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Voluntary Benefits Magazine

Official Magazine of the Voluntary Benefits Association

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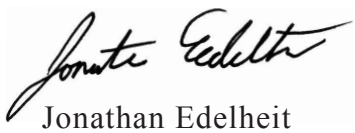
EDITOR'S LETTER

Asleep At the wheel

I feel like almost the entire industry has fallen asleep at the wheel. One of the most critical and important times for the Voluntary Benefits industry is upon us. Healthcare Reform crushes health insurance agents across the country, putting many out of business now, and a good portion out of business in the future as their business slowly dries up. I haven't seen many voluntary benefits carriers stepping up the plate and pouncing on this opportunity to bring agents and employee benefits consultants into their hands. There has been no increased education, marketing or initiatives.

The industry has an opportunity to get thousands of new marketers of voluntary benefits, and ones that would be extremely passionate with existing books of business. But instead of throwing a net out and catching these agents and consultants, utilizing their current book of business and showing them how to make revenue through voluntary benefits, everyone is just watching these people leave the industry. How many billions of dollars in lost opportunities is the industry doing? What carriers have done webinars, workshops, etc to educate these agents/consultants? How many more will leave the industry because no one has approached them. A famous phrase we all know if is, "Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime." That should be changed to "Give a starving health insurance agent/consultant voluntary benefits and feed his/her business for a lifetime." Come on, let's wake up and see some activity from the carriers, MGA's and enrollment firms out there.



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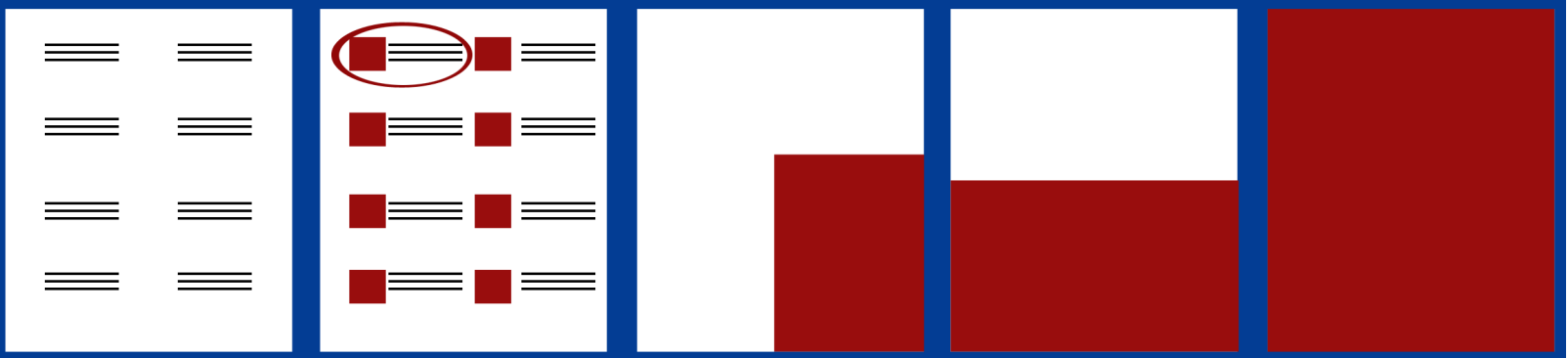

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Your Employees Can Help You Lower Healthcare

Writen By Alex Piper

Over the last decade, the Employer Healthcare Industry has seen a couple of major developments. Major developments in the Healthcare Industry are fueled by their ability to lower overall costs and are primarily driven by the gatekeepers of patients. Clinics, hospitals, drug manufacturers, equipment manufacturers, and professionals such as doctors and nurses benefit more when healthcare costs increase, provided, of course, that demand is not threatened. This article is not a supply-bashing article so I want to point out that the healthcare supply chain has provided the market with many beneficial services and products over the years. These products and services have improved the overall health of the patient public by finding new treatments, cures and drugs for the many ailments that affect the market. But, all things equal, major developments in healthcare are of the cost-reducing variety and are fueled by those who stand to gain the most from the cost reduction, namely the plan owners, patients and other payers of healthcare.

The first such development that comes to mind is Prevention. Synonymous with prevention is maintenance. The concept of prevention and maintenance was that if employees made doctor visits more often, potential serious conditions would be detected early and thus prevented from becoming full blown conditions. About fifteen years ago, the seeds of healthcare prevention and maintenance were planted. These seeds grew and bore full fruit in the late 1990's and 2000's with the emergence of HMO Plans. Whereas an explanation of HMO plans, their origin and proliferation is beyond the scope of this article, those of us familiar with the industry remember it as a time when basic healthcare benefits became more affordable. Doctor visits, prescription drugs, detection and diagnostic services went down in price. Of course, this price reduction occurred, because those services became more available. In other words, most healthcare plans made the services eligible, which in turn increased access, or volume. So, what the supply chain lost in per-visit revenue, they more than gained back in volume business. Therefore, as one would imagine, with both the healthcare supply and the healthcare demand being able to benefit from this prevention development, it persevered for a number of years.

The second such development that comes to mind is Consumerism. About ten years ago, the seeds of consumerism were

planted. Those seeds grew and bore full fruit in the 2000's with the emergence of health and wellness plans. Whereas an explanation of Wellness plans, their origin and proliferation is beyond the scope of this article, those of us familiar with the industry remember it as a time when onsite services became more available. Similar to HMO plans, Wellness plans became more available because they resulted in a reduction of healthcare costs for the plan owner. Employees, who are the healthcare consumers, were asked to become more responsible for their own healthcare. Employers incented employees to take care of themselves. In some cases, employers penalized employees for risky behavior. Employees could acquire financial compensation toward their share of healthcare costs if they engaged in certain behavior. For example, if they recorded their blood pressure a number of times each year. Another example is if they completed a healthcare assessment which was designed to target potential problems by identifying risks such as obesity or stress. There was an explosion of wellness organizations that were formed as a result of the demand the consumerism created. Employees everywhere were joining health clubs, watching their diets, getting their blood pressure checked and reading up on ways to avoid stress.

Corporations, both big and small continue to search for ways to manage their healthcare costs. They negotiate rates with healthcare providers and with third party administrators. They aggregate their healthcare buying in order to leverage their position. All these efforts help to move the healthcare cost needle in the downward direction, but it's time to move the needle down to the next level. The tool to achieve that downward trend is closer than most employees realize.

Employers should start using their own

employees to design actionable preventive and maintenance for the total employee body. Employees represent as homogenous a group as exists. When one thinks of homogenous groups, one thinks about the Army, Marines, Flight Attendants and any other group whose participants experience similar lifestyles and risk exposures. In a company, employees are as homogenous a group as can be found. Employers should tap into this resource in order to identify, duplicate, communicate and incent the healthy behaviors that exist within this group. The following action steps are recommended.

First, identify Employee Health Groups (EHG's). Most companies have already identified employee groups when they enrolled in their current health plan. Employees are grouped by whether they are full-time or part-time workers. They are also grouped by geographic location. Another way to group them is by work tasks. For example, employees who perform secretarial work can form one group. However, the incentive to group employees, in the past, has been so that the healthcare provider, whether it is the employer or an insurance company, can reliably set healthcare rates for that group. For the purposes that this article intends, the incentive should now also include the reason that the employee groups can learn from each other. For each EHG, the habits of the more healthy employees will become the standard to which the whole group will aspire. An example of an EHG could be employees who are parents. Another example of an EHG could be single parent employees. The list could go on and on. The key to creating EHG's is to identify common risk exposures BOTH on and off the job. Once this step is accomplished the next step can begin.

The next step for employers to implement in order to tap into the healthcare resource that their employees represent **is to identify the habits of the healthy individuals within each EHG.** Again, in order to enroll in the current healthcare plan, employers would have gone through some exercise of identifying health measures that they wish their employees to aspire to. The more common health measures would be, for example, doctor visits twice

each year, semi-annual blood pressure check-ups, or periodic body fat composition analyses. Within each of the health measures, the employer would have established employee goals. Examples of the goals would be that a certain percentage of employees complete the health measure activity, or that a certain percentage of employees' results of each health measure be within a certain value range. So, if the health measure is semi-annual blood pressure check up, then the goal could be that ninety (90) percent of the employees achieve normal blood pressure measurements at each check up. Once employers have established these health measures and their corresponding goals, then they can actually start establishing actionable steps to achieve the desired results.

The third step in this endeavor is for employers to implement aids to assist the employees to achieve the goals. Corporations focus so much on what's right and being politically correct that most solutions are just band aids in fancy colors, not actual solutions. Employers have to rely on employees to design the healthcare programs. Let me give you an example.

Regarding the healthcare measure of employees incorporating exercise into their lifestyle, employers have gone to varying lengths. Some companies have negotiated discounts for their employees to become members at health clubs. Other employers have installed fitness gyms and even offered aerobics classes on site, for employees. I know of companies that have implemented longer work lunch periods or flexible work hours specifically in order to allow employees to engage in daily workouts. One employer addressed the needs of its black employees EHG. As most of us who are knowledgeable about tangible healthcare statistics know, Black Americans suffer from increased levels of obesity and blood pressure when compared to their non-Black counterparts. In order to encourage the black employees at this particular employer's organization, the employer encourage the black employees to conduct on-site "Hustle Aerobics" classes. These classes were basically black versions of aerobics classes. However, because they were led by black employees and because they targeted the black employees in the organization, they were very successful amongst that particular EHG. As a matter of fact, not only did that Hustle Aerobics attract the target market, but it also became popular amongst the broader employee base. This example represents a true success story and one that embodies the intent of this article.

Of course, employers need to address the complications that can arise with the advent of such a plan as this article suggests. Complications like privacy issues, sentiments of jealousy, sentiments of favoritism and what actual lengths the employer should go to in order to gain optimum benefits. However, the decision to implement such an action plan is a first step that is bound to result in overall success. Remember, the healthier your employees, the lower your healthcare costs and the higher their output.

BIO:

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

How To Choose The Best Benefits for Your Employee Base

Writen By Elizabeth Halkos

As the United States economy experienced and emerged from recession, the work environment for many employers has changed as well. While most companies' top H.R. priority has traditionally been to recruit and retain top talent, the recession has caused many employers to take a closer look at costs than ever before. According to an annual Employee Benefits Trends Study, controlling benefits costs ranked as the number one benefits objective for employers, topping employee retention for the first time since 2006. As employee benefits account for a large percentage of H.R. budgets, companies nationwide are re-evaluating their benefits packages to ensure they are choosing benefits that will be cost-effective and highly utilized by employees.

Employee demand for a strong benefits package continues to rise. Job satisfaction and satisfaction with benefits often go hand-in-hand. The survey also found that among employees highly satisfied with their benefits packages, 81 percent were also satisfied with their jobs. Additionally, several national surveys have reported that employees view benefits as the foundation of their financial safety net. Choosing the right benefits package for your employee base will help keep your employees happy, satisfied – more productive and loyal to your organization. Although many employers offer the traditional health and life insurance offerings, the vast array of voluntary benefits on the market often allow employers to differentiate their compensation packages.

Increasing Workforce Diversity

As employers consider the array of voluntary options, they must also consider the needs of their specific employee base. According to a report by the Bureau of Labor Statistics, women only made up 30 percent of the labor force in 1950, compared to 47 percent today. Today women compose nearly half the workforce, so employers must consider how benefits needs might differ by gender. Additionally, the U.S. workforce is becoming more racially and ethnically diverse, and all of these factors can contribute to varying needs and preferences when it comes to benefits.

Income level may influence many employees' benefits priorities, especially in the aftermath of the recession. According to Prudential's Fifth Annual Study of Employee Benefits: Today & Beyond, employees with higher household incomes ($100,000 or more) are more concerned about long-term goals such as "needing to save for retirement" and "having retirement savings last as long as you need it to" than those employees making less than $50,000 annually. The survey also found that employees who make less than $75,000 are much more concerned with paying off or reducing household debt than those with incomes of $100,000 or more.

Lastly, you must consider the age and life stage of your employees. It is observed that today's workforce spans four generations – Generation Y (b. after 1980); Generation X (b. 1981-1965); Baby Boomers (b. 1946-1964) and Veterans (b. before 1946). In general, younger generations are often concerned with professional development and work-life balance, while older generations may value retirement savings plans and long-term care options. Additionally, consider the life-stage of your employees (single, married, divorced, young children, empty-nesters), as this will also influence the types of benefits they will most appreciate.

With a diverse workforce and so many voluntary benefits offerings on the market, how can

employers make sure they are choosing the best benefits for their employee base?

Choosing the Best Benefits for Your Employees

Begin by taking an inventory of your employee base and broadly categorizing them. There will always be exceptions, but think about how your employees might fit into the various groups listed above and what their needs might be. For instance, if your workforce is comprised of a number of working parents, consider implementing childcare stipends or flex time programs to allow employees to more easily care for their families. If your employees fall into the category of making less than $75,000 annually and being concerned with paying off household debts, think about implementing an employee purchase program to help them pay for household necessities like computers and home appliances via payroll deduction.

If you're unsure what people might value most, simply ask! Survey your employees to find out what is important to them in a benefits package. By including them in the decision-making process, they will feel cared for and take more ownership over their benefits packages.

Offering flexible benefits can also play a key role in satisfying a diverse workforce. In order to provide your employees with more choice, consider having a variety of low-cost voluntary options from which to choose – anything from pre-paid legal services to pet insurance to employee purchase programs. Many of these can be offered on an employee-pays-all basis, thus satisfying those employees who choose to participate without hurting the company's bottom line.

No matter what benefits you decide to offer, it is important to make sure you are communicating them well. If you introduce new products, hold meetings or lunch n' learns to make sure people understand how they work and the value of the service they are receiving.

Remember that there is no one-size-fits-all solution to creating a good benefits package for your employees. If you focus on implementing benefits more specific to your employee base, you may be able to eliminate underutilized programs – which can help lower costs for your organization. Although it takes time and effort to identify the best benefits for your employees, you will ultimately reap the reward with more motivated, loyal and satisfied employees.

BIO:

Elizabeth Halkos is the Chief Marketing Officer for Purchasing Power, an Atlanta-based voluntary benefit company. Purchasing Power offers a program that makes it possible for employees of participating organizations to purchase computers, electronics and home appliances through the ease of payroll deduction. You may contact Purchasing Power via e-mail at sales@purchasingpower.com.

1. Bureau of Labor Statistics, A Century of Change: The U.S. Labor Force, 1950-2050, www.bls.gov/opub/mlr/2002/05/art2ful.pdf.
2. Source: Deloitte's 2010 Top Five Total Rewards Priorities Survey, http://www.deloitte.com/us/2010Top5.

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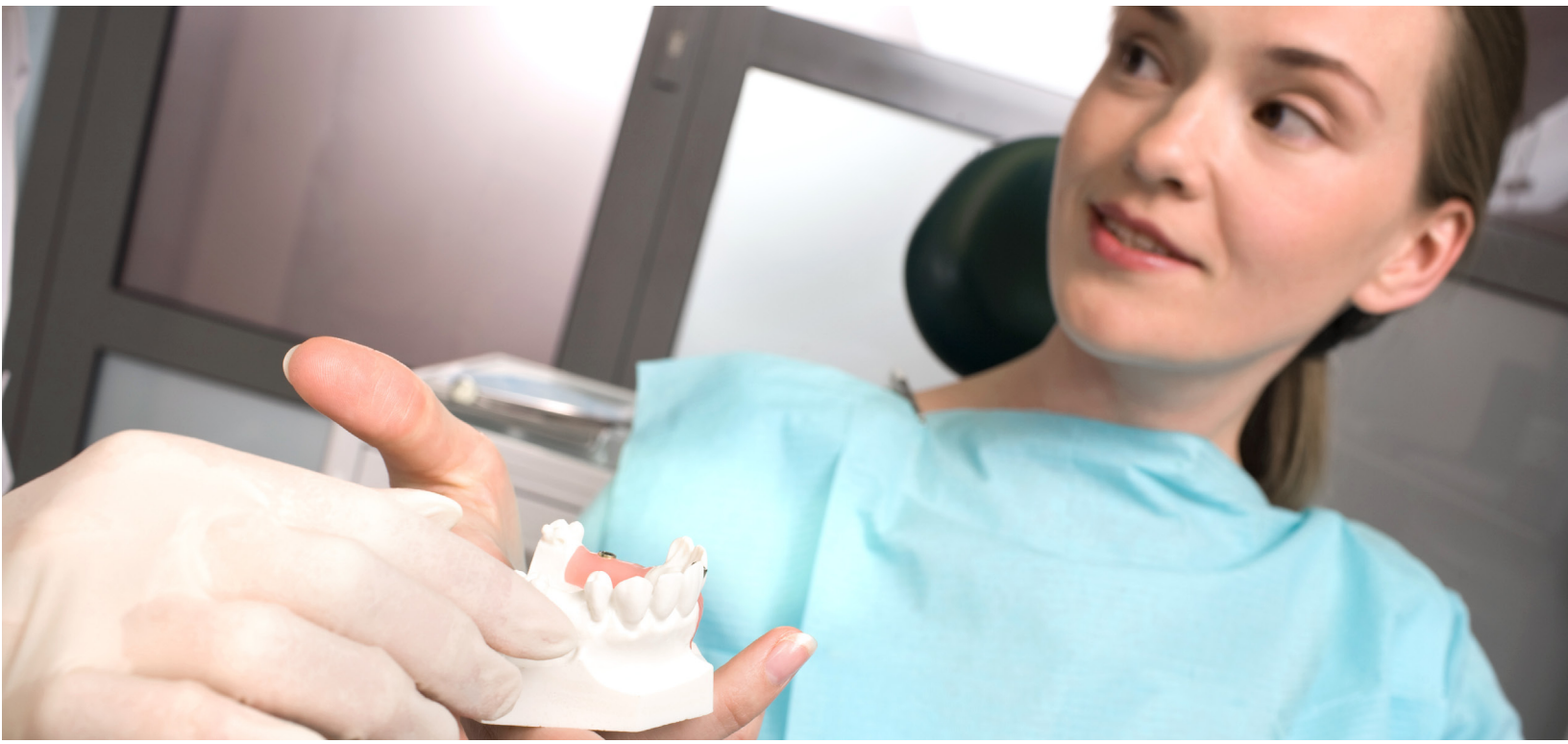


Voluntary Dental Benefits Can Be a Lifesaver – Literally

Writen By Robert P. Mulligan

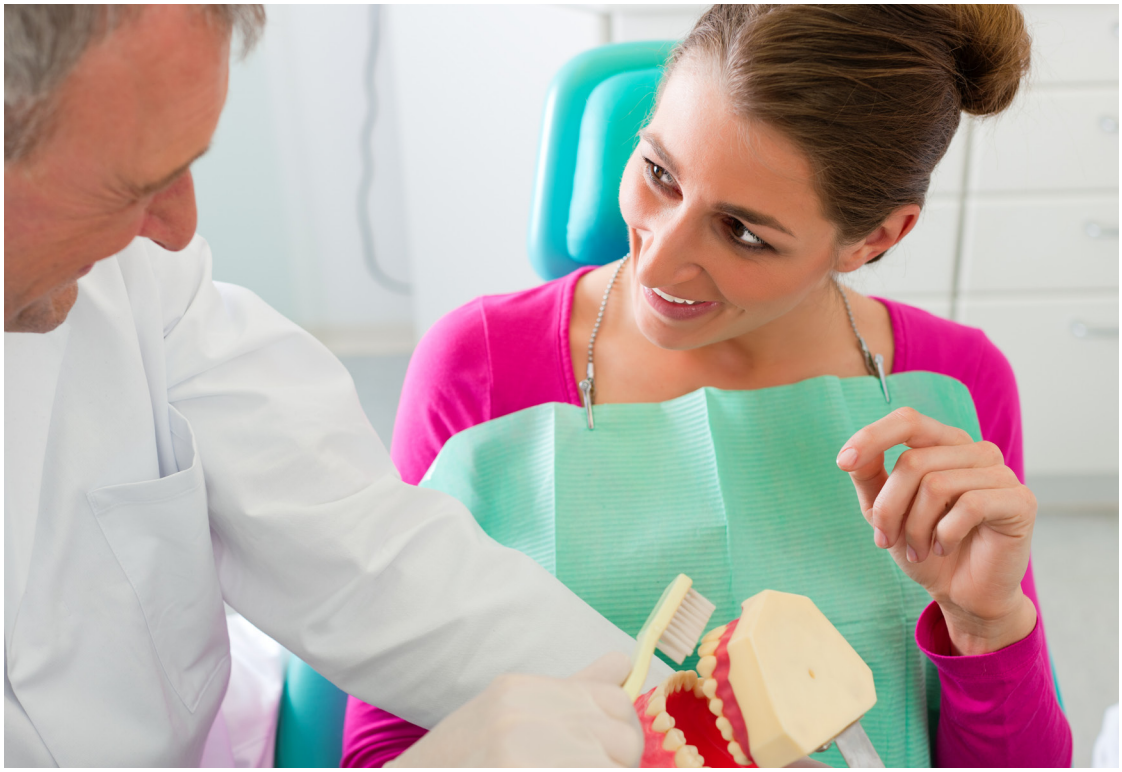
Tips for Brokers on the Impact of Dental Distress on the Workplace

Selling insurance in today's challenging economy is not for the faint of heart. We all know the scenario: businesses are slashing benefits to survive. As they examine their major expenses, it is no surprise that they find themselves caught in the grip of the current state of health care in this country. As most insurance premiums rise faster than the inflation rate, businesses are re-evaluating what, if any, insurance they should offer their employees.

Businesses generally consider health care insurance as essential to employee recruitment and retention. So where do they turn in cost-cutting efforts? Ancillary benefits such as dental insurance. Eliminating dental insurance may save money in the short-term, but it can have long-term financial and health consequences. But there is a solution. And, as brokers, you can help your clients find it. Tough economic times demand tough but smart decisions.

Voluntary dental benefits may be the answer…

I have noticed a growing trend of companies offering voluntary benefits to their employees. This option allows employers to continue offering a plan, without assuming any financial liability or administrative burden. When a company is forced to eliminate dental coverage, it still can offer an individual voluntary plan to its employees. This solution plan allows organizations to provide a solution to their employees without any administrative or financial responsibility for them. The carrier may also agree to waive the waiting periods,



if you work with a smart, reputable carrier and the group's members were previously covered under a dental plan.

What's so important about dental insurance? It could save lives.

Americans who lack dental insurance are 67 percent more likely to develop heart disease and 29 percent more likely to develop diabetes. That's a powerful message to deliver to your clients. And there's more.

Did you know that routine dental check-ups can detect the signs and symptoms of serious medical conditions such as cancer, diabetes, heart disease, kidney failure, the onset of a stroke or complications with pregnancy? As brokers it is important to help clients understand how oral health relates to overall health. Conditions in the mouth can alert dentists to major health problems at the earliest of stages. Companies that don't offer, or are considering eliminating, dental benefits need to know about the option to offer a voluntary individual plan.

Eliminating dental coverage could not only result in increased health insurance premiums in the future, it could dramatically affect productivity and absenteeism with employees.

According to the U.S. Department Of Health and Human Services report on oral health in the U.S.,

> **"Employed adults lose more than 164 million hours of work each year due to dental disease or dental visits."**

Without dental insurance, people often do not go to the dentist for preventive care. This neglect can lead to serious dental issues that may require a visit to the emergency room. Emergency room

treatment is the most expensive option, which in turn drives up health care costs. Preventive dental care helps employees avoid serious dental or related health issues, which can reduce absenteeism and increase productivity.

The evolution of the voluntary trend

Employee out-of-pocket contributions for insurance premiums have steadily increased over the past 10 years. According to the most recent survey available on group purchaser behaviors by the National Association of Dental Plans, this trend is expected to continue. Survey results estimate that 15 percent of employers currently offering dental benefits are likely to transition to employee-paid voluntary dental benefits and 28 percent are likely to increase the premium paid by employees.1

Advantages to voluntary benefits

As brokers, your knowledge and counsel can help your clients understand the benefits of voluntary individual plans offered through the employer versus individual plans that employees must find on their own. You can help your clients choose which options best suit their companies' needs and provide examples of how other companies have effectively handled their plans in similar situations. Voluntary plans often offer broad dental networks and lower out-of-pocket costs (a savings of 25 percent or more) compared to typical individual plans.

On the flip side, those seeking individual plans must do their own research and may choose policies that lack important components or have undesirable elements, such as long waiting periods, which are often waived in voluntary plans offered through an employer. Individuals who seek out their own plans also may pay higher premiums and co-pays. With less cash in their pockets and the frustration of doing research on their own, employees are likely to be less productive and more frequently absent due to dental issues or financial stresses.

Benefits are crucial to employee recruitment/ retention

Benefits are a valuable recruiting and retention tool. Employees consistently rank dental insurance as the most important benefit after health coverage. When offered some type of dental plan, employees will be more satisfied with their overall compensation and benefit package and less likely to seek other employment opportunities.

Selling tips for brokers

Voluntary plans offer terrific benefits. However, convincing your clients of this takes focus and understanding. Here are a few tips:

1.Understand the culture, goals and financial condition of a company
Research a company's financial situation and competitive position in its industry. Understand their human resource goals and corporate culture. It will help you present insurance products that accurately reflect that company's needs.

2.Serve as a consultant for your clients rather than a quote machine
Don't wait for renewal time to check in with your clients. Leverage your relationship and build trust with your clients by offering them added value. Take notes when you talk to clients and reference them in future conversations. Revisit clients' goals to identify changing needs or circumstances. Evaluate the success of previously implemented programs and recommend any modifications.

3.Meet with representatives of different plans
One plan does not fit all. Employers will value your guidance and advice if you can demonstrate that you are an expert in different plans and carriers. Know more than the price of a plan. Meet with insurance carrier representatives to learn about their products and how they process claims. Match their strengths to your clients' needs.

4.Don't just sell, customize
Sell a product because it fits your clients' objectives. Help your clients prioritize their needs in advance and then present them with options that are the best fit for their company.

Discount cards as an option

Don't walk away even if a company decides to drop all health insurance benefits. Offer the option of health care discount cards. These cards allow access to popular health care networks at the same discounted rate typically available through group insurance plans. The most popular cards provide discounts on dental, vision, hearing and prescription costs; others offer even more options.

Discount cards also are great options for new businesses that are just stepping into the world of employee benefits. Some plans offer group discounts and customizations. It's a great first step for new companies. Treat new businesses well. Your loyalty to them can pay off as they grow and recognize the value of full insurance plans in the future.

Be a part of a winning team

Voluntary dental insurance benefits employers and employees. Everyone saves money; everyone reaps the benefits. And you are the catalyst. They are excellent options to employers struggling with high insurance costs. But your clients won't know about them unless you tell them. It's a triple win – for employers, employees and you.

BIO:

Robert P. Mulligan is president and chief executive officer of Renaissance Life and Health Insurance Company of America and Renaissance Health Insurance Company of New York.

1.National Association of Dental Plans 2008 Group Purchaser Behavior Study
2.US Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General, May 2000
3.The Kaiser Family Foundation and Health research and Educational Trust, Employer Health Benefits 2010 Annual Survey

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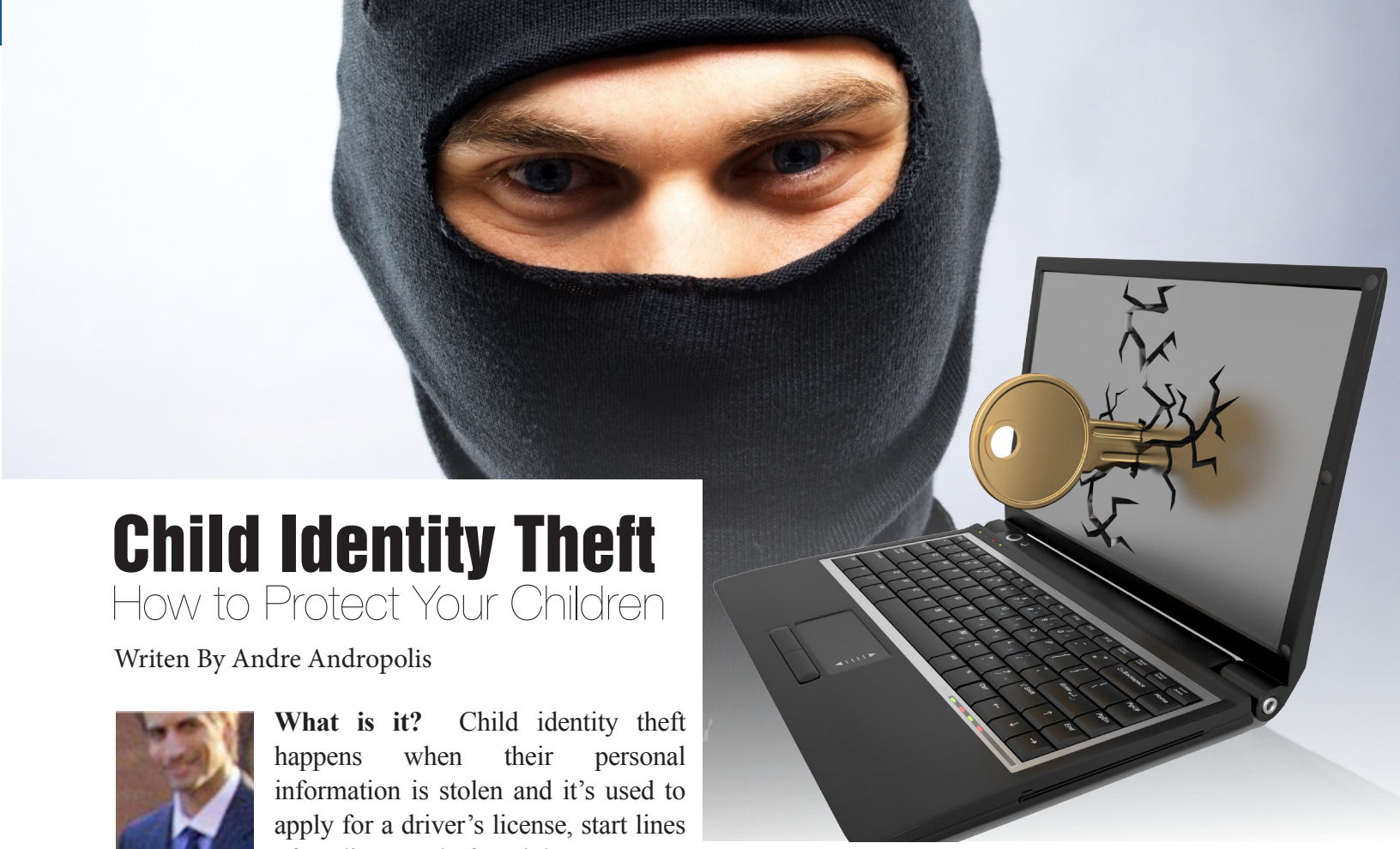

Child Identity Theft

How to Protect Your Children

Writen By Andre Andropolis

What is it? Child identity theft happens when their personal information is stolen and it's used to apply for a driver's license, start lines of credit or apply for a job, etc...

Picture this - your child has just applied to lease their first college apartment, applied for their first job or their first credit card only to find out they've been denied. Why - they're the latest victim of identity theft. Their credit has been destroyed by an identity thief and they been left with debt that they know nothing about. Your ability to apply for your next credit card, purchase a vehicle or buy or purchase auto insurance is tied to your credit. The next step for many 18 and 19 year old kids is to file for bankruptcy. The identity thief has affected their future in untold ways. Child identity theft has been growing at alarming rates in the past couple of years. Approximately 500,000 children are victims of identity theft each year! Since kids have pristine credit files, they're very easy targets for identity thieves. Children are usually issued social security numbers at birth and they're now at risk of identity theft.

One of the scariest things about identity theft is that the victims and their families have very little way of knowing that is crime in progress. **There are a variety of places where your children's social security numbers and personal information are stored, which include the following:**

1. Student records at schools
2. Patient records at hospital or doctor offices
3. Member databases at libraries
4. Athlete applications in school and private sports organizations
5. Pre-school or daycare facilities enrollment records
6. Facebook, Myspace, etc... (teens post too much personal information)

It usually happens when victims are too young to do anything about it. Child identity theft can go undetected for years and can have devastating consequences for children. In many cases, the child's parent used their social security number and other personal information to apply for credit cards and loans. A young man in his early 20s was a victim of identity theft by his estranged father. His father had been using his identity for years. When the young man applied for a credit card, he realized he was a victim of

identity theft. His financial problems cost him his dream of becoming a police officer because he couldn't pass a background check. He had a lot of hopes and dreams but those dreams are on hold indefinitely. Victims of identity theft can spend years and thousands of their own dollars trying to restore their good name and credit. Linda Foley, founder of the Identity Theft Resource Center stated "There's a feeling of denial that this can't be happening. Anger, betrayal and then a sense of grief. A loss of innocence, of 'how could they do that to me? How could they hurt one of their own and then, what am I going to do about it.?"

Most parents aren't aware that their child has a credit report so they don't think there's a need to check their child's credit reports. As I mentioned earlier, identity theft can go undetected for years. In 2007, an Experian-Gallup survey polled 3,029 adults ages 18 and older on the topic of child identity theft. The results showed that many consumers are unaware of the dangers of child identity theft. Here are some statistics the survey revealed:

- 68 percent of respondents knew "only a little" to "nothing at all" about child identity theft.
- 11 percent knew "a great deal" about child identity theft.
- 5 percent felt it would be "very difficult" to steal a child's identity.
- 39 percent of parents with children under the age 18 felt it was "not too likely" that their own child's identity could be stolen.
- 11 percent of parents thought that it was "very likely" that their own child's identity could be stolen.

How can we protect our children from identity theft?

1. Check their credit reports and have their credit files monitored. Minor children shouldn't have credit files unless their information has been stolen.

2. Monitor their mail for credit card offers, unauthorized purchases and collection letters. If your child wants to subscribe to a magazine, put it under your name and not your child's name.

3. Don't give out you child's social security number - there's no law that makes it a crime to refuse to give out their social security number. In situations where you have to enroll your children in daycare, sports organizations or when completing medical forms at a doctor's office, you're not required to give out social

security numbers. If a staff member says your child's social security number is required, parents need to question why their number is necessary. Parents also need to ask how their number will be used, what law or statute requires parents to provide a social security number and what the consequences are if parents refuse.

4. Monitor your child's activity on the internet. Kids love using Facebook and chat rooms - so monitor this activity.

5. Educate your children about the necessity of keeping their personal information private when using the internet or in any other situation

6. Explain to your children what "phishing" e-mails are and how to protect themselves from those scams. Have them delete all junk email or email that isn't from a known sender.

7. Make sure that children aren't carrying their social security cards with them. Keep their social security cards in a safe or secure location like a safety deposit box.

How do I request a credit report by mail for a child under 13 years of age?

The credit reporting agencies do not knowingly maintain credit files on minor children. If you suspect that your minor child's information has been used fraudulently, you should contact the credit reporting agencies directly and report the illegal use of your child's information to law enforcement. Please supply each credit reporting agency with your child's complete name, address, date of birth and a copy of the minor child's birth certificate and social security card. Additionally, please provide a copy of your driver's license or other government-issued proof of your identity, which includes your current address, and a current utility bill containing your current address so the credit reporting agencies may promptly respond to your request.

The addresses for the credit reporting agencies are listed below:

Equifax	Experian	TransUnion
P.O. Box 740256 Atlanta, Georgia 30374	P.O. Box 9554 Allen, Texas 75013	P.O. Box 6790 Fullerton, CA 92834

Choose an identity theft program and legal service plan that work together because identity theft is first and foremost a legal issue

Choose a comprehensive identity theft program with a legal service plan that complements it. If someone's a victim of identity theft, they're going to need to get an attorney involved because identity theft is first and foremost a legal issue. When the rubber meets the road, most identity theft providers will send a kit in the mail when your become a victim of identity theft. Getting a kit in the mail means that you'll be making all the calls and doing all the footwork. Identity Theft is the fastest growing crime in North America. The Federal Trade Commission(FTC) estimates that there are 9 million victims of fraud each year. There were 11.1 million victims of identity theft last year alone. The average time it takes an individual to resolve an identity theft situation on their own is 55 to 130 hours and between $1200.00 and $5000.00 in out-of-pocket expenses to resolve. Look for a company that is a true leader in the risk consulting industry with licensed, experienced professionals and a proven identity theft product. There is no way to stop identity theft but you can minimize your risk. The way to minimize your risk is by choosing an identity theft plan that offers 24/7 credit monitoring and a plan that provides "full restoration" services should your identity be stolen. Make sure that the identity theft program you choose also provides 24/7 monitoring of your child's credit files.

BIO:

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Teamwork Is Not "Voluntary"

Writen By Jeff Marzoff

Teamwork: It is as important to a successful Voluntary Benefits implementation as the plans offered or the enrollment method used. Voluntary Benefits brokers, insurance carriers and enrollment companies that are the most efficient at rolling out a Voluntary Benefits program demonstrate the key elements of a smooth running team: the right combination of employees who are committed to the task, strong leadership, and good communication.

Team members can contribute to a project if they follow a few basic rules. First and foremost, team members must be committed to the group. Commitment means that team members are willing to:

1. Attend all meetings
2. Be prepared to contribute
3. Support the team's decisions

To ensure effectiveness in the decision-making process, team members must be open-minded and willing to listen to alternatives offered by all group members. Team members should not attend meetings armed with solutions in mind that they feel would be best. Instead, members of the team should be prepared to listen and discuss all the options offered. The practice of attending meetings closed-minded is often counter-productive as it often leads to unnecessary disagreements among its members.

The Importance of Team Leadership

In addition to having members who are committed to the task and who are well organized, teams must have good leadership to be effective. Usually when employees are assigned to a team, they are relatively eager to be part of the group and look forward to the project. Naturally, there is some anxiety about their involvement in the project. This apprehension is usually as a result

of being unfamiliar with the client or the project itself—and the skills required to carry out their role. In this situation, employees usually feel dependent and look to the group's leader to satisfy their needs for additional information and role definition.

It is very important for the leader, usually a supervisor or manager, at this stage in the process to help team members understand the task and how they will contribute. This includes clarifying the nature of the task, setting realistic and attainable goals and planning for the acquisition of necessary skills. Clarifying group goals in a realistic way is especially important to team morale as it sets the tone for future expectations.

Managing Conflict

Even in highly productive teams, conflict is inevitable. In fact, conflict can be a valuable tool if managed properly. Team leaders must be prepared to use their conflict resolution skills to settle disputes quickly and decisively if the team is to thrive. The leaders who are most effective in resolving conflict are those that who use skills that they are most comfortable with and which the group members prefer. This approach is known as the situational leadership approach. In other words, the leader handles each conflict that arises based on his or her experience with the group and applies the method that suits the situation best.

Communication Is Key

Finally, teamwork involves communication. Communication is a process that takes place on many levels. One thing that is certain about communication: If a message can be misinterpreted—it will. That is why messages must be crafted with care, always taking into consideration the level of understanding each member has and the amount of information needed to carry out his or her role.

It is also extremely necessary for teams to use structured communication mechanisms, such as e-mail and Web conferences and blogs to disseminate information among team members. Project meetings should take place on a regular basis, with a set agenda to ensure that all members are up-to-date and working together toward the final goal—a successful Voluntary Benefits enrollment.

BIO

Jeff Marzolf is Vice President of Account Management and Marketing at Dynastar Benefits Group. Jeff is a licensed insurance professional with an impressive history of achievement in account management, marketing and sales. He has experience working with Fortune 500 companies and other employer and membership groups throughout the country.

Additional Benefits of the State Health Insurance Exchange

Writen By Moin Jafri

The Patient Protection and Affordable Care Act makes it compulsory for all states to have health insurance Exchange by the year 2014. There are certain guidelines that these Exchanges have to follow to be eligible for federal funding. However, the health reforms have only drafted a basic skeleton. The details have been left to individual states so that they can mold it according to the state specific regulations and the needs of the residents.

However, there are certain add-ons that would certainly make Exchange a better insurance market place. Though these features are not compulsory according to the federal insurance regulations, most of the Exchanges are expected to incorporate it on their insurance platforms.

One such feature would be some sort of decision support mechanism. The Exchange will be a multi-carrier kiosk which means innumerable number of health plans. The consumer might be spoilt of choices but this unlimited number of choices could also lead to a lot of confusion about picking the right plan. This is where the decision support mechanism will come into a play. Based on the basic information provided by the resident and a perhaps a few additional questions, the Exchange will recommend a few plans across carriers. The resident can then pick a health plan from the shortlisted options.

Another such add on would be the direct transaction between the health insurance company and the consumer. A consumer would be able to pay for his medical coverage directly to the insurance company. This will result in the faster processing of applications, the consumer would be able to get his coverage faster and the fear of scams by the middlemen would be eliminated. The consumer will be able to purchase or renew his policies whenever he wants, at his convenience of date, time and place.

The online portal would also ensure that there is a single, integrated system that can automatically carry the customer from enrollment at the exchange, to ID card generation, and to post-sale service. Since customers are using the internet, they would expect instantaneous results. And with so many insurance companies trying to outdo each other, the competition to provide faster and better service will only get intensified.

Since the new regulations will prohibit the insurance companies from charging more for those who have pre-existing conditions or deny them coverage completely, insurance companies will soon have to come up with new tools to know the health status of the applicants. This would include tools such as health risk assessments, personal health records, behavioral analytics, etc. The more the insurance company takes the general well-being of its client, the better are its chances of staying away from remunerating their huge medical bills.

Health Exchange across the fifty states will have the same basic structure. However, it is these add-ons and how effectively they are amalgamated into the platform that will form the essential distinguishing factor.
The state administrators will try to incorporate the maximum basic and additional features so that for the residents of that state, buying health plan from the Exchange is a truly pleasurable and hassle-free experience.

BIO

Moin Jafri is an expert on health insurance and is currently studying about the intricacies of the state health exchange that are to be formed soon.

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http://www.hcentive.com

Five Common Misperceptions about Voluntary Insurance

Writen By Ron Agypt

Let's face it, the ins and outs of health care insurance are difficult to grasp for most consumers. And now they may seem even more overwhelming and convoluted given the stops and starts of health care legislation. But there is one segment of the health care insurance industry that will remain unchanged, regardless of the outcome of health care reform—voluntary insurance.

Many forces are contributing to the growth and need for voluntary insurance for both employers and employees. For brokers and agents, now is an opportune time to help clear up the misconceptions about voluntary insurance that are prevalent among workers, and even HR benefits decision-makers. A misinformed consumer and client population is likely the greatest obstacle brokers and agents face in leveraging the growth surge within the voluntary benefits industry.

A recent survey discovered five common misconceptions about voluntary insurance options.

Myth 1: ***Payouts from voluntary insurance policies can only be used for specified medical expenses.***

According to the survey, two-thirds of employees (66 percent) and nearly as many HR decision- makers (62 percent) mistakenly believe that payouts from voluntary insurance policies can only be used for specified medical expenses.1 While this is true for major medical plans, voluntary insurance pays cash benefits directly to the policyholder, unless otherwise assigned, to be used however he or she may choose—from daily expenses like mortgage payments or rent to helping pay for gas to and from the doctor.

Myth 2: ***Voluntary insurance always pays doctors directly for medical bills.***

More than half of employees and HR decision-makers (55 percent) believe that voluntary insurance

plans always pay doctors directly for medical bills.1 This is another distinction between voluntary and major medical insurance that is often misunderstood by consumers and HR executives alike. Major medical insurance typically pays doctors and other health care providers directly for any expenses covered under the plan. However, voluntary insurance plans are designed to help policyholders pay for the many out-of-pocket expenses that major medical doesn't cover, including cash to cover copayments, deductibles, and general living expenses.

Myth 3: ***Supplemental insurance costs way too much.***

Employees are much more likely to believe that supplemental insurance plans cost way too much, with half of those surveyed indicating that belief, compared to one-third of HR decision-makers who believe this is true.1 However, many voluntary insurance providers offer a range of products that fit most budgets. For example, one leading insurance company offers consumers basic insurance coverage options, including accident, sickness and life insurance policies, for less than $12 a week using standard rates.2 The intent of voluntary insurance providers is to offer families broader insurance coverage and the protection they need to help ease the financial burden that an unexpected accident or injury can create.

Myth 4: ***It costs employers to offer voluntary insurance benefits.***

Although voluntary insurance benefits have no direct cost to employers, fewer than half (44 percent) believe this is true.1 This misperception can be a costly one for companies, many of whom are seeking ways to keep health care costs down while still providing access to the coverage their employees need and demand. Making voluntary insurance policies available to employees not only has no direct cost to employers, but may reduce corporate taxes by cutting FICA tax contributions. Adding voluntary plans to a company's offerings can help companies build robust benefits packages, while staying within budget/cost constraints.

Myth 5: ***Employers pay all or most of the voluntary insurance premium.***

One in four HR benefits decision-makers believe that employers pay all or most of the premiums for voluntary insurance plans.1 Although some companies may choose to contribute some portion of the premiums, voluntary insurance plans are typically paid for entirely by employees. Consequently, most voluntary plans are portable, and belong to the employee—an aspect that is highly beneficial and important to many workers. And finally, employees are able to purchase the amount and type of insurance that is best suited to their particular life stage or circumstance, ensuring adequate protection and peace of mind.

Brokers and agents can profit from a better informed client and consumer. Voluntary benefits, in particular, are not only growing in demand and popularity but also have the unique distinction of being one aspect of health insurance not affected by health care reform or legislation. Being aware of these top misunderstandings about voluntary insurance can help brokers and agents tailor their sales and education efforts to help close knowledge gaps.

BIO

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Women, Work, and Long-Term Care

Writen By Susan Blais

In the past several decades, women have made great gains in the workplace. Today, more than 40 percent of women are in management positions, and 28 percent of all U.S. businesses are owned by women1.

With those gains, though, has come a negative impact on women's health and an increase in heart disease, and other ailments that were more common to men in an earlier time. These health issues are a direct result of the stress and pressure that come from working in a competitive business environment.2

One stressor that is often overlooked when looking at women's health though, is the significant impact that long-term care-giving for a disabled family member puts on the caregiver. This is not to minimize the effect of caregiving on men's health as well, but recent statistics show 59 to 75 percent of caregivers in long-term care situations are women.3 This can be due to economic factors if others in the family are the main breadwinners, and is also an effect of women's natural tendencies toward nurturance and caregiving.

While caregiving for a long-term care patient is a noble and selfless act, it can create significant and sometimes traumatic damage to the caregiver, in many aspects of her life. Care giving impacts a person's physical, mental and emotional health and impacts their job performance, their earnings, and their savings. There is also a ripple effect on the caregiver's family, as the caregiver becomes less available to spend time with their spouse or partner, children and friends.

In reality, there is more than one type of caregiver. The primary caregiver is the person who provides hands-on care and often financial support for the long-term care recipient, while a secondary caregiver may make arrangements for care, oversee primary caregivers, find resources and give financial support to the long-term care recipient. Even though the secondary caregiver may not be as intimately involved with day-to-day issues, the stress on them is similar to the primary caregiver and cannot be overlooked.

A recent study was done by Genworth Financial on the true impacts of caregiving, and the findings are sobering. First, almost half of long-term care recipients had never considered the possibility of needing long-term care.4 Therefore they had no plan in place and their children were compelled to provide hands-on care and financial support, often without warning or preparation. This creates havoc with the adult children's careers, businesses, children, and social life. And, many of the care recipients moved into a family member's home for a period of time, creating further pressure and stress on the caregiver and the caregiver's spouse and children.

Currently, the average age of primary caregivers is 53.5 This is a major career and family-building time of life. Caregivers in this group find themselves in the "sandwich generation," caring for ailing parents at the same time they're raising their children. The stress and pressure from juggling these responsibilities cannot be overstated, along with the guilt that comes from the caregiver feeling they're not giving enough, and continually disappointing someone they love.

Other stresses on the caregiver's family come into play, including spouse's resentment at losing time and emotional nurture with the caregiver; children feeling neglected and missing the parent's companionship; conflicts with caregiver's siblings over how care will be provided, and how physical and financial support will be shared, and resentment from the caregiver's spouse and children if they feel the caregiver's siblings are not contributing as much as they should.

As if the emotional stresses weren't enough, there is also a financial impact to providing care that impacts the caregiver and

their family. Over 80 percent of caregivers reported that they contributed financially to the care of the recipient, at an average cost of $8800, not including facility care costs. More than 50 percent of caregivers had to dip into their own savings and/or retirement funds, and 63 percent reported a loss of income (an average of 23% loss) due to their inability to work at full capacity or to take advantage of promotions or other career opportunities. Almost two-thirds of caregivers reduced their family's savings, 40 percent reduced family vacations and 45 percent cut back on their own family expenses.6 The resentment and hurt to spouse and children by these occurrences can only be imagined.

In addition to these family stresses, there are continual pressures from trying to maintain a career or business while providing care. Many of us don't work just to get a paycheck: we find work a creative outlet for our talents and a source of satisfaction and personal growth. But primary caregiving takes a big toll on this aspect of the caregiver's life as well. Almost half of caregivers had to give up a job, reduce their hours or pass up promotions, while 38 percent incurred repeated absences and lateness to work. The inability to focus on the job creates additional stress on the caregiver, along with the physical exhaustion they feel from providing care in addition to their time at work. 57 percent of caregivers provide care for more than 16 hours each week, and 31 percent provide care for more than 30 hours each week.7 It's not hard to see how a job or career will quickly suffer when an employee needs to spend this much time in caregiving.

At the macro level, the losses to American businesses from employee caregiving are huge: an estimated $33.6 billion per year in lost productivity8. In the current economic climate, it is one more challenge employers can ill afford, especially if key employees are affected.

So what can be done to help employees and businesses better deal with employee caregiving?

There are a number of solutions that approach the problem from different angles. One of the simplest solutions is for employers to offer long-term care insurance to their employees. There are several types of group programs available, and smaller businesses can take advantage of individual policies with simplified underwriting and discounts off standard premiums. These are called "multi-life" policies and have a number of advantages over a true group model of providing coverage, such as:

1. Policies are owned by each employee instead of by the employer, and thus are completely portable;

2. If an employee leaves, there is no administration for the employer, such as COBRA, conversion, or continuation policies. The employer simply removes the employee from their billing and the insurance carrier will offer the employee the option to pay directly;

3. Because the plans are individual, the employer has great flexibility in to whom the plan is offered and the type and amount of contribution;

4. Benefit options are flexible and can be tailored to the employer's and the employee's budget; and

5. Premium discounts are also offered to the

employee's family members, such as spouse or partner, parents, grandparents and in-laws. This is a direct benefit to the employer, because these are the very individuals for whom the employee is likely to be a caregiver.

Depending on the state where the employer is located, requirements differ regarding the minimum number of employees needed for multi-life coverage. And, while purely voluntary plans are available, it is often in the employer's best interest to make even a small contribution. This ensures greater participation and more protection for the employer's bottom line. Employers have been surprised at the number of employees who enroll, with a contribution as small as 50 percent of monthly premium, to a maximum of $25 per employee.

Many employers have found it necessary to cut back on medical and dental benefits in the past couple of years. Some of them are helping boost employee morale by offering small LTCi benefits to make up the difference. LTCi is actually an essential part of retirement planning, and even a $50 daily benefit for two years creates an immediate benefit of $36,500, which protects the employee's savings and investments. The cost for a benefit like this will average from$20 to $40 per month per employee, depending on employee ages. This

can be a valuable investment for an employer, especially if the option for family members to apply is well publicized.

In addition to making long-term care insurance available to employees, employers who have employee assistance programs in place can provide valuable support to employees who are in caregiving situations. The long hours, stress, and exhaustion caused by long-term caregiving often deprive caregivers of emotional support, and the opportunity to get some counseling can be a huge relief and can provide important perspectives the employee may not see when they're mired in the daily grind of caregiving.

Another option may be to offer key employees more flexible hours or to allow them to work offsite for all or part of their work schedule. This may allow them to trade caregiving duties with other family members, and may relieve some of their stress due to daily commuting and the rigidity of fixed hours.

As the U.S. population ages and 75 million Boomers race into retirement age, the need for long-term care will multiply exponentially. The U.S. Department of Health and Human Services estimates that 70 percent of people aged 65 and older will need long-term care at some point in their lives.9 Individuals and employers can plan ahead for this eventuality by having open discussions with their families and their work teams, and take steps to protect the health, stability, and finances of their employees by facing the issue squarely.

Caregiving for long-term care patients is a growing issue for women workers and their families, and an increasing cost to business in lost productivity, but the losses can be minimized and managed with some foresight and planning. It is in the interests of all men and women, employers and agents to understand and plan ahead for the realities of long-term caregiving.

BIO

Susan Blais is a principal of Barry J. Fisher/ Paradigm Insurance Marketing, a brokerage general agency focusing on long-term care insurance and related products. Barry J. Fisher/Paradigm Insurance Marketing has offices in California and Arizona, and works with agents across the country. You can reach Susan at 818-444-7757 or at susanb@ paradigmins.com, www.bjfim.com. A national listing of professional long-term caregivers and facilities can be found on this page: www. bjfim.com/miscellaneous/my-senior-care/.

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THE ECONOMY, STUDIES AND GROUP DISABILITY INSURANCE

Writen By Joseph Rachinsky

Has Group Disability Insurance Turned the Corner? Is the current recession different than past times of economic uncertainty? Do we really know?

The direction of group disability experience has been the subject of several recently released studies. The National Business Group on Health (NBGH) released its Employer Measures of Absence, Productivity, Absence and Quality Study (EMPAQ). The Council for Disability Awareness (CDA) has also commented on CDA's own studies and Social Security Disability Studies.

As a preface to my comments, let me briefly summarize differences between the report results. "The incidence of short- and long-term disability claims declined while long-term disability costs surged during the recession, employers said in a National Business Group on Health survey released on January 28, 2011. NBGH's annual "Employer Measure of Productivity, Absence and Quality" [EMPAQ] survey found that the incidence of STD claims declined 17.3%, dropping from 8.1 claims per 100 covered employees in 2008 to 6.7 claims per 100 covered employees in 2009.

Meanwhile, LTD claims dropped 26%, from 4.6 claims per 1,000 employees in 2008 to 3.4 in 2009.

The survey also found that STD costs fell 15.9%, from $343 per employee in 2008 to $296 per employee in 2009. LTD costs increased

more than 25%, from $10,507 per claim in 2008 to $13,226 per claim in 2009." (Emphasis Added)

It is important to note that The EMPAQ results are contradictory to the Social Security Disability Insurance data (claim applications up 21% and awards up 10% in 2009).

Like many disability professionals, I read the Risk and Insurance article and the reports in question and would like to make a few observations.

In general, we believed that the SSDI results represented a much broader group of covered individuals then did the Group DI results. Group DI tends to be more white-collar oriented. EMPAQ experience is based on 648 contributing companies. While the groups are generally large, their results are much less credible than the larger groupings of insured lives covered by the major group and individual disability income insurers and the Social Security Disability program. Intuitively, EMPAQ members are also more proactive when it comes to increasing employee productivity and reducing absences. This certainly can add a bias to their results versus the rest of the insured population and, certainly in relation to the Federal government plan. In addition, the 2009 EMPAQ group contained 648 employers, the 2008 study had significantly less. This can also be a contributing factor to the wide differences. Notwithstanding, to me, EMPAQ is a clue to the puzzle. So are the Social Security Disability results. So are the CDA results. The results of the upcoming 2010 CDA study of claims will be very interesting since it should reflect what some believe is the tail end of the current recession.

I confess to being a "disability junkie" so I tend to read all of the reports that I can access. I also look at the published financial results of the major long term disability insurers as a good indicator of where we are headed as an industry. Although many do not specifically report complete disability data, you can generally sense a trend if a number of major carriers are citing increased disability claims frequency or duration or both as a reason contributing to declining group profits. Again, it's a clue.

First of all, I find it significant that Unum, the largest non-government data base of group and individual disability claims, when reporting their fourth quarter 2010 earnings indicated that their loss ratio was stable but they were seeing higher incidence in group long term disability claims but more favorable recoveries.

Of equal significance is the fact that two other top group disability carriers, Hartford and Standard both announced increases in LTD loss costs. Hartford indicated a 7% increase in the group loss ratio, attributable to an increase in LTD loss costs while Standard reported higher incidence, fewer closures and a 2.5% increase in its LTD annual incurred loss ratio.

Prudential's group insurance earnings were flat, attributable to more favorable group life experience offset by losses from group disability. Met Life reported a 4% decrease in insurance profits. Group dental and group life had favorable and solid results, respectively. These results were offset by other non-health products.

Lincoln reflected a decrease in quarterly group insurance profits from $ 30 million down to $ 18 million in 2010. Aetna reported improved underwriting margins on group disability and CIGNA's earnings were flat but they were emphasizing disability insurance claim management. Reliance Standard had not reported earnings at the time this article was written.Guardian and Liberty Mutual do not report quarterly earnings since they are mutual companies.

Overall, 2010 seems to have been a less than stellar year for most of the major group disability insurers.

1.National Business Group on Health "Employer Measures of Productivity, Absence and Quality Survey, 2009" January 2011

A Few Observations Are in Order

I don't believe that the NBGH comments (longer term claimants are more seriously ill) adequately explain the increase in LTD claim costs. Before I retired last year, the LTD professionals at my company and many of our industry counterparts, insurers and reinsurers, felt that there was some truth to the fact that employees were reluctant to go out on disability in a bad economy. Why? No job to return to. I definitely believe that's the case. I also believe that the increase in LTD costs is a function of employees who have already perfected an LTD claim saying, "You know what, I can live on my LTD benefit, it's better than the uncertainty of a return to work. Will I have a job to return to? Does my employer feel he can live without me?" I suspect that the increase is also reflective of older and more highly compensated employees who are already on claim, staying out on claim.

One of the unanswered questions is why the EMPAQ report also showed a 19.2% increase in incidence of Family Medical Leave Act (FMLA) claims in 2009 versus 2008. Since a significant portion of FMLA claims are due to the employees' own illness, it would seem to run counter to the STD trends noted in the same report. The EMPAQ report also shows a decrease in incidence in Worker's Compensation claims to 2.6 per 100 down from 3.7 per hundred in 2008. The report attributes part of the decrease to recent reductions in work force. We've all read or heard about the fact that the layoff of less experienced, newer workers leaves more experienced hands, yielding fewer Workers' Compensation claims.

I believe that the real proof of what's happening is that the shorter duration disability claims are decreasing and LTD claims are more severe or, at least, more prolonged. This to me is what the combination of the studies is saying. The 2010 results of the public companies that report disability experience seems to validate this trend, with the exception of Unum, who have always had the reputation of proactive LTD claim management.

I welcome the reader's thoughts on the increase in FMLA incidence.

Regardless, the larger concern for me is what happens now that the recession seems to be over and things are returning to the "new" normal. Will employees now find the time is better to test the disability claims waters? Has the "new" normal changed the experience of the disability industry going forward or, is it business as usual?

BIO:

Joseph Rachinsky has over forty years experience in the group disability insurance industry. He is a frequent contributor to over forty LinkedIn insurance groups and provides consulting, expert witness, arbitration and underwriting and product development support. Mr. Rachinsky is located in West Chester, PA. He can be reached at joseph.rachinsky@jrachinskyconsulting.com or j.rachinsky@hotmail.com

2. A "disability junkie" is someone who knows the ADEA Reducing Benefit Duration Table by heart.
3.UNUM Reports Fourth Quarter 2010 Results, Business Wire February 2011. Annual results as reported on Business Wire are the source for Unum and all other public company comments.

Voluntary Benefits Magazine

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