

*All the world's a stage, and all the men and women merely players
(As You Like It)*

From Shakespeare to Schwarzenegger theatrics and politics often mix but can't fix the fix in which we find ourselves. Maybe California's purpose is to serve as a warning to others if the ineptitude spawned from the decrepitude of free market exchanges didn't cause changes enough. We had high drama and low comedy, as crooks cook books and Martha Stewart looks less golden with guilt and Rose wilts while riveting attention from Democratic declension as they parse the farce of W's invention of Iraqi intention to unleash apocalyptic horsemen on our stable way of life.

The play's the thing! And the sweet September sting of loss swings across Boston and Chicago while Wall and Main Street wages come-back and Howard Dean breaks from the pack while we all shout "Wait 'Til Next Year!" That may be too late as Bill Clinton was to state: "If we don't succeed we run the risk of failure."

Some critics made similar allusions while under the illusion that we wrote with the delusion that we'd reach some conclusion to allay all the confusion we saw in last year's events. But despite many protestations we enjoyed one attestation, resounding only in its confounding expectations: "It's more than magnificent – it's mediocre!" (Sam Goldwyn).

But we play on, and the stage is set for scenic sights and brighter lights and the return of hopes and dreams. Market corrections, a year for elections and New York's new direction with the erection of a monument to represent more than glass and beams, all show that life continues and is much more than it seems – but goes beyond expression leaving, instead, impressions of what we meant to say all along:

"As if the soul's fullness didn't sometimes overflow into the emptiest of metaphors, for no one can give the exact measure of his needs, his apprehensions or his sorrows and human speech is like a cracked cauldron on which we bang out tunes that make bears dance, when we want to move the stars to pity" (Flaubert)

Que vengan las buenas tiempos!

(Let the good times roll)

THE FEDERAL STAGE

*Democracy is a device that insists we shall be governed no better than we deserve
(George Bernard Shaw)*

There are weapons, no they're not, it's just the proof we haven't got
Ask Saddam – are you crazy or are Hussein
Rummy's no dummy he stacked the deck training more corps, now Iraq's a wreck
Please refrain from singing while our troops remain

At home we'll stay secure provided we procure
A sufficiency of color coded signs
Bush's budget made no sense with so much needed for defense
Congress stopped its progress along party lines

But hawks and doves take flight as West Wing prepares to fight
A domestic war with a new election
Cabinetry needs replacing where members are not facing
The need to plan for a mid course correction

The party needs a candidate so Al Gored his old running mate
Giving Doctor Dean the antidote to the pack
Generally speaking Clarke's already peaking
And Kerry stays wary of sneak Gephardt attack

Kucinich isn't rich and Sharpton may soon switch
If Democrats don't treat him with some reverence
With no one being Caroled their hopes may be imperiled
As Republicans stay the nation's preference

But what has George Bush done this term except by actions to confirm
That the mother's milk of politics is money
Tax savings that are not there then deforming Medicare
It would all be tragic if it weren't so funny
Or is it the other way around?

Just over a Ridge lies a valley of purity, that contains the elixir for security, so why is it we don't feel any safer? Despite making an appeal to the Treasury of O'Neil it seems we're Snowed by promises of recovery. What if terrorists strike or strikes bring terror or the market is in error and companies make the discovery that the economic upturn faces consumers' upturned noses? Bill Frist still leaves a hole in the heart of the Senate and the House may move faster without Delay. Arnold's uncle Ted continues to see red with every conservative idea proposed and continues his bent by support he has lent to every liberal idea supposed.

Still Congress plods along but doesn't it seem wrong that ideas under discussion seem to provide no repercussion when tabled by chairs with political airs and make it seem no one cares? Even when major legislation is passed over protestations from both the left and the right and has problems taking flight there is engendered some cynicism as the despotism of the bureaucratic corps end up shaping laws in ways that weren't even intended.

MAJOR ROLES

Medicare Reform: Analysis follows
Health Savings Account: Analysis included in “Funding Review” in the Economics section

WAITING IN THE WINGS

The question is whether there is a need for some of these bills. Either the states have imposed their prerogative to regulate or legislate these issues, or the market itself supersedes them.

Association Health Plans

Lets create a purchasing pool that gives small businesses access to lower rates – wait, that’s what insurance already does. Of course, large enrollment numbers are no guarantee of small premium numbers, as witnessed by current market turmoil.

Family Medical Leave Act

Here’s a program that already costs business lost productivity, administrative expense, potential legal liability and premium costs. There are loopholes, lack of understanding and an annual bevy of bureaucratic rulings to make it more usable but less accessible. So we should expand it to smaller organizations (25 employees instead of 50) and allow states to offer 6 weeks of paid leave along with the 12 weeks of unpaid leave required now.

Healthy Families

It seemed like a good idea at the time (thank you Senator Clinton). The law will soon take a village to qualify instead of just the uninsured children now covered. With state subsidies needed to enfranchise their parents under the proposed law, can we afford to give people what they say they cannot afford?

Long Term Care

A traditional non starter, with an estimated \$80 billion price tag if government paid. Less taxing consequences have been consummated in recent legislation. Above the line deductions are already permitted to a limited degree for care costs and insurance premiums, and the new HSA legislation allows premiums to be paid from those accounts. In this session, it was also proposed that full deductibility be given individuals for all premiums and all expenses in all circumstances.

Mental Health Parity

The perennial co sponsor of this attempt to treat mental conditions the same as other medical expenses, Paul Wellstone, died tragically a year ago. This has not stopped Senator Domenici from continuing the fight, though consistently opposed by carriers and employers. Naturally, some of this has already been appropriated by the states.

Patient Bill of Rights

At this point, the right to sue HMOs is gaining increased judicial credence, the regulations for claims payment and “fair dealing” is regulatory (ERISA, EEOC) and legislated in the states, and the need for many of the rights being championed earlier obviated by market shifting.

Tax Credits

Always popular until they tally the bill. Just like a good restaurant, except political menus can change before you’re finished reading.

Tort Reform

The President made this a top priority in his State of the Union address, decrying as a national tragedy the huge amounts being extricated from the health care systems for defensive medicine and offensive suits. Congress, having a fair share of lawyers, and representatives having substantial support from lawyers, is generally not disposed to passing legislation that will offend their “constituency” The states are willing to take up the burden, but progress is slow.

Universal Health

The Senate’s liberal standard bearer may be more than some can stand, but he takes a definite stand and states the rationale for this concept eloquently: “For decades we have required employers to contribute to Social Security and Medicare. We require them to pay a minimum wage and contribute to unemployment insurance. Now is the time to say that they also have an obligation to contribute to the cost of health insurance for their workers”

Frankly, I’ve always liked the ad National Lampoon floated for “The Bug” (“if Teddy Kennedy had only driven a Volkswagen, he’d be President today”). Still, he’s at least consistent.

MEDICARE REFORM

*If you give Congress a chance to vote on both sides of an issue, it will always do so
(Les Aspin)*

I've been meaning to look at the legislative history of the original Medicare and Medicaid Act passed in 1965. Was everyone just as disagreeable in their disagreement over a fundamental social obligation to call for the indigent, disabled and elderly? Granted, greater foresight would have been a good idea. The usurpation of private contracting, the substantial increase in utilization fostered by greater access and the unfair burdens placed on states for funding Medicaid may have allowed for a more cost efficient and equitable program than what we have today. Overall, Medicare and Medicaid have been successful, but there have been concerns:

- 1) The lack of effective cost controls within either program
- 2) The federal subsidy provided due to the inadequacy of Part B premiums
- 3) The absence of long term care (nursing and home)
- 4) The absence of any coverage for prescription drugs
- 5) The need to continually cut back benefits to keep costs stable

Despite the limitations and lapses, the cost of providing Medicare continues to rise and its imminent bankruptcy predicted annually. A few years ago, the end was estimated at 2010, though now this has been pushed back (though a deficit may appear by 2013). Still, it's hard to say if such estimates accurately gauge the financial impact the arrival of the first Baby Boomers will have in 2010. After all, initial estimates of the cost of Medicare between 1965 and 1980 were only off 740% (they stopped counting after that)

Dan Rostenkowski, then Chair of House Ways and Means, proposed the addition of drug coverage to Medicare in 1984 and was attached (literally) by seniors. No one wanted to pay for it then, and presumably no one wants to pay for it now. Politically, that means everyone pays.

After years of debate, President Bush II made Medicare reform a priority. With an upcoming election and building Republican momentum, Democrats needed to get off the side of change. In the end, they professed profound unhappiness with the bill, and will use it as a campaign issue after all – not for what they did to save seniors but to point out Republican failure.

Wrong or right, it's now the law – or will be in 2006. What does it say and what does it mean? Essentially, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 does – and doesn't do – several things:

- 1) Adds a discount prescription drug card in 2004 – and a staggered subsidy in 2006
- 2) Reverses earlier cutbacks to doctors and rural hospitals and then increases pay
- 3) Subsidizes low income beneficiaries, employers with retiree coverage and carriers
- 4) Introduces means testing for Part B premiums

The inevitable journalistic carping came early

Business Week: "Washington seems poised to make a major error on Medicare"

Fortune: "Changes rolling through Congress are as short sighted as they are beloved"

Forbes: "Rarely have politicians worked so hard and satisfied so few"

The press consensus was:

- 1) Seniors will pay much more
- 2) Taxes will rise
- 3) Care will have to be rationed
- 4) Some companies will drop retiree coverage because the government will pay former employees, and others who were never going to drop it will pick the money they leave

What's Missing?

- 1) There are no incentives to any parties to control costs
- 2) There is no upper limit to what carriers can charge for prescription coverage
- 3) Medicare cannot negotiate with private payers to leverage their major market position
- 4) No rules on which drugs a private plan must cover
- 5) No rules on when and how Medicare beneficiaries enroll and with or without drug coverage

Who Benefits? Well, no one, but

Seniors

Someone else pays for drugs – BUT

What will the premium be and how much and when will they increase
How will the premium relate to the actual financial exposure drugs pose
Who are the carriers and how extensive their coverage
What drugs will be covered and may be removed
Will the rules change and what effect will that have

Insurance Carriers

They will have a new market to sell a new product – BUT

They must price to entice demand without operating at a loss
Future rate increases may not be enough to recoup losses
Future rate increases may not retard greater losses if they sacrifice market share
Additional regulations may compel the inclusion of certain drugs or limit premiums

They are given incentives to stay in the Medicare HMO market -- BUT

What the government giveth, they often taketh away, which is what happened the last time they set subsidies for the insurance carriers to enter this market – when they began to leave, the government changed the rules again to get them to come back

Pharmacy Companies

They also have a new market for their products – BUT

Success will depend on a confluence of interest from insurance carriers, seniors and pharmacy benefit managers. Pricing must also be balanced to generate profits with no backlash.

Key Points

Subsidies

- 1) State may pay the premium for the drug discount card
- 2) Those under 135% of Federal Poverty Level will not pay any part of the drug benefit
- 3) Those at 135-150% of FPL will pay between \$2 and \$5 for drugs
- 4) Low income may get up to \$600 for drugs in 2004-05
- 5) Self funded employers covering retirees get 28 cents per drug dollar from \$250 and \$5,000
- 6) Medicare HMOs will be paid greater of Fee for Service or local/national blended payments
- 7) New Medicare Advantage plans get 50% of risk taken if costs 103-108% of total premium
- 8) Rural hospitals to have 12% higher payment
- 9) Doctors get 1.5% increase in payment instead of a 4.5% cut

Costs

- 1) Drug discount card will charge \$30 in 2004-05
- 2) Part B deductible will increase from \$100 to \$110 and then by index starting 2005
- 3) Means testing for Part B premium payment (\$80,000 or \$160,000 couples – 2007)
- 4) Projected \$35 average monthly premium for the new drug benefit (2006)

Cost Controls

- 1) Prescription drug allowance is Average Wholesale Price – 15% in 2004
- 2) AWP gives way to ASP (average sale price) + 6% in 2005
- 3) Formularies may be used
- 4) Freeze payment for durable medical equipment for three years
- 5) Means testing
- 6) Congressional bailout if general revenues contribute over 45% of total program spending

Benefits

- 1) Preventive care included (diabetes and cardiovascular screening)
- 2) Access to Disease State Management for those with chronic illness
- 3) Prescriptions:
 - a) Patient pays first \$250
 - b) Government pays 75% of the next \$2,000
 - c) Patient pays next \$3,600 (called “the doughnut”)
 - d) Government pays 95% of cost thereafter
 - e) Done through “drug only” policy, or a drug rider attached to a Medicare HMO

Other

- 1) Medicare Advantage (beginning 2010) will be set up in 6 demonstration sites to see how well care and cost can be managed – will be done by private carriers
- 2) Reimportation of drugs from Canada will be allowed, but only after safety certification has been received from Department of Health Services and the Food and Drug Administration
- 3) Medi-gap policies can no longer offer prescription drug coverage

STATE STAGE

Society in every state is a blessing, but government, even in its best state, is but a necessary evil – in its worst state, an intolerable one. For when we suffer, or are exposed to the same miseries by a government which we might expect in a country without a government, our country is heightened by reflecting that we furnish the means by which we suffer (Tom Paine)

Welcome to the Golden State where you will recall our fate
Waging campaign battles with a bunch of neophytes
Our luster faded from gray to slate when everyone was a candidate
We reached for the densest stars but were blinded by the lights

Though he's prone to Schadenfreude, Schwarzenegger's overjoyed
And Maria Shriver may revive her career
But with a budget he can't budge The Governor is likely to fudge
Buying bonds and waving wands over voters next year

It's all some sort of Faustian joke, why else elect the Austrian Oak?
Who may branch out to act more presidential
With new laws now suspended, their leadership upended
For Senate tenets new Assembly is essential

There's disarray on "pay or play," their mandates are in court today
Now they're not so sure that Arnold's on their side
By shifting automatically to act more autocratically
His car tax move really took them for a ride

No problem if it was his goal to put us further in the hole
Now the services are cutting -- our bond rating
Business will start coming back with insurance costs under attack
We'll give workers rights without overcompensating

Gavin Newsom lessens old division with political formula revision
The young Turk now runs Baghdad by the Bay
One Brown down and one to go, Moonbeam shines on the tyro
Will the Supes stoop to having less to say?

Would anyone Ventur-a wager that Jesse's costar would wage Predator-y practices, tell True Lies about them then burnish his image as the Last Action Hero by denying his actions? The road to the Governor's mansion is paved with good attention to a script that uses both pencil and Eraser. The ex-Terminator of Governor Davis' encroachment on Californians' good will have the same challenges, with an accent is on being different.

This at a time when it takes more than white teeth and a tux to take the bite out of Senate and Assembly in flux, and where the Democrats bent has lent itself to a more adversarial position with business – and a Republican governor. Consisting of arm twisting while insisting that everyone was happy, the honeymoon was over as the money soon ran out. He may be strong but his job won't last long if his solutions are wrong – I can't recall, but I think every fall we decide whose side we're on (I voted for Gary Coleman, but he came up short). It's not like he has much on his plate, other than to save the state and ameliorate all the divisions between personalities, municipalities and the new realities that seem to surface even on a good day.

Senator Kuehl still thinks it's cool to have a state run health program (and her Zelda was my least favorite Dobie Gillis character). John Garamendi still thinks it's trendy to do the same (while running for Governor), including Workers' Comp in the game. Senator Speier does not endear herself to the insurance community, either, but has some perspective (a trip to Jonestown will do that).

Then we have new Family Leave, a possible Comp reprieve and some who believe that the new COBRA extension is a good thing. Call me jaded, call me callous – wait a minute, who's writing this? Instead look at what a national publication said Californians desire:

“Californians want low real estate taxes but keep passing initiatives for more spending on schools, health and prisons. They want cheap illegal Mexican labor to work in hotels, farms and construction but don't want want to give them drivers' licenses. They want deregulated electricity but not for consumers. They want balanced budgets but impose impossible supermajority votes to pass them. They want more jobs but subject small companies to heavy legal and health mandates that make them uncompetitive. They want better political governance, but they vote for term limits that make legislators rely on special interests – and recall governors just voted into office” – Business Week (November, 2003)

Yes, but what's the problem?

MAJOR ROLES

Senate Bill 2: Analysis follows

WAITING IN THE WINGS

Definitive Domestic Partner Coverage

The Internal Revenue Service has opened the door to deductibility – slightly. Despite some municipal mandates and insurance availability, the premium for a Domestic Partner is generally not deductible to an individual or employer. Nor may it be included for deduction in a Flex Plan.

New state legislation follows local leads to expand partners; rights where it concerns guardianship, conservatorship, property sharing and the legal division (or union) of responsibilities. Laws chaptered this year were AB 17 (prohibiting benefits discrimination against Domestic Partners for state contractors) and AB 205 (Rights and Responsibilities Act)

Universal Care

This legislation has had several different champions, both nationally and statewide. This year a major reform bill carried by Senator Sheila Kuehl was swept away in a sudden tide of enthusiasm for a less comprehensive reform bill (SB 2) signed by the governor.

SUPPORTING ROLES

But whom do they support best?

COBRA Extension (AB 1401)

Chaptered last year, but not truly taking effect until September 1, 2003, imposes a state mandate on carriers to extend coverage for those with a COBRA inception of January 1, 2003 or thereafter for an additional 18 months:

- 1) Does not apply to self insured plans, vision, dental, chiropractic or acupuncture
- 2) Carriers may charge 110% of the premium
- 3) Carriers send out notices and paperwork
- 4) Employers must update benefit communication materials to reflect the new opportunity

Family Medical Leave Act (SB 1661 and SB 727)

- 1) Offered to all employers regardless of group size
- 2) Employee pay only – additional .08% into SDI – Starting January 1, 2004
- 3) Extends disability compensation to cover individuals taking time off to care for a seriously ill family member (including Domestic Partners) or bond with a new child during the first year after birth, adoption or foster care placement
- 4) Benefits paid up to a period of 6 weeks over a 12 month period
- 5) Cannot qualify to receive Family Paid Leave while also getting SDI or Workers Comp
- 6) Benefits do not begin until 7 days after Qualifying Event
- 7) Employers may require:
 - a) Employee use 2 weeks of vacation (1 week will apply to the waiting period above)
 - b) Medical certificate to show diagnosis, cost, commencement date, time needed

Major Risk Medical Expansion

Expands the coverage requirements for conversion plans and the coverage minimums for conversion plans (AB 1401)

Workers Compensation

Gray Davis said he would fix the system, but how could he when he signed a bill to increase potential benefits from \$490 to \$602 per week (then to \$728 in 2004 and \$840 in 2005). Commissioner Garamendi said: “stability and consistency allow actuaries to predict costs. Our current fee schedule is not tied to Medicare or Medi-Cal and is not updated and does not accurately reflect the cost of care. Current law expects a state agency with inadequate funding and little experience to create and update fee schedules. It does not work”

State Fund is suing Garamendi because he allegedly does not have the authority to determine the applicability of Risk Based Capital estimates to their plan. Garamendi's predictions are also not well suited to the market, when he requested carriers to drop rates 14% -- he got some, but not all. Good luck to the future Governor...

Why are costs increasing? Some examples:

- 1) Prescription drug costs went up 15% but accounts for 10% of Workers Comp charges
- 2) Can't control drug spending because there are no cost sharing or reduction mechanisms
- 3) Costs per claim are 25% higher when chiropractor is the exclusive provider
- 4) No negotiated fees
- 5) The doctor is always presumed to be correct under the law

Fortunately some relief was passed on the last day of the legislative session and signed into law by Governor Davis. As a result, 69 of 95 carriers have modified their forecast increases, but not to the extent the Commissioner requested:

- 1) Roll back to the July 1 increase
- 2) Repeal the 12% increase scheduled for January 1
- 3) Limit chiropractic and physical therapy visits to 24
- 4) Link pay for prescriptions and out patient surgery to 120% of the Medicare level
- 5) Adopt guidelines for care for a given injury
- 6) Expand opportunities for Alternate Dispute Resolution
- 7) Expand cooperative purchasing opportunities
- 8) Replace voluntary rehabilitation for post January 1 injuries with a voucher
- 9) Require creation of Utilization Review programs connected to Comp administration

A special legislative session will consider repeal or an appeal of the new deals. The new Governor has also proposed his own plan to save \$11 billion through changes to the medical delivery system for Workers Compensation and the guidelines used to establish qualifications.

SENATE BILL 2 – HEALTH INSURANCE ACT OF 2003

If you think health insurance is expensive now, wait until it's free (Jay Leno)

At first left for dead, the recall campaign resuscitated this bill, much to employers' dread. It is a variation of the pet projects proffered by Senators Burton (President pro tem, and not shy about retiring) and Senator Speier (chair of the Senate Insurance Committee) Already the subject of a court fight, which saw petitioners putting the matter to the voters this spring, only to have their signatures tossed, it is also opposed by the new Governor. Look for several months of bureaucratic foot dragging as the plan makes its way to a ballot in the fall of 2004 instead.

Not scheduled to take effect until January 1, 2006 (groups of 200) or 2007 (20 to 199), the new law encounters a number of legal roadblocks, even without business recalcitrance. It requires all organizations with 20 or more employees to pay at least 80% of the health premium for all full time employees – groups of 200 also pay at least 80% for eligible dependents as well. A simple solution to the problem of the uninsured, underinsured or undercapitalized? Well, not exactly.

Flaws Intentional

- 1) Does not apply to organizations with less than 20 employees

Good news for them, but what about the thousands then still without coverage?

- 2) Those with 20 – 49 employees are also exempt unless the state subsequently adopts a tax credit equal to 20% of the net cost of the program per employee

With the state in financial straits, how do they get those rates?

- 3) Union employees are exempt

- 4) Employer does not pay for dependents covered by another employer

Understood if it's my spouse, since we're both "primarily" employed, but who gets the kids?

- 5) If an employer does not wish to offer benefits, they pay a fee to the state

How much, who sets it, does the state want the responsibility for providing coverage to those employees (and if so, what kind, what cost, what choices, etc.)

- 6) A new regulatory body will run to this "pay" plan (State Health Purchasing Program) under the auspices of the Department of Health Services

We need another bureaucratic arm related to health care, in addition to the Departments of Insurance, Labor and Managed Health Care

- 7) Carriers can set new plan designs rather than use their currently marketed products

Which allows...the law only says that PPOs follow Department of Insurance regulations, which dictate coverage type but not amounts, and for HMO the Knox Keene Act. The new board is to set mandatory coverage requirements (presumably without legislative approval)

- 8) Employer does not have to pay premiums for employees earning under 200% of the Federal Poverty Level (300% with dependents) – a state subsidy applies.

One study shows that 43% of subsidy recipients will actually be over 200% of the FPL because the law only looks at the wages of the individual and not the family.

- 9) Full time employee is defined as working 100 hours per month

They consider someone full time when they work roughly 23.5 hours per week?

- 10) Employers must continue paying for those out of work – except on Workers Comp

Reversing the current DOL interpretation and leaving open considerable additional cost when those unable to work may continue coverage under COBRA (just extended itself)

- 11) Must cover 1099 employees

In itself an oxymoron – these are supposed to be independent contractors (if employers are not sure of the difference, the Labor Code has a very simple “20 questions” test)

(F)laws of Unintentional Consequence

- 1) The plan will lower costs

It won't. While the cost of uncompensated care may abate, hospitals and doctors have many financial challenges and thus unlikely to lower rising charges. Premiums are also not likely to decrease, particularly for publicly traded carriers. In other words, why should providers and third party payers make changes absent any compulsion?

- 2) Plans will be affordable

Depends on your definition. Some previously uninsured employees lacked the money needed to pay premiums and co payments. By requiring their participation and payment some employees will have problems complying with the employer's need to comply.

- 3) Who does it affect and how?

Employees will have to get the money to pay for their share of premiums from other sources. Employment cutbacks, wage cuts (but hampered by minimum wage requirements), higher prices, etc. might all be imposed by employers. Opponents say the cost to business for the new law will be \$5.7 billion

The good news?

Carriers are now required to extend the small group rating guarantees, which set premium limits and guarantee coverage issuance to any group of 50 or more, regardless of health concerns

Finally...

The petition could be up for a vote, Arnold may say “that's all she wrote” and the Feds may send a note...saying ERISA preempts attempts to propose or impose certain mandates or rates

ECONOMIC STAGE

It's not getting any smarter out there – you have to come to terms with stupidity and make it work for you (Frank Zappa)

What to make of Dick Grasso's take the sleeping scandal in its wake
On the other side of growth paychecks got greener
But everyone has now been caught the market's doing what it ought
Seeking redemption leaving fat cats looking leaner

Imclone improved its own stock gains but Martha didn't quite skirt stains
The Omni-present icon conned promises by trading
Poor Parmalat has fallen flat Scruschy got cushy then went splat
Tyco's tsar found his star in the glare of headlines fading

There's been a new discovery of signs of our recovery
But we patiently await health inflation's cure
Businesses will benefits pare but unions have more strikes to spare
And lawsuits outcome will hurt income that's for sure

But on a different note

Managed care is failing
Doctors and nurses are bailing
While politicians are assailing
Business owners who are wailing
With large rate spikes impaling
Both wholesale and retailing

In an economy subdued

And the carriers are flailing
(Who knows what they're inhaling)
So "The Kaiser" is prevailing
Making tracks to start derailing
A system that's now scaling
Back to find a cure availing

Success depends on how it's viewed

But there's a movement some are hailing
New funding methods unveiling
But enrollment is still trailing
It's not clear what they're entailing
But some carriers are detailing
These new ways to smooth the "saling"

So that we don't feel fully ---

Health care is a mess, prices are too high. We want more but will pay less, is it any wonder why?

How did we get into this mess? Could it be that everyone is responsible because no one takes responsibility? I certainly will, except for all the things that are clearly someone else's fault. Since economists have correctly predicted 12 of our last 6 recessions, I think I'll eschew further expert opinion and just keep asking questions. Where there's a will, there's a way:

Will new tax stimulation present a situation where the economy can thrive?

Will we cap the budget gap when the boomers hit 65?

Will Medicare give us a scare when the trust fund's not alive?

Will my stocks rebound and earnings compound so I can shuck all this jive?

Okay, I don't know much about markets and such, there's clearly too much confusion

But if you extend economists end to end, they'd still not reach a conclusion

Health care's not much easier to fathom, but at least I'm less at sea

MAJOR ROLES

With the advent of the new Health Security Accounts, a reappraisal of the many payment options is worth a full review (outline follows)

WAITING IN THE WINGS

Consumer Directed Health Plans

Actually inching closer to the stage but not ready for a starring role, CDHPs are really just a variation on the funding themes outlined. Essentially a self funded plan with economic incentives to make medical choices based on both finances and health care criteria, using information tools provided to make educated decisions. We profiled these plans last year.

Growing Trends

Cost containment is still heard as the consistent watchword to stem the rising tide of inflation. Some employers have chosen to keep their payments frozen and ask carriers for new plan creation. Amid threats of and actual strikes and suspicion that an economic recovery is lining employers' pockets with profits, employees are unwilling or unable to afford to pay more while getting less. Ultimately, successful "controls" will depend on the integration of six factors into health care delivery and insurance:

- 1) Evidence based medicine
- 2) Results driven information technology
- 3) Interactive usable health information
- 4) Cost shifting with tax and usage incentives
- 5) Customized designs – small limit or inside funding methods
- 6) Multi tier provider and prescription networks

There is a new and powerful debate being conducted in both the private and legislative sectors as to whether the employer based benefit system should even continue. Employers are already reducing their financial participation, and a California Health Care Foundation study says that 25% of businesses here will move to a contingent work force that will not receive benefits.

SUPPORTING ROLES

Inflation

“Health care remains one of the last bastions of inflationary pressure in a subdued economy”
(Business Week)

The reasons are the same, with the underlying problem being that insurance coverage is a service contract when it should be a financial contract. With few economic or tax incentives to maintain vigilance over the escalating cost of care, these problem symptoms run unchecked:

- 1) Price: advanced technology, general increases, specialty personnel, drugs
- 2) Aging workforce (especially specialists) and population
- 3) Malpractice: rising rates cause doctors to charge more or stop practicing
- 4) Managed care backlash: made easier with fewer providers, who demand higher pay
- 5) Government mandates: said to contribute 15% of the average insurance premium
- 6) Cost Shifting: by government through Medicare and Medicaid, or due to managed care
- 7) Demand: for the newest and best drugs and technology, as spurred by advertising
- 8) Consolidation:
 - a) in medicine, with an aging workforce, fewer doctors and more specialists
 - b) in industry, with an increase in mergers and acquisitions
 - c) in health industry, with mergers as well as market departures

We see a number of surveys and analyses during the year, showing both where we have been and where we may be going. None are really region specific, but the consensus among 9 major polls is that base PPO and HMO rates will increase 14% and their drug component by 18%. Two of the largest plans in the country (Cal PERS and Federal Employee Health Benefit Plan) showed increases of 18% and 13% respectively in 2003.

GROUP FUNDING OPTIONS

President Bush signed the Medicare Reform Act on December 8, 2003. It included the new Health Savings Accounts, to succeed Medical Savings Accounts. With the implementation date set for **January 1, 2004**, there are a open questions and issues. This reviews not only some tax free options now available but also some of the design and other cost reduction features that have long been utilized in group health plans.

Tax Free Accounts:

Medical Savings Accounts:

The intention of the new legislation is to have the Health Savings Accounts replace MSA

- 1) Lower qualifying deductible allowed
- 2) Higher out of pocket maximum allowed
- 3) Includes allowance for payment of retiree health premium
- 4) Underlying plan for HSA allows differential between PPO and non PPO payment
- 5) Higher contribution allowance with catchup provision for those 55-64
- 6) Both the employer and employee may contribute rather than one or the other

Health Savings Account (new law – to replace MSA):

Who contributes:	Employer or employee – and may be part of Cafeteria Plan
How much:	100% of deductible to maximum of \$2,250 (self) \$4,500 (family) Allows catchup for individuals 55-65 up to \$500 per year (graduated)
Roll Over Allowed:	Yes
FICA/Medicare:	Exempt only for employer contributions
Excess Allowed:	No – but may continue to get paid for old claims
Earn Interest:	Yes, tax free, with account held by the employee
Withdrawal:	Expenses deemed eligible by IR Code 213 (d) – and
Additional:	COBRA, Long Term Care, health insurance if unemployed, Medicare and retiree health insurance premium
Qualifying Plan:	There must be an underlying health insurance plan as specified (Single deductible \$1000-2500, out of pocket \$5,000 maximum) (Family deductible \$2000-5000, out of pocket \$10,000 maximum)
Portability:	Yes – distributions allowed if an underlying plan is maintained
Penalty:	Withdrawal before age 65 for non allowed expenses is 10% plus tax

Health Reimbursement Accounts (sanctified earlier in 2003):

Who contributes:	Employer
How much:	Employer specifies the amount
Roll Over Allowed:	Yes
FICA/Medicare:	Exempt
Excess Allowed:	No – but may continue to get paid for old claims
Earn Interest:	No
Withdrawal:	Only for those expenses deemed eligible by IR Code 214(d)
Qualifying Plan:	None required
Portability:	None – at termination, entire account balance reverts to employer

Flexible Spending Account:

Who contributes:	Employer or employee, or both
How much:	Employer specifies maximum, employee specifies annual amount
Roll Over Allowed:	No – the money must be spent in the plan year (“use it or lose it”)
FICA/Medicare:	Exempt for either employer or employee contributions
Excess Allowed:	Yes – employer makes available entire account from inception, even if contributions are only made by employee
Earn Interest	No
Withdrawal:	Only for those expenses deemed eligible by IR Code 213(d)
Qualifying Plan:	None required
Portability:	COBRA extension allowed for the remainder of the plan year

Medical Expense Reimbursement Plan – Self Funded:

Who contributes:	Employer
How much:	Employer specifies maximum
Roll Over Allowed:	No
FICA/Medicare:	Exempt
Excess Allowed:	Yes – employer makes available entire account from inception
Earn Interest:	No – not normally held in a separate account
Withdrawal:	Only for those expenses deemed eligible by IR Code 213(d)
Qualifying Plan:	None required
Portability:	None

Discrimination: all plans have their own discrimination rules and procedures except for Insured Medical Expense Reimbursement Plan (below)

Medical Expense Reimbursement Plan – Insured:

Due to an anomaly in the Tax Code, as long as there is the presence of health insurance coverage. There are no specifics on the amount of underlying coverage provided. This allows a self funded plan to operate on a discriminatory basis, otherwise subject to the same rules as the Medical Expense Reimbursement Plan

Other Funding Options

Component Plan Building

Purchase of various parts of the health plan using different vendors, shaping them in a way that is most meaningful to the employee population. Examples include specialty discount programs (e.g. psychotherapy, EAP, wellness services) and supplements (chiropractic or acupuncture)

Base Plus Major or WrapAround

Using major components, such as a basic hospital plan with a partially self funded “major medical” program that may add supplemental components

Partial Self Funding with outside or carrier administration

Generally for larger companies when done with a catastrophic deductible, smaller plans may also leverage the difference between designs, using the savings to either fund one of the tax advantaged programs outlined, or purchase a component to supplement base coverage

Consumer Directed Health Plans

Sold for large companies (over 250 employees) combining standard self funding with employee education and account management tools (often in conjunction with an HRA) to manage costs

General Issues on the New Law

The new Health Savings Accounts are to replace Medical Savings Accounts, but:

- 1) The mechanics for account name or type transfer are not specified
- 2) Is the out of pocket maximum inclusive or exclusive of the annual deductible?
- 3) Can the out of pocket amount be lower than the specified maximum?
- 4) Is there a relationship between the deductible and the out of pocket maximum?
- 5) Is annual deductible aggregated to the family amount when dependents included?
- 6) Does the plan administrator file the same MSA return or a new type of return?
- 7) How does a participating employee state their enrollment on personal tax return?
- 8) Does the employer or administrator issue a 1099 form for interest earnings?
- 9) Are investment restrictions the same as for MSA or IRA?

The IRS has already clarified some early points with a release following the new law, but additional issues will probably not be addressed or resolved for another six months.

Market Issues:

The other issues relate to the market adaptability to the new format:

- 1) Will a standard high deductible plan meeting general parameters qualify?
- 2) If not, how long will it take carriers to file new plan designs and get approval?
- 3) Will approval be federal (pre-empting state authority) or state (probably the latter)?

STAGE LEFT – CARRIERS

We should all be so unlucky. Citing losses, sighting inflation, carriers present one side that should incite a riot (if we only had better insight into their accounting). A backlash is brewing as people are construing that non profits make too much of them and those that are traded have paraded too much gain. Suppose we juxtapose 2 findings on the property/casualty side:

Projected losses of \$3 billion for fires, \$2 billion for storms, \$4 billion for auto insurance errors outside the norms. There are still lawsuits for asbestos and mold and in some states policies are no longer sold. Yet Weiss Research says the industry earnings are up \$15.6 billion.

Weiss also showed HMO profits up 81% last year and a 214% jump for life and health companies overall. Kaiser shows hundreds of millions of profits and an increase of 33%, and all its major competitors did well this year. But they all claim to be lucky to survive – thank goodness they are so plucky and can thrive.

Consolidation continues and generation of revenues resulting has financial firms consulting astrological and pie charts to see who has the smarts to stand a breed apart when the next downturn churns the profit curve:

- 1) United Healthcare and Mid Atlantic: nowhere near the Pacific market but agitating nonetheless. United also bought Golden Rule to do MSAs and HSAs unto others.
- 2) Great West and Canada Life: a merger complementary because Canadians are so nice
- 3) Manulife and John Hancock
- 4) MetLife and parts of TIAA CREF
- 5) Hartford and parts of CAN

The biggest and most significant, of course, is the merger between Blue Cross of California (Wellpoint, which owns several Blue Cross/Blue Shield plans) and Anthem (which owns even more). So “the Blues” acquisitive bent lent voice to its new anthem as the merger creates the largest managed care company (is that a good thing to be when managed care has not managed to work? At least it’s well pointed in a dominant direction)

Who will be next? A good question, given the revival of two major companies and the revamping of another. Highlights of the major plays and players:

Aetna

From the valley to the peak it has piqued investor interest while innovating. It will ride the crest of what works best in current market circles, as we circle back to the basics of insurance protection and move to new funding models. Will potential growth be followed apace by leaving space to meet new service demands?

Blue Cross

Consolidation helps ensure market domination, as its enrollment numbers tally similar to its rising stock price (and its insurance prices). They are introducing an “HMO Lite” with a smaller network, expanding the number of plan designs available (by number and ease of access) and changing small group renewals to a true annual basis. They’re doing well – now if they could just make their service more responsive...

Blue Shield

A non profit getting battered by other carriers' ability to pitch their story to capital markets, they have raised small group rates considerably higher than most rivals, while bringing down mid market pricing. They have both HRA and HSA compatible plans, allow multiple packages, and have consumer friendly sites and access to health advice and services that outpace others.

Health Net

Their profits are gross, but the bottom line is the carrier has a wealth of products and services to continue expanding market share while they undercut competitors' prices. If they go too low, increased flow in premiums and investment capital will let them capitalize on their financial health and net new gains.

Kaiser

The Kaiser's on a roll, they're exerting more control and will helm a steady membership after blowing \$1 billion on a failed administrative system and dropping out of several outside markets. They continue to profit from the loss of other carriers, showing gains of nearly half a billion this year alone. But they are running somewhat scared, as they are now prepared to introduce a well priced PPO, a lighter HMO and set their sights to go to other areas in the state.

PacifiCare

They disappeared, now they're back, poised to make a fresh attack solely on their more well heeled opponents. They've set up HRA and will pay for wellness of which they are proponents.

Primer on What you Need to Know - When Dealing with an HMO

- 1) I just joined an HMO. How difficult will it be to choose the doctor I want?

Just slightly more difficult than choosing your parents. Your insurer provides a list of all the doctors in the plan. These doctors fall into two categories – those are no longer accepting new patients and those who will see you but are no longer participating in the plan.

- 2) Do all diagnostic procedures require pre certification?

No. Only those you need

- 3) Can I get coverage for my pre existing conditions?

Certainly, as long as they don't require any treatment

- 4) What happens if I want to try alternative forms of medicine

You'll need to find alternative forms of payment

- 5) What if I'm away from home and I get sick?

You really shouldn't do that

PRESCRIPTIVE REMEDIES

The most insidious increases in health care prices occur at the pharmacy counter, running counter to the manner in which drug therapy can replace medical treatment, presumably more cheaply. The Federal government has forecast an inflationary trend of 10-15% until the year 2010, on top of the 15-30% we have seen since 1998. Drug problems are compounded in several ways. A capsule version:

- 1) Medicare has not paid for drugs historically, but will (somewhat hysterically) in 2006. This will increase demand that has, in health care, induced a further increase in availability, capability – and cost.
- 2) Direct to consumer advertising, which fuels demand by increasing awareness, desire and optimism, has tripled in the last 2 years.
- 3) “Big Pharma” has good karma to allow their profit taking from fears, hopes and even solutions to problems that used to be tragic or have been invented as if by magic.
- 4) The Food and Drug Administration (FDA) has cited safety reasons for not allowing states and some pharmacy chains from importing drugs from Canada. Do they think the Canadians are less healthy because drugs are less expensive?
- 5) Drugs are rushed to the public so much more quickly now that unintended results are not as well known (trust me, take this pill, you won't get ill, here's my bill, get a refill, does it kill? Who knows, but won't you rewrite your will?). The New England Journal of Medicine says side effects affect 1 in 4 patients and cause for over 1 million annual hospitalizations.
- 6) Carriers change formularies but not according to any formula
- 7) Or pay even more, as carriers and large employers keep changing plan designs to expand the tiers (now up to 7) and keep you in tears as new co pays put you in arrears (“I owe my soul to the local drug store”)

O, Canada!

You've heard the myth, now do the math, just don't incur the government's wrath

- 1) While some high profile brand name drugs are cheaper in Canada, other lesser known drugs and generics may not be. Of the 27 top selling generics, 21 cost more in Canada, for these reasons:
 - a) Two companies dominate the generic market
 - b) Canada has price controls on patented drugs
 - c) The Patented Medicine Prices Review Board typically sets the maximum price for a new drug by comparing it with similar drugs already on the market. Therefore, if companies lowered prices on old drugs, profits would be hurt for their new ones.

Studies by 2 US government groups in 1992 and 1998 showed Canadian drugs were less expensive, but they ignored the generics. There is a public web site available (www.drugsvingscalculator.org) that helps to do the comparisons.

- 2) Canadian drugs are not eligible for tax deduction or reimbursement under Flex, HRA, HSA or MSA plans or on individual tax returns:
 - a) Exemption is permitted under I.R. Code Section 213
 - b) 213.1(e)(2) says “medicine or drugs” includes only those “legally procured”
 - c) Legal procurement does not exist if Federal law does not permit it
 - d) Illegal treatments are also not counted (213.1(e)(1)(ii))
- 3) The FDA is on the way (is help on the way? It’s still too soon to say)

“In our experience, many drugs obtained from foreign sources that purport and appear to be the same as U.S. approved prescription drugs have been of unknown quality” (citing authority to ban importation under the Federal Food Drug and Cosmetic Act in response to inquiry from the California Attorney General) Also: “any state law that would legalize imports in contravention of the FFDCA would be preempted by Federal law” and subject to liability

The FDA sued Rx Depot and won, which shut down that company’s efforts to profit from Canadian imports. The presiding judge said: “The court is not unsympathetic to the predicament faced by individuals who cannot afford their prescription drugs at U.S. prices. However, the defendants are able to offer lower prices only because they facilitate illegal activity determined by Congress to harm the public interest”

O Woe is Me (what can I do to cut my fee?)

There are some price remedies at home:

- 1) Formulary drugs are not inferior: They may work for you, they may not, but with little risk it’s worth a shot (or a pill) If the formulary drug does not work, some carriers allow appeals and will default to the lower co payment.
- 2) Pill splitting: The cost of a 30 day supply for one drug is usually only incrementally different from another. If you can get the doctor to prescribe more but less often, you save.
- 3) Negotiate: If you pay cash, how do you know you are getting the best deal from your local pharmacy? Shop around, shop on line and then see – if you don’t ask, they won’t tell you.
- 4) Generics: No, they’re not the same unless the brand name is off patent. Even so, like the formulary – non formulary potential, it pays to ask.
- 5) Over the Counter: the IRS now allows their deduction in various tax preferred accounts (MSA, FSA, HSA, HRA) and personally. Some drugs once heralded (e.g. Claritin and Prilosec) can now be obtained over the counter at a very low rate compared to their brand name brethren.

LEGAL STAGE

Either the doctrine of precedents is to keep man in a state of ignorance, or it is a practical confusion that wisdom degenerates in governments as governments increase in age, and can only hobble along by the stilts and crutches of precedents. How is it that the same persons who would proudly be thought wiser than their predecessors appear at the same time only as the ghosts of departed wisdom? (Thomas Paine)

No review would be complete without a summary replete
With a few legal references
Some concerns you can delete, other rulings more downbeat
It depends upon your preferences

We'll provide you some relief
And keep this section shorter than most briefs

Stop! In the name of...

The Supremes continue to hear cases that involve the liability of carriers or providers in managed care cases, and to further delineate states' rights to legislate in matters concerning health care – or whether federal ERISA law preempts their ability to do so. At this time, the providers and states are ahead on points.

Managed Care Liability

The unknown trial of the century in Florida, presided over by Judge Frederic Moreno, involves several major carriers who have been accused of a variety of crimes, but ultimately just the use of their influence to induce providers to produce lower costs. This year, Aetna and CIGNA dropped out as defendants when they agreed to settle for \$470 million and \$550 million respectively. The other defendants gamely soldier on...

Flexible Benefit Plans

Debit Cards – Revenue Ruling 2003-43

Clarifies the ability to use them, how they are used, and deductibility of expenses:

- 1) Employee certifies at enrollment and annually that the card is used only for eligible medical expenses and no other reimbursement. This will also be shown on the card itself and must be verified at the time of purchase
- 2) Employee must get receipt
- 3) Card maximum must be tied to the FSA or HRA maximum
- 4) Limited to use with authorized providers (as set by the employer)
- 5) Canceled at termination of employment

Double Dipping – 2002 Rulings

Prohibit the ability of an employer to use salary reduction plans for premium payment and then reimburse the employee for the amount of the premium separately

Individual Plans – IRS comments

Having a Flex Plan pay for dependent coverage that is not in the name of the employee “might” be permitted – this is an informal interpretation of existing statutes

Covered Expenses

YES: Breast reconstruction following mastectomy
Vision correction (e.g. LASIK)
Nutritional supplements, vitamins and other natural remedies if prescribed by a doctor to treat a specific condition

NO: Whitening teeth discolored due to age
Gym and club dues (except separate fees for prescribed weight loss programs)
Prescriptions for drugs received from foreign countries

Over the Counter Drugs – Revenue Ruling 2003-102

Covered without a medical prescription, but excludes dietary supplements and states that the drugs must treat an injury or illness (specific examples cited include antacid, allergy medication, pain reliever and cold remedy) – the plan document must allow for OTC coverage

COBRA

- 1) Verbal notification at time of qualifying event is acceptable because the law only stated that written notification be given at the time of coverage inception (US Appeals Court)
- 2) Must give notice to divorced spouse even if they were dropped earlier by the employee. Coverage does not begin, however, until the date of the divorce (Revenue Ruling 2002-22)
- 3) COBRA must be offered to undocumented aliens because the law applies to anyone who had coverage and can only be withheld if termination is for reason of gross misconduct
- 4) The IRS has published a new “model” general and continuation notice
- 5) Employee not enrolled in error is not eligible for COBRA (because there is nothing to continue) (US District Court)
- 6) Disability: it is not necessary that the qualifying beneficiary *become* disabled within the 60 days following the qualifying event – only that they be disabled during those 60 days
- 7) When a waiver of COBRA continuation coverage is revoked, the start date for coverage is at the date of revocation and not the original qualifying event date

**STAGE RIGHT – AGENCY PAGES
(Going through Stages)**

We're all in this alone (Lily Tomlin)

It has always been our goal to take less of a starring role
For service' sake and not self abnegation
Growing large by staying small we can encompass all
You need through horizontal integration

It's not that we've reorganized – more that we have actually really organized – again.

We not only affiliate with other agencies, but work intimately with them
This allows us to bring “best practices” to our clients at all times
With access to a variety of quality resources, we better adapt ourselves to our clients' needs
In this way, we provide a higher level of service than our competitors' can

Client Management:

United Benefits Advisors: National firm of allied professionals

We have recently joined this organization. Not a professional association, but a corporation comprised of individual financial planning and benefit firms. Membership is currently at 80 brokerages with expansion planned to 150 by January 1, 2005. Already, we are the fourth largest benefits brokerage in the country.

Joint agreement and national marketing allow us to access several speciality markets that would be difficult to reach on our own, and give us the opportunity for leveraged relationships with carriers, vendors and to set up regional pooling arrangements (similar to what you have)

This arrangement also gives us greater “bench strength” so no client is wholly dependent on our service team (due to life transitions) or even the limitations of our already extensive regional professional network. Instead, we act just like the large benefit “houses” except that we cull the best from each region and know the participants personally.

Regional Affiliations: formal and informal working agreements with

Insurance2Go: international travel and coverage
Regional: we have working arrangements with group brokers in the East Bay (3), Sacramento and Sonoma County to handle regional needs and special situations or which may bring particular expertise to a given situation (e.g. in house actuarial and funding analysis, specialty products)

Related Services:

Primary Benefits: Have HR contract services with benefits integration capabilities
WEA Consulting: HR contract services and HRIS programming
Benchmarking: Use consultant in Roseville
Compensation: Work with Reno and Roseville specialists to create benefit statements

Medical:

WellCall: wellness education, training, prevention – impact on medical, Comp and performance

We have worked with the principals for several years and act as their insurance advisor

North Bay Health Partners: active wellness coaching and education – same impact

Helping development of their marketing plan and broker outreach

Dental:

DR Dental: administrative services for self funded dental plans

Began work with the dentist/owner when the organization began

We have also done joint work with presentations to the California Dental Association

Utilized our knowledge and relationships to also advise the ADA and set up a similar service

Two different dental trusts

Pharmacy:

Helped start the North Bay Pharmacy Coalition and still work with their CEO

American Health: DUR and pricing review, negotiated discounts

Working jointly with other agencies to bring their services to our clients

Retirement:

Our primary relationship is with Taddei Ludwig and Associates, which is a full service organization specializing in executive compensation (non qualified retirement plans), non profit retirement programs, and arranging administrative services and education

They also have a formal relationship with AXA Advisors, a large international retirement brokerage, which has a San Francisco office and team specializing in non profit plans

Retirement By Design is a fee for service subsidiary of the firm, and they work with a regional group of financial managers called Zenith Capital, with which we have also established a strong working relationship.

Administrative:

We have been associated with the principals at Vita Insurance for many years, and rely on their expertise not only in the technical aspects of COBRA and Flex Plan law, but on administration.

We have also worked with the principals of COBRA Onque for years. This company has a turn key administrative system we make available to our clients for managing their COBRA risk.

Technology:

Our associate John Jakiemiec owns United Insurance Technologies, which not only has content and administrative platforms under development, but is also our research arm for developing specific platforms for our clients. We also have several indirect and long standing relationships:

Enwisen: web content

One of the earliest entities in this area, we have worked with one of the founders since its inception (he is also a member of United Benefits Advisors). Has a new “lite” version that should meet many of our clients’ needs at a reasonable cost

BisNet: administrative connection (some web content)

Took over the owner’s health insurance agency when he launched this firm, which has now been in this competitive market for 7 years and is growing rapidly

BeneTrac: administrative connection

Worked with the owner on a state board before he launched this program, which we have used for some of our smaller clients

Benergy: web content

Have preferred pricing through our affiliation with Brown and Brown
Also work with a Roseville consultant as a “general agent” for this product

Colt Express:

Full HR and benefits integration system for larger companies

Long Term Care:

Golden Benefits in San Anselmo works exclusively in this area and we have known the owner since she started in the business. This firm can also work with Taddei Ludwig, which provides LTC services as an adjunct to its retirement planning business.

Worksite Marketing:

Larry Lambert and Associates in Long Beach is a national enrollment and market specialist for voluntary benefits, with a clientele that is diverse not only in terms of geography and size but also the types of business served. They have worked in the voluntary sector for over 20 years Larry has served on the board of the National Association of Insurance and Financial Planners

Property/Casualty:

We work closely with a number of property/casualty agencies, specializing in particular industries (e.g. construction), areas (e.g. malpractice) and with different markets, customer approaches and practice style.