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Issue 22

Voluntary Benefits Magazine

Official Magazine of the Voluntary Benefits Association

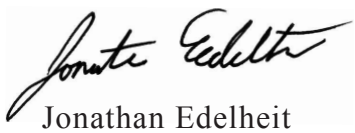
Voluntary Insurance: A Buoy In A Sea Of Change 43

The Future of The Affordable Care Act 6

Innovations In Benefit Administration Leading To Health And Financial Wellness 31

Healthcare Reform a Welcome or Unwelcome Anniversary ?

We just passed the one year anniversary of the Healthcare Reform law on March 23, 2011. I think the question everyone is asking is where do we stand with healthcare reform. People are still shaking their heads and asking what it means, how parts of it will be interpreted and what changes will occur because of negotiations between Republicans and Democrats, and where do we stand since two courts found the law unconstitutional but many found it to be constitutional. Unfortunately there is no special insight because I believe no one really knows what is going on, especially up in DC. In fact, Anthony Weiner, a democrat in the House of Representatives, and one of the biggest supporters of healthcare reform is now looking to get a waiver so that New York City doesn't have to comply with certain mandates of healthcare reform. He actually said "maybe New York City can come up with a better plan." This example of a big proponent and supporter of the law now trying to get out of it for his constituents is just an example of the bigger problems healthcare reform faces in the future. The real problem we face, is we still need true healthcare reform, which this law did not provide.



Jonathan Edelheit

VoluntaryBenefits Magazine.com

EDITORIAL STAFF

EDITOR
Jonathan Edelheit
jon@employerhealthcarecongress.com

ASSISTANT EDITOR
Sarah Hunt
Ugens Toussaint

ADVERTISING SALES
info@voluntarybenefitsmagazine.com

GRAPGHIC DESIGNER
Tercy U. Toussaint

For any questions regarding advertising, permissions/ reprints, or other general inquiries, please contact:

Sarah Hunt
ASSISTANT EDITOR

561.792.4418
PHONE

866.547.1639
FAX

Info@voluntarybenefitsmagazine.com
E-MAIL

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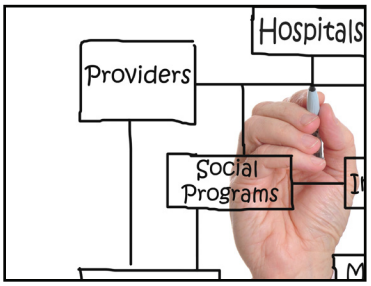
CONTENTS

Issue 22 • April 2011

FEATURES



INSIDE THIS ISSUE

FOLLOW US ON:

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- DISABILITY
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- VISION
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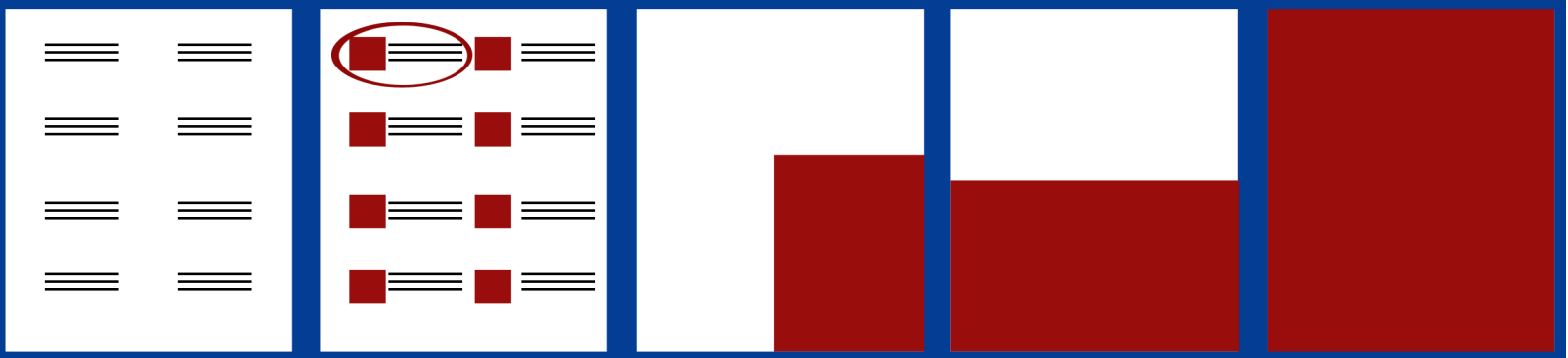

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The Future of the Affordable Care Act ~ Foreseen Challenges and Implications for Insurance Companies and Medicare Patients

Written By **David Goldstein**

The Affordable Care Act will have numerous effects on the healthcare industry. Most notably to insurance agents, brokers, Medicare and Medicaid patients.

Healthcare Reform & Insurance Companies

The Affordable Care Act (ACA) has meant big changes for premiums. Large groups with 100 or more enrollees must now spend at least 85% of their premiums on medical care. If they fail to hit the 85% mark they will be required to offer rebates to their enrollees. For small groups the percentage for the rule is 80%. One major effect that this is going to have on the industry is going to be the commissions for agents and brokers. They will no longer be receiving the same commissions they have in the past as many may move to a one-time fee setup instead of in the past what they have seen which could have been a few hundred a month.

Insurance companies will see a drastic change to their current commissions.

These regulations are going to cause many people to lose their coverage as some insurance companies will be forced to shut down. These plans, called limited or 'mini-med' plans are lower cost plans which don't provide enough coverage to be considered 'essential benefits' under the new law. The effects will be a lack of coverage and higher premiums. The elimination of these plans will lead to a lack of competition resulting in an increase in premiums and many without coverage. However, the Department of Health and Human Services (HHS) can provide a one year waiver to those plans whose elimination will cause a major disruption in their market. In simple terms, a major disruption means a significant increase in premiums or a significant decrease in access to care. Currently about 900 companies covering 2.4M people or 2% of all those with employer sponsored coverage have received waivers from HHS to remain in business.

Shareholders will be upset so the company will raise the cost of premiums to make up the difference.

Another interesting point to note is that the ACA has placed a new tax on executive pay

to all those who work in the health insurance industry. Specifically, insurance companies will no longer be able to deduct the payroll costs of executives who earn over $500k a year. This means that the first $499k can be deducted but any earnings thereafter will be taxed at the full rate. On the surface, this may appear as a way to keep costs down; however it will most likely have the opposite effect. The likelihood of finding a CEO willing to run a billion dollar company for less than $500k a year is very rare. Instead, that person would use their skills and talents in other companies where they will make more money. As a result, insurance companies will pay these folks what the going market rate is for CEOs (well over $500k a year) and will incur a big tax hit for doing so. This of course will affect their bottom line; to offset that, the companies will raise the cost of premiums to make up the difference. Ultimately, it will be the purchasers of health insurance who end up paying for the extra payroll tax.

There is currently 1 Geriatrician for every 2,700 Americans over the age of 75.

A major benefit for patients resulting from the ACA is that nobody can be denied coverage or care. In 2012, no matter how sick one is or how much cost they've incurred, they will have access to care. The law further mandates that those who are sick cannot be charged more than those who are healthy. As great as this provision is, it unfortunately removes the power of incentives which will create an economic inefficiency. Meaning there is no longer a financial reward for becoming less sick and therefore requiring less care and thus less cost.

Yes, the ACA does impose a fine to those who do not purchase health insurance, however those fines or penalties will be much less than the cost of health coverage. Since the ACA mandates that insurance premiums must be equal, insurance companies will have to raise the rates of the healthy to match those of the sick.

The Effects on Medicaid

Many states are on the verge of bankruptcy due to the effects of the Great Recession. One of those in particular, high unemployment, is taking its toll on Medicaid. The reason is that as people have lost their jobs, they've also lost their health insurance leaving with no choice but to join their state's Medicaid program. To help alleviate some of this burden, part of the 2009 stimulus package provided short-term cash to the states, however much of that cash is now drying up. As a result, 33 governors recently wrote to members of Congress as well as the Obama Administration asking for relief from many of the health care related federal mandates. For example, in California, Governor Jerry Brown is asking to cut $1.7 billion from his state's Medicaid program by limiting the number of visits to a physician to 10 per year. Likewise, Arizona Governor Jan Brewer is trying to cut 280,000 people from their Medicaid rolls. These states simply cannot afford to continue in this manner.

To make matters worse, more and more physicians are not accepting Medicaid patients. Because they get paid so little and are burdened with tedious paperwork, many of these doctors just don't feel that it's worth their time. The problem further intensifies when an additional 16 million people will be added to the Medicaid system per the ACA. Without an extra capacity of providers, existing Medicaid patients will have to compete with new enrollees to get access to physicians. Most likely, these patients will continue using their local hospital's

emergency room, which is costly to the system and inefficient for both patients and hospitals. Unless changes are made, in 2019 there will be 84 million people on Medicaid rolls costing $900 billion a year.

Medicare Donut Hole

Starting this year, the ACA will begin closing The Medicare Donut Hole, the portion of prescription drugs that Medicare beneficiaries must pay for. For instance, there are minimal out-of-pocket expenses on the first $2,800 for prescription drugs, then the 'Donut Hole' kicks in where the individual is on the hook for the next $3,600, and then relief kicks back in for all medications going forward. For those who hit the donut hole in 2010, they will receive a $250 rebate from the government. In addition, Medicare patients this year will also receive a 50% discount on brand-name drugs in the donut hole. The goal is that this donut hole will be completely closed by 2020. Another benefit of the ACA is that it eliminates all co-payments for preventive services to all Medicare patients.

Medicare ~ Access to Care

A growing concern for Medicare patients is in finding a physician who is willing to treat them. Since the cost of running a doctor's practice is increasing significantly and the payments they receive from Medicare is decreasing rapidly, many doctors are no longer accepting Medicare patients. In fact, about 25% of seniors looking for a primary care doctor are having trouble finding one that will see them. The timing of this is unfortunate as this year marks the time when the first of the 75 million baby boomers turn 65 and thus start joining the Medicare system. If left unchanged, this will have severe consequences as the baby boomer generation has more health problems than other generations in the past. In fact, if this continues, Medicare will become insolvent by 2030 as more money will be required to be spent.

Another problem Medicare patients are finding is that there are less and less qualified primary physicians and geriatricians. The reason is simple; doctors in these specialties make less than those in other fields. If these trends continue, there won't be enough people properly trained to take care of an aging population. According to the American Geriatrics Society, there are now 7,000 board-certified Geriatricians in the US. That is 1 for every 2,700 Americans aged 75 and older. It is estimated that by the year 2030 this ratio will drop in half to 1 Geriatrician for every 5,500 seniors.

Conclusion

Even though it is difficult to see exactly what the Affordable Care Act will mean for insurance companies and Medicare patients it is clear that lots will change over the next few years. It will be interesting to see how insurance companies will adjust without large commissions and what the system is going to do to prepare for the large number of seniors entering into Medicare.

Bio

David Goldstein, President of Health Options Worldwide (HOW), has extensive experience in the healthcare industry. HOW delivers a tailored network of global medical facilities within our technology platform to engage employees into bettering their health as well as reducing overall healthcare costs. For more information visit Http://www.HealthOptionsWorldwide.com or contact David.Goldstein@healthoptionsworldwide.com .

Criminal Identity Theft

Could it Happen to You?

Writen By Andre' Andropolis

It's a scary situation that happens every day. The most common way that a person can become a victim of criminal identity theft is through a lost or stolen purse or wallet. The DMV or Department of Motor Vehicles will give you a new driver's license but the problem is that your driver's license will still have the stolen license number on it.

You might be ready to purchase a new vehicle or house and find out through your banker that your loan has been denied because when they did a background check, they found that you had a criminal record. Now you have to set aside a great deal of time to try and figure out how to repair the damage that's been done to your reputation and credit. Criminal identity theft also happens when a thief gives someone's name and personal information such as a social security number or driver's license to a police officer during an arrest or traffic stop. The thief could also give the police officer a fake driver's license that has the victim's information on it and the thief's picture.

When you realize you're a victim of criminal identity theft, your first thought might be to call your identity theft plan provider. Since the overwhelming majority of identity theft providers really focus on financial identity theft related to credit cards, there's very little they can do to help you with your criminal identity theft situation. Even though local and state governments have begun with the process of putting new laws in place to help victims, the process can be slow and complicated.

Typically, the thief will provide a driver's license with their own picture on it but the victim's name

and personal information will be on it as well. In numerous cases, the thief is given a ticket for the traffic violation and isn't arrested. The thief then signs the ticket and assures the police officer that he will appear in court. If the thief doesn't show up in court, the judge might issue a bench warrant but the warrant will be for the victim because the driver's license had the victim's personal information on it.

Once the victim has a criminal record because of the crime that was committed in their name, it's almost impossible for the victim to have their name removed from the "criminal record system." This criminal record causes a whole new set of problems for the victim like being turned down for loans and insurance or being denied employment. Technology now allows "criminal databases" to communicate with one another so that all the other agencies are able to access this information. Even if the victim is able to get the criminal record removed from the police department's database, it could still appear the next time that the town or city updates their files with the state or county databases. The reality is that until their record is straightened out, the victim could be arrested repeatedly for the same bench warrant.

The US Department of Justice Report

"In one notorious case of identity theft, the criminal, a convicted felon, not only incurred more than $100,000 of credit card debt, obtained a federal home loan, and bought homes, motorcycles, and handguns in the victim's name, but called his victim to taunt him — saying that he could continue to pose as the victim for as long as he wanted because identity theft was not a federal crime at that time — before filing for bankruptcy, also in the victim's name. While the victim and his wife spent more than four years and more than $15,000 of their own money to restore their credit and reputation, the criminal served a brief sentence for making a false statement to procure a firearm, but made no restitution to his victim for any of the harm he had caused. This case, and others like it, prompted Congress in 1998 to create a new federal offense of identity theft."

Tips for Protecting Your Identity and Credit

• There are valid reasons why you could be asked for your social security number: Your employer or financial institution may need it for tax and wage reasons - it's necessary whenever a credit check is required. Don't give your Social Security number, mother's maiden name or account numbers to strangers who contact you, especially by phone, mail or online. Your social security number is the single most important part of your personal information that thieves can use to steal your identity and ruin your credit.

• Keep track of the dates your bills or credit card statements should arrive. If they don't arrive on time, call the creditor to make sure a thief hasn't changed your address.

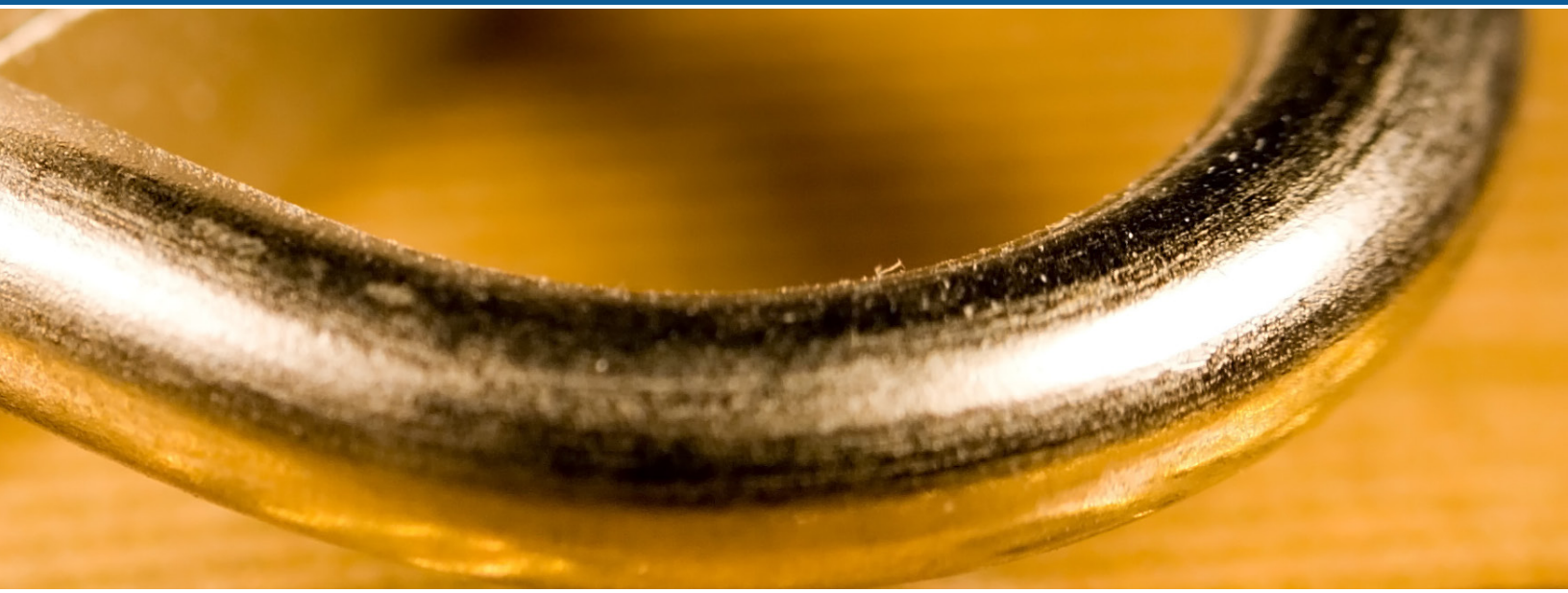
• Protect your mail. Don't leave outgoing mail in your mailbox. Take it to the post office or set-up a P.O. Box. Remove mail after it has been delivered. If you're planning to be away from home, call the post office to request a vacation hold.

• Put passwords on your credit card and banking accounts. Try to avoid using information like your mother's name, your birth date, the last four digits of your social security number or your phone number.

• Don't carry your social security card with you. Leave it in a secure place at home. Give the number out only when necessary. Try to use other types of ID when possible. Don't carry credit cards you don't need. Many people carry multiple credit cards but only use one or two.

• Remove personal information from old computers. If you delete sensitive files by using your keyboard or mouse, the files could stay on your computer's hard drive where they can easily be retrieved. To make sure your files are unrecoverable, use a "wipe" utility program to overwrite the entire hard drive. If you keep business, medical, or personal financial information on disks, simply deleting it isn't enough to protect the data when disposing of the equipment. Besides identity theft, data loss may leave you or your company liable under federal laws such as HIPAA, Sarbanes-Oxley, Graham-Leach-Bliley or other state laws. Criminal penalties include fines and prison terms up to 20 years, not to mention the civil suits that can result.

• Tear or shred charge receipts, copies of credit applications, insurance forms, physician statements,



bank checks and statements, credit offers and any tax or bank documents that you throw away. Investing in a cross-cut paper shredder would one of the best investments you can make. Cross-cut shredders provide more security by cutting paper vertically and horizontally into confetti-like pieces. The trade-off is these shredders may require more maintenance and generally cost more. With patience someone could reconstruct any shredded document if you have a regular paper shredder. Cross-cut shredders just make the job of reconstructing documents much more difficult for thieves.

• Be careful online. Before making any purchases online, look for an "icon" of a "lock" in the lower right-hand corner of your browser window. If you see the "lock icon", then you're dealing with a secure website. Many websites look very professional but may not be a safe place to leave your personal information.

• Don't put your trash out until the day that they pick it up. People that put their trash out on the street a day or two in advance are inviting anyone that walks down the street to rip open a few top bags just to see what's there.

• If you want to inspect your credit report, order a free copy from each of the three major consumer reporting agencies at www.annualcreditreport.com - Fight identity theft by monitoring and reviewing your credit report. You may request your free credit report online, request your credit report by phone or request your report through the mail. Free credit reports requested online are viewable immediately upon authentication of identity. Free credit reports requested by phone or mail will be processed within 15 days of receiving your request.

To Request your Credit Report by Mail:

1. Download the request form (You need an Adobe viewer to view the requested form.) Print and complete the form.

2. Mail the completed form to:

Annual Credit Report Request Service
P.O. Box 105281
Atlanta, GA 30348-5281

Your reports will be mailed to you within 15 days. Please, allow 2-3 weeks for delivery.

To Request your Credit Report by Phone:

1. Call 1-877-322-8228

2. You will go through a simple verification process over the phone.

Your reports will be mailed to you within 15 days. Please, allow 2-3 weeks for delivery.

Choose an identity theft program and legal service plan that work together because identity theft is first and foremost a legal issue. Choose a comprehensive identity theft program with a legal service plan that complements it. Make sure that the identity theft provider you choose are experts in handing the five types of identity theft that you might face one day: Driver's License, Social Security, Medical, Criminal or Character and Financial Identity Theft. If someone's a victim of identity theft, they're going to need to get an attorney involved because identity theft is first and foremost a legal issue. When the rubber meets the road, most identity theft providers will send a kit in the mail when your become a victim of identity theft. Getting a kit in the mail means that you'll be making all the calls and doing all the footwork. Identity Theft is the fastest growing crime in North America.

The Federal Trade Commission (FTC) estimates that there are 9 million victims of fraud each year. There were 11.1 million victims of identity theft last year alone. The average time it takes an individual to resolve an identity theft situation on their own is 55 to 130 hours and between $1200.00 and $5000.00 in out-of-pocket expenses to resolve. Look for a company that is a true leader in the risk consulting industry with licensed, experienced professionals and a proven identity theft product. There is no way to stop identity theft but you can minimize your risk. The way to minimize your risk is by choosing an identity theft plan that offers 24/7 credit monitoring and a plan that provides "full restoration" services should your identity be stolen. If you have children, make sure that the identity theft program you choose also provides 24/7 monitoring of your child's credit files as well as restoration services.

Bio

Andre' Andropolis is an Independent Associate and Group Benefit Specialist with Pre-Paid Legal Services, Inc., and subsidiaries. (PPLSI) The Life Events Legal Plan and the Identity Theft Shield are available to individuals and families. These plans can also be offered as voluntary benefit to your employees. For more information, please contact Andre' at 877-400-6693 or visit his website at: www.prepaidlegal.com/hub/andrej

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"Medical Loss Ratio" Optimization

Another Reform Bullet

Writen By Dr. Suman

Around the country there is a deep concern. With an exponential rise in the medical cost do the consumers of healthcare get a high valued coverage for the money that they pay to their insurers towards accessing care services? As an answer to this long standing question- The PPACA (Patient Protection and Affordable Care Act) directed MLR (medical loss ratio) mandate seems to assure the Americans that now the bulk of the premium dollars spent towards the access of healthcare services are no more going for bureaucracy, profits and executives pay but, will be incurred towards providing them with quality care services. A failure to achieve the mandated thresholds (large group insurers to spend at least 85 percent of premium on medical care and quality efforts, and small group and individual plans to spend at least 80 percent of premium on medical care and quality efforts) will further bind their payers in offering them substantial rebates.

But, this may not be the end…. If one deep dives into this concept, the unaddressed minimum MLR requirement might even lead payers to experience compromised revenue margins, gross administrative inefficiencies, reduction in market shares, drift in the enrollment curve, rise in premiums, budgetary constraints to support reform centric capital business projects and even challenges to offer better product and services. Such numerous unfolded implications will ultimately make payers (both short term aggressive and long term strategist) to change their operational model and way to compete in this market.

Certainly, commercial and government payers alike have been long looking for ways to stem the amount they spend towards their administrative functions (like payment reviews, broker commissions etc). However, within an existing complex fiscal environment the recent challenge to attain the directed MLR threshold is never going to be

an easy-to-fix problem. This new playbook needs to be dealt with a comprehensive approach such that Payers can scrutinize to cut their overhead administrative costs, invest more in quality medical services and simultaneously achieve higher margins within a minimum MLR environment. Focus should be on adopting processes and methodologies or streamlining the existing operations in a way that brings down the cost involved in enrollment, brokerage, claims adjudication, provider credentialing, contract negotiation. Simultaneously these processes/ methodologies should help in improving the utilizations of the care services, preserving functions like protocol-based clinical services, tracking of the hospital readmissions and unwanted procedures performed, reducing the instances of fraud and abuses etc, all that will result to a operational cost prohibitive but quality optimized business function.

Payers also have to understand and adopt the right strategic model to approach and engage consumers evaluating the correlations of factors that indicates how one of them is more amenable to an intervention than another. This can only be accomplished by leveraging some very refined data mining, predictive analytics and modeling tools that helps to transform information into strategic assets facilitating better decision making, building a competitive advantage through appropriate financial delegations for quality care services. Agreed, that this is not an un-attempted task by health plans. But what remained unaddressed is the actual ability to bring...share information and establish the best practices, identify the right cohort, and create the communication so that right action is taken at the right time and the overhead cost that is spent in handling the unwanted situations through executive interventions are rationalized. All of that was missing; needs to be addressed today for the mandated MLR.

Payers must begin to understand the financial and operational ramifications MLR will have on their organization. Traditional business models will require reevaluation, as redefining medical spending to make the mandated percentiles attainable is just one way insurers might adapt to this new legislation. Additionally, there is also a need to assess each of the existing pricing levers that will help to reduce their operational cost, use any triggers that will help them in understanding the preventive action needed to be implemented to offset the implied impacts of the law, monitor any metric that will be an indicator for their MLR non-compliance and will require further investigation or invocation of an immediate action plan. The intention will be to create the right mix and balance of services which in long term will allow in controlling the potential trend in the growth of administrative cost - finally building a quality care incentive, sustainable, consumer centric, competitive business model. Realizing that the potential premium refunds kick starts this year, it is essential that plans begin to understand and strategize to address the short term and long term impacts of this requirement.

Bio

Dr. Suman is a clinician with Masters in Healthcare Administration with over 5 years of experience in medicine and Healthcare IT domain. He comes with extensive insight on US Payer & Provider Industry. His expertise lies into the development and implementation of IT-enabled business solutions for health payers and providers related to HIPAA 5010 migration, ICD-10 transition & EMR. He is currently engaged as a domain expert in the iTransform Product development team. He has credits in authoring white papers & point of views related to HIPAA 5010 & ICD-10 transition. He is an active associate with NCPDP, AHIMA & WEDI SG for 5010 & ICD-10.

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Why Healthcare Reform is a "Perfect Storm"

and How Voluntary Benefits can Provide a Crucial Lifeline

Written By **Kevin Seeker**

MLR's, Cadillac Plan taxes, grandfathering, higher deductibles and co-pays all are, increasing costs and premiums.

Somewhere in this swirling chaos, there are some solutions that can help all involved: employers, employees, and their brokers, agents and consultants. After all, everyone is on the same surging wave, struggling to make sense of it all – and in need of a lifeline like Voluntary Benefits.

Let's examine the raging storm – and some solutions – from various perspectives:

Employers

As employers deal with rapidly rising health costs and burdensome regulations, balanced with keeping employees satisfied with their benefit plans, here comes the Patient Protection and Affordable Care Act (PPACA).

Not only does this legislation create additional confusion, it also causes many employers to brace for additional increases in their expenses, driving them to introduce Consumer Driven Health Plans (CDHP) along with Health Savings Accounts (HSA) to avoid excise taxes -- or to drop health benefits completely.

Employees

As confusing as this is to employers, think of how employees must feel as they contemplate increased out-of-pocket costs in the form of premium contributions, higher deductibles and co-pays. Even with HSA's (which may or may not be subsidized by an employer), there are still gaps in coverage, which can impact their overall financial wellbeing. Statistics show that the majority personal bankruptcies are due to medical expenses, even though more than 70 percent of people had medical coverage in place.

Brokers, Agents and Consultants

As employers search for a beacon in the storm, intermediaries are also threatened by PPACA's strong undertow and rip currents. In the small group market, there is growing concern about the impact of Medical Loss Ratios (MLRs)

on fully insured plans, resulting in lower – or no – commissions. This could deliver a devastating blow, especially if there are no plans for additional product lines to offset this.

Fee based consultants are also facing revenue pressures. Organic growth is down, and competition is fierce. Clients are demanding more value-added solutions, and often at the brokers' expense. Without additional revenue, this model can be difficult to sustain.

Enter the Lifeline ~ Voluntary Benefits

Although Voluntary Benefits cannot completely stem the rising tide, they have entered the mainstream of employee benefit plan design strategies and can offer valuable solutions for everyone. Here's how:

Employers

As employers grapple with balancing new cost-saving strategies with employees' financial wellbeing, they are considering products, such as Group Critical Illness and Group Accident plans, which have gained momentum because they:

- Help plug the gaps in coverage without being "underlying coverage", when HSA compatible.
- Do not impact the so-called Cadillac Plan excise tax issue.
- Are valued by employees, which may help increase adoption rates of CDHP elections.
- Leverage wellness benefits, by increasing health awareness and participation inherent in corporate wellness programs.
- Send a positive message to employees, while also lowering employer costs.

Employees

Instead of going under the surging wave in the storm, employees can better protect themselves and their assets (i.e. their savings, HSA's and 401k plans) with voluntary benefits that:

- Provide valuable supplemental coverage.
- Offer cash when it is needed most to retain control of the situation and to help offset many of the incidental expenses.
- Are available on a simplified or guarantee issue basis, making them easy to enroll in and qualify for.
- Include valued family coverage.

- Enhance the overall value of the benefit plan.

Brokers, Agents and Consultants

You can offer your clients a port in the storm, by introducing some of these types of voluntary benefits:

- HSA-compatible products, like Critical Illness and Accident Plans, which can help offset some of the employee risk and alleviate some of the employer concerns about higher deductibles.
- Newer generation products, like GAP and Hospital Indemnity, along with Critical Illness and Accident Plans, which provide excellent plan design strategies that help plug the holes.
- Wellness benefit riders that are included in Critical Illness and some Accident plans, which help to drive participation in testing, thereby enhancing long-term savings. For Example: Employer funds $5000 of Critical Illness for each employee (with a Voluntary Employee Buy-up Option that includes a wellness rider), under the condition that they will fund the base plan IF employees complete testing. Employer also raises employee contribution, but agrees to reduce it if the employee completes the test. In essence this pays for the plan).

Voluntary Benefits can also include commission revenue. In many instances, commissions can now be level, providing a more predictable revenue stream and fit nicely with traditional group product compensation structures. In the small group market, consider what adding two Voluntary Benefit products like Critical Illness and Accident can do to your revenue stream. In lager case markets, Voluntary Benefit commissions can often be redirected to offset employer fees, or to use towards additional value-added services such as online benefit administration. For fee-based consultants, this can be significant in riding out the storm of shrinking organic growth.

While we all weather the same "perfect storm", Voluntary Benefits are rapidly gaining acceptance as a sound product set to be integrated into well-designed benefit plans. Catch the wave and show your clients the advantages of Voluntary Benefits.

The Environment of Change

Written By **Neil Treitman and Mache Seibel**

The events and rhetoric leading to the inauguration of President Obama swept the mindset of the Nation in a tsunami of healthcare changes - to embrace healthy lifestyle changes and changes in attitudes that shift the responsibility of employee wellness to their employers. Why? Because the cost of high cost claims are causing the employer contribution to employee health insurance to soar. Employee wellness will lead to a more productive work force and lower healthcare cost. A Google search for the phrase "environment of change," reveals article after article on issues in need of transformation such as global warming and atmospheric pollution. Glaringly absent was anything related to creating a safe and supportive space to encourage employees to make behavioral changes that lead to better health – the "human environment" that leads to the betterment of the human condition.

While we rightfully are concerned with the environment in which we live, we are neglecting the environment in which we spend the second most abundant amount of our lives – the work environment. The environment we work in has both the power and the potential to either enhance or detract. To stimulate or inhibit the essential elements that motivate our employees to step out of a lifestyle that has become too familiar, and begin to embark on a new decision tree that can lead to a healthier and more productive life. To contain your healthcare costs you must create an environment of change; and one that makes it easy for your employees to adopt a plan of action.

The administrators of a company create the work environment. Just as they set the example for work, they must set the example for health in the work place. Employees will in turn follow the example of leadership and become attracted to what is comfortable. Jim Gyurke, Vice President of Marketing and Sales of PAR, Inc. the world leader in psychological testing says, "Any company that hopes to successfully implement a new program, whether in manufacturing, service or employee wellness must fully embrace that initiative and make it part of the corporate philosophy and values. In practice, what that really means is that all employees must ultimately accept the offering as both positive and necessary and value it as a personal benefit. It is not enough for management to talk about changes, they must model it; and when observed in the workforce, reward and celebrate it."

So recognize that making the decision to change when nothing is changing around you is difficult. The decision in itself can cause stress. Posters in the lunchroom or an occasional postcard from your health insurance provider will be ineffective if there is no noticeable awareness of the process of behavioral change. The key in evoking participation is to reduce the stress associated with making the decision to move toward better health by developing a new corporate culture. Those companies that are most successful create a new social norm that embraces a healthier lifestyle. It begins with the reduction of stress.

Is there really additional stress in making a decision that is good for you? In 1958, J. V. Brady, the pioneer in behavioral psychology, conducted a study in which a monkey was strapped to a chair for six hours a day. During that time the monkey would receive an electric shock sufficient to be uncomfortable, but not physically harmful to the monkey. The shock was automatically administered to the monkey every 20 minutes unless the monkey pushed a large red button placed within its reach. If the monkey stayed alert and made the decision to press the button at least once every 20 minutes, the monkey avoided the shock. The experiment continued for three weeks, six hours a day. The monkey died. Upon examination, the researcher found that the cause of the monkey's death was an ulcer. The experiment was repeated with a second monkey and at the end of three weeks, the second monkey also died which also was found due to an ulcer. The assumption was that the electric shock

the condition that caused the monkeys' deaths. Brady repeated the experiment again with a modification. This time he placed two monkeys side by side. One monkey had the button that could be used to avoid the shock. The other monkey did not have a button. The experiment continued for another three weeks until one of the monkeys died. Which one? The "executive monkey," the monkey with the button. The companion monkey that was shocked but was not repeatedly forced to decide whether or not to push the red button remained healthy and happy. Brady concluded that the monkeys who developed the ulcer died because they had an extremely stressful job.

Mitigating stress may be as simple as taking "the straps" off of the chair and promoting movement around the office. Here are some ideas:

1. Meetings in motion-When two or three team members need to meet face- to- face, encourage that meeting to occur outside. Suggest routes around the campus or neighborhood that should take 15 to 30 minutes at a casual pace. You'll be amazed at how liberating and stimulating your meetings will be.

2. Encourage stretch breaks. Ergonomics are often not ideal and many of the sub- acute injuries treated in private practice stem from repetitive physical stress in the workplace. Not from lifting in the warehouse as much as headaches and neck pain from people who sit at their work station for hours with no break. An excellent reference for low cost remedies is Pete Egoscue's book titled "Pain Free at your PC." Backs were meant to be straight; heads and backs aligned.

3. Offer help and simple tools for time management that cause people to get up and move, like a calendar or to-do list on the wall. While technological improvement seems very cool, it can sometimes become a time drain that creates "virtual straps" that bind people to their chairs.

4. Keep schedules flexible enough to accommodate emergencies or changed work requirements. Allow time for exercise during the work day. Adding 15 minutes to lunch can provide the needed time for a walk.

5. Yoga classes or simple exercise classes incorporated into the lunch hour or work day as a 30 - minute "in house" fitness and stress reduction program that becomes part of the day.

Incorporating these and related approaches might seem a huge departure from your current work environment and a potential risk. But consider the potential gain - containing rising healthcare costs without cutting benefits. People seldom make lasting changes without some external stimuli. Changes in how we eat, cope with stress, our physical activity, self-talk or relaxation activities can all lead to better health and result in lower claim costs. But to be lasting, the environment must support that change, and the employer must be willing to set the example. The influence of leadership is an extraordinary resource as leaders

are in the position of authority and power that dictate rewards and sanctions, shaping employee behavior. It has to start at the top. Be aware of how your behavior affects the employee's behavior. They are looking to you as the example.

So what about those rewards? Invest in your employee's wellness and offer incentives to ensure participation. Not every reward is expensive; recognition goes a very long way. The idea of celebrating an individual's performance by recognizing their accomplishments is often more effective than their rebate for joining the gym.

At Cambium Wellness, our job is to analyze a company's healthcare expenditures and design effective programs to contain costs. We ask a lot of questions and when we ask the percentage of management's participation in the company's wellness program, the answer is usually surprisingly low. We design executive programs and have developed ways to analyze each individual's interest to promote participation. To contain healthcare cost it's essential to first understand the trend that leads to your company's high cost claims and institute measures to mitigate them. Because people are different, the greatest success comes from providing a variety of options available. When leadership sets the example through participation, the employees are much more likely to participate..

Cambium's team of experts comes from diverse fields. We examine medical claims by codes and procedures. Using this approach, we determine your company's potential to realize a savings on healthcare costs by offering alternatives to traditional treatment protocols. Our unique method of analysis is the first step in working together to create a customized plan for your company's needs that leads to sustainable cost containment. These tools are the basis of developing a Cambium Wellness Program. The "diagnosis" is reached, the problems identified and the solutions made simple and actionable. We help you identify those areas for cost reduction first, so you can reinvest the savings in an expanded approach to better educate and motivate your employees. This approach ultimately can lead to a lower incidence of disease, and reduce unnecessary medical visits and claims for both acute and chronic conditions.

Bio

Neil Treitman is the President of Cambium Wellness. Mr. Treitman followed his entrepreneurial instincts in 2001 after 25+ years of success in the real estate development industry to pursue an undeniable trend-worthy shift into studying healthcare prevention and wellbeing. As a wellness coach and neuromuscular therapist, he pulled together a team of multi-specialty professionals to create a company that offers a solution to corporations nationwide for programs that increase the health of employees and decrease the cost of rising healthcare claims, crippling the overhead of both small and large businesses.

Dr. Seibel is a Professor at the University of Massachusetts Medical School. He is author of 14 health related books, over 200 scientific articles and consistently listed in Best Doctors in America. He speaks internationally about health and wellness. Dr. Seibel founded www.HealthRock.com to help America stay well. He serves as Medical Consultant to Cambium Wellness. You can find more about him on www.DoctorSeibel.com.

Innovations in Benefit Administration Leading to Health and Financial Wellness

Writen By Steven L. Farish

Employers today have benefited from an explosion of technology applications that can help them manage their employee benefit plans, eligibility and enrollment of all benefit plans. In addition, the best new applications on the market are able to provide exceptional tools for educating the organizations workforce on everything from benefits, wellness initiatives, financial wellness and other learning management required learning. As a result, the savvy HR professional today is about to greatly increase their productivity even as many HR staffs are reducing in size. How is that possible? Technology and communication tools with consultative advice are the keys to success. The solution also requires employers to change their philosophy of providing Core, Supplemental and Voluntary Benefits and perhaps even modify their benefits contribution strategies. Now, you say we have opened up a can of worms, but these functions are all part of strategic benefit planning today and all connected to the successful strategy implementation.

Let's discuss the components of the solution separately and then bring them together in an actionable plan that most organizations with over 1000 associates can champion as the "best in class" strategy that will:

- Increase efficiency, productivity and create a great ROI;
- Reduce fiduciary liability through comprehensive education, modeling and product menus that allow for multiple solutions to fit various lifestyles, needs and gaps;

- Engage the workforce in all organization initiatives;
- Increase Corporate Wellness and Financial Wellness;
- Reduce long term costs and;
- Increase attraction and retention of talented people.

To compete in today's competitive markets with a real need to hire the best and brightest at all levels of the organization, the organizations that communicate the best with their workforce are the champions that others strive to emulate. So the first piece of the solution is to greatly increase communication quality and quantity and engage the organization into creating a culture. This is important in all aspects of the workplace, but we are trying to stay focused on employee benefits, so let's discuss benefits communications.

I will state today that most employers, large and small, fail at adequately communicating the goals of the organization in the area of employee benefits. Most are better at other types of communications such as, safety, job performance, diversity, harassment, etc., but benefits communication usually takes a back seat. That is changing fast. The cost of providing benefits is such a large portion of the bottom-line to organizations that it has moved to a high priority. Reducing medical costs and promoting wellness in the workplace have replaced attraction and retention as the primary issues for organizations according to the most recent MetLife survey of employers. So communicating Wellness, new plan designs (CDHC or HSA, PPO or EPO) and then basing employer contributions on company goals is

central to most new Open Enrollment efforts at most employers. What problems does this pose for HR when they know that the communications and engagement with team members is essential to success? The most common issues we see are:

- The type of communication and how to engage a diverse workforce;
- How is the calendar year planning affected by communication campaigns;
- The costs associated with excellent communications;

- The rankings of the messages that we wish to communicate throughout the calendar year based on organizational priorities;

- How to measure the success of the communications, and success in changing behavior and establishing a culture?

- Making benefit or wellness communications an integral part of an organization's Learning Management strategy?

- Assessing internal talent to create engaging material or rely on the Benefit Consultant or outsource communications?

The keys to success include; involved support and participation from management, team member assistance in design and planning, health promotions that meet team member needs, managing the costs and continually monitoring the plan. While most of the current communication and education focus on Wellness and other curriculum focused on cost and risk reduction for the organization, much of the new focus is on the "Financial Wellness" of the workforce particularly in the economic times we face today.

For instance, last month we heard that John Hancock was seeking 40-100% rate increases on their Long Term Care business and just this morning, MetLife announced they were exiting the LTC market. Two giants of the industry are dramatically responding to the "Boomer Tsunami" that is causing LTC claims to rise as cost of care and number of claims goes up faster than their models had built into the premiums. Bankruptcies due to medical bills (including LTC and Disability) increased by nearly 50 percent in a six-year period, from 46 percent in 2001 to 62 percent in 2007, and most of those who filed for bankruptcy were middle-class, well-educated homeowners, according to a report that was published in the August issue of The American Journal of Medicine.

In addition, Robert Kerzner, president and CEO of the LIMRA, the authority on life insurance, blames the economy for a major reduction in the amount of life insurance owned by families today, "Clearly, more American families are living on the edge -- surviving paycheck to paycheck -- and, as our new study suggests, too many without the safety net that life insurance provides. The numbers tell a grim story. Today, there are 11 million fewer American households covered by life insurance compared with six years ago. A majority of families either have no life insurance or not enough, leaving them one accident or terminal illness away from a financial catastrophe for their loved ones."

What does this mean for the organizational workforce and how they manage their own financial risk management? What are the obligations of employers to assist them with their planning? How can employee benefit administration systems and communications assist in driving education and focus on financial wellness? What are the financial advisors and employee benefit brokers and consultants doing to assist their clients in providing Financial Wellness?

Today, there are many great changes taking place in the workplace that will address Financial Wellness as comprehensively as organizations address Health Wellness today. The world of technology and learning

systems has moved to a level where many organizations can now participate in using Benefit Administration Systems that not only combine administration and enrollment of Core Benefits for all team members, but now are aggressively moving into quasi-learning management systems that compete with the most expensive enterprise systems out there. The newest technologies combine web based learning libraries, modeling tools, calculators, flash video "coaching" and can use these tools in managing Open Enrollments while maximizing the communication efforts for both Health Wellness and Financial Wellness.

Currently there is a plethora of Wellness vendors focused on the health of an organization beginning with risk assessments and moving to health and disease management and lifestyle changes. These programs many times are tied to the contribution strategy of the employer to reward those "wellness champions" for good behavior resulting in reduced cost for the organization and lower healthcare premiums for the team member. This is part of the equation but not a complete solution.

Today, many benefit administration systems are building great tools that allow employers to dramatically increase the engagement of their workforce with corporate initiatives and educational requirements and opportunities.

Many of the older HRIS and Payroll enterprise systems do not have the new benefit administration tools that are easy to use and are engaging to the workforce. These systems are the most advanced and upgraded communication and education tools today and they are focused on delivering year round communications and education support as well as detailed open enrollment delivery. The great news for employers is that they are designed to "bolt-on" to any enterprise system or home grown system and they create all of the electronic data exchanges to serve both vendors and technology vendors. The price of entry to these systems has come down tremendously, so even if you purchased an outdated benefit administration system in the past, the price of entry is well worth the cost and the ROI is amazing. Many times the insurance carriers support some of the PEPM fees associated with these engines as their work in administering their insurance products is greatly reduced and the participation in their product offerings is increased.

While the news for employers is good on technology advances, only a handful of the technology vendors have the forethought and vision to move beyond delivering on the old norms of providing benefits with great tools and resources. The most advanced technology partners and broker/consultants, are moving to platforms that will assist the employer in moving to "flexible benefit administration" and the much higher degree of coaching and counseling on financial products offered in the workplace. Some may remember back in the '80's when a few major consulting firms rolled out "flex plans" to the large employers who could afford their expensive administration systems. The employer planned their benefit costs to a budget, while the consulting firm priced the product portfolio and managed the spending accounts to meet the employee's needs with the employer contributions and the additional employee deductions to pay for their customized plan. We are headed their again and I would surmise that many of the large broker/consulting firms are moving in that direction now.

Why wait? What can be done today provide the best engaging technology and manage corporate costs to the needs, wants and desires of the workforce. Doing this at the same time we are managing the Wellness initiatives and now moving to Financial Wellness initiatives.

Here is the checklist of steps:

1. Analyze current plan offerings to determine corporate contribution strategy;

2. Determine deficiencies in the corporate offering and determine other products needed for portfolio on a Voluntary basis;

3. Determine the needs of employees based on their choices and the affordability of products in the portfolio;

4. Provide coaching and counseling on the financial needs and the appropriate amount of risk protection based on income and lifestyle;

5. Provide offers for team members that are both Group based and Guarantee Issue, and Health qualified (underwritten) products that may allow

for greater amounts of coverage and lower costs;

6. Determine how to Reward compliance to Health AND Financial Wellness initiatives, including Focus Groups of management and rank and file;

7. Develop communication strategy and calendar;

8. Build out communications, benefit guides, video productions, counseling and coaching paraphernalia;

9. Plan Open Enrollment and support;

10. Plan New Hire on boarding

11. Review plans and adjust as needed;

12. Survey employees for the feedback;

13. Repeat the cycle.

Just to give you some perspective of some Financial Wellness initiatives, let me give you some insight to a particular strategy. Since Health & Wellness have been around long enough that most professionals reading this article have a grasp of that strategy, I believe the following strategy would be a great initial start. So let's ask a few questions of our organization and our team members.

- What is important to move the Financial Wellness of the workforce to a much higher level of personal risk assessment of financial products and tools needed to protect families and assets throughout their working career and into retirement?
- What are you major concerns that cause financial stress?
- How are you saving for college and perhaps weddings?
- How much house can you qualify for and afford?
- How do you manage credit?
- Have you taken steps to protect your Retirement savings from financial loss due to long term care?
- How would you survive without your paycheck?

Once you have answered these questions, you need

to again review both your employer provided and employee paid benefits in your portfolio to determine how you can focus on communications and education while at the same time determine if another product platform providing for Individual products is in line. This would be the example. In looking at many current benefit portfolios of large clients and prospects over 2500 employees, we have found that there are gaps in multiple areas:

- Life Insurance- Employers are paying for 1 x earnings up to $50-$100K and offering Guarantee Issue Supplemental Term at step rates usually up to 4 x earnings. Many also allow the employees the opportunity to purchase Individual Whole Life or Universal life on a Guarantee Issue basis. If we use the measure that a person with a family needs at least 8 times earnings to adequately insure their family. Looking at all available sources of coverage and the 8x factor, let's see what is needed to protect the family for the employee making $55,000. Our calculation says he needs up to $440,000 to adequately protect his family from their premature death.

a. Employer pays for $50,000

b. Employee can pay for additional $220,000 at $0.17 per $1000 at age 55 for a cost of $37.40 per month Guarantee Issue. At age 56, the cost goes up to $0.38 per $1000 and either they pay more, $83.60 per month for the same coverage(124% increase) or reduce coverage to an amount they can afford.

c. Can purchase $70,000 of Whole Life at $69.33 per month, Guarantee Issue.

d. Offer another option that allows the employee to qualify for Individual coverage. Employee could purchase a 10-30 year level premium plan. Subtracting the $50,000 the employer paid for from the $440,000 of adequate coverage, leaves us with a balance of $390,000 to purchase to meet "financial wellness". If the employee is moderately healthy, they could be issued "Standard-Non-tobacco" $390,000 for a premium ranging from $83.50-$98.00 for the top 10 carriers.

- Scenario a only leaves the employee under insured by $390,000 at no cost.

- Scenario a + b leaves the employee under insured by$170,000 at a cost of$37.40 at age 55, but $83.60 at age 56.

- Scenario a+b+c leaves the employee under insured by $100,000 at a cost of $106.73 at age 55, but $152.93 at age 56.

- Scenario a+d adequately protects the employee for $440,000 at a cost of $72.37 at age 55 and $72.37 at age 56. In addition, the premiums for the additional $390,000 over the employer provided life is locked in to age 84 and is fully portable, owned by the employee.

- Disability Insurance-Employers typically provide Long Term Disability of 50-60% of earnings up to a monthly maximum benefit of $15,000. They then may offer no additional offers; Supplemental Group LTD on a Guarantee Issue basis with step rates; and/or Voluntary Worksite Disability on a GI basis up to 70% of pre-disability income through all sources. Some will offer Individual Disability insurance for those white collar, management and executive team members that will get them to a higher income replacement and cover bonuses and incentive compensation, since Group plans only cover base earnings or wages. Using the 70% of pre-disability income replacement as our goal for "financial wellness" lets look at our same team member for the first example who makes $55,000 per year. To replace 70% of his pre-disability earnings, he would need to

have a benefit of $3,208 per month, well below the $15,000 maximum. So let's look at how our team member can meet "financial wellness."

A. Employer pays for 50% of earnings to $15,000 per month. Employee then gets $2,292 in disability benefit. Employee is in a 28% tax bracket based on married and filing jointly with income less than $70,000. So, the DI benefit provided by the employer is taxable at 28% and the net DI benefit after tax is then, $1,650 or 36% of the pre-disability income of $4,583. This benefit is provided at no cost to the team member, but we must be very careful to educate the team member on how underinsured they are with this benefit level and not get a false sense of security since it was the plan provided by the employer. This happens frequently.

B. Employer offers a Supplemental Group LTD plan on a Guarantee Issue basis that allows employee to purchase additional LTD to 66 2/3% of pre-disability income. So at age 55, our team member can get another 16 2/3% benefit, or $764 and pay $36 per month, and at age 56 it goes to $51 per month.

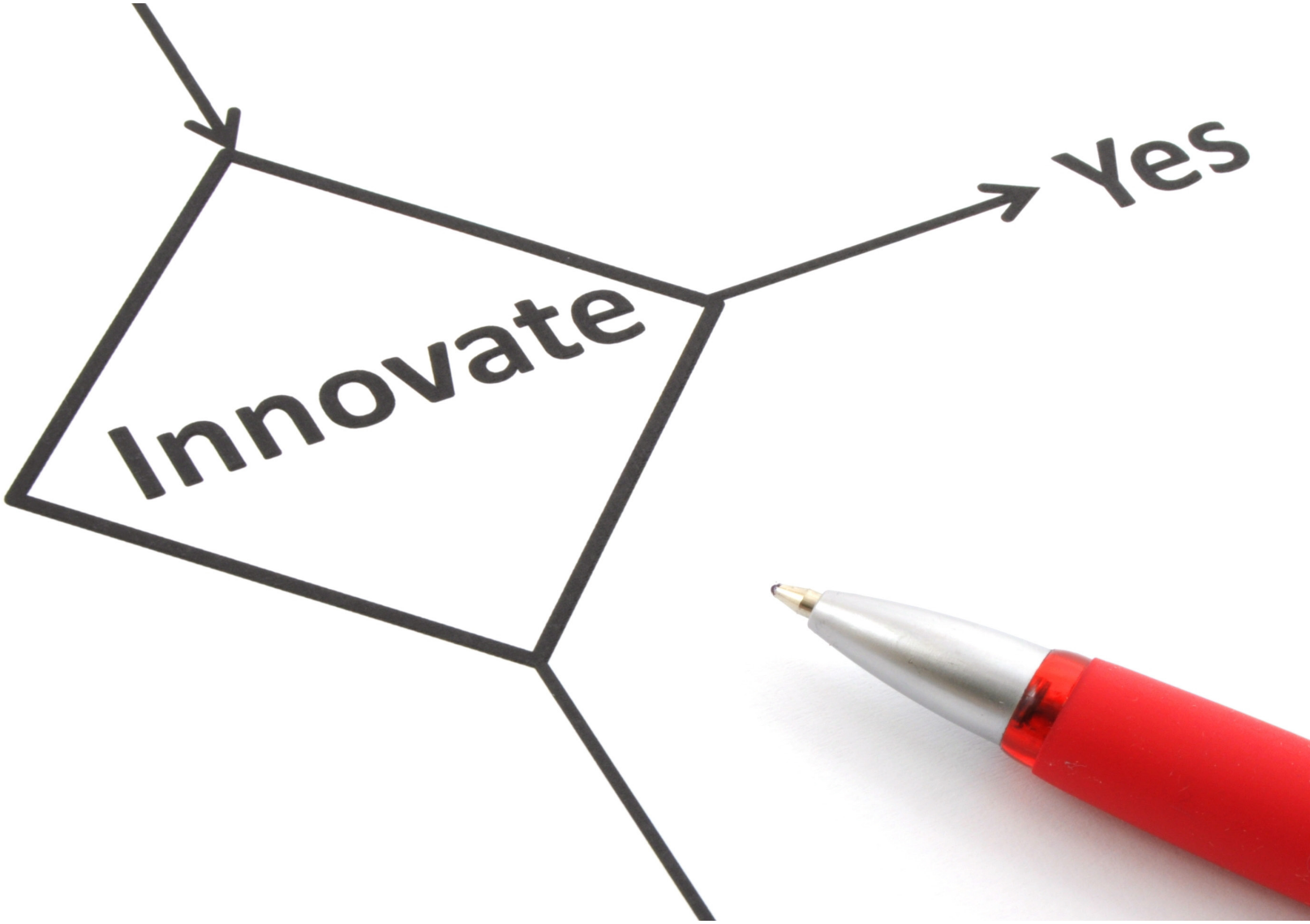
C. Employer also offers Voluntary Worksite Disability on a GI basis that does not exceed 70% of earnings on a post-tax basis up to a maximum of 15% of pre-disability income. Employee could purchase another $687 per month for about $22 per month.

D. Employer offers another option that allows employee to qualify for coverage on a Multi-Life simplified issue basis or an underwritten basis for personally owned disability insurance. The employee can qualify for up to $2500 of disability with no offsets at a price based on age 55 of $ and age 56 of $.

1. Scenario a leaves the employee underinsured with only 36% of their pre-disability income covered but at no cost.
2. Scenario a+b leaves the employee underinsured with only 52.66% of their pre-disability earnings covered at a cost of $36 to $51 per month.
3. Scenario a+b+c

- Long Term Care Insurance- LTC has been a much underutilized product in the past, but as Boomers get older and still make up a sizeable portion of the workforce, it is going to become a more sought after benefit. This will be particularly true for employers with team members who have older parents and for the team members and their spouses. Unfortunately, the benefit many times is offered to the workforce without much insight as to why the program is being offered. There is no doubt that LTC is designed and priced to protect the insured's assets or the inheritance of heirs. If the assets are minimal and the team member is lower paid, the need for LTC is limited. So it is careful to determine the need before designing the product offering. Rule of thumb here may be that a true LTC policy should be offered to team members that have significant assets either in their retirement plans, IRAs, or investments and savings. Significant should be an amount over $100,000 at least. Still, LTC exposure can cause calamity to any team member since most of the costs are not covered by any medical or disability plan including Medicare (limited) and Medicaid (requires spending down to poverty level). For those team members, there are special Life Insurance riders that will accelerate the death benefit in the event of the loss of 2 or more activities of daily living. The value of these policies of course depends on the face amount of the policy, but typically the benefit is equal to 4%-6% of the face amount as a monthly benefit.

Now, let's look at a reasonable approach for assisting the team members with their LTC needs assessment. According to many financial planners, if your assets excluding your home are between $200,000 and



$2,000,000, you are a likely candidate for LTC. Under the amount makes you a likely Medicaid prospect and over the amount makes you a candidate for self-insuring LTC, but remember, even people with assets over $2 million purchase LTC so their families have the support and expertise in treating them. So how does the plan sponsor educate and communicate the benefit in a needs test? It really is quite simple:

1. Provide LTC calculators;
2. Needs assessment will gather information on current vested retirement account balances;
3. Add any other retirement plans, investments, savings;
4. Balance between $200K-$2M, LTC should be looked at as potential coverage;
5. When to purchase? Most planners will tell you age 55 is the optimum age, but can you be sure you will be healthy at 55? Certainly healthy individuals over 55 should consider LTC.

Then it is a matter of determining the average daily or monthly benefit for the area that you live in or will retire in and getting a plan to cover at least 75-80% of the daily or monthly rate. Determine the cost of coverage and then look at your available income to determine if you can afford the plan. If not, look at reducing the coverage (self-insuring a portion) or look at a more limited offer such as a rider to a Life Insurance Policy. Benefit planning today at the Worksite is an evolving enterprise. H R teams need to have great technology

tools and communications to be able to engage the workforce and assist them in their financial wellness. In addition, most banks have a "bankname@work" programs that will provide financial planning and counseling, debt management, mortgage training, budgeting advice and college financing advice. Many of these programs are available at the worksite in lunch and learns and at no cost. These programs will greatly benefit your organization. Look at what one expert has said about wise employers who educate their workforce with "financial wellness". His company does worksite financial consulting on a fee basis.

E. Thomas Garman, president of the nonprofit Personal Finance Employee Education Foundation Inc., said, "it's only a matter of time before all employers adopt financial training. Why? Employers can cut health-care costs by $300 for each employee who improves his or her financial behaviors and financial well-being. In addition, employers can improve productivity by $450. Employers who offer flexible benefits accounts could realize additional savings of $1,274 by improving employee financial literacy". Garman continues, "Financially troubled employees are like sharks swimming around the workplace taking bites out of the bottom line. In exchange for your corporate investment, the employer gets a healthier, more productive worker, which means more profits for the company." From the website of Personal Finance Employee Education Foundation here is what one large healthcare organization experienced with finance education not associated with risk management.

This initiative began in September, 2008 and has:

- Over 450 participants
- 94% "graduation" rate
- About $1.5 million in overall financial improvement
- More than 500 credit cards destroyed

"These results are even more remarkable considering the current economic climate at a time when most people in the U.S. are very worried about their personal financial well-being," said Shannon Carr, Assistant Director of Employee Relations at McLeod Health. "It has been incredible seeing employees, family members, and accountability partners get excited about taking control of their money."

This program was focused on the financial management employees personal finances. What if they could have also utilized personalized benefit planning to further reduce the team member financial risks? More Wow! Greater impact!!

You are probably beginning to see results from health care wellness programs you have implemented in the past several years. It is time for you to research solutions that will help you provide Financial Wellness at the Workplace also. Your employees will be more engaged, less stressed, more productive and less likely to look for employment elsewhere. You will maximize your "stickiness" and attract and retain the brightest because you are the employer of choice. You will be the "The Health & Financial Wellness Champion".

Bio

Steve Farish is a Senior VP and National Practice Leader for Voluntary Worksite Benefits for Wells Fargo Insurance Services, Inc. His team provides full deployment of communications, technology and rewards portals as well as product consulting for Core and Voluntary Benefits and Affinity products.

Steve has been affiliated with Wells Fargo since 2005, and Wachovia Insurance services. He served as Partner with Palmer & Cay for 9 years. Prior to that, Steve served in sales and management of Provident Life & Accident Insurance Company for 19 years.

Steve is a graduate of Presbyterian College with a BS degree in Biology. . He can be reached at: Steve.Farish@wellsfargo.com, 803-765-3521 or 803-479-8397

The New "Traditional" Employer Benefit Package

Writen By Renita Charrlin

Benefits of any kind are powerful tools to recruit, retain and reward employees. Traditional employer provided benefits such as healthcare are continuing to rise in costs. And, employers are continuing to pass more of this cost along to the employee in the form of increased deductibles, higher premiums, reduced benefits, or all or a combination of the above. This continued cost shift from employer to employee is changing rapidly and, most certainly, is changing the overall value of traditional benefits in the eyes of the employee. Consequently – employers need to look to other options benefits if they expect to attract and retain desired employees.

Both employers and employees are increasingly in search of additional, high-value, benefits that provide employees with convenient, self-serve technology where they can receive substantial discounts, rebates, and time saving features that are not available elsewhere. These "voluntary" benefits are certainly not new. We immediately think of insurance-related products (eye, life, dental, disability, long-term care, and auto/home) offered at a reduced, group rate and convenient payment through payroll deduction.

Today, though, both employers and employees are looking for benefits that are outside of the traditional suite of insurance products. New Age forces are accelerating this need due to:

A Belt-Tightening Economy – employers and employees alike are looking to optimize their money wherever possible;

Increased Expectations –employers are expecting higher skills and more productivity from employees while salary increases are being held to a minimum. Employees, in turn, to remain loyal, are expecting more measureable "rewards" from employers that go beyond just compensation.

On-Line Consumerism – nearly 100% of employees today have access to computers at work and many already engage in on-line, employer-provided benefit shopping through their employer's intranet. And, over 75% of all households have computers where information and just about any kind of goods or services desired is just a click away. This accessibility, combined with the desire to save both money and time, is changing employee's knowledge, expectations and behaviors;

Tech Savvy and Money Conscious, Gen X and Y employees… the new movers and shakers. They expect online, high-quality information from flexible, yet reliable service options that they can view, evaluate and purchase "anywhere-anytime." And, they expect, to get on-line discounts and rebates that are not otherwise available.

The new age is here! Traditional benefits is quickly morphing into a broad suite of voluntary benefits provided at little to no cost to the employer that delivers high value to the employee . These offerings, from traditional retailers to more complex services and major investments like the buying, selling, and renting real estate, will provide discounts and rebates that are not available elsewhere. Employer-provided services dedicated to saving the employee time and money by on-line, intranet access, on-line customer support from suppliers, and empowering the employee with the ability to access high-quality resources and information will lead to better decisions, increased purchasing power or ability to use savings to offset the growing costs of traditional insurance related benefits. Recent surveys support that more than 80% of workers perceive voluntary benefits to be extremely valuable and expected.

What steps are needed? Employer's need to (1) endorse and encourage employee activity on the intranet (2) expand voluntary benefit offerings outside of non-insurance services (3) use direct purchasing power or engage a voluntary benefit outsourcer (VBO) to procure suppliers (4) look for unique, high-quality, high-tech, pre-qualified suppliers committed to the concept of "B2B" and who provide volume driven discounts and rebates not available elsewhere, and (5) communicate and encourage utilization.

Employers who expand their "care" to employee's overall health and financial wellness through expanded voluntary benefits will have happier, more productive and loyal employees….saving time and thousands of dollars for both employee and employer.

Bio

Renita Charrlin, CRP, SGMS, a well-traveled employee relocation and real estate veteran, is Co-Founder and a Managing Partner of Employee HomeView, LLC a web-based technology company dedicated to the voluntary benefit industry , providing all employees with a dynamic, single platform of real estate buy, sell, refinance, rent, and moving "tips and how-to's" , pre-qualified suppliers, live support, discounts and rebates. She can be reached at rcharrlin@ employeehomeview. com.

VOLUNTARY INSURANCE
A BUOY IN A SEA OF CHANGE

Writen By David Pringle

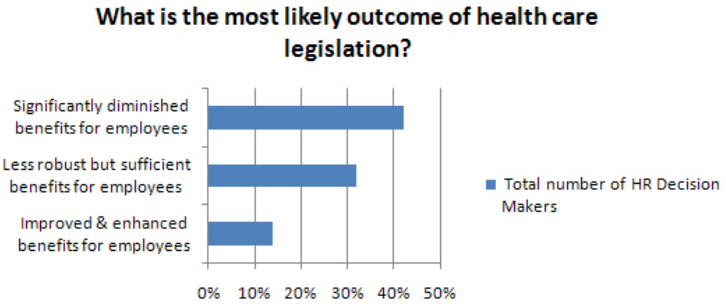
Changes, they are a-comin'. Health care reform has moved from being hailed as an event for the history books, to now on the brink of being reformed again. Recently, on the heels of countless briefs filed by states, interest groups and legislators in both support of and against health care reform, a federal judge in Virginia was the first to rule any facet of the legislation as unconstitutional. One can't help but liken the health insurance industry to a capsized boat amidst raging waves and a vast sea.

There is one sector of the health insurance market that remains on solid land, and that is voluntary insurance benefits. Health care reform focused on major medical health insurance, but given voluntary benefits is not major medical insurance, the voluntary sector is excluded from all of the insurance and market reforms mandated by the new law and currently under scrutiny. For many employers and member organizations, voluntary benefits can solve a number of concerns and challenges that have surfaced during this chaotic time and an unclear future. A recent Aflac survey determined that the top two benefits challenges for companies today are "offering robust benefits while staying within budget/cost constraints" (60 percent) and "understanding the changing health care landscape" (55 percent).

Voluntary insurance policies such as critical illness, accident, life, disability and others are offered to employees at no direct cost to the employer. With health care costs on the rise, employers are seeking ways to retain a robust benefits package while staying within cost constrictions. Voluntary benefits

accomplish this goal for companies. Business owners and HR executives at any size organization may find offering supplemental insurance to employees can enhance talent acquisition and retention efforts, while also realizing potential costs savings on the employer portion of FICA, FUTA and workers' compensation insurance premiums.

The ability to enhance current benefits for employees is of even greater importance given employers' view on potential outcomes of health care legislation.



The challenges organizations face when it comes to rising health care costs are not lost on their employees. According to the Aflac survey, 38 percent of employees believe rising health care costs have had a very strong/strong impact on their company's ability to offer a top notch benefits package, and 43 percent say it has impacted their ability to keep insurance costs low.

Despite the intentions of health care legislation, many workers (41 percent) strongly or somewhat disagree with the statement "I will have greater control over my health care decisions due to the health care reform."

Providing peace of mind and additional insurance options is a key outcome for policyholders of voluntary insurance policies. In the unexpected event of an illness or injury, policyholders receive cash benefits to help pay for daily living expenses, such as rent, gas, groceries, daycare and other necessities. Because cash benefits is always welcome, the added protection voluntary insurance offers will continue to be in strong demand.

Although some aspects of the new law are already in effect, and assuming it will remain unchanged, most of the law will be phased in over the next several years. Further, the regulations to implement those parts of the law may not be published for some time. Facing so much uncertainty, developing a plan to manage health care costs can be an overwhelming task.

Now is the time for HR professionals and benefits decision makers to seek out health care benefits options that can not only be counted on, but that will soften the impact of the inevitable cost-shifting, and rising out-of-pocket costs on its valuable workforce. This includes voluntary insurance solutions that have no direct cost to the company, but that offer workers choice in additional coverage that best suits their needs.

Bio

David Pringle, Senior Vice President of Federal Relations, has more than 30 years experience in a variety of roles at Aflac. He began his career with Aflac's sales forces as a sales associate and quickly advanced to state sales coordinator. During his tenure at Aflac, Mr. Pringle was the Assistant Agency Director for the West Territory and Director of Training. He was appointed to his current position in 1990 to coordinate Aflac's government relations and lobbying efforts in Washington, D.C. For additional information, please visit aflac.com.

1"Insurance for Living," a study conducted by Harris Interactive for Aflac, September 2010.

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