June
2011
Issue 24

Voluntary Benefits Magazine

Official Magazine of the Voluntary Benefits Association

Who's Keeping Me Well?

Pg 11

Small Potatoes~

An Article on Vision

Pg 20

The Vision for a Strategic Alliance

Interview with Aetna & Allstate

Pg 6

EDITOR'S LETTER

Rob a Bank for Healthcare - The Only Option in 2011?

This indeed did seem like the only option for Richard James Verone, a 59-year-old from North Carolina, who robbed a bank on June 9, 2011 claiming this was the only way for him to get coverage; because they have to provide healthcare in prison.

Verone handed a note to the teller claiming he had a gun, and demanded $1 US dollar. After she gave it to him, he sat in the bank's lobby waiting for the police to arrest him. He asked only for one dollar so that it would be clear his motive was not to rob the bank, but get arrested for medical care. He has no job, two ruptured disks and a growth on his chest. He hoped he would be sent away to prison for three years and that would allow him time to get all the medical care he needed to be healed. Verone told reporters, "If it is called manipulation, then out of necessity because I need medical care, I guess I am manipulating the courts to get medical care." Unfortunately for Richard, it is estimated he will only get sentenced to 12 months in prison, and may not get all the medical treatment he intended to.

I think as individuals, many of us who are involved in the healthcare and health insurance industry forget about the people who don't have or can't afford health insurance. We forget to put ourselves in their shoes, to feel their fears, pain and desperation. We are removed by it all, because while it is an emotional topic, we have health coverage, we may not be happy with it, it may be expensive, but we have it.

It's not a healthcare crisis; it's a healthcare disaster. It's not getting better, it is only getting worse, and the passage of healthcare reform legislation will just continue to degrade it as costs are increasing.

Is this what America has come to? People committing crimes so they can get free medical care from the state while in prison? There are more and more Americans like Richard who don't have jobs, and in the future small employers may be forced to lay off more employees because of rising healthcare costs. Many small employers are getting renewals on their group health insurance as high as 40%. That's crazy! What happened to the promises of lower costs under healthcare reform? People are starting to finally realize, that's all it was, promises, and we need real healthcare reform and soon.

Jonathan Edelheit

VoluntaryBenefits Magazine.com

EDITORIAL STAFF

EDITOR
Jonathan Edelheit
jon@employerhealthcarecongress.com

ASSISTANT EDITOR
Megan Chiarello

ADVERTISING SALES
info@voluntarybenefitsmagazine.com

GRAPGHIC DESIGNER
Tercy U. Toussaint

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

Megan Chiarello
ASSISTANT EDITOR
561.792.4418
PHONE
866.547.1639
FAX
Info@voluntarybenefitsmagazine.com
E-MAIL

With Aflac Group Critical Illness, you can offer a powerful way for people to be prepared for whatever life throws their way. Unlike other carriers, Aflac pays 100% of the benefit for additional occurrences

Group Critical Illness— with some critical differences.

and re-occurrences, and offers guaranteed issue for employees and spouses. Not only that, but we cover children at 25% of face amount at no charge. With features this remarkable, no broker's arsenal should be without it. Get the critical info at **aflac.com/critical** or call **888-861-0251**

NAD1121

BENEFITS CONSULTING | ENROLLMENT SERVICES | GROUP AND INDIVIDUAL INSURANCE

Aflac®

We've got you under our wing.®

VoluntaryBenefits Magazine.com

CONTENTS

Issue 25 • July 2011

FEATURES

6

The Vision for a Strategic Alliance-Interview with Aetna & Allstate

11

Who's Keeping Me Well?

17

Inpatient vs. Outpatient Observation Hospital Status

INSIDE THIS ISSUE


Employer Healthcare
CONGRESS.COM
2011 KEYNOTE SPEAKERS
BILL RANCIC
AND
DR. CECIL B. WILSON
OCTOBER 26TH-28TH 2011
CHICAGO, ILLINOIS
BILL RANCIC
WINNER
"THE APPRENTICE"
DR. CECIL B. WILSON
PRESIDENT
AMERICAN MEDICAL ASSOCIATION
THE APPRENTICE
AMA
AMERICAN MEDICAL ASSOCIATION
CorporateWellness CONFERENCE
3rd Annual Voluntary Benefits & Limited Medical Conference
2nd Annual SELF FUNDING EMPLOYER HEALTHCARE & WORKERS COMPENSATION CONFERENCE
2nd Annual National Healthcare Reform Conference

Voluntary Benefits Magazine Exclusive

The Vision for a Strategic Alliance-Interview with Aetna & Allstate

By Megan Chiarello

Both James Reid, head of Aetna Voluntary Plans, and David Bird, President at Allstate Benefits, have genuine excitement and enthusiasm in their voices. Upon the official announcement of the strategic alliance between Aetna and Allstate Benefits, Reid and Bird talk passionately about the decision to offer financial protection plans to Aetna's more than 33 million members and why both seized an opportunity to partner two Fortune 100 companies with strong brand recognition.

David Bird puts it perfectly when he quotes his predecessor telling him, "David, you'll never go broke splitting profits." Bird explains of the gentleman's advice, "It's another good description of why this partnership was so interesting to us." Both Aetna and Allstate will benefit from the incremental income generated from Allstate workplace voluntary benefits.

James Reid describes the alliance similarly, stating "I think that Aetna and Allstate recognize the significant opportunity as well as the good synergies between both organizations," and "when you look at a company that has traditionally played in the core medical benefits field with a company that played in the traditional voluntary medical field, you can see how those two get along very nicely."

Voluntary Benefits Magazine: Tell us about the unique partnership between Allstate and Aetna. How was it created and why?

James Reid: We felt that in selecting them as a partner and vice versa, them selecting us as a strategic alliance partner, it was a good fit. When you look at a company like Aetna that's been in business for well over 150 years and has played in the medical insurance field with individual and Medicaid, Medicare and group benefits, dental and group insurance, and life and disability, we really thought there was a good opportunity for us to really look at the voluntary space. We also wanted to look at an opportunity to form a strategic alliance that would

allow us to offer new products to our customer base that really focuses on providing them with financial protection.

David Bird: One of the reasons it was so interesting to us [to partner with Aetna] is based on studies done by LIMRA, the Life Insurance Marketing and Research Association. One employer survey found that over 75% of employers said they would prefer to purchase their voluntary benefits from a broker/agent/consultant with which they are already doing business. So if you think about that, Aetna's already there in the workplace. They are a trusted insurance provider. We think Aetna is well positioned to offer voluntary benefits products to their employer clients. Instead of watching them do this with someone else, we thought Allstate could offer a very attractive partnership with them in that type of program.

VBM: How would employers market the joint products to employees?

James Reid: There are a number of important elements that we are working on to make a smooth experience for brokers, employers, and their employees. Some of these key areas include -brochures and marketing materials, enrollment capabilities of how we receive enrollment data, whether that would be paper or electronic, online or a wire transfer, that we're able to get it from the employer and the prospective member to enroll with Allstate. We feel confident that it should provide a really good experience for customers, brokers, and members.

VBM: For insurance agents, would there be a unique commission structure and how would it be tracked?

James Reid: Our plan is to use options of the Allstate commission structure that they have in place. More importantly, we are really excited about introducing these products to the insurance agents and brokerage houses that we've done business with over the years. Brokers, as you know from what you've covered in your magazine so well, are looking for new solutions to provide their clients as well as new revenue streams for their own firms. We plan on using the Allstate commissions and discussing those individually with the partners that we do business with, and then following up on case by case opportunities with the customers that will have these products offered to them.

VBM: What are some of the additional advantages to enrollment options because of the partnership?

David Bird: These products are attractive to employers and employees because they provide financial protection and additional financial security to middle to moderate income working Americans and their families. The group critical illness and the group accident benefits are paid directly to an employee in addition to benefits from any coverage they have. From an employee perspective, these products give them some level of financial empowerment to then go out and address their medical needs. A recent article from Levi Marketing Research was titled, "50% of Americans Couldn't Come up with $2,000." That speaks to the need of middle –to- moderate-income Americans for financial empowerment that can come from owning these types of products and receiving benefits from them, in times of illness and injury.

James Reid: The advantage that we see for both parties is that we [Aetna] have customer and broker relations with a significant amount of group business and already have enrollment, whether it be our medical products, dental products or vision products, and group life and specialty products. We're doing enrollment for a majority of those cases, whether for Small Group Business, Middle Market customers or National Accounts, so the advantage is really where we have the customer today. We offer their core benefit offerings and now we can offer two new products through the group Critical Illness and Group Accident plans

that can be part of that enrollment offering. We have resources within our voluntary marketing team that will work with our customers if they decide to offer these products, to ensure that they develop customized marketing and enrollment strategies that meet the needs of each client and employee base. Allstate, as you well know, has a suite of enrollment options, as well as we [Aetna} have, that we're going to tap into. Allstate's capabilities, including administrative, are industry leading. We plan on using the existing relationship we have and hopefully bring in new ones with both national and regional enrollments, to make sure however the customer wants to enroll in these products, that we meet their needs.

`

VBM: Do you feel the Aetna/Allstate Alliance will spur other major health insurers like United Healthcare, Humana or Cigna to offer something similar?

David Bird: Humana has already done this, having acquired KMG Kanawha Insurance Company, which is in the voluntary benefits space. Via this acquisition, Humana has entered the voluntary benefits space and has these types of products available. In terms of United Healthcare and CIGNA, I'm not sure what they have planned, but I would think that they would want to follow suit in order to remain competitive and on a level playing field with others in the industry.

James Reid: I really can't speak for other carriers, but as I mentioned in your initial question, I believe that the opportunity and synergies between Aetna and Allstate are tremendous. Creating the Group Critical Illness and Accident Products, with our core products, provides new opportunities for customers to provide their employees some protection, so I wouldn't be surprised to see other large carriers try to get into this space in a different fashion.

VBM: In your opinion, do you feel this alliance will change employee benefit plans in the future?

James Reid: I think that between both organizations, we hope it changes it significantly. That is why we are partnering and creating this strategic alliance with Allstate, but I think that based on the trend that you've [VBM] seen and that you've [VBM] reported on, we're seeing a shift in and convergence between the traditional core medical benefits coverage and the traditional voluntary plans, to get it to address some financial needs and affordability for consumers. As consumer directed health plans become more rapid and are more uniform, we feel that consumers will see a degree of visibility and transparency on what they're spending on healthcare and what their expenditures are. With this newfound visibility, it's very important that these types of products are out there to meet the unique needs of each individual customer. I think there has been a shift in the voluntary sales over the last ten years and you've seen a significant growth in these types of products and in that market space because that really addressed the needs of the employers, their members and their employees. I think you'll continue to see that over the next few years.

David Bird: I think voluntary benefits are becoming more and more accepted in the industry and accepted by employers and employees—they're almost really starting to blur and transition in categorization from being voluntary to being part of the core offerings. As the voluntary products we know today are being integrated with the medical insurance plans offered by Aetna, I think that's going to make them more prevalent and accepted in the industry.

VBM: What are the key components you feel Voluntary Benefits Magazine readers should know about the Aetna/Allstate Alliance?

David Bird: I think the key components are the things we mentioned, as I described in the partnership. Generally, the structure is the key and how unique the alliance is. We're excited about it and I think Aetna is as well.

James Reid: I would say really trying to provide best in class product, distribution, and brand. I think that between the products that we offer historically at Aetna and partnering with Allstate, we can come into an employer and can really say we can meet the unique needs of you as an employer as well as the very individual needs of your employee. When you think about brands, Allstate and Aetna are two brands that are known not just in the voluntary and the traditional medical business, but brands that are reputable and known worldwide. I think that there is a significant opportunity in knowing how we structured the deal, but really an opportunity to make sure that we create return to our collective shareholders; our plan sponsor customers, the brokers that we do business with, and most importantly, the people that we cover.

VBM: How do you feel the alliance brings value to the voluntary benefits industry?

James Reid: We have to deliver on the value of proposition that both David [Bird] and I stated collectively for our organizations. From the beginning, I think that the alliance will create significant awareness and opportunity that the convergence of medical coverage and the traditional voluntary coverage are crossing over. This alliance highlights the fact that two companies are really coming together to make sure that they're helping plant sponsors, helping members and brokers they do business with, and meeting the needs of their clients.

3rd Annual Employer Healthcare CONGRESS.COM

EXHIBIT HALL

CRACK THE 6 DIGIT SAFE CODE

HAVE A CHANCE TO

WIN EITHER

$200,000

— OR —

A LAMBORGHINI

3rd Annual Corporate & Wellness Conference

3rd Annual Voluntary Benefits & Limited Medical Conference

2nd Annual SELF FUNDING EMPLOYER HEALTHCARE & WORKERS COMPENSATION CONFERENCE

2nd Annual National Healthcare Reform CONFERENCE

Terms and Rules Apply. Contact Event Manager for details on complete rules and terms. Not everyone is eligible to participate. Contest provides opportunities for eligible participants to attempt to enter a six digit code for a chance to win $200,000 or they can use those funds towards the purchase of a new Lamborghini. Contest may be discontinued at any time without notice for any reason. Payment will not be made unless all requirements of the insurer are met and recipient complies with all insurer requests and rules. This contest does not guarantee a winner.

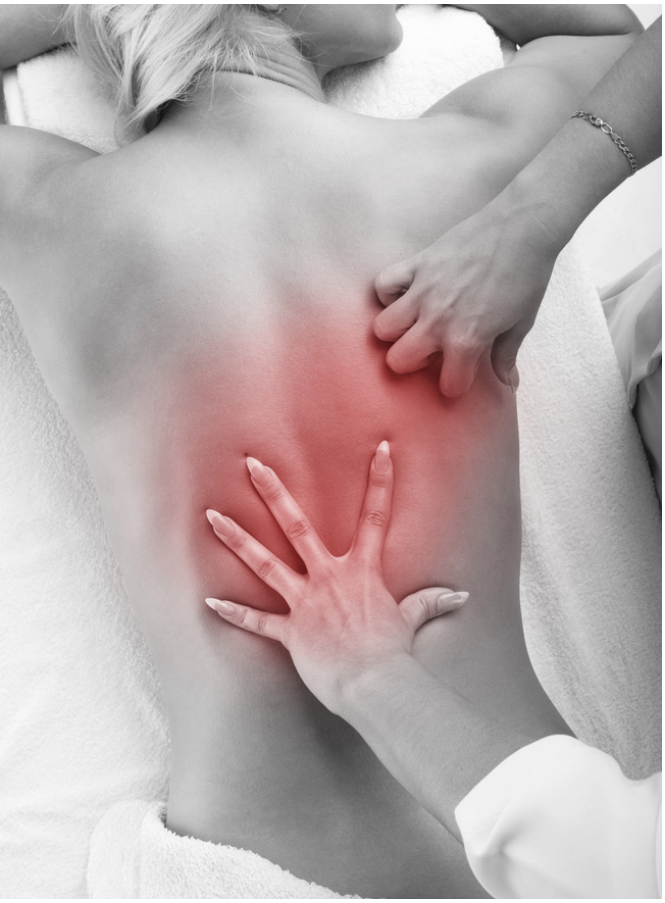
Who's Keeping Me Well?

By Mark Roberts

Disease management comes in many forms, depending upon the health care issue and case size. One question that employees ask when going to a health care facility or personal physician, especially if the medical situation is critical or urgent, is: "Who is going to take care of me?" Even when going to a primary care center or family physician practice, patients often are not sure what doctor they will see, or what quality of care exists, unless they are seeing someone with whom they have an established medical history and case management over time.

Disease management is an approach to health care that teaches patients how to manage a chronic disease. Patients learn to take responsibility for understanding how to take care of themselves to avoid potential problems or exacerbation, or worsening, of their health problem. The concept of teaching patients disease management was initiated to improve the quality of a patient's care. The theory was that if patients learned to take better care of their health problems, it would save the insurance company money, according to Advo Connection.

Chronic illnesses can range in severity from troubling to debilitating. Either way, health plan members need help handling treatments, medications and learning better ways to manage the disease at home, according to McKesson. As the number of people in the United States with chronic illnesses continues to increase, more people will need assistance. In 2006, 28% of all Americans had two or more chronic conditions, and in the future, it gets worse.



According to Managed Care Magazine, it's an American epidemic — 70% of all US deaths are related to a chronic disease. Half the adults here endure at least two ever-present illnesses, according to the National Council on Aging (NCOA). Traditionally, the focus has been on medical treatment of each condition, but the growth of the affected population calls for innovative strategies to delay disease progression, improve function, and tackle the daily problems of life with a chronic ailment. Also, the NCOA reports that 75% of health care costs stem from chronic conditions.

When diabetics' blood sugar is so out of control they face amputation or blindness, throwing a lot of treatment at them won't change the trajectory very much, but giving them access before that point to self-management programs with proven efficacy offers a chance to improve their condition. That's the big payoff. If people with chronic diseases take better care of themselves, they stay out of the hospital and costs go down. Becoming more involved in their health is good for patients and the bottom line. It's a win-win. When health care organizations are asked about why they offer chronic disease self-management, the most common answer is, "They deliver results."

There is a growing national trend toward health care organizations finding more ways to serve people with chronic conditions, according to NCOA. Are disease management programs delivering value to the client? Employers and health care organizations must also look carefully at ROI as well as effects on individual behavior. For managed care providers, a big goal is bending the curve — decreasing the increases. If costs have been rising 8 to 10 percent, the hope is that they will rise only 5 to 7 percent or less. Some companies have almost flattened the curve. Others are beginning to ask how they can contain increases.

Group participants are more likely to ask questions and discuss medications with their doctors. If they set realistic personal goals, they can sometimes reduce the dosage, or even come off medication. If they make changes to food choices — by reading [nutrition] labels and controlling portion size — and increase any [physical] activity, they can lower their blood pressure. When they're at the point of diabetes, most patients--if they don't already have hypertension or cardiovascular disease--are at very high risk. All these tasks help patients reduce the risk of more challenging medical situations.

The primary cause of poor health behaviors among people with serious chronic conditions is not lack of knowledge. It's depression and lack of confidence, often undiagnosed in this population. Sometimes the health system gives so much information that many people feel inadequate to the task and give up. Group support builds confidence and helps ease depression. Chronic diseases exact a substantial toll on people who live with them and the community at large. Healthy life choices, such as participating in a regular program to stay physically active, avoiding tobacco use, limiting alcohol intake and achieving and maintaining a healthy body weight, significantly reduce the risk for most common chronic illnesses, according to the Lance Armstrong Foundation.

The aim of disease management is to increase the delivery of appropriate care to enrolled patients. Policy options focus on expanding the use of disease management in public and private insurance programs, according to the Rand Corporation. There is mixed evidence about the effect of disease management on overall health spending. In theory, disease management programs use up-front investments in care management services to achieve savings through decreased treatment costs over the longer term. Evidence is mixed on the effect of disease management on spending. Disease management approaches vary widely. The effect of disease management on spending may differ depending on the disease management approach or the disease targeted.

Disease management (DM) programs attempt to improve the delivery of care to patients with chronic disease through self-care management techniques, patient education, provider training and individualized care plans based on clinical guidelines. In theory, if patients with a chronic disease receive better preventive and maintenance care, they will have fewer disease complications and require less intensive and less expensive care. Disease Management may also cause shifts in health care spending among types of services. For example, patients who improve adherence to drug therapy will see an increase in pharmacy costs.

Similarly, a primary goal of DM is to improve the coordination and continuity of care with the patient's health care provider. Thus, we would expect to see increases in the volume of outpatient visits to the primary care provider and, as a natural extension of such increases, increased laboratory and radiological diagnostics relevant to the disease and its related complications and co-morbidities. Ultimately, the effect of DM on spending will clearly depend on the targeted diseases, the severity of the illness, and the intensity, costs and duration of the program.

DM programs attempt to improve the treatment and management of chronic diseases so that complications can be avoided or minimized. To this end, they may encourage patients to seek more frequent outpatient care, increase diagnostic testing and increase use of pharmaceuticals, according to Rand. In doing

so, these programs try to avoid the use of more costly medical services, such as emergency department visits and hospitalizations. If DM programs succeed in changing patterns of health care use, there may be changes in consumer financial risk. Patient cost sharing may differ between inpatient and outpatient care, so changes in health service use could affect costs to patients. If DM programs alter health care use patterns, changes in the individual's financial risk will depend largely on his or her health insurance coverage.

Also, the goal of disease management (DM) programs is to improve the care of patients with a chronic disease so that expensive, potentially avoidable, and arguably wasteful care can be averted. To this end, DM programs encourage the use of appropriate services for patients with a chronic disease, according to Rand. Programs typically encourage patients to have regular follow-up with their physicians; however, many DM programs do not integrate significantly with these physician practices. Without such integration, these programs may add another layer of services and complexity to an already fragmented health care system. If that layer does not save costs, it may actually increase waste.

The measure of patient experience is the extent to which health care is delivered in a manner that is respectful of and responsive to the patient's needs, preferences and values. Patient satisfaction is an element of patient experience and refers to the degree which patients regard the health care they receive or the manner in which they receive it as useful, effective and beneficial. If DM programs increase continuity of care and disease control, patient satisfaction with care should increase.

In theory, disease management (DM) should lead to improved clinical processes of care,

reduced health risk behaviors and improved disease control; these improvements should result in improved clinical outcomes. However, it can be challenging to isolate the effects of DM programs from other efforts to improve quality of care and long-term trends in health outcomes. In addition, the health effects of improved disease control may manifest only over the long term. Health outcomes include both life expectancy and health-related quality of life. Low-income and minority populations, which suffer from greater morbidity from chronic disease, may not experience the same level of health effects from DM programs as other groups. In addition, health effects of DM may vary by disease and severity of illness.

Then, there is the whole issue about dental care and oral hygiene. Studies have shown that there is a correlation between dental health and medical health, according to Ambrose Employer Group in New York. When faced with increasing

Critical Illness Plan

INDIVIDUAL AND WORKSITE

"What's *Better* Than Waiver of Premium?

A Cash Lump Sum Equal to 6 Months of Premium!*"

That's Right!

If full benefits are paid for a covered Critical Illness, we will pay your client a **cash lump sum equal to 6 months of premium.***

- **Pays Lump Sum Upon Diagnosis of:** Cancer, Heart Attack, Stroke, Major Organ Transplant, End Stage Renal Failure, Coma, or Paralysis
- Simplified Issue up to $50,000
- Re-occurrence Benefit
- **Mortgage Protection Rider Available**
- **Great Commission**
- Personalized Marketing Support *that lets you focus on selling*
- Online Systems to Help You 24/7
- And Much More

health care insurance costs, one of the first things an employer may wish to do is consider lowering, or forgoing altogether, its contribution to employees' dental benefits. The rationale in doing this was to save employer contribution dollars on dental and be able to use those toward the increase in medical costs, keeping the increase to employees' medical contributions at a lower rate. An oral infection such as a cavity, tooth decay or gum disease can put you at risk for other problems like cardiovascular disease, diabetes, osteoporosis and Alzheimer's disease. Gum disease in pregnant women has even been linked to lower birth weights and premature births.

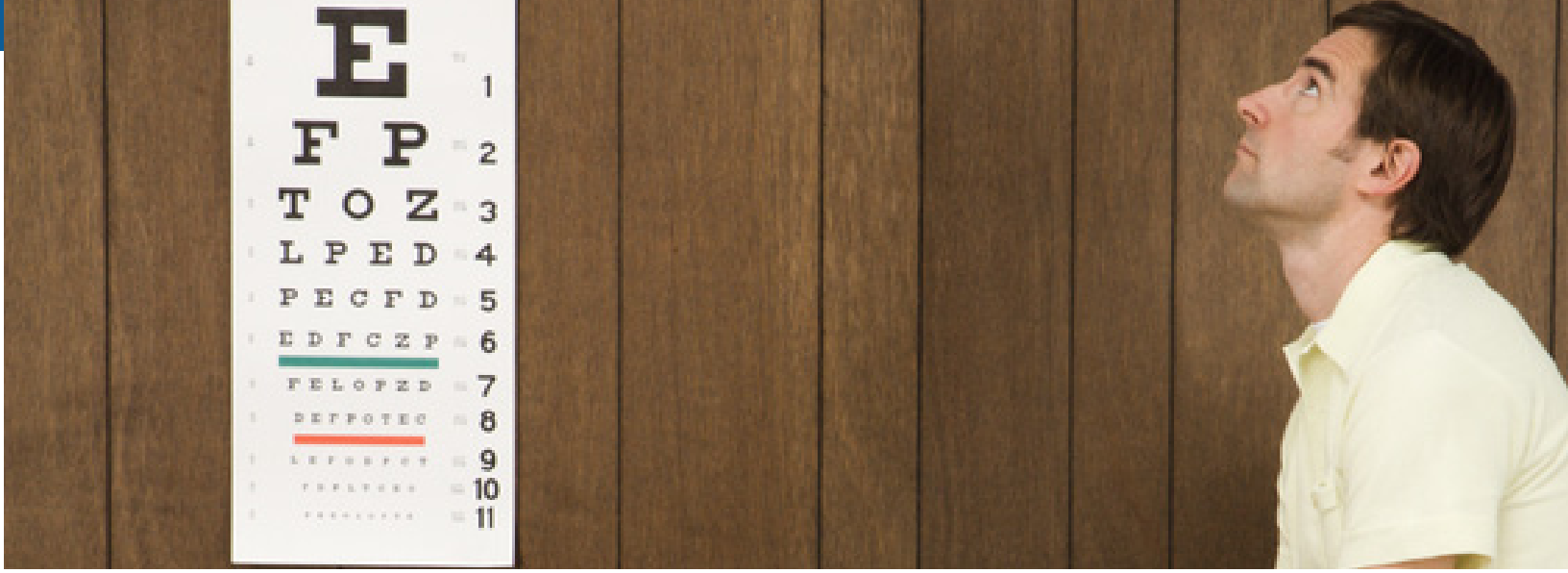
Now, consider the impact of changing your dental plan from one with a decent employer contribution to one with a very low employer contribution, or even no employer contribution at all. Doing this means you're increasing the cost for the employee to have dental coverage. And, at the same time, the employee's medical contributions are also likely to increase even with the extra money you pick up by not contributing to the dental plan. As employees look at their benefit options and see the increased cost of their dental coverage alongside the increased cost in their medical coverage, many are likely to drop dental coverage altogether to have less contributions coming out of their paychecks. These employees may then forgo dental care altogether (now that they don't have dental coverage), putting them at risk for more serious medical conditions, as reported by Employee Benefit News.

Consider the cost impact a heart attack or premature birth claim will have to your plan - much higher than the contribution you would have paid toward that employee's dental coverage. Plus, the financial effect of that claim on your next medical renewal will be much higher than simply keeping your dental plan contributions in place. Benefit budgets everywhere are stretched thin by increases in medical costs, and employers are looking to lower costs. However, rather than skimp on your dental plan, consider using it as a wellness tool to encourage employees to have better oral health, which in turn will lead to better overall health.

Consider even enhancing your contribution to the dental plan to encourage more employees to enroll in the coverage and get regular dental checkups. If nothing else, include 100% preventive care coverage on your dental plan. In addition, if you have a wellness plan, consider adding an incentive to encourage employees to get routine dental preventive care twice a year. If dental insurance cost is a factor, consider a discount dental plan. There are some good ones in the benefits market, including Aetna and Careington. Remember, managing your medical and dental health using preventive care goes a long way to prevent more critical or chronic disease from developing later.

Bio

Mark Roberts' professional sales background includes 30 years of sales and marketing in the tax, insurance, and investment markets. Mark is a licensed life, health and accident insurance agent in all 50 states and DC, for insurance products, and discount health plans. He serves as Manager of National Accounts at Careington International (www.careington.com). Additionally, Mark has been writing a health care blog for the past 3 years, found at www.yourbesthealthcare.blogspot.com , which is a topical weblog about various health care issues. He also regularly contributes articles to magazines for both medical and dental topics both in the US and the UK. You can reach Mark at markr@careington.com.



Inpatient vs. Outpatient

Observation Hospital Status

By James Baker

To detect and reduce Medicare waste, fraud and abuse, the Centers for Medicare & Medicaid Services (CMS), as well as many insurance providers, have increased scrutiny on the medical necessity of a one-day length of stay for inpatient admissions to hospitals.

In response to this, hospitals are now screening inpatient admissions for Medical necessity, and educating providers, nurses, administration and other staff on the medical necessity requirements for inpatient status.

The result has been an increase in the number of outpatient observation patients and an increase in confusion on what the differences are between inpatient versus outpatient (observation) status. I recently attended a presentation by a south central Pennsylvania area hospital COO who said outpatient observation status admissions at their hospital totaled ~2500 in 2007, whereas in 2010 they totaled >5000 (100% increase).

To see an example of how these guidelines are being used by the Blues in level of care audit reviews, go to: **https://www.bcbsnd.com/docs/providers/29306598_4.pdf**

Below are a series of questions and answers on CMS's guidelines for inpatient vs. outpatient (observation) status, which will hopefully help you become more familiar with this decision making process, since this criteria is also being used by the health insurance industry as a cost containment strategy.

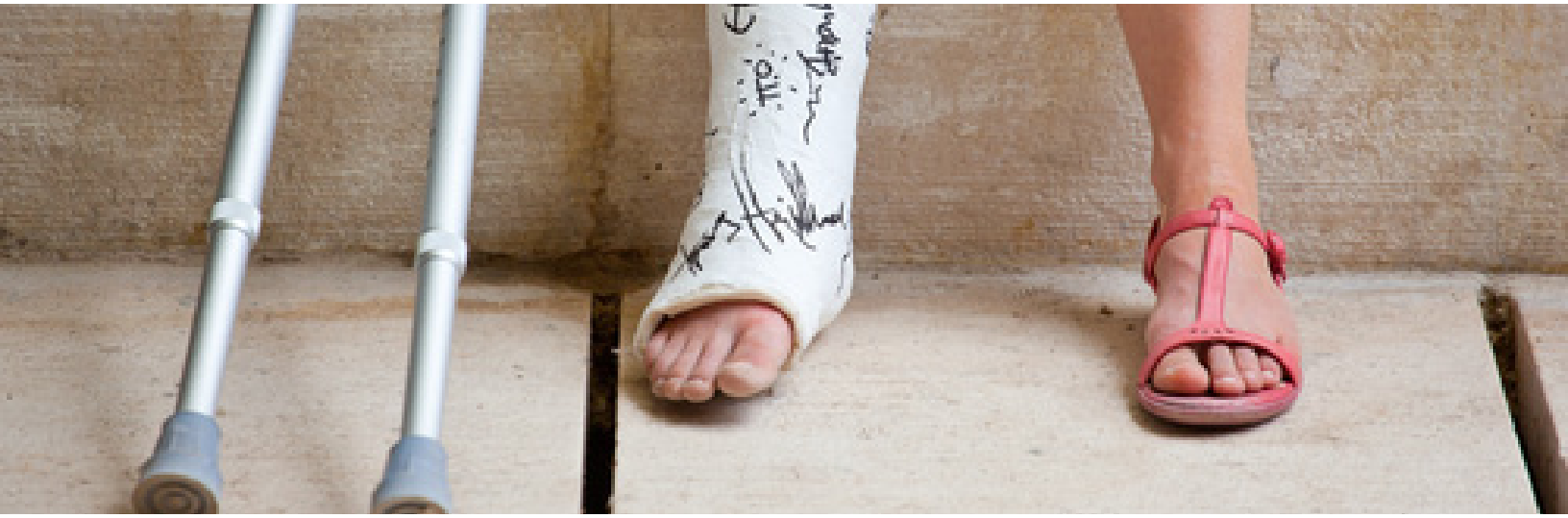
What does a Medicare patient pay as an "inpatient"?

Medicare Part A (hospital insurance) covers inpatient hospital services. Generally, this means you pay a one-time deductible for all of your hospital services for the first 60 days you're in the hospital. If you are hospitalized again after 60 days Medicare may apply another deductible.

Medicare Part B (medical insurance) covers most of your physician services when you're an "inpatient". You pay 20% of the Medicare-approved amount for physician services after paying the annual Part B deductible.

What is "inpatient" status?

Physicians and hospitals follow a specific set of clinical criteria (severity of illness and intensity



of service needed to diagnose and treat) that assists in determining whether a patient meets medical necessity for "inpatient" status in the hospital. The Centers for Medicare & Medicaid Services (CMS) has specific guidelines (medical necessity) on whether a patient should be Inpatient or Outpatient Observation — depending on how severe the patient's symptoms or condition is.

What is "outpatient" status?

"Outpatient" status is commonly referred to patients who typically go to an outpatient department such laboratory, radiology or to the Emergency Department for diagnostic services. Your physician may write an order for you to be admitted as an outpatient or observation patient at Austin Medical Center. The observation stay is intended for short term diagnostic testing and monitoring, which are reasonable to evaluate your condition. This is done to determine your need to be admitted to the hospital as a hospital patient or be discharged to go home.

Why is it important to know if a patient is an "inpatient" versus "outpatient observation" status no matter if they are on Medicare or not?

If you or a family member is in the hospital more than a few hours, always ask the physician or hospital staff if you're an "inpatient" or "outpatient or observation" because it WILL affect how you are billed and what you will have to pay for out-of-pocket.

Can a patient be an "outpatient" anywhere in the hospital, even if they were told they were being admitted to the hospital?

Yes. A patient can be receiving any service anywhere in the hospital (Radiology, Emergency Department, or nursing floor) and still be considered an "outpatient" according to CMS guidelines. The term "outpatient" is used by Medicare and other insurance companies for billing status only, not patient care status.

Who reviews a patient's health admission information to determine the criteria?

Your health care team, which includes physicians, nursing staff, and hospital case management staff (Utilization Management), reviews the medical record for the clinical information and applies the research-based clinical criteria utilized by CMS that provides a recommendation for either "outpatient" or "inpatient" status.

Your physician determines the final status however, if Medicare does not agree with the determination, Medicare will not reimburse the hospital for costs incurred. The hospital costs may then be billed to the patient.

Why am I an "outpatient observation" patient instead of an inpatient?

Specific criteria (based on severity of illness and intensity of service) must be met to admit a patient to the hospital. In some cases it is not immediately clear whether you are well enough to go home or if hospitalization is needed until further testing and evaluation is completed.

If a patient has been in the hospital over 24 hours, do they get changed from "outpatient observation" to "inpatient" status?

No. A patient status is only changed if they meet full "inpatient" medical necessity or severity of illness criteria.

What does a Medicare patient pay as an "outpatient" or "outpatient observation"?

Medicare Part B covers outpatient hospital and physician services. Generally, this means you pay a copayment for each individual outpatient hospital service. This amount may vary by service.

For more detailed information on how Medicare covers hospital services, including premiums, deductibles and copayment, visit www.medicare.gov/Publications/Pubs/pdf/10050.pdf to view the Medicare & You Handbook, or call 1-800-MEDICARE (1-800-633-4227).

How does "inpatient" versus "outpatient observation" status in the hospital affect the way Medicare covers care for the patient in a skilled nursing facility (or nursing home)?

Medicare requires a "qualifying hospital stay" for Medicare A to cover care within a skilled nursing facility. A qualifying hospital stay is defined as a hospital "inpatient" for a minimum of 3 days in a row — counting the day you were admitted as an inpatient, but not counting the day of your discharge.

For example, a physician may have determined that a patient be on "outpatient observation" status to help decide whether the patient needs to be admitted to the hospital as an "inpatient" or whether they should be discharged. During this time, the patient is still considered an "outpatient" even while receiving hospital services, which may include staying overnight multiple nights.

If you are still on an "outpatient observation" status even if you have a 3-day stay in the hospital, Medicare will not count this time toward the required 3 day minimum hospital stay for your stay in a Skilled Nursing Facility. If you are ready for discharge, you may need to either pay part of your stay at a Skilled Nursing Facility or ask for other options for payment. The hospital discharge planner or Social Worker can assist you and your family with these decisions.

Bio

Jim is employed as Sr Consultant Talent Management at the Manufacturers' Association of South Central Pennsylvania and a member of the Society for Human Resource Management. He is certified as Senior Professional Human Resources (SPHR); past president of MASCPA affiliated Employee Relations Council; past president of Hanover Area Management Association; past president of Hanover Area Human Resource Association; Past president of York Personnel Association, and past chair of Baltimore Industry (OFCCP) Liaison Group. A graduate of York College of Pennsylvania with a Bachelor of Science degree in Accounting, Jim earned his Masters of Administrative Science from Johns Hopkins University. Jim can be reached by emailing jbaker@mascpa.org

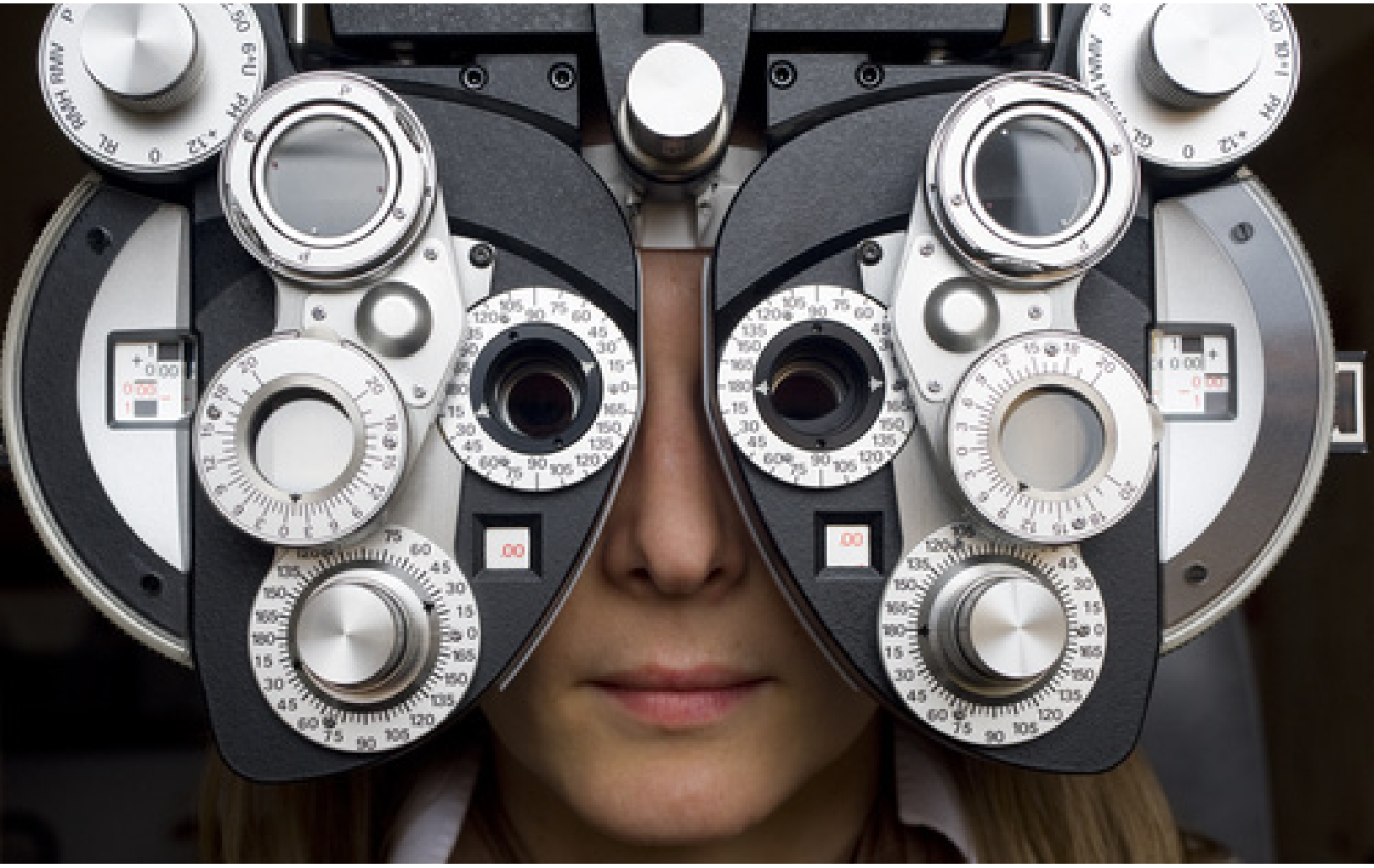
Small Potatoes~An Article on Vision

By Mike Locono

Sometimes a solution is right before your eyes – it might even be resting on your nose. It is all too easy to overlook an orchid while searching for a rose (if you don't remember Mickey Gilley, stay with me). In an effort to close the next Stop Loss Reinsurance sale or other big ticket item, a broker can easily neglect what may be the best relationship starter on the benefits horizon – vision. We all know the bottleneck created by an existing relationship or decision maker apathy, but with voluntary vision plans come the opportunity to start a relationship without stepping on an incumbent's toes. Normally, you are working on an unaddressed or inadequately addressed benefits issue. This humble beginning allows a producer with patience, access and wins kudos from employees as well.

Before you pick a favorite though – there are some markers in the road and the first sign reads, not all plans are equal. To be sure, there are some very consistent plan design patterns along with similar bells and whistles – but a little attention to detail can set you apart when someone else is trying to land the vision business or a less than great plan already exist at the group.

Network is very important with any benefit, but you may find some welcomed freedom when it comes to provider loyalty with vision.



There won't be the typical separation anxiety often felt when looking at dental or pediatric provider lists – instead, try to geo-search the relevant zip codes and ideally seek a mixture of private practitioners and big box operations for employee convenience.

Plan maximums can be a big deal, for example - don't settle for less than a $120 contact lenses allowance. Some carriers may separate out fitting fees from the available annual maximum for contact lenses; this is really great for the first time user or someone who needs to update their strength. The largest annual maximum I've ever installed was $250, but this was an anomaly for a big law firm.

Normally, "medically necessary" contact lenses are covered in full with a copay. Most consumers will be using the "elective" benefit, opting for contacts due to cosmetic reasons. Unless you are already a contact lenses user, expect to learn new terms like "toric" and become quite conversant with product subtleties.

Frequency of benefits can also be a moving part in the plan design process. The likely approach is 12/12/24 (exam once a year, lenses once a year and frames every two years). Similarly, you will see broad variety of copay setups for exam cost versus materials cost. Simply doing the math will allow you to evaluate relative overall cost to employees but if employer wants to incent a behavior of prevention, choose a lower exam copay than materials.

Even though vision is often under addressed health plans, it is not surprising to find an exam benefit (especially in managed care type health plans), so you may need to offer a "materials only" product for such a setting.

There are fewer sources for this approach and the relative cost reduction may be modest, so don't assume it is your only solution. There may be sub-constituency within an employer group that still need exams (e.g., dependents who aren't on the group plan for health) or even entire sub populations of employees who don't qualify for the health plan but may be offered voluntary vision.

LASIK eye surgery, though not typically covered by vision plans at all, may be represented in the package with access to discounted network services. Though the relative value of this discount may depend on a particular area, it is beneficial to have it included. Be sure enrollees understand it is only a discount – not a paid benefit.

Frame allowances may be quoted as a wholesale figure (you should know that mark up in frames could be similar to jewelry or furniture), but make sure you use apples to apples in case other plans show "retail" value of frames. Even eyeglass lenses have a myriad of variables like progressives for bifocals or polycarbonate lenses. Most plans will allow for cosmetic upgrades on frames, this is really handy for employees who take their divas in for glasses (also known as teenage girls).

Participants may find other ways to make the most of their voluntary vision program by creatively combining existing benefits under their health plan with the new benefits available with vision. For example, suppose a diabetic employee uses an MD for his eye exam that is covered under the health plan with a copay due to his health malady – but the doctor is not in the network. This employee may use his out of network benefit (normally much lower than in network but a fixed amount, say $35) to pay the office visit copay. After his MD gives him a prescription for glasses, this employee might opt to go to an in network provider to secure his prescription with just the materials copay. The point is to help enrollees think outside the box for ways to garner the most benefit from their plan.

Be careful, as with any voluntary benefit, about minimum participation issues and any late entrant penalties. Happily, vision plans can be one of the most accommodating and forgiving of benefits when it comes to underwriting.

Vision is a complement, not contraindication, when it comes to FSA's. Make it clear if you get push back that unlike an FSA alone, you are using the insurance company's money to buy the glasses while still benefiting from pre-taxed copays, premiums and upgrades that are your own money.

Some decision makers will actually challenge how the vision plan can deliver so much for the modest premium. I know this sounds like a good problem to have, but be ready – accounting types may well go there in the sales process. Of course, an underwriter would easily be able to address this, but I find that highlighting "mark up" of frames and provider discounts can help assuage some of the CFO's angst.

If you have been neglecting vision plans as small potatoes, wake up. We are talking fourteen carrot opportunity here. Do you see it?

Workplace Stress Strains Organizations' Bottom Lines

By Jacqulyn Ferguson

Stress is the plague of our nonstop, hyper, 21st Century lifestyle. Ignore the negative consequences at your own peril. The American Institute of Stress (AIS) definitively reports job-related pressure is the top source of stress for Americans, skyrocketing in recent decades. Organizations' bottom lines are eaten away by escalating health insurance and worker compensation costs for many conditions that could be prevented by reducing stress. For example, it's estimated that:

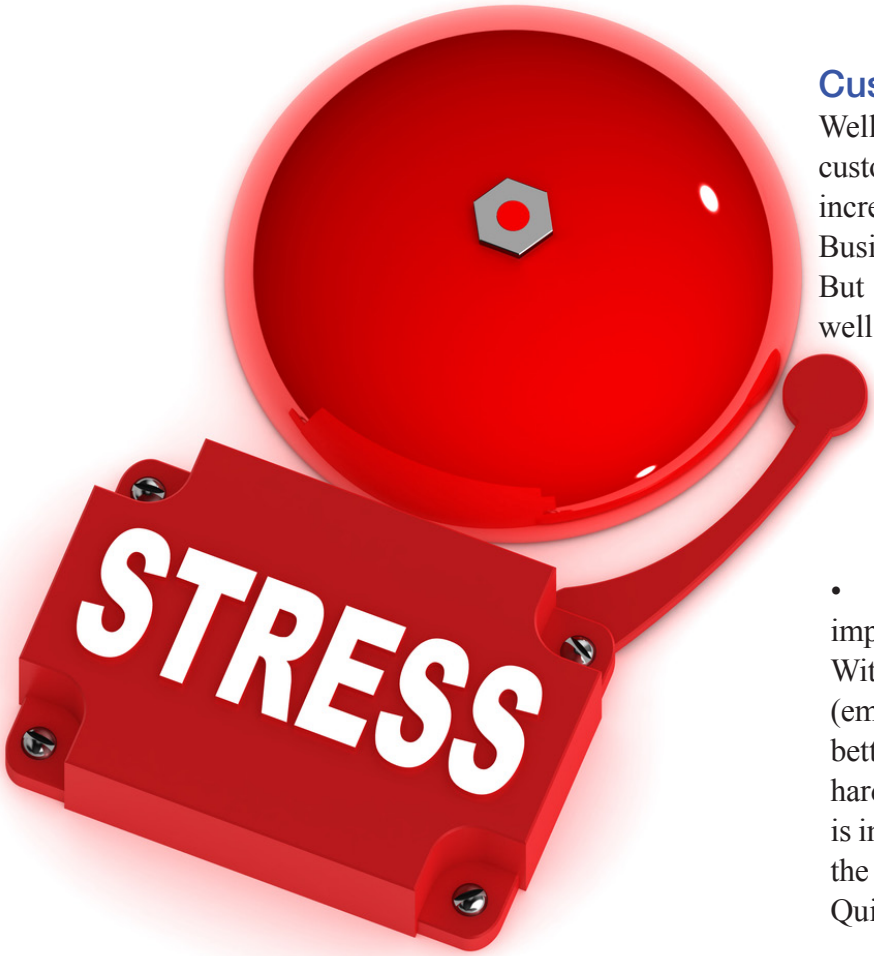
- Occupational pressures are responsible for 30% of workers' back pain
- 80% of workers feel stress on the job
- Nearly half say they need help learning how to manage it
- 42% say their coworkers need such help

The Great Recession

Whether organizations supply any, part or all employee health care coverage, they must understand employees feel stretched too thin from the effects of the Great Recession. More than ever, workplaces need to be made less stressful and more appealing to retain valued workers – especially as jobs open up elsewhere.

Rewards of addressing worker well-being

Robert Levering's book, "The 100 Best Companies to Work for in America" found companies that enhance worker well-being have more than twice the earnings per share and more than twice the rate of stock appreciation compared to the average Standard & Poor's 500 company.



Work stress is expensive

AIS statistics

Workplace stress in America is estimated at over $300 billion annually due to:

- Job turnover - 40% is due to stress
- Accidents
- Absenteeism
- Employee turnover
- Diminished productivity
- Direct medical, legal, and insurance costs
- Workers' compensation awards
- The 2000 Integra Survey of employees found:
  1. 60.2% routinely have work-related neck pain
  2. 44% strained eyes
  3. 38% hand pain
  4. 34% difficulty sleeping

Customer service suffers

Well-treated customers result in a 5% reduction in customer defection translating into a 30% to 85% increase in corporate profitability. Source: Harvard Business Review study by Reichheld & Sasser.

But strained employees don't treat your customers well enough and cause problems like:

- Loss of intellectual capital: Stressed-out employees don't focus on quality and improvement.

- "Organization's ability to make process improvements nearly always stops due to resistance. With overwhelming workloads … and going so fast, (employees) don't have time to make the process better. It creates a terrible cycle of trying to work harder … because the volume you have to put out is increasing, but you aren't doing anything to make the process more effective and efficient," says Jack Quirk of Blue Cross/Blue Shield.

- High-stress jobs with low control cause employees' thought processes to become more rigid, simplistic and superficial; not conducive to innovation.

- The more helpless a person feels, the less likely he is to come up with effective coping responses. Source: Dr. Martin Seligman's research on "learned helplessness."

Workplace accidents

When over-stressed, your distraction increases and attention narrows, leading to more accidents and injuries:

- High stress workers are 30% more likely to have accidents than those with low stress; 60% to 80% of on-the-job accidents are attributed to stress. Source: Jonathan Torres, M.D., of Workmed Occupational Health Services, ME;

• On average, stress-related accident claims are two times more costly than nonstressed related ones. Source: Harvard Business Review;

• A study of 3,020 aircraft employees found those who "hardly ever" enjoy their jobs were 2½ times more likely to report back injury.
Can you hear your bottom line chipping away?

Factors causing employee stress

Working longer and harder

Until around 1995, Japan had the record of most hours worked compared to the labor force of any other industrial nation. Now America holds this stressful record. According to a 2000 International Labor Organization study, Americans put in the equivalent of an extra 40-hour work week compared to 1990 and work almost a month more than the Japanese and three months more than Germans!

Absenteeism

From 1996 to 2000 the number of employees calling in sick due to stress tripled according to a survey of 800,000 workers in over 300 companies with an estimated one million workers absent daily. It's estimated to cost American companies $602.00 per worker a year. The price tag for large employers could approach $3.5 million annually.

Job insecurity

A 1999 government study found more jobs had been lost in the previous year than any other year in the last half century, and the number of workers fearful of losing their jobs had more than doubled over the past decade. And this was before the dot.com collapse of 2000 – 2001 and the Great Recession! How safe do you think your employees feel today?

Job demands versus control

The amount of job stress depends on the extent of

the demands and the worker's sense of control or decision-making freedom she has in dealing with them. Multiple scientific studies confirm workers who feel the stress of high demands with little control are at increased risk for cardiovascular disease.

"Tunnel vision"

Stress creates "tunnel vision," which causes judgment errors decreasing creativity and the ability to cope with change. When stressed, humans revert to familiar behaviors, making it harder to adapt to never-ending organizational changes.

Workplace violence

Work shouldn't be a scary place, but it is for many:

• On average 20 workers are murdered each week in the U. S. making homicide the second highest cause of workplace deaths and the leading cause for women.

• The Bureau of Labor Statistics reports that over two million Americans are affected by workplace violence annually making "desk rage," "phone rage," and "going postal" part of our lexicon.

• A 2000 Gallup Poll found:

1. 14% of respondents had felt like striking a coworker in the past year, but didn't
2. 25% have felt like screaming or shouting because of job stress
3. 10% feared a coworker could become violent
4. 9% knew of an assault or violent act in their workplace
5. 18% experienced a threat or verbal intimidation in the past year

Interpersonal conflict

The St. Paul Insurance report found the main causes of burnout were interpersonal demands from working with teams and supervisors.
Phew! That's a lot of stress.

But what constitutes too much stress?

Not all stress is bad. So how can a manager tell when their employees have too much?

An optimal stress level is the amount that makes you feel motivated to tackle the day's challenges. When you notice employees losing enthusiasm, stress may be the culprit.

Too much stress causes everything from physical illness and increased health care costs to resistance to change and high turnover, negatively affecting your bottom line.

Too little stress can be just as damaging.
Everybody has it, not just the weakest. According to 2006 surveys from ComPsyche and the Anxiety Disorder Association of America (ADAA), employees cite their top work stressors:

- Deadlines, 55%;
- Management, 50%;
- Workload, 46%;
- People issues, 28%;
- Juggling work and personal lives, 20%;
- Lack of job security, 6%;

The ADAA's 2006 Stress and Anxiety Disorders Survey found the most common ways employees react to stress:

- Caffeine, 31%;
- Exercise, 25%;
- OTC medications, 23%;
- Alcohol, 20%;

- Smoking, 27%;
- Eat (46% of women, 27% of men);
- Talk to family or friends (44%, 21%);
- Sex (19% for men, 10% for women);
- Illegal drugs (12% for men, 2% for women);

Fewer than 40% of employees whose stress interferes with their work have spoken to their employers about it mainly because they fear it would be:

- Perceived as lack of interest or unwillingness to do something
- Labeled "weak"
- Detrimental to promotion opportunities
- They'd not be taken seriously

Strive for a healthier workforce

When employees grumble about workplace stress around the water fountain, what do they say? Not knowing can cost you dearly.

With an improving economy, retaining employees is increasingly important. How many of your employees will jump ship to get away from their stress? Which ones can you afford to lose? How much does it cost? To understand how much stress costs you, management can begin by answering these questions:

- How can you help identify and relieve employees' main stressors?
- How can you give them more control over their day-to-day activities?
- How can you help them enjoy their jobs more?

Your answers, and more importantly your actions, to reduce their stress will gradually improve your bottom line.

Reduce turnover costs

Since an estimated 40% of turnover is due to stress, it's imperative to determine employees' perceptions

of their main stressors before creating a plan. Use employee surveys, exit interviews and their statements about what bothers them the most at work. Usually it's about situations over which they have little control.

Once identified, put the requisite amount of energy into preventing and decreasing their stress. Options range from stress reduction classes tilted heavily toward those with "how to" skills, to individualized wellness coaching for those in need.

Also, find out what your competitors are doing to help their employees. Some provide concierge services while others pay for on-site yoga classes.

A vital step for all employees - over-stressed or not - is to give them increased control over their biggest frustrations. For example, an employee who's distracted by a coworker talking to himself requested and received the right to work in a different part of the building when necessary.

Happy workers are more productive and more likely to stay Experiment with ideas to reduce employee stress and increase their satisfaction.

- Train all to do their jobs more efficiently and safely.
- Stop supervisory personnel from driving away your

staff by providing them with management training.

• Facilitate work and life balance by having teams manage many job functions vs. an individual. If an employee has her child's soccer game to attend, for example, other team members could cover for her; a wonderful motivator.

• Encourage employees to take weekends off and vacations. Price Waterhouse Coopers employees receive a pop-up reminder when sending an e-mail on a weekend: "…it's important to disconnect and allow others to do the same. Please send your e-mail at the beginning of the workweek."

• Flextime and creative scheduling help employees balance their work and home responsibilities.

• Give more personal time. HomeBanc Mortgage Corporation in Atlanta gives employees 24 "being there" hours for times they need a couple hours to take care of personal responsibilities without using vacation time.

• Offer regular stress reduction training to all.

• Offer individual stress coaching as needed.

• Concierge services pamper employees and decrease their errand-running stress. Employees pay for the services, such as dry-cleaning, but not for the concierge service itself.

• On-site childcare addresses many parents' biggest stressor. Offer it year-round, during the summer when school's out or before and after school hours.

• Serenity rooms offer a few minutes of solitude, particularly helpful for those who work in cubicles where there's no privacy.

• Encourage employees to take twenty minutes of work time to meditate daily and watch their errors decrease, energy and wellbeing skyrocket.

• HomeBanc sends massage therapists to each office monthly for free neck and shoulder massages. ARUP Laboratories subsidizes on-site massage where employees pay $5 for a 15-minute massage.

• Provide healthy snacks or meals during particularly stressful times of the year, like during tax season for accounting firms.

• Traditional wellness initiatives like subsidized health club membership, nutrition advice, health screenings for cholesterol and blood pressure, financial incentives for quitting smoking, and work time to exercise AND a variety of stress reduction classes such as prioritizing, assertiveness training, etc.

• Give everyone, yes everyone, their birthdays off!

A cost and benefit analysis can tell you if ideas that seem appropriate for your workers could actually save you money when compared to the high cost of turnover and increased insurance rates.

So what are you waiting for? With stress mounting in our frenzied workplace costing you every step of the way, how can you reduce stress in your organization?

Bio

Jaquelyn Ferguson is the founder of InterAction Associates, her speaking and coaching firm. For over 25 years Jackie has designed and presented keynotes and workshops on stress management, diversity, workplace harassment, motivation, and communication skills.

Jackie is also a Stress & Wellness Coach helping people achieve more success with less stress. Jackie is the author of "Let Your Body Win: Stress Management Plain & Simple" and a weekly column "Stress for Success" in Gannett Newspaper, at www.letyourbodywin.com.

Disease Prevention through Healthy Lifestyle Choices ~
Fitness and Proper Nutrition

By Deborah MacArthur

he mere mention of the words cancer, heart disease and diabetes strikes fear in all of us. These and other disease can affect the young and old, strong and weak, male or female. There are studies, theories, and a multitude of proposed ideas on preventing diseases. New studies show that certain diseases can be prevented through healthier lifestyle choices, including regular exercise and a good nutritious diet. By taking care of the body through proper nutrition and being physically active, it is possible to help ward off mysterious and often fatal diseases.

Regular exercise offers numerous health benefits, including an improved sense of well being, increased strength and flexibility, toned physique, increased body function, and better sleep and reduced fatigue. Research indicates that exercise can prevent certain diseases and cancers. Here is some food for thought:

• Exercise reduces obesity, which has been noted as major factor in some forms of cancers and other diseases. Generally, people who exercise grow into other good lifestyle habits including eating healthier to stay fit.

• Exercise speeds up your metabolism, which helps flush out food waste and other harmful substances. These toxins travel at a faster rate through the digestive track, which decreases the time that the colon tissue is exposed to waste and toxin.

• Exercise helps to balance hormone levels, which are often linked to certain cancers. The female hormone estrogen seems to play a key role. Exercise lowers blood estrogen, which helps lower the risk of breast cancer. Exercise also reduces other cancer-growth factors such as insulin.

• Dr. Inge Haunstrup Clemmensen, of the Danish Cancer Society, has theorized that regular exercise can boost the immune system, and having a strong immune system can stop the growth of cancer cells. Research by the American Cancer Society has indicated that an inactive lifestyle and poor diet are key factors to increased cancer risk, it becomeswhich makes imperative to add exercise into your daily schedule. Below are some suggested activities to engage in that will burn fat and boost metabolism. Keep in mind that the benefits of exercise increase as you increase the intensity:

1. **Brisk walking:** This can be done indoors on a treadmill, or outdoors around the neighborhood, or on a nature trail.

2. **Yoga:** A great stress reliever, as well as good physical activity.

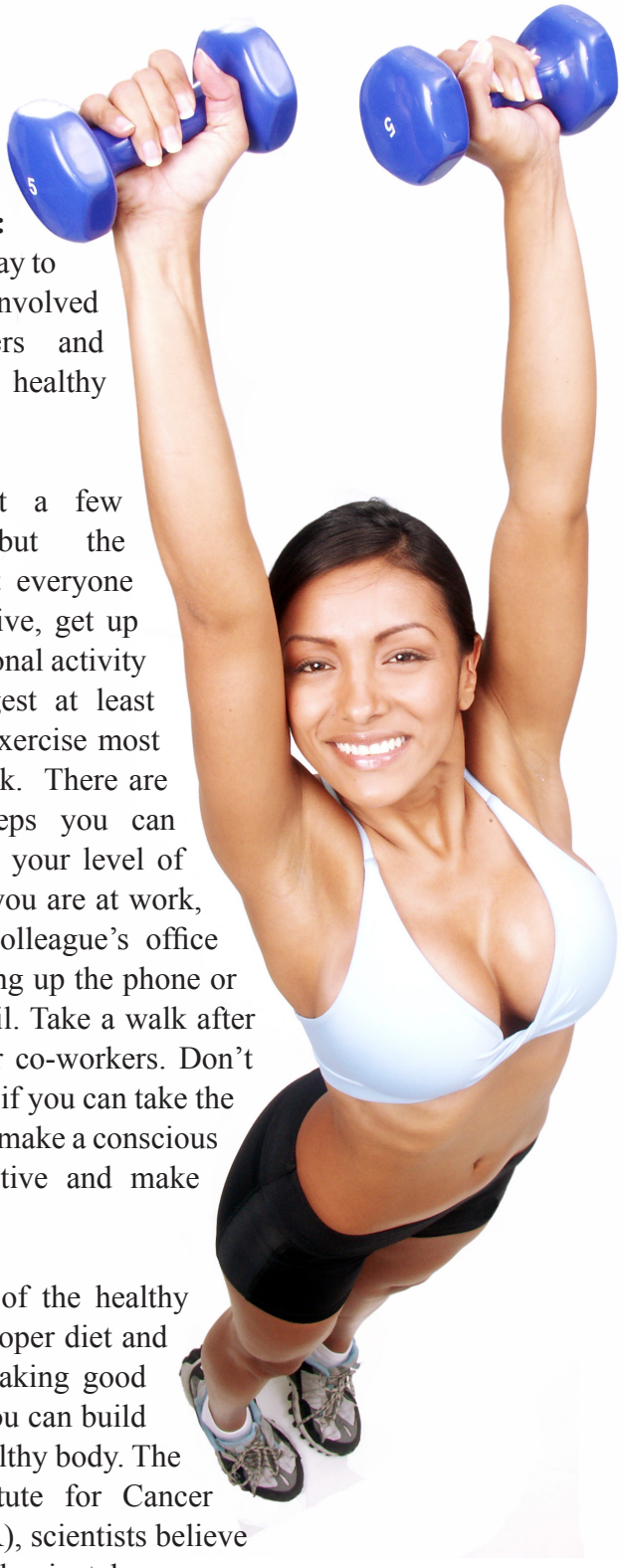
3. **Dancing:** You can put some music on and dance at home in your living room, at a dance studio or at the health club. Zumba and other dance-based aerobic classes are popular offerings.

4. **Swimming:** Uses all muscles in the body and is a great cardio exercise, which is gentle on the joints.

5. **Tai Chi:** This form of martial arts promotes good health through controlled breathing and slow moving exercises.

6. **Cycling:** Whether on a traditional or stationery bike, this is a great cardio exercise.

7. **Organize a team sport through your workplace:** This is a great way to be active, get involved with co-workers and enjoy some healthy competition.



These are just a few suggestions, but the message is that everyone needs to be active, get up and move! National activity guidelines suggest at least 30 minutes of exercise most days of the week. There are other small steps you can take to increase your level of activity. When you are at work, walk to your colleague's office instead of picking up the phone or sending an email. Take a walk after lunch with your co-workers. Don't take an elevator if you can take the stairs. Each day make a conscious effort to be active and make good choices.

The other side of the healthy living coin is proper diet and nutrition. By making good food choices, you can build a strong and healthy body. The American Institute for Cancer Research (AICR), scientists believe a diet based predominately on

plant-based foods may help protect against certain cancers. This type of diet includes vegetables, beans, fruit and whole grains. The fiber and water in plant foods gives a feeling of fullness without supplying a lot of calories. AICR recommends that two-thirds of your plate should be filled with vegetables, beans, fruit and whole grains, and one-third or less animal protein.

Below are recommendations regarding healthy lifestyle choices that will help prevent cancer from the AICR's Expert report. These coincide with the recommendations from the American Cancer Society:

1. Be as lean as possible without becoming underweight.
2. Be physically active for at least 30 minutes every day.
3. Avoid sugary drinks. Limit consumption of energy-dense foods.
4. Eat more of a variety of vegetables, fruits, whole grains and legumes such as beans.
5. Limit consumption of red meats (such as beef, pork and lamb) and avoid processed meats.
6. If consumed at all, limit alcoholic drinks to two for men and one for women a day.
7. Limit consumption of salty foods and foods processed with salt (sodium).
8. Don't use supplements to protect against cancer.

There are a multitude of reasons to fit regular exercise and proper nutrition into your daily schedule. This is an area of your life that you have control over, and making the proper choice may save your life someday. Keep in mind that the choices you make each day regarding exercise and nutrition impact your chances of getting cancer. You can begin taking steps today to protect yourself against cancer, heart disease and other diseases.

Many companies offer corporate wellness programs to provide the support and resources to their employees to make a healthier lifestyle a reality. If your company doesn't offer a corporate wellness program, consider being an ambassador at your workplace. You can suggest initiating a wellness program to your human resources department or company management. Your efforts will not only benefit you, but they might be instrumental to affecting others to make healthier lifestyle choices to prevent obesity, diseases, cancer and maybe even save someone's life.

Bio

Deborah MacArthur is the Director of Marketing and PR for FACTS Fitness, a Commercial and Corporate Fitness Management Company located near Philadelphia, PA.

FACTS Fitness is a one stop fitness management company offering corporate wellness and fitness programming, fitness staffing, fitness center design, corporate fitness IT programming, multi-tenant fitness facilities and more.

To learn more about FACTS Fitness services including corporate wellness programming, fitness management, fitness center design, etc. please visit www.factsfitness.com, email info@factsfitness.com or call 610-355-3236.

Cross Selling Made Easy!

By J.R. Jordan

Do you know someone who has suffered a heart attack, stroke or cancer?

I already know your answer, so let me ask you another question: "Was their quality of life affected in a negative way because of the critical illness they suffered?"

Once again, I already know your answer. One more thing: "If I could show you a product that would give you a check for $25,000 dollars (and up to $250,000) if you were to suffer a heart attack, stroke, cancer or any of the other covered critical illnesses, would you be interested?" Yes, I know your answer. Last question: "If unfortunately you suffered a heart attack, stroke, cancer or any of the other covered critical illnesses, six months from now would you like me to send you a check for $25,000 or a get-well card? You would want that check, wouldn't you?" You have answered "yes" every time and so will your client!

I have just shown you a new way to start every appointment. Read that first paragraph again. You just said yes four times! Isn't that how we are trained? Get as many yes answers in a row as possible so when it is time to close all you hear is, "yes"! Well, if you look at that last question that I posed, you would see that it is an automatic yes and it is the close!

I am going to show you how to save your clients money, provide them with more coverage than they have ever had before and put more paychecks in your mailbox or deposits in your bank than you have ever had before. I am going to show you how

to have at least one sale on every appointment you go on and three sales on more of them then you can possibly imagine.

Finally, I am going to show you how to make as much money as you want; all I ask in return is for you to give this system a try. Maybe it won't work the first time you use it and maybe you will get shot down the second, third and even forth time you try. I will tell you this, though: once you get this system down you will be making more insurance sales than you have ever made on one appointment before.

Let's get started. Here's what you need:

1. A major medical, health savings account, limited coverage health or membership plan to sell. 2. An accident plan with several options (e.g., $2,500, $5,000, $7,500 and $10,000.) 3. A critical illness plan. Make sure it is life based (you want those premiums guaranteed), and make sure the company knows the C.I. marketplace and ensure you have someone to turn to anytime you have a question or need anything at all. Here is a great way to cover your clients: sell them a critical illness plan (on both spouses), sell an accident plan with a face amount of at least $5,000 (for this example) and sell your client a major medical plan with a deductible of $5,000. This will give your clients life insurance, critical illness coverage, disability coverage, accident insurance, and in most cases, AD&D, emergency air ambulance and major medical coverage. It will give your clients more coverage than they have ever had before, it will be less expensive than what they were paying for that old $500 deductible major medical plan and it will provide you with three separate checks from three separate companies. So let me ask you another question: "Would you like one check a week from one company or three checks a week, some of them every day of the week from three separate companies?" Once again, I know your answer!

Here is a sample script to use:

When you sit down with your client they know that you are there to try and sell them health insurance. Start this way:

"As we both know, I am here to take a look at your current health plan or provide you with health coverage that you do not currently have. In order for me to give you the best possible coverage for the lowest price I need to ask you a few questions. Do you know someone who has suffered a heart attack, stroke or cancer? (YES) Was their quality of life affected in a negative way because of the critical illness they suffered? (YES) If I could show you a product that would give you a check for $25,000 dollars (up to $250,000) if you were to suffer a heart

critical illnesses, would that interest you? (YES) If unfortunately you suffered a heart attack, stroke, cancer or any of the other covered critical illnesses, in six months would you like me to send you a check for $25,000 or a get-well card? You would want that check, wouldn't you?" (YES) Now all you have to do is show the client the brochure and they are sold!

Sell Three Every Time:

"Did you know that when someone has to satisfy their deductible on a health insurance plan they usually do so because of a critical illness or an accident? I have shown you the critical illness plan and now I would like to show you the accident insurance. It would be best to go for a $5,000 plan, and I will explain that to you further when we cover your health insurance plan. For around $40 a month (in most cases) we can provide you and your family with accident coverage, too. Now let's get to your health insurance. (Remember that on a national average, switching from a $2,500 deductible to a $5,000 deductible will save your client around $200 per month.)

So, what is your current deductible? (Probably between $500 and $2,500.) Well, if we switch you to a $5,000 deductible it will save you around $200 per month. To cover the gaps from raising that deductible we now turn to the critical illness plan and the accident coverage we have previously discussed. We can add $40 per month of critical illness coverage on you and your spouse, a $40 per month accident plan that will cover you and your family, and then sell you that major medical plan with a $5,000 deductible. The critical illness and accident plans will cost about $120 for you and your spouse, but we have saved you almost $200 by increasing your deductible!

That means a savings to you of $80 per month and you now have life insurance, critical illness coverage, disability coverage, accident insurance, and in most cases, AD&D, emergency air ambulance and major medical coverage. You now have all of this for less than what you were paying for just health insurance."

There it is, ladies and gentlemen. You just sold three products, saved your clients money, gave them more coverage than they've ever had and ensured that your block of business will pay you for a long time to come!

One last thing: After you read these you will be in front of clients almost immediately. I would like you to imagine two scenarios:1. You read this and sold your client the critical illness plan. They call you in six months and say, "I had a heart attack. What do I do?" You tell them not to worry because they purchased the critical illness plan!

2. You read this and decide not to cover your clients with critical illness coverage and you get that same call six months from now. How many sleepless nights will you have after that call?

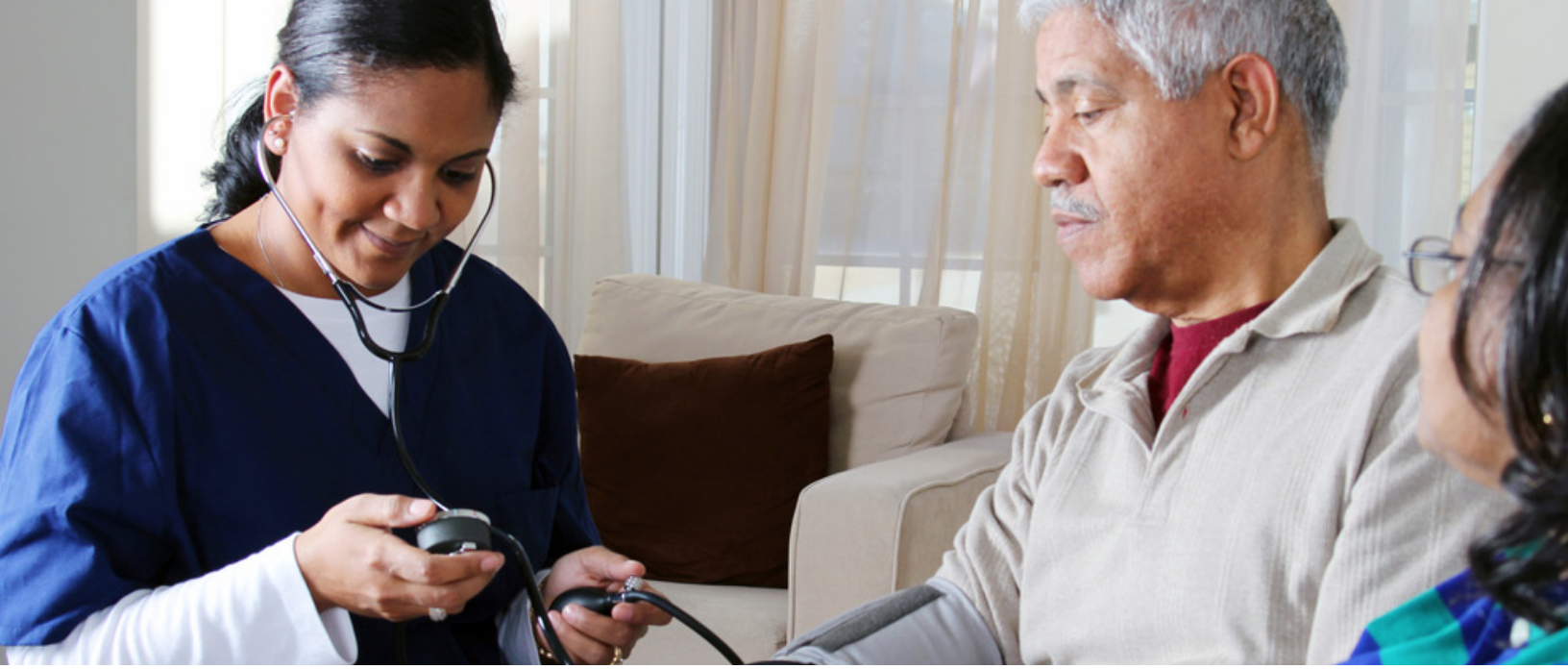
Bio

J.R. Jordan is the Senior Vice President of Colorado Bankers Services. For over twelve years he has focused all of his efforts in the ancillary product market, specifically critical illness & accident Insurance. Along with his brother and late father he has been a key player in bringing critical illness Insurance to the marketplace and has provided education, marketing tools/tips and training to thousands of agents nationwide. He is also a Nationally Acclaimed Certified Public Speaker and travels the nation conducting seminars and symposiums on cross selling and how to make an amazing living while embracing healthcare reform. You can follow him on twitter at www.twitter.com/jrjtalker to see where he will be speaking next! He can also be reached at (888) 455-7462

Join the Voluntary Benefits Association

www.VBAssociation.com

VBA VOLUNTARY BENEFITS ASSOCIATION



Diabetes and Its Effect on Future Employer Health Costs - Guidance for Employers

By Jonathan Spero

Diabetes is a disease caused by elevated blood sugar with medical complications, which are costly and devastating. According to the Centers for Disease Control and Prevention (CDC), the number of diabetics in the United States has grown to nearly 26 million, a 10 percent increase in the past 2 years.

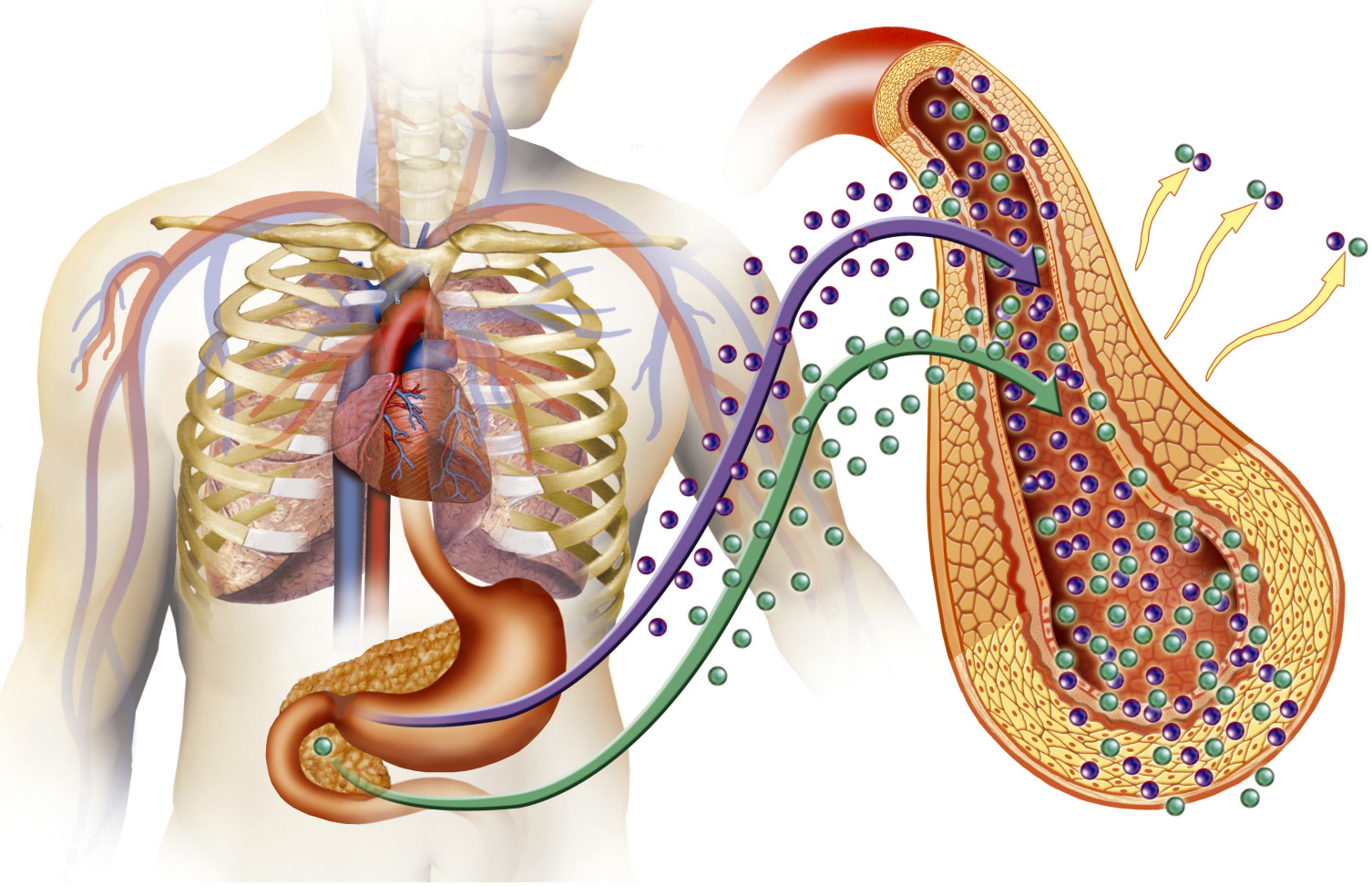
What is more alarming is that, according to the CDC, over 79 million adults in the U.S. are classified as pre-diabetic, a precursor of diabetes. This is a 33 percent increase in the past 2 years. According to the CDC, it is predicted that 25 to 33 percent of the U.S. adult population will have diabetes in 2050. (1,2,3)

So why are so many Americans developing pre-diabetes and diabetes?

The prevalence of diabetes is directly related to increased weight and age. With the epidemic of obesity, currently two-thirds of the U.S. population is either overweight or obese. In addition, the average age of the U.S. population is steadily getting higher secondary to people living longer and the baby boom generation now all above the age of 50.

How will this impact employers?

Well, it turns out that the cost of health care for people with diabetes is 230 percent more expensive than for people without diabetes according to the American Diabetes Association. (4) This statistic has been confirmed by a recent report from United Healthcare, which compiled data from 10 million members and found that the average annual health care costs in 2009 for a person with known diabetes were about $11,700 compared with about $4,400 for the non-diabetic public – 260



of this decade it is estimated that medical care for pre diabetes and diabetes will account for ten percent of the total healthcare spend in the U.S. Employers will bare a significant portion of this financial burden.

Why is care for diabetes so expensive?

To start, the actual medical care required to treat diabetes is costly. Furthermore, the complications of diabetes are very serious and enormously expensive to treat. These conditions include heart disease, kidney disease, eye disease, nerve disease, and many other conditions.

So what can employers do to address this issue?

The solution for this issue requires a three-pronged approach – screening, prevention, and disease management. The necessary tools are currently available for employers to tackle all three. Let's take a closer look at what these initiatives are and why all three are necessary.

Screening - – Almost 30 percent of persons with diabetes are not aware they have it.(5) Therefore, screening for diabetes is critical to diagnose the large population of persons who are undiagnosed. Furthermore, screening also identifies the much larger population of persons with pre-diabetes, a precursor of diabetes.

-Employers can screen their entire employee population for diabetes easily and inexpensively with a simple blood finger stick.

Prevention - – Modest weight loss achieved by lifestyle coaching can prevent persons with pre-diabetes from every developing diabetes. In fact, a large, nationally recognized study published in the prestigious New England Journal of Medicine demonstrated that achieving a modest 7% weight loss goal resulted in a 58 percent% reduction in the incidence of diabetes in a high-risk population that had pre-diabetes.(6)

-Employees with pre-diabetes must be encouraged to enroll in diabetes prevention program with a focus on proper nutrition and exercise.

Disease Management - By all measures, diabetes is sub-optimally managed by physicians in the United States. Poorly controlled blood sugar and lack of routine maintenance care leads to an accelerated risk of complications and increased healthcare costs. Several key diabetes studies have demonstrated that proper disease management intervention not only significantly improves HEDIS scores but also reduces healthcare claims for those patients enrolled in the program.

-Employers' investments in diabetes disease management programs show promise in delivering both short term and long-term health and financial benefits.

In summary, diabetes is an epidemic that will significantly impact the cost of healthcare for employers in the near future. There exists well thought out strategies for addressing this issue that demonstrate a clear return on investment.

Bio

Jonathan Spero, MD, is CEO of InHouse Physicians and board certified in Internal Medicine. Dr. Spero is an expert in the field of targeted employee wellness programs with measureable ROIs. InHouse Physicians is a global employee health and wellness provider delivering innovative cost containment solutions to corporations around the world. InHouse Physicians high touch employee health services include a wide range of offerings such as cost effective worksite health centers, evidence based "pre- disease" wellness initiatives, health screenings plus analytics, flu vaccinations, and travel medicine.

References

1. Narayan KM, Boyle JP, Geiss LS, Saaddine JB, Thompson TJ: Impact of recent increase in incidence on future diabetes burden U.S., 2005-2050. Diabetes Care 2006, 29(9):2114-2116.

2. Magliano DJ, Shaw JE, Shortreed SM, Nusselder WJ, Liew D, Barr ELM, Zimmet PZ, Peeters A: Lifetime risk and projected population prevalence of diabetes. Diabetologia 2008, 51(12):2179-2186.

3. U.S. Census Bureau. National Population Projections Released 2008 (Based on Census 2000).

4. American Diabetes Association: Economic costs of diabetes in the U.S. in 2007. Diabetes Care 2008, 32:596-615.

5. 2005–2008 National Health and Nutrition Examination Survey.

6. Diabetes Prevention Program Research Group N England Journal of Medicine 2002; 346:393-403 February 7, 2002.

Diabetes Management:
Corporate Programs Can Make a Difference

By Maureen Young

If you don't have diabetes, you may assume that it's managing the disease is a simple matter of staying away from sugar, testing your blood sugar and giving yourself an insulin injection. It's not that easy. Putting aside the fears that many people have regarding needles and the finger pricks required for managing this disease, it is much more complicated thant simple testing, injections and medications. Diabetes is an individual battle that people fight every day. It differs for everyone regarding in terms of what works, what they can eat and which particular outside factors affect them. Corporations can have an impact on their employees' ability to manage their disease, which will ultimately impact their bottom line.

The Rising Incidence and Cost of Diabetes

Diabetes continues to be a problem for millions of Americans, and it's costing us billions of dollars to manage and treat. According to the American Diabetes Association1, over one- third of all Americans will develop type 2 diabetes by the year 2050 unless radical changes are made in our lifestyle and eating habits. Over 57 million people have pre-diabetes or metabolic syndrome with a very high risk of developing diabetes, and over 24 million children and adults already live with type 1 diabetes. The difficulty lies not only in managing your blood sugar to prevent serious, life-threatening side effects, but keeping your health insurance to cover you if any serious

complications arise. If you have diabetes and you aren't paying attention to your glucose levels every day, you could be setting yourself up for severe problems.

In 2007 the total cost of Diabetes in the United States was $218 billion. Of this number $44 billion goes toward undiagnosed diabetes, pre-diabetes and gestational diabetes. Diabetes contributed to 231,404 deaths during 2007, and the number continues to grow as more Americans develop type 2 diabetes.

Of the remaining $174 billion spent on diabetes each year, $116 billion goes toward excess medical expenditures attributed to diabetes and $58 billion in reduced national productivity. People with diagnosed diabetes have medical expenditures that average 2.3 times higher than the expenditures of those without diabetes. Almost $1 in every $10 can be attributed to diabetes. The indirect costs include absenteeism, reduced productivity and lost productive capacity due to early mortality2.

People with diabetes between the ages of 18-64 average 8.3 lost work days per year as compared to 1.7 days per year for those without diabetes. The medical expenditures are significantly higher for diabetics at $10,071 per person and only $2,669 per person for non-diabetics3. Any headway that corporations are able to make in guiding people who liveing with diabetes toward better management of their disease would offer a considerable cost-savings to the corporation and to the American public.

Diabetes Complications Are Serious

There are so many factors that can affect glucose levels, and many of them are difficult to control. If the pancreas is working just fine, the body handles daily, small changes without any active intervention. Job or personal stress, lack of sleep, skipping a workout, a little too much salt, and obviously, too much sugar can interfere with balanced blood sugar. What if an employee's job is stressful causing a poor night's sleep, or they catch a cold or the flu? Even minor illnesses can cause glucose levels to rise. For diabetics, staying in touch with their doctor during these times is critical when blood sugar levels are difficult to manage. Doctors may recommend additional insulin injections or reduceing the amount if the patient is taking oral insulin.

Diabetes is an underlying cause in many health conditions, including heart disease and stroke, blindness, high blood pressure, and kidney disease. Maintaining a healthy, stable blood sugar level over time can reduce the risk of serious complications. Watching for stressful situations, which no one can avoid completely, and then making changes to account for fluctuations in glucose levels can mean the difference between saving a person's sight or limbs and continuing to be a productive employee.

Diabetes is the leading cause of new cases of blindness among adults ages 20 to -74 and the leading cause of kidney failure. Forty-four percent44% of new cases of kidney failure were attributed to diabetes in 2008. In combination with heart disease and stroke and non-traumatic amputations, the downside of ignoring large fluctuations in glucose levels can be disastrous. Every person is different, and this holds true for those trying to manage diabetes. Something that causes a major glucose shift in one person may be barely noticeable in another. In addition, beyond each person's individual reactions, over time those may shift within an individual that require constant adjustments to what may have been stable diabetes maintenance. Providing guidance and help for diabetics dealing with shifts in glucose levels and new symptoms is critical to a diabetic's long-term health and productivity.

What Can Businesses Do To Help Diabetic Employees?

The CDC has partnered with the National Institutes of Health to improve the treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately, to prevent diabetes. Together these organizations developed the National Diabetes Education Program (NDEP). Their document, Making a Difference: the Business Community Takes on Diabetes4, offers some guidelines to employers:

• Develop a supportive work environment so that employees with diabetes feel comfortable adopting and performing the behaviors that promote good diabetes control.

• Provide encouragement and opportunities for all employees to adopt healthier lifestyles that reduce risks for chronic disease.

• Coordinate all corporate diabetes control efforts within the organization to make them more efficient as well as accountable. (The NDEP publication shows successful examples.)

• Demand the highest quality medical care for people who are dealing with diabetes.

If corporations decide to embark on a program specifically tailored to diabetes management, one of the obstacles they will face is employee resistance for many reasons. Employees may worry about privacy and not want others to know that they are diabetic. They may not be ready to accept that they are ill and need to seek treatment. Whatever the cause of employee apathy, there are ways to increase employee awareness and participation in a new diabetes management program. Without employee buy-in, the program will falter and fail wasting dollars that could have been saved when employees control their diabetes well, reduce absenteeism and lost productivity and reduce complications due to diabetes. The website www.diabetesatwork.org provides tool kits and reference materials designed to help employers start a diabetes management program within their organization.

Promote Employee Awareness

Employees first need to become aware of the prevalence of diabetes and pre-diabetes in their community and in their workplace. Highlighting behaviors that contribute to the development of diabetes type 2 and how avoidance of those behaviors can reduce the chances of developing diabetes can alert employees to how easily their own behavior can increase their risks.

Specifically, some steps to increase employee awareness5 include:

• Including the local medical community in your efforts, so that they see the program as an aid to compliance and not competition.

• Work with other businesses in the community who may be interested in sponsoring specific events or promotions for the program.

• Invite an educator specializing in diabetes in for a company hosted brown bag lunch to discuss warning signs and symptoms of diabetes type 2 with focus on the importance of balanced nutrition and exercise.

• Post NDEP flyers and posters and include the NDEP newsletter in the internal corporate newsletter.

•Advertise the program in internal communications such as newsletters and email announcements.

Promote Employee Participation

Once employees are aware of the program, the right employees need to be encouraged to participate in the program5 to really see cost savings from decreases in absenteeism and medical complications that , which will raise health care costs and insurance premiums. Make sure that employees know that you value their privacy and that their information will not be shared with other employees and that it will not increase their health insurance premium.

Develop an incentive program for participation in the program. Financial incentives such as bonuses are effective, but other types of financial incentives can be effective as well. Provide financial coverage for testing supplies and in-house testing or health fairs to encourage frequent testing to control glucose levels.

Use in-house activities such as lectures or brown bag lunches and take advantage of national campaigns such as Diabetes Awareness month. Use targeted mailings sent to prospective participants.

It's Not a Sprint, It's a Marathon

Most of us deal with little surprises andor changes every day and just plow ahead. For diabetics the small changes in blood sugar caused by these little "inconveniences" could raise blood sugar consistently, leading to serious long term complications and increased health care costs. Insurance companies see people who do not manage their blood sugar well as high risk, increasing the cost of health insurance or raising the chances of losing it.

It will take time to see the financial benefits of a corporate diabetes management program, but with sincere effort and commitment, it can reap large rewards, like those recognized by GM with their LifeSteps Initiative6. GM saw a $2.70 to $1 ROI, the reduction or elimination of 185,000 health risk factors and an increase in low risk participants from 55% to 63.1%. Diabetes is not a disease to be taken lightly. It requires serious attention, EVERY DAY, and can't be ignored. Help your employees manage their disease better, so that they are in control of their diabetes and keep them happy, healthy and productive!

Bio

Maureen Young is a Consumer Education Advocate for ANY LAB TEST NOW®, a healthcare lab testing facility. She is a writer, health care advocate, and fitness enthusiast driven to explore advances in the health care and medical industries and share her research with the public.

References

1http://www.diabetes.org/diabetes-basics/diabetes-statistics/
2The Lewin Group, "The Economic Costs of Diabetes in the U.S. in 2007," Diabetes Care, March 2008, vol, 31 no. 3, 595-615
3American Diabetes Association, Economic consequences of diabetes mellitus in the United States in 1997. Diabetes Care, 1998; 21:296-309.
4Centers for Disease Control and Prevention. Making a Difference: the Business Community Takes on Diabetes. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1999. NDEP Pub #33.
5http://www.diabetesatwork.org/NextSteps/AwarenessAndParticipation.cfm
6Tim McDonald, PA, Michigan Department of Community Health, Workplace Wellness Chronicles, August 2005. Online at http://www.michigan.gov/documents/MDCH-Chronicles-GM-0805_134908_7.pdf.

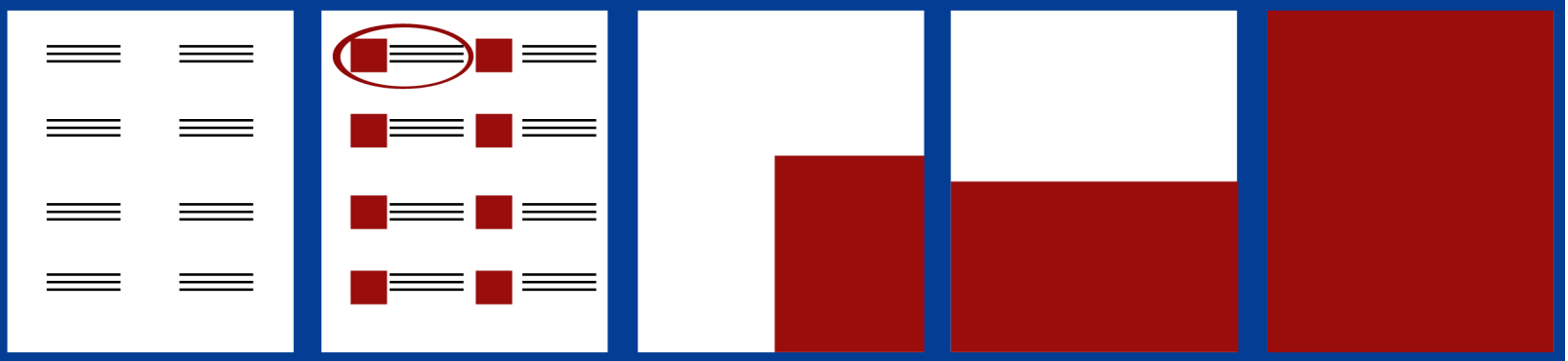
WHO'S IN THE VOLUNTARY BENEFITS INDUSTRY

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



BASIC LISTING $250

BASIC LISTING (W/LOGO) $500

1/4 PAGE $1,000

1/2 PAGE $2,000

FULL PAGE $3,000

1128 ROYAL PALM BEACH BLVD., SUITE 138 WEST PALM BEACH, FL 33411, USA
TELEPHONE ~ US 561-792-4418 FAX ~ 866-547-1639
EMAIL ~ INFO@VOLUNTARYBENEFITSMAGAZINE.COM
ONLINE MAGAZINE ~ WWW.VOLUNTARYBENEFITSMAGAZINE.COM

The Role of the Professional Case Manager In New Models of Care Delivery

By Patrice Sminkey

For professional case managers, delivery of care is accomplished through a network of resources. Whether case managers work in a hospital or other acute-care setting, for an insurer or third-party provider or in another venue, identifying the appropriate resources is at the heart of advocacy for patients. Now, as new models of care delivery continue to emerge, the professional case manager--particularly one who is board-certified--will be at the heart of these networks to coordinate care, facilitate communication and employ evidence-based practice in pursuit of positive outcomes. 1

In the era of healthcare reform, healthcare organizations, clinicians and practitioners are pursuing continuous improvements in quality, efficacy and efficiency. Among the models that have emerged is the patient-centered medical home (PCMH), which is led by the primary care community. The PCMH is a model of care delivery that requires a primary care physician to achieve a critical balance of clinical and administrative resources, all while recognizing Medicare reimbursement policies that put greater emphasis on outcomes.

Amid these new complexities in care delivery, primary care physicians must either try to do everything themselves--which while effective, is not efficient--or they must hire case managers whose roles and responsibilities are integrated into

the PCMH. Therein lies the challenge for primary care physicians, who may not be familiar with the roles and functions of a case manager. Physicians who have limited knowledge of case management could erroneously utilize non-clinical staff for case management duties. Although non-clinical staff can be used for duties such as paperwork processing, use of these individuals to address patient needs is inappropriate and could expose the physician to liability.

The roles and function of case management must be performed by a professional case manager, preferably one who is board certified. The Commission for Case Manager Certification (CCMC), which has more than 30,000 board-certified case managers, defines case management as: "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human services needs."2

The CCMC's most recent case management role and function study, which involved scientifically conducted field research with nearly 7,000 participants, identified and evaluated essential activities of case management, including: case management process and services, resource utilization and management, psychosocial and economic support, rehabilitation, outcomes and ethical and legal practice. Knowledge domains

identified from the study were case management concepts, healthcare management and delivery, principles of practice, psychosocial aspects, healthcare reimbursement and rehabilitation. As an analysis of the study concluded, "…the activities and required knowledge will put case managers in an excellent position to distinguish themselves through certification as competent professionals who are able to contribute to the health and well-being of clients/patients, and the overall efficiency and efficacy of the health care system." 3

Given this thorough analysis of case management--what professional case managers do and the knowledge that is required of them--it is only logical that new models of care such as PCMH would utilize best-in-class case management in the pursuit of quality, efficiency, and efficacy goals. Through board-certification, such as achievement of the Certified Case Manager (CCM) credential, professional case managers attest to their competence, professionalism, adherence to ethical standards and commitment to pursue continuing education, which is required for certification renewal.

New models of care delivery such as PCMH play to the strengths of the professional case manager. "These new models of care, which are fashioned around networks of providers and resources, still need to be coordinated around the patient's needs," commented Dr. Maureen Boshier, RN, LP.D, MSN, MBA, FACHE, who is an independent researcher and writer on healthcare issues and an assistant professor at Eastern Virginia Medical School. "This requirement emphasizes the role of the professional case manager."

The care coordination component within new models of delivery such as PCMH is critical. Care coordination, which is a central role of the professional case manager, provides access to the right care and treatment resources at the right time, avoiding duplication and unnecessary use of resources.

According to a recent study published by Southeastern Consultants, uncoordinated care in the United States costs an average of $240 billion a year, with the average annual cost for an "extremely uncoordinated care patient" more than five times higher than for other patients. Among the recommendations for improvement, according to study author Mary Kay Owens, R.Ph., C.Ph., president of Southeastern Consultants and a Clinical Associate Professor at the University of Florida College of Pharmacy, were interventions to improve care coordination including the PCMH, disease- and care-management programs, patient education, and emergency room diversion to primary care physicians. 4

The link between care coordination and improved outcomes calls for use of qualified, board-certified professional case managers within models such as the PCMH. By utilizing the skills and expertise of such highly qualified case managers, physicians are able to extend their reach across a larger population of patients, improve quality, pursue health status improvements in patients and elevate the purpose of the PCMH. These positive outcomes are at the heart of the goals of healthcare reform.

As primary care physicians, clinicians and providers join forces in pursuit of significant, measurable improvements in the quality of care delivery, they must examine the strengths of each link in the chain of the network being established. A board-certified, professional case manager is a strong contributor to network, with proven competencies to achieve the goals that are integral to PCMH success.

Bio

Patrice Sminkey, RN, is the Chief Staff Executive of the Commission for Case Manager Certification (www.CCMcertification.org), which is the first and largest nationally accredited organization that has board-certified more than 30,000 professional case managers.

Voluntary Benefits Magazine

Official Magazine of the Voluntary Benefits Association