

FAMILY & MEDICAL LEAVE

The U.S. Labor Department examined FMLA compliance issues facing employers. Among the key findings:

71% of employers allow all FMLA-qualified leave requests.

30% of employers don't know if the law applies to them.

85% of employers say compliance with the law is easy.

68% of employers say compliance has minimally affected benefits costs.



EMPLOYMENT PRACTICES

After 20 years, FMLA still tests some employers

BY MATT DUNNING

Twenty years after the Family and Medical Leave Act became a national law, many employers still struggle to correctly apply several of its rules.

Enacted on Feb. 5, 1993, the FMLA allows eligible employees up to 12 weeks of unpaid leave a year in cases of serious illness or injury, or to care for sick or injured family members.

Generally, employers have not found FMLA compliance to be overly burdensome, according to a study the U.S. Department of Labor released last week marking the 20th anniversary of the law.

However, issues such as requests for intermittent leave, employee notice requirements and certification procedures, as well as

See **FMLA** page 29

WORKERS COMPENSATION

YOGA CLASSES POSITIONED AS ALTERNATIVE TO PAIN MEDS

Practice used in functional restoration programs



BY ROBERTO CENICEROS

Yoga is flexing its way into the workers compensation world.

Industry experts say yoga, which combines stretching and strengthening exercises with meditation, even could help address a formidable workers comp problem: how to resolve complex claims involving patients with chronic pain treated with addictive narcotics.

Yoga's potential benefits for other work-related injuries are already documented in several evidence-based medical treatment guidelines that workers comp payers and state regulators expect treating doctors to consult.

The American College of Occupational and Environmental Medicine's guidelines say yoga can help address chronic lower back pain, persistent pain and arthritic hands, said Christopher Wolfkiel, director of ACOEM's practice guidelines in Elk Grove Village, Ill.

In workers comp cases, yoga is being incorporated into functional-restoration programs, said Mark Pew, senior vice president of business development for Prium, a Duluth, Ga.-based workers comp

See **YOGA** page 29

HEALTH CARE REFORM

Guidance given on pairing HRAs with exchanges

Feds draw roadmap for health care option

BY JERRY GEISEL

New federal regulatory guidance on the 2010 health care reform law eliminates uncertainties about how employers can pair a popular health care funding approach with one of the hottest benefits trends: having employees obtain coverage via private health insurance exchanges.

The guidance gives a roadmap on how health reimbursement arrangements can and can't be linked to policies employees obtain through private insurance exchanges.

Typically, HRAs are paired with high-deductible health care plans. An employer might credit an employee's HRA with perhaps \$1,000 or \$2,000.

Employees then could tap their HRA credits to pay for expenses that, for example, fall under the deductible of the linked health care plan. Credits that remain at the end of the plan year roll over for employees to use during the next plan year.

The design of HRAs — a set dollar credit provided by employers to cover a portion of employees' health care expenses — triggered questions from employers about how they would comply with a health care reform law provision that bans annual and lifetime dol-

See **HRA** page 29

KILLING PAIN

19%

Prescription drugs as a percentage of workers comp medical costs



1%/40%

Top 1% of work comp narcotics users cause 40% of narcotics costs



8%

Workers getting narcotics within one year of injury in 2001



13%

Workers getting narcotics within one year of injury in 2008



25%

Narcotics as a percentage of work comp prescription drug costs

Source: NCCI Holdings Inc.

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Country profile of Guatemala; U.K. regulator slams Solvency II

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HEALTH EXCHANGES & HEALTH CARE REFORM IMPLEMENTATION

Opening the door to a new health care era; Massachusetts lowers uninsured rate; contraceptive mandate litigation; employers explore "mini-med" option; exchanges reshaping group plan market.

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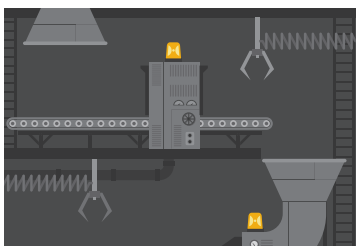
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Crerar: Council president, CEO



Ken A. Crerar, president and CEO of the Council of Insurance Agents and Brokers, talks about the group's past, present and future in the year of its 100th anniversary.

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Buffett run to offset junk food

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MARINE

Marine liability rates set to rise as P&I clubs look to offset 2012 losses

Shipowners may face double-digit increases

BY SARAH VEYSEY

The Feb. 20 protection and indemnity renewal looks set to be one of the toughest in recent years for shipowners.

The 13 members of the International Group of P&I Clubs, the largest P&I clubs in the world, are asking their members for an average general increase of 7.5% at the annual Feb. 20 renewal, according to research by Standard & Poor's Corp.

The highest general increase asked for by a member of the international group is 15% to 16%, while the lowest is 5%, S&P noted in a report released last week.

S&P — which views the P&I sector as stable and upgraded six P&I clubs last year — “would be concerned” if many clubs did not achieve the rate increases they are seeking at the 2013 renewal, said Ali Karakuyu, a credit analyst at S&P in London.

Challenging operating conditions for ship operators, a 13% increase in incurred claims, a 5.9% underwriting loss for the P&I market in



AP PHOTO

Last year's loss of the cruise ship Costa Concordia is among factors that set the stage for hard-fought P&I club renewal negotiations this year.

the 2011-2012 year and the largest claim ever for the reinsurers of the International Group — the loss of the cruise ship Costa Concordia in January 2012 (see story, page 30) — are among the factors that set the stage for “some of the hardest-fought negotiations since the turn of the century,” said Ben Abraham, global P&I practice lead-

er for Willis Group Holdings P.L.C. in London.

Claims inflation has been a major factor behind rising rates, experts say. And the increased individual size and less predictable frequency of individual claims have caused huge volatility, according

See CLUBS page 30

LIABILITY & LITIGATION

Government suit against S&P may trigger claims

D&O coverage unlikely to be hit, but general liability policies may respond

BY BILL KENEALY

The Justice Department suit accusing Standard & Poor's Financial Services L.L.C. of defrauding investors and being a major factor in the 2008 financial crisis may lead to insurance claims.

The suit filed last week accuses S&P and parent McGraw-Hill Cos. Inc. of misrepresenting the true risks of residential mortgage-backed securities and collateralized debt obligations to increase its revenue and market share, thus defrauding investors who relied on its ratings out of billions of dollars.

S&P denied the allegations.

The fact that the government chose to sue under the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 is consequential, said Kevin LaCroix, Beachwood, Ohio-based attorney and executive vice president of RT ProExec, a division of R-T Specialty L.L.C.

The law enables the Justice Department to seek civil penalties equal to losses suffered by federally insured financial institutions. The fact that the suit does not



“A claim like this would be something they would be able to present to their liability insurance companies.”

William G. Passannante, shareholder and co-chair of the insurance recovery group at Anderson Kill & Olick P.C.

name individual defendants will present a high hurdle for S&P to collect on any directors and officers coverage that it may have, Mr. LaCroix said.

“It's an open question if this would meet the definition of securities claim,” Mr. LaCroix said. “The carrier would have a good argument that it does not; and since no individuals are named as defendants in the claim itself, it might not trigger D&O” coverage.

Nonetheless, S&P may be able claim defense costs and the costs of potential settlement under a general liability policy, said William G. Passannante, shareholder and co-chair of the insurance recovery group at Anderson Kill & Olick P.C. in New York. “A claim like this would be something they would be able to present to their liability insurance companies.”

After reviewing the 119-page suit, Mr. Passannante also said the outcome of the case against the rating agency is an open question.

“The complaint looks pretty straightforward, but the

D&O LIABILITY

SEC takes tougher stance on enforcement

LIBOR, whistle-blowers also a threat to insurers

BY JUDY GREENWALD

NEW YORK — Tougher enforcement by the Securities and Exchange Commission is among major factors expected to increase liability exposures for company directors and officers.

During the Professional Liability Underwriting Society's annual D&O Symposium last week, speakers discussed litigation threats that are increasing directors' and officers' potential to be sued. If confirmed, Mary Jo White, President Obama's recent nominee to head the SEC, was mentioned as another threat.

Paul Ferrillo, litigation counsel at law firm Weil, Gotshal & Manges L.L.P. in New York, said he anticipates a “little bit more of an aggressive approach” by the SEC under Ms. White, whom he described as “very even-handed, very fair.”

However, Ms. White would be “hamstrung by budgetary concerns” as SEC chief, he said.

Judges who review proposed SEC settlements or consent decrees have to determine “what's fair, adequate or reasonable,” said U.S. District Court Judge Jed S. Rakoff, who in 2011 rejected the SEC's \$285 million settlement with Citigroup Inc. over its mortgage practices as “pocket change.”

“The tension is how much independent review that enables a judge to exercise,” Judge Rakoff said.

“The SEC has a long, long history of regarding all settlements as an opportunity for a victory parade” as part of its effort to get funding, said John C. Coffee, a law professor at Columbia University Law School in New York. There is a question, though, whether the SEC settlements have been victories or defeats, he said.

David Siegel, a partner with Irell & Manella L.L.P. in Los Angeles, said there is confusion as to whether the SEC “is supposed to be about collecting money.” It should be a regulatory agency “and stop wrongdoing when they see it. When they try to collect money, they do a bad job of it, and it puts courts in a position of having to apply rules as to whether the monetary settlement is just.”

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ONLINE
FEATURES

SOLUTION ARC

Executive's risks rise
as guidance grows

Why D&O liability is of increasing concern, and details of guidance from courts and regulators.

www.BusinessInsurance.com/ExecutiveRisksArc

VIDEO



D&O liability trends

An array of developing litigation issues face directors and officers of public companies.

www.BusinessInsurance.com/Video

RMS 2013

Save the date for 2013 summit

The 2013 *Business Insurance* Risk Management Summit will be held March 5-6 at the Westin Grand Central in New York. www.BusinessInsurance.com/RiskSummit

WHITE PAPER

Toughest work comp claims



How to best use available resources and handle the most difficult-to-resolve workers

compensation cases, many of which began as a medical-only claim.

www.BusinessInsurance.com/WhitePapers

BUSINESS INSURANCE (ISSN 0007-6864)
Vol. 47, No. 3, is published biweekly by Crain Communications Inc., 150 N. Michigan Ave., Chicago, IL 60601-7620. Periodicals postage is paid at Chicago and at additional mailing offices.

POSTMASTER: Email address change to customerservice@businessinsurance.com or mail to Business Insurance Circulation Department, 1155 Gratiot Ave. Detroit, MI 48207-2912. \$10 a copy and \$149 a year in the U.S. \$169 in Canada and Mexico (includes GST). All other countries, \$249 a year (includes expedited air delivery). Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 40012850. GST No. 136760444. Canadian return address: 4960-2 Walker Road, Windsor, ON N9A6J3. Printed in USA. Copyright © 2013 by Crain Communications Inc.

NEWS

WORKERS COMPENSATION

Employers seek to overturn
attorney-client privilege rulings

BY SHEENA HARRISON

Employers in Texas and Montana are expected to seek a legislative fix for state Supreme Court rulings that have restricted employers' access to legal information in some workers compensation cases.

Both states' high courts have held that attorney-client privilege is nullified when information is shared between an insurer's defense counsel and the insurer's policyholder.

As a result, insurers and third-party administrators are restricting legal information they provide to employers in workers comp litigation, according to memos by American International Group Inc., Travelers Cos. Inc., Broadspire Services Inc., ESIS Inc., Gallagher Bassett Services Inc. and others.

"In a word, the reaction has been frustration," said Joe Tixier, executive vice president and general counsel for Itasca, Ill.-based Gallagher Bassett, about client response to the rulings.

Though the rulings apply only to Texas and Montana, insurers could consider limiting information elsewhere because similar legal arguments could be raised, said William Eustace, New York-based managing director of the national casualty practice at Marsh Inc.



"Employers really have to bond together and get this changed. Otherwise, they're going to be in the dark about their claims."

Joe Picone,
Willis North America

"I would expect that you'll see more discretion surrounding the handling of opinions from counsel in the future in a lot of states, not just these two," Mr. Eustace said.

Workers comp policyholders are expected to seek legislative support in the next several months to reverse the attorney-client privilege rulings, said Joe Picone, Richmond, Va.-based chief claim officer of Willis North America Inc.

"Employers really have to bond together and get this changed," Mr. Picone said. "Otherwise, they're going to be in the dark about their claims."

Cathy DeWitt, vice president of governmental affairs for the Texas Association of Businesses, said employers are hiring their own attorneys to communicate with insurer counsel. The association is lobbying for legislation that would allow direct communication without losing the attorney-client privilege.

"I think it's just more of a hiccup that should be addressed, but obviously it does increase the cost for employers," Ms. DeWitt said.

The Montana case is *American Zurich Insurance Co. v. Montana Thirteenth Judicial District Court et al.* and the Texas case is *In Re: XL Specialty Insurance*

See **PRIVILEGE** page 28

AGENTS & BROKERS

Late-year surge in agent, broker mergers

BY TIMOTHY J. CUNNINGHAM

OPTIS PARTNERS L.L.C.

Announced mergers and acquisitions of insurance agents and brokers in the United States and Canada totaled nearly 300 transactions in 2012, with nearly one-third occurring in the fourth quarter alone.

2012 started out as a good year on the M&A front, but it did not telegraph that it would be the biggest year this century with 291 transactions compared with the previous high of 285 in 2008 (see chart).

While 2012 M&A activity started at a slower pace than 2011, concern that the "Bush tax cuts" would not be extended provided strong motivation to close deals by the end of 2012. Sellers appear to have read the tea leaves correctly as the expected 33% increase in the capital gains rate, rising from 15% to 20%, took effect on Jan. 1 of this year.

In addition, the new 3.8% Medicare surtax on capital gains for

certain high-income individuals provided significant incentives for sellers to close deals before the end of the year. Depending on the circumstances, some sellers could

have suffered a net reduction in after-tax sale proceeds of nearly 10% if they closed this year rather than last year. It is no surprise, therefore, that 2012 was a stellar year for deals.

Public brokers and private equity-backed buyers had the greatest gains in the number of M&As during 2012, but private brokers still led in total deals completed for the year.

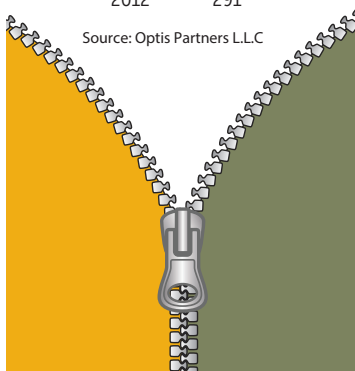
Public broker Arthur J. Gallagher & Co. led all buyers with 30 announced deals in 2012, followed by three private equity-backed firms: Hub International Ltd., 21 deals; Confie Seguros Insurance Services, 18; and Assured Partners Inc., 17. Public broker Brown & Brown Inc. rounded out the top five with 15 deals announced.

Public brokers had the biggest increase in number of transactions at 14 and percentage increase at 26%, although the public equity-backed firms were close behind

AGENT AND
BROKER M&As

Year	Deals
2008	284
2009	167
2010	193
2011	279
2012	291

Source: Optis Partners L.L.C.



See **M&A** page 28

CAPTIVE INSURERS

Captives used
to battle rise
in medical costs

Collection of data
leads to better control

BY MIKE TSIKOUDAKIS
AND RODD ZOLKOS

AVENTURA, FLA. – Companies are increasingly looking to fund employee benefits through their captive insurance programs as they seek efficiency, greater control over their benefits programs, reduced costs and greater control over data, among other advantages.

Employers funding medical benefits through captive insurance structures, for example, are able to get access to critical medical data they can use to reduce claims and the overall cost of health care.

Employers increasingly are looking at their captive structures to reduce rising medical costs globally, panelists said during a session at the 22nd annual World Captive Forum late last month in Aventura, Fla.

Bill Fitzpatrick, London-based vice president of corporate risk benefits and insurance and risk management at Deutsche Post A.G., said the Bonn, Germany-based transportation and logistics company's global medical spending is approximately €600 million (\$818.5 million).

The overall medical costs that run through DHL's captive are €100 million (\$136.4 million), which includes 100 countries and 600 legal entities, he said.

"If you do absolutely nothing in the next five years, you can see (medical costs) increasing basically €60 million (\$81.9 million) per year" for DHL, Mr. Fitzpatrick said. "Since we're operating on such low margins, we're going to have to figure out a way to go out and control medical costs on a long-term basis."

DHL's employee benefits captive program has eliminated frictional costs "through the elimination of brokers" and negotiated retention levels with vendors, which saves the company 20% to 21% a year, he said.

But the captive program also provides crucial data that helps DHL figure out the cause of certain claims, Mr. Fitzpatrick said.

Francis Coleman, director of international consulting at Towers Watson & Co. in Universal City, Calif., said inadequate health care

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MANUFACTURERS SHOULD TAP EXECUTIVES TO HELP IDENTIFY SUPPLY CHAIN RISKS

Superstorm Sandy reinforced importance of thorough risk assessments

BY MIKE TSIKOUDAKIS

To successfully manage their often extensive supply chain risks, manufacturers should make sure that their senior executives are fully involved in the risk assessment process.

Supply chain risk assessments should focus “above and beyond some traditional risks” such as floods, high winds, earthquakes and hurricanes, said David Gluckman, senior vice president and property risk control executive for Willis North America Inc. in Morristown, N.J.

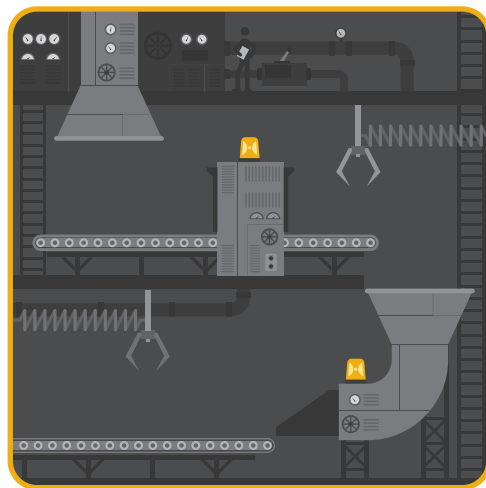
“The time period that’s involved where the effect of the event is really starting to have a significant impact on the business ... is what we’re trying to figure out,” Mr. Gluckman said.

Such risk assessments should examine suppliers’ production and service capabilities, potential bottlenecks and supply routes, and identify critical single-source suppliers, he said.

Superstorm Sandy reinforced the need for such risk management assessments last year when electrical outages left some businesses closed for weeks (see story below). Such disruptions can come from several sources (see box at right).

“Supply chain disruptions are increasing in frequency, duration, consequences and costs,” said Cal Beyer, head of commercial manufacturing for Zurich North America in Edina, Minn.

First, middle-market manufacturers should determine areas of vulnerability in their product and supplier mix and then identify critical suppliers without which business could be lost or the operation could fail, he said.



DISRUPTIONS

New Jersey manufacturers dealt with numerous disruptions of their businesses due to Superstorm Sandy. They included:

- Power outages
- Flooding
- Wind damage
- Lack of inspectors required before reopening
- Fuel shortages
- Employee home damage
- Employees unable to get to work
- Lack of supplies, transportation

Source: New Jersey Manufacturing Extension Program Inc.

Rather than focusing on suppliers with which a company spends the most money, manufacturers “should factor in the criticality

of the different components,” said Jill Dalton, partner in charge of Dempsey Partners L.L.C.’s New York office. “There may be something in the supply chain that they spend the least amount on, but actually is the most critical piece.”

Such in-depth risk assessment also can help middle-market manufacturers secure insurance coverage, experts say (see story at right).

Aside from top executives, manufacturers need to include all parties within a company when conducting a risk analysis and buying insurance, experts say.

“It’s not been uncommon, even in larger companies, for us to see a disconnect between the people who purchase insurance and those that are responsible for procurement,” Mr. Beyer said. “There should be more collaboration between the disciplines in the manufacturing company” to include the CEO, chief financial officer, operations and procurement managers, he said.

Supply chain, business continuity and enterprise risk management are interrelated and should be part of a robust risk assessment, Willis’ Mr. Gluckman said. “It’s all part of a holistic approach to risk management and supply chain risks.”

Manufacturers also should strive to have suppliers adopt the main company’s risk management philosophy, said Jeffrey Beaman, FM Global’s Johnston, R.I.-based vice president and manager of all-risk underwriting.

“Well-managed companies ... are going to help assure that their supply chain becomes more resilient by asking their third parties to believe and subscribe to those same aspects,” Mr. Beaman said.

Assessments help secure coverage

Supply chain risk assessments can help middle-market manufacturers provide critical information to secure supply chain insurance.

For example, supply chain exposures can be insured by a property policy for interrupting a manufacturer’s business because contracted materials did not arrive or arrived late, said Jeffrey Beaman, FM Global’s Johnston, R.I.-based vice president and manager of all-risk underwriting.

Business interruption or time element coverage “is designed to help the client achieve the similar financial results they would have had if they were operating their business except for the fire that happened or the earthquake or flood,” Mr. Beaman he said.

The insurance typically covers a loss from a first-tier supplier, he said.

As supply chain risks often involve multiple tiers, FM Global provides what it calls contingent time element extended coverage that can be extended to multiple tiers of suppliers.

Risk assessments help identify events that can disrupt a manufacturer’s operations, rank them on a probability and severity basis, and then determine which risk-transfer solution works best, said Cal Beyer, head of commercial manufacturing for Zurich North America in Edina, Minn.

Zurich provides all-risk supply chain insurance with limits up to \$100 million on a named supplier basis, he said.

“Capacity is not generally the issue,” Mr. Beyer said. “It would be the availability of underwriting information and access to the key decision-makers to have an understanding of the operation to properly underwrite those exposures.”

Risk assessments also can help manufacturers know which exposures may be excluded from coverage, such as civil authority and ingress/egress, said Jill Dalton, partner in charge of Dempsey Partners L.L.C.’s New York office.

“Wording can vary dramatically from policy to policy,” Ms. Dalton said. “People who are placing that kind of coverage need to carefully look at the exposures and compare that with the coverage to make sure it’s a good fit.”

By Mike Tsikoudakis

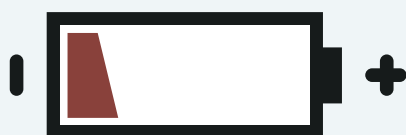
N.J. MANUFACTURER LEARNS TOUGH LESSONS FROM POWER OUTAGE

Superstorm Sandy left at least one New Jersey company in the dark for 10 days. “We hadn’t really experienced anything like that, so we didn’t have any backups in place and we didn’t have any generators,” said Josh Smith, warehouse operations manager at Atlas Bronze, a unit of Maranatha Now Inc.

The power outage after Sandy struck the copper, bronze, brass and iron distributor and manufacturer’s main facility and warehouse in Trenton, N.J.

The company did not have contingency plans to respond to the outage, Mr. Smith said. “It wasn’t even on our minds.”

And the outage left the company unable to perform rudimentary tasks. “We couldn’t even



get the garage door open,” he said. “We couldn’t really receive material because we couldn’t get the forklifts out.”

But the company avoided major losses by having its suppliers fill customer orders.

Still, Atlas Bronze said it will “absolutely” develop a plan to handle future supply chain disruptions and a backup generator will be part of the plan.

“We need some way to keep our machinery

up and running so that we don’t have to expose ourselves,” Mr. Smith said.

“You’re going to go down. One way or another, something is going to happen,” he said. “You need to be prepared.”

John W. Kennedy, Morris Plains, N.J.-based chief operating officer for nonprofit New Jersey Manufacturing Extension Program Inc., said Sandy’s widespread effects on the state’s 11,000 manufacturers was “staggering.”

After meeting with more than 1,000 manufacturers, NJMEP found that about 22% were “severely damaged” in losing more than two weeks of production. About 90% lost about a week of production, he said.

By Mike Tsikoudakis

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**Andrew M. Miller, President & CEO
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Helping executives at midsize firms and their brokers develop benefits solutions.

EMPLOYERS FIND WAYS TO CONTAIN PHARMACY BENEFITS COSTS

Narrow networks, carve-out coalitions help mid-size firms

BY JOANNE WOJCIC

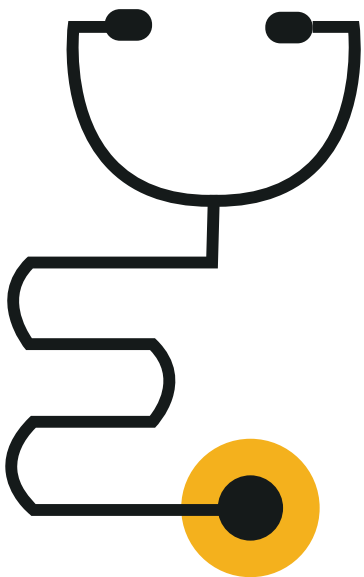
As employer spending on prescription drugs continues to outpace other types of medical expenditures, many midsize U.S. employers are focusing their health care cost containment efforts on pharmacy benefits.

While encouraging generic drug utilization through lower copayments is perhaps the most prevalent pharmacy benefit cost-containment tool employed by middle-market companies, those that self-insure are carving out their pharmacy benefits from their medical plans, contracting with pharmacy benefit managers either directly or through coalition-led group purchasing initiatives.

Some employers are using a technique that has worked to trim medical costs: narrow pharmacy networks, which work like narrow provider networks by offering discounts to employee benefit plans that send more business their way.

And with specialty drugs becoming more prevalent in the treatment of certain conditions such as cancer, multiple sclerosis and rheumatoid arthritis, midsize employers have begun following the lead of their large-company counterparts by introducing specialty drug utilization management programs, usually led by PBMs.

And, in an effort to stem overall medical costs, growth in the use of value-based insurance design continues among mid-market employers. Though VBID programs require additional investments by employers who either waive or



“There are still those health plans out there that will push back.” Although “the medical’s the bigger piece of the business, they’ll wind up getting into a competitive bidding process and go skinny on the medical piece and use the pharmacy to subsidize the medical.”

Paul Burns, Buck Consultants L.L.C.

lower copayments for patients being treated for certain chronic conditions, most employers that adopt this strategy believe they will save money over the long run.

Pharmacy benefits carve-outs continue to be a popular way for midsize employers to focus on and manage their prescription drug expenditures, expert say.

“We are seeing heightened interest among midsize employers in exploring carve-out models through coalitions or group purchasing arrangements,” said Nadina Rosier, North America group and health benefits practice leader for pharmacy at Towers Watson & Co. in New York.

Carving out pharmacy benefits via a coalition enables midsize employers “to pull together with other employers to leverage their purchasing power,” said Lisa Zeitel, senior vice president and national pharmacy practice leader at Aon Hewitt in Norwalk, Conn. “This enables them to access pricing negotiated based on the group size versus the individual employer size. Size still does matter with pharmacy benefits, though not as much as five to 10 years ago.”

However, “the employer must be willing to self-insure their health benefit so that they can carve out the pharmacy piece,” she said.

In the past, many insurers with in-house PBMs have resisted such efforts by self-funded midsize employers to separate the administration of prescription drug benefits from medical benefits, usually by raising fees on administrative services-only contracts for self-funded benefit plans, industry sources say.

“There are still those health plans out there that will push back,” said Paul Burns, national

pharmacy practice leader for Buck Consultants L.L.C. based in Atlanta. Although “the medical’s the bigger piece of the business, they’ll wind up getting into a competitive bidding process and go skinny on the medical piece and use the pharmacy to subsidize the medical. If the PBM gets carved out, that changes the dynamic. Typically, the ASO fee gets changed.”

“Insurers were loading the medical rate between 2% and 3% if the employer carves the pharmacy benefits out,” said Stephanie Ward, vice president of account management at Corporate Synergies in Mt. Laurel, N.J.

After a dispute last year between Express Scripts Inc. and Walgreen Co. that temporarily kept the popular Deerfield, Ill.-based drugstore chain out of ESI’s network, more and more midsize employers are introducing narrow pharmacy networks, experts say.

In fact, “most plan sponsors actually chose to keep (Walgreens) out of network when they did come back in late last year,” said Sean Donnelly, president of the commercial division at Express Scripts in St. Louis. “Over 60% of our book of business is now in a narrow network that doesn’t include Walgreens.”

Mr. Donnelly said that “roughly 70% of any given employer’s membership is already using a narrow network pharmacy.”

Buck’s Mr. Burns estimated that narrow pharmacy networks usually “save 1% or 2% off the use of the larger network.”

TOP 5

PHARMACY BENEFIT MANAGEMENT COST CONTAINMENT TOOLS USED BY EMPLOYERS



1
Multitiered drug formularies that promote generic utilization



2
Narrow pharmacy networks to leverage deeper discounts



3
Carving out pharmacy management to PBMs



4
Specialty drug utilization management



5
Value-based insurance design

PLAN DESIGNS PROMOTE USE OF GENERIC DRUGS TO SAVE MONEY

With generic drugs continuing to cost significantly less than their brand name counterparts, employers increasingly are implementing plan designs that promote their use.

“At some point, you’re going to see formularies that are just generics,” said Brian Anderson, a consultant at Milliman Inc. in San Diego. “I’m not sure where the tipping point is, but we see clients with over 80% generic dispensing rates.”

Stephanie Ward, vice president of account management at Corporate Synergies in Mt. Laurel, N.J., said almost all of her clients are creating multitiered formularies, where generics are either free or as little as \$5 per prescription, and then “really hik-

ing up copays for brand and nonformulary drugs to get people to go to generics.”

Midsize employers “are capitalizing on the generic wave,” said Nadina Rosier, North America group and health benefits practice leader for pharmacy at Towers Watson & Co. in New York. “Some 30 brand name drugs lost patent in this last year.”

“While we recognize there are drugs where the generic may not be as clinically effective, there are many studies that show that generics are highly effective to treat nine out of 10 patients.”

By Joanne Wojcik



BUSINESS INSURANCE

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SESSIONS DAY 1

MARCH 5TH, 2013

Session: Emerging Markets

Case Study: **Richard J. Coyle**, executive director, Emerging Markets Institute, Samuel Curtis Johnson Graduate School of Management, Cornell University

Panelist: **Scott McHugh**, criminology department faculty member, Texas A&M University San Antonio

MARCH 5TH, 2013

Session: Cloud Computing

Case Study: **Emily Cummins**, director of tax and risk management at the National Rifle Association

Panelists:

Scott Godes, partner ,
Dickstein Shapiro L.L.P

Doug Pollack, chief marketing officer, ID Experts

Innovation Awards Luncheon and Session

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U.K. regulator slams cost of Europe's new rules

■ A senior official at the United Kingdom's financial watchdog said the "shocking cost" of Europe's new solvency regulations could not be justified, given that they are expected to total billions of pounds to implement. Solvency II aims to better protect consumers by insisting insurers improve risk management and more closely match their capital to the risks on their books. But the rules have faced repeated delays amid industry lobbying to change details, such as the treatment of investments.

Reuters

IRM creates education advisory board

■ The Institute of Risk Management has announced the composition of its new education advisory board. The London-based IRM said the advisory group is intended to act as a high level "sounding board" to provide guidance on the development of its qualifications. The board comprises 29 risk academics and practitioners from Australia, Belgium, Canada, Denmark, Finland, France, Hong Kong, Luxembourg, Malaysia, Singapore, South Africa, the United Kingdom and the United States.

7 European countries up premium tax rates

■ Seven countries in Europe have increased insurance premium tax rates for 2013, according to research by the London-based International Underwriting Association, which represents underwriters in the London company insurance market. Cyprus, Denmark, France, Finland, Hungary, Italy and the Netherlands all have introduced tax rises some of which came into force on Jan. 1, and others which will take effect over the course of this year.

Bermuda will not apply Solvency rules to captives

■ The Bermuda Monetary Authority confirmed that it will not apply a Solvency II-style regulatory regime to captives. In setting out its 2013 business plan, the BMA said that while the regulator plans to implement refined reporting requirements for captives, it would not apply Solvency II-equivalent rules to captives. Bermuda is developing a regulatory regime for insurers and reinsurers that is intended to be equivalent to Sol-

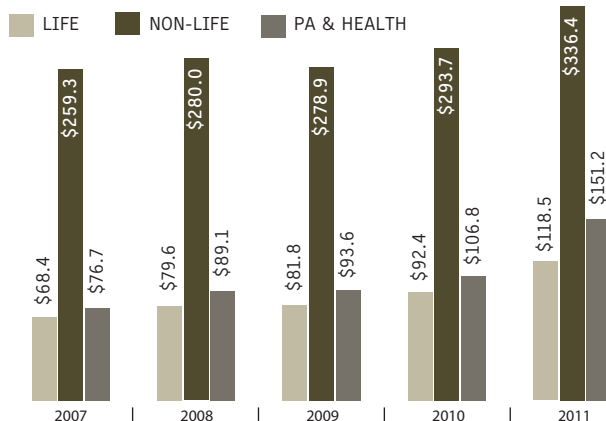
PROFILE: GUATEMALA

\$336.4
MILLION

The insurance market in Guatemala is adapting to the country's new insurance law enacted in 2010. Property/casualty premiums increased 14.5% to \$336.4 million in 2011, the latest year for which figures are available. Last year, several foreign insurers entered the market, and more new players are expected. El Roble, the fourth-largest insurer in Central America, remains the biggest property/casualty insurer in Guatemala with a market share of 26.4%. As of Dec. 31, 2011, there were 17 insurance companies registered with authorities, including one state-owned insurer.

◀ P/C premiums in 2011

MARKET GROWTH IN MILLIONS OF U.S. DOLLARS



COMPULSORY INSURANCE

- Third-party liability and other covers for transporting oil and oil products
- Aviation liability
- E&O and fidelity coverage required for insurance agents and brokers
- Third-party liability cover and employee group life insurance for private security companies
- Goods stored in general warehouses

NONADMITTED INSURANCE

Nonadmitted insurance is not permitted because Guatemalan law mandates that insurance must be purchased from local insurers. The provisions explaining this requirement are contained in the nation's new insurance law. Exceptions include commercial marine, aviation and space satellites, international cargo and reinsurance

INTERMEDIARIES

For the first time, brokers are recognized under the country's new insurance law. Individual and corporate agents are required to register with the nation's superintendent of banking. Broker sales of unregistered insurance policies are prohibited. Brokers who sell policies from nonadmitted insurers are subject to a fine and up to three years in prison.

MARKET PENETRATION

At 1.24%, market insurance premiums as a percentage of gross domestic product are the lowest compared with other countries in the region.

Information provided by Axco Insurance Information Services.
www.axcoinfo.com



POPULATION

14.4 million

AREA

42,043 square miles

ECONOMIC GROWTH

3.2% estimated for 2013

NATIONAL LEADER

President Otto Perez

MARKET DEVELOPMENTS

UPDATED JANUARY 2013

- Effective Jan. 1, 2013, the corporate tax rate was reduced to 25% from 31%. The higher rate had been in effect since July 2000.
- In November 2012, a 7.4-magnitude earthquake struck the Pacific coast, killing 52 people and rendering 10,000 homes uninhabitable. Insurers still haven't reported insured losses from the disaster.
- In September 2012, thousands of people were evacuated when the Fuego volcano started to emit ash and lava. It was the worst eruption since 1999, but there were no reported insured losses.
- In July 2012, the nation's civil aviation authority revealed it had not renewed the insurance policy covering Guatemala's airports when it expired in 2010. The reason was that the state-owned insurer did not cover claims arising from volcanic ash that fell at the airports in May 2010.
- Although the insurance market is adapting well to the new state insurance law, escalating competition and new players might put pressure on profit margins.

veny II, the risk-based capital regulatory regime for insurers and reinsurers in the European Union slated for introduction in 2016.

European regulator sees more cooperation

■ The European Insurance and Occupational Pensions Authority said there were improvements in cooperation and communication between colleges of supervisors of cross-border insurance groups during 2012. The Frankfurt, Germany-based regulator said that, for 2013, its action plan for colleges of supervisors would focus on the development of a common understanding of risks and on further alignment of work on the application of internal models in the run-up to the implementation of Solvency II. EIOPA said there were 91 insurance groups with cross-border operations in the European Economic Area compared with 89 in 2011. Of those 91 insurers, 78 had

colleges of supervisors, compared with 69 in 2011, it said. The European Economic Area is made up of the 27 member states of the European Union, Iceland, Liechtenstein and Norway.

Marsh's risk map shows increase in violence

■ The number of countries experiencing escalating political violence has risen by 36% from a year ago, according to a political risk map released by a Marsh Inc. unit and a risk analysis and mapping company. Thirty-eight countries, or nearly one in five of those analyzed, are experiencing escalating political violence, up from 28 in 2012, according to the Political Risk Map 2013 issued by Marsh's global political risk and trade credit practice and Bath, England-based Maplecroft. The map highlights political risks across 197 countries, including conflict, terrorism and regulatory and business environments.

Corporate manslaughter cases rise in U.K.

■ The number of corporate manslaughter cases opened by the U.K. Crown Prosecution Service rose by 40% last year, according to research by law firm Pinsent Masons L.L.P. The CPS opened 63 cases in 2012, compared with 45 in 2011, according to the research. Currently, 56 cases are being investigated, Pinsent Masons said. Since 2009, when the first cases of corporate manslaughter were brought, there have been 141 cases opened, the law firm said.

More typhoons expected in Asia

■ The number of typhoons in east and southeast Asia likely will increase in coming months, according to a study by Munich Reinsurance Co. and Deutsches Zentrum

fur Luft-und Raumfahrt e.V., the Cologne-based German Aerospace Center. Typhoon losses in the region are affected by climate oscillation that alternately leads to periods of about 10 years with more or fewer windstorms.

Bermuda eliminates work permit term limits

■ The government of Bermuda said it has eliminated its work permit term limit policy for non-Bermudian workers, effective immediately. The suspension of the term limits, which allowed expatriates to work in Bermuda for a maximum of nine years, will help the country's large contingent of captive and reinsurance companies attract top talent, insurance industry experts say. The controversial policy, effective in 2001, intended to prevent permit approval from leading to permanent residence rights for non-Bermudians.

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SESSIONS DAY 2

MARCH 6TH, 2013

Session: Reputational Risk

Case Study: **Chris Gidez**, co-chair of the Global Crisis Practice at Hill+Knowlton Strategies

Panelists: **Larry Walsh**, vice chairman, the Hawthorn Group

Shannon M. Wilkinson is founder and president of Reputation Communications in New York.

MARCH 6TH, 2013

Session: Mergers & Acquisitions

Case Study: **James R. Loughlin**, Director of Risk Management Insight Portfolio Group LLC, the risk management services company for Icahn Enterprises

Panelists: **Joseph W. Bauer**, Principal at Bauer Advertising LLC, member of the Council of Chief Legal Officers of The Conference Board

Meghan Magruder, partner at King Spalding

Risk Manager Only Session

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EDITORIAL

REFORM LAW'S INCONSISTENCY HITS WORKERS

It's hard to see any logic behind a provision in the health care reform law that offers an affordability-based federal premium subsidy for individual coverage but not family coverage. The law says if the premium an employer charges for individual health care coverage exceeds 9.5% of household income, the coverage is unaffordable. That makes the employee eligible for premium subsidies to purchase coverage in public health insurance exchanges.

But the law is silent on an affordability test for family coverage. And that has big consequences for lower-income employees whose employers require them to pay most of the premium if they want to receive family coverage. Those employees may not be able to afford coverage provided by their employers, yet will not be eligible for premium subsidies from the government.

Lawmakers' central goal in drafting the health care reform legislation was to reduce the number of uninsured, so why they chose to exclude family coverage from the affordability test is perplexing.

Unfortunately, because of the way the bill was passed, there are no clues for that decision. Normally, when the House and Senate pass different versions of a bill, a conference committee is set up, differences are ironed out, and a final report detailing the changes is prepared before the House and Senate vote for a final time.

In the case of the health care reform law, there was no conference report and, for that matter, no conference committee. As a result, the landmark measure did not get the scrutiny it deserved.

And that is only one big problem. A much bigger one was that Republican members stayed out of the drafting process, due in part to a decision by the GOP leadership to stay on the sidelines and in part because Democrats weren't much interested in GOP input.

Regardless of the reasons, we know the public is the loser when major pieces of legislation are put together by only one party. No one party has a monopoly on good ideas, and the Patient Protection and Affordable Care Act would have been a much better measure had both parties worked together in crafting it.

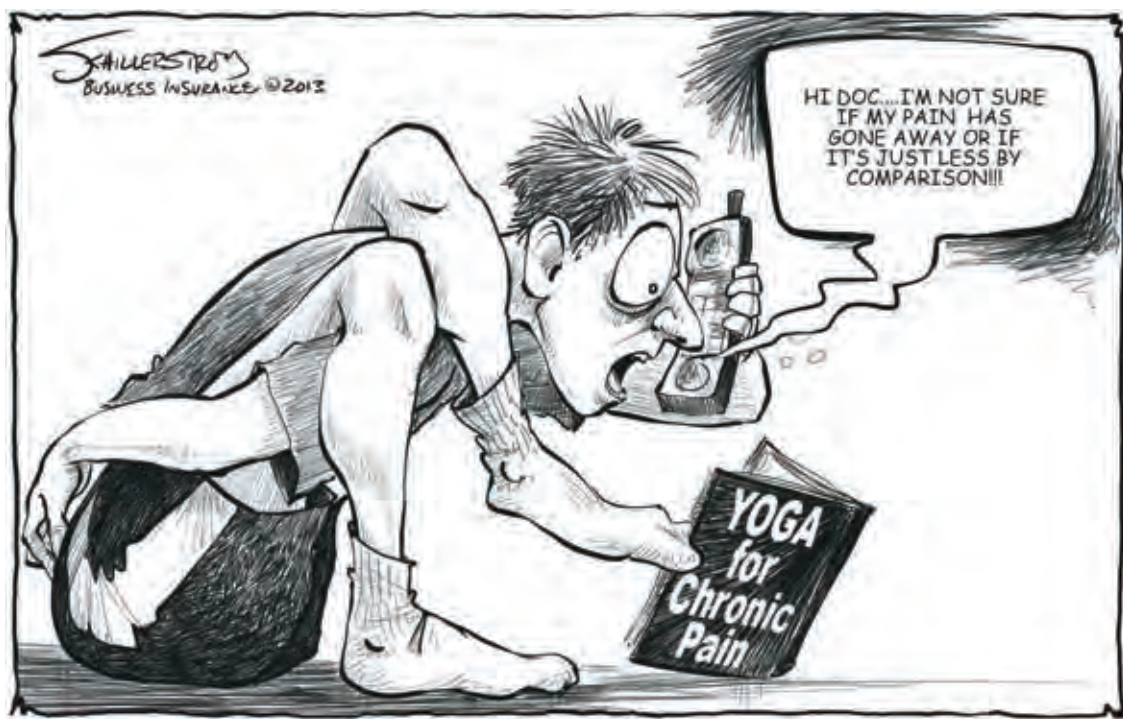
We hope that lesson is not lost on lawmakers and that bipartisanship will again become the order of the day.

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Fax: 312-280-3174; email: gsouter@businessinsurance.com

SCHILLERSTROM



COMMENTARY

Employees should tap new resource to achieve weight-loss goals

Many workers who resolved to lose weight and get in shape this year may get a little help from Obamacare.

The Patient Protection and Affordable Care Act requires that health insurers cover obesity screening and weight management without any cost-sharing. This landmark health care reform law also mandates that Medicare, Medicaid and most employers — including those that are self-insured — cover the cost of these services without copayments or deductibles. The only exceptions are employer-sponsored plans that are grandfathered.

But many people probably are unaware that they can tap this valuable resource in the battle of the bulge, a condition that is becoming one of the leading causes of premature death in this country.

In fact, obesity is one of the many reasons why U.S. residents are less healthy and die younger than people in other wealthy countries, according to a report last month by the National Research Council and Institute of Medicine. Two-thirds of U.S. residents are either overweight or obese, noted the report, which also found people on average consume more calories than people in most similar countries. Americans also are less active than citizens of other similar nations.

Historically, many U.S. insurers and employers did not cover obesity treatment. But the PPACA paves the way for health plan members to obtain coverage for a variety of proven health promotion services, including weight management and counseling to quit smoking, another major contributor to America's unhealthy nation status.



**JOANNE
WOJCIK**

SENIOR EDITOR

Research has shown that removing financial barriers creates a strong incentive for patients to seek out preventive health care services. Such value-based insurance designs also can lower health benefit costs for employers, as has been demonstrated by the American Health Strategy Project, a VBID program sponsored by the

Washington-based National Business Coalition on Health.

Obesity is expensive, accounting for nearly 21% of U.S. health care costs, an astounding \$190 billion annually. Obese men rack up an additional \$1,152 a year in medical spending on things such as hospitalizations and prescription drugs, while obese women use an additional \$3,613 in medical care each year, according to a January 2012 study in the *Journal of Health Economics*.

But addressing obesity won't be easy, even with insurance support. Just like with smoking cessation, it often takes multiple attempts for a person to lose weight, and it's even harder for them to keep it off.

Of the estimated 50 million U.S. residents who go on a diet each year, less than 20% successfully maintain their weight loss, according to Colorado Health Institute research.

SPECIAL REPORT

Health Exchanges &

Health Care Reform Implementation

Opening a new era

Health care reform
opens doors
to big changes

Massachusetts boasts success
in lowering uninsured rate

PAGE 15

Contraceptive mandate
litigation adds uncertainty

PAGE 16

Data poster: Reform law
changing how employers think

PAGE 17

Employers exploring options
to replace 'mini-med' plans

PAGE 21

Rapidly growing exchanges
reshaping group market

PAGE 22

BY JERRY GEISEL

The biggest-ever changes to the nation's health care delivery system are about to be rolled out. Under the nation's health care reform law, millions of lower-income uninsured U.S. residents will be able to use federal premium subsidies to buy policies from commercial insurers participating in public health insurance exchanges during open enrollment periods that begin Oct. 1. Coverage will be effective Jan. 1, 2014.

"Starting in 2014, Americans in all states will have access to quality, affordable health insurance," Department of Health and

See **CHANGES** next page

CHANGES: A new era

Continued from previous page

Human Services Secretary Kathleen Sebelius said in conjunction with the awarding of \$1.5 billion in federal funds to help states develop their exchanges.

The exchanges also will be available, though federal subsidies will not, to higher-income uninsured individuals as well as small employers. Massachusetts and Utah already have set up state exchanges (see stories, below and page 15).

Seventeen states plus the District of Columbia have made commitments to the Department of Health and Human Services to set up exchanges. Other states will work with HHS through partnership agreements in which the states will assume some exchange responsibilities.

For states that decline to set up their own exchanges or enter into partnerships, the federal government will establish exchanges.

In 2014, the exchanges will issue policies to 6 million people eligible for premium subsidies, according to Congressional Budget Office estimates.

In all, about 10 million people, including those working for small employers, will receive coverage through exchanges in 2014.

By 2016, total exchange enrollment will exceed 26 million, including 18 million people using federal premium subsidies, 4 million purchasing unsubsidized coverage and another 4 million people whose employers purchase coverage through the exchanges, the CBO projects.

The cost to the federal government will be significant. In 2016 alone, the CBO projects that the

government will spend \$85 billion on premium subsidies, with exchange enrollees receiving an average of \$5,210 to offset the cost of coverage.

"Billions of dollars will be spent to provide coverage to the uninsured," said Helen Darling, president of the National Business Group on Health in Washington.

The law also will affect what are known as "mini-med" health plans (see story, page 21).

Separately, employers have found success in deploying coverage provided by private health insurance exchanges (see story, page 22).

It is an expansion of coverage that is unprecedented in size, said Frank McArdle, an independent benefits consultant in Bethesda, Md.

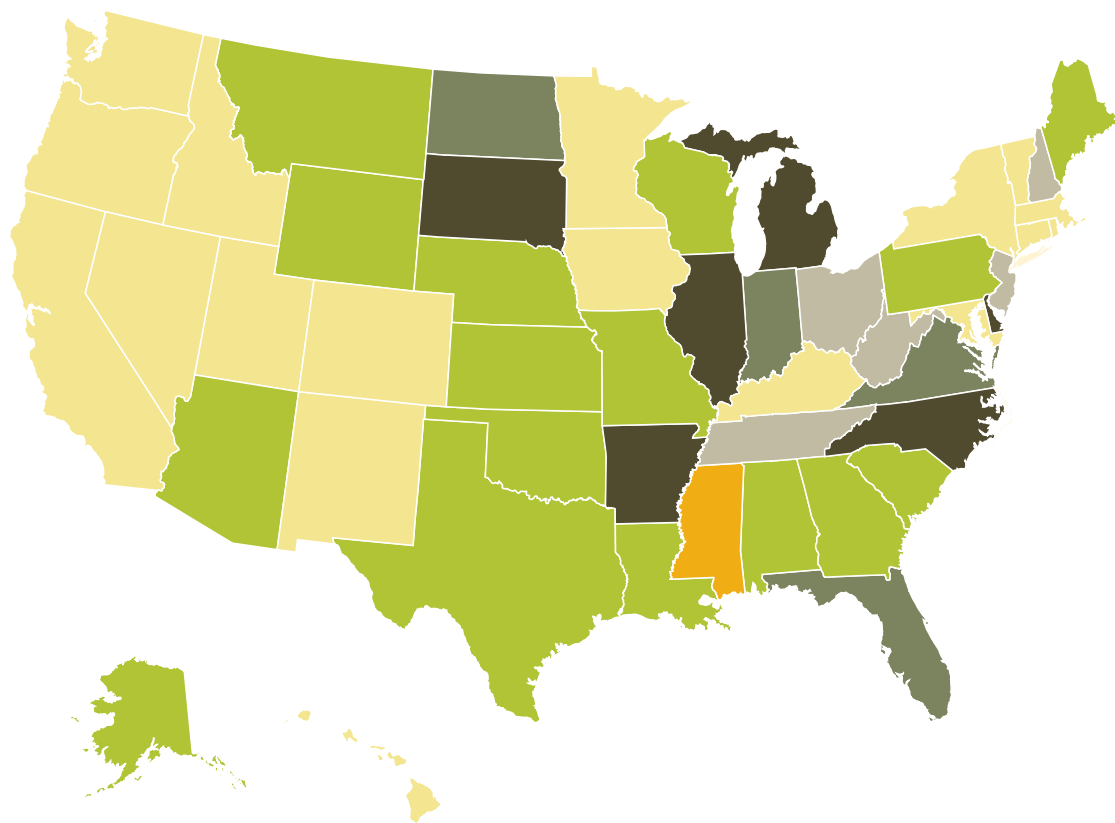
While the uninsured clearly will benefit from that expansion of coverage, employers could benefit as well. To the extent that more people have coverage, health care providers will incur less uncompensated care, a cost they now pass on to those that have coverage, which drives up group health care costs and premiums.

"The vision of lawmakers was, if we have more insured, cost-shifting is alleviated," Mr. McArdle said.

While no one knows how accurate those exchange enrollment projections will be, benefit experts say many states are moving full speed ahead to set up their exchanges.

"States have been working non-stop to get it done," Ms. Darling said.

"Some states are in very good shape," said Carolyn Pearson, a director at health care consultant



INSURANCE EXCHANGES

The federal government will be a major force in public insurance exchanges mandated under the health care reform law. The federal government will run or is likely to run exchanges in 20 states or districts, and will partner or is likely to partner with another 12 states.

- HHS-approved state-run
- State-run (blueprint submitted)
- State-federal partnership
- Likely partnership
- Federal
- Likely federal

Source: Avalere Health L.L.C.

Avalere Health L.L.C. in Washington. In particular, she cites California, Connecticut and Oregon as making rapid progress in developing their exchanges.

An unknown, though, will be the ability of the federal government to set up exchanges in more than

two dozen states. When Congress passed the Patient Protection and Affordable Care Act in 2010, the expectation was that nearly every state would set up an exchange, Ms. Pearson said.

"Lawmakers clearly had hoped and anticipated that states would

do it — with a federal fallback," Mr. McArdle said.

"The feds will be challenged to get it done," Ms. Darling said.

Legal uncertainties also remain. The biggest unknown may be the outcome of a lawsuit filed last year by Oklahoma Attorney General Scott Pruitt charging that, under the health care reform law, premium subsidies are available only to those buying coverage in state insurance exchanges (see story, page 16).

If his suit — now pending before a U.S. District Court in Muskogee, Okla. — is successful, millions of uninsured U.S. residents obtaining coverage in federal exchanges would not be eligible for the subsidies, making the coverage unaffordable, resulting in a much smaller reduction in the number of uninsured than had been projected.

But some benefit experts are skeptical that the suit will succeed.

"I personally would not put a lot of money on that lawsuit," Mr. McArdle said.

Federal regulators clearly believe they have authority to provide premium subsidies in federal exchanges, Ms. Pearson said.

Utah's exchange program 'a win-win'

While the Massachusetts Connector is the best-known state health insurance exchange, health insurance policies also have been available in Utah's exchange, known as Avenue H, since 2011.

But Avenue H differs in a key way in that there are no premium subsidies.

Avenue H is offered only to employers with up to 50 eligible full-time employees — those working at least 30 hours a week.

Rather than state-provided premium subsidies, Avenue H uses a defined contribution model in which employers allocate a flat amount of money for employees to use to purchase coverage from the three insurers that participate in the exchange: Regence Blue Cross/Blue Shield, Regence BlueCross BlueShield of Utah, SelectHealth Inc. and United Healthcare Services Inc.

If an employee selects a high-deductible health plan that costs less than the employer's contribution, the employee could, for example, put the difference in a health savings account and later withdraw HSA contributions to pay for uncovered health care expenses.

"This defined contribution model really gives more choice to all sides: Employers choose to contribute an amount that fits their overall budget, while employees shop for the health care option that best fits their family needs," said a spokesman for Avenue H.

"So far, considering our 92% renewal rate, it seems like a win-win for everyone involved," he added.

Currently, 335 employers obtain coverage through Avenue H to cover 2,840 employees and a total of 8,016 lives.

By Jerry Geisel

"So far, considering our 92% renewal rate, it seems like a win-win for everyone involved."

MASSACHUSETTS BOASTS SUCCESS IN LOWERING UNINSURED RATE

State's program was inspiration for national health care reform law

BY JERRY GEISEL

Massachusetts' trailblazing health insurance exchange programs authorized under the state's 2006 health care reform law have reduced its uninsured rate to the lowest in the nation and provided a new source of coverage for other individuals and small employers.

Nearly 200,000 uninsured state residents with incomes up to 300% of the federal poverty level, \$70,550 for a family of four in 2013, now receive state premium subsidies to buy coverage from five insurers — Boston Medical Center HealthNet Plan, Network Health, Fallon Community Health Plan, CeliCare and Neighborhood Health Plan — through the Commonwealth Care exchange program.

Those same five insurers, plus four others — Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan and Health New England — offer nonsubsidized coverage through the Commonwealth Choice program to individuals and employers with up to 50 employees.

In all, just more than 43,000 people have coverage through Commonwealth Choice, including about 4,700 employees and dependents working for small firms.

While the uninsured rate in most states has increased or shown lit-

tle change since 2006, according to annual surveys by the U.S. Census Bureau, Massachusetts has gone in the opposite direction due to the subsidized coverage and expanding its Medicaid program.

In 2006, 9.6% of Massachusetts residents were uninsured. In 2011, the most recent year available, 3.4% of the Massachusetts' population lacked coverage, the lowest uninsured rate of any U.S. state and far less than the national uninsured rate of 15.7% in 2011, according to the Census Bureau.

Success extends beyond reducing the uninsured rate.

For example, according to a survey by the Connector Authority, which administers the exchange programs, 77% of state residents were satisfied or extremely satisfied with Commonwealth Care and 80% rated the exchange's choice of providers as excellent.

Massachusetts' success made it a closely watched model when federal lawmakers crafted health care reform legislation in 2009.

The exchange concept is a key element of what became the Patient Protection and Affordable Care Act. That law authorizes states to set up insurance exchanges where lower-income uninsured — those with incomes up to 400% of the federal poverty

level, which is \$94,200 for a family of four in 2013 — can use federal premium subsidies to purchase coverage starting in 2014. Small employers also will be able to buy coverage through the exchanges.

It will be some time, though,

The Massachusetts exchange programs have "made insurance available to small groups and to individuals. That has been its primary mission, and that mission has been a success."

Philip Edmundson,
William Gallagher Associates
Insurance Brokers Inc.

before it is known if those exchanges will be as successful as Massachusetts in reducing the number of uninsured.

The Massachusetts exchange programs have "made insurance available to small groups and to individuals. That has been its primary mission, and that mission has been a success," said Philip Edmundson, chairman and CEO of

William Gallagher Associates Insurance Brokers Inc. in Boston.

Experts say there are several lessons that other states and the federal government can learn from Massachusetts' success, including not interfering with coverage offered by employers.

"That is one of the positive attributes of the law. It built on the current system. It did not disrupt what employers had been doing," said Richard Lord, president and CEO of Associated Industries of Massachusetts, an employer association based in Boston.

But Massachusetts had an advantage in that its uninsured rate was among the nation's lowest when it began setting up its exchange programs.

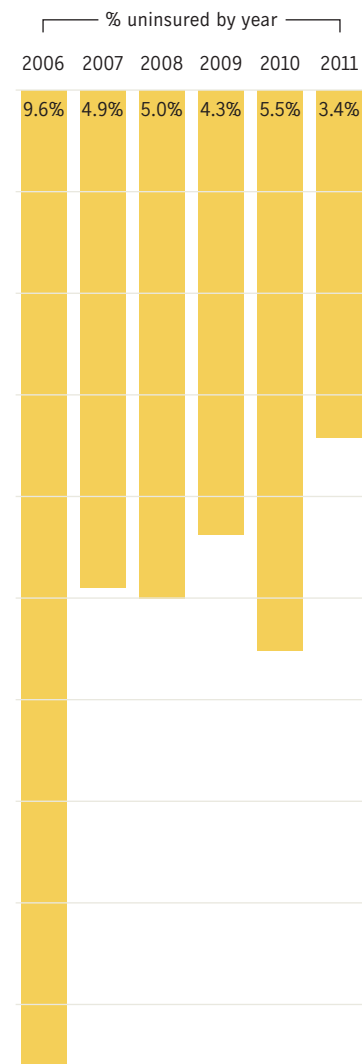
"The gap was much smaller than other states. It will be a bigger challenge in other states," Mr. Edmundson said.

Still, the exchanges have not solved all of the state's health insurance problems. Provider cost-shifting continues chiefly because the state's Medicaid program does not adequately compensate providers, experts say.

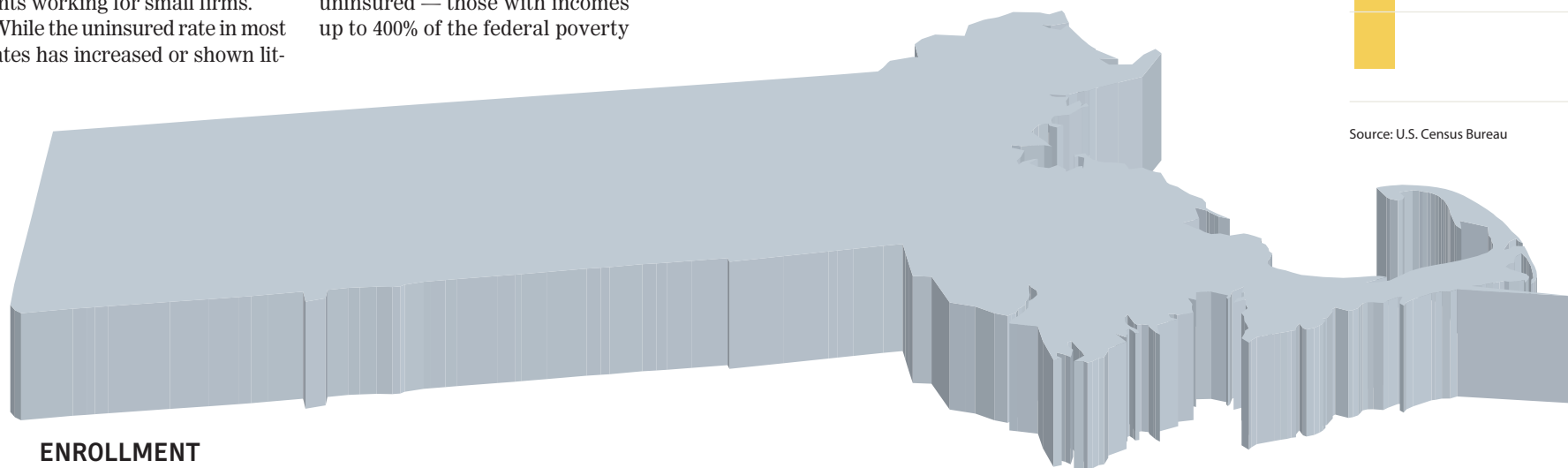
"That still is a significant problem," said AIM's Mr. Lord.

UNINSURED RATE

Massachusetts' uninsured rate has dropped dramatically since passage of the state's landmark health care reform legislation in 2006.

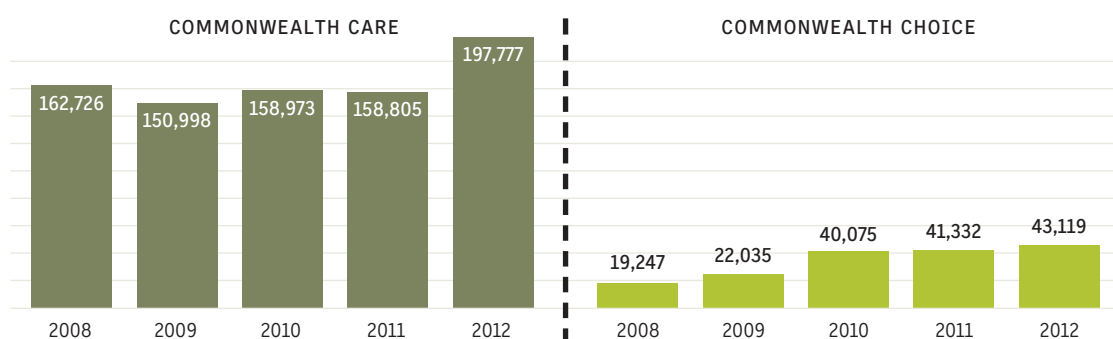


Source: U.S. Census Bureau



ENROLLMENT

The number of people getting health insurance through Massachusetts' two state health insurance exchange programs topped 240,000 in 2012, up from nearly 182,000 in 2008. Enrollment by year*.



*Measurement taken in December.
Source: Massachusetts Health Connector

REFORM LAW OPPONENTS STILL BATTLING AGAINST FULL IMPLEMENTATION

Legal challenges target contraceptive mandate, federal exchanges

BY MATT DUNNING

Despite the U.S. Supreme Court's ruling last year upholding the federal health care reform law's individual mandate, several legal challenges affecting employers' obligations under the law remain unsettled.

Several dozen privately owned companies and nonprofit organizations filed suit in 2012 seeking exemption from a 2011 Department of Health and Human Services rule requiring employers and/or their insurers to provide cost-free contraceptive prescriptions and other preventive care benefits.

In nearly all cases, plaintiffs allege the rule violates their rights to religious expression under the Religious Freedom Restoration Act and the First Amendment.

The rule, which went into effect on Aug. 1, 2012, for nongrandfathered benefit plans, imposes a penalty on companies that do not offer the coverage if an employee uses a federal subsidy to purchase health insurance through a public health insurance exchange.

Certain types of religious employers are exempt from the contracep-



"Because the central issue of these cases seems to be of great importance as part of the health care reform act, and given that there could be a significant split among the appeals courts, it's certainly possible that this could find its way to the Supreme Court."

Nicole Bogard,
Seyfarth Shaw L.L.P.

tive coverage requirements. Initially, the exemptions were limited to houses of worship and affiliated organizations. On Feb. 1, HHS proposed a rule extending exemptions to religious nonprofit organizations, such as health care providers, universities and other charities.

Under the proposals, an exempted organization's group health plan members would be offered no-cost contraceptive coverage through separate, individual health care plans directly administered by insurers or, if an employer self-insures their group health benefits, by a third-party administrator.

The exemptions do not include for-profit employers, regardless of their religious convictions. Nonetheless, experts said it may be difficult for those employers to prove that the coverage requirement substantially infringes on their right to religious expression.

"It's a bit of a more compelling issue for the self-insured market because they're paying for the benefits directly as opposed to paying through premiums, but I still don't know if that means they'll succeed at trial," said Steve Wojcik, vice president of public policy at the

Washington-based National Business Group on Health.

While no suit has yet received a final verdict, several district and appeals courts have issued varying rulings on employers' requests for temporary exemptions from the rule pending the outcome of their suits. Experts say the disparate court rulings indicate the issue is destined to go before the U.S. Supreme Court.

"Because the central issue of these cases seems to be of great importance as part of the health care reform act, and given that there could be a significant split among the appeals courts, it's certainly possible that this could find its way to the Supreme Court," said Nicole Bogard, an Atlanta-based partner at Seyfarth Shaw L.L.P.

The other significant challenge to the health care reform law's implementation concerns the availability of federal premium subsidies for health insurance purchased through public exchanges.

In September, Oklahoma Attorney General Scott Pruitt asked a federal judge to overturn an Internal Revenue Service rule penalizing employers whose employees

use subsidies to buy coverage through any public insurance exchange. The suit argues that the health care reform law's original language allows the government to offer subsidies for insurance purchased only through state-run exchanges, and not through exchanges operated by the federal government.

Experts said a ruling in favor of Mr. Pruitt's claim could threaten the very framework of the health care reform law since it would limit the government's ability to enforce minimum coverage requirements for employers in states that refuse to establish insurance exchanges, as well as provide access to subsidized coverage for millions of lower-income uninsured adults.

However, experts said, it remains unclear if the court will reach a consideration of the merits of Mr. Pruitt's case, as the state first must prove that it has a legal standing to challenge the IRS rule.

"That's going to be a difficult challenge for the state," Ms. Bogard said, noting that the Oklahoma suit does not establish that the state — as an employer — would be subject to the tax penalties.

Most employers still plan to offer health care coverage after reforms take effect

BY JERRY GEISEL

Despite increased costs and opposition to the health care reform law, the overwhelming majority of employers intend to keep providing health care coverage for their employees, according to a *Business Insurance* survey.

Eighty-two percent of respondents said they will continue to offer coverage in 2014, the first year that public health insurance exchanges will be available for individuals to purchase coverage.

Just 17% of respondents said they will explore terminating coverage and increasing employees' salaries to help offset premiums employees would pay to buy coverage in exchanges.

Just 1% said they would terminate coverage (see poster, page 17).

Competition for needed employees is the top reason employers said they will con-

tinue offering coverage after exchanges start operating, with 63% saying they have to continue to sponsor plans to remain competitive.

In addition, 25% said they thought it is their obligation as employers to provide coverage to their workforces, while 5% said the cost of eliminating coverage would exceed the costs of continuing it.

Those costs would include a nontax-deductible \$2,000 penalty for every full-time employee not offered coverage, plus the cost of boosting employees' salaries to offset premiums the employees would pay for those employers that decide to do so.

The passage of time, though, has not lessened employer opposition to the Patient Protection and Affordable Care Act. In fact, 62% of respondents said employer opposition to the reform law has increased in the past two years.

Sixty-one percent of employers expect

the law to increase their health insurance costs over the next five years.

When asked if there is one health care reform law provision they hope Congress repeals, nearly one-third of respondents backed repeal of the penalty on employers that do not offer coverage or offer coverage that flunks a health care reform set affordability test. Under that test, employers are liable for a \$3,000 penalty for each full-time employee whose premium payment for single coverage exceeds 9.5% of household income.

In addition, 29% of employers said No. 1 on their list of provisions for Congress to repeal is a \$2,500 annual cap on employee contributions to health care flexible spending accounts that went into effect Jan. 1.

The survey, which was conducted for *Business Insurance* in December by Signet Research Inc., is based on the responses of 343 employers.

Just 17% of respondents said they will explore terminating coverage and increasing employees' salaries to help offset premiums employees would pay to buy coverage in exchanges.

EMPLOYER ATTITUDES TOWARD HEALTH CARE REFORM



Gauging employer reactions and responses
to Patient Protection and Affordable Care Act



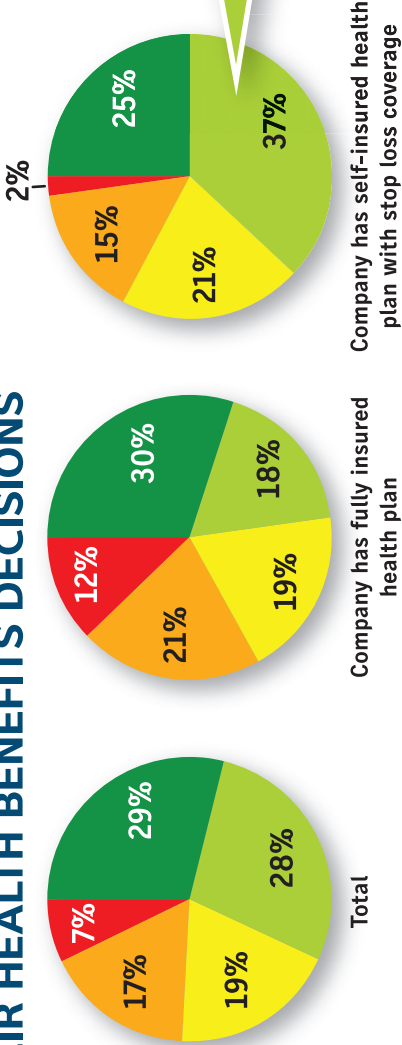
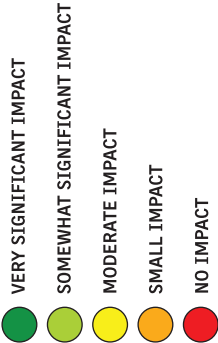
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HEALTH CARE REFORM LAW

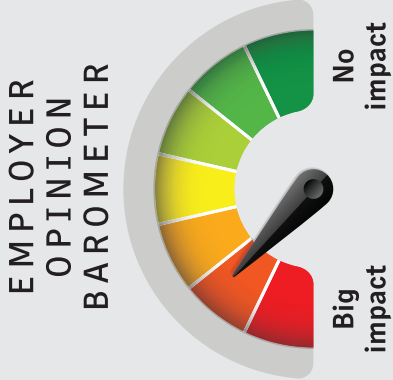
IS CHANGING THE WAY SOME EMPLOYERS THINK ABOUT EMPLOYEE BENEFITS

EMPLOYERS SAY THE LAW IMPACTS THEIR HEALTH BENEFITS DECISIONS

How do you think the health care reform law has or will impact your company's health benefits decisions?



INSIGHT: Self-insured companies are more likely than fully insured companies to expect the reform law will have an impact on their health benefits decisions.

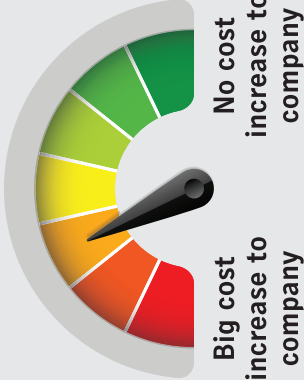


EMPLOYERS ALSO EXPECT IT WILL INCREASE HEALTH BENEFIT COSTS

Expected impact of the health care reform law on company's health insurance costs over the next 5 years

	Total	Public	Private	Nonprofit	Gov't.
REDUCE/NO IMPACT (NET)	5%	4%	4%	6%	8%
Will reduce overall costs	0%	0%	1%	0%	3%
Will have no impact on costs	4%	5%	4%	6%	5%
INCREASE COSTS (NET)	61%	53%	67%	66%	50%
Will increase costs slightly	12%	13%	12%	16%	8%
Will increase costs moderately	25%	20%	24%	32%	34%
Will significantly increase costs	24%	20%	31%	18%	8%
UNKNOWN	34%	43%	29%	28%	42%

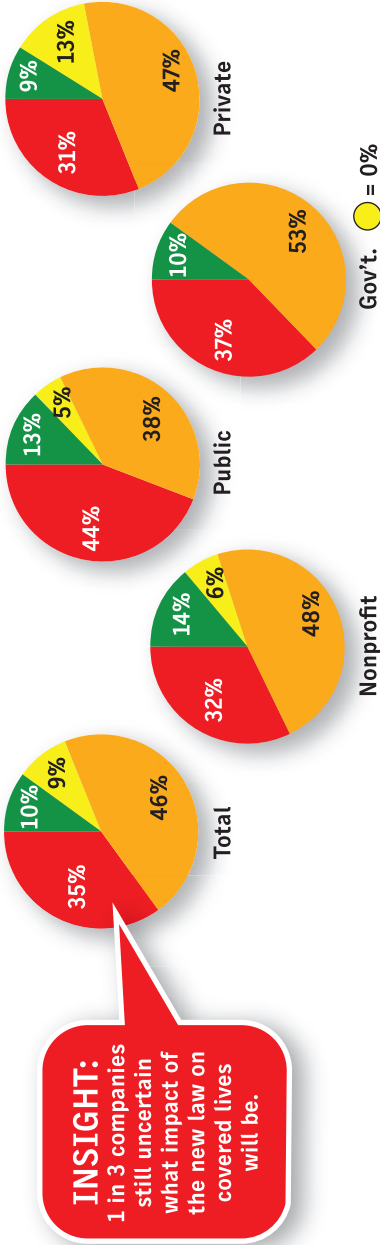
INSIGHT: 1 in 3 companies still uncertain what impact of the new law on costs will be.



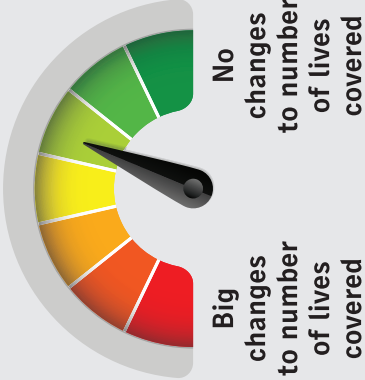
NEARLY HALF DO NOT EXPECT CHANGES IN NUMBER OF PEOPLE COVERED BY THEIR HEALTH PLANS

Which of the following is the most likely company response to the health care reform law?

- Increase the number of employees and dependents with health coverage
- Reduce the number of employees and dependents with health coverage
- There will be no changes in the number of employees and dependents with health coverage
- We do not know at this point if there will be any changes



INSIGHT: 1 in 3 companies still uncertain what impact of the new law on covered lives will be.

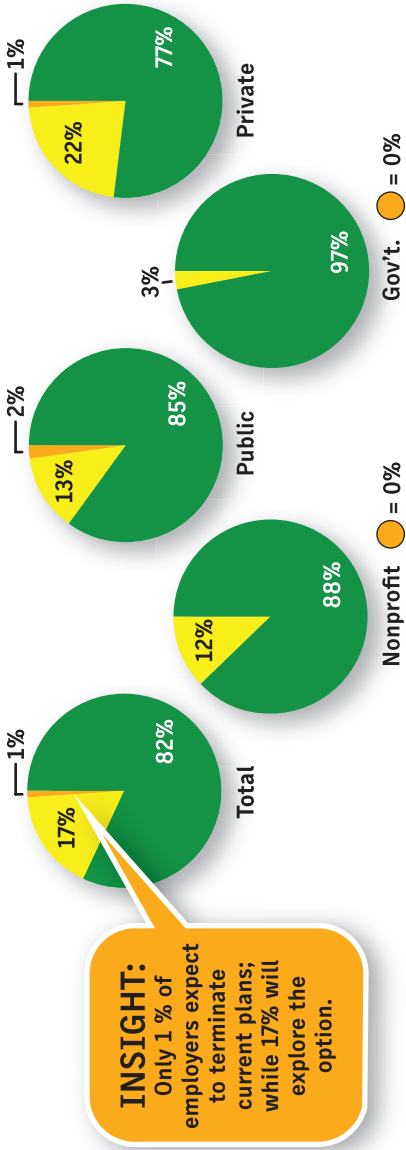


USE OF EXCHANGES WILL BE LIMITED AMONG COMPANIES CURRENTLY OFFERING HEALTH INSURANCE

Most likely company response once public health insurance

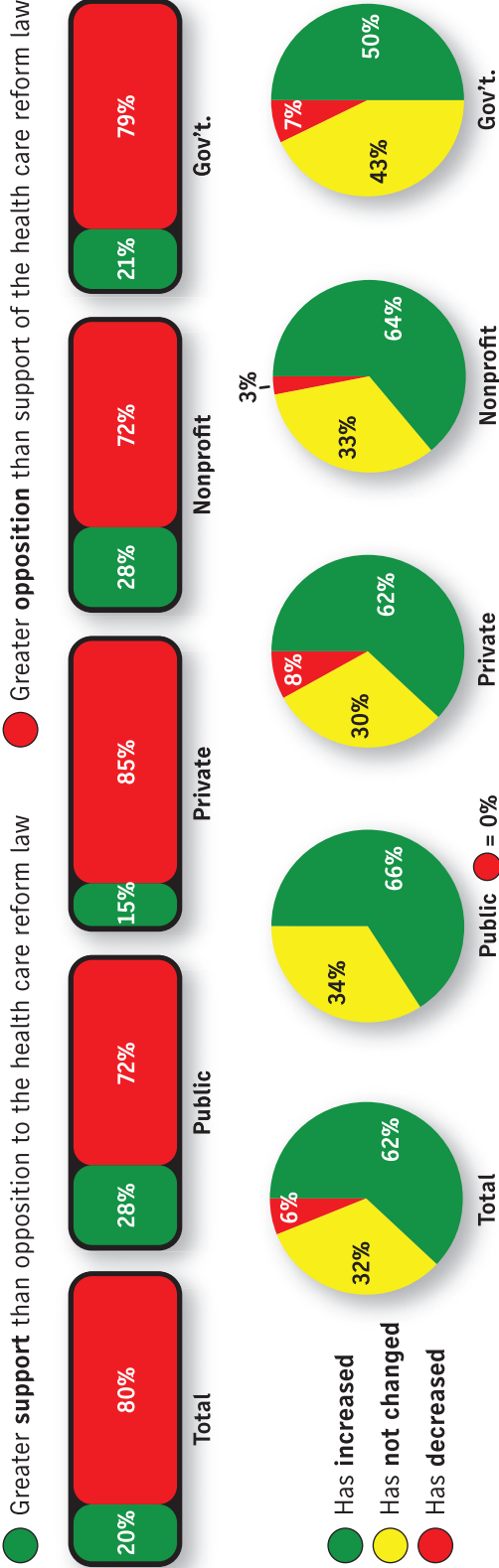
- The company will continue offering employees group health plans as it is doing today
- The company will explore the termination of current health plans and bump up employees' salaries to help offset their cost of buying coverage through an exchange
- The company will terminate coverage and will not boost employee compensation to offset employees' costs when buying health coverage on their own

exchanges are available to the uninsured in 2014

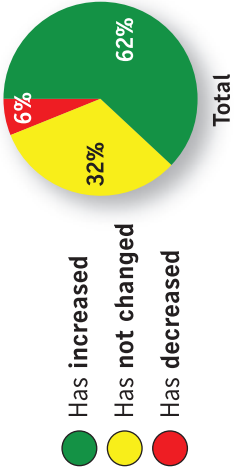


EMPLOYERS SEE SIGNIFICANT – AND GROWING – OPPOSITION TO HEALTH CARE REFORM LAW

Based on your own personal observations, do you think that among employers today there is ...



Do you think that in the last two years, opposition to the health care reform law among employers ...



CONTINUING TO OFFER HEALTH INSURANCE IS AN IMPERATIVE IN TODAY'S COMPETITIVE ENVIRONMENT

What is the main reason for continuing to provide health coverage after insurance exchanges are available?

	Total	Public	Private	Nonprofit	Gov't.
Company must do so to remain competitive	63%	81%	60%	68%	38%
Cost associated with dropping coverage would exceed cost of continuing coverage	5%	4%	7%	0%	3%
It is our obligation as an employer to provide coverage	25%	10%	24%	30%	43%
Other	7%	5%	9%	2%	16%

CHANGES TO THE LAW EMPLOYERS WOULD LIKE TO SEE

If there is one provision of the law that you hope Congress repeals, what would it be?

	Total	Public	Private	Nonprofit	Gov't.
Penalty on employers if they do not offer coverage/do not offer affordable coverage	32%	33%	34%	32%	18%
Penalty on individuals if they do not enroll in a health care plan	13%	15%	14%	6%	24%
Federal premium subsidies to the lower-income uninsured	11%	11%	15%	2%	8%
The \$2,500 cap on flexible spending account contributions	29%	28%	23%	42%	32%
Other provision	15%	13%	14%	18%	18%

All data in this poster was compiled from a survey conducted in December 2012 by Signet Research Inc. on behalf of *Business Insurance*. Signet's analysis was based on completed responses by 343 respondents who actively manage the employee benefit programs for U.S.-based organizations. Respondents were fairly evenly divided by size, with 23% having fewer than 100 employees; 23% with 100 to 499 employees; 29% with 500 to 2,499 employees; and 25% with more than 2,500 employees. All respondents offer some type of employee health insurance plan. By type of plan, 38% offer a traditional fully insured plan; 42% are self-insured with stop loss coverage; 10% are fully self-insured; 8% offer a consumer-driven health care plan; and 2% offer other plan types.



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DESIGNS FOR NEW PLANS UNDER WAY

Designs are being developed to provide affordable coverage for employees now enrolled in mini-med health care plans.

"We're working on alternative designs" for the 20,000 to 35,000 employees and dependents covered by Western Growers Association's multiple employer welfare arrangement, including "a replacement for the 60% who are in mini-med plans," said Jonathan Alexander, compliance counsel for the association in Irvine, Calif.

The association is considering a plan developed by the California Health Benefit Exchange.

"The most affordable (replacement) looks like a high-deductible health plan plus fairly robust coinsurance," Mr. Alexander said. "It may be a replacement, but not a solution," he said in citing higher employee costs.

Limited-benefit or fixed-indemnity plans, which are structured differently than mini-med plans, pay a fixed amount toward hospital and doctor visits, critical illness, accidents and other charges that "are direct out-of-pocket hits" to the employee, said Christopher Covill, benefits product solution leader at Mercer L.L.C. in Atlanta. "There's a whole host of (supplemental) products out there today. I think there will be an absolute growth in that market," he said.

The fixed-indemnity plans are "excepted" from the Patient Protection and Affordable Care Act, said Joe Murgo, president of Strategic Resource Co., a Columbia, S.C., subsidiary of Aetna Inc. specializing in limited benefit insurance plans.

One reason that Aetna's fixed indemnity plans make coverage affordable is they access Aetna's nationwide provider network. Offered as stand-alone products now, they could supplement coverage employees obtain through an exchange to satisfy the individual mandate, he said.

Brian Thompson, vice president of special markets for Transamerica Employee Benefits in Atlanta, said employers that offer mini-med plans have been migrating to limited-benefit plans since 2011. Transamerica offers limited benefit plans that could supplement the exchanges' plans and is developing new products "to cover the new points of risk an employee has in the market today," he said.

By Louise Kertesz

Employers review health cover options with future of 'mini-med' plans in question

BY LOUISE KERTESZ

Employers offering "mini-med" plans are examining their options for when the low-cost plans no longer meet federal health care reform law requirements.

Several million employees and their dependents are enrolled in the plans that offer limited coverage. Common in the retail, service and hospitality industries, the plans often are offered to low-wage, part-time and seasonal employees.

While mini-med plans cap health care expenses they will cover in a year, often \$25,000 to \$50,000, the Patient Protection and Affordable Care Act bans annual dollar limits on coverage starting in 2014.

"Clients of ours are preparing for the worst," said Pat Haraden, a principal at Longfellow Benefits in Boston. "Once you remove the limit on the benefit, it's hard to price a plan that will be affordable."

One strategy is reducing employees' hours to less than 30 hours a week, which is less than full time. That would exempt employers from the \$2,000 per employee penalty if they do not offer coverage or the \$3,000 penalty if they offer health insurance that is considered "unaffordable" because the employee's premium for self-only coverage exceeds 9.5% of wages, qualifying the employee for a federal premium subsidy.

Making employees ineligible for an unaffordable employer plan by cutting their hours to less than 30 a week "would be helping them," Mr. Haraden said.

"Sometimes it's in the employees' best interest to set up a plan so that the lowest-paid employ-

ee can go to the exchange," said Mike Thompson, a principal in PricewaterhouseCoopers LLP's human resource services practice in New York. "Employers are now determining what can we afford to provide and what would employees be subsidized in the exchange."

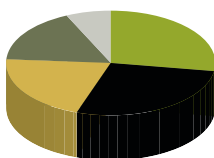
"Employers are going to be thinking through what their workforce is going to look like — whether to transition more employees to part-time and let them buy coverage through the exchanges," said Christopher Covill, benefits product solution leader at Mercer L.L.C. in Atlanta.

But employers have to ask, "How does that affect my ability to run my business on a day-to-day basis?" said Karen Vines, vice president of benefits, governance and compliance at IMA Benefits in Wichita, Kan.

For example, Appearance Group Inc., a Wichita-based company that cleans and details corporate jets, will not cut the hours of its 80 full-time employees to make them part-time, said President Matthew Henry. Instead, it will upgrade its plan for full-time employees and ensure that it meets affordability criteria.

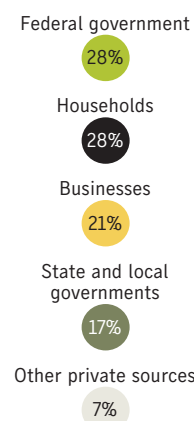
"Low turnover is a key to my business because of the liability of what we're working with," Mr. Henry said. "It's in our best interest to have skilled technicians. I know other industries are cutting back to under 30 hours exclusively, but I don't believe it's right for our company."

Appearance Group has 30 part-time employees who are offered limited indemnity plans. In the future, those employees may choose to purchase coverage through an exchange, he said.



SPENDING SOURCES

U.S. health care spending rose 3.9% to \$2.7 trillion in 2011, or \$8,680 per person. Sources of that funding were:



Source: Centers for Medicaid & Medicare Services

Private health insurance exchanges add extra dimension to market

BY JERRY GEISEL

Private health insurance exchanges are reshaping the group market.

A novelty several years ago, exchanges are growing rapidly as employers look for a middle ground between unsustainable costs at one extreme and no coverage at the other, especially for their Medicare-eligible retirees.

"Employers want to give choices while gaining control over costs," said Maureen Scholl, CEO for exchanges at Aon Hewitt in Lincolnshire, Ill.

At the same time, exchanges, which handle plan enrollment and communications, remove much of the administrative burden from employers.

"Ask any human resources director what their biggest headache is, and they will say administering a health care benefits plan," said John Connor, founder of Transition Assist, a Norwell, Mass.-based exchange. "If they can find a partner, like an exchange, that takes administrative responsibility off their plate but not at the expense of quality, then HR has a sustainable path."

For retirees (see related stories on this page) exchanges mean access to a much wider range of health care plans.

"Exchanges provide more choices, and help employers and employees manage costs," Ms. Scholl said.

"There is a lot of win-win. There is a win for employers and a win for participants," said Bruce Richards, a partner and chief actuary in the Richmond, Va., office of Mercer L.L.C.

Bryce Williams, founder of Extend Health Inc., a San Mateo, Calif.-based exchange, says the exchange has doubled over the past two years to more than 250 employer clients.

"Employers can offer quality benefits at less cost," said Mr. Williams, who also is managing director for exchange solutions at

Towers Watson & Co., which acquired Extend Health in 2012.

Since 2010, Aon Hewitt's exchange for Medicare-eligible retirees — Aon Hewitt Navigators — has seen enrollment in plans offered through the exchange leap to 200,000 individuals from just 30,000.

More growth is certain as exchange providers tap new markets.

For example, Aon Hewitt now offers a second exchange in which employees can choose from various health care plans offered by

participating insurers.

More than 100,000 employees — including U.S. employees of Aon Hewitt parent Aon P.L.C., Hoffman Estates, Ill.-based retailer Sears Holdings Corp. and Orlando, Fla.-based chain Darden Restaurants Inc. — have chosen plans through the exchange.

"There is keen interest in this marketplace," Ms. Scholl said.

In addition, for fall 2013 enrollment, Xerox Corp. is launching an insurance exchange designed by Xerox unit Buck Consultants L.L.C. for Medicare-eligible retirees.

The new exchange is designed for employers with at least 3,000 employees, said Sherri Bockhorst, a Buck Consultants principal in St. Louis.

"At launch, we expect to have over about 200,000 enrollees," Ms. Bockhorst said.

And in December, Mercer and Connexions Inc., an Orlando, Fla.-based unit of health services company Optum, said they were launching an exchange, myCustomHealth, offering coverage from a variety of insurers to Medicare-eligible retirees.

"We have a good number of discussions under way with employers," said Mercer's Mr. Richards.

In January, Mercer launched Mercer Marketplace, which will enable employers with at least 100 employees to offer employees a wide choice of plans provided by participating insurers.

90% FEDERALLY SUBSIDIZED



By 2021, the individual exchange population is projected to grow to **29 MILLION** and generate **\$205 BILLION** in health insurance premiums.

Source: PricewaterhouseCoopers L.L.P.

EXCHANGE HELPS FIRM BROADEN COVER OPTIONS

United Parcel Service Inc. and about 8,000 of its age-65-and-older Medicare-eligible non-union retirees are reaping the benefits of the Atlanta-based package delivery company moving health care coverage to a private insurance exchange.

For years, UPS offered a single self-insured health plan to Medicare-eligible retirees.

"There was no choice. It was one size fits all," said Al Rapp, corporate health care manager at UPS. "We didn't think it was a great value" in many cases for retirees.

In 2011, UPS decided on another approach. It contracted, effective Jan. 1, 2012, with Aon Hewitt to offer coverage to the retirees through an insurance exchange — Aon Hewitt Navigators.

Now, the retirees, depending on where they reside, can have nearly three dozen plans from which to choose to find one that best fits their health care needs.

"We knew that providing choices would be a lot better than what retirees had before," Mr. Rapp said.

"We knew that providing choices would be a lot better than what retirees had before."

Al Rapp, United Parcel Service Inc.

The retirees apply UPS contributions toward the premium charged by the plans. If the UPS contribution is more than the premium charged by the plan, retirees then can apply the difference to pay for out-of-pocket expenses, such as costs that fall under a plan's deductible.

To prevent confusion, the exchange provides benefit advisers to help the retirees evaluate and select an appropriate health plan.

"The retirees quickly saw the value of the benefit advisers and became very positive about the change," Mr. Rapp said.

Retirees also can turn to exchange staff throughout the year for assistance with numerous issues, such as questions about a claim. As a result, UPS no longer has to devote corporate resources to administer the retiree program.

"That allows us to concentrate on meeting the many other needs of our people," Mr. Rapp said.

Moving to a private health insurance exchange was not a cost issue as the company's retiree health care plan contribution formula has not changed.

"It was a choice issue. We knew the plan choices would be better than what retirees had before," Mr. Rapp said.

By Jerry Geisel

City's retirees benefit from expansion of coverage plan options

BY JERRY GEISEL

For years, Medicare-eligible retirees who worked for Waco, Texas, had a simple decision when choosing a health care plan offered by the city.

"There was the robust, high-cost plan, or 'Cadillac' plan, and there was the low-cost, scaled-back 'Pinto' plan," said Missie Pustejovsky, Waco's assistant director of human resources.

For retirees with modest health care needs and who were higher utilizers of health care services, the plans were a good fit.

But for retirees between the extremes, neither plan worked very well, leaving them with high expenses or paying for coverage they didn't need.

In 2010, Waco contracted with private health care exchange Extend Health Inc. to offer coverage to retirees through commer-

cial health insurers. Now, retirees have more than 15 plans from which to choose.

The exchange "is a win for retirees," Ms. Pustejovsky said, noting that, on average, retirees pay about \$600 a year less in premiums and other out-of-pocket costs compared with the prior arrangement.

The exchange arrangement is a win for Waco too, she said. Benefit advisers with San Mateo, Calif.-based Extend Health, which Towers Watson & Co. acquired last year, assist retirees in evaluating and enrolling in the exchange's health care plans.

"Retirees got more choices," cost savings and benefit advisers, she said. Now, "we can focus more on active employees."

Waco is just one of dozens of employers that no longer directly offer coverage to Medicare-eligible retirees. Instead, they contract with private health insurance exchanges. Other exchanges include those

offered by Aon Hewitt Navigators Insurance Services Inc., My Medicare Advocate, a Xerox Corp. unit.

In addition, Mercer L.L.C. last year announced that it, along with tech firm Connexions Inc., will offer an exchange for retired employees eligible for Medicare.

The private exchanges are growing rapidly. For example, Extend Health, in a registration statement filed with the Securities and Exchange Commission, said its revenue since 2008 increased more than four-fold to \$51.1 million in fiscal 2011. Most revenue comes from commissions from insurers.

"Exchanges can make a lot of sense," said Bruce Richards, a partner and chief actuary for health care in the Richmond, Va., office of Mercer L.L.C. "For employers, they are relieved of a big administrative burden," while retirees will have more choices and potential premium savings.

EVOLUTION CONTINUES FOR BROKERAGE BUSINESS

Q What does the council have planned to mark its 100th anniversary?

A We're really excited about reaching 100. It gives us a chance to not only look backward but also to look forward. The theme of the year is "leading on the edge of history." We've been an organization since 1913, founded around the concept of urban metropolitan agents who were having issues around rates being set by regulators. Our birth was always around advocacy, although as we evolved we got more involved in the business and the relationship piece, and the relationship with carriers and the real focus on larger commercial accounts. Whether they were large meaning large in 1913 or large now, we've always been in the same space.

Q What are some of the big ways the industry has changed in the council's lifetime?

A I think you can look at a number of issues. It was in 1927 that

Q&A

compulsory auto insurance was put in place. That changed the whole distribution sector, because for the first time we had a product that had to be bought rather than had to be sold. That affected the industry.

You've got a much more sophisticated sales process going on. That's a reflection of the clients. Clients buy differently, and brokers have to respond. The whole industry has grown in an extraordinary way in the last 100 years. Our initial advocacy efforts were

around rates, setting rates and setting commissions. Today, the market sets those rates and commissions and the compensation piece is driven by the client rather than the broker. So much has changed and will continue to change.

Look at the whole benefits sector of the business, which really is a relatively newer sector of the business. Seventy-five years ago, our brokers were probably not selling any benefits. It's in my lifetime that we've seen them grow from a small component to a major component of a lot of these multiline businesses.

Q What challenges are ahead?

A One area the industry has to get its arm around is the pace of change around technology. I think there's a fear of technology within the industry; I think there's a lack of understanding of how technology really works. People look at it as sort of a friend or a foe, and actually it's just a tool. We're so much further behind in how we've



KEN A. CRERAR
COUNCIL OF INSURANCE AGENTS & BROKERS

The Council of Insurance Agents & Brokers is celebrating its 100th anniversary in 2013. Council President and CEO Ken A. Crerar recently spoke with *Business Insurance* Senior Editor Mark A. Hofmann about the council's past, present and future and the state of the brokerage industry. Edited excerpts follow.

adapted to technology. The reason that has become critical is ... all of our clients are all taking technology and not only are they utilizing it, but from it they're getting huge amounts of data, the question of big data, and they're utilizing that data to begin to understand better how they do what they do.

We don't have access to that information. There is no big data for us. And the reason there's no big data is because half of our stuff's still on paper or is being stored in a machine that we can't

get it out of.

Q Is it a challenge getting talented new people into the industry?

A This has always been an industry that has struggled for talent for no other reason than we've been pretty quiet about it. I think we just have to do our part in telling our story. Because it's a good industry and because it's an industry that's built on relationships that will continue to attract some strong people, we just have to keep working at it.

COMINGS & GOINGS

UP CLOSE: CHRIS MANDEL

NASHVILLE, TENN.-BASED SENIOR VICE PRESIDENT OF STRATEGIC SOLUTIONS
Memphis-based Sedgwick Claims Management Services Inc.

PREVIOUS POSITION: Nashville-based president of Excellence in Risk Management L.L.C. and executive vice president of professional services for sister company RPM3 Solutions L.L.C.

CHALLENGES FACING INDUSTRY: I've been a buyer for more than 30 years with claim management services. The insurance industry still remains antiquated when compared to other industries. We have our regulatory challenges ... (but) the industry could benefit from more technology that could lead to higher performance.

INDUSTRY OUTLOOK: The industry is still in consolidation mode and who knows where that will take us. We want to stay ahead of the curve.

BEST THING ABOUT A BAD ECONOMY: It probably motivates us as a firm to be all the better at what we do, including how we price our products. Many public entities are pretty significantly financially stressed and are always looking for inefficiencies. This economic climate forces us to be better.



FIRST MARKET EXPERIENCE: I started in claims management, so I am really coming full circle. My first job was as a claims adjuster with Liberty Mutual (Group). I spent five years there and then I went on to Marsh (Inc.). That was my segue into risk management.

ADVICE: To get a broadly diversified set of experiences in the insurance industry as the best preparation for playing a more significant role in the future. We need smart,

emerging leaders.

OUTSIDE THE INDUSTRY, A DREAM JOB: My son is a youth pastor and I am very involved in church leadership as a volunteer. I could see myself in different ministry leadership roles.

HOBBIES: I am a guitarist and a racquetball player. I spend most of my spare time in Christian ministry-related work.

FAVORITE BOOK: The Bible, if you count that, and you should. It's the best-selling book of all time.

FAVORITE MEAL: Steak and lobster.

Professional Moves & Promotions

Visit www.businessinsurance.com/ComingsandGoings for a full list of this week's personnel moves and promotions. Check our website daily for additional postings and sign up for the weekly email.

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Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news and photos of recently promoted, hired or appointed senior-level executives to: Anna Gaynor, *Business Insurance*, 150 N. Michigan Ave., Chicago, Ill. 60601-7524. agaynor@businessinsurance.com.

			Target Employer Markets			PBM services				Other services		
Company	Location	Website	Small	Medium	Large	Retail	Largest retail network	Mail order	Specialty pharmacy	340B ⁶	GPO ⁷	PHM ⁸
4D Pharmacy Management Systems Inc.	Troy, Mich.	www.4dpharmacy.com				N/A		N/A	N/A			
American Health Care	Rocklin, Calif.	www.americanhealthcare.com					63,000					
AmWINS Rx ¹	Warwick, R.I.	www.amwins.com					59,000					
Argus Health Systems Inc.	Kansas City, Mo.	www.argushealth.com					64,000					
BeneCard Prescription Benefit Facilitator	Orlando, Fla.	www.benecard.com					55,450					
Catamaran Corp. ²	Lisle, Ill.	www.catamaranrx.com					67,000					
Cigna Corp.	Hartford, Conn.	www.cigna.com					62,000					
Coventry Health Care Workers Compensation Inc. ³	Downers Grove, Ill.	www.coventrywcs.com					67,000					
CVS Caremark Corp.	Scottsdale, Ariz.	www.caremark.com					65,000					
Cypress Care Inc.	Duluth, Ga.	www.cypresscare.com					66,500					
Employee Health Insurance Management Inc.	Southfield, Mich.	www.ehimrx.com					62,000					
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Fairview Pharmacy Services L.L.C., dba ClearScript	St. Paul, Minn.	www.clearscript.org					63,000					
Humana Pharmacy Solutions	Louisville, Ky.	www.humanapharmacysolutions.com					65,000					
Kroger Prescription Plans	Blue Ash, Ohio	www.kroger.com					60,000					
LDI Integrated Pharmacy Services	Creve Coeur, Mo.	www.ldirx.com					N/A					
Medical Security Card Co. L.L.C., dba ScriptSave	Tucson, Ariz.	www.scriptsave.com					62,000					
MedImpact HealthCare Systems Inc.	San Diego	www.medimpact.com				N/A		N/A	N/A			
Meridian Rx L.L.C.	Detroit	www.meridianrx.com					56,000					
myMatrixx L.L.C.	Tampa, Fla.	www.mymatrixx.com				N/A		N/A	N/A			
National Pharmaceutical Services	Omaha, Neb.	www.pti-nps.com					64,500					
Navitus Health Solutions L.L.C.	Madison, Wis.	www.navitus.com					64,000					

\$18.3B

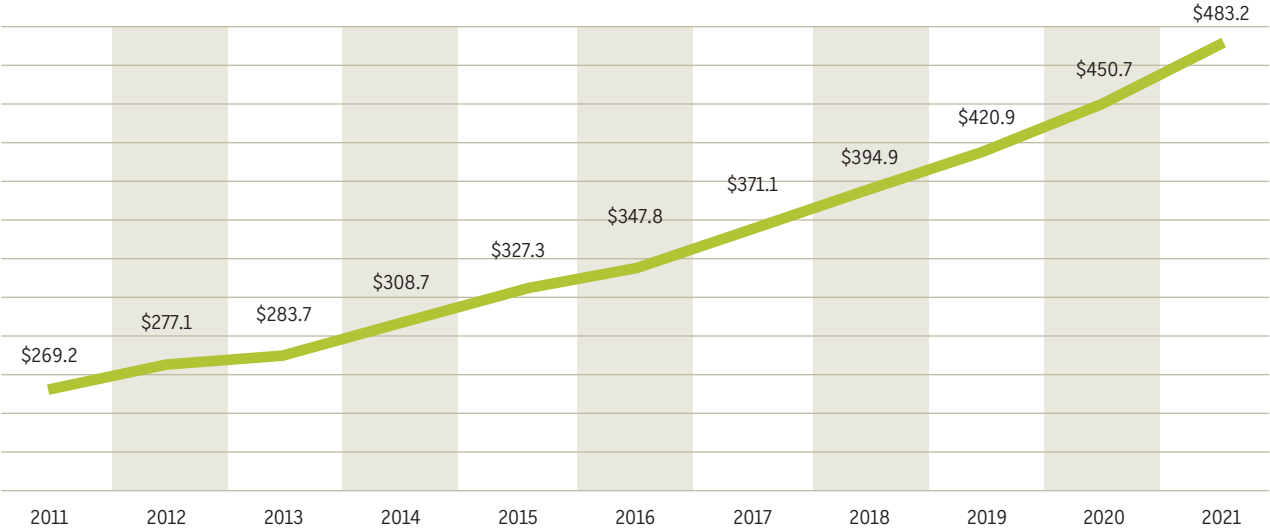
GENERIC GROWTH

- Traditional pharmacy spending continues to decrease as more generic versions enter the market.
- Between 2013 and 2016, brand drugs with about \$55 billion in sales will lose their patent protection.
- Generic versions of those drugs are projected to capture about \$18.3 billion in sales, reducing 2012 spending by about two-thirds.

Source: CVS Caremark Corp., Express Scripts Inc.

SPENDING

Prescription drug spending is projected to increase by more than \$200 billion dollars by 2021 to \$483.2 billion, with private health insurance paying 42% to 45% of the total. In billions of dollars.



Source: Centers for Medicaid & Medicare Services

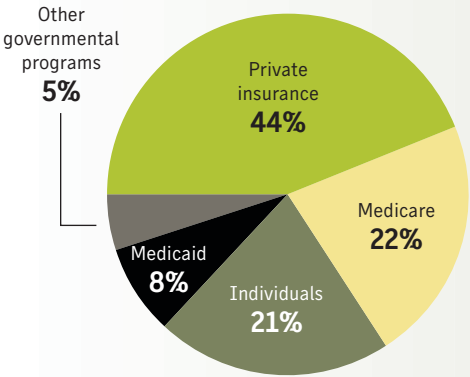
			Target Employer Markets			PBM services				Other services		
Company	Location	Website	Small	Medium	Large	Retail	Largest retail network	Mail order	Specialty pharmacy	340B ⁶	GPO ⁷	PHM ⁸
NEC Network L.L.C., dba CaptureRx	San Antonio	www.capturerx.com				N/A		N/A	N/A			
OptumRx Inc. ⁵	Irvine, Calif.	www.optum.com					62,000					
Partners Rx Management L.L.C.	Scottsdale, Ariz.	www.partnersrx.com					60,000					
PBM Plus Inc.	Milford, Ohio	www.pbmplus.com					59,000					
PerformRx L.L.C.	Philadelphia	www.performrx.com					55,000					
Pharmacy Data Management Inc.	Poland, Ohio	www.pdmi.com					60,000					
PharmAvail Benefits Management Co.	Woodstock, Ga.	www.pharmavail.com					60,000					
PharmPix Corp.	Guaynabo, Puerto Rico	www.pharmpix.com				N/A		N/A	N/A			
Phoenix Benefits Management L.L.C.	Cumming, Ga.	www.phoenixPBM.com					60,000					
PMSI	Tampa, Fla.	www.pmsionline.com				N/A		N/A	N/A			
Prime Therapeutics L.L.C.	Eagan, Minn.	www.primetherapeutics.com				N/A		N/A	N/A			
ProCare Rx	Duluth, Ga.	www.procarerx.com					59,000					
Progressive Medical Inc.	Westerville, Ohio	www.progressive-medical.com					66,000					
Ramsell Public Health Rx L.L.C.	Oakland, Calif.	www.ramsellcorp.com					62,000					
RegenceRx	Portland, Ore.	www.regencerox.com					60,000					
Restat L.L.C.	Milwaukee	www.restat.com				N/A		N/A	N/A			
ScripNet Inc.	Las Vegas	www.scripnet.com				N/A		N/A	N/A			
SelectScripts	Philadelphia	www.selectscripts.com				N/A		N/A	N/A			
Serve You Custom Prescription Management	Milwaukee	www.serve-you-rx.com					60,000					
U.S. Script Inc.	Fresno, Calif.	www.usscript.com					65,000					
VRx Pharmacy Services	Salt Lake City	www.myvrx.com					63,000					
WellDyneRx	Lakeland, Fla.	www.welldynerx.com					65,000					

Source: Pharmacy Benefit Management Institute, companies' websites.

1 Formerly Ideal Scripts. 2 Catamaran Corp. formed in 2012 with April 2012 merger of SXC Health Solutions Corp. and Catalyst Health Solutions Inc. 3 Formerly First Script Network Services. 4 Acquired Medco Health Solutions Inc. in April 2012. 5 Prescription Solutions rebranded as OptumRx, August 2012. 6 Reduced-price drug program for covered entities under Section 340B of the Public Health Service Act. 7 Group purchasing organizations. 8 Public health management.

DRUG COSTS

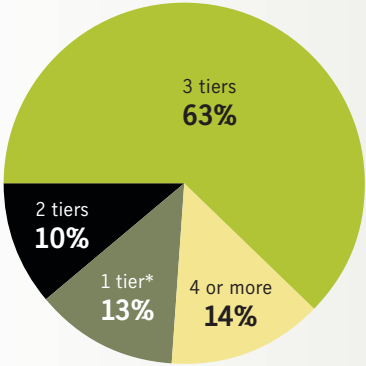
Prescription drugs accounted for about 15% of total U.S. health care expenditures in 2009, with several entities paying those costs.



Source: U.S. Census Bureau's 2012 Health Statistics

MULTITIER DRUG PLANS

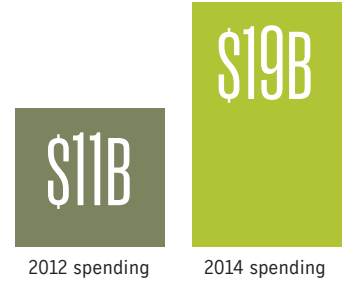
Multitier drug plans, which layer higher copayments and coinsurance for lifestyle, biologic and other specifically identified prescription drugs, have grown in recent years. The number of plans with four or more tiers grew from 4% in 2004 to 14% in 2012. As of 2012:



*Same payment regardless of drug type or no cost-sharing plan. Source: Kaiser Family Foundation

SPECIALTY PHARMACY

Specialty medications, which accounted for 18% of U.S. pharmaceutical drug spending in 2012, are projected to rise to 26% of in 2014, due in part to an increase in chronic conditions, an aging population and drugmaker interest in the higher-cost medications.



Source: Truven Health Analytics Inc.'s MarketScan research

QBE credit facility backs European clients

QBE Insurance Group Ltd. has launched a top-up commercial credit insurance facility for clients domiciled in continental Europe and the eurozone.

Called CreditFlex, the facility operates above existing, primary whole-turnover policies issued by insurers other than QBE.

Policyholders are able to obtain up to 100% of the value of their underlying primary limit. The program also allows purchasing supplementary cover on select buyers without the obligation to insure all of their sales above the underlying whole turnover policy. Premiums are based on the total amount of cover that is underwritten in the policy period.

QBE is underwriting the new facility, while Belgium-based Tinubu Square provides policy management services through its online system.

For more information, contact QBE at enquiries@qbecreditflex.com.

Cloud-based e-discovery resource from Navigant

Navigant Consulting Inc. will release a legal resource platform to help clients with the electronic discovery process.

The cloud-based system will offer a legal process management module to coordinate, measure, document and audit workflow, and a legal hold notification module to manage and track the process of directing custodians and data stewards to preserve data, the company said in a statement.

Later this year, Navigant plans to add two modules: legal hold-in-place to lock down data in secure systems and move data from insecure systems to safe repositories; and data mapping to identify potentially relevant information by sys-

PRODUCTS & SERVICES

Highmark offers 'pay-or-play' tool

Pittsburgh-based health insurer Highmark Inc. has introduced an interactive tool to help employers decide whether to "pay or play" under the federal health care reform law.

Highmark Health Care Reform Planner helps employers consider their options under the Patient Protection and Affordable Care Act, which requires employers with 100 or more employees to provide health insurance to their employees or pay a penalty of \$2,000 per employee.

The tool was developed with technical support from Monroeville, Pa.-based information technology consultant SDLC Partners L.P.

Interested employers should contact their broker or their Highmark client representative.

tem, custodian, need and risk profile.

A monthly subscription charge is based on client-specific factors. For details, contact Erik Post, managing director and the leader of the disputes and investigations technology solutions team, at erik.post@navigant.com or 312-583-3641.

Dual, Everest offer D&O to U.S.-listed foreign firms

Dual Specialty Underwriters L.L.C. has partnered with Everest Reinsurance Co. to offer directors and officers liability coverage for foreign companies listed on U.S. securities markets.

The program offers management liability coverage, including D&O, employment practices and fiduciary liability.

Policies are written on a worldwide basis subject to U.S. Office of Foreign Assets Control requirements.

Scott Misson has been named chief underwriter for the business and is based in New York, Dual said in a statement.

For more information, contact Mr. Misson at 786-275-3236 or smisson@dual-su.com.

Allied World, Mechanic partner on new coverages

Allied World U.S. and The Mechanic Group Inc. have partnered to offer primary and excess liability insurance to security guard, electronic security alarm and investigation firms.

Subject to underwriting, security training schools, security consultants, building maintenance and intelligence firms also could be covered by the general and professional liability insurance, Allied World Assurance Co. Holdings A.G. said in a statement.

The managing general agency's general liability and umbrella coverage offerings include errors and omissions, broad form property damage, contractual personal injury, and assault and battery in cases of vicarious liability created by an employee's intentional actions. The umbrella coverage follows the form of the enhanced general liability cover.

For more information, contact Mr. Katz at mkatz@mechanicgroup.com.

DEALS & MOVES

UNFCU Financial Services acquires brokerage Industrial Coverage

UNFCU Financial Services L.L.C. has acquired the Patchogue, N.Y.-based insurance brokerage Industrial Coverage Corp. Terms of the purchase were not disclosed.

Based in Long Island City, N.Y., UNFCU Financial Services is a wholly owned subsidiary of the United Nations Federal Credit Union, which provides banking, insurance and other financial services to active and retired United Nations staff and their families.

Under the terms of the deal, ICC will maintain its headquarters in Patchogue and continue to operate under its current name.

Stephen Ryerson, UNFCU Financial Services' president, said in a statement that the acquisition of Industrial Coverage was intended in large part to enhance the credit union's portfolio of commercial insurance coverages, including property, general liability, third-party property, crime and business interruption.

The companies will be fully integrated within 30 days, according to UNFCU's statement.

Cross Insurance buys Maine-based agency

Cross Insurance, a subsidiary of Cross Financial Corp., has acquired Skillings Shaw & Associates Inc., a Lewiston, Maine-based specialty insurance agency.

Skillings Shaw, which provides fidelity and surety bonds, will keep its name and products and operate as an independent subsidiary of Cross Financial, the Bangor, Maine-based agency said in a statement.

Terms of the transaction were not disclosed.

"As we look ahead and plan for the future growth of Cross Financial Corp., we see the acquisition of Skillings Shaw & Associates as an integral expansion of our surety bond business line," Royce Cross, CEO of Cross Insurance, said in a statement. "Having a surety bond-only agency provides distinct advantages in the marketplace."

Skillings Shaw President Robert Shaw and all employees will continue working for the insurance agency.

MMIC Insurance to purchase Salt Lake City med mal insurer

MMIC Insurance Inc. agreed to purchase the Salt Lake City-based Utah Medical Insurance Association, which insures medical professional liability for physicians in Utah, Montana, Idaho and Wyoming.

The financial terms of the sale were not disclosed.

Upon completion of the transaction, the combined companies will insure medical professional liability for nearly 20,000 physicians, clinics, outpatient and long-term care facilities, hospitals and health care systems across 14 states in the Midwest and Northwest regions, according to a statement from Minneapolis-based MMIC Insurance.

"A partnership between UMIA and MMIC will provide benefits for both sides," Bill McDonough, MMIC Insurance's CEO, said in the statement. "This partnership will extend MMIC's geographic footprint and broaden UMIA's access to products and services — and we are both interested in preserving our companies' legacies."

The acquisition is expected to be finalized in the first half of 2013. UMIA will retain its branding and board of directors after the acquisition, the statement said.

RMIS software evolving with changing expectations

TECHNOLOGY

HOW DOES IT WORK?



BILL KENEALY

New pressures on risk managers are changing their expectations for risk management information systems and, in turn, changing the way technology providers develop and sell RMIS software.

Increased regulatory requirements and scrutiny from corporate boards and rating agencies have driven interest in analytics among risk managers, said Aaron Shapiro, executive vice president at Glencoe, Ill.-based RMIS provider Origami Risk L.L.C. He said risk managers now are expected to address the total cost of risk, in addition to securing the proper amount of insurance.

"There's no question that risk managers themselves are now deeply embedded in discussions about analytics, instead of trusting their broker partners to do their work for them," he said. "Risk managers are being driven

to glean more insights beyond just claim frequency and severity."

Mr. Shapiro said, as a result, RMIS providers are building more responsive systems that have flexibility to change and respond to evolving customer needs. In the case of Origami, the firm features cloud-based delivery models and uses an agile development methodology plus complimentary tools and architecture to bring new enhancements to its product in as little as eight weeks. The company also worked to automate as many back-office process-

es as possible in order to speed delivery and help the company devote more of its staff to helping clients with unique needs.

"Insurance professionals and risk managers need to push RMIS providers to focus on their business outcome," he said. "The definition of success can no longer be how many data feeds you have converted."

Elsewhere, Atlanta-based RMIS provider Risk Sciences Group Inc. said it was restructuring. RSG CEO Mark J. Stergio said the company would split into divisions that would sell bundled and unbundled versions of its RMIS Dmitri Suite. The bundled unit would seek to leverage the global footprint and resources of parent companies Broadspire Services Inc. and Crawford & Co. The unbundled unit would focus on more streamlined distribution and direct client contact, he said.

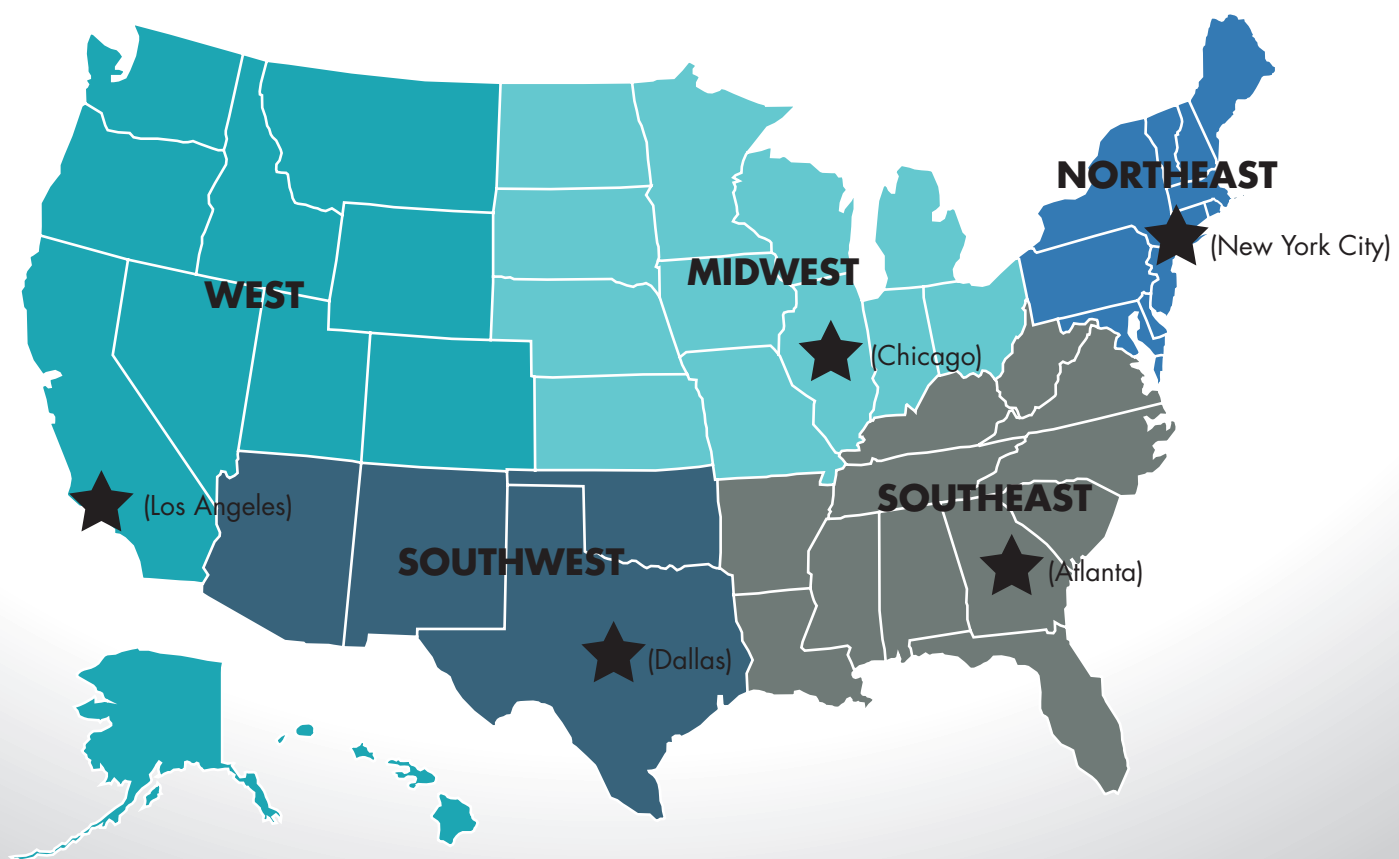


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systems around the world have shifted the cost of care to employers.

“The ability to control costs is much greater under a captive,” Mr. Coleman said, who also moderated the session. “Medical data is absolutely critical. Without that, you can’t really manage anything.”

Medical data collected by the captive also helps an organization align its corporate wellness strategy in different parts of the world, said Stacy Apter, Atlanta-based director of global benefits financing and asset management for The Coca-Cola Co.

“You want a broad-enough wellness philosophy from (a human resources) perspective, but the captive gives you that detailed information to really be able to make it practical and measurable on a local level,” she said.

“If you take that data you’re getting from the captive, you can turn that into very tangible things. You can really start addressing what the issues are in those local countries,” Ms. Apter said.

In a case study session, Ms. Apter said Coca-Cola runs international life, disability and medical insurance; U.S. life, accidental death and disability, and post-retirement medical benefits; and pension plan funding through its captive program.

In December, the U.S. Depart-

Mid-market driving cell captive growth

Middle-market companies are behind much of growth of cell captives, as those particular structures offer greater flexibility and lower operating costs, panelists said during a session at the 22nd annual World Captive Forum in Aventura, Fla., Jan. 28-30.

Protected cell captives provide for the assets and liabilities of one cell to be very separate and distinct from another, said Justin Mead, Chicago-based senior vice president of R&Q Quest Management Services USA L.L.C., during the session.

“Companies may set up their

own cell captive and then put different types of business into different cells,” he said, such as separate subsidiaries, lines of business and risks by geographic region.

The middle market’s use of cell captives is the major driver of their growth in the U.S., Mr. Mead said.

Lower operating costs coupled with an accepted view that cell captive structures are mainstream “makes it a little bit easier for middle-market companies to get into it,” he said.

John Hernick, Minneapolis-based insurance administrator for Xcel Energy Inc., said cell

captives allow knowledge sharing among industry groups.

“Utilities don’t necessarily compete with one another. So in an industry group captive, we have the advantage of being able to work together, share ideas and help each other out,” he said during the session. “We learn from one another.”

Xcel runs its primary casualty program through the cell captive, at \$2 million per occurrence and property insurance at \$5 million per occurrence, among other coverages.

The session was moderated by *Business Insurance* Senior Editor Rodd Zolkos.

By Mike Tsikoudakis

ment of Labor proposed allowing Coca-Cola to also fund U.S. employee life insurance benefits through its South Carolina-domiciled Red Re Inc. captive.

Running the benefit programs through the captive provides central management and increased efficiency and control of the benefits plans, Ms. Apter said. Using the company’s captives for benefit coverage also reduces costs, provides greater control of data, provides security to plan members and more efficient funding to the company, allows the company to take advantage of scale by consol-

idating pension plan assets and allows for more efficient tax treatment of captive premiums by bringing third-party business into the captive mix, she said.

“These things do require a lot of attention,” she said. “Obviously, you’ve now entered into a crossover between HR and finance.” Support from the top in both areas of the company is critical to the captive benefits program’s success, Ms. Apter said.

Michael Lusk, vice president of insurance and risk management at Decatur, Ill.-based Archer Daniels Midland Co., whose company was

one of the first to win Department of Labor approval to fund U.S. employee benefits through its Vermont-domiciled Agrinational Insurance Co. captive in 2003, said a captive employee benefit program must have cooperation between human resources and risk management or “it’s doomed to failure at some point in time.”

“HR and risk management are both working to make the corporation better,” Mr. Lusk said. To successfully put employee benefits in the captive, it’s necessary to determine “how you meld those two capabilities.”

M&A

with an increase of 11 deals and 14.7%, respectively (see chart).

The biggest decline in M&A activity was among bank-owned firms. Wells Fargo & Co. completed five transactions in 2011 but none in 2012.

The only firm in the category that did more than two deals was Western Financial Group, which did five transactions in 2012 vs. seven in 2011.

In addition, there were fewer private broker transactions announced during 2012, perhaps due to competitive pressure as private firms were unable or unwilling to compete with public and private equity-backed buyers.

It also is instructive to look at the makeup of the firms that were sold (see chart).

Property/casualty and property/casualty-employee benefits firms continue to dominate the M&A marketplace. Given significant uncertainty in the employee benefits world due to the Patient Protection and Affordable Care Act, it is interesting that the number of employee benefits deals did not decrease materially.

Other than 2009 and 2010, when such transactions were at or near their lowest point since 2000, the 67 and 66 employee benefits deals in 2011 and 2012, respectively, were only marginally lower than the 70 deals in 2008.

A potential motivating factor for employee benefits-focused firms was the need to affiliate with a buyer having significant added value and other resources to be able to compete in the changing marketplace in the wake of the 2010 health care reform law.

There were also several large sales during

LARGEST ACQUIRERS

Category	2012	2011	2010	2009	2008
Private brokers	93	101	78	68	77
Private-equity owned brokers	86	75	48	28	49
Public brokers	67	53	44	26	68
Bank-owned brokers	24	37	18	24	42
Insurer-owned brokers	12	6	4	14	40
Other	9	7	1	7	8
Total	291	279	193	167	284

LARGEST SELLERS

Category	2012	2011	2010	2009	2008
P/C insurers	109	103	62	61	66
P/C insurers, employee benefits	78	63	45	41	75
Employee benefits	66	67	42	35	70
Other	38	46	44	30	73
Total	291	279	193	167	284

Source: Optis Partners L.L.C.

2012, including:

- Brown & Brown’s acquisition of Arrowhead General Insurance Agency Inc.
- Assured Partners’ acquisition of Dawson Cos.
- Gallagher’s acquisition of Schiff Kreidler Shell Inc.
- Payne Financial Group acquired Western States Insurance.

- BB&T’s acquisition of Crump Group.
- Fidelity National Financial Inc.’s acquisition of Digital Insurance.

Finally, we saw movement in several private equity-backed firms:

- Onex Corp. (Canada) replaced Goldman Sach Group Inc.’s investment in USI Insurance Services.
- KKR & Co. L.P. bought Blackstone Capital’s interest in Alliant Insurance Services Inc.
- Genstar Capital sold its ownership in Confie Seguros to ABRY Partners.

Looking to the future, there likely will be a modest pullback in deals in 2013 as the active buyers digest what they acquired late last year and early this year.

Further, sellers will need to adapt to the lower after-tax proceeds they will receive as it is unlikely buyers will be willing to pay 10% more for the same businesses today that they could have bought in 2012.

A big unknown is what may happen with the employee benefits-focused firms and whether the significant activity of the past few years will continue as a result of or in spite of PPACA.

There likely will be additional recapitalization activity with private equity-backed firms as many liquidate their investments five to six years after making them.

As with the last few years, 2013 will nevertheless be interesting on the mergers and acquisitions front.



Timothy J. Cunningham is managing director at Chicago-based Optis Partners L.L.C., an investment banking and financial consulting firm that serves the insurance distribution industry.

Co. and Cambridge Integrated Services Group Inc. (see box).

Experts note that neither affects self-insured employers, because those companies serve as the insurer that would be allowed privileged access to legal information.

However, for insured clients, insurers and TPAs have issued notices indicating that they would limit legal information on workers comp cases.

“With the exception of certain Montana-specific reports, ... employers insured under a workers compensation policy will not receive claim information from Travelers or any third-party administrator handling Travelers policies, beyond that which is necessary to assist an injured worker to return to work,” according to an undated memo from Travelers. “The information will be limited to applicable work restrictions, if any, or release to return-to-work status. All other claim information ... will not be provided.”

In an email last month to clients, broker Lockton Cos. L.L.C. said that “access to (risk management information) systems is being restricted or eliminated” by workers comp insurers in light of the Texas and Montana rulings. “It is predicted that a majority of carriers and third-party administrators will begin to communicate similar positions on these matters.”

PRIVILEGED INFORMATION

In *In Re: XL Specialty Insurance Co. and Cambridge Integrated Services Group Inc.*, an outside counsel for XL shared information about a workers comp claim with Cambridge, which was XL’s adjuster, and the employer. The employee sued, alleging bad-faith negotiations, and sought communications between XL’s lawyer, XL and Cambridge. XL and Cambridge argued that attorney-client privilege should prevent sharing their communications. But the Texas high court ruled in part that such privilege exists only when information is shared between lawyers for each party.

In *American Zurich Insurance Co. v. Montana 13th Judicial District Court et al.*, a third-party adjuster shared a legal opinion and evaluation of a claim by Zurich’s defense attorney with an employer. The worker later requested access to documentation, but his employer sought to quash the subpoena based on attorney-client privilege. The Montana high court ruled the company did not share a common legal interest with Zurich based on the workers comp exclusive remedy provision.

By Sheena Harrison

FMLA

Continued from page 1

the statute's interaction with other laws, continue to present considerable challenges for many employers, experts say.

"Without question, the No. 1 issue that employers struggle with is managing unscheduled, intermittent leave," said Jeff Nowak, a Chicago-based partner at law firm Franczek Radelet P.C.

According to the labor department's survey, 41% of employers offering FMLA leave said administering intermittent leave was somewhat or very difficult. Primarily, Mr. Nowak said employers find it challenging to determine when intermittent leave is appropriate, as well as obtain accurate, adequate information to confirm the validity of an employee's reason for requesting the leave.

"Because intermittent leave can be taken in small increments, it lends itself to abuse, and that can cripple an employer's operations," Mr. Nowak said.

Employers also struggle with the law's rules governing notification and certification requirements for employees, though the percentage of companies reporting difficulty with those provisions has shrunk considerably since 2000, according to the Labor Department study.

In 2008, the Labor Department issued revised regulations clarifying employers' rights to require formal notification of leave requests from employees, as well as medical certification of their reasons for requesting leave. The revised rules permitted employers to require eligible employees to submit written notice of their FMLA leave requests to a design-

nated leave administrator.

"Previously, it was sort of up for grabs," said Ellen McLaughlin, a Chicago-based partner at Seyfarth Shaw L.L.P. "Employees could simply tell their manager they were taking leave, and that was good enough. But the managers weren't trained, so they wouldn't know what kinds of leave are permissible under the law."

The 2008 regulations also clarified employers' rights to obtain medical certification for FMLA-qualified leave requests, as well as the types of information they can demand from employees and their health care providers.

Despite the clarifications, nearly 20% of employers surveyed by the Labor Department in 2012 said navigating the law's notification and certification provisions was somewhat or very difficult.

Ms. McLaughlin said several of the revised rules have been challenged in civil courts. It remains to be seen how those cases will inform notice and certification requirements going forward.

Another persistent concern for employers is the extent to which the FMLA interacts — and in some cases, conflicts with — other federal, state and local laws. In the early years following the FMLA's enactment, it was widely accepted that qualified leaves of absence would satisfy an employer's obligations under the Americans with Disabilities Act, as well as corresponding state and local statutes.

"That clearly is no longer the case, and what employers are left with is a three- or four-pronged obligation to assess what constitutes a qualifying medical claim or disability," said Ricki Roer, a New York-based partner at Wilson Elser Moskowitz Edelman & Dickler L.L.P.

HRA: Pairing with health exchanges

Continued from page 1

lar coverage limits on health care expenses.

Questions also were raised about whether employers could simply credit employees' HRAs with a specific amount of money to be used to buy coverage through private exchanges, without violating the ban on annual and lifetime dollar limits.

The departments of Health and Human Services, Labor, and Treasury now have made clear how employers can use these accounts without running afoul of the ban: As long as an account is "integrated" or linked with an employer group plan, the design would not run afoul of the reform law's prohibition of annual and lifetime dollar limits, regulators say.

"The HRA is OK if it is tied to a group plan," said Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington

On the other hand, if the account were linked to an individual health policy, the arrangement would not fly, regulators said.

Regulators said they intend "to issue guidance that an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies."

That would rule out, for example, a health plan design in which employers would provide HRA credits for employees to use to purchase individual medical policies from private insurance exchanges.

As a practical matter, though, while employees select health insurance policies from private

insurance exchanges, the policies are considered group policies sponsored by the employer.

In addition, exchange providers say employees typically pay for their share of the premium for the employer group health plan they select through payroll deduction, not with credits in their HRAs.

"That is not the design we use," J.D. Piro, a senior vice president with Aon Hewitt in Norwalk, Conn., said, referring to an HRA premium payment approach. Aon Hewitt recently launched a private insurance exchange offering cov-

"Any lingering ambiguity has been eliminated. How a plan is funded" is irrelevant with regard to providing minimum essential coverage.

Paul Dennett,
American Benefits Council

erage for employees and their dependents.

Still, the new guidance will prevent an evolution in private health exchange design in which HRAs would be linked to individual health care policies as a way of further limiting employer involvement in providing coverage.

"They may have been heading in that direction, but that pathway seems to be closed off for now," said Amy Bergner, a managing director with PricewaterhouseCoopers L.L.P. in Washington.

The regulatory guidance, though, has no bearing on retiree

health care coverage. The health care reform law's ban on annual and lifetime dollar limits does not apply to health care plans only covering retirees.

Separately, federal regulators made clear that self-funded health insurance plans are considered to offer "minimum essential coverage."

It's a significant point for employers because, starting in 2014, a company will be charged \$2,000 per full-time employee if their plans do not offer such coverage.

It also is an issue for employees and other individuals because they are liable for penalties if they do not enroll in a health care plan offering minimum essential coverage.

Regulators, in a notice of proposed rulemaking, said how a health care plan is funded is irrelevant in determining whether it offers minimum essential coverage.

Group health plans meet the minimum essential coverage standard, regulators said, if they are employer group health plans, "whether an insured group health plan or a self-insured group health plan."

The issue arose due to language in the health care reform law that described plans offering minimum essential health coverage as a group health plan or group health insurance coverage, with no specific mention of self-funded health plans.

Paul Dennett, senior vice president for health care reform with the American Benefits Council in Washington, said, "Any lingering ambiguity has been eliminated. How a plan is funded" is irrelevant with regard to providing minimum essential coverage.

YOGA

Continued from page 1

utilization review company.

Businesses providing the functional restoration programs aim to help patients, including those who have struggled with chronic pain from workplace injuries, Mr. Pew said. Often, such patients' conditions have deteriorated following their injuries because they took increasing quantities of pain medications such as opioid drugs (see chart, page 1).

Functional restoration programs often provide differing combinations of physical therapy, counseling for psycho-social issues, occupational therapy, addiction education and physical fitness activities such as yoga.

Rehabilitation service providers say their goals include helping patients improve their ability to cope with pain, increasing physical functioning and addressing emotional conditions to promote a more productive lifestyle.

The programs can cost workers comp payers tens of thousands of dollars for sessions that patients attend daily over several weeks. Yet their results, like their offerings, are mixed, several sources said.

There is a lack of quality outcomes data showing what works and what doesn't, said Eunhee Kim, CEO at EK Health Services Inc., a San Jose, Calif.-based workers com-



HEAR MORE

Access the tablet edition of *Business Insurance* on an iPad to listen to an extended interview with Prium's Mark Pew on how yoga can be included in functional restoration programs.

restoration program, only to relapse months later with their pain and narcotic use increasing, Ms. Kim said. There could be several physical or social reasons for that.

Payers may close a claim immediately after claimants complete such programs or they may offer follow-up care.

To help injured workers suffering from multiple complications requires treatment with "interdisciplinary themes," such as cognitive behavioral therapy blended with occupational or physical therapy, said Dr. Kathryn Mueller, a medical professor at the University of Colorado in Denver.

Overall, increasing functional outcomes that are measurable should be the goal of all medical treatment, said Dr. Mueller, who is also medical director for the Colorado Division of Workers' Compensation.

"That is particularly true with opioid management, but it is true" for all care, she said. "In workers comp, we think of that as return to work or at least increasing job tasks" that an injured worker is capable of performing.

Without a strict definition of functional restoration, providers can assert that they offer such programs while providing nothing more than physical therapy, sources said.

Some are even "fly-by-night" operations, Mr. Pew said.

To recommend which functional restoration programs provide good outcomes, Mr. Pew said he is attempting to score them based on a set of questions he developed for

the service providers.

The goal is to help work comp payers decide what action to take after utilization review and peer-to-peer discussions with a treating physician have concluded that an injured worker is consuming too many drugs without showing improvement.

While scoring functional restoration programs, Mr. Pew said he found that those that appear to have the best practices are making yoga part of their offerings.

Yoga "helps with flexibility, which obviously is part of trying to get (patients suffering from chronic-pain issues) beyond the 'I can't move' stage," Mr. Pew said.

Yoga also appears particularly suited for helping patients, such as workers who have experienced failed back surgeries, focus on something other than their pain, Mr. Pew said.

"However you came to chronic pain, you have to figure out some way to not let it drive you," Mr. Pew said. "That is really what functional restoration is trying to do — improve your function, which improves your quality of life."

But several experts said patients must be interested in the functional restoration program's offerings and motivated to make lifestyle changes to achieve positive results. Better programs properly screen participants for their motivation before admitting them, sources said.

Motivated patients can find yoga to be beneficial, Dr. Mueller said.

to Willis' Mr. Abraham.

"Over the past 10 years, each and every claim has been getting more expensive," said Rolf Thore Roppestad, senior vice president and co-head of underwriting at Gard P&I (Bermuda) Ltd., which is asking members for a 5% increased advance call.

For example, he said, 10 years ago the average claim for Gard was about \$25,000, while last year the average claim size reached \$70,000.

Claims costs have increased because of various factors, he said, including the cost of wreck removal and pollution cleanup. There also are underlying causes such as increases in cargo values and crew wages, he said.

Mr. Roppestad said that, for the previous two renewals, Gard was able to offer rate reductions to its members. But this year "there was no way round" rate increases, he said.

Significant recent claims

The most significant recent claims have been seen in the passenger and dry cargo sectors, and that is where rate increases are being seen, said Nick Taylor, head of P&I in Marsh Inc.'s marine prac-

Some could see 40% hikes in reinsurance

The cost of the reinsurance program for the International Group of P&I Clubs may increase by as much as 40% when the renewal is completed, experts say.

Reinsurers bore the brunt of heavy losses on the container ship *Rena*, which sank off the coast of New Zealand in October 2011, and the *Costa Concordia*, which sank off the coast of Italy in January 2012, Standard & Poor's Corp. said in a report last week.

S&P said that while these losses have demonstrated the robustness of the International Group's reinsurance arrangements, they have led to an increase in costs of about 40%.

The program, which still was in the process of being placed last week, likely will see a rate increase of at least 35%, said Nick Taylor, head of P&I in the marine practice of Marsh Inc. in London.

Last month, the International Group announced several changes to its reinsurance arrangements intended to offset the impact of rising premiums. Those included:

- An increase in individual clubs' retentions to

\$9 million for the 2013-2014 policy year from \$8 million for the 2012-2013 policy year.

■ The excess point on the general excess-of-loss reinsurance contract will increase to \$70 million from \$60 million. The extra \$10 million will be retained within the group pool that is reinsured by the group's captive Hydra Insurance Co. Ltd. Bermuda-based Hydra reinsures \$40 million in excess of \$30 million of the International Group's exposure.

■ Hydra's coinsurance share in the first layer of the group's general excess-of-loss coverage will increase to 30% from 25%.

■ For the 2013-2014 year, there will be a three-layer pool structure for the general excess-of-loss program. That structure will include a lower pool layer from \$9 million to \$45 million, an upper pool layer from \$45 million to \$60 million, within which there is a claiming club retention of 10%, and an upper pool layer from \$60 million to \$70 million, within which there is a claiming club retention of 5%.

By Sarah Veysey

tice in London.

For example, he said, the grounding of the container ship *Rena* off the coast of New Zealand in October 2011 typifies the problems for the dry cargo sector. The *Rena* was a fairly small container, he said, but cleanup costs will be in excess of \$300 million, with the brunt of that cost borne by the

reinsurance sector, largely within Lloyd's of London.

The cost of pooled losses that are shared among P&I clubs and the cost of reinsurance have increased, and this eats into the amount that clubs can retain to pay attritional claims, said Marsh's Mr. Taylor.

Clubs that have taken on a large

amount of newer tonnage have fewer years of retained premiums built up than those with a large number of older ships and, therefore, are less able to be flexible on rates, he noted.

There are 17 pool claims, according to S&P, and the high number and cost of these claims has caused some clubs to fall into

deficit even when their own loss experience would not have dented profits, it said.

Some shipowners, faced with large calls from their clubs and increased reinsurance costs, may seek to change clubs, experts said.

While there typically is about a 98% retention rate for owners remaining with P&I Clubs, the large rate increases being sought by some clubs may test shipowners' loyalty, said Peter McClean, a director of financial institutions ratings at S&P in London, and there may be more movement of shipowners between clubs than usual.

There likely will be an "above-average movement of tonnage" at the Feb. 20 renewal, likely as shipowners attempt to improve their positions for the 2013-2014 year, said Mr. Taylor.

Some shipowners may consolidate their membership from several clubs into just one, he said.

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HHS rejects Mississippi's insurance exchange application

■ Mississippi on last week became the first state to have its proposal for a health insurance exchange rejected by the U.S. government, and federal officials said Republican Gov. Phil Bryant's opposition to the plan was to blame. "With a lack of support from your governor and no formal commitment to coordinate from other state agencies, we do not see a feasible pathway to conditionally approving a state-based exchange in Mississippi for 2014," the U.S. Department of Health and Human Services said in a letter to the state.

Reuters

U.S. commercial rates expected to keep firming

■ While a traditional hard market remains elusive, U.S. commercial insurance rates are expected to continue firming in many lines of business and industry sectors in 2013, a report by Marsh Inc. finds. The report noted that the "price increases are not uniform, capacity is plentiful and competition among insurers remains intense." Commercial property/casualty insurance rates continued to climb in 2013, increasing an average of 5% in January compared with the same month a year earlier, according to a MarketScout report.

Large-employer pension funding jumped in January

■ Aided by strong investment returns and a slight increase in interest rates, the funded status of pension plans sponsored by large employers rose in January, according to Mercer L.L.C.

On average, pension plans sponsored by companies in the S&P 1500 were 77% funded as of Jan. 31. That's up from 74% at year-end 2012 and 72% as of Nov. 30, 2012. Meanwhile, Milliman Inc. said defined benefit plans offered by the 100 U.S. employers with the largest pension programs were on average 81.7% funded as of Jan. 31. That's up from 76.5% as of Dec. 31 and 74% as of Nov. 30.

2012 cat bond supply does not meet demand

■ Despite issuance volume of \$1.9 billion in the fourth quarter of 2012, the supply of catastrophe bonds was insufficient to meet investor demand, according to a report issued by Willis Capital Markets & Advisory. The report notes that while the \$5.9 billion of catastrophe bonds issued in 2012 represent a 37% increase over the volume issued in 2011, surging investor demand for insurance-linked securities triggered bidding wars on some bonds. In addition, last year saw the second-largest issuance of insurance-linked securities, according to analysis by Swiss Re Ltd. In its report, Swiss Re said about \$6.3 billion in bonds were brought to market in 2012 compared with about \$8.0 billion in 2007. There were 27 deals in 2012 producing 47 tranches with an average size of \$227 million per deal.

TRIA extension bill introduced by lawmakers

■ A bipartisan group of members of Congress has introduced a measure to extend the federal government's terrorism insurance program through the end of 2019. The terrorism insurance backstop, which would respond to truly catastrophic terrorist attacks, was reauthorized in 2007, but it is slated to expire on Dec. 31, 2014. The TRIA Reauthorization Act would

extend the program — first created by the Terrorism Risk Insurance Act of 2002 — through Dec. 31, 2019.

Retaliation charges increase in 2012: EEOC

■ Retaliation charges filed with the U.S. Equal Employment Opportunity Commission in fiscal year 2012 continued to increase, even as the total number of charges filed with the agency declined slightly, the agency said. The number of charges filed in fiscal year 2012, which ended Sept. 30, was 99,412, a 0.5% decrease from fiscal year 2011. Retaliation charges, though, again topped the list and increased by 1.3%, to 37,836. There was a 3% increase in retaliation charges in fiscal 2011, to 37,334 charges.

Antitrust, environment cases expected to increase

■ Increased antitrust activity and an evolving set of litigating risks from environmentalists and the plaintiffs bar are among the litigation issues facing companies this year, according to a report on the legal outlook by law firm Crowell & Moring L.L.P.

Treaty reinsurance renewals see rates rise slightly

■ Rates rose slightly at the treaty reinsurance renewals on Jan. 1, with marine rates experiencing "appreciable" increases, according to Hannover Reinsurance Co. In a statement, the reinsurer said the reinsurance market at Jan. 1 had been more competitive than the previous year, adding that the impact of Superstorm Sandy had a stabilizing effect on prices.

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S&P

Continued from page 3

claims are probably defensible," Mr. Passannante said.

He also expressed skepticism about the government's ability to collect the \$5 billion in damages the suit is seeking given the wording of FIRREA, which limits damages to \$5.5 million for a continuing violation.

"FIRREA is fairly recent, so there's not a huge body of case law," Mr. Passannante said, noting that media reports indicated the Justice Department and S&P previously were in talks to settle the charges in the neighborhood of \$100 million.

"To get to \$5 billion in damages, there would need to be a lot of underlying counts, but the complaint only lists 24. So the headline number is very scary, but \$100 million is a probably lot closer to reality," he said.

Mr. LaCroix said the case's direct effect on the larger insurance market is likely to be muted, but also said its indirect effect could be substantial.

"There's only a limited number of rating agencies," Mr. LaCroix said. "Even if all three suffered

losses, while it would be a significant event for the carriers paying the losses, it won't be the type of systemic event that is going to cause major disruption in the marketplace."

He said the more likely effect of the case would be in altering the dynamic of previously filed litigation against rating firms where individuals were named as defendants. "The government's case could make it harder to settle all those cases and make them costlier to defend," Mr. LaCroix said.

Bob Friedman, a partner at Boston-based Burns & Levinson L.L.P., said a settlement between S&P and the government is possible, but the public nature of the case and public resentment over the 2007-2009 financial crisis make a rapid resolution unlikely.

"In the complaint, the Department of Justice makes a pretty bold public statement about the merits of the case," Mr. Friedman said. "Cases usually don't get settled in the wake of that."

Reacting to the litigation, S&P described the charges as "meritless."

The allegations filed by the Justice Department "are simply untrue. Our ratings were issued in good faith," S&P said in a statement.

PLUS

Continued from page 3

Samuel Rudman, a partner with plaintiff law firm Robbins Geller Rudman & Dowd L.L.P. in New York, said the SEC would say its job is "to collect money, but not rely on the plaintiff bar."

While the agency has increased penalties only recently, "My problem with SEC settlements is they conduct extensive discovery over a multiyear period and then refuse to make any of that information public," Mr. Rudman said. "What the process needs is transparency."

Mr. Siegel said he anticipates more cases in connection with the LIBOR rate-setting scandal and whistle-blower provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act.

"Clearly," Mr. Coffee said, there also is "great enthusiasm for insider trading cases" at the SEC.

"Whatever the trends are, (they're) going to result in higher premiums for D&O" insurance, said plaintiff attorney Max W. Berger, senior partner at Bernstein Litowitz Berger & Grossmann L.L.P. in New York.

There are three "powder keg sit-

uations" with respect to private-sector D&O litigation, said David J. Hensler, a partner with Hogan Lovells U.S. L.L.P. in Washington. They are a dominant shareholder taking advantage of his or her position over a minority shareholder, dissent among family members in family-owned businesses and bankruptcy.

One area of contention for non-profits has been donors who have been "absolutely acting like investors," said Beth Goldberg, a New York-based senior vice president and head of middle market for Zurich in North America.

As an example, she cited last year's \$1 million jury verdict awarded to country singer and donor Garth Brooks, after a hospital failed to name a women's medical center in honor of his mother.

Peter Herron, vice president and head of the private and nonprofit liability business unit for Travelers Bond & Financial Products, a division of Travelers Cos. Inc. in Hartford, Conn., said inappropriate investments and the comingling of funds are other litigation threats facing nonprofits.

About 1,200 people attended this year's PLUS D&O Symposium. Next year's meeting will be held Jan. 28-29, 2014, in New York.

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BLOOMBERG PHOTO

Buffett's fun run takes ironic turn

Berkshire Hathaway Inc. Chairman and CEO Warren Buffett hopes to lure some fleet-footed followers away from the buffet at this year's upcoming annual shareholders meeting.

The avuncular octogenarian will fire the starting gun at the inaugural "Invest in Yourself" 5 kilometer fun run, which will be held on May 5 in Omaha, Neb.

While Berkshire's portfolio of investments famously contains positions in popular but nutritionally questionable entities such as Coca-Cola and Dairy Queen, the race is intended to encourage "participants to take stock of their health" and "embrace an active lifestyle."

Mr. Buffett seemed to acknowledge the incongruity in a news release announcing the race.

"It's going to be a great weekend for Berkshire Hathaway shareholders, and a 5k will be the perfect complement to the See's Candies, Dilly Bar and Cherry Coke everyone will enjoy while here," he said in the statement.

DA finds fraudster too close to home

The potential wrongdoers that the Fresno County District Attorney's Workers' Compensation Fraud Division pursues includes doctors, lawyers, employers, insurance company employees and claimants, according to the California county's website.

The county's site doesn't mention that one of the DA's former investigators also could be a potential workers comp rip-off.

But according to a report, a former Fresno County DA investigator recently was ordered to pay nearly \$24,000 in restitution after he pleaded no contest to a charge of grand theft for improperly receiving workers comp benefits.

John Harding Swenning allegedly lied to receive surgery as part of his workers comp benefits, according to the Fresno Bee report. The Fresno paper cited an attorney for Mr. Swenning, who said his client exaggerated symptoms so that he could receive a surgery and return to work.

Mr. Swenning reportedly is eligible to have the felony reduced to a misdemeanor after paying the restitution.

CHILD TAKES THE RAP FOR TIMBALAND'S \$1.8M LOST WATCH



FEATUREFLASH/SHUTTERSTOCK.COM

Hip-hop producer Timbaland says his toddler lost his \$1.8 million bling.

Hip-hop producer and rapper Timbaland is suing American Home Assurance Co. after the insurer reportedly denied reimbursement for a \$1.8 million watch he believes was lost by his toddler. Timbaland — aka Timothy Mosley — says he purchased an insurance policy from American Home in May 2010 to cover nearly \$5 million in jewelry, according to a complaint filed last month in Florida's 11th Circuit Court. One of the items included a "limited edition (baguette) rainbow tourbillion watch," which was made by Jacob & Co. and included 294 special cut diamonds.

Mr. Mosley's watch vanished in August 2010 after he set it on a nightstand at his home following a late-night recording session, according to his complaint. He and his wife testified that their daughter, who was 2 years old at the time, may have played with the watch while her father was sleeping and later discarded it.

The lawsuit does not say why Mr. Mosley's insurance claim was allegedly denied by American Home, which is a unit of American International Group Inc.

Mr. Mosley is seeking \$1.8 million in damages, interest dating back to the watch's 2010 disappearance, and attorney fees.

Business Insurance isn't all business all the time, and we know you're not either. So visit www.businessinsurance.com for more Off Beat stories and monthly photo galleries featuring the best of the weirdest news about insurance, fraud, liability issues and related topics that make people and companies do funny, silly and strange things.

Talking Heads song burns S&P

The U.S. Justice Department's lawsuit alleging that Standard & Poor's Corp. inflated mortgage investment ratings includes an emailed video parody of the Talking Heads hit "Burning Down the House."

An unnamed S&P analyst reportedly produced the video of himself singing and dancing and passed it to co-workers some time during 2007. According to one news account, the housing market at that point was on the road to nowhere.



S&P co-workers reportedly found the email amusing. The problem for S&P may be that the parody warned that a cooling housing market was "bringing down the house."

In its lawsuit filed in Los Angeles, the Justice Department alleges that S&P engaged in a scheme to defraud investors by knowingly inflating credit ratings for risky mortgage-backed securities and collateralized debt obligations.

Skateboarder loses auto cover

An insurer in Canada is cracking down on helmet use — not by motorcyclists, as one might expect, but by skateboarders.

Security National Insurance Co., which does business as TD Insurance Meloche Monnex, dropped auto coverage for a 25-year-old Halifax, Nova Scotia, man after police notified the insurer that he had been ticketed twice over the past three years for not wearing a helmet while skateboarding at the Halifax Common.

According to Halifax Regional Police, Pat Harland was among 226 individuals cited last year for not wearing helmets. Among those ticketed were cyclists and skateboarders. Each ticket comes with a fine of \$141.16 Canadian (\$140.34).

"Any type of violation that goes against the Motor Vehicle Act does take points off of your license and thus counts against your insurance rating," Mr. Harland said during a television interview. "If it affects your motor vehicle report, it does affect your overall insurance as well."

Now Mr. Harland has to find another insurer or possibly buy coverage through the state's high-risk plan, which usually is reserved for bad drivers or those convicted of driving under the influence of alcohol or drugs.



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