January 2011

# Voluntary Benefits Magazine

Official Magazine of the Voluntary Benefits Association

January 2011

## RFID Skimming

Your RFID-enabled credit cards and mobile devices are at risk of identity theft

## Open Enrollment

Help Employees Navigate Options with Targeted Communication

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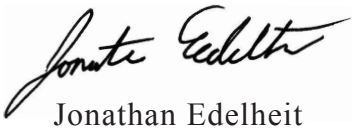
# 2011- A New Road Lies Ahead

As we enter the New Year many of us are eager to leave behind the troublesome and complicated tribulations that 2010 brought. This past year has been one of the most difficult years for employers, insurance companies, agents and other healthcare and health insurance industry stakeholders. Healthcare reform has been a wild and bumpy roller coaster ride that has yet to stop. It seemed everyone was forced to stop in their tracks, and put on hold new initiatives and innovative programs to focus on understanding what healthcare reform meant and the implications it would have on their enterprise, learning not only how it would affect them, but how they would need to comply with it. Just when everyone started feeling comfortable and felt like they had a good grasp of healthcare reform and its provisions, the republicans swept in with a huge win in the fall elections, winning the House and reducing the Democratic majority in the Senate. With Republicans vowing to cut off funding for healthcare reform and its implementation, and one Federal Court striking down the individual mandate, no one knows when or better yet, how this roller coaster will really end.

Unfortunately, one negative effect of healthcare reform is that it has caused insurers, employers and agents to sit back and wait. It is now time for action. Employers and insurers need to start implementing those new programs they had previously set aside for the last year and start putting them into place so that they can reduce their healthcare costs and make healthcare consumers more price/quality conscious. A focus should be put on corporate wellness and health and wellness initiatives, valued based benefits design, consumer driven plans, and innovative new pharmacy and specialty drug programs. Voluntary Benefits will be the lifeline that keeps many insurance agents in business as insurers eliminate their commissions or reduce them to unsustainable levels. Employers will turn toward self funding their healthcare benefits as a way to lower healthcare costs. It's a year of ACTION and the New Year is a time that marks resolutions and plans for a fresh new start!

As the government gets more organized and develops better infrastructure to deal with healthcare reform, hopefully they will provide more insight and guidance and in a much more timely fashion going forward. 2011 will be a very interesting year. There will be challenges, but along with challenges come opportunities and new paths to venture on. I wish everyone a very successful year.



Jonathan Edelheit

# Open Enrollment

## Help Employees Navigate Options with Targeted Communication

**by**
*Paul Lundy*
*and Rohail Khan*

Open enrollment. It comes every year to employees around the nation, and most don't anxiously await its return. Choosing the right mix of benefits can be a time-intensive, intimidating process, but it's extremely important, especially now. With all of the changes occurring over the next five years with healthcare reform, there's more pressure than ever to understand the available options and make the right choices. According to a recent survey, health insurers and employers are not communicating as effectively as they could. Fifty-one percent of Americans think their employer should make the options easier to understand, and 55 percent say the same for their insurance provider.

### Reform = confusion

The need for better communication is fueled by consumer uncertainty about federal healthcare reform, with 44 percent of those surveyed saying they are not sure how their health plans are impacted. To combat the confusion, both health insurers and employers need to communicate what the reform meansnow and in the years to come. Though the full implications of the healthcare reform will

not be in full effect till 2014, certain aspects – such as keeping adult children on a plan until age 26 – have already begun. The current and i mpending changes create an opportunity for insurers and employers to engage with their constituents more than ever before.

The survey also indicates that only 14 percent of those surveyed feel that the communications they receive from their insurance company are extremely easy to understand – 36 percent find it difficult, and 56 percent say they're most likely to pick up the phone to contact their insurer when they have a question. Consumers are open to interaction, and seeking information to help with their decisions. Insurers and employers that act on this with targeted and clear communications will benefit by getting the right people in the right plans and opening the door for future interactions.

## Insurers should get personal

Healthcare in general is a very personal experience. Insurance companies who tap into that with customized communication will rise above the noise that is healthcare today, and reap the benefits of increased customer loyalty. In fact, 36 percent of those surveyed would like the communications from their insurance company personalized to fit their or their family's needs, and 27 percent say they want employers to personalize benefits communications, revealing a need for health insurers and employers to revamp their approach.

While most information from insurers today appeals generically to a mass audience, they are more likely to generate a customer response if they personalize every document, e-mail, etc. Even something as simple as incorporating variables in documents such as the customer's name, product type or life event is the key to generating response rates that far outstrip the typical 0.5–2 percent expected from direct-mail campaigns. When it comes to communicating benefit options, the information also needs to be targeted to the recipient's demographic – for example, a retiree vs. a Gen Y employee are likely to communicate and receive information in entirely different ways. It's essential that providers and employers understand how these different demographic groups synthesize and make sense of the information they are providing. From open enrollment to claims processing, there's a tremendous opportunity to better communicate with customers through their preferred channels – whether its e-mail, smartphone, direct mail – and deliver a more positive experience.

## Engaging a capable partner

Insurance companies and HR departments are under enormous pressure to do more with less. Engaging a partner to help design more effective communications, develop outreach using a variety of media channels (Facebook, mobile apps,

SMS, etc.), and field and answer questions from constituents can help them stay focused on their core business – member/employee services.

Insurers considering a partnership can take the lead from Regence, headquartered in Portland, Ore. Regence sought to partner with Xerox to improve customer satisfaction among its 2.5 million members by improving member understanding of the information presented in the company's explanation of benefits (EOB) statements. Before the partnership, this document was like most EOBs in the business. It contained information that made sense to healthcare professionals, but not necessarily to members. Coupled with financial charges, the EOB ultimately left members confused about their benefits, deductibles and costs. After collecting member feedback to understand how they read and interpret the information presented in EOBs, the two companies worked together to redesign the document and personalize the information presented to each customer. To help members make better choices for coverage, the new EOB provides a helpful comparison of the costs of branded and generic prescriptions, referrals to other sources of health and wellness information, and clear-cut direction on how to contact Regence by phone, mail or through the Internet. It also delivers additional information on the benefits received on a year-to-date basis and the status of deductibles and out-of-pocket expenses.

"One of the Regence core strategies is to enable our members to make informed decisions based on the value of healthcare services. This redesigned EOB gives us the opportunity to educate our members and give them the tools they need to make these decisions," said Carol Rouzpay, director of Membership Operations for Regence. In addition, with 44 percent of survey respondents looking for more information from their employer on benefits options during open enrollment, HR departments may also choose to partner with a company dedicated to benefits management. By outsourcing benefits management, companies can free up valuable time to focus on recruitment and employee retention, allowing a benefits administrator to answer specific insurance information questions and develop communications plans to easily answer employee questions.

## Never underestimate the power of communication

Healthcare reform, reduced staff and the continuing plea to do more with less can lead both insurance companies and employers to glaze over the importance of effective communications. However, examples like Regence demonstrate how better communication from insurance companies and employers save time and money by reducing calls related to member confusion and result in more satisfied employees, making better choices for coverage.

Paul Lundy serves as vice president for the Healthcare Practice within the Communication & Business Process Outsourcing business of Xerox Services. Rohail Khan's background includes more than 20 years of sales, account management, strategy and operations, enabling clients to traansform the delivery of benefit administration services to participants.

# Selling Disability Insurance in a New Season

By Rick Wilcox

The ways in which benefits are being sold are evolving, due to a combination of factors including healthcare reform legislation, economic conditions, consumers' increasing empowerment and technology that makes benefits transactions and maintenance both accessible and secure.

This is true of all insurance markets, but especially so for voluntary products such as Disability Insurance.

## The biggest trend in Disability Insurance

It's clear that in this economy, employers are having a harder time paying for benefits that, in the past, were once considered standard parts of benefits packages.

According to a 2009 JHA U.S. Group Disability Market Survey, between 2006 and 2009 the percentage of contributory premium, employee-paid plans, increased by 58 percent for Group Long Term Disability Plans (from 12 percent to 19 percent), and rose by 63 percent for Group Short Term Disability Plans (from 19 percent to 31 percent of premium).

Short Term Disability plans cover the period between the injury or event when a disability occurs, and the time when Long Term Disability benefits take effect--usually three to six months.

Over the past four years, rising costs have

made it necessary for many employers to only offer employer-paid Group Long Term Disability coverage, and then provide employees the option of paying for Group Short Term Disability out of their own pockets. In these cases, employees are forced to choose between purchasing Short Term Disability or taking a chance that, if they are disabled, they may have to "stick it out" and rely on personal finances before LTD payments commence.

Because of this shift from employer-paid to voluntary benefits, the role of the benefits "gatekeeper" is also in transition. In order to remain relevant and adapt to the changing environment, it's a good idea to re-evaluate how we communicate with clients and reach their employees: the end users.

## Yesterday's gatekeepers

In the past, three sets of gatekeepers usually managed the employee benefits sales process:

- **Brokers, who sold the insurance products;**
- **Employers, who decided which products to offer their employees, and**
- **Employees, who enrolled or applied for benefits.**

Under this scenario, the employee had the most passive role. But the roles have started to change. As noted, more employees now pay for at least a portion of their Disability premiums. And since they are being asked to pay for more of their benefits, employees are playing larger roles in choosing their benefits from a suite of products, the benefits options of those products, and how the products are communicated, bought and paid for.

So the role of gatekeeper has morphed into the new role of subject matter expert, educator and super-consumer advocate.

Here are a few aspects of this new reality to keep in mind, moving forward:

## Health care reform:

The full impact of the Patient Protection and Affordable Care Act is still being determined and debated. As we move toward 2014, employers will continue to have many questions about healthcare reform. The unknown costs, as well as the global economic condition, continue to impact decisions surrounding ancillary insurance products such as disability insurance. Our guidance will be critical in helping them develop informed decisions, which could have far-reaching impacts. Carriers and brokers have a responsibility to provide this guidance for both short- and long-term, flexible solutions.

Prioritization of needs: While employers dedicate time and energy on major medical products, voluntary benefits such as Disability Income, Dental, Vision, and Life Insurance are garnering less attention. Carrier and brokers would be well served to look for ways to promote these products as well—for instance, by providing easy, efficient communication tools (and even via new forms of media) to reach and educate employees.

Enrollment: The enrollment process is also being transformed. One result of more significant employee involvement and funding is that employees will spend more time learning about the benefits from which they can choose. Employees will also want to include their family members in the decision-making process. Therefore, making access to benefits information in places that are convenient for employees and their families--such as in their homes rather than just at their places of employment--will become even more important.

Voluntary terminology: In the evolving employee-driven environment, traditional lines between worksite and group voluntary products will continue to fade. Employers and employees won't care how the insurance industry classifies certain benefits; instead, they will want access to coverage they need and will purchase that coverage based on the availability of the benefits they want most.

**Product designs:** Expect the Disability market to become more competitive. Insurance carriers will offer a greater variety of voluntary Disability products and features. With a greater variety of products and features to choose from, voluntary disability may become more challenging to understand and enroll.

**Carriers:** Carriers will need to invest in new product designs and enrollment-support functions that allow for ease of online capabilities, customized enrollment packets, and call center enrollment. Seek out carriers that enable employees to make informed decisions about voluntary benefits through offering flexible benefit options, easy processes, a strong willingness and connectivity to help educate and serve these end users, and affordability within the context of the products.

**Tech tools:** Online tools that help assess employees' needs based on their own individual lifestyles and situations will help create savvy, informed, and satisfied consumers. Embrace new media and new delivery methods to reach employees and provide them with the content and information they are seeking.

**Simplicity is better:** Successful Disability products will need to become easier to understand and explain to an employee. Enrollment will occur when and where employees choose, utilizing enrollment methods and communication formats they are most comfortable using for making informed financial decisions.

Look for products that are easy to understand, explain, and enroll end users in (whether via call center, customized enrollment packets, online tools, or face to face). Occasionally, the consumer may focus more on the process than the product, although product design is critically important as well.

**Choosing to change**.

The time of transformation in the benefits world may feel unsettling to everyone involved in the process. Knowledge, ease of use, and an ability to effectively communicate the transformation are the keys to helping us navigate this new territory. As our roles evolve, keep in mind that we become more valuable than ever to our clients, employers and employees alike.

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Rick Wilcox is vice president of sales distribution and client retention at American General Benefit Solutions

# Marketing Insurance vs. non-Insurance Voluntary Benefits

by Alex Piper

Perhaps you have seen your revenues decrease over the past years from carrier changes. Now with the implementation of MLR requirements, brokers are being squeezed more and more. In government speak, MLR stands for Minimum Loss Ratio's required because of the healthcare reform bill. In the broker world, it means something totally different. I refer to MLR as Major Loss of Revenue. This not only impacts the agents and brokers, but it will eventually impact services that brokers can provide to their clients. But from a broker perspective, how can you maintain your agency with fixed costs remaining unchanged, client requirements increasing due to PPACA and carriers reducing commissions to be in compliance with PPACA?

Most brokers, at least in Ohio where I am located, are still somewhat resistant to embracing the many non-traditional products available to their clients. The voluntary market of worksite benefits has been dominated by a couple of carriers. Some brokers see these carriers as partners but most view them as potential adversaries and a risk to their client relationship. Brokers have spent the better part of 20+ years convincing their clients there is little or no need for critical illness or accident products. This logic has always been predicated on two things. The first is a perceived lack of value since critical illnesses are covered under the group medical plans. The second is that most brokers don't want to sell a product they don't understand or cannot control the enrollment process.

Things started changing when deductibles went from $250 or $500 to $5,000 or higher. Employees now have a major gap in coverage and the need for these products along with medical gap products are greater than ever. Brokers who understand this and are willing to fill the gap with voluntary benefits stand a better chance of maintaining their agency. MetLife did a study in 2006 which showed a huge gap between what employees want and what employers think they want. We have all heard the employer objection: "My employees are not interested, so there is no need to offer voluntary benefits."

This is an incorrect assumption as per the same study; over 75% of employees want their employers to bring them benefit opportunities as there are not insurance agents sitting around the kitchen table discussing them. So what's a benefits broker to do?

The good brokers will start reviewing their client's benefits using a more holistic approach to health insurance coverage's. For example, will a broker make any effort to close the gap of a high deductible health plan or just sell the renewal and move on? Will the broker discuss with their account the available options to do so? Or will the brokers continue to ignore the gap allowing other reps and companies to swoop in and gain the business? My guess is a little of both.


There are many products that brokers can embrace to offset the losses. But before they do this, they need to accept one key item. They need help and cannot do it themselves. They can hire a person to focus on this niche or they can partner with a firm that specializes in alternate benefit solutions. I say alternate benefit solutions since there is so much available in addition to the traditional voluntary benefits. And this also means being willing to split commissions when necessary.

GAP plans make an outstanding addition to current HDHP's but yet brokers are hesitant to discuss the solution as the health insurance renewal in usually difficult enough. GAP plans are very popular with employees as they are sometimes unprepared to visit their doctor without the convenience of a co-pay. While employees still pay the doctor, GAP plans are able to reimburse the employee sometimes up to $75 or $100 per office visit which helps curtail out of pocket costs. In addition, many of the marketers of GAP plans have revised their plan designs in order to become more compatible with HSA plans. While GAP plans are fairly new, they should become a more relevant part of broker renewal discussions as with the increase in deductibles, the out of pocket exposure of employees is growing rapidly despite attempts to retain grandfathered status. There are Gap plans available down to groups of 5 or more covered employees.

Critical illness is another excellent benefit that can be sold in conjunction with HDHP's. Your larger claims are going to come from some of the more sever conditions such as stroke or heart attacks that are covered by most critical illness policies. The payments made under a CI policy not only cover the deductibles and co-insurance but normally allow an employee to keep the difference since these plans are indemnity in nature and paid directly to the claimant.

Perhaps an accident plan

in addition any medical plan is a good fit. Personally, I do not recommend them in white-collar situations but most blue-collar employees embrace this coverage as an added protection. Coverage can be on or off the job so the broken finger incurred while playing football would be covered. In addition, some carriers have worked wellness benefits into their accident plans so an employee will actually receive a benefit just for going to the doctor for any reason. The wellness benefit will not cover all of the doctor's visit but just one of the perks within a good accident plan.

Wellness and cost containment are major initiatives for most organizations. There are some wellness benefits that are now being made to groups of 10 or more lives. If these are successful in reducing claims, you have done a great service for the client and also increased your revenue in the process. But how many brokers currently discuss wellness? Not many. And these are lower cost items that can certainly help reduce claim costs for lifestyle related issues which any experience rated account would appreciate.

Recently, a voluntary benefits firm has just started marketing a virtual physician office visit benefit that can cost the employer down to $2.00 per employee per month based on size of group. The idea is for employees under HDHP's to access a physician via phone, e-mail or video feed. The 24/7 service is capable of calling in prescriptions for the patients and the benefits are many. This benefit has normally been part of a limited medical plan but is now being marketed separately.

There are many advantages. First, the person does not have to leave his house to speak with a physician. Normally, they have to wait to be squeezed in by the doctor's office, wait in the waiting room and then in the treatment room. The doctor then says… you have strep throat and here's a prescription for an anti-biotic. The patient covered under a HDHP has now waited several hours and some of that in a waiting room full of other sick people. He has also paid a large out of pocket medical visit and had to travel to his physician and then bring his RX to be filled. If the employee utilizes this service, the claim is NOT submitted to the health insurance carrier thereby lowering claims costs.

This benefit can be employer paid or voluntary. Part-time and 1099 employees are eligible. If an employer has no plan at all, at least he can give his employees access to doctors. This can also be added to an HSA plan.

The point being is all these products are readily available, easy to sell and pay the broker a decent compensation to make up for his or her Major Loss of Revenue (MLR). With 2014 approaching, the time is perfect to start exploring alternate benefit options. For those who wish to maintain their current lifestyle without adjusting your business model, best of luck to you.

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With over 17 years experience in Insurance, Marketing and Employee Benefits Management, Alex Piper possesses extensive knowledge of the U.S. Voluntary Benefits Market and the influence that Insurance Carriers, U.S. Employers, TPA's, and Government will have on the next generation of voluntary benefits. He can be reached at **alex@vbassociation.com**

# RFID Skimming

by **Andre Andropolis**

## Your RFID enabled credit cards and mobile devices are at risk of identity theft

If you own one of the new RFID-enabled credit cards or one of those keychain credit card fobs that some credit card companies are promoting, you are at risk of credit card fraud and identity theft. RFID stands for Radio Frequency Identification. If you haven't seen or used a keychain fob yet, it's a little device that credit card companies are making available to replace the standard plastic credit cards. Credit card companies are constantly running commercials for faster and more convenient ways to make purchases using your credit card. When a keychain fob is passed over a scanner at a convenience station or other retail establishment to make a purchase, its computer chip is activated which allows your credit card to be charged. This technology allows you to make small dollar amount purchases relatively fast. If you replace your credit card with a keychain credit card fob, your risk of identity theft and fraud increase should you lose your keychain. Some banks also make debit cards available as debit card keychain fobs.

Criminals have added another weapon to their arsenal, wireless identity theft via RFID Skimming. Skimmers are looking for venues such as sports arenas, concerts and malls where a large percentage of consumers are carrying a mobile device or RFID-enabled credit card. Millions of consumers have their credit card information stored on their mobile devices for making online purchases. A criminal will walk into a crowded venue with a hardware skimming device and small antenna hidden in his hand. This skimming device then begins to collect and store data. The criminal leaves the venue and heads back to his home or apartment where he will port or send the harvested credit card information to his PDA, laptop or desktop computer to retrieve this data. Having data stored on a computer chip is supposed to be safer in comparison to the older method of your data being stored on the magnetic strip of a standard credit card. Advertisers have touted the safety of encrypted RFID-enabled credit and debit cards but the evidence shows the opposite is true. Some of the radio frequency signals are strong enough that your credit card information can be "skimmed" through your clothing, wallets and the mail. American consumers now face another threat because their RFID-enabled credit or debit cards are an open target to fraud and identity thieves. Tests have proven that people have been able to skim credit card information right

through envelopes and make purchases via internet retailers. The most frightening part about these tests - the information that was skimmed through envelopes were from newly issued credit cards that hadn't been activated yet by their owners.

Encryption hasn't kept up with the speed of technology like RFID - and criminals know it and are taking advantage of its weaknesses. If an identity thief can get within a few feet of you, your credit card information could be stolen without you being aware of it. While you're at work, a thief could come within a few feet of your home mailbox and skim information from your newly issued, unactivated credit card. Most likely, this crime wouldn't be detected until you received your next credit card statement thirty days later. By the time you received your next statement in the mail, this thief could have wreaked havoc on your good credit.

## What can and should each of us as consumers do?

**A.)** Make sure to do your research before you decide to switch to RFID-enabled credit cards. RFID is also called " contactless payment." Ask your bank or credit card issuer about the security measures they have in place, including what type of encryption this new RFID-enabled card has. Make sure that the bank or credit card company can prove their claims about encryption. These companies should have had independent testing done to verify their encryption claims. Before you agree to switch to the new RFID card, ask your bank or credit card company what their policy is if someone steals your information to commit fraud. Your identity is at great risk so make sure they back up any guarantees they make in writing.

**B.)** Consider a locked mail box - then no one has access to your mail but you. If you're concerned about someone skimming your credit card information from your wallet, consider researching RFID shielded wallets.

**C.)** Choose a comprehensive identity theft program. 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 mal 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.

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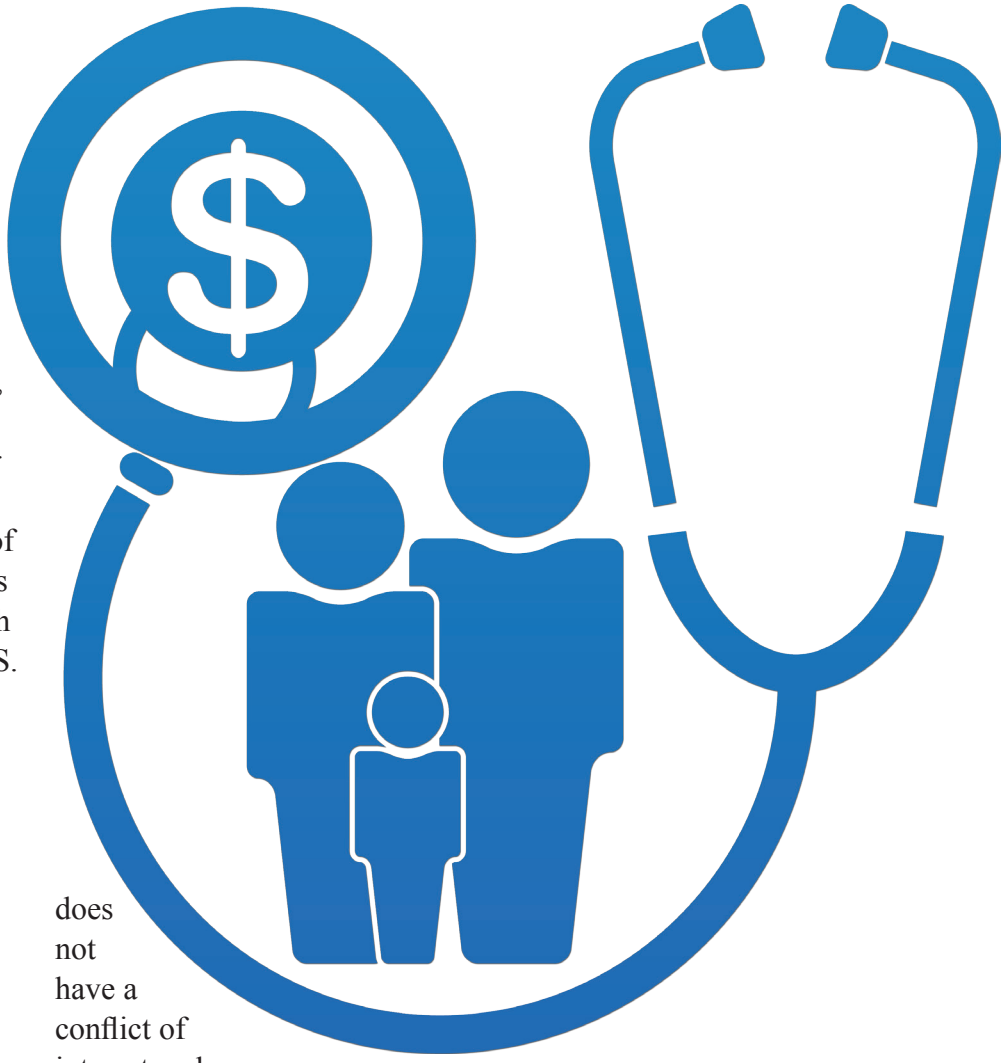
Andre' Andropolis is an Independent Associate and Group Benefit Specialist with Pre-Paid Legal Services. The Life Events Legal Plan and the Identity Theft Shield are available to individuals and families. These plans can also be offered as a voluntary benefit. He can be contacted at **877-400-6693** or visit his website at: **www.prepaidlegal.com/hub/andrej**

# The Value Proposition of a Medical Advocate Program.

by **Bill Crimmins**



I want to inform you about a fantastic service that I have become a big fan of. Allow me to highlight the current environment and let you be the judge of if there is need for improvement:

In the name of consumerism, advocates are promoting the need for consumers to be better shoppers and have "more skin in the game."The Department of Health and Human Services has concluded that regarding Health Literacy, only 12 percent of U.S. adults have proficient health literacy. Over a third of U.S. adults—77 million people—would have difficulty with common health tasks, such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart.

Nowadays, consumers have assistance from their Primary Care doctor (who may or may not have a conflict of interest) in guiding the consumer to the best lab, specialist, hospital, etc. Let's hope that other than network responsibilities, the good doctor does not have a conflict of interest and simply desires to direct the consumer to high quality care.

What objective data does the primary care doctor have to guide vulnerable consumers? Since no objective data is at hand, the doctor uses his " reasonable judgment." The Primary Care doctor has virtually no objective data that can guide someone to the highest quality providers in the network or in the area. There are services that exist which provide relevant, high quality information to consumers (employees and their families), directing them to high

performance (high success outcome) providers. These services save money too!

This service is for employer and group health benefit plans. Punctuating the fact that, "Steerage is far more financially important than discounts!" These advocate services direct members to high performance (high success outcomes) specialists, then navigates the members to the lower net cost facilities (in the contracted PPO) these specialists serve.

You may already be familiar with transplant specialty care networks. Essentially, this is like a specialty care network for all radiology, specialist care and hospital care.Patients are guided through the procedure by skilled navigators (nurses) to improve the outcome and therefore lower the cost.

These vendors apply the same process to all of the other specialty medical care. Non-emergency inpatient care, outpatient surgical, diagnostic imaging (imaging alone can save seven times the fees), colonoscopies, pain management, and more. Milliman has reviewed these services and identified some save $28 to $53 PEPM (per eligible per month) for engaged groups (some groups are currently experiencing over $100 PEPM in hard dollar savings), just on directing facilities utilized. The great news is that high quality health care often costs the least.

The highest quality specialist skills and decision processes can cut waste, shorten hospital stays and return employees to work faster, lowering sick leave time and employee absenteeism.

Unlike self-serve competitors, concierge type vendors are data driven and have access to high quality data in all 50 states. Some have more than five years of commercial experience and multiple programs that help you to find the right fit.

Even at the same facility, cost can vary widely by who the doctor is: for a knee replacement, a range in cost

## How do these vendors choose the best physicians?

- They Establish guidelines for the minimum number of procedures done annually.
- They look at complication rates and mortality rates.
- They look at malpractice suits and disciplinary actions.
- They explore education, license, and Board Certifications.
- They check availability to make sure they are still taking patients. When should consumers call an Advocate?
- 24-48 hours after new diagnosis or referral to specialist.
- When quality information on any physician or medical facility is desired.
- When a specialist is needed or whenever the consumer plans to have a procedure done in a hospital or an outpatient facility.
- Whenever the consumer would like information on an alternative treatment.

**Facility Costs vary so much that discounts are less important than directing patients:**
**Large City contracted (discounted) fees:**

| MRI (Brain) | Colonoscopy | Colonoscopy |
|---|---|---|
| 43 Locations | 71 Locations | 56 Locations |
| $425–$3900 | $479–$3528 | $5,165–$16,966 |

from $23,116 to $43,282 is well within the norm (for the same operating room, nurses, and level of difficulty). The right physician makes a huge difference in the facility cost.

The best doctors have fewer complications, lower mortality rate, spend less time in the operating room, order fewer tests, and have lower length of stays. Picking the best physician will save 12.5% on facility costs.

Consumers can contact these type services via the internet or toll free. The best vendors will have the nurse provide up to three high quality doctors and/or facilities in the area and network within 24 hours of the request.

The program can be implemented on a voluntary or mandatory call basis, as an incentive and/or with penalties. In the end, the consumer always has freedom to do what they think is best.

These vendors are HIPAA compliant and should provide group reports on savings, participation, and description of services provided.

The right vendor will have an immediate impact on employer cost and employee's welfare, much more than other programs that cost about the same with results that are typically less measurable.

The goal is to assist employees to get to the highest quality and most efficient healthcare available…it means better care for employees and families. A secondary benefit is the plan saves money! The highest quality providers are almost always in the lower third of cost.

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Bill Crimmins has a twenty-six year career marketing group health benefits and numerous ancillary support products primarily in the Health Management business. Contact him at **765-720-0392** or **crimmins@link2000.net**

# How can Brokers Sustain Reduced Medical Commissions?

by **Dan Feiwell**

Perhaps you have seen your revenues decrease over the past years from carrier changes. Now with the implementation of MLR requirements, brokers are being squeezed more and more. In government speak, MLR stands for Minimum Loss Ratio's required because of the healthcare reform bill. In the broker world, it means something totally different. I refer to MLR as Major Loss of Revenue. This not only impacts the agents and brokers, but it will eventually impact services that brokers can provide to their clients. But from a broker perspective, how can you maintain your agency with fixed costs remaining unchanged, client requirements increasing due to PPACA and carriers reducing commissions to be in compliance with PPACA?

Most brokers, at least in Ohio where I am located, are still somewhat resistant to embracing the many non-traditional products available to their clients. The voluntary market of worksite benefits has been dominated by a couple of carriers. Some brokers see these carriers as partners but most view them as potential adversaries and a risk to their client relationship. Brokers have spent the better part of 20+ years convincing their clients there is little or no need for critical illness or accident products.

This logic has always been predicated on two things. The first is a perceived lack of value since critical illnesses are covered under the group medical plans. The second is that most brokers don't want to sell a product they don't understand or cannot control the enrollment process.

Things started changing when deductibles went from $250 or $500 to $5,000 or higher. Employees now have a major gap in coverage and the need for these products along with medical gap products are greater than ever. Brokers who understand this and are willing to fill the gap with voluntary benefits stand a better chance of maintaining their agency. MetLife did a study in 2006 which showed a huge gap between what employees want and what employers think they want. We have all heard the employer objection: "My employees are not interested, so there is no need to offer voluntary benefits."

This is an incorrect assumption as per the same study; over 75% of employees want their employers to bring them benefit opportunities as there are not insurance agents sitting around the kitchen table discussing them. So what's a benefits broker to do?

The good brokers will start reviewing their client's benefits using a more holistic approach to health insurance coverage's. For example, will a broker make any effort to close the gap of a high deductible health plan or just sell the renewal and move on? Will the broker discuss with their account the available options to do so? Or will the brokers continue to ignore the gap allowing other reps and companies to swoop in and gain the business? My guess is a little of both.

There are many products that brokers can embrace to offset the losses. But before they do this, they need to accept one key item. They need help and cannot do it themselves. They can hire a person to focus on this niche or they can partner with a firm that specializes in alternate benefit solutions. I say alternate benefit solutions since there is so much available in addition to the traditional voluntary benefits. And this also means being willing to split commissions when necessary.

GAP plans make an outstanding addition to current HDHP's but yet brokers are hesitant to discuss the solution as the health insurance renewal in usually difficult enough. GAP plans are very popular with employees as they are sometimes unprepared to visit their doctor without the convenience of a co-pay. While employees still pay the doctor, GAP plans are able to reimburse the employee sometimes up to $75 or $100 per office visit which helps curtail out of pocket costs. In addition, many of the marketers of GAP plans have revised their plan designs in order to become more compatible with HSA plans. While GAP plans are fairly new, they should become a morerelevant part of broker renewal discussions as with the increase in deductibles, the out of pocket exposure of employees is growing rapidly despite attempts to retain grand fathered status. There are Gap plans available down to groups of 5 or more covered employees.

Critical illness is another excellent benefit that can be sold in conjunction with HDHP's. Your larger claims are going to come from some of the more sever conditions such as stroke or heart attacks that are covered by most critical illness policies. The payments made under a CI policy not only cover the deductibles and co-insurance but normally allow an employee to keep the difference since these plans are indemnity in nature and paid directly to the claimant.

Perhaps an accident plan in addition any medical plan is a good fit. Personally, I do not recommend them in white-collar situations but most blue-collar employees embrace this coverage as an added protection. Coverage can be on or off the job so the broken finger incurred while playing football would be covered. In addition, some carriers have worked wellness benefits into their accident plans so an employee will actually

receive a benefit just for going to the doctor for any reason. The wellness benefit will not cover all of the doctor's visit but just one of the perks within a good accident plan.

Wellness and cost containment are major initiatives for most organizations. There are some wellness benefits that are now being made to groups of 10 or more lives. If these are successful in reducing claims, you have done a great service for the client and also increased your revenue in the process. But how many brokers currently discuss wellness? Not many. And these are lower cost items that can certainly help reduce claim costs for lifestyle related issues which any experience rated account would appreciate.

Recently, a voluntary benefits firm has just started marketing a virtual physician office visit benefit that can cost the employer down to $2.00 per employee per month based on size of group. The idea is for employees under HDHP's to access a physician via phone, e-mail or video feed. The 24/7 service is capable of calling in prescriptions for the patients and the benefits are many. This benefit has normally been part of a limited medical plan but is now being marketed separately.

There are many advantages. First, the person does not have to leave his house to speak with a physician. Normally, they have to wait to be squeezed in by the doctor's office, wait in the waiting room and then in the treatment room. The doctor then says…you have strep throat and here's a prescription for an anti-biotic. The patient covered under a HDHP has now waited several hours and some of that in a waiting room full of other sick people. He has also paid a large out of pocket medical visit and had to travel to his physician and then bring his RX to be filled. If the employee utilizes this service, the claim is NOT submitted to the health insurance carrier thereby lowering claims costs.

This benefit can be employer paid or voluntary. Part-time and 1099 employees are eligible. If an employer has no plan at all, at least he can give his employees access to doctors. This can also be added to an HSA plan.

The point being is all these products are readily available, easy to sell and pay the broker a decent compensation to make up for his or her Major Loss of Revenue (MLR). With 2014 approaching, the time is perfect to start exploring alternate benefit options. For those who wish to maintain their current lifestyle without adjusting your business model, best of luck to you.

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Dan Feiwell is a Regional Manager for PlanChoice a regional general agency that specializes in providing ancillary and voluntary solutions to a network of independent agencies and brokers. Dan has been selling voluntary solutions for almost 10 years and is the current president of the Northeast Ohio Health Underwriters Association.

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# Health Reform Prompts Employers to Get Creative with Wellness

by **Dr. Ann D. Clark**

The epic debate on health care raised plenty of controversy and confusion – but one thing that people across both aisles seemed to agree on was the need for a renewed focus on wellness and prevention at the workplace, in schools and at home. While wellness didn't get nearly as much media coverage as other aspects of health reform, the bill does include grants for small businesses to implement wellness programs; requires qualified health plans to cover the cost of certain preventive care services; and allows employers to increase incentives for participation in wellness programs to 30% of the cost of coverage, up from 20%.

These latest incentives in health reform are prompting more and more employers to start or expand wellness programs. In fact, a recent survey of 282 employers by Watson Wyatt and the National Business Group on health found that 72% were enhancing onsite programs aimed at stress management, EAPs or health coaching; or plan to do so in the next 12 months. As workplace wellness programs become the increasing norm, the question is no longer "Why wellness?" but "How?" How does wellness work on a limited budget? How does a wellness program achieve maximum results?

The answer begins with engagement. If employees don't believe that it is in their best interest to prevent illness and make healthy lifestyle choices, they will have no interest in participating in wellness at the workplace. Achieving employee buy-in can be a major obstacle in wellness, as a recent Towers Watson survey found that 58% of employees lack

of individual empowerment and betterment needs to be clear and strong in all written, online, and verbal communication about the program. By crafting a strong marketing and communication strategy behind a wellness program launch, an organization prevents employee cynicism and skepticism, and builds employee enthusiasm and excitement from the start.

An easy way to make the wellness message personal is to get employees involved in creating it. Companies can hold a contest to have employees come up with the best name or slogan for the wellness program, and employees can all vote on the submissions. Another idea is to invite employees to share what motivates them to get well: "I want to fit into my pre-pregnancy skinny jeans," "I want to walk my daughter down the aisle without getting out of breath," "I want to blow people away at my 20-year reunion" or "I want to feel less exhausted at the end of the day." Share these motivational statements with employees by posting them on the wellness website, flyers, t-shirts, or other wellness promotional materials, and have employees vote on the funniest, most inspiring, or most likely to succeed. Incorporating personal goals into the wellness message helps employees identify with the program and feel more inclined to engage in ongoing activities.

Get creative with communication and outreach In addition to a strong message and marketing campaign, it is important to insure that the method of wellness communication is effective and reaches the maximum amount of employees. If employees have large populations of Hispanic employees, wellness materials should be provided in Spanish and Spanish-speaking staff should be available to administer BMI testing and answer questions at health fairs.

Some companies have large populations of off-site or remote employees, and require creative communication strategies to effectively engage these employees. For example, ACI Specialty engagement. To maximize employee engagement, wellness leaders need to involve employees in the entire wellness process, from preliminary planning through implementation.

Before launching a full-scale wellness initiative, the first question to ask employers is, "How well do you know your workforce?" Too often, brokers, HR and wellness leaders think they know exactly what employees need in a wellness program, but never ask the employees themselves. A simple electronic survey will gather this imperative data, and get employees engaged from the start. These surveys are extremely cost-effective, completely confidential, and employees appreciate the opportunity to provide input. This critical step in the planning process gives employers vital information and insight about what employees' biggest health concerns are, what motivates employees, what communication and outreach will be most effective, and what employees think the wellness program should include.

Wellness needs to be less corporate, more personal The next step to maximizing employee engagement involves creating the message, and in essence, 'selling' wellness to the workforce. With trust in government, big business and corporations waning in tough economic times, wellness cannot come across as a 'Big Brother' program, created to financially benefit the corporation and access employees' private information. The focus has to be less corporate, more personal. Companies have to offer wellness to employees because it is the right thing to do, an investment in employee well-being, and a way to give back to employees for all their hard work and dedication. Wellness is supposed to help employees feel empowered and take control of their health. Employees don't care about saving the company money; they only care how wellness benefits them on a personal level. Employees would welcome a program designed to reduce stress, increase energy levels, strengthen personal resilience, and enhance quality of life. This message

Benefits was recently challenged to work with a corporate trucking firm who had utilized two previous wellness vendors without significant success. Thomas Lee, Chief Sales Officer for ACI remembers, "Early on in the program, ACI conducted an assessment of the groups 'Readiness to Change,' and found major communication barriers in reaching truckers on the road. Truckers could benefit most from wellness offerings, but they just weren't getting the message. We decided the best way to overcome this obstacle was to utilize the "MobileMax" message delivery system in all trucks to deliver wellness information and HRAs. The strategy was a huge success, and we were able to increase HRA participation over the previous vendor by 1000%."

Build enthusiasm with strong health fair and annual challenges Creativity does not end with marketing and communication; the wellness program must get creative in the program launch, health fairs, and ongoing promotions and challenges to maintain high levels of enthusiasm and engagement. Health fairs and benefit orientations should be lively, with plenty of interactive elements like dance and yoga classes, massage chairs, great giveaways and other outside-of-the-box elements. After an exciting launch, there should be an immediate and strong wellness promotion, like a Biggest Loser contest.

ACI Specialty Benefits kicked off the 2010 New Year with its own resolution to serve as a model of wellness, and began a 10-week Biggest Loser challenge. Staff was broken into teams, each led by an executive for this wellness challenge. To ensure fairness, ACI's wellness team created a unique points and reward system that measured success by percent of total body weight lost, not just pounds. Additional points were earned for participating in physical activity, including ACI's on-site yoga and strength-training classes, and smoking cessation. At the end of each week,

individual and team winners earned anything from ½-day Fridays to healthy catered lunches. At the end of 10 weeks, employees lost over 100 pounds and completed over 400 hours of physical activity. "We had an incredible 86% participation rate," says ACI's Senior Vice President of Marketing, Erin Krehbiel; herself a marathon runner. "It was great to see everyone motivate each other to eat healthier, take the stairs, try yoga, and make healthier choices in general. That's what wellness is all about."

Challenges should be based on employees' health goals in order to maximize engagement. It

helps to involve employees in the development phase, by creating workforce wellness committees focused on specific goals: the stress management team, the smoking cessation committee, the healthy eating task force for example. Employees of all levels can work together to develop the best strategies to tackle these major wellness goals, share best practices, and brainstorm on creative challenges, promotions and incentives that would work best. Employees involved in the wellness planning and implementation help generate buzz throughout the workforce, and are more invested in wellness success.

Shift the discussion to insure leadership buy-in One of the major reasons behind ACI's Biggest Loser success was the high-level of engagement by executives and company leadership. When it comes to executives, the wellness discussion often gets stuck in a numbers game. What is the projected ROI in year one, year two, year five? What is the financial impact on health care costs? While these are all important business questions, there exists countless data, research and case studies that consistently confirm the financial benefit of wellness programs. It's time for a major shift in the conversation. It's time to ask leadership their thoughts on wellness, stress management, family health, preventive care, and health education; and what role the company has in fostering a healthy work environment. A good indicator of a workplace that is ready for wellness is one that already has other healthy initiatives in place like an employee assistance program, work/life programs, concierge services, and safety training. If leadership believes that these programs help attract and retain employees while building a healthy and more productive workforce, they will be more inclined to buy into workplace wellness. Leadership buy-in requires more than lip-service though, it requires action. Considering that executives generally set the tone for everything from work styles to dress codes, when they serve as an example of wellness, employees will follow.

Leadership also likes instant gratification, which can a bit of a challenge in the beginning of the wellness process. When reporting wellness outcomes, it is important to keep the focus on engagement success and include employee feedback, survey results, success stories, participation rates and other engagement-related information and results. Another often overlooked component to wellness reporting is the number of employees "who didn't get worse," or in other words, employees who maintained good health--an extremely important factor in prevention and wellness success. The bottom line is that wellness success begins and ends with employee engagement. When employees are excited about wellness, they take the message home to families, support co-workers in healthy initiatives, and become part of the solution.

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Dr. Ann D. Clark is CEO and Founder of ACI Specialty Benefits, a Top 10 EAP and leading provider of student assistance programs, wellness, concierge and work/life services. A best-selling author, Dr. Clark is one of the original Certified Employee Assistance Professionals (CEAP) and a licensed Marriage and Family Therapist. She can be contacted at **aclark@acispecialtybenefits.com.**

# Cartwheels Anyone?

**How to find that one program that will get your audience truly excited about your benefit package.**

By Eric Glickstein

If you're like me, you probably give a variety of gifts to your family during the holidays. Your bundle of gifts probably includes some old favorites: the warm wool sweater, a new scarf, maybe a book, a DVD, a video game for the kids. Without these traditional gifts it just wouldn't seem like the holidays, would it?

But if it stopped there, and that's all you gave, you might disappoint. Why? Because even though your gifts were surely appreciated, in the end, the traditional gifts are just what they were meant to be: routine, matter of fact, ho-hum. Sure, they're nice to have, but let's face it, another sweater, scarf or video game is not going to exactly inspire your loved one into doing cartwheels across the living room.

To avoid this "let down" what I do is buy that one gift that will surely be an eye popper (an IPAD maybe?) and make the rest of the gifts seem perfectly acceptable – even necessary. That's all I need – just that one gift with enough WOW factor to make my audience truly excited. It always does the trick. It's a strategy that would bode well for brokers providing benefit packages to their clients and for employers providing benefits to their employees. Sure, most benefit packages are perfectly fine. They're the kind of packages that include the traditional favorites: medical, dental, life, disability, and retirement. You know, the reliable workhorses –like the fuddy duddy wool sweater.

But if that's all you provide, you may set yourself up for disappointment again. Only this time it will be coming directly from the face of an HR Benefits manager – or a potential top talent. And that could be costly to say the least.

Instead, what you need is to include that one eye-popper that will get your audience doing cartwheels across the office. Voluntary benefits, especially the ancillary non-insurance kind, can provide just the answer. By including an exciting non-traditional benefit in your portfolio, you will not only separate yourself from others, you'll light a spark in your audience, and that could make all the difference.

Today, according to some studies, the most popular voluntary benefits among employees are the kind that offer affordable payment plans on retail products, travel opportunities, and health and wellness. This is not surprising. As you can imagine, employees get pretty excited with employee purchase programs, because unlike the traditional benefits, they offer tangible benefits with immediate gratification.

These types of programs are not merely a candy-coated distraction either. They can truly benefit employer and employee alike. For e xample, according to the Better Sleep Council Organization, sleep deprivation and workplace stress costs US employers an estimated $200 billion per year in absenteeism, lower productivity, staff turnover, worker's compensation, medical insurance and other stress related expenses. Armed with this information benefit managers should seriously ask themselves: what is the impact a brand new mattress may have on boosting employee production? Hence, the need for an employee purchase program that offers mattresses.

Similarly, what is the impact on an employee's production when a work-related benefit provides them with the opportunity to purchase products to fix up their home, or enjoy a cruise vacation? With a new living room or kitchen to come home to every night – not to mention a few days spent cruising the Caribbean -- might your employee show up to work with a smile, less stressed, feeling better about themselves than ever before?

Clearly there is a lot to think about when choosing that additional program that will make a difference. Here are some basic guidelines for looking for that one eye-popping program that will make your benefit packages scream "WOW."

## PROVIDE A TANGIBLE BENEFT

Most employee benefits, especially insurance related ones, do not provide immediate gratification. Furthermore, they are intended to protect the employee against "bad" events occurring. Obviously necessary but not always exciting. Maybe even downright depressing. Instead, an employee purchase program can provide the employee with immediate tangible products designed to improve their lives. It's a "feel good " benefit that makes employees excited right away.

## PAYROLL DEDUCTION MAKES EMPLOYEES FEEL SECURE

According to a MetLife study, 65% of employers believe employees are less productive at work when they are worried about personal financial issues. This is an alarming statistic especially when you consider the current economic slump. But the fact is employees still need to purchase products, take vacations, and entertain themselves. That's why employers that offer payroll deduction would be providing a great service to their employees. Payroll deduction can provide a safety net because it gives employees a disciplined purchasing option. That means they can purchase products they need while managing their budget wisely. It also gives them a responsible alternative to using credit cards.

## MAKE IT ALL INCLUSIVE, NOT EXCLUSIVE

If only a few employees can participate, it's not a benefit. It's a country club. Make sure, for example, if you bring aboard an employee purchase program, the company offers opportunities for all employees to purchase products on terms they can afford. When marketing the program, be sure you find a way to reach out to all your employees from the board room to the mail room.

## ROI – RETURN ON THE INDIVIDUAL

The best news about many of these types of voluntary benefits is that usually they are free to implement. They also provide free marketing tools and materials. In other words, they don't cost the employer a thing. They can even provide strong commission incentives to brokers. So, instead of worrying and focusing on the ROI – Return on Investment, you can focus on the ROI – Return on the Individual.

And In the end, isn't that what you were aiming for in the first place? Providing that one gift – that one benefit – that will make your employee happy and productive and so excited they will want to do cartwheels across the office.

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Eric Glickstein is the Vice President at LutherSales Furniture & Appliances. He can be reached at **1-800-358-6466 x123** or **eric@luthersales.com**

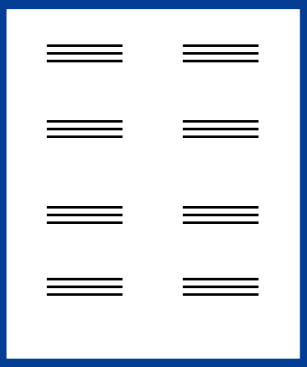
# WHO'S IN THE VOLUNTARY BENEFITS INDUSTRY

WHO 2011 EDITION

## CATEGORIES INCLUDE:

- LIMITED MEDICAL & MINI MEDICAL PLANS
- DISABILITY
- ACCIDENT
- CRITICAL ILLNESS
- LONG TERM CARE
- PHARMACEUTICAL
- DENTAL
- VISION
- REINSURANCE
- THIRD PARTY ADMINISTRATORS

## PRICING & PLACEMENT OPTIONS



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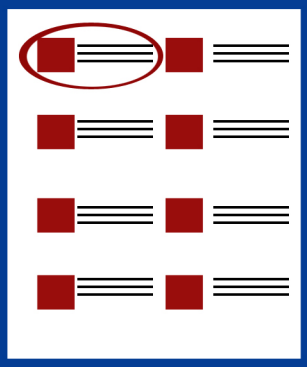
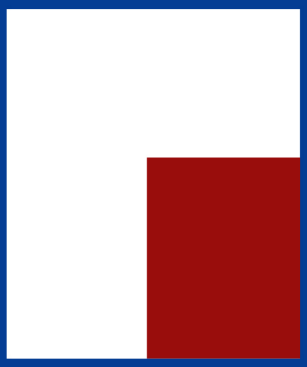


BASIC LISTING (W/LOGO) $500



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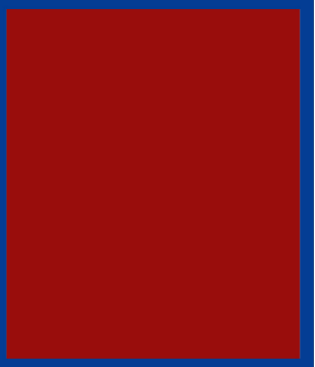
1/2 PAGE $2,000



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# ARE YOU AND YOUR COMPANY READY TO TRAVEL?

by Fredric Havens

Is travel insurance really necessary and worth the added expense? According to the leading travel website Expedia, 19% of every traveler cancels or postpones their plans because of work-related reasons. A survey conducted by the Insurance Information Institute corroborated this trend by finding that 17% of travelers, one out of every six, file some type of claim during their business travels or vacations. Are you ready to travel?

Travel insurance is widely regarded as the best way to protect travelers against a wide range of situations, well beyond emergency illness or injury. Even if your company group health plan covers typical medical circumstances, a business traveler would be well advised to upgrade to a comprehensive travel insurance policy for additional overseas business protection.

The first step should be to check with the HR Department about your group coverage. Examine the policy to see what is, or what is not, covered. Does "healthcare abroad" appear in the policy? How about "medical evacuation?" If you company has an HAS or a Section 125 pre-tax plan, payment for this upgraded coverage would qualify. Don't rely on the common misconception that credit cards give adequate travel coverage. The vast majority offer protections so narrow that they may as well have none at all.

The same is true for domestic health insurance companies. Most do not cover foreign travel, nor do they have the logistics to help with most emergencies away from home. They may reimburse for emergency medical procedures incurred while traveling, but what about the rest? Medical evacuation is ruinously expensive and almost never covered. Terror delays are no longer as rare

**travel risks that many employees travelers typically underestimate:**

- foreign auto accidents
- legal help needed unexpectedly
- evacuation due to weather or natural disasters
- medical evacuation often costing as much as $100,000
- air ambulance from a remote local to a city large enough to host a modern hospital
- repatriation, whether for a health crisis, a lost passport or a military coup
- terror evacuation or kidnap/ransom protection for dangerous hotspots
- sudden departure prompted by a work-related emergency
- embassy referrals from experts on the ground

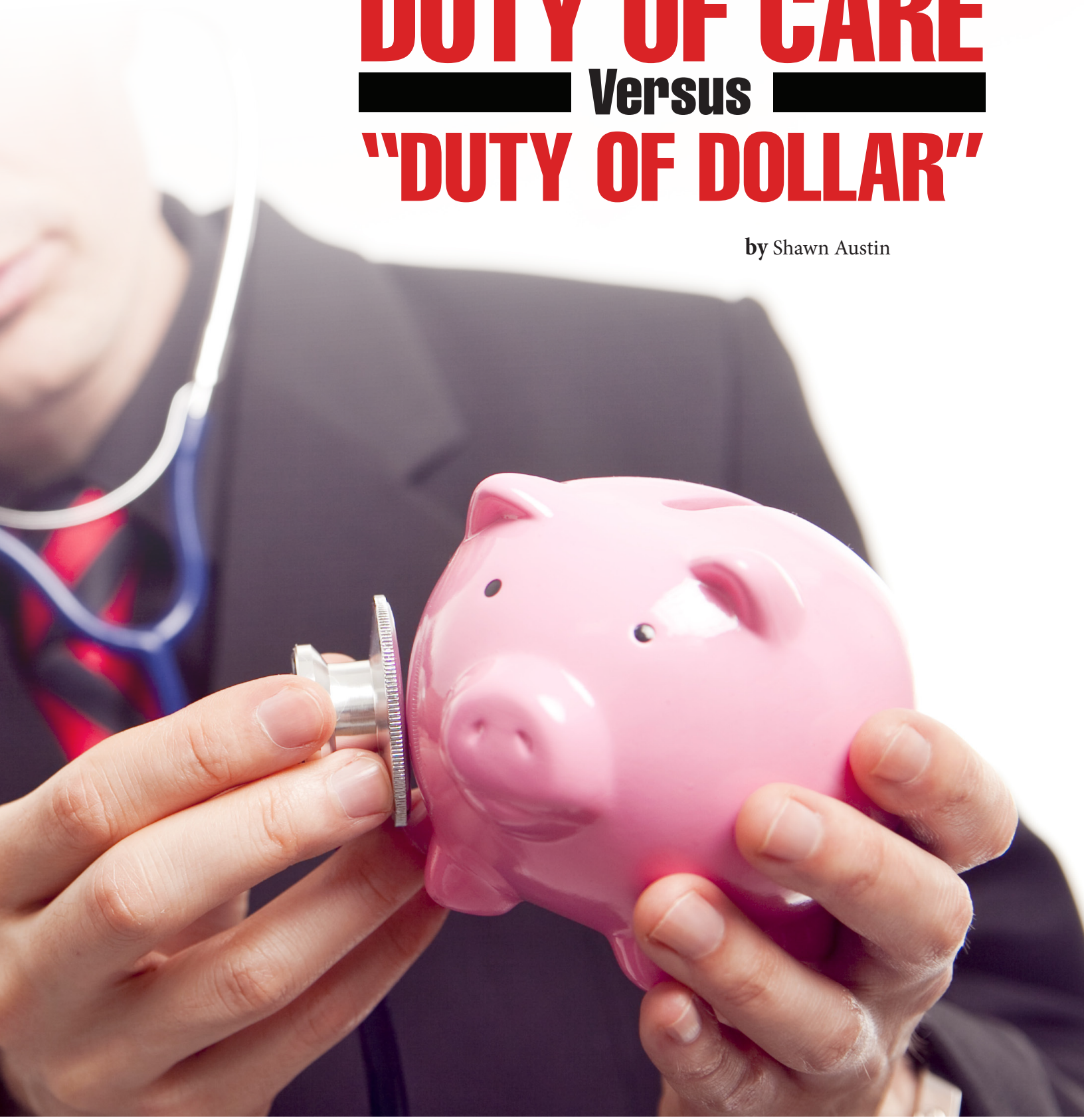
as in the past. Who hasn't heard about a friend losing their passport at the most inconvenient moment? What if your need translation for a crucial prescription refill and you're in Outer Mongolia?

A typical comprehensive plan should provide a wide range of assisted services.The risk of travel delays should not be underestimated. In these unforeseen instances, who pays for the hotel and meals? Who finds the accommodations? Without travel insurance, you do.What about lost luggage? That brand new business suit for the important meeting might have to be replaced overseas. Replacing a stolen laptop could deplete your traveling funds. The important documents in your carryon may have to be emergency couriered at a high price tag.

Traveling abroad should be exciting and adventuresome. Having the foresight to insure away these risks with a comprehensive travel policy helps make this happen.

# DUTY OF CARE Versus "DUTY OF DOLLAR"

by Shawn Austin



# How HR and Risk Professionals Can Still Care for Employees While Watching Their Costs

Globalization has brought today's travelers to new, far-flung locations that they would not have visited even just a decade ago. From engineers and doctors to information technology specialists and banking financial executives, more and more people in a myriad of industries are traveling aro und the globe. Companies are also expanding operations internationally, with a growing population of expatriates stationed around the world.

At the same time that worldwide business travel is increasing, so is the frequency of natural disasters, political unrest, and terrorist incidents affecting travelers and expatriates. Disasters – both natural and manmade – pose a host of health, security, safety, and risk concerns for individuals traveling on business. For instance, a medical evacuation can cost at least $10,000, according to the U.S. Department of State, and can easily have a pricetag in excess of $100,000 in more remote areas of the world.

Now, more than ever, employers are faced with the challenge to control costs. At the same time, employers have a legal, fiduciary, and moral Duty of Care for their employees. This responsibility extends globally and must apply to employees stationed in all corners of the world. Meeting this very important and essential Duty of Care obligation is more challenging than ever. The question becomes: "How can employers balance the need to send employees overseas and protect these employees, while still keeping an eye on the bottom line?"

One solution is a comprehensive travel risk management program that incorporates extensive international security and medical assistance services available on a 24/7 basis for overseas travelers and expatriates.

Benefits of such a program include: protecting the health and safety of traveling employees, mitigating potential legal and financial liability, protecting the company's brand and reputation, fulfilling corporate social responsibilities, meeting shareholder and stakeholder expectations, and contributing to the recruitment and retention of key employees. Even in times when increasing scrutiny of expenses has become the new norm and will continue despite an improving economy, providing Duty of Care must continue. But, even with business travel expected to rebound - particularly to

emerging regions of the world – human resource directors, risk managers, and travel managers still need to watch expenses.

HR professionals are tasked with evaluating and selecting a cost-effective benefits program for their employees. Increasingly, they are being called upon to provide, evaluate, and select comprehensive travel risk management programs that incorporate extensive international security and medical assistance services.

When evaluating travel risk management options, company decision makers should look for a provider that offers cost management solutions, while continuing to provide high-quality service. These solutions should also take into account and help address Duty of Care requirements. Since no two organizations are the same, you want a program that can be customized to meet the unique needs of your organization.

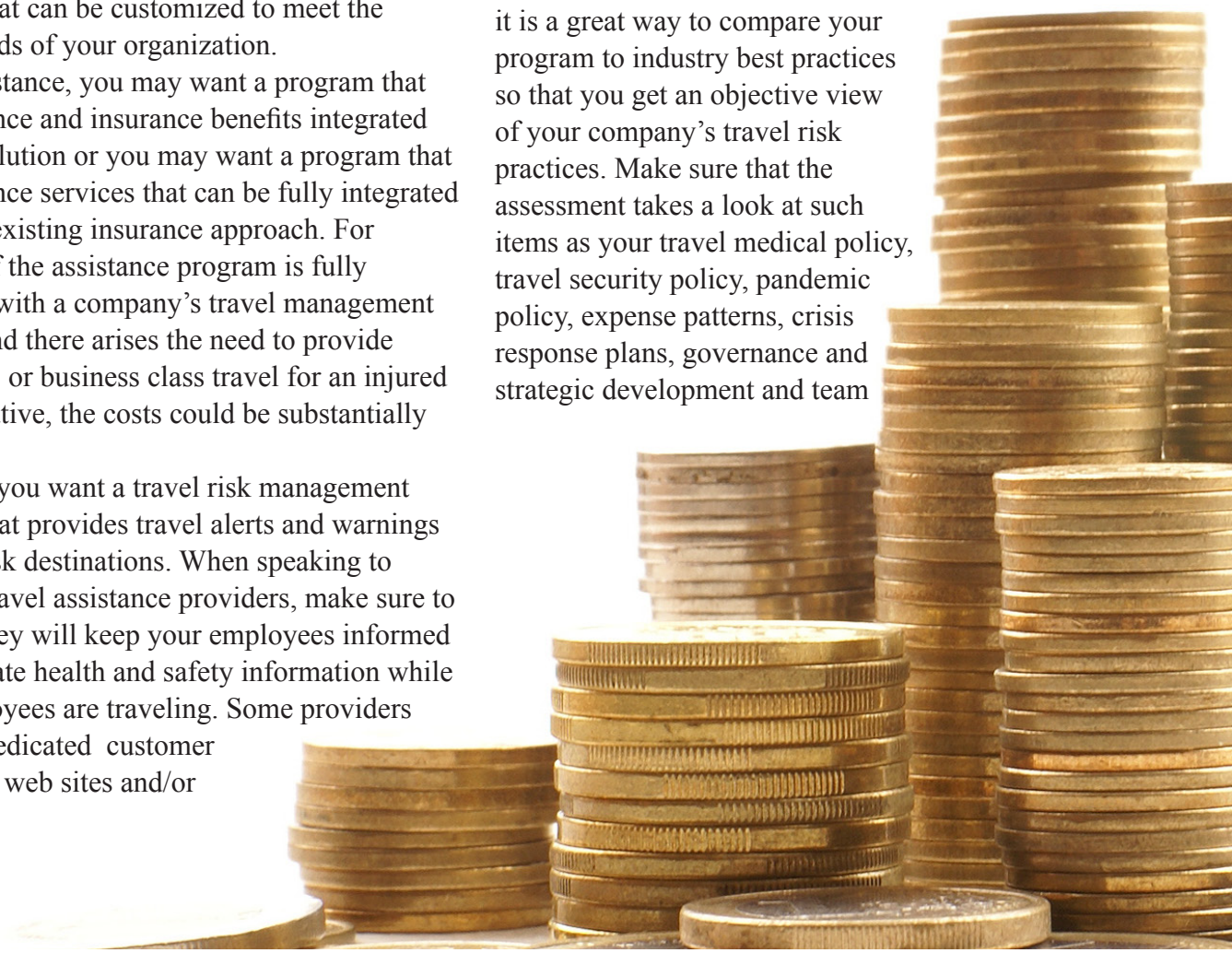
For instance, you may want a program that has assistance and insurance benefits integrated into one solution or you may want a program that has assistance services that can be fully integrated with your existing insurance approach. For example, if the assistance program is fully integrated with a company's travel management program and there arises the need to provide last-minute or business class travel for an injured or ill executive, the costs could be substantially lowered.

Also, you want a travel risk management program that provides travel alerts and warnings for high-risk destinations. When speaking to potential travel assistance providers, make sure to ask how they will keep your employees informed on up-to-date health and safety information while your employees are traveling. Some providers maintain dedicated customer or member web sites and/or provide the capability to send e-mail alerts and text messages with the latest updates. In addition, examine the cost drivers once you have fully assessed a provider's quality.

## Ask these questions:

- Is there a fee for service?
- Is there a mark-up for third-party expenses?

If you currently have a program, but you're not sure if it's working as efficiently as it possibly could or providing all the services your company needs, request that an assessment be performed. Some providers will do this free of charge, and it is a great way to compare your program to industry best practices so that you get an objective view of your company's travel risk practices. Make sure that the assessment takes a look at such items as your travel medical policy, travel security policy, pandemic policy, expense patterns, crisis response plans, governance and strategic development and team



composition.

Lastly, but possibly most vital, is that once you've selected a provider and have a program in place, make sure you communicate this information to your employees on an ongoing basis. It doesn't do your employees any good if you have a great travel risk management program that they are not aware of when they travel. Offer this information in your company newsletter. Also, consider sending internal e-mail blasts that are repeated and instruct department heads to brief their staffers about this program. Communication and understanding of these programs are essential, if they are to be utilized to their fullest potential and greatest benefit to travelers within your company.

Knowing this important information in advance is a key component in being able to contain costs and manage an efficient and well-developed travel program. And, at the same time, you can provide Duty of Care and quality care for employees who are venturing out to the far reaching corners of the globe.

Shawn Austin is the Senior Vice President, Employer Markets at the Accident & Health Division of Chartis


# CUSTOMIZE YOUR VISION PLAN

# INCREASE YOUR BENEFITS ROI

by Ken Stellmacher

Controlling benefits costs and enhancing employee productivity are top benefits objectives for most employers these days. At the same time, nearly 1/3 of Americans over the age of 40 have a vision problem.* This challenge finds its way into the workplace in the form of decreased productivity. One estimate reveals that uncorrected vision can decrease employee performance by as much as 20%.**

Helping your employees take care of their eyes by providing a vision benefit helps them and your company, but few realize that tailoring your vision coverage to the unique needs of your business can also help you achieve advantages in your health care cost and productivity battles.

The common starting point for selecting coverage to meet your business' needs is a standard vision plan. These plans typically include a comprehensive eye exam, basic prescription lenses, frame allowance, or contact lens allowance.

Many companies stop there and fail to realize the opportunity to impact their health care costs and employee productivity. By taking the next step of considering customized vision plans via additional plan options or enhancements, you can have your cake and eat it too.

**Here are a few plan enhancements that you should consider to maximize the return on your vision care investment:**

## Diabetic Eyecare

Diabetes affects roughly 24 million Americans. Eye doctors can be the first line of defense in detecting signs of diabetes in their patients through a comprehensive eye exam. By detecting chronic conditions early, employers can save money in the long run in overall healthcare costs. Americans living with undiagnosed diabetes incur an estimated $18 billion in healthcare expenditures each year, or $2,864 per person in medical services and lost productivity from diabetes-related complications.*** A Diabetic Eyecare Program may provide additional eyecare services specifically for members with type 1 and/or type 2 diabetes including medical follow-up exams, specialized screenings and tests, and medically necessary retinal imaging.

## Laser Vision

This plan enhancement offers additional coverage for laser vision correction surgery by providing discounts which can add up to hundreds of dollars in savings. Additionally, some plan designs can cover a portion or all of the cost of popular laser vision procedures such as, Custom LASIK, Conventional LASIK or PRK.

## Computer Vision

Computer eyestrain is America's number one office health complaint, ahead of carpal-tunnel and neck and back pain. There are vision plans that offer a program specifically designed to help prevent, manage and treat the symptoms. Almost 90% of those who work on computers at least three hours a day suffer from eye trouble. This makes eyestrain the most common complaint of office workers. The culprit? It may be Computer Vision Syndrome, a condition that comprises a wide range of issues from extended computer use, including neck and shoulder pain, headaches, dry irritated or fatigued eyes, blurred vision and loss of focus.

## Eye Safety:

This product makes sense for employees requiring on-the-job eye protection. Every day, about 2000 U.S. workers experience job-related eye injuries that require medical treatment. 90% of these

injuries are preventable when employees wear the proper eye protection****. Those injuries add up to more than $300 million a year in lost time, medical expenses and workers' compensation claims*****. By putting a safety eyecare plan in place, you're likely to have to have more productive, injury-free employees and significantly lower your healthcare and employment costs.

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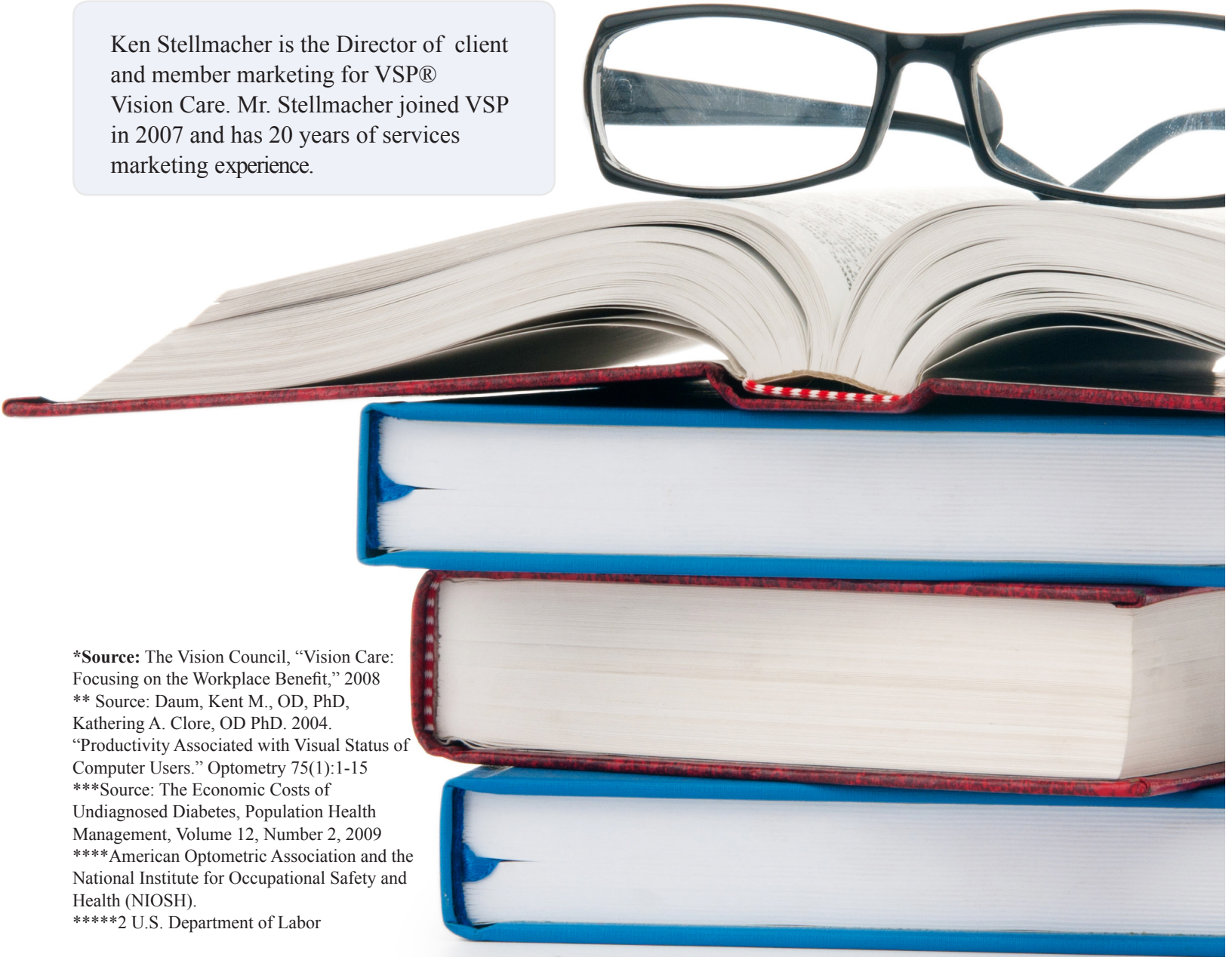

***Source:** The Vision Council, "Vision Care: Focusing on the Workplace Benefit," 2008
** Source: Daum, Kent M., OD, PhD, Kathering A. Clore, OD PhD. 2004. "Productivity Associated with Visual Status of Computer Users." Optometry 75(1):1-15
***Source: The Economic Costs of Undiagnosed Diabetes, Population Health Management, Volume 12, Number 2, 2009
****American Optometric Association and the National Institute for Occupational Safety and Health (NIOSH).
*****2 U.S. Department of Labor

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