
- Employee newsletter or e-letters.
- Materials on resilience and how resilience defeats depression.

It is important to note that there are many available resilience interventions that are not evidence-based. Be sure to select a resilience strengthening program that is research-based, and especially one that includes the five core components of resilience, as described above.

How to Tell if your Resilience Training Program is Effective

An increase in resilience and a reduction in depression in the workforce indicate that your resilience training program is effective. Here are a few of the ways you can measure this:

- Use the Resilience Scale (either the 25-item scale or the shorter RS-14) to measure resilience before and after the intervention to assess changes in resilience.
- Incorporate questions specific to the Resilience Core into your company's Health Risk Assessment (HRA) process.
- Monitor questions specific to depression in the HRA.
- Measure the use of resilience training through online programs, coaching, or other offerings and employee satisfaction with these programs.
- Compare scores on measures of depression and resilience between those who use resilience strengthening modules versus those who do not.



Summary

By expanding your existing employee assistance and wellness programs to include resilience training, your organization can increase worker resilience. This will reduce depression and contribute to increased morale and productivity of talented workers. An effective resilience training program, based on the five core components of resilience, with clearly measurable, positive outcomes, will help your organization to compete more effectively in the global marketplace.

About the Authors

Gail Wagnild, RN, PhD is the Director of the Resilience Center and author of the Resilience Scale™. She is currently working with Life Advantages to produce a comprehensive suite of clinical programs for building and maintaining a resilient life for the EAP, Managed Behavioral, Wellness, Medicaid, and college student marketplaces.

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Cake or Carrots?

Using Incentives to Motivate Healthy Choices







Written By
Ryan Beckland
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Challenge



Written By Drew Schiller co-founder of Scale Down

Incentives motivate behavior change, yet there is a widening gap between those of us who use incentives to encourage healthy behavior and those of us who prefer not to provide rewards to encourage healthy behavior. Well, both camps are right, and we're here to bridge the gap.

Natural Incentives vs. Artificial Incentives

Incentives are little more than providing someone a good reason to do something. For example, when Ryan helps his brother-in-law move a new sofa into his house, he is rewarded by the feeling of doing something nice for a family member. This is an example of a reward that occurs naturally for performing a behavior. He does the deed because it feels good, and it's what his brother-in-law and him do for each other.

Compare this to when Drew's wife promises that if he cleans the kitchen he can choose the movie for their date night. Is Drew happy the kitchen is clean? Sure. But the real reward for him is knowing that this weekend he'll be able to watch the new Woody Allen movie rather than The Help. This clever system Drew's wife uses to keep the house in order is an example of an artificial reward. In other words, Drew is performing a task that should be performed anyway (cleaning the kitchen) but the reward he's receiving is not derived directly from that task.

These simplistic examples illustrate how natural and artificial rewards motivate our behavior, but you may know them better by the types of motivation they create: intrinsic and extrinsic motivation.

How We Are Motivated

Intrinsic motivation comes from within. In corporate wellness, we often see this among "high performing" individuals who have the drive to exercise regularly, eat the right foods, and take care of their mental and physical health. We often see intrinsic motivation as the type of motivation everyone "should" have.

Predictably, extrinsic motivation is the result of an artificial incentive and is motivation that is precipitated by an outside factor such as cash, prizes, points, or rewards that are personally meaningful (like getting to choose the movie on date night).

Some wellness professionals have propagated the idea that using incentives in wellness programs is bad and that intrinsic motivation is somehow better than extrinsic motivation. These arguments are based on evidence that conclusively shows that while artificial incentives (e.g., cash and prizes) are highly effective at motivating behavior change, modified behaviors often revert back to their original state once the incentive is removed. Thus, the argument is that artificial incentives

cannot motivate behavior change for the long term and are therefore valueless.

The conclusion that incentives don't work is wrong, and it exposes an industry-wide misuse of the term "incentive" to simply imply artificial rewards. As we've demonstrated, both intrinsic and extrinsic motivators are the result of incentives. The external motivator of receiving a cash reward for losing weight is an incentive, as is the intrinsic desire to be healthier for your child.

Overcoming Immediacy is the Key to Behavior Change

Eating a piece of chocolate cake has a strong natural incentive — the immediate gratification of enjoying chocolate cake. For almost everyone, the immediate reward of enjoying chocolate cake is stronger than the idea of being healthy. Thus, people choose to eat the chocolate cake, us included.

Our experience in wellness comes from helping individuals lose weight, so this chocolate cake example is important to us. The fundamental problem we must solve is this: For an overweight person, how can we make the idea of "being healthy" overpower the immediate gratification of enjoying that piece of chocolate cake? In other words, we have to figure out a way to flip the strength of these competing incentives.

Debating the value of intrinsic versus extrinsic motivation misses the much larger point, which is the strength of incentives.

In many cases, artificial incentives provide strong motivation for healthy behavior change. Just think: when one of your employees has a choice between eating a carrot or eating chocolate cake, you know very well which one they will choose. But if that same employee had the choice between receiving \$50 or eating chocolate cake, which do you think they'll pick? Of course, almost all of them will choose the \$50 over the chocolate cake.

The objection that the removal of an extrinsic incentive will result in a changed behavior slipping back to the old behavior is valid. If you offer an employee \$50 to not eat cake, they'll make the healthy choice. But if you don't offer \$50 next time, then the employee probably picks the cake.

And this should not be surprising. Consider this: If your employer stopped paying you would you still go to work? Probably not. Does that mean you don't care about your job or the work you do? No it doesn't. Similarly, when an external incentive is removed and a healthy behavior is lost, that doesn't mean the healthy behavior was valueless, or that an employee doesn't care about being healthy. It only means that a powerful incentive that had previously shaped a positive course of action was removed.

There is a larger issue underlying the intrinsic/extrinsic debate. We've heard dogmatic ideas about what behaviors people "should" practice and what "should" motivate them. Ideas like being healthy, living longer, even looking better "should" be motivating enough on their own. Well, obviously people aren't adequately motivated by those ideas, because our country has a growing obesity epidemic.

What is maddening for us wellness professionals is that all employees want to be healthy. Ask 100 of your employees if they want to be healthy, and all 100 of them will say yes. But as we know, just because they want to be healthy, doesn't mean that they will do what's necessary to get healthy.

By using artificial incentives (in this example, \$50), we can change the decision making process involved in choosing between carrots and chocolate cake. The financial incentive makes the carrots much more appealing by making the reward for the healthy behavior more immediate. Research has proven time and time again that strong incentives, such as financial rewards, create extrinsic motivation that leads to healthy behavior change in the short term.

Transitioning Incentives for Long-term Effectiveness

Artificial incentives are the key to motivating behavior change by helping people make healthy choices in the moment. But natural incentives (e.g., looking and feeling better, lowering blood pressure, fitting into smaller clothes) are critical to maintaining those healthy behaviors over time. Intrinsic motivators are terrible at getting people started, but they're good at facilitating long term change. For example, a smart weight management strategy will use extrinsic incentives to jumpstart the weight loss process, then transition to intrinsic incentives to leverage those positive results.

The debate over using intrinsic or extrinsic motivators is wrong. It is irrelevant whether a motivation is extrinsic or intrinsic, what matters is what works. Both natural and artificial incentives have their place, and both are necessary to motivate long term behavior change.

About the Authors

Ryan Beckland and Drew Schiller are co-founders of Scale Down Challenge, an online platform that helps wellness programs administer healthy weight loss challenges for employees. The low cost, collaborative challenges help prevent weight-related medical diseases by using the power of incentives to motivate behavior change. Learn more at www.scaledownchallenge.com



Written By Fabien Loszach co-founder of Scale Down

Challenge

Improve Your ROI With a Wellness **Diagnostic**

The benefits of promoting healthy lifestyles in the workplace have been proven; good employee health boosts productivity, stimulates creativity and reduces company insurance costs. Creating a structured wellness program prepares businesses and their employees to meet the demands of the new economy. which requires high levels of creativity, immediate responsiveness and ever-shorter turnaround times.

Studies have shown businesses that implement health and wellness programs see improvements in productivity, recruiting efforts and workplace morale, as well as decreases in absenteeism, insurance costs and internal conflicts. Studies typically demonstrate a \$4 to \$5 saving for every \$1 invested in health promotion. With a well-structured program, employees will perform at their maximum potential, because they are more invested in their work and are more loyal to the company.

However, every workforce has a different profile when it comes to the health of employees and the health of the business as a whole. Therefore, before implementing a wellness program and making costly investments (such as installing a fitness centre, for example), it is essential to identify the specific issues that are affecting the workforce and the company's bottom line. Simply put, employers must conduct a diagnostic to assess the wellness of their employees and their organizations. However, not all diagnostics are created equal.

Objectives of a Wellness Diagnostic

A wellness diagnostic must provide an organizationwide measurement of the health and wellness of employees and determine those employees' needs. A practical diagnostic will identify the specific health and wellness issues that have the biggest impact on the company. The diagnostic should also generate an accurate picture of the general health-and any health risks-of the company as a whole. In other words, simply analyzing the physical health and lifestyle choices of employees won't cut it; employers must assess the wellness of the organization itself, by analyzing communication efforts, job satisfaction, workload balance and the causes of stress in the workplace.

If a diagnostic achieves these objectives, it will provide a foundation upon which employers can build a structured wellness program. A corporate wellness diagnostic will allow managers to identify problems, set goals, and measure the results and the impact to the organization. It should also provide a comparison to past initiatives and to the competition.

After understanding the objectives of a diagnostic and the reasons for conducting one, managers must determine what different types of diagnostics are out there, and which particular diagnostic is right for their business.



Elements of a successful diagnostic Most large companies rely on a health risk assessment (HRA) to diagnose the health of their employees. While this type of diagnostic has advantages, HRAs do have some shortcomings. For instance, employees cannot participate anonymously, because they each take part in a one-on-one health assessment.

The upside of this is that each employee is provided with an individualized health report, but their responses are likely to be censored if they know their employer can review them. What's more, it can be difficult to incite healthy habits among employees when they are each working off of an individual report. For a wellness program to truly be successful, it must focus on the bigger picture, so an HRA needs to be complemented with a more thorough diagnostic.

A good corporate wellness diagnostic must be easily accessible and not overly long or complicated, in order to ensure strong employee participation. Participation should be voluntary and employees must feel comfortable taking part; ideally, they would do so in a calm, non-stressful place, and they shouldn't find the survey too tedious or too personal. To obtain honest answers about sensitive subject matter such as drug and alcohol use, employer approval and job

satisfaction, employees should be assured their responses will remain anonymous. To facilitate maximum participation and honesty, the diagnostic should be conducted by an objective source and the importance of answering honestly must be well communicated to the workforce. This last point cannot be stressed enough.

The diagnostic should provide a global perspective on the health of a business, while also providing detailed statistical analyses of each individual issue addressed. It should be made up of at least three different sections that correspond to the three essential components of health and wellness: lifestyle choices, physical health and psychological health.

Any diagnostic must include a focus on lifestyle aspects that strongly correlate with wellness, such as nutrition, exercise, sleep and tobacco, alcohol and drug use. Lifestyle choices have a huge impact on health costs; in fact, preventable illness makes up approximately 70 percent of the burden of illness and the associated costs. Unfortunately, most people do not prevent these illnesses simply because they are making the wrong lifestyle choices.

Separate from issues related to lifestyle, but equally important, is the assessment of physical health. This section



should cover medical problems and physical disorders that may affect employees; it should take into account chronic diseases and other health problems that affect insurance claims. (If you have operations in the U.S., bear in mind that questions related to family medical history are not permitted by U.S. law if employees are given an incentive to take part in an HRA.).

The next critical section of a good corporate wellness diagnostic is an assessment of the psychological wellbeing of employees. It is not necessary to test employees for mental instability or psychological issues, but rather for their ability to handle stress at home and work, and their ability to maintain healthy relationships with their colleagues. Stress has a huge impact on productivity and insurance claims, and the current trends of layoffs and increased workload are only serving to further increase stress levels.

I should point out health-related costs and weak productivity are not caused solely by employees and their behaviors. As mentioned earlier, many employers rely on an HRA to diagnose the health of their business, but neglect to analyze workplace issues that are affecting employee health. This can create an environment where employees feel they are under the magnifying glass, and even a sense they are being blamed. It also leaves employers with an incomplete understanding of health and wellness in their company.

This is a common problem with unsuccessful wellness programs: there is a narrow focus on individuals' health-related attitudes and behavior, often to the exclusion of job, organization and management factors that affect employee health and wellbeing. A smart diagnostic will include an evaluation of what is sometimes known as organizational health—that is, all the factors that affect employee productivity and morale in a given workplace. These factors could include job satisfaction, workload, stress and co-worker relations, including relations between managers and employees.

A thorough employee wellness diagnostic is an essential tool; every successful wellness program is based around the results of a diagnostic. By analyzing potential problems in the workplace, the lifestyle choices of employees and their physical and emotional wellness, employers can determine which problems are directly impacting the organization. Building their program to focus on these problems maximizes the potential return on investment.

In essence, a comprehensive diagnostic provides employers with a clear and detailed understanding of the health of their business as a whole, so they know what goals their wellness program needs to achieve.

The Philippine Health and Wellness Program



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Written By Roger Schultz

President of the Hawthorn Consulting Group

The Challenge of Product Development for Voluntary Benefits

A speaker at a recent Voluntary Employee Benefits Board conference pleaded with attendees to take a fresh look at their product development processes and commit to significantly improve them. Their current approach is simply not working.

Speaking in the context of voluntary products, it was noted that most carriers are getting less than 20 percent participation, which means carriers are failing to meet the needs of more than 80 percent of their customers.

To be more successful, carriers need to create truly innovative products that solve real customer problems!

The Goal of Marketing

The goal of marketing is to create a value proposition that solves a customer need. That is, to create a product or service that is useful and valuable (i.e., relevant) to the buyer.

But, relevancy is insufficient. Having tires on a car is useful and valuable. But, people do not make purchase decisions based on whether a car has tires. The analogy in insurance is claims. Everyone values good claim service. Since most carriers pay claims promptly, claim service does not drive a purchase decision. Value propositions need to be compelling as well as relevant.

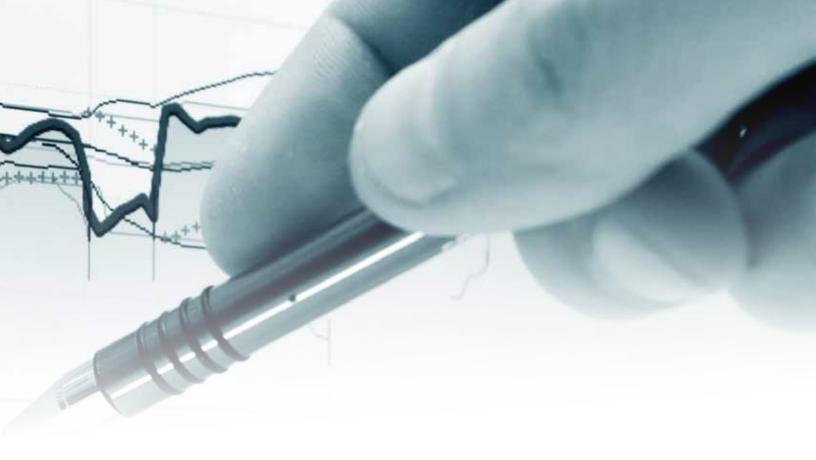
For the carrier, there are two additional objectives. Since there are hundreds of carriers in the market, it is important for a carrier to provide something other carriers don't. This calls for a value proposition to be differentiated from those of the rest of the market.

Further, we don't want to ignore the importance of "shelf-life" and miss a key challenge for the product development process. An effective product development process will give carriers the opportunity to deliver a sustainable competitive advantage. This is important because sustainability will drive results for a long time.

Creating Actionable Consumer Insight

Traditional industry practices have failed to deliver the necessary levels of consumer insight to enable companies to develop products that

^{1.} www.theacsi.org



delight customers, respond to their most important needs and result in highly satisfied customers. Consider:

- The industry is viewed very unfavorably and has a low reputation. Based on the recent American Customer Service Index, the health insurance industry ranks lower in customer satisfaction than the United States Postal Service, public utilities and cell phone companies. Only airlines and gas stations rank lower.
- Mistrust of the industry is very high and results in high levels of regulatory scrutiny and legislation.
- Acceptance rates and satisfaction with current voluntary products, such as critical illness, are low. A 20 percent acceptance rate for voluntary insurance plans means that current products fail to satisfy real customer needs.

What is it about current industry practices that have resulted in such poor performance? Consider the following:

• Current product development processes are focused more on competitors than customers It's a competitive marketplace. In the end, customers, employers and brokers are choosing between products of different carriers. It's important to understand how current products compare with those of competitors. It's easy to get access to competitors' current products. Analysis of competitor products tends to focus on benefits and features of the currently marketed products. It's common for competitor analysis to be the basis of carrier product development practices. The result is rapid adoption of market "best practices" and only incremental innovation. But, this approach contributes to the commoditization of the industry and severely impairs a company's ability to create sustainable differentiation.

Current product development processes are often focused on internal industry mechanics, with focus on mitigation of risk and achievement of profitability, not on meeting customer needs and solving their problems. Product development often sits with the actuary or underwriter. These are industry professionals whose training centers on complex internal insurance company operations, who are held accountable for achievement of profitability and who are responsible for management of risk.

Many actuaries and underwriters do not have training on product development, innovation or marketing. Many will struggle to embrace the concept of consumer value (the relationship between value of a benefit and price). Little priority is given to satisfaction of a customer need or the solving of a real customer problem as the basis for the product development discipline. A more consumer-oriented approach can produce a better result. Consumers at a recent focus group were asked to design their own product. When complete, they were asked how much they would be willing to spend on their product. They indicated they were willing to spend as much as five times the current market rate for the product that they designed!

Current product development processes are hampered

by confusion as to who is "the customer." There are a large number of constituents in the voluntary benefit market. Carriers market to managing general agents who work with their agents to market to corporations who offer benefits to their employees. This makes it hard to think clearly about "the customer." There are distinctive sets of needs for brokers, corporations and employees. It is hard (and maybe unfair) to expect any one constituent to be able to provide deep insight into the needs of the other constituents.

The solution is to turn up the volume on the voice of the customer...to the point where it is the loudest voice in the analysis. Direct research with the end consumer is needed. This highlights the importance of primary market research to the product development process.

Current industry product development practices often fail to incorporate the deep, actionable customer insight needed to enable truly innovative product development.

Creating a Sustainable, Differentiated Competitive Advantage

Current industry product development practices rely heavily on competitive analysis. This is an essential component of an effective product development process. I am not suggesting carriers stop conducting competitive analysis. But, failure to incorporate new, actionable consumer insights into the process will result in the continued underperformance of current process. Don't stop doing competitive analysis. Start doing more consumer analysis.

Products are easy to copy and fail to provide long-term competitive advantage. Most carrier products are filed with insurance departments, where records are easily available for public consumption. Agents are eager to share market innovations with their carrier partners, hoping they will respond (i.e., copy) to help them compete. There are highly efficient competitive intelligence providers, such as Competiscan , that help carriers rapidly identify product innovations. As a result, only the lightest of competitive intelligence processes are needed to enable a carrier to disarm even the most creative product feature.

This results in a constant migration toward product commoditization, making it terribly difficult to utilize product as the means of creating sustainable competitive advantage. Commoditization inevitably results in greater rate competition. Carriers get low margins, undifferentiated products and low customer satisfaction. The product development process has failed!

The solution is to avoid actions that lead to commoditization. Seek not to be the same, seek to be different ... in ways that bring real value to consumers ... by responding to their real issues. Focus on real customer problems and issues, especially unresolved ones.

You do this by conducting market research. Conduct primary and secondary research. Ask your customers for feedback. Examine the customer experience and consider the opportunity to differentiate on the basis of services and your customer's experience.

Most importantly, build solutions that will delight and impress your customer! Demonstrate that you are listening to customers and that you care. This may require you to think long term - and think out of the box! Tackle barriers wherever they appear, especially if they prevent you from addressing a customer concern!

Can this be done? Consider Progressive Insurance Company's online price comparison service. In 1994, Progressive created a new service that sat outside of the core auto insurance product but complemented it in a very customer-friendly way. This service allows customers to get online rate quotes instantly, from a number of leading carriers (Progressive's competitors) without an agent.

This required brave new thinking, deep commitment to resolve issues faced by their potential customers and a significant investment. This sort of customer orientation is working. Today, they are the fourth largest auto carrier in the country and they continue to grow. They continue to advertise this service as it remains a competitive advantage even to this day...more than 15 years after they launched it.

Industry Structural Constraints

The structure of the industry makes product development in the insurance space difficult.

- Health Care Reform in the health insurance market limits the range of options for product differentiation by requiring all carriers to provide certain benefits, such as preventive care. The environment gets worse in 2014 when the "essential benefits" provisions of the law take effect.
- Heavy regulation of benefits and rates for certain products in certain geographic markets create excessive scrutiny of profitability, driving profit levels down to low levels.

Consumers aren't the industry's best friends either, as their attitudes and behaviors create challenges for carriers.

- Health insurance is a low involvement category. Customers
 do not enjoy shopping for insurance and spend little time
 doing so. A recent Guardian study indicated the average
 customer spent 1.7 hours selecting their employee
 benefits, yet spent 2.2 hours shopping for school supplies,
 3.5 hours preparing Thanksgiving dinner and 5 hours
 holiday shopping.
- The insurance concept is not well understood by customers, leaving them confused and feeling like they are treated unfairly.

^{3.} www.progressive.com/progressive-insurance/history.aspx

^{4. &}quot;Reluctance in Studying Benefit Choices"; Guardian Life Insurance Company of America; 2010

^{5.} www.healthadvocate.com



Despite that, opportunities abound for carriers to create competitive advantage through their product development activities.

- Health Advocate is a company that offers independent advocacy services to help health insurance customers in their "battle" with their carriers and to help them navigate the American health care system.
- Progressive's use of Flo, GEICO's Gecko and Aflac's duck makes insurance entertaining and more engaging.

Product Development Process Improvements

We've suggested that carriers "turn up the volume" on the voice of the customer, making consumers the primary focus of the process. We've also suggested that carriers look beyond the features and benefits of the product for customer-oriented solutions that offer carriers competitive advantage for a longer period of time.

Here are some ways to accomplish this:

- Implement a clearly defined, robust process lead by people who are knowledgeable about the industry, but also have the ability to focus on customer needs and enjoy challenging traditional industry paradigms. Here's an example:
- Invest in market research and look for real customer problems and pain points.
- Solve real customer problems. Be a good listener during your research. Design solutions that solve real problems.
- Think beyond traditional features and benefits of the insurance product. Recognize that the value proposition involves the total customer experience and

- all aspects of the relationship between the carrier and the customer.
- 5. Be patient and disciplined. The process takes time. And, often development of solutions takes a long time. Consider market testing to validate and test out your solutions. It's hard for carriers to be patient with the process, but the payoff can be significant and long lasting.
- 6. Don't abandon traditional competitive intelligence, and don't ignore the perspectives of the broker and the employer. Be sure, however, to keep the primary focus on the end consumer. After all, what employer will reject a concept that truly makes their employees happy? And, what broker will resist marketing products that make their customers incredibly satisfied?

The insurance business is complicated. Product development exists within every company, however, and can often be the key to a carrier's success. Focusing on solving real customer problems and thinking beyond the traditional insurance product can help a carrier improve their product development practices. Industry winners will be those that can identify and deliver a value proposition that is highly relevant and compelling to their customers in ways that are clearly different from those of their competitors and that are difficult to replicate.

About the Author

Roger Schultz is the President of the Hawthorn Consulting Group, a firm specializing in product development, marketing strategy and product management for the insurance industry. He is a 35-year veteran of the insurance business and has held multiple product development and product management leadership roles. He can be reached at rogerschultz@comcast.net.



Written By Elizabeth Halkos

CMO, Purchasing Power

Recruiting, Retaining & Rejuvenating Employees:

Incentive Top Talent with Voluntary Benefits

Faced with uncertainty about the potential effects healthcare reform will have on employee benefits, and the knowledge that budgets will not be increasing to cover current healthcare plans in the future, more HR professionals are looking towards voluntary benefits to create a robust benefits package.

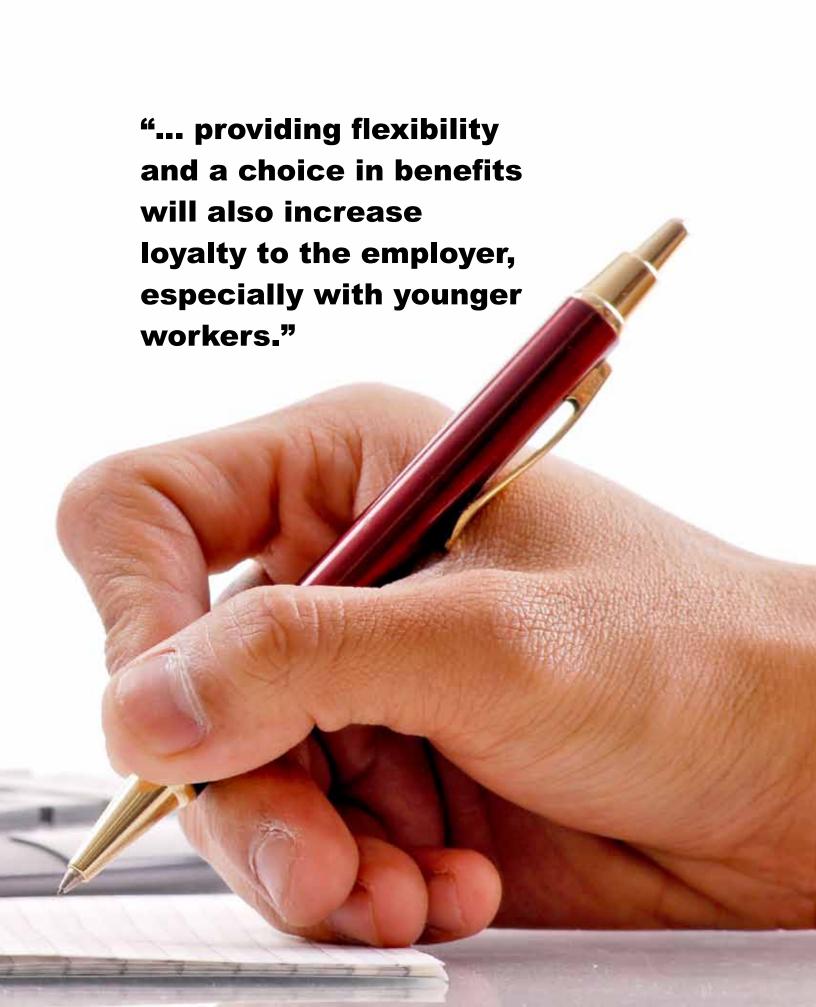
According to the July 2011 Employer Healthcare Benefits Survey, 81 percent of the employers participating in the survey currently offer voluntary benefits to their employees. That figure is expected to increase as we move closer to 2014 when the Affordable Care Act is implemented and more employers begin to shift their traditional medical benefits to voluntary programs.

Leading up to 2014, HR professionals will continue to be challenged with restricted budgets, while being expected to retain employees and recruit new talent. According

to the McKinsey & Co. Employer Survey on US Healthcare Reform, 30 percent of respondents who said their companies offered employer sponsored health insurance said they would "definitely" or "probably" drop coverage after 2014.

Voluntary benefits can be the value-creating solution to bridge between the extremes of dropping existing health coverage and making no changes. Employers who offer voluntary programs like disability, long-term care, critical illness, and accident insurance with special underwriting concessions can demonstrate their concern for their employee's well-being by providing access to programs and rates they could not otherwise obtain on their own. This is reflected in MetLife's 9th annual "Study of Employee Benefit Trends" where 64 percent of Gen Y (age 21 to 29), 66 percent of Gen X (age 30 to 45), 62 percent of "younger boomers" (age 45 to 54) and 66 percent of





"older boomers" (age 55 to 65) understand that comparable products outside the workplace cost more.

In a recent survey of 5,200 workers conducted by CareerBuilder, 42 percent of workers are living paycheck to paycheck. Combine these financial concerns with rising healthcare costs, and you risk having employees that literally become sick with worry over their financial future. Even if you are able to maintain your current employer-sponsored insurance coverage, offering your employees the ability to supplement gaps in their healthcare with voluntary benefits will demonstrate to each of your employees that you care about their health and financial security. According to a national study on medical bankruptcy published in the American Journal of Medicine in June 2009, of the 1.5 million Americans who declared bankruptcy, 60 percent was due to medical bills, and of these 78 percent had health insurance.

While the MetLife study revealed that employees are willing to pay to personalize their core benefits, savvy HR professionals should look to broaden the appeal of their benefits packages with nontraditional voluntary benefits, if they are to retain and reengage their talented employees. In addition, creating a benefits package that includes exclusive benefits and perks will be attractive in recruiting talented, new employees.

Importantly for HR professionals, the MetLife study also revealed that providing flexibility and a choice in benefits will also increase loyalty to the employer, especially with younger workers. Providing a "choice of benefits that meet their needs is extremely important for creating loyalty" among 41 percent of Gen Y and 40 percent of Gen X employees, along with 30 percent of younger boomers and 31 percent of older boomers.

Many nontraditional voluntary benefits provide employees with tangible benefits, which further increase their appeal as they can be used year round to obtain something that an employee needs, rather than the traditional core benefits that employees only utilize when they are sick or injured.

For example, offering college tuition assistance or the ability to obtain a computer through an employee purchase program demonstrates support for your employees' education while the company obtains a more highly educated staff. Companies that relocate or recruit nationwide can provide access to household furniture and appliances through purchase programs. Leadership development programs will help to develop star performers and contribute to their engagement and loyalty to the company.

In addition to improving employee loyalty and morale, voluntary benefits can support a company's HR objectives, and reinforce company culture. Offering gym memberships, subsidized health food vending machines, and access to purchase home workout equipment will reduce healthcare costs, reinforce a company's wellness program, and promote a healthy lifestyle. Promoting regular fun gatherings such as potluck lunches, bagel breakfasts, or a departmental activity in a large firm, can encourage team-building and contribute to company loyalty.

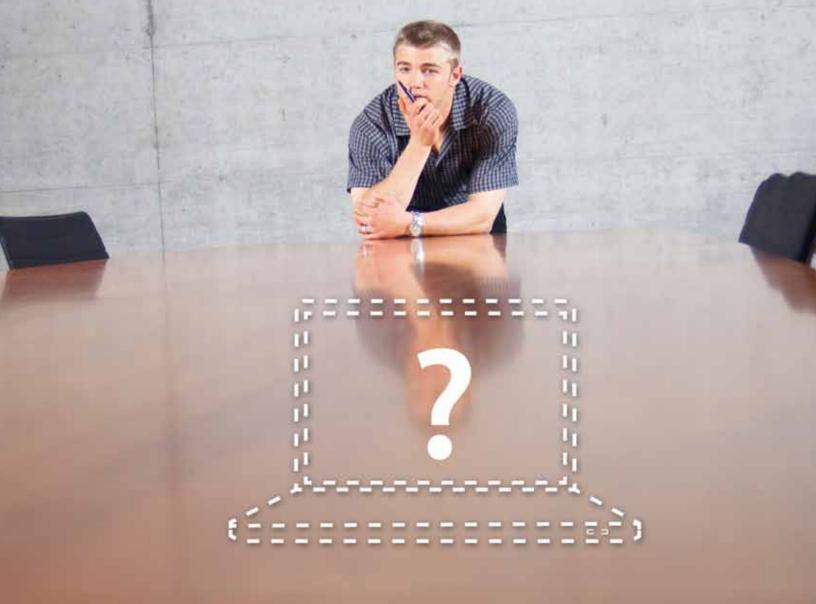
Voluntary benefits can help level the playing field, enabling smaller or startup companies to compete with larger, more established organizations for top-quality talent. Small business owners can offer new employees the ability to customize their traditional benefits package with a variety of practical voluntary benefits, including a flexible spending account, pet insurance, credit union, and employee purchase program, without increasing the employer's costs or administrative burden.

Whether or not healthcare reform becomes one of the biggest influencers on employee benefits decisions, all HR professionals should start talking to their benefits broker about their voluntary benefits options. Look to your HR objectives and company culture to indicate which options will be utilized by current employees and make your package attractive during recruitment. By spending the next 12 months researching and adding the most appropriate voluntary benefits for your company, you'll be in better shape to recruit and retain employees, when the implications of the healthcare reform bill unfold.

About the Author

Elizabeth Halkos has become a strong and influential leader in the field of voluntary benefits. She has been instrumental to the rapid growth and success of Atlanta-based Purchasing Power, and as an expert in the voluntary benefits industry has been featured in magazines such as Benefits Selling, Employee Benefit Advisor, Employee Benefit News, Health Insurance Underwriter and VoluntaryBenefitsMagazine. com. Elizabeth was a presenter at the Benefits Selling Expo in Nashville in April 2011 and the EBA Summit in Dallas in September 2011. She has conducted numerous webinars for brokers and employers to educate them on voluntary benefits trends and improving communications of benefits in the workplace.

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Written By
Rajeev Mudumba
works with a leading HRO/
Healthcare organization

Will Employer Sponsored Insurance Erode Over Time?

Last week, I read a few articles that were lambasting last quarter's McKinsey Health care research study. The consulting firm, McKinsey & Company published a study in June 2011 stating that, once the health care reform law is fully implemented, huge number of employers will drop or restructure their companies' health care benefits.

Sources, outside and within the firm have said that the survey was not conducted using McKinsey's standard methodology. They stated that the study did not deliberate the matter with the same thoroughness as other studies did; particularly the Congressional Budget Office study, which came to the opposite conclusion.

The Congressional Budget Office has estimated that only about 7 percent of employees currently covered by employer-sponsored insurance (ESI) will have to switch to subsidized-exchange policies in 2014. However, the McKinsey survey of more than 1,329 employers across industries, geographies, and employer sizes, as well as other proprietary research, found that reform will provoke a much greater response.

The survey methdology (which is discussed seperately from the article on the McKinsey website) clarifies that the February 2011 McKinsey commissioned survey of 1,329 U.S. private sector employers was an opinion survey and is not intended as a predictive economic analysis of the impact of the Affordable Care Act. It further states that the survey results are not comparable to the healthcare research and analysis conducted by others such as the Congressional Budget Office, RAND and the Urban Institute since each of those studies employed economic modeling, not opinion surveys, and focused on the impact of healthcare reform on individuals, not employer attitudes. Upon review of the survey questionnaire, it can be argued that the McKinsey survey questions were leading and that the survey is a collection of employer attitudes at a point in time than data of empirical value.

You can read the study for yourself at http://www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/How_US_health_care_reform_will_affect_employee_benefits_2813

In summary, the report indicates that more than 30% of businesses will drop health care plans by 2014 when insurance exchanges are due to be fully implemented under the 2010 Affordable Care Law. The details in the report indicate that the changes may be beneficial for many employers and employees. About 50-60

percent of the highly informed employers will pursue alternatives to traditional ESI. About 30 percent of employers stand to gain economically by dropping coverages even if they compensate employees through higher salaries or other benefits. It further states that more than 85 percent of employees would remain at their current jobs even if their employers dropped coverages although over 60 percent would expect increased compensation. 45 to 50 percent of employers will definitely or probably pursue alternatives to ESI in the years after 2014.

Given that this is an opinion poll with a relatively small pool of respondents, employers distancing themselves from ESI or thinking of dropping it seems to be in line with historical trends although there was a surge in employers offering health benefits between 2009 and 2010. With other options becoming available in the changing healthcare landscape, it is possible that in the long term, more and more employers will disassociate themselves from ESI; after all there is much to gain in terms of not having to deal with an unpredictable thorn in the side.

Let us take a look at employer-sponsored healthcare and how it has fared over time.

Before World War II, relatively few workers had health insurance coverage and when wages were frozen during World War II, some employers began offering health insurance circumventing government wage controls. Other factors that influenced the growth of an employment-based health care system were union support of health insurance and favorable tax treatment for both the employers and the employees. Additionally, employers are typically able to purchase group health insurance coverage at better rates than individuals.

United States is virtually the only industrialized nation that ties health care so closely to employment; most other industrialized nations have universal health care systems run by their governments. Costs for employer-paid health insurance are rising rapidly. According to a 2007 study by the Kaiser Family Foundation; since 2001, premiums for family coverage increased 78 percent, while wages had risen 19 percent and inflation, 17%[1]. The percentage of total compensation devoted to health benefits has been rising since the 1960s[2]. Employees on average were paying nearly \$4,000 in 2010 toward the cost of family health coverage - an increase of 14 percent, or \$482, above what they paid in 2009, according to the 2010 Employer Health Benefits Survey by the Kaiser Family Foundation and the Health Research & Educational Trust (HRET). Since 2005, employees'



contributions to premiums have gone up 47 percent, while overall premiums rose 27 percent, wages increased 18 percent, and inflation rose 12 percent. Family health premiums rose 3 percent to \$13,770 in 2010, but employees' share rose 14 percent as employers shifted cost burden. In contrast, the amount employers contribute for family coverage did not increase [3]. The spiraling health coverage costs are one reason why employers have been shifting the balance of these costs to the employees over the last decade.

Employment; commonly viewed as the gateway to health insurance is no guarantee of coverage. Between 1979 and 1998, the proportion of U.S. workers with insurance through their own employer dropped from two-thirds (66 percent) to just above half (54 percent). Between 1994 and 2000, the percentage of workers with health benefits through an employer held steady at between 73 percent and 75 percent. Between 2000 and 2007, the percentage of employees with health benefits had fallen to about 71 percent [4].

The percentage of firms offering health benefits in 2010 increased significantly from 2009. This is primarily driven by a 13 percentage point jump in the percentage of firms with 3 to 9 employees offering coverage, from 46% in 2009 to 59% in 2010[5].

The nation's current recession has also contributed to the shift in health coverage cost burden to employees. According to the 2010 Employer Health Benefits Survey by the Kaiser Family Foundation and the Health Research & Educational Trust (HRET), 30 percent of employers reported reducing the scope of health benefits or increased cost sharing and 23 percent reported increasing the amount employees pay for coverage in response to the economic downturn [6].

One point to take note of in the McKinsey study is that it states that shifting away from ESI will be economically rational not only for employers but also for the lower-income employees because they will be eligible for exchange subsidies. As for higher-income employees, they would have to pay the entire cost of individual coverage out of pocket. These higher-income employees, however, are also more likely to be satisfied with partial compensation or with tax-advantaged forms of compensation, such as retirement benefits.

Though firms that employ more than 50 employees would have to pay a penalty for failing to offer health benefits, the financial advantages of dropping coverage would more than offset that cost. The exchange subsidies will somewhat alleviate concerns about employers dropping coverage due to the availability of a myriad choice of plans through the exchanges that the employees will have access to.

The McKinsey study goes on to say that even for an employer that drops ESI for all or some employees, maintaining their health, productivity, and satisfaction will continue to be important. Employers could not only expand or refine wellness programs to focus on elements that have a substantive,



positive, and documentable impact on employee health and satisfaction but also provide the right incentives to encourage participation.

This, I fail to understand. Health care costs have been a debatable item in every corporate budget. Employer interest and investment in wellness was to contain these spiraling costs through employee health outcome intervention. With ESI out of the way, wouldn't employers have a lesser incentive to invest in the health of their employees? Employer-sponsored wellness programs would be good to have with the savings garnered by the employers when they do not support ESI. Such programs will remain one of the best tools available to employers seeking ROI in terms of healthy and productive employees. In the absence of dealing with ESI, would employers take on such an investment where they are liable to comply with numerous laws?

Having employers involved in providing health care benefits to their employees has shown its advantages over the years. In particular, employers actually care about the health of their employees and about the cost of their healthcare. Consequently, employers have incentives to promote healthy habits and lifestyles, as these can both reduce healthcare costs and improve employee well-being and productivity. Moving away from an employment-based health care system would reduce these positive incentives that employers have adopted to improve the health of their

employees. Alternatives in terms of tax advantages and subsidies have to reviewed to ensure that employers can justify their wellness spend. \blacksquare

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About the Author

Rajeev Mudumba works with a leading HRO/ Healthcare organization. Rajeev has over 16 years of leadership experience in the HRO, Healthcare and Technology consulting industries. His distinguished record of accomplishment and innovation includes high level strategy and ideation, precise execution and enhanced focus on efficiencies through the use of technology in business across various verticals. He can be contacted at rajeevsagar@gmail.com. Follow Rajeev on Twitter @HifromRaj.

2011



Written By Beena Thomas

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&

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Management

Health Culture at Work Promotes Loyalty and Drives Savings

An increasing number of companies are implementing wellness programs in an effort to help employees adopt healthy behaviors, increase productivity and tame medical costs.

But these programs are often rolled out with little understanding of employees' attitudes about health in the workplace – their expectations, motivations and concerns.

Before developing a wellness initiative, or tweaking an existing program, employers should ask themselves a more fundamental question: "Does our workplace really support a culture of health?"

This question goes far deeper than deciding whether or not to offer incentives for workers to join the local health club. Companies with a culture of health have an environment that supports healthy behaviors. That support may take a variety of forms: providing an onsite workout facility, offering incentives to lose weight or quit smoking, promoting the use of stairs over elevators, encouraging parking further away from the office, supplying healthy food alternatives in vending machines and cafeterias, and implementing compassionate sick-leave policies.

Beyond that, key ingredients of a culture of health include: buy-in and support from senior management, continually making workers aware of available programs, and strongly encouraging participation.

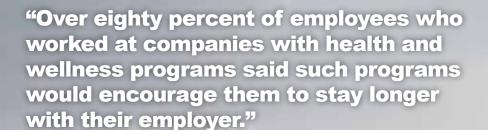
To get a better appreciation of employees' views of their companies' culture of health, OptumHealth and GfK/Roper surveyed over 1,400 employees, split evenly between white collar and blue collar occupations, at both large and small businesses. A large majority of respondents had been with their employers for several years. Respondents' demographics covered a wide range of ages, races, education and income levels.

Employees affirm wellness benefits. Among the key findings was that employees recognize distinct differences between organizations that have a culture of health and those that do not.

Health-focused companies not only tend to have healthier workers and fewer absences due to illness, they also derive important intangible benefits. Workers at these firms feel they have a valued partner in addressing their health concerns, which in turn influences how they feel about their jobs.







For example:

Close to nine in ten employees believe it is appropriate for employers to encourage workers to take steps to be healthy.

More than eight in ten employees believe that workplace health and wellness programs show that an employer really cares about their employees.

Over eighty percent of employees who worked at companies with health and wellness programs said such programs would encourage them to stay longer with their employer.

Nearly three-quarters of employees feel that the availability of a gym or exercise program at work would increase productivity.

The environment at a company and the degree to which it promotes a culture of health is just as important to workers as the actual health-related programs themselves. For example, those who worked in organizations emphasizing health felt that they had more control over maintaining a healthy lifestyle at work than those who did not (92 percent versus 79 percent).

Of course, tangible results matter too. Six in ten people surveyed — those who had successfully lost weight or quit smoking — reported that a workplace program was very helpful to their success. Compared with employees at firms that don't stress a culture of health, higher percentages of workers at health-conscious employers view weight loss programs, wellness coaching, and health fairs as useful.

One company's positive experience. A large financial services provider with a deeply embedded culture of health achieved a solid return on investment from its wellness and disease prevention initiative through a combination of health behavior improvements, productivity increases, and lower health care costs.

In designing and implementing its program, the company followed established best practices: securing visible leadership support, assessing the employee population, tailoring offerings to its employees, focusing on specific health behavior change, and rigorously tracking results.

Key aspects of the program included:

- A comprehensive communications strategy for building member awareness and enrollment, delivered through a combination of outreach and follow-up, promotional campaigns, and an extensive employer toolkit.
- Cash participation incentives to change behavior.
- Use of five separate data streams online health assessments, onsite biometric screenings, medical insurance claims analysis, employee self-identification and program referrals—to identify at-risk members for proactive engagement and coaching.
- Wellness coaches, cross-trained in exercise, stress, tobacco cessation, weight management, nutrition and heart health counseling, who work closely with employees to achieve lifestyle improvement and behavior change.

Now, three years into the program, the company continually promotes wellness to all its employees as part of its ongoing culture of health.

Overcoming obstacles to wellness. For companies seeking to develop a culture of heath, today's work environment can pose a challenge. Indeed, employees report that lack of time, lack of self-discipline, stress, and easy access to unhealthy foods are the chief obstacles to staying healthy on the job.

Here again, our research shows that health-conscious companies stand out. For example, workers at these companies were less likely to say that stress prevented them from maintaining a healthier lifestyle, compared with those at firms that don't promote health.

Employers with a culture of health also do a better job of recognizing employees' needs. For example, over two-thirds of workers at these firms say it is acceptable to take breaks for exercise, compared with only 44 percent of those at companies not emphasizing health.

Health-conscious employers are also more generous about letting employees leave work for a doctor's appointment or to care for a sick child. They also are less tolerant of smoking – only forty percent of employees at firms emphasizing health say that smoking is acceptable, compared with 53 percent of those at firms not focusing on health. Huge communication gap.

The research uncovered a remarkable perception gap between employers and employees as to the availability of workplace wellness programs. In an earlier survey of 400 large and small businesses across the United States, OptumHealth asked employers about their wellness offerings. Three-fourths of companies with 3,000 or more employees said they offered health risk assessments. Yet in the more recently completed employee survey, only nineteen percent of workers at companies of this size said that they were offered HRAs.

This significant difference clearly underscores the need to make a much more concerted effort to communicate wellness programs. Another chasm between workers and employers concerns wellness coaching – two-thirds of large

firms said they offered it, compared with only seventeen percent of employees at large firms who said it was available. At some companies, low awareness among employees of wellness programs is particularly acute at satellite offices which may be the result of not receiving thorough benefits communications from headquarters.

Understanding employees' desires. Employers who want to create a culture of health should constantly assess their wellness programs to determine which offerings have the most impact.

According to the survey, health kiosks, flu shots, lunchtime exercise programs, smoking cessation programs, and interactive online coaching programs on healthier living and diet are viewed by employees as the most helpful in helping them become healthier.

The survey research offers insights for companies looking to boost their wellness programs. Those employees who don't have workplace wellness offerings, or who have them available but don't currently participate, cited several initiatives that they would find helpful, including:

- Incentives for participating in counseling or coaching and achieving certain outcomes;
- Workplace gym;
- More healthy foods in vending machines or cafeterias.

There is no one-size-fits-all approach, but one of the most effective ways managers can promote healthier lifestyles among employees is to foster a culture of health throughout the company. Communicating the benefits of healthy living is just the beginning. To show they are really serious, senior managers should make it clear to all employees that taking time during the work day to exercise, for example, is acceptable.

There are no short cuts to developing a workplace culture of health. It takes resolve and disc ipline to institute a well-thought out initiative tailored to employees' unique needs, championed by leadership and supported by a comprehensive foundation of communications and incentives. But the potential rewards — motivating employees to lead healthier lives, and enabling them to be more productive and loyal - are well worth it.

About the Author

Beena Thomas, is a seasoned healthcare professional with over 11 years of experience in innovative product development/ implementation, strategic planning and evangelism in total health solutions. Nationally recognized as a subject matter expert in corporate wellness and population health, she has held various roles in the healthcare technology sector and managed care. Thomas spent 10 years at WellPoint/Anthem in sales, human resources and product strategy roles. As WellPoint's first Wellness Director, Thomas' responsibilities included developing and expanding a national total health management strategy for 42,000 employees across the United States and directing a national women's health strategy.

Laura Karkula, vice president of Product Management, Wellness, OptumHealth

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Paul Gulstrand

Head of Beazley U.S. Accident & Health Insurance

n this time of unprecedented industry reform, interest in voluntary benefits has continued to surge. This month, Beazley U.S. Accident & Health introduced a suite of gap protection products to help employers broaden benefit options that address employee needs in these uncertain times. To learn more, we turned to industry veteran Paul Gulstrand, who now heads Beazley Accident & Health Insurance in the U.S.

Voluntary Benefits Magazine: Paul, tell us about your background.

Paul Gulstrand: I have experience at mid-size and Fortune 50 insurance companies. Prior to joining Beazley, I spent six years at UnitedHealth Group leading a division that launched several group specialty benefits products. Before that, I spent about 23 years at ING (formerly ReliaStar/NWNL), including leading the employee benefits and voluntary divisions. Each role involved rebuilding or building a team that developed a successful top and bottom line track record, as well as working together to deliver an ever-increasing portfolio of group and voluntary products.

Voluntary Benefits Magazine: Why did you join Beazley?

Paul Gulstrand: Beazley was the logical next step in my career. I was excited to come on board at a time of great

change, affording me the opportunity to build upon what I had learned and hopefully make a difference.

Beazley is an approximate \$1.7 billion stable and growing organization with solid financial ratings, a history of success in launching new strategies, and a firm commitment to build out the US Accident & Health (A&H) space. It had just purchased an A&H company (in 2008), with operations in London and Australia, and was eager to build out in the U.S.

Since then, Beazley has continued to expand its presence in the U.S., while diversifying its portfolio in the A&H space. Today, our growing U.S. operation already has A&H Insurance licensures in 46 states, approvals for two products in 35 plus states and we are ready to roll out a total of 5 new products in the fourth quarter of 2011. Our team is in place to capitalize on Beazley's reputation as a premiere specialist insurer, to create long-term collaborations and to develop niche distribution opportunities.

Voluntary Benefits Magazine: Since you joined Beazley, what has struck you the most about the changing marketplace?

Paul Gulstrand: No doubt, health care reform has stirred up uncertainty in the marketplace. But it has also generated new opportunities for producers, based on changing market needs.

Producers are increasingly interested in and open to diversification, especially in the voluntary benefits space. At one time supplemental products were an afterthought; now we are seeing voluntary benefits coming into the mainstream and becoming part of the benefits planning process.

We've been hearing talk about the need for affordable health plan alternatives for a long time. But now it's not just talk – it's here, right now. This seismic shift is paving the way – and demand – for new solutions that can ease the transition, that are simple to implement, that can help fill gaps.

Voluntary Benefits Magazine: What other opportunities do you see?

Paul Gulstrand: Expectations have changed at all levels. It seems like there is news almost daily about how employers are gravitating to higher deductible health plans, health saving accounts etc.

And it's not just employers who want creative and cost-effective solutions. Their employees are expecting to pay for some part of their benefits, but in return they want some protection for out-of-pocket costs, plus family coverage and greater choice.

Producers are responding to the demand by broadening their benefits offerings, which in turn enable them to diversify their own book of business and create new revenue streams.

Voluntary Benefits Magazine: As a result, what are producers looking for in a carrier?

Paul Gulstrand: Producers are looking to build strong, long-lasting relationships with carriers that can help them respond to customer needs in creative ways. That means products that are simple to understand, easy to implement, and can be bundled together in unique ways. They also want carrier support with everything from product training modules, innovative enrollment solutions, customer retention programs, and other tools that help them navigate the new landscape.

As a new player, Beazley is able to offer a clean sheet advantage. We listened to the marketplace as we developed products. As a result, we focused on gap protection – products like supplemental medical and critical illness, disability and others that help fill gaps, offset expenses, and guard against unexpected financial consequences.

Again, that is why I joined Beazley: to build a select number of preferred producer and program management relationships, to face the unprecedented changes in the marketplace, to recognize them as opportunities, and to hopefully make a difference.

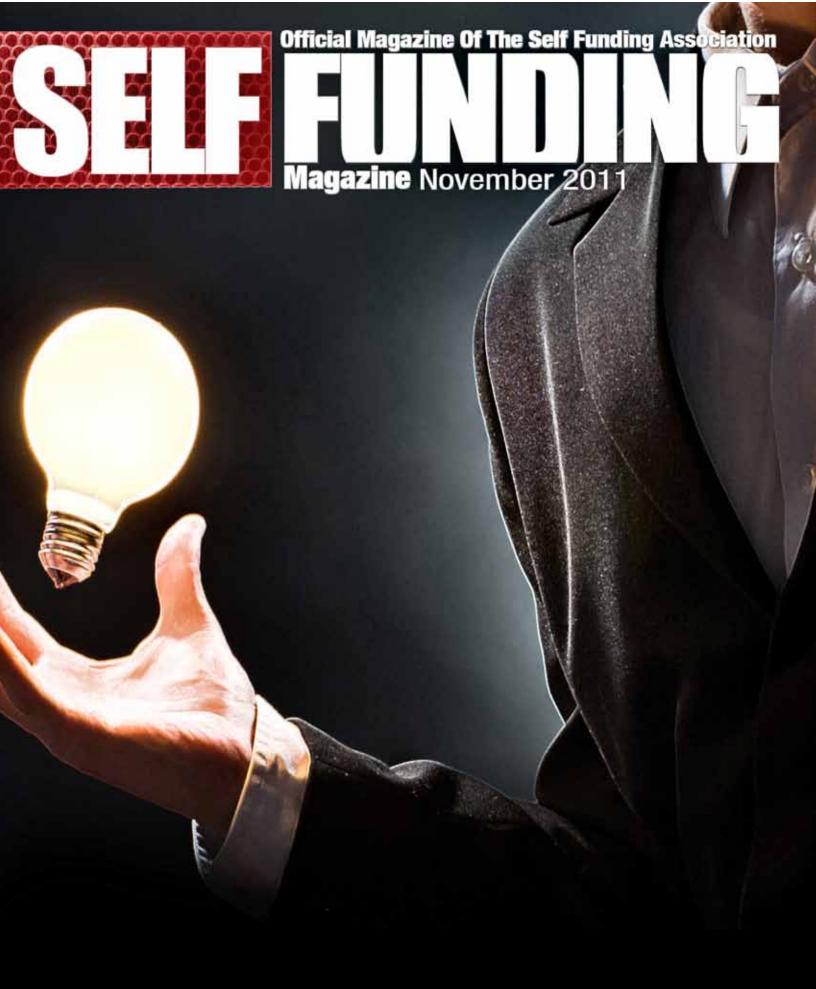




Paul Gulstrand is responsible for building the strategy for the US Accident and Health Insurance business. His team is based

in Minneapolis, Minnesota. He has been in the Accident and Health business for 29 plus years, including leading divisions in his two most recent roles with other organizatons.

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Written By Tron Emptage MA, Chief Clinical Officer,

Progressive Medical, Inc.

The Implications of Acetaminophen Overdose for Injured Workers

One of the most commonly used drugs to relieve pain and fever, acetaminophen is contained in a number of prescription medications and is a popular over-the-counter medication. However, the increasing connection between cases of liver toxicity with overdosing of acetaminophen has caused the United States Food and Drug Administration (FDA) to take aggressive action. Overdose from prescription drugs containing acetaminophen account for nearly half of all acetaminophen-related liver failure cases, according to the FDA. Many of these cases result in the need for liver transplants or death.

In response to continuing concern of liver toxicity due to acetaminophen overdose, the FDA recently took the following actions related to prescription medications containing acetaminophen:

- Manufacturers of pain relievers containing acetaminophen must restrict the amount of acetaminophen to no more than 325 mg per tablet or capsule.
- All prescription acetaminophen products must include a boxed warning on the label that warns of the potential risk for severe liver injury. Boxed warnings are the FDA's strongest warning in drug labels.

Products affected by the FDA's action include medications commonly found in workers' compensation medication plans including Vicodin® and Percocet®. According to the Progressive Medical 2011 Workers' Compensation Drug Spend Analysis, these drugs are among the top 10 most frequently dispensed medications for workers' compensation claims.

When used in smaller amounts, acetaminophen is still considered to be safe. Liver injury typically occurs when injured parties take multiple products containing acetaminophen at one time, exceeding the maximum dose of 4,000 milligrams within 24 hours. However, it is widely known that liver toxicity also occurs when injured workers are taking high levels of acetaminophen while consuming alcohol.

Under the new dosage limitations, the FDA plans to eliminate products from the market that contain up to 750 mg of acetaminophen per tablet, capsule or other dosage unit. To comply with the new restrictions, manufacturers will need to either limit the amount of acetaminophen to 325 mg or no longer market the product. These new dosage limits are not expected to cause a shortage of pain medication as there are many prescription combination products on the market that do not exceed the new maximum amount. In addition,



FDA reduced dosage requirements will be phased in over a three-year period.

It should be noted that over-the-counter acetaminophen products are not affected at this time. A complete list of affected products and other information related to the latest FDA action can be found at http://www.fda.gov/acetaminophen.

What Self-Insured Payors Can Do:

Here are three steps to reduce over-utilization of acetaminophen.

1. Educate and Inform. The majority of the adverse effects associated with acetaminophen are due to injured workers unknowingly taking too much of the drug. In fact, according to a 2007 study published by the American Pharmacists Association, fewer than 15 percent of the adults surveyed realized that Vicodin® contains acetaminophen.

Self insurers should issue regular communication to injured workers on facts about the risks associated with acetaminophen. They should also proactively provide education on which medications contain acetaminophen. For example, injured workers may unknowingly be receiving additional acetaminophen-containing medications under a group health benefit, such as certain popular migraine medications.

The FDA offers flyers and other materials that encourage consumers to read and follow label directions. It's also essential to remind employees on the importance of informing their doctors of any medications they take regularly.

2. Proactively Review Employee Utilization. By engaging in a comprehensive drug utilization review program, self insurers can proactively monitor an employee's intake of acetaminophen. Many pharmacy benefit managers offer this type of program. However, it's important to engage in a multifaceted program that encompasses prospective, concurrent and retrospective reviews.

A prospective program allows all involved parties to plan for future outcomes with up-front information. If potential problems are found, the claims professional may withhold the approval of the claim. At this point, a formulary is established based on the date and type of injury.

Typically a concurrent drug utilization program occurs in realtime at the pharmacy. When a prescription is filled, it is audited for inappropriate use versus what is allowed on the formulary, duplication of therapy, multiple physicians, excessive dosage and drug-to-drug interactions. Depending on the medication formulary, the pharmacist may also be required to seek authorization from the pharmacy benefit manager or the claims professional.

A retrospective program occurs after medications are filled using historical pharmacy data. A pharmacy benefit manager typically works with a self insurer to determine which key areas they would like to review on a retrospective basis. Key areas often include setting thresholds for excessive quantity, early refill, high dollar amounts and certain classes of medications.

3. Build Effective Physician Relationships. Establishing an effective strategy for communicating with physicians enables self insurers to better ensure employee safety. It is important for self insurers to take steps to communicate recommendations of clinical reviews conducted by a pharmacy benefit manager to prescribing physicians.

It is essential to alerting physicians on recommendations related to excessive duration or duplication of therapy and high dosages of specific medications. This communication can be in the form of a letter or conference call with the physician. In addition, pharmacy benefit managers often have a clinical pharmacist or a physician available to explain the rationale for their recommendations directly to the prescribing physicians.

While acetaminophen is still considered to be safe when it is used as directed, self insurers should monitor usage as with any prescription medication. Not only will this mitigate risk by reducing opportunities for fraud, misuse and abuse, it will also yield cost savings per claim over time.

About the Author

Tron Emptage is chief clinical officer at Progressive Medical, Inc., which helps payors achieve better outcomes for injured workers and more control over expenses through a powerful combination of network capture and conversion programs and clinical expertise. He can be reached at Tron.Emptage@progressive-medical.com or 800.777.3574.



Written By Burt Wilson

Vice President, Captives, Chartis Accident & Health Corporate Benefits

Midsize Firms Can Benefit From a Self-Funded Health Care Plan

It's easy to understand why many large firms (1,000 to 5,000+ lives) opt for self-funded healthcare plans – they can be an effective way to mitigate the escalating cost of healthcare. According to Kaiser, 2010 premiums for family coverage under fully insured plans were \$14,678 versus \$13,903 under self-funded plans.1 In today's economy, \$700 per employee can be a sizeable savings that has a direct impact on a company's bottom line.

Midsize firms (100 – 1,000 lives) have been more reluctant to take the self-funded route. While 93 percent of firms with 5,000 or more employees have self-funded healthcare, only 58 percent of midsize firms chose this option.1 To many firms, the cost of administering a self-funded plan, coupled with premium payments for stop loss coverage to cap their risk may seem more costly and complicated. Taking into account these considerations, most mid-sized employers do not deem themselves to be good candidates for a self-funded health care plan.

Captive Stop Loss May Be an Option

A small but growing number of midsize firms have found that by joining forces with other like-minded employers, they can achieve cost savings for self-funded healthcare plans similar to those enjoyed by larger-sized companies. In fact, small-to-midsize employers are driving growth in self insured health plan enrollment. Over the previous five years, membership in self-funded insurance plans grew 11 percent while enrollment in commercial risk plans fell 13 percent according to Mark Farrah & Associates, a data aggregator for the healthcare industry.2

Typically, these companies work with their broker or a third-party administrator to bring together companies in the same industry or companies that share common business characteristics to create a Captive Stop Loss arrangement. Captive Stop Loss groups require a pooling of risk with other insurers to achieve critical mass and stability. Different



structures have evolved from a single pool to a layered approach in which most of the risk sharing occurs in the second layer. These group captive programs combine the advantages of retaining risk while acquiring group purchasing power for reinsurance or excess insurance.

Companies using this approach can significantly increase their ability to realize underwriting savings and reduce their health costs. For employers who are already self-funding their health care plan, the Captive Stop Loss option adds an additional level of insurance protection against catastrophic losses that can otherwise impact their business operations significantly.

Once a captive is set up, the employer participants purchase their stop loss insurance through a fronting carrier and use the captive as a reinsurer for the risk. The fronting carrier thus provides an excess layer of insurance protection to the captive coverage. In the short term, this type of arrangement helps minimize administrative costs. In the long term, captive arrangements can increase the buying power of each company participating and help each company realize underwriting savings that can reduce their health care costs. In some cases, participating companies may also benefit from investment returns on their capital contribution. The captive can also provide a primary layer of medical stop-loss coverage that is used before tapping into traditional stop loss insurance. This can help employers avoid the financial impact of costly claims.

Three Layers of Risk in a Captive Stop Loss Arrangement

Within a group captive, there are commonly three layers of risk. The first layer is absorbed by the employer, who is issued a stop loss policy that is individually negotiated and underwritten. In this arrangement, deductibles can vary and each employer maintains full control of their self funded healthcare plan in this arrangement.

The captive absorbs the second layer of risk by reinsuring the risk for all participating employers in the captive risk pool. All employer participants share in the economic results of this layer of coverage between each employer's specific and aggregate retentions in their stop loss policy and the group captive's specific and aggregate retention. Deductibles can vary.

The third layer of risk falls upon the shoulders of the fronting carrier that writes the insurance and reinsures some of the risks to the captive. This carrier will cede a portion of the policy premium to the captive, but the carrier is ultimately responsible for paying all covered claims under the stop loss policy. The fronting carrier also provides the captive with specific and aggregate retention for its second layer of risk.

A Captive Stop-loss arrangement isn't right for every employer. The best candidates include companies that are willing to implement aggressive preventative and wellness programs to control health care costs, and are looking to join other companies that are committed to aggressive cost control measures.

Self-insurance has been an effective alternative for employers to provide healthcare benefits to employees for more than three decades. As we enter this new season of healthcare reform, self-funding will continue to be the leading method of funding healthcare – offering employers flexibility, efficiency, and control. For those employers committed to providing quality healthcare coverage and investing in strategies to control healthcare costs, there are now additional opportunities to participate in the financial savings generated by assuming a portion of the medical stop-loss coverage through a captive insurance company.

- 1 "Employer Health Benefits," Kaiser Family Foundation, 2010.
- Mark Farrah Associates, 2010.

About the Author

Burt Wilson is Sr. Vice President, Captives, Chartis Accident & Health Corporate Benefits, with responsibility for delivering Medical Stop Loss Group Captive solutions to the small to mid-size employee benefit market. His background includes tenures as President of Medical Excess and as President of New Life, Inc.









Health reform won't stop providers from overcharging for care, only consumers can do that.

Here's my story of how I could have paid tens of thousands of dollars more for two minor outpatient surgical procedures, had I not understood how the healthcare system worked. It illustrates just how much we need a healthcare system with price transparency built in – something we will not get under the Affordable Care Act (ACA).

I am a doctor and the father of a 12 year old boy who has cerebral palsy. My son is fortunate to be healthy and active with minor medical needs. But as he has grown, he experienced some issues with contractures in his right lower leg which recently required a minor two hour outpatient surgical procedure.

When my son's surgery was scheduled, I started getting price estimates from the surgeon, anesthesiologist and the facility, since we have a high

deductible insurance plan. The physician's fees were straight forward and relatively easy to obtain.

Not so with the facility. My son's surgery was scheduled at the local hospital's outpatient surgical facility which sent the procedure codes to an external reviewer. Three days later the reviewer came back at \$37,000. The hospital referred me to my insurance company. The PPO network said that they could not reveal the prices until after the case was performed.

The hospital said it expected to discount the price, which would be in the range of \$15,000 to \$25,000. Then I asked my son's surgeon if he ever operated at any independent Ambulatory Surgical Centers (ASC). One phone call and 10 minutes later, I have the exact price for his surgery: \$1,515.

Five years ago, there were virtually no tools that could help consumers figure out what they should pay for a healthcare. Today, with the availability of

new technology and new methods to analyze claims data, service providers can develop tools that will help companies examine what different providers in their network charge for tests, procedures, treatments and services in their market. With that knowledge in hand, they can find a fair price for what is needed. The better educated people are about what a fair price should be, the better equipped they are to talk with providers and facilities about fees before a procedure is done.

Customized tools are available for self-funded employer plans, so employees can search provider pricing within their own networks. We have found that even within the same plan the price for a routine test can vary by thousands of dollars.

ACA and Consumerism: No Price Transparency

Even after the Affordable Care Act, large gaps which cost consumers and self-funded employers a lot of money, must be addressed. The ACA does not address the wide disparity in healthcare pricing or encourage, much less mandate, pricing transparency. While my case was an extreme situation of potential overcharge, there is still an enormous amount of price variability in the health care system, even within individual health plans. Employers and their employees will continue to pay way too much for common healthcare services, often as much as five times more than they should.

The ACA will also impact the ability to encourage consumerism in plan design. Some of the provisions may foster consumerism such as the excise tax on rich benefits plans and the increased threshold for medical expense itemized deductions. Other provisions will limit an employer's ability to foster consumerism, such as the elimination of lifetime limits, the requirement to provide certain services at 100 percent coverage, and the limitations on Flexible Spending Accounts.

The ACA does not help employees or employers learn the real costs of care. The Massachusetts Attorney General report entitled Investigation of Health Care Cost Trends and Cost Drivers from January, 2010, provides a good overview of the wide variation in healthcare pricing and the factors that lead to it. It says price variations are not correlated to quality of care, the sickness of the population being served, volume of Medicare or Medicaid patients, whether a provider offers services at an academic teaching or research facility, or differences in hospital costs of delivering similar services at similar facilities.

The report concluded that price variations are correlated to market leverage, as measured by the relative market position of the hospital or provider group, and then compared with other hospitals or provider groups in the local area.

Congress has considered other legislation (HR 4700, HR 2249, HR 4803) which would have addressed the transparency issue, but these bills did not make significant progress in passage. Employers are left to find their own solutions to these challenges.

Turning Employees into Educated Healthcare Consumers

Most employees don't realize that if they use in-network providers the cost of their care could vary by over 500 percent depending on which in-network provider they choose. If they need an MRI, they could get it for \$500 at one imaging center and pay over \$3,000 at another center (see Graph 1). Their colonoscopy might cost \$950 at one location and over \$3,500 at another (See Graph 2). The same holds true for almost every service they need.

Why don't they know? First, they don't have any idea how much healthcare services should cost or what is the fair price they should pay. Second, they are rarely told how much the service will cost before they get their care, and many times they don't even realize that they can ask. Finally, many benefit designs with fixed co-payments remove patients need to know or care.

Even when employees have access to insurance company portals, these portals are rarely used and most don't provide clear pricing information.

When reviewing employee purchasing behavior, it is clear that the current system is not producing favorable results. Most employees pay too much for care. And this occurs regardless of employer location, insurance company or provider network (See graph 3).

Employers are consistently spending 4 to 15 percent more on healthcare than they would if their employees made value based care decisions. It is important to note that this spending is not for higher quality care. Numerous studies have shown that higher healthcare prices do not indicate high quality care. Health reform has the potential to make this situation even worse as the push to create Accountable Care Organizations (ACO) encourages providers to consolidate. Employers will need to carefully consider the value offered by new provider network arrangements, and ensure that they come with transparent offerings with respect to both quality and cost.

Effective Ways to Reduce Costs and Still Deliver Quality Care

Think of it as a cost/value gap. People would never knowingly overpay for a car or home. They would do research ahead of time, find out what current market rates are and approach the buying process as knowledgeable consumers. In healthcare, that's unusual. Employers and employees can



deliver the same value at a lower cost, if they approach the situation as educated consumers.

Employers are the key to solving the cost/value gap in healthcare. Employers make the ultimate decisions regarding benefit designs that encourage consumerism, the networks that direct patients to high value providers, and the education and tools to support employees in selecting healthcare services.

Many employers have implemented wellness and disease management programs often with incentives for participation or even penalties for failure to engage in healthy behaviors. However, when it comes to encouraging employees to make better choices about buying healthcare services, most employers have not supported or encouraged real consumerism. Here are a three methods that can help.

1. Put consumerism into all health and wellness programs.

Every nurse or member of a call center support staff should have access to pricing and transparency tools needed to fully educate a patient on cost of care. There are tools available that show the range of prices charged by the health plans and providers in their network, so employees can make educated choices about which providers they should use. Why recommend an employee get a colonoscopy but not also suggest where they might get a high quality study at one-third the cost of some locations? Employers could triple their cancer screening rates without spending any additional money if they design their programs correctly.

2. Make sure employers understand their network prices and quality variations. Employers should look at their data. They may be surprised at the variations and opportunities in price. At a minimum, it may affect how benefits are designed. Some employers are even taking additional steps, such as setting up narrower networks to ensure their employees get the best care at the best price.



3. Don't be satisfied with just a provider directory. Employers may want to rethink the traditional approach of the provider directory that places the providers first and may not even include pricing information. To be effective consumers, employees must first know how much care should cost. Then they must have the ability to find providers who offer fair pricing. Make sure this information isn't hidden on a little used portal; put it at the employee desktop. Make it available in their hands in the doctor's office by way of their mobile phones. Make sure every nurse or health coach they talk to can support them.

The Affordable Care Act may not address health transparency issues, but there is no reason why, with t technological tools in hand, employees or medical professionals like myself for that matter, have to overpay for care. Employees that are given the chance to understand healthcare pricing, particularly under Consumer Directed Health Plans (CDHP), are often very appreciative of the results. More importantly, employers can achieve substantial savings that allow for continued health benefits at affordable rates.

About the Author

Dr. Jeffrey Rice is CEO of www.healthcarebluebook.com.The Healthcare Blue Book provides employers with analytics to help them understand their provider network costs and comprehensive programs to support employees with healthcare consumerism. The Healthcare Blue Book is a leader in supporting employers with high deductible health plans, consumer directed health plans and reference pricing).



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Cross-Border Healthcare: A Creative Option for Texas Self-Insured Employers

One of the advantages of self-funding for employers in Texas is the ability to include cross-border healthcare. What this means is that self-insured employers are able to include medical providers from Mexico. This obviously begs the question, why would any employer choose to include medical providers from Mexico? The three major reasons are:

- 1. Employers may have Latino workers who may prefer their healthcare from Mexican medical providers;
- 2. Cost of Care in Mexico is significantly less expensive than in the US, so any Health Plan utilization that can be rendered in Mexico versus in the US will have a lower expense; and,
- 3. In some rural US communities along the border, there is a long wait for access to some medical specialties.

The case for cross-border healthcare is not a new phenomenon. Take for instance California's experience with cross-border healthcare. Because of the consumer demand, laws were enacted and regulations were developed to allow for cross-border healthcare coverage. The Department of Managed Health Care, the regulatory agency for HMOs in California, approved several plans that allow for cross-border healthcare, including Blue Shield of California, Health Net, CIGNA, Aetna, Delta Dental as well as a Mexican Health Plan. Some of these health plans have been operating for over 10 years. Needless

to say, the concern for quality has been adequately addressed to the point that cross-border health care is now an established option with consumer appeal for its affordability.

The cost of healthcare coverage is largely a function of the unit cost for hospital services, physician services and medications. Since the unit cost of healthcare in Mexico is significantly less than in the US, the cost of healthcare coverage for similar benefit plans would also be significantly less.

The cost differential can be seen in the Aetna health plan offerings. Aetna is one of the approved carriers in California that offers cross-border health coverage plans. Take the Aetna small group HMO Plan offering for San Diego employers with a standard 1.0 Rate Adjustment Factor based on October 2010 Rates.

For this illustration, an employee is 38 years old with a spouse and two children. The Aetna HMO offering for care delivery in San Diego County is \$1,311 per month. The Aetna HMO Plan offering for care delivery in Baja California, Mexico is \$465 per month, or just over one-third of the cost of a similar Aetna offering in the US. Under this comparative illustration, the copayments are slightly more favorable for care delivery in Baja California than in San Diego.

Unlike California, Texas law does not allow its insurance carriers to contract with Mexican providers. Several studies in the early 2000's were conducted by

Family Size	38 year old Employee, Spouse, and 2 Children	
Plan Name	Aetna AVN HMO \$10/\$20 Plan	Vitalidad HMO \$10 Plan
Healthcare Delivery	San Diego County, CA	Baja California, Mexico

Benefits		PCP Office Visit -\$10 Copay Specialty Office Visit - \$10 Copay Hospital - \$100/Day; 7 day max Rx (Gen/Brand) -\$10/\$20 Copay ER- \$100 Copay
Monthly Premium	\$1,311	\$465
Annual Premium	\$15,732	\$5,580

the University of Texas to look into the merits of crossborder healthcare for Texas after California had allowed cross-border healthcare plans. Unfortunately for insurers, employers and consumers, Texas legislators in dramatic public hearings were convinced by the Texas medical community that patients could be seriously harmed if insurance carriers were allowed to contract with Mexican providers.

Therefore, the millions of workers from El Paso to Brownsville who may have potentially preferred to receive their employer-sponsored healthcare benefit services in Mexico, such a product is not available, at least not through a Texas Department of Insurance fully insured health plan.

For those Texas employers who might be considering the merits of going self-insured, access to cross-border health care might be a positive tipping point factor. Under ERISA and federal law, a self-insured Texas employer is not prohibited from establishing benefit plan services that would allow participants to access healthcare services in Mexico. Such a plan could be developed to offer much more healthcare benefit bang for the employer's allocation buck.

There are several well-known examples in California where some agriculture employers and some union trusts have formed ERISA self-funded plans that included cross-border healthcare benefits. The Western Growers Association, United Agriculture Benefit Trust

and the United Farm Workers RFK Trust are but a few ERISA programs with cross-border health care benefits.

Yet, interestingly, the Texas market has been largely void of any self-funded employer benefit program with integrated cross-border healthcare benefit services. This is not entirely surprising given the Texas market and the relative complexity of an employer going self-insured versus the easier fully-insured health plan model.

A Work in Progress

One such pioneering effort is underway in Laredo, Texas with a large self-insured employer association. Although the name of this association will not be disclosed, we will share salient points that could be of interest to other employers, associations, TPAs and consultants who may contemplate self-insurance and cross-border healthcare benefits.

Our firm was contacted a year ago by a regional TPA. This TPA had heard of our expertise in developing cross-border medical networks for limited benefit insurance carriers. The TPA was prospecting new business clients and knew that a particular employer association offering self-insured health coverage had several employer members with a large Hispanic workforce along the Texas-Mexico border. The TPA Account Executive looking for a new business opportunity shared the notion of cross-border healthcare coverage with the Employer Association and it struck a powerful chord. What started



as a cold call with an innovative notion quickly bloomed into serious client interest.

The client, as it happened, had a good number of employees who were already accessing care in Mexico, since some of them actually lived there and worked in the US, while others were attracted by the much more affordable price tags for their care than those they could find locally in the United States. Everybody agreed that the standards of care that they found across the southern border were excellent, and that they could find high quality doctors and medical providers, if they knew where to look.

After many meetings with staff, actuaries, benefit consultants, steering committees, claims processing centers, medical directors, legal counsel, reinsurance carriers and countless other entities, the green light was finally given to proceed. It seems that cross-border health care is going to be a new win-win initiative that provides relevancy to the employer association in demonstrating innovations in the form of out of the box thinking to achieve healthcare cost savings to its Employer Members, while expanding consumer choice for the workers. Now both the TPA and the Employer Association have important differentiations that provide value in today's competitive environment.

More to Follow

Since self-funding has more moving parts than fully insured coverage, introducing cross-border healthcare benefits into the self-funding coverage offering increases the level of complexity. The biggest challenge by far is the lack of credible information and basic knowledge related to cross-border healthcare expenses, utilization frequencies, medical management processes, quality of care standards, provider

networks credentialing and operations, the legal framework and the operating environment.

It just so happens that our company has been focusing on this kind of question for over 6 years now. Cross border healthcare is an idea whose time has come, as the cost of care continues to increase in the United States, notwithstanding the good intentions of the Healthcare Reform Act and of other such initiatives. For those who live close to the border with Mexico, it is no news that the price differential for the same procedures is very significant and continues to widen between the two countries.

The same model can be applied to companies that are not located directly across the border with Mexico, but that are willing to give their members access to Mexican healthcare providers for non-emergency high cost procedures. These would be procedures such as hip or knee repairs or replacements, heart function repairs, kidney or gall bladder stone removal, etc. These procedures can be very costly for the self funded group in the US, while they become manageable in Mexico. After all, the function of any health insurance plan is to mitigate risk, and access to a qualified pool of medical care providers in Mexico turns out to be a superb risk mitigation tool for these groups.

About Sekure Healthcare

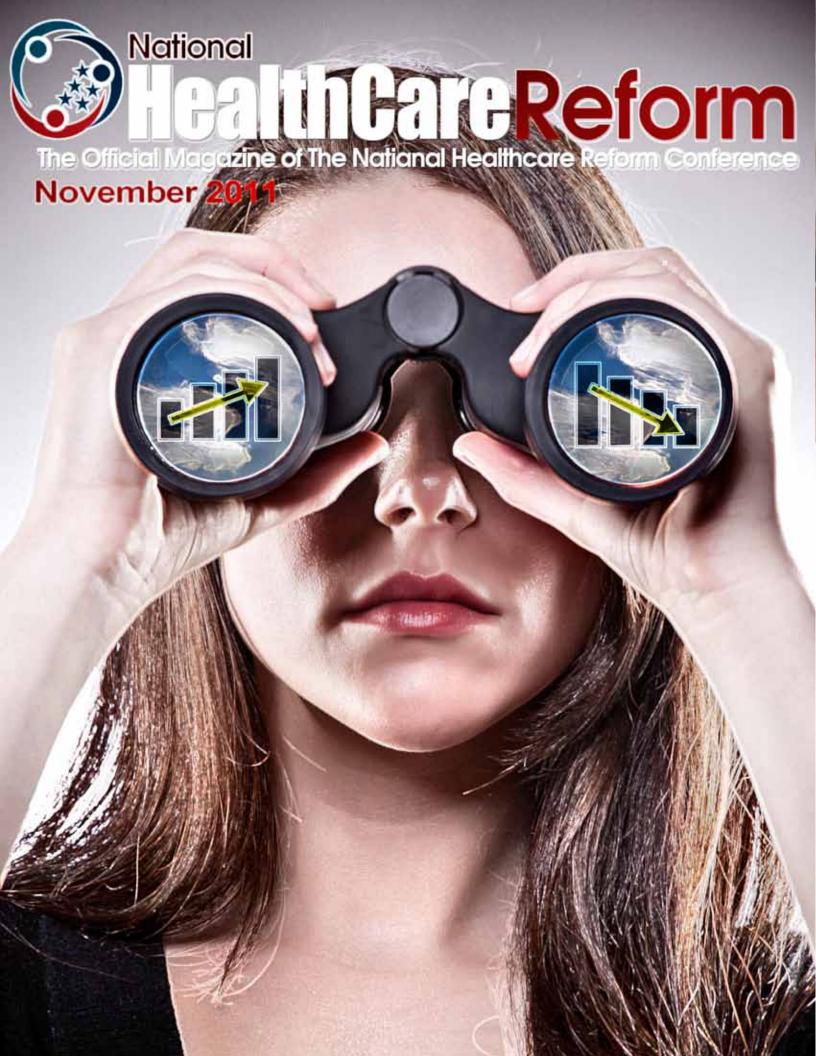
Sekure Healthcare is a California-based company that provides healthcare solutions to US employers with special emphasis on Latino and cross-border healthcare services. For more information, contact Jim Arriola, CEO, 619.210.4836, jarriola@mysekure.com, or José Aroeste,

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Why Long Term Care Insurance?

Written By Jim Del Vecchio

President, Asset Protection Unit, Inc.

When we examine the voluntary benefits landscape, certain features rise to the obvious. For example, few voluntary participants doubt the desirability, indeed the necessity of medical insurance. Nor do they labor over the ins-andouts of a vision care plan or dental benefits. However, people put off thinking about Long Term Care insurance (LTCi) as long as they possibly can. I suspect it's because so many forces and subtleties attend the decision matrix. Let's examine some of these factors, and explore how LTCi approaches them.

The Social Components

Few people cherish the thought of long term care. Unlike medical insurance, its risks smack of the distant future and old age, two scenarios we tend to avoid thinking about. After all, our lives are too busy -- or the prospects are too scary - for us to ponder it for long. In addition, we as a society haven't settled our notions on how to treat, react to, or fund the process of growing old (ironically, a process that is as inevitable as the phases of the moon or the rising of the sun). And, also

ironically, involving a subset of the population that everyone agrees is growing. Yet one thing seems certain: There is a perceived vulnerability to senior citizenship which compels the involvement of family, friends, caregivers, and the state into the lives of the elderly. Combine these factors with the usual crop of anecdotes, stereotypes, and speculations that drive social movement in our country, and it's no wonder that sober consideration of the ramifications of LTCi does not pervade the voluntary benefits landscape.

The Uncertainty of Needs

Most of us can only guess what our needs will be upon aging. This uncertainty is derived in large part from the evolving treatments that are available to seniors. When the first LTCi policies came out in the 80s, convalescent care (i.e. nursing homes) ruled the day. Things like home health, assisted living, and adult day care simply did not exist mainly because, apart from catastrophic illness or injury, seniors aged and died at home. Since then, however, all kinds of things have contributed to the evolution of what I'll call the "aging industry:"



People are living longer. A corollary of this is the extension of morbidity. In other words, people live longer in a disabled or dying condition today than they did 40 years ago. Therefore, the need for extensive care is far greater than before.

Self-directed care diminishes with age. This is another corollary of long life and extended morbidity. I recall a bumper sticker that said something like, "Be kind to your children, they'll pick your nursing home," a thought-provoking quip for anyone contemplating life as a senior or considering LTCi. Here's the real point: People other than the policyholder influence the policyholder's care.

Stay-at-home family has diminished. For better or worse, the children of seniors now work outside the home. No one is around to care for mom or dad as was the case in generations past.

Government regulation intrudes. Most states – I'm tempted to say all – have some form of regulation governing senior care. Difficulty arises because the focus of regulation addresses compliance rather than quality. Put differently, a compliant care provider comes with no guaranty of being a quality care provider. Regulators have yet to develop a method to mandate universally kind, sensitive, gentle, patient-centered providers.

So, why bother with all of this? Events will certainly resolve all of the foregoing considerations in much the same way that dying ends discussions about life insurance. Yet, while most of us agree that we cannot predict the time or manner of death, we do plan on growing old (a far lengthier and indeterminate process than simply dying). And so, as the uncertainties of "age management" nag, consideration of LTCi harkens.

The Financial and Social Forces of LTCi

What does LTCi have to offer? Many things, and most of them good.

Estate protection. We have all heard about this one, but don't dismiss it out of hand. The fact remains that most of us accumulate wealth in varying degrees as we age. One way to insure that it stays in the family is to protect it from otherwise insurable risk. Considering the risks associated with age, long term care costs loom large and virtually guarantee estate erosion if they are not contained.

Estate planning. Here's another old saw that deserves second glance. Imagine planning an estate with uncontained long term care risks. Now imagine the same estate but with long term care out of the picture. Which would you choose? In the second scenario, the premise becomes



estate distribution rather than the estate conservation that's implicit in the former. I can hear the "hmph's" from here...

Care planning. If you think predicting one's long term care fate is difficult, try applying for LTCi. Don't get me wrong: The application process is no more complicated than for any other benefit or policy. The difficulty lies in choosing coverage, benefit levels, and care options. I commend the voluntary participant who undertakes this exercise. It's a real eye opener!

Social Impact. I like to think I've saved the best for last. Try to do any late-stage life planning without involving at least one family member. Impossible! Addressing long term care and LTCi is always a very social event. Assuming you are not an ostrich, I can just about guarantee you will connect with another human being somewhere along the line. After all, activities that make us think about ourselves produce thoughts we like to act on. We are our most important subjects! The actions I refer to will certainly include those related to LTCi, be they financial, familial, or political – most likely all of the above.

The conclusion? Actions on a broad enough scale (e.g. the entire insurance marketplace) are going to have social impact. If that impact begins the process of solidifying society's actions towards aging, that can only be a good thing. Collectively, the benefits of LTCi, not to mention its related planning, outweigh the burdens. Addressing LTCi and its inevitable effect on long term care planning forces us "out into the open" and makes us confront those questions that complexity made us put off. ■

That's why LTCi!



Written By Dr. Salinder Supri

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Developing Leadership in Medicine:

The Importance of "Institutional Awareness" in Managing Change and Transforming Healthcare

Leaders grapple with constant change. Evolving societal needs, tastes and expectations, developments in science and technology, new and revised legislation, and pressure from government, all place constant demands on leaders to adapt and transform their organizations, improve quality, manage costs, and increase efficiency and profits, to maintain a competitive advantage. In common with leaders in almost every other industry, leaders in health care also face the ever constant challenge of change. They need to respond to continual developments medical practice and health care needs, rapid expansion in scientific knowledge and greater scrutiny from government, patients and society.

As part of an ongoing research collaboration between the University of Medicine and Dentistry of New Jersey (the largest academic health center in the U.S.), and Änderung Consulting (a change management consultancy), we addressed the question of why some change management

initiatives were substantive, successful, and lasting, whilst others were met with resistance, were never fully embedded, and became unsustainable. We interviewed many leaders in medicine and medical education responsible for delivering change, often at the highest levels. These included leaders of large and leading organizations and bodies, medical schools and university teaching hospitals from across the U.S.

We identified one key variable that distinguished truly successful leaders. Our findings revealed that these leaders are "institutionally aware," that is, they have an explicit recognition of the acute importance of the institutional framework in which their organization is located, and in which they operate. These leaders know that they do not operate in an organizationally independent, closed system. It is this knowledge that gives these leaders their edge, and is fundamental to their ability successfully to lead and manage change.



Institutional Awareness and Medicine

What does it mean to be institutionally aware? It means to be aware of the institutional matrix in which an organization is located. This institutional matrix is typically composed of a multitude of agencies, bodies, groups and associations that ultimately shape the environment in which organizations operate.

Medicine is one of the most complex institutional arrangements in the country. The institution of medicine is composed of insurance companies, pharmaceutical companies, Health Maintenance Organizations, the hospital sector, and medical schools. It also encompasses a large range of government agencies, including the Institute of Medicine and the National Institutes of Health, professional associations, examination and licensing boards, and a myriad of related bodies.

This institutional matrix is large, powerful and dynamic. Not only does it determine the shape of the system of U.S. health care, it also ultimately influences its leaders' ability to effect change. This is because it is at the institutional level that the "rules of game" are devised. By "rules of the game" we mean the terms by which the system operates. These rules shape and dictate the parameters in which organizations are framed, and in which their leaders maneuver. Thus, it is only through understanding of institutions and the "rules

of the game," that leaders can be truly successful and effect substantive change within their individual organizations.

To show the importance of institutions in effective change management, we contrast two different leadership styles - the traditional approach to leadership with that of the "institutionally aware" leader. In doing so, we illustrate how an understanding of institutions gives leaders the edge they need to effect successful transformation of their organization.

The Traditional Approach to Leadership

Most leaders understand the need for change management of their organizations in response to an altering operating environment. They attempt to lead and manage change by drawing upon an array of skills typically associated with good leadership and devise strategies, policies, and systems to meet the challenges they face.

While they may be able to effect valuable and useful change, the transformation process is often ultimately constrained and limited. They mainly focus on effecting change at the level of their own organization, and neglect the importance of the wider institutional framework in which their organization is located and in which it operates. Consequently, the process of change often meets resistance as it does not necessarily accord or align with the agendas, intentions and priorities of the bodies and agencies within the institutional matrix.



One example of where change has met institutional resistance is in the area of "defensive medicine." This is the practice by which doctors routinely over-test patients to avoid or minimize

the risk of litigation on the grounds of a missed diagnosis. As a result, many doctors argue that they are compelled to practice defensive medicine, and conduct sometimes excessive and even unnecessary diagnostic tests and medical procedures.

Since there is no real need for these interventions on medical grounds, and the practice adds significantly to the costs of health care, many leaders in health care have sought to change policy towards defensive medicine within their individual organizations. However, they have experienced significant difficulties in trying to do so, and have been unable to effect substantive and lasting change. This is because the policy of defensive medicine is determined not at the organizational level, but at the institutional level. Consequently, proposed changes to this policy have run into opposition and proven short-lived, ineffective, and difficult to sustain. This approach to change has been against, rather than with the "rules of the game" of the system of medicine.

The Institutionally Aware Approach to Leadership

In contrast, institutionally aware leaders know that they do not operate in an autarky, or an organizationally independent, closed system. They recognize that the traditional attributes, skills and qualities of good leadership, while important, are just a starting point. To this basic leadership skill set, they add institutional awareness. This gives them insight into how the institutional matrix has an impact on what they do, and influences their ability to make lasting change.

Institutionally aware leaders know that these institutional agencies operate to their own agendas and determine the "rules of the game," and that these in turn shape the business environment and their individual organizations. Moreover, these leaders are able to ascertain what the rules are, and then use this knowledge to effect change in their organization that becomes truly embedded and effective. Thus, their efforts at change management are not focused narrowly on the organization per se, but seek to alter their

organization so that its priorities align with the institutional matrix. By working with the system and aligning with its rules, they are less likely to encounter resistance to change.

Transitioning from Traditional to Institutionally Aware Leadership

The importance of institutionally aware leadership in effecting positive change can be demonstrated through recent initiatives to make medical practice more responsive to growing demands from patients, society and medical leaders that physicians be assessed not just on scientific knowledge, but on a broader range of competencies \square including communication and interpersonal skills \square so that they listen more, be more empathic and better communicate with patients.

In response, some medical leaders made attempts to integrate this broader array of competencies into the medical curriculum. Since their efforts were focused primarily at the level of their organization, these changes often came up against resistance and met with little success. This is the approach taken by traditional leaders. Their changes were not successful primarily because there was no change at the institutional level: the new competencies they introduced are not adequately assessed in the licensing examinations, which continued largely to test for basic science knowledge and clinical skills. Consequently, students did not have an incentive to develop this wider range of competencies, nor did faculty have much incentive to teach these skills.

To remedy this deficiency and better meet the demands of patients, change needed to take place at the level of the medical examination system

that is, at the institutional level. This is the cognitive shift □ from organization to institution

that these institutionally aware leaders in medicine knew that they needed to make. Recognizing the central importance of the institution of medicine, they focused their change management efforts at this level. They formed the Committee to Evaluate the United States Medical Licensing Examination Program (CEUP), and entered into a process of engagement with the main agencies responsible for licensing examinations. This committee then proposed fundamental changes to the national medical examination system, that would give greater recognition to, and testing of, this broader range of competencies. They developed a series of recommendations for change that were received

and endorsed by the U.S. medical licensing examination bodies (the National Board of Medical Examiners, the Federation of State Medical Boards, and the United States Medical Licensing Examination Composite Committee). These institutionally aware leaders were acutely aware that for substantive change to occur, change needed first to take place at the institutional level - an approach that contrasts sharply with that of traditional leaders yet to transition to institutional awareness.

Conclusion

The traditional values of good leadership are all well and good, but they are far from the whole story. The truly successful leader is "institutionally aware," and has developed a recognition of the acute importance of the wider institutional framework in which their organization is located, and in which they operate. They know that they do not operate in an autarky \square that is, in an organizationally independent, closed system.

As medicine represents one of the most complex institutional arrangements in the country, it provides important lessons for leaders in all sectors and industries. Our findings are therefore generalizable, extending beyond medicine and medical education, and are of relevance to all leaders, whatever their background. Furthermore, the approach to change taken by these institutionally aware leaders accords with a substantive body of work highlighting the centrality of institutions in our understanding of markets and economic systems. Indeed, of the Nobel laureate prize winners for Economics since the 1970s, eight have addressed the importance of institutions. These include Friedrich Hayek and Gunnar Myrdal (1974), Herbert Simon (1978), James Buchanan (1986), Ronald Coase (1991), Douglass North (1993) and most recently, Oliver Williamson and Elinor Ostrom (2009).

The importance of institutional awareness is universal. It is fundamental to leading and managing truly successful change. All leaders, in whatever industry they operate, need to understand how the institutional matrix shapes and determines their ability to affect substantive and lasting change.

About the Authors

Dr. Salinder Supri and Prof. Karen Malone have worked at senior and executive levels in the U.S., the United Kingdom and New Zealand, leading major change management initiatives and developing strategy and policy in Healthcare, Medicine, Education and Economic Development. They have published together, and separately, on a variety of areas including Healthcare Policy, Institutional and Organizational Strategy, Economics, and Education Reform.





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