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News and Tips for America's Benefits Professionals

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AUGUST 2013

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AUGUST 2013

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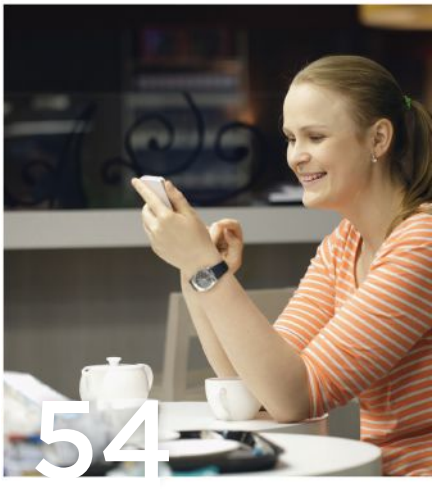

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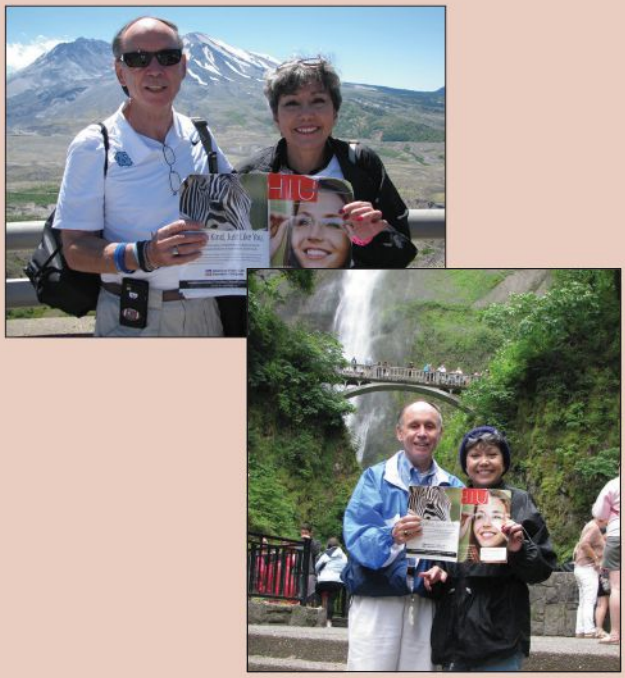

Rufus and Toni Langley at Mount St. Helens, Washington, and Multnomah Falls near Portland, Oregon.

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VOLUME 60, NO. 8

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Back issues are $4 each.
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MAILING ADDRESS
1212 New York Avenue NW, Suite 1100
Washington, DC 20005

The opinions expressed in this magazine are not necessarily endorsed by NAHU nor does the magazine assume responsibility for statements made in advertisements or published articles. **Send editorial submissions to:** HIU Editor, 1212 New York Avenue, Suite 1100 Washington, DC 20005.

Health Insurance Underwriter (ISSN 0017-9019, publication no. 238660) is copyrighted and published 12 times a year by the National Association of Health Underwriters. All rights reserved. Periodicals postage paid at Washington, DC, and at additional mailing offices. $25 annual subscription rate is included in member dues. **Postmaster: Please send address changes to:** Health Insurance Underwriter, 1212 New York Avenue, Suite 1100, Washington, DC 20005.

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THIS MONTH'S EXPERTS

Andy Alquist is benefit partnership program manager at The American Worker Plans. Andy started his career in the employee benefits field in the early 80s. He has worked in the brokerage world and in personal production. His experience includes product design and marketing, agency startup and operations, direct and brokerage sales, recruiting, training and sales management. His interests include golf, hiking, reading and travel. Andy resides in Lake Barrington, Illinois, and is married to Lynne. Together, they have three children.

Tony Boquet is the Executive Director of the Penn Mutual Center for Veterans Affairs at The American College. For 30 years, he has been a leader in the financial services industry, much of which has been as a fee based Estate Planner and Financial Planner. Tony has earned the Chartered Life Underwriter, Chartered Financial Consultant, Chartered Advisor for Senior Living, Chartered Leadership Fellow, Life Underwriter Training Council Fellow, Fraternal Insurance Counselor (FIC) credentials, as well as his Series 7, 24 and 63. He is a graduate of the Purdue University Professional Management Institute.

A native of South Louisiana, has been happily married to Toni Ann for 34 years. They have two great children and three adorable grandchildren. His hobbies are playing guitar, instructing Taekwondo and self-defense classes in HapKiDo, riding motorcycles and reading.

Dean M. Hoffman is the owner of a consulting firm and has been in the employee benefits industry for more than 35 years, with a primary focus on large group employee benefit plans. Dean has expertise in a broad range of employee benefits, including prescription plan analysis and all funding arrangements for large group plans, including conventionally funded as well as minimum premium, retrospective, experience refund, stop-loss and self-funding. He is a past president of the Wisconsin AHU and chaired NAHU's Membership Committee in 2009-2010. Recently, he chaired NAHU's 2011-2012 Professional Development Committee.

Arthur "Abbie" Leibowitz is executive vice president, chief medical officer and cofounder of Health Advocate Inc. Dr. Abbie is a nationally recognized authority in managed care, clinical management, quality assurance and medical data and information systems. Prior to cofounding Health Advocate, he was executive vice president of Medscape Inc. and chief medical officer for Aetna U.S. Healthcare and U.S. Healthcare. Previously, he spent 12 years in private pediatric practice. Abbie earned his medical degree from Temple University Medical School. He is board certified by the American Board of Pediatrics, is a fellow of the American Academy of Pediatrics and a member of the Philadelphia Pediatric Society.

Dan Maynard is the president and cofounder of Connecture, a Wisconsin-based company that makes the information systems that carriers use to sell, administer and manage their products online. Dan has more than 25 years of experience in the health insurance technology industry, including executive roles in sales, marketing, operations, software development, financial management and corporate development. He built and led several companies, including CCISoft, Riverwood Solutions and Connecture. In his current role as president of Connecture, he drives revenue growth and corporate development. In addition, he serves as member of Board of Directors at Hayes Technology Group and as a strategic advisor to SoLoMo Identity, GrandCare Systems and Planet Wise. He is a graduate of the University of Wisconsin-Milwaukee.

Dwane McFerrin is the vice president of Medicare solutions at Senior Market Sales. Dwane is responsible for the strategic direction of the Medicare product line, carrier

relationships and a team of 22 marketing coordinators that generates over 150,000 new enrollments into Medicare-related products annually. Dwane has more than 30 years of experience in executive-level positions in the insurance industry. Prior to joining SMS, he was vice president of marketing at Mutual of Omaha, senior VP of agency at Physicians Mutual Insurance Company and owned a marketing consulting firm. Dwane also served as an adjunct professor for Bellevue University teaching the capstone class to the MBA program.

Dwane holds a Master of Science Degree in Industrial/Organizational Psychology from the University of Nebraska at Omaha, a Bachelor of Arts from Central College and LIMRA's Leadership Institute Fellow designation.

Gentrie Pool is the sales director for Sterling Health Services Administration. Her role is to make doing business with the company as easy as possible for agents and their support staff. She educates them on products, keeps them abreast of market and carrier trends and stays in front of changes to the law. Her goal is to increase visibility in Texas and other states through developing and growing relationships with agents and general agents. She holds her CSA, REBC, RHU and SGS designations and is a former Fort Worth AHU president and Texas AHU board member. Prior to joining Sterling, she worked at IIS Benefit Administrators and U.S. Health and Life. She has more than 10 years of experience and is completing a master's degree at Texas Christian University.

Dustin Sapp is cofounder and president of TinderBox, a web-based platform designed to manage and streamline the creation, delivery, and tracking of sales proposals, contracts and business communications. Dustin Sapp is an executive experienced in building and growing high-technology businesses. He has established expertise in operations, product development, implementation, management, budgeting and customer identification. He graduated with honors from Rose-Hulman Institute of Technology with a degree in Computer Engineering.

Michael Zuna is executive vice president and chief marketing officer for Aflac U.S. He is responsible for all marketing and sales enablement strategies, including product, consumer engagement, customer acquisition and retention, as well as field marketing to Aflac's 70,000 agents and broker ecosystem. Prior to joining Aflac, he served in executive roles at Saatchi & Saatchi and Arnold Worldwide. Last year, *Forbes* named him one of the most influential CMOs in the country. He earned a BS in economics from the United States Naval Academy in 1991.

THE LEGISLATIVE FRONT

News from NAHU's Government Affairs Department

There has been a lot of talk around town about President Obama's health reform law lately, but it's been a while since we have actually heard anything from the president himself. However, on July 18, President Obama spoke for the first time on the healthcare law in over a month.

The president noted that the law is doing what he intended it to do, despite some glitches and major political opposition. The president didn't comment on the recent delay of employer mandate penalties in this week's speech; instead, he focused on the medical loss ratio (MLR) requirement we are all too familiar with. As expected, he touted the MLR provision, highlighting that because of this requirement, 8.5 million middle-class Americans received rebates from their insurance companies last year, which added up to approximately $1.1 billion. An infographic released by the White House just hours after the president spoke shows just how the MLR rebates work.

The president's speech came less than 24 hours after the House of Representatives passed two pieces of legislation, one that would delay the employer mandate and another one that would delay the individual mandate.

The president also highlighted early reports from some states that health insurance premiums will be lower for some individuals. The Department of Health and Human Services released a report reaffirming the president's statements. The report shows that proposed health insurance premiums for 2014 are nearly 20% lower than the Administration projected in 11 states and the District of Columbia. Critics of the law, however, are not impressed with the rate projections, given that the states expected to see the biggest reductions had highly regulated insurance markets even before PPACA was even written.

Also worth noting is that the Administration is comparing the cheapest policy in the middle tier of benefits to estimates for the second-cheapest policy, obviously not a direct comparison. The rate information to date also does not include details about provider networks, and many anticipate those will be substantially skinnier than what consumers are used to in today's marketplace.

During the speech, the president, interestingly enough, noted that more Americans would be getting more for their money, but not necessarily spending less on their insurance. It is obvious that insurance rates will go up for many Americans across the country; we won't know just how much they'll rise until all states submit their 2014 premium rates. Obama also noted, "I recognize that there are still a lot of folks—in this town, at least—who are rooting for this law to fail…Some of them seem to think that this law is about me. It's not. I already have really good healthcare."

Following the speech, Speaker of the House John Boehner responded, "The picture the president paints of his healthcare law looks nothing like the reality facing struggling American families. They know that the law is turning out to be a train wreck."

RATES IN NEW YORK TO DROP 50%?

New York's insurance market has always been a little different, and not necessarily in a positive way. The market itself is highly regulated and, like everything in the big apple, incredibly expensive. New York State has approximately 2.5 million uninsured people, yet only 17,000 people statewide purchase their own individual insurance coverage. New York's individual market has long been one of the most expensive and regulated in the country, due to pure community rating and guaranteed issue of coverage without regard to preexisting conditions.

State officials are predicting 615,000 of the state's 2.5 million uninsured will purchase coverage in the state exchange in the first year, and that may be because late last month news broke that individual insurance premium rates in the state of New York are set to drop 50% or more in 2014 for some individuals. Democratic Governor Andrew Cuomo touted the rate drop in an announcement (www.governor.ny.gov/press/07172013-health-benefit-exchange) on July 18 but complete details remain sketchy.

Skeptics have pointed of that because New York insurance premiums were already so expensive, while some rates are going to drop in 2014, premium rates in New York will still be higher than the country's average. Also, it's unclear if rates for all individuals will drop that much or just some consumers will see a big difference.

COMPLIANCE CORNER

Your Regulatory Questions Answered by NAHU's Legislative Team

Q: *Does the minimum value apply to groups self-insuring?*

A: Minimum value applies to large employers irrespective of type of funding. Actuarial value applies to small-group and individual plans and is represented by the metal levels.

Q: *I believe that PPACA required that employers notify employees, in writing, at least 60 days in advance of any proposed plan change. Has this been postponed?*

A: No.

Q: *Should an employer decide to make a plan change at renewal, is there a time period these changes must be made and employees receive notification before hand—i.e., 30 or 60 days?*

A: Thirty days.

Q: *If a group implements changes to the group health plan at any time other than the group renewal, what timeline and notification is required by the employer to the employee, if any?*

A: Sixty days.

Q: *If a group decides to cancel group coverage due to HCR, is there a required notification period the employer needs to notify the employee in advance? If so, what do they need to provide to employee? (I'm mainly thinking about groups under 50 not subject to mandate.)*

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A: I would think a minimum of 30 days. It certainly will tie into how early any payroll deductions are made. There is new guidance on this. In the FF-SHOP, an employer may terminate coverage for all enrollees covered by the employer group health plan effective on the last day of any month, provided that the employer has given notice to the FF-SHOP on or before the 15th day of any month. If notice is given after the 15th of the month, the FF-SHOP may terminate the coverage on the last day of the following month.

Q: *I heard that a married couple HAD TO file jointly to get a subsidy in the exchange. Is that correct?*

A: According to the rules published on May 23, 2012:

Health Insurance Premium Tax Credit

iii. Married Taxpayers Filing Separately

Section 36B(c)(1)(C) provides that **married taxpayers who do not file a joint return are not applicable taxpayers and are not allowed a premium tax credit.** Accordingly, married taxpayers who receive advance credit payments but do not file a joint return must repay the advance credit payments. The advance credit payments must be allocated equally to each taxpayer for purposes of determining the amount of excess advance payments. The final regulations clarify that this equal allocation also applies if one spouse is treated as unmarried under section 7703(b) (and may, for example, properly claim the premium tax credit on a return filed as head of household). The proposed regulations requested comments on special rules for taxpayers who receive advance payments but face challenges in meeting the joint

An educated guess based on the experience in other states is the later. Also, building on that other state experience, we'd also be willing to wager that provider networks for those low-cost NY policies might be a little slimmed down than normal.

NO NAVIGATOR SURPRISES

The Obama Administration released its final regulation on health insurance exchange navigators and other assisters on July 19. We went through it and found it to be a surprisingly quick 200+ page read. The reason why is there were few surprises in it. Instead, it largely codified the proposed requirements released earlier this spring.

The final rule formally established three different kinds of exchange-based assistance programs: navigators, non-navigator assisters and application counselors. HHS also released this fact sheet that describes the role of each program in detail: www.cms.gov/CCIIO/Resources/Files/Downloads/marketplace-ways-to-help.pdf.

All navigators and non-navigator assisters working in partnership or federally facilitated exchanges must fulfill training requirements, pass a certification exam and receive continuing education, and be certified or recertified on at least an annual basis. The rule specifies 15 topics that must be covered in the federal training module and provides for up to 30 hours of training. The training module includes a section on privacy and security standards, and the rule stipulates navigators and other sisters must meet privacy and security standards, but the consequences for fraud and violations and means for making impacted consumers whole still remain unclear. Furthermore, while the rule provides for federal navigator screening, it also specifically allows for additional state-based standards as long as they do not conflict with the application of PPACA and claims states may not impose requirements on non-navigator assisters.

Navigators and assisters will not have a direct exchange portal to use, but instead will assist consumers via www.healthcare.gov.

The final rule also finalizes rules governing certified application counselors, who are expected to have more limited duties than navigator or other assisters. It clarifies that all exchanges, including state-based ones, must have certified application counselors. State exchanges may choose to certify individuals or whole organizations or both, and individuals or organizations must agree to comply with the standards and requirements of the regulation. Certified organizations must oversee compliance by their employees or volunteers. The federal exchange will only certify application counselor organizations.

At the same time the final rule was released, HHS published guidance on the certified application counselor program and a sample of the application form that will be used by CMS for certified application counselor organizations.

In addition to these materials, on July 10, CMS published an FAQ addressing the requirement that state exchanges must be self-sustaining by 2015.

NAHU COMMENTS ON MARKET REFORMS AND EXCHANGES

NAHU recently submitted a letter to the Obama Administration concerning the proposed rule titled "Proposed Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs and Market Standards." Our national exchange coordinators working group, the Legislative Council and a specially convened group focused on web-based brokers helped to develop it. Here are the highlights:

- Clarification is needed about coming changes to carrier participation and contribution requirements in the group marketplace. Specifically, we'd like to know about the applicability of the changes to

stop-loss insurers, if the changes allow for issuers to charge groups with lower participation more, and what will be considered valid waivers of coverage for small-group plans that are not issued between November 15 and December 15 each year. Also, we've asked what will happen to employer groups with mid-plan year renewals that can meet issuer participation requirements one year but cannot upon renewal. Will that employer plan be forced to disband until the next November 15-December 15 open-enrollment window?

- Federal policies that will require all non-grandfathered individual policyholders and many small-group policies to renew each year either in December (small group) or January 1 (individual) could spell trouble for marketplace customer service.
- Carriers should be allowed to offer consumers new non-exchange plans year-round.
- Exchange business partners should have longer than one hour to report potential data security and privacy breaches and incidents.
- Unless the proposed web-based broker liability standards are modified in the final rule, they have the potential to substantially limit a key point of exchange access for independent agents and brokers in the federally facilitated marketplace.
- HHS does not really need to step on any state insurance commissioner toes when it comes to enforcing federal exchange privacy and data security requirements.

NAHU had a meeting with HHS leadership in July to discuss our thoughts on key components of the proposed rule concerning exchange development. Final requirements are expected at the end of this month. We will keep you posted! HIU

NAHU HAD A MEETING WITH HHS LEADERSHIP IN JULY TO DISCUSS OUR THOUGHTS ON KEY COMPONENTS OF THE PROPOSED RULE CONCERNING EXCHANGE DEVELOPMENT. FINAL REQUIREMENTS ARE EXPECTED AT THE END OF THIS MONTH.

return requirement, for example because of the incarceration of a spouse, domestic abuse, or a pending divorce….

The final regulations do not provide special rules allowing married taxpayers to claim the premium tax credit on separate returns. However, the IRS and the Treasury Department intend to propose additional regulations regarding eligibility for the premium tax credit to address circumstances in which domestic abuse, abandonment, or similar circumstances create obstacles to the ability of taxpayers to file joint returns. Comments are requested on the documentation that a taxpayer could provide to establish that he or she cannot file a joint return because of the domestic abuse, abandonment, or other similar circumstances, on what treatment should be accorded the other spouse if he or she does not file with documentation supporting an exception, and the need for anti-abuse rules.

Q: *If a company offers insurance to at least one-third of the EEs during open enrollment, it will not be subject to the shared responsibility. In the notice, it says that you have to offer the insurance to the full-time and part-time EEs to come up with the one-third count. Is that correct?*

A: Both must be considered for this calculation.

Q: *I have a group that has 129 EEs, of which 79 are on the health insurance. This company has 300 1099 independent contractors that are not eligible for the insurance. Do you know of any new changes to the Common Law Employees rules? We are concerned that the company might have to start offering their coverage to the 300 1099 EEs.*

A: 1099 numbers of that magnitude would be a red flag to me. I encourage a thorough review of such persons, as both IRS and DOL are increasing audits of this. But common law employee is the standard.

NAHU Members: If you have a question about compliance with health insurance laws or regulations, send it to legislative@nahu.org.

INDUSTRY INNOVATIONS

BENEFITMALL LAUNCHES HEALTHCARE-REFORM COMPLIANCE ANALYSIS TOOL

BenefitMall recently announced the expansion of its regulatory compliance suite with allCheck, an online broker-centric compliance analysis tool geared toward the small to midsize employer.

"As 2014 draws near, it is absolutely critical for the groups we serve to have a full understanding of the implications surrounding PPACA provisions," said Michael Gomes, senior vice president of Government and Carrier Relations. "The allCheck tool, along with our online community for healthcare reform, HealthcareExchange.com, are examples of how we are making information available to all audiences to better understand how the Patient Protection & Affordable Care Act impacts business decisions and what to expect in the future."

There are more than 6 million small businesses in the U.S. trying to understand PPACA, and how the legislation will have a bearing on their business. allCheck is an educational tool that provides employers with an initial assessment of how this sweeping legislation may impact them. allCheck takes employers through a 10-minute survey that bases its assessment on some of the most critical factors of PPACA: eligibility, tax credits, affordability and reporting.

Once employers answer a few questions about their business, allCheck then generates a customized report that provides an overview of how PPACA will impact them. This report highlights possible actions to consider including reviewing the employers current benefits offered with a broker to ensure they meet minimum standards, evaluating their workforce to determine appropriate eligibility rules, and talking with a tax professional about claiming possible tax credits. Additionally, employers will receive advice about other benefit and payroll compliance considerations, including a review of the new Summary of Benefits and Coverage (SBC) and W-2 reporting requirements.

allCheck is complimentary for all registered BenefitMall brokers. Employers can gain access to allCheck through a registered BenefitMall broker. In the near future, BenefitMall will also offer complimentary access to allCheck to CompuPay payroll clients. For more information, visit www.BenefitMall.com.

GUARDIAN WEBSITE ENHANCED TO ACCEPT BENEFIT CHANGES ONLINE

The Guardian Life Insurance Company of America has announced that it is one of the first to permit brokers and plan holders to now request plan changes online through the Guardian Anytime website. This enhancement is part of Guardian's ongoing commitment to providing tools and resources to help its brokers and plan holders succeed.

Brokers and plan holders can now quickly and easily request popular benefits plan changes, such as waiting period, termination of coverage, dependent age limit, open enrollment period, and legal plan name and address through the website. Users are updated throughout the process with email notifications and transaction logs to ensure the experience is as efficient and seamless as possible. The new online capabilities take the place of previously manual tasks, which were paper-intensive and difficult to keep track of.

"Healthcare reform is putting unprecedented pressure on brokers and plan holders, who are increasingly looking to their service providers to help them save time and be more efficient," said Andrea Csaszar, VP of group customer service delivery. "We are always looking for ways to make our customers' lives easier, and this enhancement is an example of how Guardian is using technology to add value."

In addition to requesting plan changes, other functionality includes bill payment, employee enrollment, and access to eligibility information, as well as forms and materials. The Guardian Anytime Mobile app for both iPhone and Android is also available. For more information and to download the free app, please visit www.guardiananytime.com.

NEW DENTAL, VISION PRODUCT FROM THE STANDARD IDEAL FOR SMALL-BUSINESS CLIENTS

Small-business owners interested in providing employees quality dental and vision insurance benefits without incurring the expenses of administering two plans can now offer PolicyLink Dental + Vision Plan, the newest product from Standard Insurance Company. PolicyLink Dental +

Vision Plan combines two valued employee benefits, dental and vision, into a single, affordable plan.

"For many small businesses, dental and vision benefits are in a second tier of offerings," said Griff Bailey, second vice president, dental, at The Standard. "Most will offer health benefits first, and add ancillary dental and vision benefits once they're able. PolicyLink Dental + Vision Plan makes these products more accessible to small-business owners, allowing them to provide dental and vision insurance with minimal extra cost and enjoy streamlined administration."

PolicyLink Dental + Vision Plan allows employers to choose their benefits offerings from The Standard's eligible dental products and determine a plan maximum. Within that overall plan maximum, employers can designate an amount for their vision maximum benefit from four options: $150, $200, $300 and $350.

This provides employees with a flexible approach to managing their care. If an employee doesn't require vision care this year, he or she will have the full plan maximum available for dental care. If he or she were to use only a portion of the allotted vision care amount, the remaining money could be put toward dental care.

"Small businesses face a constant struggle, balancing the pressures of running an organization with the need to offer robust benefits to attract qualified employees," Bailey said. "Recent LIMRA data suggests only 25% of small businesses offer dental plans, while only 21% offer vision. Producers can offer PolicyLink Dental + Vision Plan as a solution for clients with tight budgets and limited resources."

To learn more, call 800-633-8575 or visit www.standard.com.

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DIGITAL BENEFIT ADVISORS LAUNCHES PRIVATE EXCHANGE FOR EMPLOYERS OF ALL SIZES

Digital Benefit Advisors is launching Digital Benefits Marketplace, a private exchange to help employers of all sizes control rising benefits costs through defined contributions and fostering consumer engagement. The sophisticated marketplace will offer a comprehensive array of benefits.

"As employers try to control costs and employees assume greater financial responsibility for health insurance, our nation is moving toward a consumer-driven system," said Mike Sullivan, Digital's executive vice president and chief marketing officer.

Digital already has the infrastructure, operational capability and distribution system to effectively launch and manage private marketplaces in multiple states for an employer segment that most of the industry neglects: both middle market and small employers. The company is negotiating with health insurance carriers in additional states, as well as providers of ancillary and voluntary products. Offerings will include health, life, disability, accident, critical illness, long-term care, dental and vision insurance, along with other products and services.

Digital's focus is on a differentiated consumer experience that is a harbinger of things to come in the healthcare arena. Digital's marketplace will become a true online storefront with a comprehensive range of policies and plans from multiple carriers—and one crucial element: a call center with licensed customer advocates to guide individuals through the selection process.

"We know from 13 years of experience that complex benefits decisions require support from knowledgeable personnel," explains Sullivan. "Our company has invested in technology that enables us to efficiently focus on providing a superior level of service to any size employer. Our view is that we have built a capability and cost advantage that will drive our competitive value well into the future."

Digital Benefits Marketplace will be introduced in the coming months in many states across the country. For more information, visit www.digitalinsurance.com.

CASTLIGHT HEALTH WELLPOINT

CASTLIGHT HEALTH AND WELLPOINT INTRODUCE REFERENCE-BASED BENEFITS

WellPoint and Castlight Health have announced a joint offering for employers called Reference-Based Benefits. Innovative healthcare benefit designs are an important component of controlling costs while increasing access to quality care. The new offering combines Castlight's consumer-focused healthcare transparency solution with WellPoint's affiliated health plans' focus on customer service, broad provider networks and efficient administrative processes.

Wide price variations often exist for the same healthcare services, even within the same geography and same network. However, higher prices do not necessarily correspond to better-quality care. This creates an opportunity to reduce costs without sacrificing quality.

With Reference-Based Benefits, employers can set a benefit limit, or "reference price," for specific types of services covered under their group health plans administered by WellPoint's affiliated health plans. Using the new consumer-friendly tools provided through the Castlight and WellPoint collaboration, covered employees can easily find high-quality providers that provide the services for a fee that is at or below the reference price.

"The high cost of medical care is one of the biggest challenges facing U.S. businesses today. While some companies are evaluating whether to continue to offer health benefits, the most innovative of them are looking for new solutions to control healthcare costs while preserving employee choice and flexibility," said Giovanni Colella, CEO and co-founder of Castlight Health. "Reference-Based Benefits builds on our collaboration with WellPoint and its affiliated health plans by offering a new way for individuals to become smarter healthcare consumers and help control healthcare costs."

Reference-Based Benefits are highly configurable based upon an employer's needs. They can be dynamically tailored to each specific company in each of its geographies, including variations in which services are included in the program and the reference price for each.

"Our pilot programs for referenced based benefits have driven strong results. We have found that customers want transparency; however, Referenced-Based Benefits bring it to the next stage to help drive a 'call to action.' Coupling transparency with benefit design heightens the shopping experience and encourages greater consumer interaction," said Ken Goulet, WellPoint's executive vice president for Commercial and Specialty Business. "We are able to provide our customers—some of the largest employers in the country—with benefits that can move the needle on cost and quality."

Reference-Based Benefits options are available immediately with implementation to begin for launches in the first quarter of 2014. Additional information is available at www.wellpoint.com.

PULSE CONNECT 3.0 DELIVERS IN-THE-MOMENT HR, HEALTH AND WELLNESS COMMUNICATIONS

Pulse Connect 3.0, an employee-engagement platform developed and published by BackBone Inc., has been successfully migrated to the Wayin Hub, enabling HR departments, benefits brokers and benefits providers to reach, engage and motivate users as they never could before. The Wayin Hub gives Pulse Connect the ability to use Twitter as a uniquely powerful content engine for delivering targeted news and information, while providing organizations with an employee-facing Twitter framework, adding speed and immediacy to their communications.

Pulse Connect is still centered on magazine-style features that use the draw of prominent athletes, artists, movie makers, writers, pundits, business leaders, etc. to spark frank conversations and culturally reinforce lasting positive behaviors; however, the features are now reconfigured as "tweetures"—stories conveyed in a series of multimedia "tweets," making them a fast and thoroughly engaging read. The new version also includes polls and reporting via Google Analytics.

"We believe that Pulse Connect can change HR, health and wellness communications much as Twitter has changed the way news and information is delivered and received around the globe," said Charles Epstein, developer and publisher of Pulse Connect and president of BackBone, Inc. "Twitter's power is in its simplicity and ability to cut through the noise via concise, in-the-moment communications. Pulse Connect is a true engagement hub, combining magazine-style 'tweeture' stories, a dynamic employee-facing Twitter feed, and an eye-catching array of curated tweets from top health, wellness and lifestyle sources. HR and benefits communications are typically disjointed and, for the most part, uninvolving... with Pulse Connect, employees now have a go-to source for up-to the-minute news, tools and information."

"Designed to spark conversation and give people a voice in the issues that directly affect their well-being, Pulse Connect fully leverages the flexible, dynamic power of Wayin Hub," said Elaine Wood, CEO of Wayin. "The Pulse Connect Hub provides a vital framework to centralize communication. The unique design of the Wayin Hub platform provides them with a way to deliver in-the-moment news and information that is important to Pulse users and relevant to their employees."

Compared to traditional communications materials—brochures, newsletters, etc.—Pulse Connect reduces costs and improves outcomes by deepening engagement and creating a more proactive health-conscious user community. Pulse Connect can be customized and integrated into an HR or benefits portal within days. A dedicated editorial team develops weekly "tweetures," topical polls and curates Twitter content from such top health, wellness and lifestyle sources as Men's Health, O, Lifehacker, Bon Appétit and more. Administrators can communicate with their employees via their embedded Twitter feed, dynamically engaging their workforce.

Pulse Connect combines a personality-driven, magazine-style approach to health and wellness with the dynamic, "in the moment" communications of Twitter, promoting more sustained and meaningful engagement around the issues that directly affect people's lives and well-being. For more information, visit www.pulse-news.com. HIU

THE POWER OF THE PAUSE

By Denise VanPutten
Chair, NAHU's Membership Council
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As everybody else is rushing around like a lunatic out there, I dare you to do the opposite. Pausing allows you to take a beat—to take a breath—in your life.

I believe we have an important opportunity in front of us.

We have the power, each and every one of us, to change the way we speak to one another. Even if we can't stop or change any or all of PPACA, we can make a difference in the lives of the clients we serve and the employees who work for them. We are a constant in their lives and will not be going anywhere anytime soon.

We do have to learn the power of pause, though.

It saddens me when people who I care about and have known for years can't return a phone call or an email for days and sometimes weeks. That really bothers me—I take it personally. Really—your time is more valuable than mine?

We have the chance to change the way we are treat one another. You know, this stop-everything-and-pause idea is not a new thing.

Jesus fasted for 40 days and nights in the desert. Thoreau went to Walden Pond. Buddha, Gandhi, Mother Teresa—the greatest and wisest have often stopped and withdrawn from active lives to journey within themselves. The wisdom they garnered there and shared with us has impacted the world.

Don't worry, I'm not asking you for 40 days and nights! I'm only asking you to stop every so often and turn off your mobile device, put down the iPad and the Words with Friends and take a moment. Stop to look up and look around. Pause and check in with yourself… and spend a moment there.

While you're at it, how about pausing and doing something refreshingly different, like talking to someone who works with or for you? Put it all down and look them in the eye. Have a conversation face to face.

And dare I suggest that you pause and write an actual thank-you note—with a pen on paper? My office hired the guy who wrote *The Richest Man in Town*, a book all about a guy who wrote a note that changed the life of the person that he wrote it to. He's still changing people's lives, something we should all aspire to.

Please take the time to pause. When you make others feel good and appreciated, it comes back to you tenfold!

Today I'm pausing to be in awe of you. I'm in awe of where we have been together, what we have gone through and what we have yet to face. I'm so proud of all of you and what you've done and continue to do. Thank you for who you are, thank you for representing our industry at the highest level and thank you for being a leader!!

Whenever you're in doubt, feeling crazy, busier than busy, wondering when it is going to slow down (pretty much every day these days), PAUSE. Take a moment. Be thankful for what we do have. And then share your thankfulness with those around you. Be kind and remember we are all in this together. HIU

AN INTERVIEW

WITH NAHU PRESIDENT

TOM HARTE

In a candid conversation with NAHU President Tom Harte, HIU magazine discovered his passion for making significant improvements in the affordability and accessibility of health insurance and for encouraging NAHU to deliver unprecedented value to our membership.

TELL US ABOUT YOUR BACKGROUND. HOW DID YOU GET INTO THE INDUSTRY?

After graduating from the University of Massachusetts in 1989, I was invited to visit with one of the nation's largest insurance companies to sell life insurance and related products. At that time, it was required that I meet certain prerequisites prior to my receiving any compensation. After several challenging weeks of sales and education, I earned my position and was able to enjoy the opportunity of providing financial security of hundreds of individuals and families during my seven years at this company.

In 1997, I started Landmark Benefits, which was founded on the core values of delivering excellence to our customers and giving back to charity, community and industry. As a result of these characteristics, complemented by a dedicated staff and loyal clients, Landmark Benefits has become one of the most prominent and respected employee benefit companies in New England.

Tom with attendees at NAHU's Capitol Conference earlier this year

HOW DID YOU BECOME INVOLVED WITH NAHU?

In 1996, I was approached by a member of the New Hampshire AHU, Jim Better, and he invited me to assist the association with legislative initiatives that would serve to improve the marketplace in New Hampshire. After a short period of time, the leadership team of NHAHU delivered transformative legislation that served the New Hampshire marketplace by reducing cost and providing for a competitive individual marketplace. I will never forget the public remark made by a member of House of Representatives; she said, "We will not make any decisions until we hear from the Health Underwriters." It was that day that I recognized the positive influence that NAHU delivers to our states.

WHAT DO YOU FOCUS ON SELLING?

At Landmark Benefits, we don't focus on selling anything—we focus on delivering exceptional value to our clients. The clients appreciate our participation in comprehensive wellness programs, compliance resources, communications, human resources and several other services that provide for the productivity and efficiency of our clients while reducing long-term employee benefits costs.

As a result of our efforts on behalf of our clients, we are grateful that our clients demonstrate extraordinary loyalty to our agency. Our clients have always appreciated working with an agency that is dedicated to improving their bottom line and prefer to work with an agency that is involved in the industry while giving back to charity.

YOUR COMPANY IS A PROPONENT OF WELLNESS. DO YOU FIND MORE AND MORE CLIENTS LOOKING FOR THAT?

Absolutely. Studies have shown that 70% of the cost of healthcare in the United States is the result of preventable healthcare conditions. As a result, it is in the best interest of companies across the country to embrace wellness programs to reduce their long-term cost of healthcare.

Some may argue with the implementation of the new rating model under PPACA that wellness programs will have less of an impact on small groups, however, all groups receive the same benefit of improved health with increased productivity, presenteeism and lower related costs.

HOW DO YOU THINK DOING BUSINESS IN NEW HAMPSHIRE MIGHT BE DIFFERENT FROM OTHER PARTS OF THE COUNTRY?

With the implementation of healthcare reform, the New Hampshire market is similar to most of the other markets across the country. The fact is, as our markets continue to evolve, it will be the employee benefit broker that will play a defining role in determining the competitive marketplace.

Jesse, Kevin, Chrissy, Tom and Melinda Harte

Across the country, employee benefits brokers are searching for that competitive edge; however, too many fail to recognize that membership in your professional trade association, NAHU, is greatest differentiator. Consider this: Most brokers' competition is providing the same service but approximately 20% belong to their professional trade association. I am 100% confident that our clients want to work with a professional employee benefit broker, and membership in NAHU is the foundation of professionalism.

My suggestion to audiences across the country is, when competing against another broker, ask the client if the other broker is a member of NAHU and if he or she is PPACA-certified. Furthermore, explain the value of belonging to NAHU and professional development programs that provide for your certification. Isn't it time that employee benefit brokers, as professionals, are subject to the same standard of approval as other professionals?

THE BOTTOM LINE: NAHU IS DELIVERING TO ITS MEMBERS TODAY, BUT WE NEED TO DO MORE.

WHAT WOULD YOU LIKE TO SEE HAPPEN OVER THE NEXT YEAR FOR NAHU?

NAHU's primary focus must provide for a multifaceted approach to providing our members with exceptional value. NAHU must provide for:

- Aggressive and consistent advocacy for the affordability of our products while preserving the role of the employee benefit broker
- Comprehensive education and certification programs
- Tools and resources to communicate effectively with your clients on matters that will affect your business
- Improving the membership experience by delivering valuable tools and resources.

HOW SHOULD AGENTS AND BROKERS CHANGE TO BE SUCCESSFUL IN THE NEW HEALTH INSURANCE MARKETPLACE?

An overwhelming number of NAHU members have transformed their businesses since March 23, 2010. These efforts have been the result of a deliberate intent to adapt to the changing marketplace and prepare for unprecedented change. Our members must continue to evolve and provide for their value in the marketplace, and NAHU will be their partner in ensuring their future.

Specifically, our members will be engaging in communications, human resources, wellness, compliance and related services to establish their competitive edge.

HOW SHOULD NAHU CHANGE?

NAHU will provide its members will extraordinary membership value in the coming years. This value will be the result of a growing membership, which will provide for additional staffing that will be responsible for delivering ready-to-use resources that our members can immediately deploy in the local market.

Let's not forget that under the leadership of my predecessors, NAHU delivered value with our new website, compliance corner, certification programs, advocacy and other value. The bottom line: NAHU is delivering to its members today but we need to do more.

HOW DO WE, AS AN INDUSTRY AND AS AN ASSOCIATION, ATTRACT AND MOTIVATE THE NEXT GENERATION?

The future of NAHU, and our industry, is in the next generation of members. Our Young Agent Health Underwriters (YAHU) are working tirelessly to provide this next generation with opportunities that will provide for their success. NAHU must accept that demographic groups communicate with considerable differences, and we must understand these differences and determine how to most effectively communicate.

WHAT ARE SOME THINGS THAT MOST PEOPLE AT NAHU DON'T KNOW ABOUT YOU?

I suppose that most would be most surprised at my charitable endeavors, which have primarily benefited the Make a Wish Foundation of New Hampshire. Since 1999, my company has hosted several fundraisers, such as an annual golf event and holiday gala, that have allowed us to make donations totaling over $560,000 to the Foundation.

ANY CLOSING THOUGHTS?

I am hopeful that our membership will exceed 20,000 by June 2014. Considering our membership has been below 20,000 since May 2008, this task will not be easy. However, I am confident in those in national leadership and the Board of Trustees, and I think that we will be successful.

NAHU represents the top 20% in our industry and the time is right for the remaining 80% make an investment in their future. HIU

SELF-FUNDING

OPPORTUNITY IS KNOCKING, BUT ARE YOU READY?

By Dean Hoffman
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Self-funding or partial self-funding is by no means a new mechanism to fund and administer a group health plan. However, as a result of healthcare reform, a renewed interest has sparked many new players, products and opportunities for agents, brokers and consultants who are seeking creative and financially sound ways to help their employer group clients.

Self-funding first started with the passage of the federal Taft-Hartley Act in 1947. Its early use was primarily with union plans and it enjoyed steady growth until the 1970s and the passage of the Employee Retirement Income Security Act (ERISA). It was then that the state regulation of self-funded plans changed to the federal government; this accelerated self-funding acceptance as a funding mechanism for larger employer group plans. According to the 2012 Annual Benefit Survey prepared by the Kaiser Family Foundation, 60% of covered workers nationally are in a partial or true self-funded health plan.

A widely accepted rule of thumb is that an employer group with 100 or more covered employees with good claims experience evidenced by moderate to low rate increases in the recent past may be a good candidate for partial self-funding. However, with PPACA bearing down on the industry, self-funded products are being offered to employers with 50 employees, some at 25. Two vendors recently even launched products down to employers with 10 or more employees in selected states. As interest and new product launches respond to the demand of this funding mechanism, I would suggest caution when you consider these new products for your smaller groups.

SELF-FUNDING AN EMPLOYER-SPONSORED HEALTH PLAN SHOULD NOT BE A LEAP OF FAITH BUT A WELL-THOUGHT-OUT, LONG-TERM STRATEGY FOR EMPLOYERS TO FUND THEIR MOST COSTLY EXPENSE AFTER PAYROLL.

SELF-FUNDED MODELS

This continued growth ultimately evolved into two basic self-funded models available to employer groups nationally. Both of these models provide ERISA-governed self-funded products to financially sound employer groups.

The first model is an administrative services only (ASO), which is an insurance carrier-based self-funded arrangement. This

is usually a packaged product that is built on the claims-paying platform of the insurance carrier. This bundled approach often includes all of the basic claims administration features offered to its fully insured groups. These services include disease/care management, wellness plans, stop-loss protection, provider networks and other services required to properly administer a group health plan.

An ASO model is viewed as a "take as is" product offering, and may be the only product available in some markets.

The second model is a third-party administrator (TPA), which usually features an independent claims payer marketing self-funded plans and unbundled services to employer groups. Some TPAs have been acquired by insurance carriers but, for the most part, function independently within their specific market. The unbundled approach offers basic claim functions and provides additional a' la carte administrative services, enabling the employer to purchase services outside of the TPA's list of services and attach them as needed.

Each model has merits that will need to be considered in your evaluation. For example, an ASO model may have the best provider network discounts in the area, or a TPA may have access to national networks for employers with multiple locations.

ADVANTAGES AND DISADVANTAGES

Self-funding an employer-sponsored health plan should not be a leap of faith but a well-thought-out, long-term strategy for employers to fund their most costly expense after payroll.

There are several advantages in a partially self-funded plan that should be considered. Specifically, cash flow as payment is made only at the time of claim—not payment of a level premium, as with a conventionally funded insured plan. As a plan sponsor holds its own reserves, there is additional interest on those funds that is retained by the employer, not the health insurance carrier.

One area of great importance is the fact that an employer has control of plan design and network configuration, and can avoid selected state-mandated benefits. The ability to choose state-mandated benefits is a critical advantage, as each one of the state-mandated benefits applies to insured group business, not ERISA-governed self-funded products. Employers can select what state-mandated benefits they feel are appropriate for their own employee population and their financial situation. Each one of those state-mandated benefits has a cost associated with it and that cost is passed down to the employer in premium for those who are fully insured.

The Council for Affordable Health Insurance website, www.cahi.org, provides an excellent summary where you will find that states vary greatly with mandates, and some are rather onerous. For example, my good neighbor to the west, Minnesota, and nine other states mandate "hair-prosthetics" coverage in their insured products. I am hesitant to single out any one state or one mandate, but there are many special-interest groups who lobby for health-related items to become state-mandated. Many times, they don't consider the cost that is ultimately passed to the employer and to the employee who has a fully insured plan. In addition, premium taxes charged by most states are included in insured group plans, most of which are avoided in a self-funded arrangement.

There are several disadvantages in a partially self-funded plan that must be considered, including possible poor claims experience and budgeting for claim costs. Your partial self-funded employer groups will love you during the low-claim months. But, in those months that trend higher, the CFO starts to question you and this funding mechanism.

Additionally, there is more employer involvement, such as banking, and there is additional fiduciary and legal responsibility. However, the most disconcerting aspect of any partially self-funded plan is the use of "lasers" on individuals with large shock claims or large claim potential. The use of a laser is a practice of stop-loss carriers, commonly used on the initial effective date and at renewal time, when they carve out those large claims from stop-loss protection and shift the risk back to the employer. Additionally, it is easy for employers to get into a self-funded arrangement, but it can be very difficult to return to an insured product should your employer client get cold feet on risk tolerance, experience a down-sizing of the employee population or experience changes in the local insured market.

STOP-LOSS PROTECTION

Make no mistake, partial self-funding is all about the stop-loss contract available to protect the employer from abnormal risks. Entering into or providing consulting advice without a full and complete understanding of stop-loss protection is a disaster waiting to happen.

An employer-sponsored self-funded group health plan is a lot like a promissory note to the employees to provide certain employee benefits. The employer that has established a plan document guarantees employees and their dependents a health plan that would be funded with employer and employee contribution dollars. Stop-loss protects the employer's plan for claims exceeding predetermined levels. There are two types of stop-loss protection to protect the employer from unaccounted for fluctuations in claims: specific and aggregate.

Specific stop-loss provides protection for that single catastrophic claim—an accident, premature baby, organ transplant or cancer claim. It is not health insurance; it protects the employer and is expressed in dollar amounts from a low of $20,000 to a high of $500,000 on a contract-year basis. Specific stop-loss usually reimburses the employer after proof of loss is submitted to the stop-loss carrier. In addition, there are special stop-loss arrangements that may provide immediate transfer of funds when a claim exceeds the stop loss level and can

vary from one TPA/ASO vendor to another. Specific stop-loss can be offered in conjunction with aggregate but may be written freestanding for larger employers that choose not to purchase aggregate. My favorite underwriter will utilize the following guide when pricing a particular employer.

Number of covered employees	Minimum per person	Maximum per person
101-150	$30,000	$75,000
151-250	$125,000	$150,000
251-500	$100,000	$200,000
501-1000	$150,000	$250,000
1000+	$200,000	$500,000

Again, this is only a guide and the ultimate selection of a specific stop-loss level is determined by the employer's risk tolerance, your guidance and the underwriting guidelines of the reinsurance carrier.

Aggregate stop-loss protects the employer against unusually high overall claim levels for the entire employer group due to high frequency or an unexpected number of large claims not quite meeting the specific stop-loss level. Aggregate is commonly offered in conjunction with specific and is rarely offered freestanding. Aggregate stop-loss claims are expressed as a "single and family aggregate attachment point factor" that is offered as a percent of "expected" claims. The most common are 125% or 130% of expected claims, but they can be found as low as 105% and high as 150%, though that is very rare. The 125% or 130% is the percent over the expected claims, or the corridor, which is the difference between expected claims and the aggregate deductible; this is the risk the employer is accepting in its self-funded plan.

Reimbursement for aggregate stop-loss claims usually occurs at the end of a contract year but can be offered with a monthly aggregate feature that would reimburse monthly when one-twelfth of the aggregate attachment point has been breached. The monthly aggregate feature is generally for smaller employers that may be concerned with cash-flow issues.

Larger employers that have been self-funded for multiple years and whose claims experience is actuarially considered near or at 100% creditability may drop aggregate protection. It is at this point when they are comfortable with the risk and actual claims usually do not differ significantly from expected claims due to that credibility.

CONTRACT TYPES

If there is one thing that you need to take away from this article, it is a complete understanding the various contract types that are available in the market. You may see the use of terms like "true paid" or "gapless" stop-loss contracts, which are variations of the traditional description of the terms of coverage. The most common approach is when the contract terms are expressed with two numbers reflecting the contract period. The first number is the incurred period and the second is the paid period. A 12/12 means claims incurred in 12 months and paid in the same 12 months would have stop-loss protection. A 12/12 would not have run in or run out, and is viewed as an immature contract year. However, a 12/15 contract is defined as incurred in 12 months, paid in 15 months or hard run out of three months.

Traditional contract terms can change at renewal date or when there is a change in stop-loss carriers. Therefore, use caution as these can be different between specific and aggregate stop-loss for the same contract year. It is imperative you and your group clients understand the implications of improper use of contract terms and understand that the use of a terminal liability option (TLO) may appear to be the same as a hard-run-out contract, but they are not.

Consider the following chart as an explanation of how contract terms can change at renewal time and how these may differ from one stop-loss carrier to another when a change in carriers is warranted. Understanding the run-in and run-out responsibility is critical when considering self-funding for the first time. I prefer to start new employers with a hard-run-out contract: 12/15, 12/18 or 12/24 from the inception of the self-funded arrangement. Doing so will help facilitate a change in stop-loss carriers in the future and help smaller employers return to a fully insured arrangement if they need to.

First year	First year description	Renewal year
12/12	Incurred in 12; paid in 12	24/12,18/12 or 15/12
12/15	Incurred in 12; paid in 15	12/15 or 12/18
15/12	Incurred in 15; paid in 12	24/12, 18/12 or 15/12
12/24	Incurred in 12; paid in 24	12/24

PLUG AND PLAY SERVICES

A partially self-funded product with a third-party claims administrator can be very transparent in the various services provided. Those a' la carte or "plug and play" services enable you and your employer groups to evaluate each service to ensure it is performing at optimal levels. When a service is not performing as promised, remove it and replace it with one that meets the requirements of your employer group.

It should be noted that some ASO vendors will entertain a select plug-and-play approach to these services. But, for TPAs, they might include:

- Stop-loss protection
- Provider networks
- Pharmacy benefit managers
- Utilization review
- Disease care and case management
- Lifestyle/wellness plans
- Transplant, specialty Rx and dialysis carve-out protection
- Member support and healthcare navigation
- Data-integration tools

PPACA

With PPACA racing toward January 1, 2014, the industry that we have made our careers around will morph yet again. We will find many smaller employers with less than 100 employee lives consider this funding mechanism to avoid some healthcare-reform provisions. This becomes even more important after 2016, when the definition of small groups grows to include 50 to 100 employee lives.

The renewed interest with small firms seeking self-funding can be partially attributed to the exemptions under PPACA that currently apply to large insured group plans. Smaller groups of less than 50 employee lives, when self-funded, would not be required to:

- Participate in modified community rating of small group insured
- Medical loss ratio requirements in insured plans
- Being assessed the HHS-calculated annual tax to which health insurers are subject starting in 2014, starting at one percent and increasing to 1.5% by 2018
- Avoid all fees associated with enrollment on the federally facilitated SHOP marketplace.

It should be noted that partially and fully self-funded plan sponsors would not be able escape all of the PPACA provisions and would be required to pay:

- Reinsurance contributions to fund the Transitional or Temporary Reinsurance Program (2014-2016). There is an estimated per-person cost of $63 annually in 2014, $42 annually in 2015 and $26.25 annually in 2016.
- Patient-Centered Outcome Research Institute (PCORI) from 2013 to 2019. This would be one dollar annually per person per year in 2013 and two dollars annually per person in 2014.
- Other provision of PPACA, including the preventive mandate, minimum value, the $6,350 cap on out of pocket, eliminating preexisting or exceeding the 90 limit on waiting periods.

SUMMARY

The use of partial and fully self-funded products for employer group plans is certainly not a new concept. As noted earlier, more than 60% of covered workers nationally utilize this funding mechanism to effectively manage their healthcare spend. What will be new is the infusion of new stop-loss contracts and vendors seeking to fill the demand of employers seeking a financially sound alternative to manage their group health plan.

Please use caution! During my travels around the country hosting self-funded workshops for agents, brokers, consultants and employers, I have uncovered many variations in stop-loss contracting, some that are rather unnerving for those who might be risk-averse. Each variation has its implications and must be fully vetted so that you and your employer groups fully understand this funding arrangement before signing on the dotted line. HIU

SOCIAL SELLING FOR THE CARRIER REPRESENTATIVE

By Mel Schlesinger

As a carrier representative or other wholesaler, you face a challenge not faced by other salespeople: You cannot close your target prospect. The best that you can hope for at the conclusion of any meeting with any insurance agent is a promise that the next time that there is an opportunity, the agent will use your product. That promise and $2.25 will generally get you a coffee at Starbucks.

That promise is further complicated by the fact that products such as medical and dental insurance tend to be viewed through the lens of premium competitiveness by the insurance agents that you are working with. So the question is: How do you break through the clutter, stay top of mind with agents and get them to choose you over the competitors even when your products may not be the lowest-cost product in the mix? The answer is: social selling.

Social selling recognizes that buyers make their decisions very differently today than they did 10 years ago. For carrier representatives and wholesalers, working with agents selling has always been social. For years, the above-average carrier representatives understood that out of sight was out of mind, so they scheduled meetings with key brokers at least once every quarter, if not more frequently. And the smartest of those made a point of learning about the brokers' interests and took actions on that knowledge in a way that strengthened the relationship. In addition, the smart carrier representative identified important dates such as birthdays and used to those dates to further strengthen the relationship.

The challenge today is that brokers are busier than they have ever been and are less willing to schedule time in their calendar to hear about products that they can read about.

The social in social selling in the 21st Century is very different than the social of the 20th Century. Today, there are four components to social selling: effective use of social media channels, use of social proof, content marketing and the continuation of the one-on-one personal touch. In addition to those components, there is another change that must take place to achieve above-average production numbers: You must become an entrepreneur within your company. As long as your compensation is directly related to achieving sales goals, you must be willing to invest your own money in technology that can give you a competitive edge.

SOCIAL SELLING RECOGNIZES THAT BUYERS MAKE THEIR DECISIONS VERY DIFFERENTLY TODAY THAN THEY DID 10 YEARS AGO.

SOCIAL MEDIA AND THE CARRIER REPRESENTATIVE

Every carrier representative needs to be involved in both Facebook and LinkedIn. Why? The answer is that many of the agents in your territory are on one or both of those platforms. These platforms offer you the opportunity to touch every one of those brokers on a daily basis and advance the relationship.

But Facebook and LinkedIn are very different environments requiring a very different approach. Facebook is less about business and more about purely social interactions. The agents on Facebook are talking about their drive home, their family and friends and the things that are personally important. LinkedIn, on the other hand, has a purely business focus. For the most part, there is very little talk going on because most people on LinkedIn have not figured out how to use it. They are on LinkedIn because someone sent an invitation to connect or because they think that they should be on it, but they rarely post on it. That is a huge opportunity to the carrier representative who understands how to use the platform. HIU

Mel Schlesinger was president of NAHU in 2011-2012. He has more than 20 years of employee benefit experience and 10 years as a sales coach to benefit professionals. Today, Mel has positioned himself as a social selling strategist, helping agents get more referrals and close more of their new-business opportunities. Mel can be reached at 336-525-6357 or via his website, www.socialproofmarketingmachines.com.

THE DELAY IN PPACA LARGE-EMPLOYER REQUIREMENTS OFFERS AN OPPORTUNITY TO ASSESS SELF-FUNDING AS AN OPTION

By Andy Alquist
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Now that large employers (50 employees or more) have some breathing room as it pertains to the requirement that they offer coverage to all employees working 30 hours or more, they should carefully weigh the option of partially self- insuring their employee benefit plan, as the continuing runaway cost of healthcare is the real issue they face. Most employers with 50 or more lives now offer coverage but are fearful of being able to continue.

Historically, self-insurance has been the preferred option for employers with 1,000 or more employees. Recently, more small and midsize employers are converting to self-insurance. Massachusetts, the only state to enact health reform similar to PPACA, has seen a rise in employers switching to self-insurance. The advantages are numerous, including avoidance of state premium taxes, avoidance of state coverage mandates and, most important, the opportunity to directly affect cost through meaningful plan design and utilization data.

The biggest hurdle for employers with 25 to 150 employees to transition to a self-insured plan design is, to quote George Duczak, president of The American Worker Plans, "You don't know what you don't know." Employers in this size category typically don't receive any useful claim data from their fully insured insurance carriers. Since self-insured—or, more accurately, partially self-insured—plans contain a level of financial risk, many employers are reluctant to consider them since they have no data to base the decision on.

There are essentially two methods for these size employers to remedy this issue. The first and most prevalent method is to have all their employees complete an insurance application that contains detailed health history questions for the employee and any dependents. While this method will provide useful information about current and past medical conditions, it has limited value in predicting future morbidity. In other words, it will not identify any risk exposure that is not known to the applicant.

The second method to secure meaningful data is to have each employee and covered spouse undergo a health assessment screening. The assessment should include a blood draw and a full biometric screening. The health history is not self-reported by the employee but is instead collected by a

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MASSACHUSETTS, THE ONLY STATE TO ENACT HEALTH REFORM SIMILAR TO PPACA, HAS SEEN A RISE IN EMPLOYERS SWITCHING TO SELF-INSURANCE.

THAT'S A WRAP!

ERISA IN THE BRIGHT LIGHTS

By Gentrie Pool, CSA, REBC, RHU, SGS
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Did you know ERISA language is required for groups down to two lives (technically, one life, should an employee drop off)? Did you know the Department of Labor is performing audits now? Did you know your clients are probably out of compliance and this is your chance to be their hero? Look at it as a prospecting tool or a way to bolster yourself as a consultant, not just a spreadsheet pusher. How likely are the ERISA police to come knocking? Let's take a look at the facts.

Which groups? Most groups… except government employers (are you surprised?) and churches that offer health or welfare plans such as health, dental, vision, retirement accounts, vacation/PTO, employee assistance programs, scholarships, daycare, prepaid legal, death benefits, disability, wellness plans, HRAs, FSAs, group life, holiday pay, unemployment, severance, prescription plans, apprenticeships and training.

Intent? ERISA was established to inform and protect employees and plan participants of their rights, coverage and entitlements. ERISA also ensures that employers do not abuse their power or the employees' money.

What are employers supposed to do? There are certain time frames by which the employees must receive the ERISA SPD: upon enrollment of any of the benefits above, first day of coverage, special enrollment and upon request.

How? An ERISA wrap bundles all of a company's benefits in one Summary Plan Description for ALL company benefits. Carriers do not (except for one) include ERISA language because it is not a Department of Insurance requirement. The Department of Labor governs ERISA. So agents may not be responsible for educating their clients on this per se, but you are de facto because they will turn to you upon receiving a love letter from the DOL about their benefits.

What do they want? The DOL asks for 24 items, including but not limited to: SPDs, SARs, COCCs, fidelity bonds, corporate minutes, special enrollment rights notices, WHCRA enrollment notices and annual notice, Newborn's Act Notice relating to hospital stays in relation to childbirth, Medicaid or CHIP notices relating to premium assistance, COBRA Notices, Michelle's Law (medically necessary leave of absence for

DID YOU KNOW YOUR CLIENTS ARE PROBABLY OUT OF COMPLIANCE AND THIS IS YOUR CHANCE TO BE THEIR HERO?

students), financial records and board meeting minutes.

Likelihood of DOL ERISA Compliance Request?

- One out of three employers are receiving them now, 75% by October 2013 and 100% by 2018.
- There are seven days to respond in full or automatically face a full-blown financial and benefit audit (including COBRA compliance) performed by DOL/IRS.
- Seventy-five percent to 90% are out of compliance currently, according to the DOL.
- Penalties: $1,000 may apply for each failure to provide a summary; $100-$110/day per employee with a three-year look-back provision for ERISA language up to a $500k max, and DOL can impose civil and criminal penalties ranging from $10,000 to several hundred thousand dollars.
- No statute of limitations for Form 5550 (for those companies affected) so penalties can go as far back as the plans inception and/or company began offering health and/or welfare benefit plans. Some ERISA wrap providers may include 5500 filings as part of the wrap service.
- Small employers (fewer than 250 lives) are at higher risk of being out of compliance because they may not have HR specialists who are aware of these requirements.
- Not all ERISA document providers indemnify the client. Whoever files the documents holds the financial liability. (Agents, are you sure you want to administer ERISA for your clients? It is not covered under your E&O.)
- You can share this information with your clients… or the DOL or another agent will.
- The Employee Retirement Investment Security Act, enacted in 1974, has not changed. The attention paid to it has, in light of healthcare reform.

You should consult with an ERISA wrap provider, ERISA attorney or the Department of Labor for any changes or clarifications. HIU

THE DELAY IN PPACA

Continued from page 25

professional who can drill down to get more detailed data.

Health risk assessments are most commonly associated with a wellness programs and play an important role in identifying high-risk individuals and engaging them early on to avoid catastrophic claims. The cost of these programs averages around $150 per year per employee, and there are numerous studies that bear out that they pay for themselves in the form of reduced claims many times over.

While there are myriad companies that provide wellness and screening services to employers, it is important to note that not all are equal. The panel of tests that are run on each blood draw can vary significantly, thus the data returned can look different too. One company, HealthCheck 360, located in Dubuque, IA, offers a very robust health risk management solution for employers. It has developed a method of aggregating the data collected from employee screenings and utilized the information to determine if an employer is a viable candidate for a partial self-insurance plan. If the results are favorable, this same data can then be utilized to underwrite the group. If it is unfavorable, the employer now has a risk-management plan in place to improve the health of all the employees moving forward.

HEALTH RISK ASSESSMENTS ARE MOST COMMONLY ASSOCIATED WITH A WELLNESS PROGRAMS AND PLAY AN IMPORTANT ROLE IN IDENTIFYING HIGH-RISK INDIVIDUALS

Needless to say, this method of collecting quality risk data takes more time than simply having employees self-report via an application. Forward-thinking employers would be wise to utilize the extra time afforded them with the delay in PPACA requirements to assess the overall risk of their employee population, and thus be prepared to make intelligent decisions with regard to the future of their healthcare plan. HIU

ARE YOUR SALES PROPOSALS WORKING?

SIX QUICK TIPS TO EVALUATE THEM

By Dustin Sapp
President, TinderBox
Indianapolis, IN

The sales pipeline is the lifeline of any business. It's a well-known fact: Not just sales reps live and die by the numbers; organizations do too, regardless of the product, service or solution. Are your sales proposals up to the task?

In today's fast-paced business and technology landscape, the most important question to ask is whether your sales process is working. Your sales proposals are the culmination of that process. Despite the intricacies of an organization's sales process, there's typically only one thing the customer is exposed to in the final stage of the process, and that's the proposal. It's often the first impression you make on decision-makers, and it's your last chance to remind the prospect of why they should buy instead of overwhelming them with contract details. It's an extension of your brand that sets the tone for the rest of the relationship. So it's time to take a moment to evaluate.

How do you know you need to evaluate your proposal process? Answer these five easy questions. If you answer "yes" to any one of them, your proposal process is probably due for a facelift.

1. Do you use technology to manage your proposal process? If so, is it dated?
2. Are you managing important conversations and documentation through email?
3. Are you unsure which documents are the most current version with the most up-to-date content?
4. Do you lack visibility to proposals while they're being developed internally? More important, do you lack visibility on how a proposal is consumed once it's sent to the prospect?
5. Is proposal collaboration—whether between you and the prospect or you and the rest of your team—clunky and disorganized?

IN TODAY'S FAST-PACED BUSINESS AND TECHNOLOGY LANDSCAPE, THE MOST IMPORTANT QUESTION TO ASK IS WHETHER YOUR SALES PROCESS IS WORKING.

When you're dealing with documents, it takes a significant amount of time to create, review, approve and obtain a signature. As such, your team is constantly wasting time and productivity. That can, at the end of the day, result in lost leads. The five questions listed above highlight some of the biggest issues plaguing the proposal process today. Not only that, but they're perfect examples of why **90%** of proposals don't convert.

Creating a proposal that does convert, however, requires crafting personalized, approachable sales documents that your prospects will appreciate, and will be more likely to interact with and sign. How do you effectively evaluate your sales proposals to increase conversions?

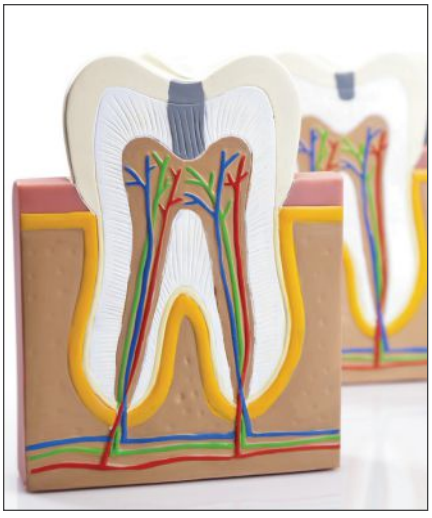
Consider developing an evaluation checklist for your proposals. This is what you'll want to look at:

- **Is it organized?** Often, when you spend weeks working on a proposal, you know your way around the document to a flaw. Regardless of how well you know the proposal, the real question is whether the document is organized well enough that someone else can understand it. Can an important decision-maker easily search through it and find what interests them most? Before you send a proposal over, ask yourself: "Are all the sections organized logically and can a third party easily understand this document?"
- **Does it address the prospect's pain-point?** If your company creates proposals that are self-driven, it is time to turn over a new leaf. Instead of writing about your company's benefits, the clients you've worked with in the past and detailed pricing, first list the pain-points you noted during your conversations with the prospect. Then tell the prospect how your company is positioned to help them succeed. Your proposal should address the prospect's needs directly, not your own. While the solution offered and the execution thereof is a piece of the overall proposal, it's not the core. Your proposal should articulate what the problem is and the impact a solution to this problem will have on the prospect's business. Your proposal is, in essence, the solution to getting rid of that problem.
- **Are you demonstrating your value without compromising the prospect's needs?** Your proposal is your chance to draw a clear correlation between today's inadequate reality and tomorrow's impressive results. Pinpointing your value means positioning your offerings as an investment that will pay for itself many times over. Use case studies to show the results your product, service or solution are capable of bringing. If you're using an analytics tool that allows you to track your prospect's past activities on your website and blog, take advantage of this insight to appropriately tailor your communication to their activity, which will strengthen the relationship as well as the likelihood of their commitment to your brand. If you can incorporate content into your proposal that is aligned with what is on pages viewed by the prospect, do it. You can't imagine the impact it has on your conversations when, all of a sudden, you're being educated on and given insight into what your prospect engages with behind closed doors, so to speak. It's time to use the tools available today and stop flying in the dark.
- **Is it engaging?** Your proposal should be professionally written, but also easy to absorb. Too much industry jargon and too many technicalities will turn the reader away or just confuse them. Your ability to break down the complexities and make the problem and solution easy to understand will be another reason the prospect signs a contract to work with your business. If your proposal seems hard to read, then your prospect will assume you may be hard to work with, you don't know what you're talking about or, worse, you don't care to make sure they understand what you're talking about.
- **Have you optimized your proposal viewing experience with technology?** Proposal-management solutions are quickly becoming a necessary tool to improve an organization's sales process. With the inefficiencies of offline documents—such as Word, PDF, Excel or PowerPoint—coming to a head, more sales professionals are turning to technology and web-based solutions to improve the proposal creation and viewing experience. What's more, the ability to track proposal activity, compared to sending proposals off into a black hole, is a new age miracle.
- **Does it address pricing and timeline?** No prospect likes ambiguity, especially when it comes to how much they need to pay and how long things will take. Be upfront and let them know your estimates. Outline tactics and goals with dates to accompany each. Laying out your plan means you've thought through the prospect's pain-points and devised a strategy to make the prospect successful.

YOUR PROPOSAL IS YOUR CHANCE TO DRAW A CLEAR CORRELATION BETWEEN TODAY'S INADEQUATE REALITY AND TOMORROW'S IMPRESSIVE RESULTS.

When it comes to proposals, live by these guidelines and always check each box before sending over your proposal to a prospect. Remember, a prospect will only buy what you're selling if they're convinced you can help them solve their problems and improve their processes. So make your proposals engaging, relevant and positioned around their needs and how your company can help them succeed. HIU

DENTAL INTELLIGENCE



from the NADP

THE IMPORTANCE OF DENTAL HEALTH THROUGHOUT ADULTHOOD

PPACA includes a dental health benefit for children as part of the defined Essential Health Benefits. The prospect of child-only coverage being promoted and sold both in and out of exchanges come 2014 means some adults could question the value of purchasing dental benefits just for themselves. However, good dental health is important not only for children but for their parents as well. The following are key points to consider regarding the importance of dental health throughout adulthood.

Young Adulthood: As an adult, care of your teeth continues to be important. Although the occurrence of cavities typically decreases once you reach young adulthood, your need for dental treatment can still be acute, particularly if you have had a history of decay when you were a child or adolescent.

When permanent teeth come in improperly with overcrowding or crooked teeth, these situations can cause issues related to speech and/or eating as well as creating a poor self-image. Additionally, malposed teeth are harder to maintain, which could lead to gum inflammation and even periodontal disease. It's important to have them adjusted through the use of braces.

Young adults, not just children and adolescents, might find themselves involved in team and individual sports where the possibilities of face and head injuries increase. Mouth guards lower the likelihood of tooth loss in the case of a hit to the face or head.

A disorder common in people between the ages of 20 and 40 is temporomandibular joint. TMJ, which is often related to stress, can lead to pain of the facial muscles, grinding/clenching teeth and joint dislocation, requiring therapies ranging from palliative treatments to a night guard and, in rare cases, surgical intervention.

Gingivitis, or inflammation of the gums, becomes more common during young adulthood. If left untreated, it can result in periodontal disease, which is a breakdown of the bone and ligaments holding the teeth in place.

Adulthood: Issues first appearing in young adulthood can begin to worsen during our middle years. Periodontal disease can occur at any age, but tends to become more prevalent in the mid- to latter adulthood. A study titled "Prevalence of Periodontitis in Adults in the United States: 2009 and 2010," release by the Centers for Disease Control and Prevention in 2012, reported an estimated 47.2% (64.7 million) adult Americans have mild, moderate or severe gum disease.

Individuals in this group will also see an increase in failing dental work. Fillings that crack or fall out or older technology that fails may result in unexpected dental care. Caries (cavities, tooth decay) that may develop in the cracked or loose filling, if allowed to go untreated long enough, can result in larger fillings, the need for crowns and/or root canals.

Often, adults who lost teeth years earlier and chose not to take care of the gap may now see that their teeth have moved or become loose, causing problems with their natural bite.

Seniors: The same 2012 CDC report estimates increases in periodontal disease to 70.1% for adults 65 and older. These numbers are staggering, considering the availability to dental care for most Americans, and should be a signal for concern considering the relationship gum disease has and may have with a number of chronic conditions.

Increased use of prescription drugs may impact oral health in a variety of ways that could include changes in tooth color, a weakened tooth structure, oral fungus and decreased levels of saliva, leading to dry mouth and even higher rates of tooth decay.

Teeth can become darker often because of changes in dentin and/or a lifetime of eating stain-causing foods and beverages. Dry mouth caused by reduced saliva flow can be related to medication but could also result from chronic diseases such as diabetes.

Root decay, caused by exposure of the tooth root to decay-causing acids, often results from gum recession. The tooth roots are not protected by tooth enamel and are, therefore, more prone to tooth decay.

Tooth loss has multiple causes, including tooth decay and gum disease, and can result in an uneven bit and jaw pain.

Ill-fitting dentures, poor dental hygiene or a buildup of fungus cause denture-induced stomatitis, which is inflammation of the tissue underlying a denture.

All age groups are susceptible to oral cancer, but those who smoke or drink excessively have a higher risk. Oral cancer is also

increasing in younger members, thought to be the result of human papillomavirus.

The prevalence of periodontal disease is extensive and should be a consideration for adults of all ages, but especially those who have chronic illnesses. Let's explore these relationships further.

Diabetes: Nearly 26 million Americans have diabetes. Many may be surprised to learn that there is an increased prevalence of gum disease among those with diabetes.[1]

Gum disease involves infection, which can affect blood sugar levels, making it harder for diabetics to control symptoms. Controlling the infection can help control a person's diabetes.

Heart Conditions and Coronary Artery Disease[2]: Heart disease remains the leading cause of death and disability in the United States. By 2030, it will be the leading single-disease cause of death globally.

A recent review of published studies reinforce that heart disease and gum disease are associated independent of other risk factors, such as smoking or diabetes. Heart patients should include good oral health as part of their overall heart health to reduce inflammation and their disease burden.

Asthma: Patients taking asthma medication may be at risk of dental caries, dental erosion, periodontal diseases and oral candidiasis. Patients with bronchial asthma on medication should seek regular professional dental care.[3]

Kidney Disease: Twenty-six million (14%) American adults have chronic kidney disease (CKD). About half a million have end-stage renal disease (generally associated with diabetes). Kidney disease accelerates the progression of heart disease and increases the risk of heart attacks and heart disease-related death[4], both of which show increase risk of gum disease.[5] Interestingly, those with CKD are 25% less likely to visit a dentist.[6]

COPD: COPD is the third leading cause of death in America, with a projected cost to the nation of approximately $49.9 billion.[7]

Based on current evidence, gum disease is a significant and independent risk factor of COPD.7 COPD patients may use steroids, which can make them susceptible to oral fungal (yeast) infections called candidiasis, or thrush.[8]

These studies support the importance of maintaining good dental health and having an annual periodontal exam. HIU

1 American Diabetes Association, Diabetes and Oral Health Problems, 2013

2 American Heart Association, Periodontal Disease and Atherosclerosis: True, True, Possibly Related

3 Asthma and oral health: a Review, Aust Dent J. 2010 Jun; 55(2):128-33.

4 American Society of Nephrology, Kidney Disease by the Numbers

5 U.S. National Library of Medicine, National Institutes of Health, BMC Nephrol. 2012 Apr 2

6 American Lung Association, Chronic Obstructive Pulmonary Disease (COPD) Fact Sheet, February 2011

7 Periodontal Disease and Risk of Chronic Obstructive Pulmonary Disease: A Meta-Analysis of Observational Studies, U.S. National Library of Medicine and National Institutes of Health, 2012 October 19

8 Colgate Oral and Dental Resource Center, Respiratory (as reviewed by Columbia University College of Dental Medicine), 2012

The National Association of Dental Plans, a nonprofit corporation with headquarters in Dallas, is the representative and recognized resource of the dental benefits industry. The trade organization includes the full spectrum of dental benefits companies operating in the United States. NADP member plans provide dental HMO, dental PPO, dental indemnity and discount dental products to 160 million Americans, more than 90% of all Americans with dental benefits. Follow NADPorg on Twitter.

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THE FUTURE OF MEDICARE

AND HOW PRIVATE PLANS ARE AFFECTED

By Dwane McFerrin, CLU, CFP, RHU, LLIF
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The continuing aging of America is sending seismic waves of change through Medicare and all programs that service the Medicare beneficiary. The senior segment will continue to make gains as 20% of the U.S. population is projected to be over age 65 in 2050.[1]

Barring unforeseen actions by legislators or regulators, the continuing demographic shift to more Medicare beneficiaries would project as positive for the private Medicare insurance market, namely Medicare Supplement and Medicare Advantage. Consumers are buying private Medicare plans, with an estimated 64% owning supplemental or replacement coverage today.[2] CSG Actuarial predicted the growth below late last year.

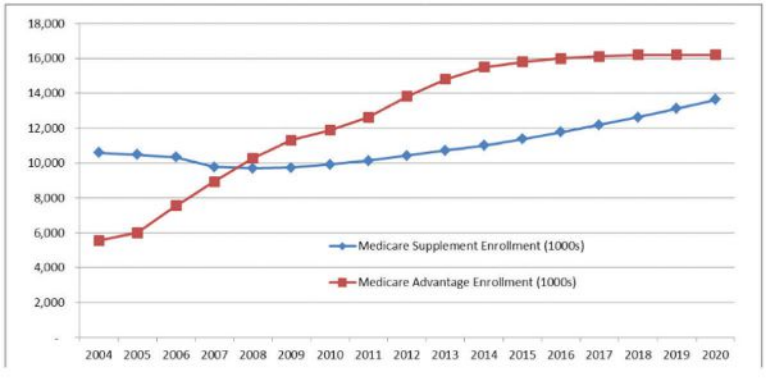
Their prediction assumes a leveling out of Medicare Advantage sales and a solid climb in Medicare Supplement over the next seven years. But there's quite a story to tell on how agents navigate the changes we can expect to see over that period.

For example, a report from the Kaiser Family Foundation[2] in April shows how Medicare Supplement policy counts shifted significantly from 2006 to 2010, ranging from a gain of 31% in Arizona to a loss of 32% in Minnesota. Further, nine states plus the District of Columbia grew in Medicare Supplement in-force counts by over 10%, but nine states decreased in counts by over 10%! Clearly, market changes are happening at the state level—they're not just controlled by events on a national basis.

The Congressional Budget Office has projected that Medicare Advantage enrollments will decline from 13.9 million enrollments in 2012 to 10.7 million in 2019.

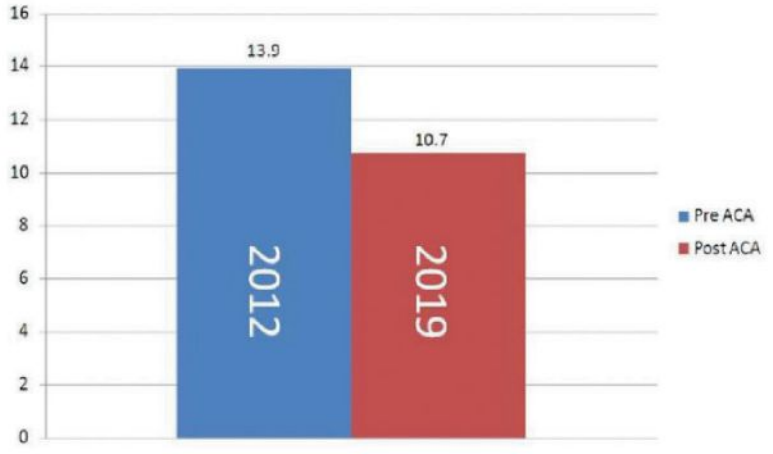
Of course, these projections are all based on assumptions and there are many variables that can change. But it appears that politicians on both sides of the aisle are coalescing around the idea that the growth of Medicare, in particular, needs to be slowed. No party wants to be first to

Past & Projected Medicare Supplement & Medicare Advantage Enrollment



Source: CSG Actuarial LLC, Future of Medicare Supplement, November 2012

2019 MA Enrollment Estimates, Pre-and Post-ACA (millions)



Source: The Insurance Barn, Medicare Advantage's Future Is Bad But Not as Bad as Rumors Would Have You Believe, November 2012

anounce changes, so expect to see plenty of blue-ribbon committees, representing both parties involved. The waters are safer for our elected officials if the committees involve former members of Congress; nevertheless, we've seen the bipartisan Bowles-Simpson Commission get little traction on its budget-saving proposals.

So what are the proposals out there and what is the likelihood of any of the proposals becoming the law of the land? Here are five ideas worth considering:

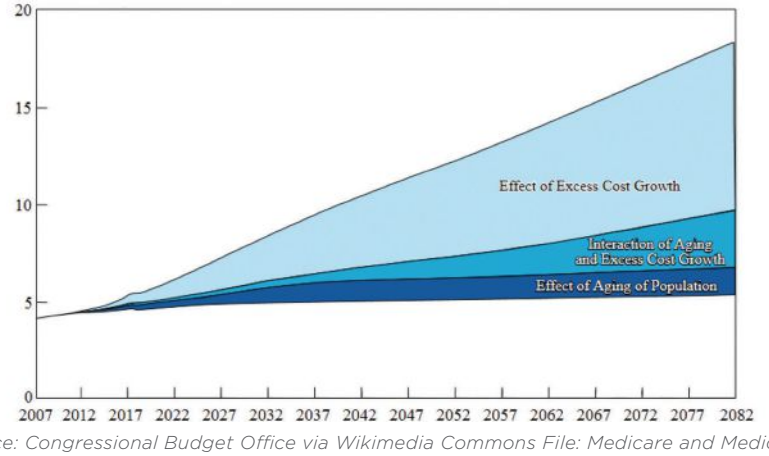
1. President Obama proposed $716 billion in cuts to Medicare but these funds are redirected to PPACA. In his proposed 2014 budget, the president indicates he's open to reform, perhaps by combining Parts A and B of Medicare into a single deductible.[3] He proposes a 15% surcharge on new buyers of Medicare Supplement Plan F to discourage seniors from buying plans that have first-dollar coverage. Republicans and Democrats already have misgivings due to cuts to critical access hospitals, cuts in graduate medical education and cuts to nursing homes. Persuading lawmakers of some grand bargain that cuts Medicare entitlements further and raises revenue will be difficult.[4]
2. Senator Coburn (R-OK) and former Senator Lieberman (I-CT) propose raising the eligibility of Medicare by two months every year, thereby gradually increasing eligibility from 65 to 67 years.[5]
3. The Medicare Payment Advisory Commission (MedPAC) has discussed a 20% surcharge on Plan F.
4. House Continuing Resolution 25 applies means testing for Medicare Parts B and D and to freeze thresholds until 25% of beneficiaries are paying income-related premiums.[6] Means testing for 25% of all Medicare beneficiaries goes way beyond taxing the rich!
5. The Bowles-Simpson Commission proposed in 2010 to combine Parts A and B into a $550 deductible and 20% coinsurance rate with $7,500 out-of-pocket maximum. Sounds more like a Medicare Advantage plan!

Meanwhile, CMS regulators are using a carrot-and-stick approach with Medicare Advantage and Part D carriers. The carrots include higher reimbursement for carriers with four- and five-star plans and year-round selling for carriers achieving five stars. Carriers performing below three stars for three consecutive years are labeled as low-performing plans, which means their members will receive letters from CMS urging them to switch to a higher-performing plan, they will be denied any service-area expansion plans, and they will be threatened to have their contract terminated by CMS.

Original Medicare is due for an overhaul. There haven't been material changes in years and there are changes swirling in healthcare. Some issues that would benefit from an overhaul:

- COBRA—Currently, it isn't considered creditable coverage even when the em-

Medicare and Medicaid Spending as a Percentage of GDP



Source: Congressional Budget Office via Wikimedia Commons File: Medicare and Medicaid GDP Chart, September 2009

ployer plan provided to active employees is creditable. Those leaving the group and paying for COBRA may not realize the difference and face delays in enrolling in Part B—and face a late enrollment penalty as well!

- Observation Status—Recent increases in the length of time that Medicare beneficiaries spend as hospital outpatients receiving observation services put their benefits in limbo, especially when the Part A claim is denied. CMS is proposing changes to help reduce the financial impact on beneficiaries and hospitals.
- Accountable Care Organizations are being funded as demonstration projects by CMS. At the same time, carriers are entering into agreements with providers that are similar in design. The intent is to reduce healthcare costs and improve disease and medical management.
- Navigators are contracted, certified and paid to help under-65 individuals understand their plan options. Will the same concept apply to private Medicare plans in the future?
- Provider reimbursement rates have been year-to-year for over 10 years and there is an indication that more providers are not accepting new Medicare patients, just as the numbers of new Medicare beneficiaries are swelling to 3 million per year. A July 2012 study by the Texas Medical Association shows a steady decline of Texas physicians accepting new Medicare clients. The percentage dropped from 78% in 2000 to only 58% in 2012.[7]

Lastly, how else can Medicare costs be pared? Increasing efforts by HHS to combat Medicare fraud is producing some impressive results but fraud is estimated to cost the program $60-$90 billion annually. Recent publicity about how hospital costs vary greatly and perhaps requiring such data to be disclosed show an increasing focus on reducing costs.

Despite the myriad changes mentioned above, we're seeing an interesting development in terms of consumer choices. Medicare Supplement plan choices are increasing, with new players such as Aflac and Equitable Life & Casualty entering the market. Traditional players such as Mutual of Omaha have introduced new plans, and commercial carriers like Aetna and Cigna have entered the space through acquisitions of Continental Life and American Retirement Life, respectively.

Conversely, the Medicare Advantage space is going through consolidation. Two of the larger carriers, UnitedHealthcare and Humana, acquired Care Improvement Plus and Arcadian, respectively. Aetna expanded its geographic footprint by purchasing Coventry, and Cigna bought the capabilities of HealthSpring.

The Part D environment continues to be highly competitive with Humana and UnitedHealthcare continuing to be the leaders, but Coventry and CVS/Caremark have significant membership as well. The coverage gap is narrowing and, for the first time, deductibles and thresholds will go down in 2014. There is fierce competition for the clients aging into Medicare as well as plans competing for clients seeking a zero-deductible plan. More brand-name drugs are moving to generic status and carriers are introducing referral programs for the agent who doesn't want to certify annually. Commercially available quoting and enrollment tools are also becoming available to the agent who can work effectively with technology.

SO WHAT DOES IT ALL MEAN?

Changes are needed to the Medicare program, with the primary drivers being rising healthcare costs, the federal budget deficit, demographic changes and regulations already underway. However, these same factors likely ensure the role of the agent in the new age of Medicare, regardless of the form it takes. This is due to consumer preferences, demographic changes and cost-containment efforts such as ACOs. Any legislation involving substantive change will likely be phased in over time.

It is hard to see any change when politics in Washington are so polarized. Whether the GOP claims of scandals by the Administration or fading support among Democrats for PPACA, change is needed. It is just a matter of time.

As agents, we need to survive in a changing environment. Being knowledgeable and educating your clients is paramount. Embrace technology or you risk being a dinosaur. Support NAHU and industry organizations. They are your voice in Washington, DC, and your involvement matters.

Lastly, put a polish on your value proposition. Find ways to do business with your customers the way they want to do business. At my company, we have a trademark on the phrase "Call, Click, Mail or Meet." Why? Because our goal is to equip agents with tools to help them compete with exchanges that attempt to do business directly with a consumer.

Changes are coming and the agent who embraces technology will be more likely to survive the changes in the next generation. HIU

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1 CRS computations based on data in the U.S. January 21, 2011 based on the Census Bureau's December 2010 data release. These data do not include results from the 2010 census.

2 Kaiser Family Foundation, Medigap: Spotlight on Enrollment, Premiums and Recent Trends, Medicare Policy. www.kff.org/medicare/8412.cfm, April 2013.

3 http://nyti.ms/161LB6C 3/28/2013

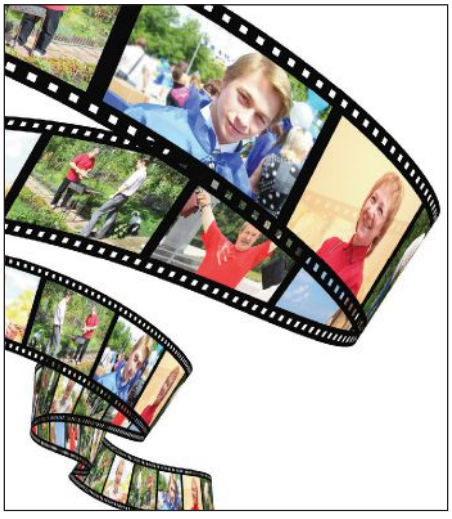
4 Mary Agnes Carey, Kaiser Health News 4/18/2013

5 http://1.usa.gov/14Mk4uP 4/18/2013

6 Kaiser Family Foundation, Medicare and the Federal Budget http://bit.ly/ZbKJMN 4/2013

7 Texas Medicare Association, July 9, 2012 http://bit.ly/101vyaY

LIFETIME



By Kenneth A. Shapiro
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SIX LIFE INSURANCE STRATEGIES FOR PROTECTING YOUR BUSINESS CLIENTS

Not too long ago, there was a story in the Today, the U.S. workforce is just about equally divided between large corporations (51%) and midsize and small businesses (49%). For advisors who want to be more active in the business marketplace, these statistics express the magnitude of the opportunity.

With midsize and small businesses employing nearly half the workforce, this marketplace is an attractive niche, particularly for specialization. Besides the sheer numbers, the needs are nearly identical, whether a business has five, 50 or 500 employees.

For those who own and manage these companies, the primary focus is on making or keeping their enterprises successful rather than protecting the assets they have created. This is an unusual opening for astute advisors. Here are six strategies that can benefit owners and managers of small to midsize businesses:

1. Partnership protection. Frequently, partnerships start with a handshake and continue over the years the same way they began, with each partner bringing something special that makes the business successful.

Yet, over the years, partnerships can falter and cripple a business. The partners may have a falling out, or one might just want out. Frequently, it can end with a partner's death and the consequences that follow, including a loss of customers, a surviving spouse's expectation of continued income in the face of a revenue crunch, or some combination of these.

Partnerships can have their own special magic. There's often the feeling that nothing should be allowed to upset the synergy that created the relationship. To do so could upset the special trust that exists between the partners. Simply put, if the partnership works, don't mess with it.

The aware advisor can play a role in helping the principals preserve their relationship by recognizing the value of a funded buy-sell agreement. Having such an agreement without a funding mechanism is like buying a car but refusing to put gas in the tank. And that can happen to buy-sell agreements that are drawn up and signed but never funded due to insufficient capital or the inability to borrow the money when needed.

However, with a life insurance policy, funds can be available from its cash values or death benefit to purchase a deceased partner's share of the business.

2. Financial crisis protection. While the product is long-term care insurance, it might be more accurate to call it "financial crisis protection" since it helps meet the high cost of nursing-home care.

Even though long-term care represents the single largest financial risk faced by the elderly and their families, according to America's Health Insurance Plans, the sales of LTCI have been rocky. Since 2000 alone, a number of companies have left the market, premiums have increased, doubts have risen about governmental financing and the economic downturn have made consumers wary of purchasing the product.

However, a major change has occurred that can improve LTCI sales. Instead of individual LTCI policies accounting for 90% of the sales as they did in the past, today the group market represents 42% of the sales, according to an AHIP report. It's particularly made up of married couples in the 50- to 65-year-old age group and college graduates with incomes of $50,000 and over.

By identifying work groups that fit this profile, advisors have an opportunity to market LTCI successfully, including both voluntary and employer-paid programs. In addition, employer groups benefit from a variety of group discounts and portable coverage so employees can take it with them when they retire or leave their job.

3. Estate protection. A split-dollar plan is an easy way for owners of successful businesses to reward key employees selectively, as well as themselves, with life insurance at little or no cost to themselves or the company.

Split-dollar plans are flexible in terms of meeting specific needs of the individuals involved and those of the company. With the endorsement method, the employer owns the policy but the key executive names the beneficiaries. Quite often, the employer pays the non-deductible premiums, with the key employee receiving a "taxable benefit" and

residual death benefits are paid to the company to offset its costs. Finally, the employer owns the cash values, which are carried on the company's books as an asset.

Gifting strategies can be incorporated in the planning to gain substantial estate benefit.

Most important, the life insurance provides liquidity when it may be needed most—at the time of death.

4. Business stability protection. While it may be true that no one is indispensable, the death of a key employee or business partner can raise havoc, even to the point of placing an enterprise in jeopardy.

The turmoil caused by an untimely death can come from a loss of customers, management turmoil, a negative impact on the organization's financial stability or marketplace doubts.

Even though those involved in a going enterprise may be slow in coming to terms with a need to protect the stability of their business, today's customers, suppliers and lenders expect such assurance. They want to know that the business will remain stable should the loss of a critical player occur.

The solution is providing key-person life insurance coverage. The process is simple: The company purchases a policy with the participant's consent, which makes the business the owner, premium payer and beneficiary on the policy. If a death occurs, the company receives the policy proceeds to fund its needs in keeping it sound and productive.

Ensuring stability is good for everyone involved—vendors, customers, employees and owners.

5. Workforce protection. As the economy climbs ever so slowly from its recessionary doldrums, there are signs that companies are gaining confidence but with a cautious outlook when it comes to risks. This offers advisors a significant opportunity for marketing employer-owned life insurance (EOLI).

However, it's important for advisors to overcome employer reluctance because of the adverse publicity associated with EOLI. It's a long tail that continues to linger today.

Starting in August 2006, EOLI contracts had to meet specific requirements to qualify for favorable tax treatment. In summary, employees must be given notice of insurance and must consent to the coverage before the contracts are issued and understand that the employer will be the direct or indirect beneficiary of the death proceeds. There are also annual reporting requirements.

EOLI makes good business sense. Today's employers invest heavily in their employees, whether it's reimbursing them for educational programs, investing in training or helping them enhance their skills and knowledge base. The loss of such an employee is a loss to the company, which EOLI can help offset. Non-qualified deferred compensation and executive benefit bonus plans are serviceable concepts that provide excellent flexibility for employers.

6. Retirement protection. It's quite common for self-employed people and those with less than a handful of employees to work hard and live well but fail to set aside funds to maintain their standard of living in retirement.

While some may opt to continue working, a fully insured defined-benefit retirement plan can be an attractive alternative, particularly since it's simple to set up, offers maximum tax-deductible contributions and can help to make up for lost time.

A fully insured plan is funded with annuity or life insurance contracts, or a combination of the two—and contributions are tax-deductible. The plan is particularly appealing since it offers a guaranteed, stable income, up to $195,000 a year.

A fully insured plan is not for everyone, since it requires contributions over a limited period of time. However, it can be particularly helpful in situations where there is substantial profitability.

These six business marketplace sales ideas are effective strategies that can help position you as a valuable advisor for small and midsize business owners. Since most have spent their working years in building their company, the knowledgeable advisor has an opportunity to help them maximize the value they have created. HIU

Kenneth Shapiro is president of First American Insurance Underwriters Inc., a national life insurance brokerage firm specializing in coaching growth-oriented producers. He began his career with Northwestern Mutual Life and later worked for The Guardian Life Insurance Company. He can be contacted at 800-444-8715 or kshapiro@faiu.com.

Friends in High Places

Indianapolis AHU member Susan Rider (right) with Congresswoman Susan Brooks at the Noblesville, Indiana, Fourth of July Parade

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Where in the World is HIU?

The Colorado AHU held its Strategic Planning Meeting in Denver in July. And they brought an HIU!

COBRA CONUNDRUMS

By Robert Meyers
President, COBRAGuard
robert.meyers@cobraguard.net

CERTIFICATES OF CREDITABLE COVERAGE

Dear COBRA Bob,

Many of my employer clients have been asking if HIPAA Certificates of Creditable Coverage will still be required under health reform once preexisting conditions are no longer an issue. Your thoughts?

—Wannabe Credible in Clearwater

Dear Credible,

Great question! Proposed regulations say you have to continue to provide HIPAA certificates until December 31, 2014. After that, they are no longer required. The requirement to provide them during 2014 is due to the ban on preexisting conditions applying differently to non-calendar-year plans.

As I'm sure you know, certificates of credible coverage were originally created so that individuals could transition from one health plan to the next while minimizing preexisting condition exclusions by their new plans. Currently, when participants terminate group health coverage, are entitled to COBRA or terminate COBRA coverage, they receive a certificate of creditable coverage documenting the most recent period of creditable health coverage. In most cases, a pre-health-reform plan can impose a 12-month preexisting condition clause. However, this exclusion period must be reduced by an individual's creditable coverage amount. If a participant has 12 months of creditable coverage, the usual preexisting condition limitations do not usually apply.

While it's true that PPACA eliminates preexisting condition limitations, the change applies for health plans beginning on or after January 1, 2014. Therefore, employers should continue to provide certificates of creditable coverage throughout 2014. This will prevent transitioning employees from encountering preexisting condition clauses on plans that transition mid-year.

For example, Susan leaves her employer on March 14, 2014, and terminates her coverage. She is unemployed for roughly four months and finally lands a new job in September. When she tries to secure health coverage with her new employer, she discovers that its PPACA-compliant plan does not take effect until November 1. In the meantime, the existing health plan contains a preexisting condition clause. Because Susan does not have a certificate of creditable coverage, she may encounter preexisting condition exclusions.

Of course, this is exactly the kind of situation we all want to avoid. With this in mind, please tell employers to continue issuing certificates. They should also know that when they issue a certificate of creditable coverage for the participant, they should also issue creditable coverage certificates for any dependents. If the creditable coverage period is the same for all, they can issue one certificate that includes employee and dependent information.

Employers should provide the certificate of creditable coverage upon these triggers:

- If participant is eligible to elect COBRA coverage: Certificate must be provided no later than when an election notice is required to be provided for a qualifying event under COBRA (no longer than 44 days but sooner is already better than later).
- If a participant loses health plan coverage but is not eligible for COBRA: Certificate must be provided within a "reasonable time" after the coverage ceases. I would recommend providing the notice within 14 days and absolutely no later than 30 days.
- When COBRA coverage ends for any reason (including a grace-period lapse): Again, the certificate must be provided within a "reasonable time" after the coverage ceases.
- Upon employee request: Must be issued within a reasonable time period.

While the creditable coverage certificate requirements may sound complicated, most of your employer clients can simply keep doing what they've been doing – at least through 2014. And that will be good news for employers who have a lot of other changes to worry about!

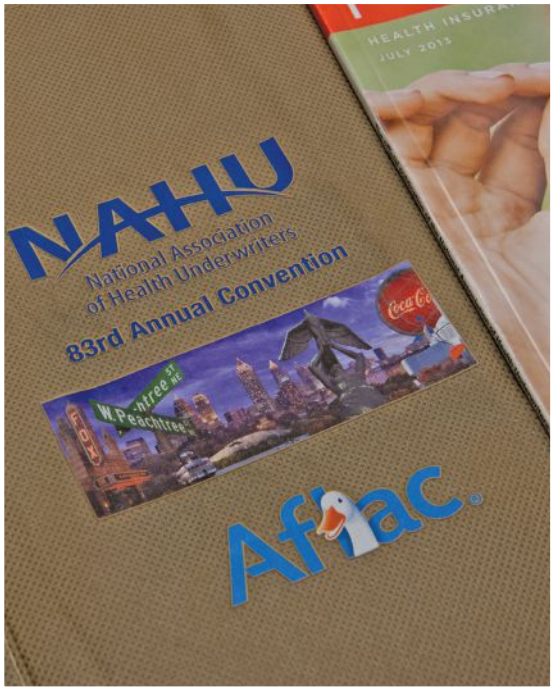
Do Your Best,
COBRA Bob

Robert Meyers has more than 25 years of experience in business management and COBRA. He is the founder and president of Kansas-based COBRA administrator COBRAGuard. For more information, visit www.COBRAGuard.net.

This column discusses potential COBRA conundrums and their possible outcomes. The information contained in this column should not be construed as legal advice. Always follow state and federal COBRA rules and seek the advice of an attorney when confronting your company's COBRA conundrums.

Marcy Buckner and Pam Mitroff lead a discussion on legislation, the media and HUPAC.

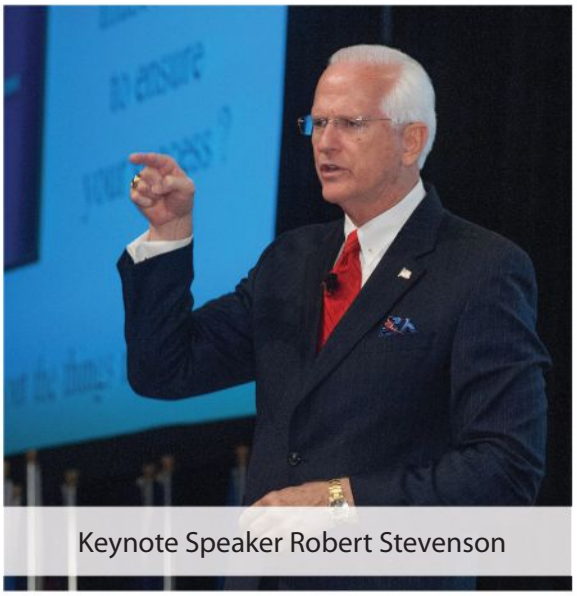
Ryan Thorn, Dave Fear Jr. and Dave Fear Sr.



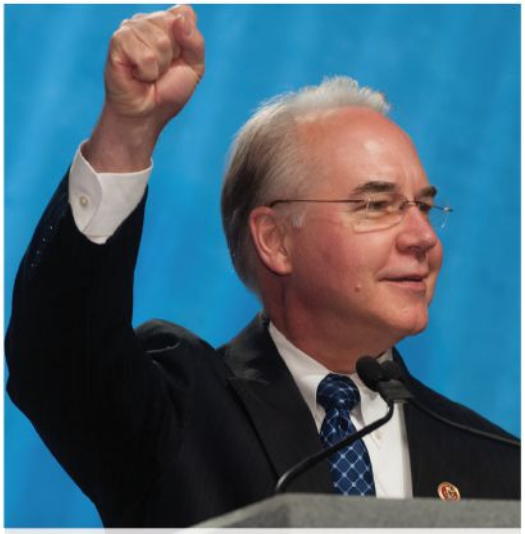
Highlights *from* NAHU's Annual Convention

In late June, NAHU members from all over the country convened in Atlanta, Georgia, for the association's 83rd Annual Convention. Here are some photo highlights.

Jill Pedersen and Terri Olson



Keynote Speaker Robert Stevenson



Congressman Tom Price of Georgia

Dana Perino and Donna Brazile participated in a lively and entertaining discussion about healthcare, politics and more.

The Charity Walk/Run sponsored by the Young Agent Health Underwriters was very well-attended… even though it started before the sun came up!

Art Jetter, John Nelson and Mike Gray

Rick Bailey's family enjoys the regional meeting.

The Town Hall Meeting

Photos courtesy of Jim Tkatch

Tkatch Photo (www.tkatchphoto.com)

Trei Wild gives thanks to his mentors during a great Gordon Award acceptance speech.
See next month's HIU for more info on Trei.

President Tom Harte starts his term in style!

Bruce Benton bids farewell to all of his friends as his year as NAHU president comes to a close.

Thank you!

To our very generous sponsors for supporting this year's convention.

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Solstice

TheStandard

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ups

WELLS FARGO

Congratulations, Award Winners!

MEMBERSHIP AWARDS

Recruiter of the Year
Michelle S. Howard - Michigan

Most New Members
Large Local Chapter – Metro Detroit AHU
Large State Chapter – California AHU
Small Local Chapter – Mid South Tennessee AHU
Small State Chapter – Kentucky AHU
Region 8

Highest Growth Rate
Large Local Chapter – Metro Detroit AHU
Large State Chapter – Michigan AHU
Small Local Chapter – Piedmont Virginia AHU
Small State Chapter – West Virginia AHU
Region 2

Highest Retention Rate
Large Local Chapter – Omaha Nebraska AHU
Large State Chapter – Michigan AHU
Small Local Chapter – West Texas AHU
Small State Chapter – Alabama AHU
Region 4

Overall
Large Local Chapter – Metro Detroit AHU
Large State Chapter – Michigan AHU
Small Local Chapter – Southwest Michigan AHU
Small State Chapter – Connecticut AHU

Membership Cup
Region 8

ANNUAL AWARDS

Blue Chip Award
Region 4 Small Region of Excellence
Region 8 Large Region of Excellence

Distinguished Service Award
Ashley Wynkoop FL – Region 5
Chad Gay AL – Region 5
Dan O'Brien IN – Region 3
Danine Baca NM – Region 7
David Fear Sr. CA – Region 8
Don Goldman CA – Region 8
Jodie Braner GA – Region 5
Kelly Fristoe TX – Region 6
Krista Zimpel TX – Region 6
Robin Frick LA – Region 6
Ronald David Knight GA – Region 6
Thomas Harte NH – Region 1
William D. Robinson IN – Region 3

Emerging Leader Award
Heather Fortner NM – Region 7
Whitney Martin FL – Region 5

Landmark Award
Alaska AHU Region 8
Idaho AHU Region 7
Indiana State AHU Region 3
Maryland AHU Region 2
Nebraska AHU Region 4
New Mexico AHU Region 7
North Carolina AHU Region 5
Texas AHU Region 6
Virginia AHU Region 2

Media Relations Award
Clark County AHU NV – Region 8
Triad AHU NC – Region 5
North Carolina AHU NC – Region 5

Pacesetter Award

Atlanta AHU	GA	– Region 5
Central California AHU	CA	– Region 8
Central New Jersey AHU	NJ	– Region 2
Charlotte AHU	NC	– Region 5
Eastern Virginia AHU	VA	– Region 2
Golden Gate AHU	CA	– Region 8
Orange County AHU	CA	– Region 8
Southern Arizona AHU	AZ	– Region 7
Southern Idaho AHU	ID	– Region 7
Texoma AHU	TX	– Region 6
Triad AHU	NC	– Region 5
Western North Carolina	NC	– Region 5

Presidential Citation Award

Al Schiebel	Atlanta AHU	– Region 5
Carolyn Beck	Indiana AHU	– Region 3
Daniel Tompkin	Georgia AHU	– Region 5
Jean M. Miller	Tulsa AHU	– Region 6
Kelly Fristoe	Texas AHU	– Region 6
Michelle Howard	Metro Detroit AHU	– Region 3
Shannon Zajec	Sacramento AHU	– Region 8

Robert W. Osler Professional Development Award

Sacramento AHU	CA	– Region 8
Texas AHU	TX	– Region 6

William F. Flood Public Service Award

Orange County AHU	CA	– Region 8

Website Award

Triangle AHU	NC	– Region 5
Coastal AHU	NC	– Region 5
North Carolina AHU	NC	– Region 5
Ohio AHU	OH	– Region 3

LEGISLATIVE AWARDS

Legislative Achievement Award

Cerrina Jensen	CA	– Region 8
Kelly Fristoe	TX	– Region 6

Legislative Excellence Award

Baltimore AHU	MD	– Region 2
Oklahoma AHU	OK	– Region 6

HUPAC AWARDS

Top HUPAC Contributors

Arthur Jetter, Jr.	NE	– Region 4
Don Goldmann	CA	– Region 8
John J. Nelson	CA	– Region 8
Karl Albrecht	MI	– Region 3
Maurice Lyons	NY	– Region 1

Highest Annual HUPAC Contributions

First Place	Region 5
Second Place	Region 8
Third Place	Region 6

Highest Average Donation per Member

First Place	Region 1
Second Place	Region 4
Third Place	Region 8

Highest Percentage of Monthly Contributors

Region 5

Highest Percentage of Increase in Contributions

Region 1

Michael D. Gray Award

John Nelson CA – Region 8

Excellence in Journalism Award

Daniel Steenerson CA – Region 8

BLUE RIBBON OF EXCELLENCE

Colorado AHU	Region 7
Idaho AHU	Region 7
Indiana AHU	Region 3
Michigan AHU	Region 3
Missouri AHU	Region 6
North Carolina AHU	Region 5
Ohio AHU	Region 3

PUT YOUR MASK ON FIRST

By Anthony Boquet, CLU, ChFC, CASL, CLF, LUTCF
Vice President/Executive Director
Penn Mutual Center for Veterans Affairs
The American College
Bryn Mawr, PA
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"Should we experience a decrease in cabin pressure, four oxygen masks will fall from the ceiling compartment in front of you. Should this occur, reach up, pull a mask toward you, placing the cup over your nose and mouth, securing it with the elastic band. Please secure your own mask before assisting others. Breathe normally. Even though the bag will not inflate, know that oxygen is flowing." Anyone who has traveled by air has heard this safety presentation.

I guess I travel way too much; however, it dawned on me on one of my flights that we can all learn something from this statement and apply it to our lives. I have been in business for over 30 years now, and I am still guilty of ignoring the lessons of the oxygen mask. What lessons am I speaking of? Let's take a closer look.

How many times in life do we or someone we care about have a decrease in cabin pressure, requiring "oxygen" to make it through the experience? That decrease in cabin pressure can be any event where we have to rely on someone or something in order to persevere. When this sort of event happens, we hope we have that someone or something close by to ease the burdens brought on in this unforeseen circumstance.

As an advisor, you would be that proverbial oxygen mask, delivering the aid that person needs at those critical moments.

Put your mask on first before assisting others. Why do you think that is so important? Well, if you are ever in an oxygen-deficient state for long enough, you will pass out and be unable to be much good to anyone, indirectly causing harm to those you wish to assist.

I have seen thousands of clients through the years, many coming to me when their current advisor could not satisfy their "oxygen" needs. As mentioned earlier, even the airline offers options over which lifesaving devise you can choose. Starting my sales career at the ripe old age of 21, by the first couple of years, I came to the understanding that I was not making the sales I should have been making. Always being the humble one, at least in my own mind, I

AS AN ADVISOR, YOU WOULD BE THAT PROVERBIAL OXYGEN MASK, DELIVERING THE AID THAT PERSON NEEDS AT THOSE CRITICAL MOMENTS.

assumed it was something wrong with the picture but never imagined the problem to be something I was doing or not doing that caused this phenomenon.

With the infinite wisdom that only a 23-year-old can possess, I decided I needed to grow a beard to make myself look older, thus appearing wiser than I really was. After about three weeks of not shaving, my mentor called me into his office and asked if my razor broke. I quickly and proudly explained my plan to him. After an inordinate amount of laughter on his part, he made a revelation that changed my entire life and the life of everyone of my clients.

Henry Mattason, CLU, proclaimed: "Son, you cannot make yourself older than you are but you can make yourself smarter than all your competition."

Right then, he reached for the phone and enrolled me in the Chartered Life Underwriter designation program through The American College. At the time, Henry saw something in this impetuous young man that I did not see in myself. He was my assistant on the plane, already wearing his oxygen mask, his CLU credential. Because I could see Henry's mask, I knew the importance of me taking his guidance. It put my mind at ease. Education is the oxygen flowing through the mask.

Breathe normally, knowing that oxygen is flowing, even through the bag will not inflate. This statement is added to diminish the level of anxiety the passengers will feel at the unexpected moment of the appearance of those trusty masks. The airline wants to create a level of trust so that the flight attendants can do their jobs without dealing with an abundance of panic-stricken people. In my opinion, the "oxygen mask" of education and knowledge gives you the confidence to "breathe normally" while helping others. For those you assist, it gives them the trust that all will be well in their world since you are confident in your ability. Without trust and confidence, people make foolish and costly decisions.

As I was contemplating this scenario of the masks, I found it funny to think that four masks would appear right in front of the needy party's face. What a time to have to make an important decision over which one to choose! One might get hung up and be hanging upside down. Another might be shiny and new while another might be drab and wrinkled. Which would I choose if given a split second to decide?

The passengers on the airplane are not experts in oxygen-dispersal systems; neither are your clients experts in the credentialing process. Not all education is the same, yet a consumer may not know this. It is your responsibility to make sure you are not branding yourself with credentials that mislead our clients. If you ever need to defend your credentials in a courtroom, could you do so?

By the way, the airline provides four masks per compartment when only three people usually occupy the row. Why do you think that is? Is it possible that one of the three might not work or not work out adequately? I will come back to this in a minute.

What if the airline skimped on the cost of the oxygen system in its planes? Very few people would know since they are rarely used. In my life, I know only one person that has been on a flight where the oxygen was deployed and lived to tell about it. How many do you know?

If you ever see those yellowish-orange masks and clear tubes, you make the assumption that they are the best (or at least that is your silent prayer). When you need a professional—a doctor, lawyer or financial advisor—do you ask them for their credentials? Why not? If one of my family members is in need of their expertise, I want the very best.

As a professional myself, I personally suggest that my clients look at other professionals before they choose one. I am confident in my level of knowledge and experience and, if they like and trust me, we will be able to navigate through any storm that they face.

Since the day that Henry opened my eyes, I have strived to be the smartest advisor as well as a trusted mentor. Notice I did not say I was the smartest—only that I have strived to be. After 30 years of practicing my craft, I understand I still do not know it all.

Being a professional in a highly regulated industry where laws, regulations and tax codes change daily, I think it is impossible to know it all. However, it never ceases to amaze me that advisors and leaders—people held to a high level of authority and responsibility—rely on periodicals, company meetings, one-hour webinars and the Internet when developing their level of expertise. Those are usually the individuals that come up to me and ask with a smirk on their face, "Why do you have that alphabet soup behind your name?" The reply can be something fun like, "I am trying to grow another name. " But my usual professional response is, "I continue to grow professionally so that I can be the best I can be for those who depend on me."

I will do everything in my power to not be that mask hanging unused when needed. I use my credentials as a visible oxygen mask that brings peace to those that know what they represent.

Henry has long retired now but is still in my thoughts and prayers. I hope I have been able to carry on in his footsteps in a manner he would be proud of. I do not think I can ever quit learning because education is the oxygen and the mask is the credentials I need to be able to assist others. So the next time you find yourself on a plane and the flight attendant pulls out the oxygen masks, ask yourself, "Do I have a professional mask that provides me the oxygen I need to be the best I can be to those I serve?" HIU

DI SELLING DECRYPTED

Straight talk, super simple solutions

By Daniel C. Steenerson, CLU, ChFC, RHU

MASTERING THE SALES MIDDLE MILE

Those of you who routinely sell income In many ways, sales and entrepreneurship are similar to running a marathon. At the starting line, your mind is filled with eager anticipation. You're highly committed to the journey and reaching your destination. As you approach the finish line, you feel a surge of adrenaline. It's easy to be motivated when the end is in sight.

However, before you get to the finish line, you must conquer the middle mile.

The miles between the start and the finish —the middle miles—are the most problematic. During the middle miles, we are tempted to throw in the towel. This is the place where we experience pain, fatigue and rejection. We stumble, we gasp for air and we curse the inclines.

During the middle mile of selling, prospects either tell us "no" or they make the journey much more difficult than it needs to be with countless objections and delays. During the middle mile of entrepreneurship, we often forget the thrill that inspired us in the beginning. We begin to question the meaning of what we're doing, and we wonder if we should have taken another path.

If you're cursing the middle mile, recognize that it's an inescapable and essential leg of your journey. Although the middle is frustrating, it's where growth and learning occur.

Here are five strategies to help you conquer the middle mile:

1. **Visualize the finish line.** Look at your goals every day, measure your progress and adjust your pace as needed. Why did you start your journey? Allow your destination to inspire you. If your goal is to close a disability insurance policy, help your client visualize the finish line, which is the peace of mind made possible by income-protection strategies.
2. **Put one foot in front of the other.** When the hill seems too steep, focus on small forward steps. Have faith that the time and energy you invest will pay off. In selling, small steps equate to meticulous follow-up. Never forget that most sales occur after the eighth contact with a prospect. Execute the activities that instigate success.
3. **Know the surge is coming**. Sales and careers rarely progress at an even, regular pace. You can work very hard for three years, seeing only gradual progress and then, suddenly, you'll see a big surge in revenues or profits. Although the surge appears to happen in a moment, it is a cumulative result of many small steps. If sales are falling through the cracks, reassess your process and keep working hard. The surge will come.
4. **Stay nourished.** Don't let your creative juices run dry. Read, get a business coach and continually pursue personal development. By investing in yourself, you give fresh legs to your business or career. In our business, a seasoned mentor can be an invaluable way to get through the middle mile a little faster.
5. **Hold yourself accountable.** Remember: Successful people have the discipline to do what others don't want to do. That includes getting up earlier, working harder and persevering. Work your plan every day.

As French novelist Marcel Proust once said, "We don't receive wisdom; we must discover it for ourselves after a journey that no one can take for us or spare us." And that is the essence of the middle mile. HIU

Dan Steenerson is the president of Disability Insurance Services, headquartered in San Diego, CA. Dan is known for helping DI agents succeed with straight talk and super-simple sales solutions. He is also the recipient of the 2013 HIU Excellence in Journalism Award. For more information and to obtain free sales tools and articles, visit www.diservices.com.

THINKING ABOUT HR

Are you thinking HR? You should be!

By Laura Kerekes, SPHR
Chief Knowledge Officer, ThinkHR
Pleasanton, CA

This column features actual questions about HR-related client issues and answers from the experts at ThinkHR.

Question: A former employee is telling us that he sent in his COBRA election forms within the 60-day window, but we never received it. Assuming that we take his word for it and allow him on COBRA, will that create a precedent in the future when we don't allow former employees onto COBRA when they forget to return their paperwork in a timely manner?

Answer: The circumstances are different. In the current situation, you have no way of really knowing whether or not the employee or COBRA beneficiary sent the paperwork in a timely fashion, and you wouldn't be able to disprove that in court. Further, because the former employee is calling either because he did mail in the paperwork and/or he actually needs the coverage, you have to assume, by not allowing COBRA (within reasonable time frame as allowed by carriers), there is an increased risk for liability including the actual cost for medical claims not covered by the insurance because you didn't reinstate, when they had no proof otherwise.

For a former employee or other COBRA beneficiary who admittedly did not turn in paperwork on time and is asking for COBRA, if the employer (assuming within reasonable time frame as allowed by carriers) allows the employee to go on COBRA, this will set a precedent for those similarly situated in the future. Be sure to document details of reason for denial, if applicable.

For example, note the file on DATE, NAME called and inquired about COBRA and said he/she did not yet turn in paperwork. Or save and print email or other written communication where the person admits fault and keep with employee benefits file in COBRA section should anything come up in the future.

If the employer is going to allow the person on COBRA, the rationale should be documented in order for the employer to understand how to handle future situations. This process/decision should go into some kind of HR/benefits training or history file/document so, if and when there is turnover in the department, it will be easy to determine that there is a precedent or practice already in place.

Question: I have a client that offers medical coverage for employees working 30 + hours. The client has 20 hours eligibility for medical and has an employee that is dropping to 20 hours. Can she remain on the FSA plan? Is there any restriction that requires an employee to work 30 hours to be on an FSA under the healthcare-reform or any other benefits rules?

Answer: Health FSA eligibility is up to the employer or plan sponsor to determine and is not tied to working a certain number of hours per week. Your client should check the plan documents to determine the rules it has set for eligibility for the health FSA and that should provide them with the answer.

If you need more detailed IRS rules governing health FSAs, visit www.irs.gov/publications/p969/ar02.html#en_US_publink1000204020_en_US_publink100038736.

Question: When an employee is on an approved FMLA leave of absence, we continue benefits and have employees pay their share while they are out. We provide all the proper communication at time of leave and give them a 15-day warning notice as well if we do not receive payment. If we cancel due to non-payment, is this a COBRA-qualifying event under FMLA?

Answer: It is our understanding that, as long as the employer provides the proper notifications regarding payment amounts and schedules as well as the consequences for not making the payments, the employer may suspend health benefits for the duration of the FMLA; however, loss of coverage due to failure to pay required premiums or contributions during FMLA is not considered a COBRA-qualifying event.

Here are more details regarding the employer and employee obligations during FMLA:

- When the FMLA begins, or as soon as the employer can determine the facts, the employer must inform the employee whether the leave is protected by FMLA.
- If the leave is certified as FMLA, then the employee must be given information about coverage continuation, the amount and due dates of any required

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READY OR NOT, CONSUMER-DRIVEN HEALTHCARE IS HERE TO STAY

By Michael Zuna
Executive Vice President and Chief Marketing Officer, Aflac
Columbus, GA

The American workforce is about to gain more control over its health insurance. Consumer-driven health plans place costs and care in the purview of employees, which has already proven to drive down overall healthcare costs[1] and will continue to encourage productivity and innovation in the marketplace. Empowered to make their own choices, employees can make benefits selections that are best for them and their families. So why are consumers anything but excited?

The 2013 Aflac WorkForces Report reveals a sobering gap in employee readiness to take on the shift toward consumer-driven healthcare and defined-contribution models. A majority of workers (54%) would prefer *not* to have more control over their insurance options, citing lack of time and information to manage it effectively, while 72% have never even heard the phrase "consumer-driven healthcare."[2]

This gap in readiness and healthcare understanding is accompanied by significant disconnects in expectations and plans for the future. Aflac found that while 62% of employees think their medical costs will increase, only 23% are saving money for those hikes. Only 30% of workers say that, when selecting an insurance product, they always have a full understanding of the deductible costs. And another 15% do not check if their coverage deductibles are correct or that their preferred medical professional is in their network.[2]

Most concerning of all: While a full three-quarters of the workforce think their employer will educate them about changes to their healthcare coverage as a result of reform, only 13% of employers say educating their employees about healthcare reform is important to their organization.

When it comes to matters of financial security or healthcare, it's fair to say that many consumers would prefer for someone else to manage it for them—or at the very least educate them—while another segment is simply not equipped to take ownership at all.

Ready or not, the consumer-driven healthcare revolution is here. In 2012, J.D. Power and Associates reported that 47% of employers would "definitely" or "probably" switch to a defined-contribution health plan in the coming years.[3] As the remaining healthcare legislation is implemented, more employers will adopt CDHPs. This shift requires an entirely new degree of decision-making for consumers.

If consumers aren't educated about the full scope of their options, they risk making costly mistakes without a financial backup plan. A lack of communication not only exacerbates an already-dangerous information gap, but also forgoes opportunities to

EMPOWERED TO MAKE THEIR OWN CHOICES, EMPLOYEES CAN MAKE BENEFITS SELECTIONS THAT ARE BEST FOR THEIR FAMILIES.

communicate benefits that can both satisfy worker demand and improve key aspects of the workplace, such as voluntary and supplemental offerings.

CONSUMER UNPREPAREDNESS

When consumers were asked how they would pay for out-of-pocket expenses because of an unexpected illness, more than half (59%) of workers said they would have to tap into savings, 28% would use a credit card and 24%—nearly one out of four people—would have to withdraw funds from their 401(k) plans to cover the costs, according to the Aflac study.[2]

The U.S. government predicts that household out-of-pocket healthcare expenses will reach an average of $3,301 per year by 2014,[4] not including other costs associated with taking time off work due to illness or injury. This can intensify the challenges of an already financially vulnerable segment of consumers.

The estimated out-of-pocket costs for a patient who suffers a heart attack span $5,000 to more than $8,000 over the expected year of treatment, according to the American Cancer Society[5] Strokes are among the most costly illnesses— approximately $23,380, according to the *American Journal of Medicine*.[6] And someone who is diagnosed with coronary heart disease can expect to pay about $75,000 per year, according to a 2011 Milliman Research Report.[7]

The costs that injuries and illnesses pose to employers are also very real and can seriously impact a company's bottom line. Employees' financial difficulties translate to decreased job performance, absenteeism and dissatisfaction on the job. Nearly four out of 10 workers (37%) attribute distraction and/or lost productivity at work to financial or health problems.[2] In fact, the Centers for Disease Control and Prevention state that the indirect productivity losses related to personal and family health problems cost U.S. employers $1,685 per employee per year, totaling $225.8 billion annually nationwide.[8]

IF CONSUMERS AREN'T EDUCATED ABOUT THE FULL SCOPE OF THEIR OPTIONS, THEY RISK MAKING COSTLY MISTAKES.

HELPING CONSUMERS TAKE THE HELM

Helping workers learn to effectively manage their healthcare choices presents an opportunity for employers to demonstrate they care about their employees and to curb potential absenteeism, low morale and low productivity. Workers may well be the ones responsible for their healthcare decisions, but the wrong choices can affect their performance and state of mind in the workplace. To succeed in turning what most employees see as an unfavorable form of cost-shifting on its head, employers must present a robust menu of benefits options through abundant communication.

In a defined-contribution model plan, for instance, sponsors decide how much they are going to contribute (usually as a dollar amount, based on a percentage of the first year's premium), lay out multiple options and allow employees to choose from an expanded menu of options, making them more engaged and, with the right education, more empowered. The fixed contribution amount helps employers keeps costs predictable, and the flexibility allows employees the opportunity to "buy up." These fixed contributions can and should be allocated to different pockets, such as major medical, voluntary benefits and Health Savings Accounts.

Rising healthcare costs and the move toward consumer-driven plans are leading to a growing need for voluntary insurance products that employees can purchase with their defined-contribution dollars. Voluntary insurance plans can provide a much-needed resource in the face of a high-deductible health plan because the cash benefits can add safety and stability for workers and their families.

Voluntary policies—including critical illness, short-term disability, accident, dental, life and more—pay the policyholder directly, unless otherwise assigned, for unexpected costs associated with serious illness, injury or loss. Since many of these costs are not covered by major medical insurance and families may not have extra cash for emergencies, voluntary insurance provides a safety net to help protect the policyholder's assets.

Because the costs are shifted to the employee, there is no harm in offering a robust menu of ancillary benefits from which employees can select. Supplemental insurance allows for thorough customization, which also helps employees feel appreciated. And offering competitive benefits boosts employers' ability to attract and retain a talented workforce with little or no cost to their bottom line.

Frequent communication is paramount for instituting healthcare changes. Employers must accept that sending a yearly message during open enrollment is no longer adequate. Sponsors must be encouraged to communicate through a number of channels, including print, intranet and face-to-face meetings, highlighting their benefits as well as demonstrating how other employees have utilized them.

Brokers can also keep the lines of communication open by helping employers understand the degree to which employees want guidance—without which they may be inadequately protected. The current economic landscape, combined with a lack of basic knowledge about financial

principles, has left many American workers financially insecure and with high debt. Companies must view a worker's physical and financial wellbeing holistically and understand the costs of not protecting their overall health. HIU

1 The Effects of Consumer-Directed Health Plans on Episodes of Health Care, by Amelia M. Haviland, Neeraj Sood, Roland McDevitt and M. Susan Marquis. Published in: Forum for Health Economics and Policy, v. 14, no. 2, article 9, Sept. 2011, no. 9, p. 1-27

2 2013 Aflac WorkForces Report, a study conducted by Research Now on behalf of Aflac, January 7–24, 2013

3 J.D. Power and Associates Reports: Amid Uncertainty, a Large Proportion of Employers Prepare to Pursue Alternate Health Coverage Offerings for Their Employees. June 18, 2012

4 Bankrate.com (2009) Paying out-of-pocket health care costs. Accessed on May 23, 2013, from www.bankrate.com/finance/insurance/coping-with-out-of-pocket-health-care-cost-1.aspx

5 American Cancer Society Cancer Action Network (2009). New Study Reveals Popular Federal Employee Health Plan a Good Starting Point to Determine Minimum Benefits Coverage, accessed on January 22, 2013, from action.acscan.org/site/News2?page=NewsArticle&id=11253&news_iv_ctrl=1321

6 Himmelstein, David U., Thorne, Deborah, Warren, Elizabeth, Woolhandler, Steffie (2009). Medical Bankruptcy in the U.S., 2007: Results of a National Study. The American Journal of Medicine; page 4, access on January 22, 2013, from http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

7 Milliman (2011) Benefit Designs for High Cost Medical Conditions, accessed on March 28, 2013, from publications.milliman.com/research/health-rr/pdfs/benefit-designs-high-cost.pdf

8 The Centers for Disease Control and Prevention (2012). Comprehensive Workplace Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace, accessed on January 8, 2013, from www.cdc.gov/workplacehealthpromotion/nhwp/index.html

THINKING ABOUT HR

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contributions (not exceeding the amount applicable to employees not on leave) and a minimum 30-day grace period to make payments.

- If the employee fails to make a required payment during FMLA, the employer must notify him/her in writing at least 15 days before terminating coverage.
- When the employee returns to work at the end of FMLA, the coverage must be restored with no waiting period.
- Failure to return to work at the end of the 12-week FMLA period is a COBRA-qualifying event regardless of whether the employee made required payments during the leave.

The full text of the rules surrounding the failure to pay health plan premium payments while on FMLA can be found in Section 825.212 of the law at www.gpo.gov/fdsys/pkg/CFR-2010-title29-vol3/pdf/CFR-2010-title29-vol3-sec825-213.pdf.

Question: We are designing our wellness programs for this year and want to offer a wellness benefit to our nonsmokers. Are there special compliance rules surrounding wellness programs?

Answer: A group health plan is allowed to offer a discount to nonsmokers if it is part of formal wellness program that is nondiscriminatory under HIPAA. The Department of Labor has specific guidelines:

For a group health plan to maintain a premium differential between smokers and nonsmokers and not be considered discriminatory, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, under the final rules, this wellness program would be permitted if:

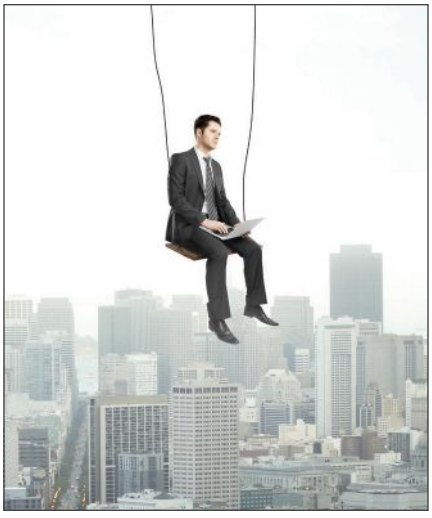
- The premium differential is not more than 20% of the total cost of employee-only coverage (or 20% of the cost of coverage if dependents can participate in the program)*
- The program is reasonably designed to promote health and prevent disease
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year
- The program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch)
- Plan materials describing the terms of the premium differential describe the availability of a reasonable alternative standard to qualify for the lower premium.

Source: www.dol.gov/ebsa/faqs/faq_hipaa_ND.html

*The potential incentive for employers offering wellness programs increases to 30% of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. HIU

If you have HR questions you'd like answered, send them to hiu@thinkhr.com. An expert at ThinkHR will respond to you and we may include it in a future installment of this column.

THE MODERN BROKER



By Dave O'Brien
Divisional President, Insurance Solutions
Zywave
Milwaukee, WI

DETERMINING YOUR WORTH: A VITAL PART OF YOUR FEE-FOR-SERVICE STRATEGY

Not too long ago, there was a story in the news of a rare nickel that was found in a closet. It had been stored away for 40 years. The nickel was recently sold for over $3 million.

The owner thought it was a fake and, when she passed away, her siblings decided to have it examined and it was determined to be real. One leaves a lot of money on the table if they do not know the value of what they have or have to offer.

In speaking with brokers, one of the biggest issues they have is implementing a fee-for-service strategy, starting with determining what to charge a client for their services. There are many schools of thought, from charging standard commission fees to a flat amount based on number of employees. However, for a tightly run business, a process should be formed to determine acceptable profitability levels and to help create a story to sell it. This is step 1 of a successful fee-for-service strategy.

Each client is different depending on service levels and expectations. Analyzing the profitability of each account in your book of business can help you:

1. Re-evaluate and quantify relationships
2. Identify your most and least profitable clients
3. Adjust service models to ensure acceptable margins
4. Power conversations with current clients as you transition to a fee-for-service model

HOW DO YOU EVALUATE CLIENT PROFITABILITY?

Nailing down the fee structure itself can be the trickiest part. To assist brokers in this endeavor, we have created a Client Cost Calculator. You can fill in the boxes on areas like revenue and fixed costs (plus costs associated with servicing specific accounts). The calculator will then determine the dollars needed for each account.

Another interesting aspect to the calculator is it can clearly illustrate which accounts are and are not profitable—i.e., which accounts should be moved out of your book to make room for more profitable clients. This in itself is a valuable exercise every producer should conduct with their book.

CRAFT YOUR NEW STORY

Once you've decided on your fee structure and evaluated (and tweaked, if necessary) your current service models, the next step is taking the message to your clients. Many brokers I talk to struggle with how to have this conversation.

Start by telling both prospects and clients that you take service seriously, and you do an annual account review to measure all the services you're providing. This helps set up an opportunity to introduce fees for those clients who haven't been on that model yet.

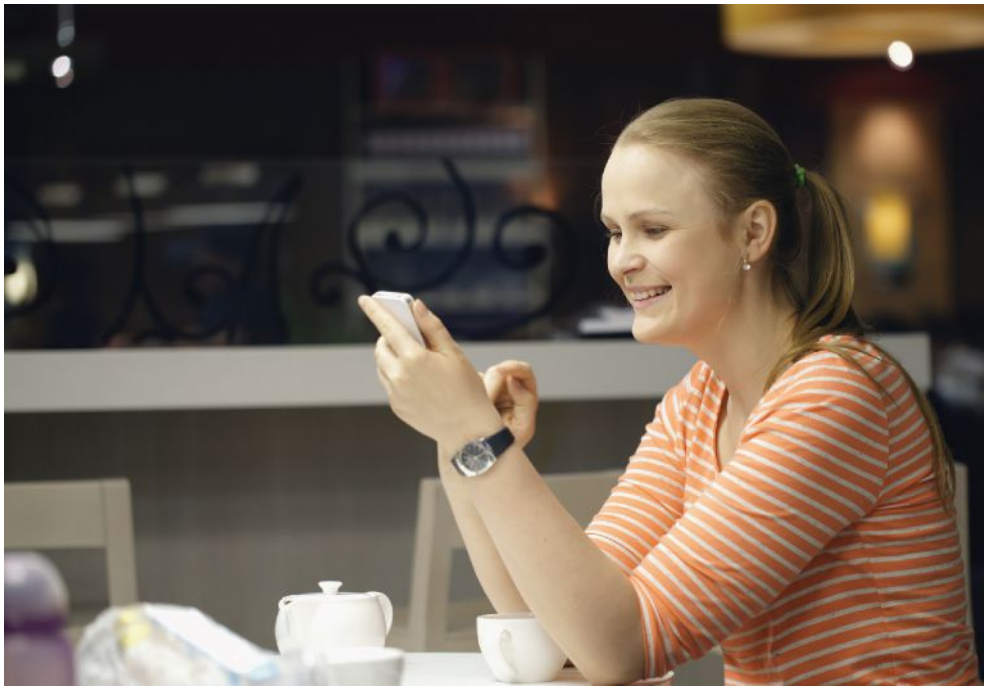
For all your clients, go in with the mindset that "if they don't pay for it, they won't value it"—this goes for you, your agency's service, and all the additional resources and tools you've been giving your clients for free all these years. If you can confidently articulate your value, clients should have no problem paying you what you're worth.

You may not have a valuable nickel stored away in your closet, but without this type of process, you are leaving a mountain of nickels on the table. I think it's best to let your competitors do that. HIU

IF YOU CAN CONFIDENTLY ARTICULATE YOUR VALUE, CLIENTS SHOULD HAVE NO PROBLEM PAYING YOU WHAT YOU'RE WORTH.

Dave O'Brien is divisional president of insurance solutions at Zywave. Dave's career in sales began in the 1980s with MetLife. In 1992, he joined Frank F. Haack and Associates, where he built a substantial book of business as a large-group broker. He also helped the firm create new technology tools for use with its clients—which evolved into a stand-alone company, Zywave. Today, he leads Zywave's Insurance Division to help clients succeed in today's marketplace.

TEXT-MESSAGING AS AN EFFECTIVE ENGAGEMENT STRATEGY



By Abbie Leibowitz, M.D.
Executive Vice President, Chief Medical Officer
Health Advocate Inc.
Philadelphia, PA

Corporate wellness programs are only successful if they can engage employees in activities and sustain participation rates long enough to produce meaningful results. Encouraged by PPACA's emphasis on wellness and tobacco cessation, employers that never before designed a worksite wellness strategy are taking another look. Yet many organizations struggle with low participation rates and poor levels of success. The use of mobile technology and text-messaging is emerging as a wellness engagement solution that's proven to work.

Statistics show that 90% of Americans have a cellphone and more than half have a smartphone. The widespread use of this technology presents an enormous opportunity for employers to communicate, educate and engage their employees.

Reading and sending text messages has become an important means of daily communication. Communicating motivational wellness messages and behavior change reminders through text is a convenient way to give employees support and enhance coaching efforts.

A growing number of employers are discovering that text-messaging presents an immediate way to offer encouragement to help employees stick to their goals and overcome obstacles, like the temptation to smoke or overeat.

"Pushing" personalized phone texts to a targeted audience is an inexpensive way to reach and engage a greater number of employees.

Here at Health Advocate, we've employed a team of wellness experts to study and develop unique wellness strategies. While texting is an important part of several of our wellness programs, our experience shows that it has had great impact in our smoking-cessation and weight-loss programs.

THE USE OF MOBILE TECHNOLOGY AND TEXT-MESSAGING IS EMERGING AS A WELLNESS ENGAGEMENT SOLUTION THAT'S PROVEN TO WORK.

PUTTING OUT THE LIGHT ONE TEXT AT A TIME

Employer-sponsored smoking-cessation programs have become a very popular wellness strategy to help protect the health of employees and lower costs. Almost everyone is aware that smoking can increase the risk of lung cancer, heart disease and a host of other diseases, but many people don't realize how truly expensive it is.

Compared to nonsmoking employees, every employee who smokes costs their employer on average nearly $6,000 more each year, according to a report by the College of Public Health & Moritz College of Law at Ohio State University. This figure is based on the smokers' costs associated with absenteeism, presenteeism (lower productivity while working due to smoking-related health problems), smoking breaks, excess healthcare expenses and retiree benefits.

Despite the risks and costs of smoking, nicotine is highly addictive and quitting smoking can be difficult. In fact, most people don't succeed the first time they try to quit. Quitting usually takes more than one try.

As more employers struggle with the costs of smoking, they're looking for alternatives to help their employees quit—and to quit for good. There is emerging evidence that mobile-based smoking-cessation interventions can fit the bill. The Cochrane Library published a review of mobile messaging-based smoking cessation interventions involving 9,000 smokers. The findings revealed that the smokers who used text interventions were twice as likely to quit smoking in six months as those who did not.

TEXTING AND THE GREAT AMERICAN SMOKEOUT

In October 2011, we initiated a campaign to coincide with the American Cancer Society's annual Great American Smokeout. This national event is a period of heightened awareness about smoking and it created a unique opportunity to demonstrate the impact of supporting the message to kick the habit using text messages.

During the campaign, employees who decided they wanted to quit had unlimited access to a Health Advocate wellness coach. If they texted "HELP," they received a call from a wellness coach for encouragement and to provide assistance in developing a quit plan. Participants were also asked to text a diary of their average tobacco usage each week.

PERSONALIZED TEXT-MESSAGING OFFERS A POWERFUL TOOL TO REACH MORE EMPLOYEES WITH MEANINGFUL COMMUNICATIONS.

The results were significant: Thirty-eight percent of the participants texted "HELP" and 35% texted a record of their average tobacco usage each week. In addition, those participants who submitted questions via text received personalized responses from their wellness coach.

As might be expected, the project demonstrated that the timing of responses from the coach is critical to the success of the program. The first few weeks are the most challenging for many who are trying to quit smoking, and this is when motivational messages and encouragement from a coach can be most helpful.

Through the use of text messaging during the Great American Smokeout campaign, 59% of employees cut their tobacco usage by at least half, and 21% reported quitting altogether. Texting continued following this special campaign as a way to provide extended support and inspiration to participants after they quit.

MOBILE MESSAGING FOR WEIGHT LOSS

As with smoking, employees who are overweight exact a high financial toll on businesses. A recent survey by Duke University revealed that obesity costs employers $73 billion a year. Employee wellness programs can alleviate some of the enormous costs associated with obesity.

But sticking to a plan to shed pounds and keeping the weight off long term is not easy for most people. Extreme dieting and other quick fixes typically fail. Achieving weight loss takes ongoing motivation and step-by-step behavior change. Studies have shown that text messages might prove to be a productive channel of communication to promote behaviors that support weight loss in overweight adults.

For example, for individuals who want to maintain a healthy weight, the holiday season can be a minefield of fattening foods that can easily derail sticking to a healthy plan. Having access to a wellness coach at their fingertips can be helpful in situations where on-the-spot encouragement is needed.

We designed a "Maintain, Don't Gain" program to help employees maintain their weight during the tempting holiday season through the use of social media, including text-messaging. Maintaining weight and sticking to a new eating and exercise regimen is a difficult process. Knowing you have a wellness coach at your side providing a support system can be a big help.

Of the participants involved in the Maintain, Don't Gain campaign in 2011, 31% texted "HELP" to their wellness coach. During the campaign, 14% of participants lost five or more pounds and 62% maintained their weight within two pounds over the 10 week period.

MOBILE MESSAGING INCREASES ENGAGEMENT CHANNELS

Engagement in wellness initiatives is a challenge and using multiple channels to reach employees is vital for success. Personalized text-messaging offers a powerful tool to reach more employees with meaningful communications and provide interventions to inspire long-lasting behavior change for better outcomes and lower costs. HIU

WHAT'S UNDER THE HOOD AS OPEN ENROLLMENT APPROACHES?

By Dan Maynard
President, Connecture
Milwaukee, WI

Open enrollment for health insurance, and the first use of the exchanges called for by PPACA, begins in two months. Whether you look at the ramifications of PPACA or the efforts of health plans to lower costs, technology is fundamentally changing how health insurance is distributed and how business is done. We are all facing the uncertainty of uncharted territory.

Public health insurance marketplaces, private exchanges and even health plans' own website-based shopping and enrollment systems reveal an inescapable fact: While technology is never the only issue, technology-related questions lie at the core of nearly every pivotal trend shaping the health insurance industry. And for health plans, brokers and agents, there continues to be more questions than answers.

HEALTH PLANS AND BROKERS WILL BOTH NEED TO EXPEND SIGNIFICANT ENERGY IN GUIDING AND EDUCATING THE PUBLIC.

Quite often a significant issue that surfaces for health plans is how one can effectively sell in the public marketplace. Although there may not be a single defining answer, it begins with the ability to differentiate your product and presence in a commoditized world.

Start by creating a specific value-added brand that is reinforced at every opportunity. This brand needs to be tangible and resonate with the consumer purchasing the product, whether it's because you provide a superior level of service and experience, consumer support—before, during and after the shopping and enrollment process—or defined direction and guidance. Regardless, it's important to refine and promote your brand and take steps to ensure that it

remains relevant in a time of uncertainty and confusion. Consumers will have many opportunities to make health insurance purchasing decisions on an ongoing basis and the health plans that most effectively drive their differentiators will have a greater frequency of selection.

In addition to the challenges of brand distinction, the technologies and skills required to properly integrate with the federal and state health exchanges currently being developed present an additional set of hurdles. Finding ways to accommodate the massive amounts of health insurance data that will result in real time is no small undertaking. Establishing a successful and consistent path, one that is responsive to the ongoing developments of web-service interfaces and real-time feeds, will alleviate many of the pain points that will inevitably emerge otherwise. The initial launch is sure to be a bumpy one, with some manual processes being necessary to go live, but intelligent and seamless integration will eventually become a requirement in order to successfully navigate this developing landscape.

While back-end data processing is a key component, the role of purchasing health insurance—particularly for the Americans who will have health insurance for the first time—is just as important. The nature of the health products being offered, their nuances and structure (deductibles, coinsurance, networks, etc.) are undeniably complex. Providing the tools to help consumers better understand these products and appropriately marry them to their individual and family needs will be critical to the success of the exchanges, both public and private, as well as health plans' websites. This formula needs to be as simplistic as possible and should consider tapping into the knowledge base of brokers and navigators that can provide years of experience in the industry—a process that will likely yield an increase in broker demand. Decision-support tools, glossaries of terms and pop-up descriptions will promote a more rewarding online shopping experience.

ONE OF THE MOST IMPORTANT THINGS TO REMEMBER DURING THIS TIME OF CHANGE IS THAT EVERYONE WILL BE AFFECTED: INDIVIDUALS, SMALL BUSINESSES AND LARGE ENTERPRISES.

There will be a tremendous amount of uncertainty gripping the consumer, and with uncertainty comes angst. Health plans and brokers will both need to expend significant energy in guiding and educating the public. Surveys indicate that the health plans' websites are viewed as a trusted source for information on healthcare reform, and the quality and presentation of information can certainly be an area for differentiation.

One of the most important things to remember during this time of change is that everyone will be affected: individuals, small businesses and large enterprises. From an individual consumer point of view, a new requirement has been detailed that states that every citizen will be required to have health insurance coverage or face a penalty. As a result, we'll see an increase in individual policies being sold in addition to policies provided through employers.

Small employers will have several options available. The initial federal SHOP (Small Business Health Option Program) exchange will not have the multi-carrier choice that was hoped for in the first year but it will exist in some of the state-based exchanges. Additionally, health plans, brokers and other intermediaries are working to create private exchanges that will offer plan groupings allowing for employees to shop from a selection of plans. This provides employees with greater opportunities to personalize their coverage and address their unique family needs. Large employers will (eventually) be required to provide health insurance coverage to their employees or face applicable penalties. The implications to these requirements remain uncertain and how this will all play out has yet to be determined.

The technological planning, development and implementation behind the infrastructure of an exchange is incredibly complex and will require a significant effort from all involved. Integrating across a variety of departments, state agencies, the federal hub, health plans and call centers, while attempting to accommodate for a fluid and intuitive work flow, may prove difficult and should be planned for accordingly. Continuous education of the public will be a monumental undertaking, while simplifying the process for the average consumer will ultimately dictate the future success or failure of any program. Differentiate yourself through your brand and the method by which you interact with your prospects and members. Continuing to be proactive now will help you through this rapidly changing and still-evolving health insurance landscape. HIU

MEMBER SPOTLIGHT

Brought to you by the Young Agent Health Underwriters

In the Spotlight: Alycia Riedl

President, Minnesota AHU

Senior Consultant, Towers Watson

HOW LONG HAVE YOU BEEN IN THE INSURANCE INDUSTRY?

Since I was born! My dad is a broker. He started in the industry as a rep and, in the early 80s, he opened his own agency in Minnesota. I wouldn't have believed anyone if they would have told me that I would follow in his footsteps because I was going to be an astronaut or a social worker. Seriously, though, I started working full-time in the industry in 1999.

I worked for my dad off and on all through high school and college, preparing renewals, answering phones, supporting the sales process and just all-around small business stuff. I took my first job as a customer service rep at HealthPartners in 2003.

HOW DID YOU GET INVOLVED IN NAHU?

When I took my first real sales job at Medica in 2007, I joined MAHU. It took about a year before I really started being an active member. I went to luncheons and the convention, but that was about it. My first involvement on a committee was with the Legislative Committee. It was like being thrown in the deep end! All these long-term MAHU guys who own their own agencies were sitting around the table, wondering what the heck this little carrier rep was doing at their meeting. It didn't take long, though, before I learned to respect them and they learned to appreciate my involvement. It is all history from there.

HOW WOULD YOU DESCRIBE YOUR AVERAGE DAY AT TOWERS WATSON?

I am in charge of the middle market (defined as roughly 1,000- to 10,000-life employers) business-development efforts in the Minneapolis office. My days vary. Some days, I am barely in the office at all, as I am running around meeting with potential clients and trying to get my name out there. Other days, I am immersed in prepping for a finalist presentation or getting a proposal ready to go out the door.

Most of all, though, since I am new to this role, I am learning. TW has so much to offer and an amazing amount of resources. It is sometimes overwhelming but, at the same time, so encouraging to know that I work for a company that is rooted in data, benchmarking and proven results. They have the best of the best coming up with solutions for our clients.

HOW HAS YOUR EXPERIENCE BEEN AS THE PRESIDENT OF YOUR STATE CHAPTER?

I was supposed to be president-elect this year. I expected this year to be one where I learned, practiced and prepared for my presidency. Instead, I had to step up at the last minute as our elected president changed jobs to one outside of our industry. There is nothing like jumping in the deep end and learning to swim! I have loved being the president of MAHU and have learned so much this past year. The people who serve this great organization are amazing and I truly feel blessed to have had the opportunity to learn from them and to lead us into the future of our industry. We have had our ups and downs this year, that is for sure. But I think that we faced our challenges with grace, embraced the good times and maximized all of our opportunities. It has been a tough year with healthcare reform and I am proud of how hard we have worked to protect the role of the agent while evolving the MAHU member value proposition.

ARE THERE PARTICULAR CHALLENGES OR BENEFITS TO BEING AN AGENT IN MINNESOTA?

The political landscape has certainly been a challenge for the agent in Minnesota. We are a very innovative state with regards to the evolving landscape of health insurance and delivery, and that has been something that agents and employers have benefited from, as it gives more choice and levers for employers to pull with regards to their employee benefits program. However, we

are concerned that this innovation could be stamped out to some degree because of the implications of healthcare reform, especially in the small-group market. It is also very challenging to be a producer in a state that has one of the lowest agent-compensation models.

HOW DO YOU THINK YOUNG AGENTS CAN IMPACT NAHU AND THE HEALTH INSURANCE INDUSTRY?

Young agents are the future of NAHU and the health insurance industry. If we don't find a way to educate, mentor and encourage them, our industry will be a dying breed. Period.

WHAT ADVICE WOULD YOU GIVE TO SOMEONE JUST ENTERING THE INDUSTRY?

Don't let anyone tell you "the way it is." We are in a rapidly evolving industry, and that can be a very good thing. Be open to new ideas. Find mentors. Work hard. Build relationships. Develop your brand. Work hard.

WHAT DO YOU SEE THE ROLE OF THE AGENT BEING IN THE FUTURE?

I see the role of the agent as a trusted advisor and consultant.

YOU'VE BEEN A LONGTIME VOLUNTEER FOR THE RED CROSS. WHAT KIND OF EXPERIENCE HAS THAT BEEN?

Volunteering for the Red Cross has been a great experience. I started there as a health and safety instructor because I wanted to teach people CPR. My dad had a heart attack at 49, and again at 50, and literally died for a few minutes. If he had not been somewhere where there was an AED and people that knew CPR, he would have died, for good, in a matter of minutes. CPR and using

an AED are simple skills that I could teach someone in a matter of hours. It felt good to know that teaching someone a very simple skill could help them save a life, maybe even the life of someone whom they love.

I have also volunteered after disasters like the bridge collapse in Minnesota and Hurricane Katrina. For me, having something to do and somewhere to go to help when something tragic like that happens is cathartic. I hated sitting at home feeling helpless when I saw people that on TV that needed help. The Red Cross has given me a way to turn my horror into action so that I am not left feeling sad and helpless.

I am also a volunteer Guardian ad Litem for children in protective services the 4th Judicial District in Minnesota. That role is not as straightforward. But one of the core things that drives me as a person is the need to help children. It is not an easy job—it is not even one that I always like—but it is worth every moment and tear I have put into it. Kids should be protected; when they are not, when they are hurt, abused, neglected or otherwise treated badly, I am outraged. Volunteering as a Guardian ad Litem gives me somewhere to put that energy.

WHAT YOU DO WHEN YOU'RE NOT WORKING, VOLUNTEERING OR LEADING YOUR CHAPTER?

I have two wonderful children, Aryanna and Dylan. They are what drives me to do everything I do to the best of my ability. I want to show them that you can lead a happy life while being a contributing member of society and successful in whatever you set your mind to. If I don't set that example for them, who will?

I spend most of my time when not working, etc., with my kids, friends and family. I love to kayak, go to our cabin, play with my dogs, travel, cook and try new adventures. HIU

WELCOME TO NAHU

NAHU would like to welcome the professionals who joined us in May. Thank you and welcome to the NAHU family!

ALABAMA
Andrea Hand

ALASKA
Christopher Kane

ARIZONA
Jennifer Atkins
Lindsey Baird
Anthony Miller
Matthew Nelson
Melanie Thornton
Cynthia Walter
Fay Willis

ARKANSAS
Pam Stout

CALIFORNIA
David Acuna
Roxanne Alexander
Peter Arnold
Pamela Bakaly
Anne BeDell
Kimberly Cain
Richelle Casasola
Michele Childers
William Consterdine
Alonso Contreras
Adrian Donovan
Frank Garrison
Jon Greulich
Robert Guenther
Eric Hing
Jeff Hoss
Anthony Jones
Heidi Kavajecz
Lisa Kearsley
Mary King
Sarah Knapp
Cindy Lagorin
Meneleo Largoza
Judy Larson
Colleen Laws
Jackie Lee
Carl Lundgren
Harlan Maita
Jodi Martin
Edward Martinez
Brian McCloskey
Kristin McCulloch
Donald McDonald
Carol McMullen
Gary Myers
Jessica Olson
William Parish
Nichole Parker
Doris Passalacqua
Jessica Powell
Reshmi Prasad
Alissa Puccio
Dudley Robnett
Linda Rouland
Glen Schaffer
Ruthan Smith
Stephen Soll
Teresa Vizcaino
Tatausha Webster
Eva Williams
Allan Wiser
Leonard Wollin

COLORADO
Edward Clements
Nia Ingram
Taryn Murtagh
Eric Northrop
Kristen Russell
Kevin Scanlon
Marilyn Stroo

CONNECTICUT
James Arconti
Seth Brauer
Nicola Casella
Jeffry Coleman
Roberta Czarnecki
Arnold Finaldi
Michael Geake
Philip Klinck
Jane McDermott
Michael Montanaro
Anthony Renzoni
Carol Rosenblatt
Tyler Vartenigian
Cathi Waas

FLORIDA
George Alonso
Penny Courtney
Gregory Cruice
Daniel DeWeese
Sean Donovan
Paul Ignas
Josh Kitchner
Timothy Murno
Heather Nolan
Twinata Paige
Richard Pike
Marjorie Sither
Jessie Vasquez
David Weaver

GEORGIA
Gerald Bohus
David Burke
Catherine Crowel
Timothy DeLoache
Josh Hoppe
Michael Jackson
Marilyn Mercer
Joe Lynne Pollock
Cory Scott

HAWAII
Adam Dreher
James Harbour

IDAHO
Floyd Hutchens
Tami Mosqueda
Jimmy Potts
Scott Stufflebeam

ILLINOIS
Kristin Aufmann
Joel Babbitt
Vicki Baker
Julianne Baron
Brian Blalock
Edward Briggs
Patrick Carlson
Lauren Cassidy
James Crose
Rita Daemicke
Dawn Doe
Allison Falk
Joshua Garrett
Michael Grant
Donald Harms
Steve Heney
Thomas Herr
Jack Hull
Richard Kaufmann
Grace Keyser Talarico
Patrick Kosloski
Sharon Leonard
Angie Love
Michelle Mastalerz
Patricia Musachio
Kimberly Nelson
James Pockross
Kathryn Powell
Howard Schuff
Peggy Stillwell
Carol Vogt
Don Wachal
Lorrie Walker
Richard Walker
Dan Walter
J. Wood
David Wylly

INDIANA
Dana Blose
Hugh Collins
Jeff Fabini
Charles Hunt
Louis Hunt
Timothy Konich
Wendy Labrum
Jim Mansfield
Jamie Martin
Anthony Nefouse
Michael Owen
Dianne Sarber

IOWA
Chris Boling
Deb Ferjak
Jeff Stewart

KANSAS
Julian Duarte
Dwight Menke
Shari Rains

KENTUCKY
Jerry Catlett
Thomas Estes
Mindy Farnsley
Patricia Petter

LOUISIANA
Brad Burke
Jeltje Roudolfich
Alicia Sanders
Tony Scelfo
Chris Wrba

MAINE
Benton Cash
Justin Holmes

MARYLAND
Thomas Casey
Christina Gutierrez
Julie Roberts

MASSACHUSETTS
Maureen Baker
Michael Cortez
Rhonda Dresner
Ellen Glew
Brian Lynch
Bianca Saul

Linda Saunders
Larry Tereso
Matt Waugh

MICHIGAN
Lani Corriveau
Nicholas Fontana
Kenneth Hurtt
Paul Jaboro
Michael Momrik
Jeff Nielson
Michael Pannuto
John Peterson
Kathleen Stahl
Tonya Todson

MINNESOTA
Jeff Berg
Paul Coglitore
Diego Coig
Allan Glad
Patrick Keaveny

MISSISSIPPI
Richard Cothern
Clayton Johnson
Bari Longgrear
Robert Owen
Anna Rineheart
Don Taylor
Angela White

MISSOURI
Douglas Brown
James Conger
Diana Isch
Lee Lucero
Margaret McVey
Karen Schneider
Tina Strebler
Jeff White

MONTANA
Jacquelyn Gomes
Debra Jones

NEBRASKA
Patricia Dendinger

NEVADA
Stephen Carlson
Vicki Cox
Todd Mays
Robin Mazzone
Lauren Yurick

NEW HAMPSHIRE
Patricia Stewart

NEW JERSEY
Tara Alter
James Burns
Thomas Conroy
John Evans
Suzanne Fitzgerald
George Griffaton
Lawrence Kenney
Curtis Lackland
Christina Mangelsdorf
John Mooney
Beth O'Hara
Pamela Oleary-Disette
Douglas Paquette
Erica Reisman
Robert Rosin
Anthony Santarella
Michael Scavone
Michelle Woods

NEW MEXICO
Jim Britton
William Klebesadel
Joseph Knight
Kevin Lorenzen
Lynn Weeks

NEW YORK
Stephen Baldino
Jennifer Bosco
Michael Capaldo
Kevin Conlon
Robert Dunton
Steve Gadaleto
Clark Gronsbell
Lance Jacksland
Lisa Lagon
Lauren Marecek
Melissa Morley
Cheryl Plant
Paul Russo
Mary Salamone
Gary Smith

NORTH CAROLINA
Aaron Afarian
Raymond Moore
Kevin Slater
Naveed Ulhag
Nancy Xiong

NORTH DAKOTA
Wanda Vining Alber

OHIO
Shane Ash
Richard Bogucki
Gary Conlin
Daniel Jones
Randy Jones
Nancy Vice

OKLAHOMA
Amber Lawson
Travis Murray
Lance Pearcy
Margaret Ramos
Belynda Tayar

OREGON
Randy Cline
Nola Evans
Jennifer French
Sean Grogan
Carol Kenyon
Marci Otis
Nathan Sanow
Bernie Sims
Dee Togikawa
Jillian White

PENNSYLVANIA
David Adams
Chris Burchard
Frank Doherty
Robert Fink
Brandi Franklin
David Garver
Starlynne Gornail
Sharon Herrle
Michael Kapustin
Autumn Lang
Cheryl Littman
Tami Miller
Karen Murphy
Timothy Murray
Lynn Noble
Susan Schuster
Sara Sivers
Michael Stoffel

PUERTO RICO
Maria Chipi
Benjamin Kauffmann
Dolmarie Mendez-Vidot
Victor Perez-Sepulveda
Alberto Santiago Rosario
Carlos Severino-Garcia

RHODE ISLAND
John Larned

SOUTH CAROLINA
Robert Fairbairn
Gregory Lunn

TENNESSEE
Stan Gaines
Jennifer Helton
Dennis Lovin

TEXAS
Jeanette Abbe
David Adams
Lynette Azar
William Baschnagel
Kimberly Bouie
Claire Campbell
Elizabeth Carmichael
Christy Cortez
Tammy Dickey
Kacie Dieter
Peggy Ellis
Jill Hardy
James Hassig
Melissa Holle
Matt Horn
Andrea Hoxie
Lorie Jensen
Brian Johnson
Janelle Johnson
Ric Johnson
Clay Kelley
Peter Krause
Angellar LaCour
Lindy Lauderdale
David Mahan
Bradford Marsh
Teresa Martinez
Randal Mitchell
Beth Ott
Jan Patterson
Linda Pitchford
Boyd Reeh
Joseph Rodriguez
Melissa Sims
Deborah Sopher
Debbie Sotelo
Matt Tayrien
Martha Tejeda-Briney
Johnny Wallin
Holly Waugh
Anja Wilburn
Kai Yang

UTAH
Jared Balis
Amy DeSpain
Shane Loftus

VIRGINIA
William Beavers
Kimberly Canterbury
Rich Loftus
Randall Mitchell
Michael O'Brien
William Schmidt

WASHINGTON
Michael Crosetto
Barbara Dickson
Madeline Hicks
Jeff Jones
Shari Layson
Connie Marvik
Carol Mathis
Joel Newman
Chari Parker
Kristen Plaisance
Deborah Wallace

WISCONSIN
Tina Bender

NOTEWORTHY

DELAY IN HEALTH REFORM PENALTIES FOR EMPLOYERS LEAVES MANY ISSUES STILL TO RESOLVE

While the announcement that employer shared-responsibility penalties will not apply until 2015 was a welcome relief for employers, addressing the fundamental challenges raised by the reform law remains a priority. At the heart of the matter is cost.

In the short term, new fees, plan design changes and the expectation of additional enrollment will add an estimated two to three percent or more to health plan cost in 2014, even if employers table plans to extend coverage to all employees working 30 or more hours per week. Longer-term, avoiding the excise tax on high-cost plans slated for 2018 remains a daunting challenge. More than a third of employers surveyed by Mercer in May said that they were taking steps in 2014 to help bring down cost by 2018.

"The delay will give employers more time to cope with some of the requirements, but they know it's no free pass," said Julio Portalatin, president and CEO of Mercer. "We expect employers to stay 100% focused on cost management. Last year, they slowed benefit cost growth to its lowest level in 15 years, but in 2014 they have the new fees and the likelihood of new enrollment to contend with, on top of normal medical inflation. As employers evolve their go-forward benefit strategies, private exchanges continue to be a powerful strategy for corporate cost management and expanded employee customized choice."

Mercer expects employers will continue to prepare for compliance. In May, about a fourth of employers surveyed hadn't yet decided how they would track and report variable employee work hours and a third hadn't decided what look-back period to use. The delay gives them more time to address these administrative challenges. The Treasury Department has suggested that proposed Reporting and Disclosure regulations will be provided this summer. However, public exchanges, which are slated to be operational in 2014, may still reach out to employers to verify applicant eligibility for health insurance.

Half of employers surveyed in May were concerned about handling employee questions about the exchanges, and 43% were concerned about establishing processes and systems for interacting with exchanges. Employers must still prepare to address employee confusion about their need to have health coverage and their options for coverage—both from their employer and the public exchanges.

According to Mercer's survey, about a third of employers currently do not extend coverage to all employees working 30 or more hours per week, and many of these employers had already made plans to do so in 2014. "While we don't know for sure whether these employers will choose to expand eligibility early, they have sufficient lead time to decide to hold off," said Tracy Watts, a senior partner in Mercer's Washington, DC, office. "Most have not announced changes yet, and if they have an extensive part-time work force, the money to be saved by not expanding coverage in 2014 could be considerable."

The delay creates a "gap year" for employees that had been enrolled in mini-med plans. These limited coverage plans may not be offered after the end of 2013 plan years. This may provide another reason for employers to consider offering a private health exchange in 2014—to allow employees who do not qualify for subsidies in the public exchanges to purchase lower cost medical plans and supplemental medical benefits. Because employers don't have to make their coverage affordable for another year, employers can choose whether, or how much, to contribute to the cost of coverage.

"Offering employees lower cost plans through private exchanges is one way employers can reset plan value while giving employees the option to buy up for richer coverage," said Watts. "Creative cost management is going to be a fact of life under reform, and the delay doesn't change that."

For more information, visit www.mercer.com or follow @MercerInsights on Twitter.

REPORT REVEALS THE GAP BETWEEN CONSUMER PRICING EXPECTATIONS AND AFFORDABILITY

The Agency Inside Harte-Hanks recently announced the release of its 2013 Consumer Healthcare Market Report. The research analyzes consumer awareness of and attitudes toward PPACA and the implications for health plan marketers who need to fully understand, segment and engage a new, uncharted healthcare market. The report highlights opportunities to mitigate risk and make the most of this new healthcare reality.

The Agency Inside surveyed over 600 consumers about factors such as motivation, channel consumption, affordability and likelihood to purchase. Participants were screened to ensure they were uninsured, subsidy-eligible, between the ages of 18 and 64 and influential in decisions about healthcare coverage. Data was weighted by state to approximate the proportion of the uninsured as per the U.S. Census and respondents represented a cross section of individuals and families. Analysis revealed that there are two consumer segments identified as most attractive to insurers among the subsidy eligible, uninsured: adults who rate their health (and that of their family members) as good, and young adults ages 18-39. Both key segments:

- need education on PPACA
- are uniquely motivated
- will require different marketing approaches in terms of content and channels.

"This research was conducted to help insurance providers gain a better under-

standing of an entirely new healthcare audience. This uninsured market is both an opportunity and a risk for insurance providers. If not approached correctly, the costs to serve could weaken payers financially," said Scott Overholt, vice president, healthcare markets, The Agency Inside. "We worked with a major health plan in Massachusetts during the state's healthcare reform in 2007 and experienced firsthand how this market responds. This experience, combined with our research, arms us with strategies that work to focus budgets on consumers who will keep risk portfolios in balance."

Perhaps the most significant finding from the research for healthcare providers is what these segments consider to be affordable. The average response to what monthly cost consumers expect to pay for insurance was $161. "Although insurers have yet to publish premiums, the expectations are that, even with the subsidy, plans could still cost more than people are willing or able to pay," said Overholt. "Providers need to invest in a sustained campaign of education and persuasion in order to convince consumers that this is a necessary and worthwhile expenditure."

To download the 2013 Consumer Healthcare Market report, go to http://response.harte-hanks.com/HC2013marketreport.

SOLE PROPRIETORS' UNIQUE VIEWS ON HEALTH INSURANCE

There are an estimated 42 million Americans making up the self-employed segment of today's workforce. This group is independent and confident; however, many of them lack health insurance. Cigna Individual and Family Plans surveyed 250 self-employed Americans and found that nearly 25% of respondents do not have health insurance. Given this finding, Cigna's "My Business, My Health" study took a closer look at this uninsured population to better understand its views on personal health and wellness, business priorities and perceptions and misconceptions about health insurance.

According to the study, 60% of uninsured respondents place business priorities ahead of personal health and overall wellness. Yet more than one-third of respondents said that one month away from work due to personal illness would result in either a loss of customers or worse—going out of business.

"Clearly, the stakes are high for this population to stay healthy in order to stay successful in business," said Lisa Lough, vice president, Cigna Individual and Family Plans. "However, a majority of this group readily admit that their personal health takes a back seat to the demands of their business."

The findings highlight popular misconceptions about health insurance and medical costs. The study found a large majority of uninsured respondents (82%) stated they did not have health insurance because it was too expensive, yet 80% overestimated the cost of insurance and about a third underestimated the cost of medical care.

While most uninsured respondents (60%) worry about not having health insurance and what impact it could have on their business, the majority (also 60%) categorize themselves as "reactive" or "inactive" when it comes to their own health, meaning the reactive only go to the doctor when they feel sick or believe something might be wrong and the inactive very rarely go to the doctor even when they feel sick. And a small percentage of business owners feel that they don't need health insurance because they are "healthy and maintain an active lifestyle." Among those respondents, 15% aged 41 to 60 adhere to this belief despite the greater frequency of health issues among this demographic in the general population.

Based on the study findings, Cigna has created www.mybizmyhealth.com to continue this important conversation with sole proprietors and provide clear information on healthcare reform and other helpful resources. My Business, My Health provides a glimpse into the mindsets of uninsured business owners featuring real entrepreneurs telling their personal stories about life, health and wellness and owning a business today.

"America's small-business owners and entrepreneurs—the independent contractors, sole proprietors and freelancers—power the economy. To stay healthy and successful, self-employed workers need to plan for their healthcare needs and think more about healthcare in terms of prevention, instead of reaction," added Lough.

UNTREATED MENTAL HEALTH PROBLEMS CAN COST $1.4 MILLION IN LOST PRODUCTIVITY

A newly released white paper from Standard Insurance Company details how employees who are struggling to work though mental health conditions affect an employer's bottom line. The latest white paper in the Productivity Insight series, "Behavioral Health and the Workplace: Productivity Costs and Solutions," identifies the causes of mental-health-related presenteeism and strategies employers can use to mitigate problems.

"Employees are facing longer hours, layoffs and budget cuts, which is contributing to an increase in mood disorders, such as depression and anxiety disorders that result from excessive stress," said Michael Klachefsky, strategic partner consultant, absence management, at The Standard. "This type of lost productivity can add up over time. Based on the evaluation of data from the Integrated Benefits Institute, The Standard has estimated that an employer with 1,000 employees could lose upward of $1.4 million a year if his problem isn't addressed."

A recent success story from The Standard's Workplace Possibilities program, which helps employers manage employee absence and disability, highlights how an employer can help employees with elevated stress levels.

An employer that operated a number of call centers was experiencing an increase in mental-health-related absences. The employer's Workplace Possibilities onsite consultant intervened early, in many instances before an absence occurred, connecting employees with the employer's employee assistance program. In six months, 125 employees with mental health conditions returned to work. Over 18 months, the

company avoided $740,000 in short-term disability claim costs.

"This is an example of how an employer can use existing resources to manage incidences of employee mental-health-related disability leaves," Klachefsky said. "In addition, employers can offer options such as behavioral health screenings, employee education on behavioral issues and job modifications to help address behavioral-health-related presenteeism. In this economy, employers can't afford to not proactively intervene."

To read more on additional steps employers can adopt to lessen the impact of mental-health-related absences among employees, visit www.workplacepossibilities.com.

THE RATES OF SERIOUS WORKPLACE INJURIES VARY WIDELY BY STATE

Rates of serious workplace injury and illness vary significantly between states—even for workers in the same industries—according to a new report released by Allsup, a nationwide provider of Social Security Disability Insurance representation. The report is based on data obtained from the Department of Labor's Bureau of Labor Statistics (BLS).

The report, "Allsup Study of Workplace Injuries," spotlights the most work-threatening industries by location, based on the rates of injuries that are serious enough to involve "days of job transfer or restriction." The full report is available on www.WorkInjury.Allsup.com.

"At a time when nearly 9 million workers are receiving Social Security Disability Insurance benefits—many of whom were originally injured on the job—this report should draw attention to the widely varying rates of worker injury across states," said Mike Stein, Allsup assistant vice president of claims. "In this new study, Allsup drills deeper into the data to show not just which industries are responsible for the most serious injuries, but where."

The report opens with a chart and map that show the differing injury rates between states. The states with the highest rate of workplace injuries that involve days of job transfer or restriction are:

- Maine—1.4 injury or illness cases with job transfer or restriction per 100 workers
- Indiana – 1.1
- California – 1.0
- Connecticut, Kansas, Nevada, New Mexico, Oklahoma and Wisconsin—0.9
- Alabama, Iowa, Kentucky, Michigan, Missouri, Oregon, Pennsylvania, South Carolina, Tennessee and Washington—0.8

These states all have rates higher than the national average of 0.7 injury or illness cases with job transfer or restriction per 100 workers.

Allsup drilled further into the issue by building a database using workplace safety data that the BLS reported from 41 states and the District of Columbia in 2011. Allsup's database can be used to quickly search for and present direct comparisons of injury rates across states and industries, which otherwise are difficult to find.

Allsup's report includes information on the 11 industry groups with the highest serious injury rates nationwide:

- Amusement parks and arcades—3.2 cases involving job transfer or restriction in 2011 per 100 workers
- Animal slaughtering and processing—3.1
- Beverage manufacturing—2.7; Foundries—2.7
- Nursing care facilities—2.6
- Beer, wine and distilled alcoholic beverage merchant wholesalers—2.4
- Motor vehicle body and trailer manufacturing—2.3
- Hog and pig farming—2.2; Motor vehicle manufacturing—2.2; Community care facilities for the elderly—2.2; Poultry and egg production—2.2.

The study also reports state-level information showing the variation between locales within the same industry group. For example, serious injury rates in the motor vehicle manufacturing industry group ranged from 1.1 in Tennessee to 3.5 in North Carolina (Michigan equaled the national average at 2.2).

According to Allsup's research, the state-level industry with the highest rates of serious injury was animal slaughtering and processing in Oregon, with 8.3 cases involving job transfer or restriction per 100 workers in 2011 (U.S. average – 3.1).

State-level data for 2011 are not available for nine states: Colorado, Florida, Idaho, Mississippi, New Hampshire, North Dakota, Ohio, Rhode Island and South Dakota. However, Ohio recently received a grant to begin participating in the BLS survey. See ftp://ftp.bls.gov/pub/time.series/ii/ii.txt for more information about these data.

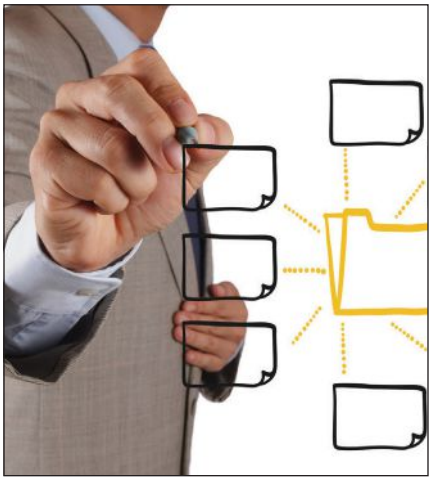
More than 1 million U.S. workers each year experience an injury that causes them to miss a day or more of work. A recent report from the Social Security Administration's Office of Retirement and Disability Policy used statistical sampling to identify injuries as the sixth-leading cause of SSDI claims.

Many claims not filed as injuries involve conditions that can be job related. For example, musculoskeletal conditions make up the largest category of SSDI claims. This group includes impairments such as degenerative back disorders that can be caused or exacerbated by work and severely hamper an individual's ability to find a new source of employment.

"The injury issue takes on new importance in light of our aging population and the fact that the trust fund supporting SSDI is projected to reach insolvency in just three years," said David Bueltemann, manager of senior claimant representatives at Allsup. "Allsup's report should be eye opening for policymakers, workplace safety advocates and Americans who may underestimate their chances of experiencing a disabling injury."

Find the complete report at www.WorkInjury.Allsup.com. HIU

YOUR STRATEGIC COACH



By Dan Sullivan
President and Founder
Strategic Coach

YOUR TEAM IS AN INVESTMENT, NOT A COST

What if growing your business exponentially didn't require you to take on more complexity but to actually simplify your business and your life? You can start this simplification process by becoming more productive and efficient yourself, or by developing better systems and tools, but the real multiplier comes when you invest in your relationships.

THE END OF "RUGGED INDIVIDUALISM"

The independence and self-reliance that make it possible (and preferable) for you to be an entrepreneur can also get in your way. If you refuse to let go of any task—even ones you have no talent or passion for—you're in danger of becoming a "rugged individualist" and being the main factor that keeps your business from growing.

The world is full of people with boundless talent and energy, and some of them will be excited about what your business is doing. Team up with them and you suddenly multiply what you're capable of.

WHY WOULDN'T YOU?

The three biggest justifications for not investing in a team are time, money and trust. People say, "I don't have the time," when they imagine having to get involved in training and managing each new person. Or they say, "I don't have the money," because they're thinking about the extra demand of adding another salary to the payroll. Yes, it can be difficult to trust others with the business you've worked so hard to build, especially since they don't share your stake in it.

Yet these arguments are all about protecting what you've created in the past. The money, time and relationships that will build a bigger, better business and an exceptional quality of life—they're all in the future.

PREPARING FOR THE FUTURE YOU WANT TO SEE

Invest financially and emotionally in the people around you, and let them into your future vision for the company. Give them the opportunity to hook their own personal goals and self-development to your star.

Some of your existing team members will be up for taking this journey with you. Others will self-select out because they really just want a job. That's fine—"batteries not included" people just drain you and their colleagues. Let them go with no hard feelings and keep an eye open for someone who's a better fit. You'll be surprised how having a vision attracts the perfect new team members in coincidental ways.

THE SELF-MANAGING COMPANY

Delegate everything except genius and you give yourself an incredible freedom from the activities that wear you down, and a wonderful freedom to get on with what you really want to achieve.

Over time, this approach creates a "self-managing company"—a business where you're in charge, but don't need to be in control.

In fact, you never know how good your team is until you're not there: Each year, my wife and business partner, Babs, and I work 30 weeks of the year and take 22 weeks completely away from the company—no phone calls, no email, no contact, period.

Have there been mistakes and breakdowns? Of course! But we teach entrepreneurs tools for thinking and problem-solving, so that's how our team members approach their work too. They know we totally trust them to act like owners and run the business while we're away, and we all learn from whatever happens. No amount of pay could equal the boost in confidence, creativity and personal satisfaction they get from this.

Now it's your turn. What three things would you like to be free from doing? Who in your organization might have a talent and an interest in doing them? And what three things are you best at—things you wish you could focus on more? How could you create protected time for these activities over the next 90 days?

Running your business this way makes your life a lot simpler and opens up the possibility of multiplying your income, your team's rewards and your impact on the world. HIU

Dan Sullivan is the founder and president of The Strategic Coach Inc. and the creator of the Strategic Coach Program, which helps entrepreneurs reach new heights of success and happiness. To learn more, visit www.strategiccoach.com.

INSURANCE EVENTS

JULY 30-AUGUST 1

WORKPLACE BENEFITS MANIA
Las Vegas, NV

http://eba.benefitnews.com conferences/

AUGUST 1-2

REGION 8 LEADERSHIP CONFERENCE
Millbrae, CA

www.nahu.org

AUGUST 2-3

REGION 6 LEADERSHIP CONFERENCE
New Orleans, LA

www.nahu.org

AUGUST 7-9

OREGON AHU CONVENTION
Mt. Bachelor Village, OR

www.orahu.org

AUGUST 13

REGION 1 LEADERSHIP CONFERENCE
Hancock, MA

www.nahu.org

AUGUST 15-16

REGION 7 LEADERSHIP CONFERENCE
Salt Lake City, UT

www.nahu.org

AUGUST 15-16

INDIANA AHU ANNUAL CONVENTION
Muncie, IN

www.inahu.org

AUGUST 22-23

REGION 4 LEADERSHIP CONFERENCE
Urbandale, IA

www.nahu.org

SEPTEMBER 9-11

MEDICARE SUPPLEMENT INSURANCE SUMMIT
Scottsdale, AZ

www.medicaresupp.org/2013/

SEPTEMBER 22-24

EBN'S BENEFITS FORUM & EXPO
New Orleans, LA

http://ebn.benefitnews.com/ conferences/benefitsforum/

OCTOBER 20-22

LIMRA'S ANNUAL CONFERENCE
New York NY

www.limra.com/annualconference

OCTOBER 21-23

SIIA's National Educational Conference & Expo
Chicago, IL

www.siia.org

OCTOBER 24-25

Region 2 Leadership Conference
Baltimore, MD

www.nahu.org

OCTOBER 29-30

WOMEN IN INSURANCE LEADERSHIP FORUM
Chicago, IL

www.insurancenetworking.com/ conferences/women-in-insurance/

OCTOBER 30

CHAMBER OF COMMERCE HEALTH CARE SUMMIT
Washington, DC

www.uschamber.com

NOVEMBER 3-5

EMPLOYER HEALTHCARE & BENEFITS CONGRESS
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PEOPLE ON THE MOVE

Walsh Benefits, an employee benefits general agency with offices in Fair Haven and Cranford, New Jersey, has named **David Mordo** vice president of education, compliance and Medicare operations. Mordo's responsibilities include overseeing the Walsh School of Insurance, training brokers and staff on healthcare reform and other compliance issues, employer presentations and expansion of the agency's Medicare Supplement new business submissions. He will also continue in his previous role with small-group new business submissions.

Mordo started in the insurance business in 1980 as a sales representative with MetLife in Brooklyn, New York. He joined Walsh Benefits in December 2000 managing the small-group department. Mordo is past president of the Monmouth/Ocean AHU and serves as a member of the NAHU Legislative Council.

Michael Stephens recently received the prestigious Texas Small-Group Specialist Designation. Stephens, a member of the Tulsa AHU, is the first non-Texan to receive the designation. Stephens' good standing as a NAHU member, his position of holding the approved Registered Health Underwriter designation and passing the eight-hour Small Employer Health Benefit Plan Specialty Certification (SB79) made him an eligible recipient.

"The leadership of NAHU members has a far-reaching impact on providing for the healthcare needs of individuals, families and business in their communities. We are grateful for Stephens' hard work in the healthcare industry and recognize him for his efforts with this well-deserved award," said NAHU CEO Janet Trautwein.

Stephens is the president of Tallgrass Benefits LLC and has worked in the healthcare industry for more than 20 years. A member of NAHU since 1993, he has held leadership positions on the local, state and national level, including the TAHU Board of Directors and HUPAC Board.

Digital Insurance (Atlanta, GA) has appointed **Brian Melanson** senior vice president of strategic channel partnerships. Melanson collaborates with carriers, retailers and other emerging models to help bring efficiencies to the selling and renewal of insurance products. His experience on the carrier and broker sides of the business, combined with his knowledge of channel strategies and the evolving small group to consumer market dynamics, underscore his qualifications.

Prior to joining Digital, Melanson served as the director of distribution and ancillary strategy for Premera BlueCross in Washington. He founded a national sales strategy group that focused on bringing channel and product innovations to Blue Cross Blue Shield plans in 31 states. In addition, Melanson served as a vice president with Digital Insurance, and in sales management and group health insurance sales positions at Destiny Health and Humana. He is a featured speaker on a various topics including: state exchange distribution models, retailers' role as channel partners, optimizing carrier channel approaches and the emergence of private marketplaces.

Mercer recently announced that **David Stacey** joined the firm's Dallas office as partner and senior consultant in its health and benefits business. In this role, he will advise clients in the Central and Western U.S. in all areas of health and group benefits, including design strategy, administration, financing, cost management, mergers and acquisitions, measurement and data analysis, claim reporting, and health plan networks evaluations.

Stacey brings more than 20 years of experience in the health benefits and consulting industry. Prior to joining Mercer, he was senior vice president for Cigna, where he led the National Accounts West Region team for medical, dental and group insurance business. Before his time at Cigna, he served as principal and Midwest market leader at Hewitt Associates in its health management practice. Stacey began his career at Aetna, where he held positions of increasing responsibility including sales/district manager.

Stacey earned his MBA from the University of Houston and a BBA from the University of Iowa.

Mercer has also announced that **James Bernstein** has been appointed leader of its health and benefits business for Cincinnati and Columbus, Ohio. Bernstein is responsible for growing Mercer's client relationships throughout Cincinnati, Dayton, Columbus and Northern Kentucky. He will also work closely with Mercer's other business lines in order to provide the best and broadest spectrum of solutions to clients.

Bernstein has been with Mercer for 11 years, holding roles of increasing responsibility. Most recently, he served as the health and benefits operations leader for Cincinnati. He earned a bachelor's degree in sociology from the University of Michigan.

Cavignac & Associates (San Diego, CA) has named **Zemi Solis** its newest employee benefits account administrator. Solis brings six years of experience in the insurance industry to her new position. She will be charged with assisting the firm's account managers with the day-to-day service activities of her assigned customer accounts. Her responsibilities will include assisting with completion of RFPs and preparing quotations for new or renewal coverage, preparing open enrollment material and ordering supplies from carriers, preparing presentations and proposals for new and renewal business, assembling material packages for open enrollment meetings and assisting with those meetings when requested, and personally handling open enrollment meetings with smaller digital clients.

Prior to joining Cavignac & Associates, Solis served as an insurance agent at Farmers Insurance in the North Park area of San Diego. Previous career experience includes having served four years as a customer service representative at American Specialty Heath in San Diego, where she earned the distinction of being the highest producer in the agency's call center.

A graduate of the University of Phoenix, Solis holds a Bachelor of Science degree in business administration.

Cross Insurance announced that **Hugh Devlyn** has joined the firm as a benefits producer at TGA Cross Insurance in Wakefield, Massachusetts, office.

Devlyn possesses over 25 years of progressive insurance and employee benefits brokerage/consulting management experience. Most recently, he was the Massachusetts employee benefit practice leader for USI, after returning to the brokerage/consulting industry following a three-year stint in the corporate human resources department of the Liberty Mutual Insurance Group, where he managed global benefits and insurance programs.

In his new role with Cross Insurance, Devlyn is charged with building a world-class employee benefits practice for middle-market employers, providing clients with a full range of employee benefit services and solutions including healthcare cost containment and data analytics, population health management, compliance, communication, benchmarking, benefits administration and HR services.

Devlyn holds a bachelor's degree in business administration from the University of Wisconsin-Stevens Point and holds health, life, property & casualty, Series 6 & 63 licenses. He served in the U.S. military as a major in the U.S. Army Reserve, where he was responsible for the HR function of a U.S. Army Reserve Command consisting of 136 army reserve units comprised of 26,000 troops in six states. HIU

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LAST LAUGH

Quote of the Day

"It was so hot today, I saw a dog chasing a cat. And they were walking."

Fishy Request

A man walks into a seafood store carrying a trout under his arm. "Do you make fish cakes?" he asked.

"Yes, we do," replied the fishmonger.

"Great," said the man. "It's his birthday."

Life Lesson

During a science lesson, my sister-in-law picked up a magnet and said to her second-grade class, "My name begins with the letter M and I pick things up. What am I?

A little boy answered, "You're a mommy."

Labor Pain

When my friend got a job, her husband agreed to share the housework. He was stunned by the amount of effort involved in keeping a house clean with small boys to pick up after, and insisted that he and his wife shop for a new vacuum cleaner.

The salesman gave them a demonstration of the latest model. "It comes equipped with all the newest features," he assured them.

The husband was not convinced. "Don't you have a riding one?" he asked.

Computer Issues

I left my laptop on the floor of my room.

My grandma thought it was a scale.

Conclusion: My grandma weighs $950.

Did you hear the one about the claustrophobic astronaut?

He needed space.

Did you hear who wrote the new bestseller *Why You Need Insurance*?

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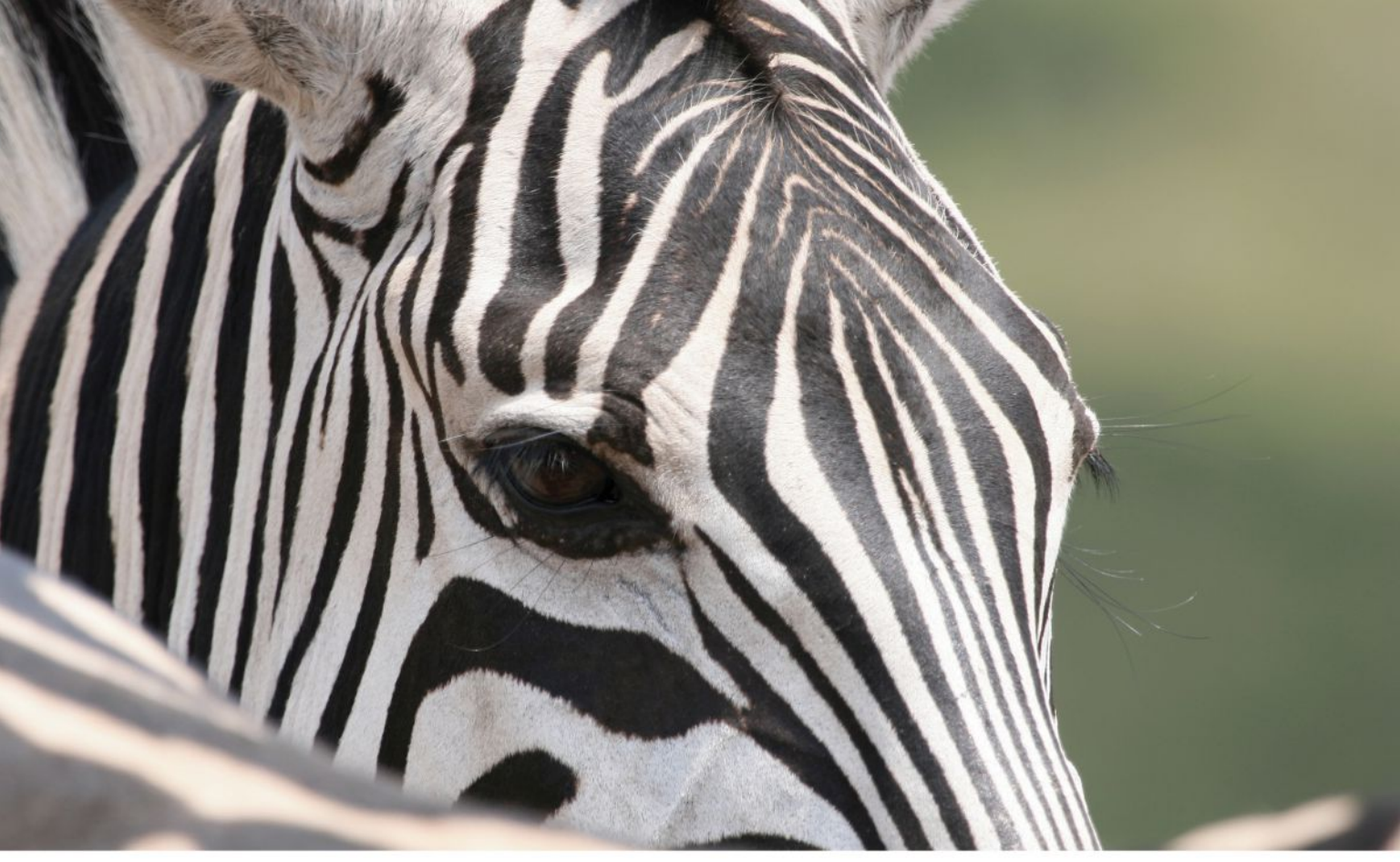

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