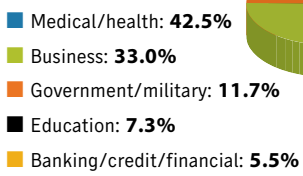


## CYBER BREACHES

Percentage breakdown by industry of the 783 data breaches in 2014



Source: Identity Theft Resource Center

## CYBER RISK

### Congress seeks solutions on cyber risk

Insurance seen as key tool to bolster security

BY MARK A. HOFMANN

Following a year of several widespread cyber breach incidents, Congress is poised to encourage the insurance industry to take a lead role in bolstering cyber security.

That was evident earlier this month as the Senate Commerce Committee's Subcommittee on Consumer Protection, Product Safety, Insurance, and Data Security held the first congressional hearing on cyber insurance.

As the panel's chairman, Sen. Jerry Moran, R-Kan., put it, cyber insurance "may be a market-led approach to help businesses improve their cyber security posture by tying policy eligibility or lower premiums to better cyber security practices."

Meanwhile, several bills have been introduced in Congress — the

See **CYBER** page 27

## EMPLOYMENT PRACTICES

# WHITE-COLLAR FIRMS TARGET OF GENDER BIAS CLAIMS

Ellen Pao's high-profile case one of many



Gender bias cases share similar claims of women's treatment. PAGE 29

AP PHOTO

Ellen Pao leaves court in February. Her lawsuit against a venture capital firm alleges bias and retaliation.

BY JUDY GREENWALD

The "good old boy" corporate culture at white-collar firms could allow gender discrimination to continue to flourish, despite employers' efforts to alleviate it.

This is one of the reasons gender or sex discrimination lingers at venture capital, accounting and law firms, among others, experts say.

The problem has recently garnered attention because of national publicity in a San Francisco jury trial in which Ellen Pao, a former junior partner at Kleiner Perkins Caufield & Byers L.L.C.

accused the prominent Menlo Park, California, venture capital firm of gender discrimination and retaliation.

On Friday, the jury returned a verdict rejecting Ms. Pao's claims. She had sued Kleiner Perkins in May 2012, alleging the Silicon Valley firm paid men more than women and favored them for promotions. Five months after filing suit, the firm terminated her employment.

Ms. Pao's case is among several similar suits, including one against Facebook Inc., alleging bias

See **BIAS** page 29

## BENEFITS MANAGEMENT

### Overlooked rule on deductibles could be costly

Some health care plans may need revisions

JERRY GEISEL

Recent federal regulatory health care reform law guidance will require many employers with high-deductible health care plans to redesign those plans to reduce claim costs picked up by employees with family coverage.

The little-publicized guidance from the U.S. Department of Health and Human Services leaves untouched annual limits set by the health reform law on the maximum out-of-pocket expenses employers can require employees to pay before plan coverage kicks in: \$6,850 for single coverage and \$13,700 for family coverage when the rules go into effect in 2016.

The rules add a new and potentially costly requirement for employers, who will have to cap at \$6,850 the maximum out-of-pocket expense any individual with family coverage — whether an employee or covered dependent — will have to pay before plan coverage kicks in.

In short, the \$6,850 annual cap on how much a plan participant can be asked to pay will apply, regardless if the individual has single or family coverage.

"The intent is once an individual with family coverage hits the out-of-pocket limit for single coverage," he is or she would have full

See **DEDUCTIBLE** page 29



## Q&A: CHRISTOPHER J. SWIFT

Chairman and CEO of Hartford Financial Services Group Inc. discusses how the insurer sharpened its focus.

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## COMMENTARY

The acceleration of technology has been accompanied by an acceleration in risk.

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## INDUSTRY FINANCIALS

Brokers, reinsurers and health and property/casualty insurers' 2014 results.

PAGE 6



## SPECIAL REPORT

## CLAIMS MANAGEMENT

Health insurer claims data tempt hackers; business interruption losses require robust strategies; return-to-work programs expand beyond workers comp; paying doctors more to speed up the claims process.

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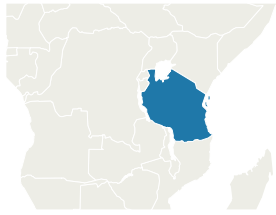
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Profile: Tanzania

The small Tanzanian property/casualty market continues to struggle. Eleven of the 25 insurers reported underwriting losses in 2013. **10**

PERSPECTIVES

U.S. insurers on the defensive



U.S. insurers and their regulators face an unprecedented threat of scrutiny and intrusion from U.S. and foreign entities, says Dave Snyder, of the Property Casualty Insurers Association of America. **15**

OFF BEAT



Not taking any dot-com risks

Representatives for Taylor Swift have acquired domain names ahead of June 1, when many new domain suffixes become available. **30**

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NEWS

SAFETY

ENERGY SECTOR STRIVES TO CUT SILICA EXPOSURE

OSHA zeroes in on byproduct of sand used in fracking

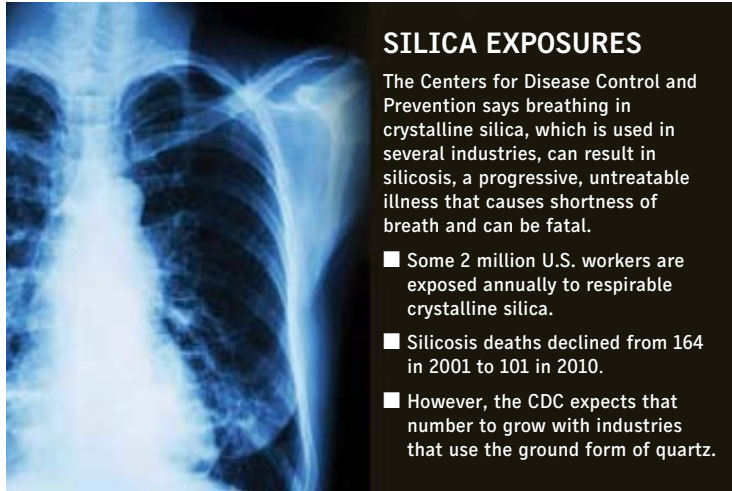
BY BILL KENEALY

Companies in the energy sector are working to get ahead of new federal rules to protect workers from inhaling crystalline silica, which is used in many industries, by improving processes and investing in new technologies.

As the U.S. Occupational Safety and Health Administration works to finalize rules on worksite exposures to crystalline silica, opportunities to limit dust exposure are plentiful across the fracking process, experts say, as large quantities of silica sand are used as the “proppant” that holds fractures in rock formations open, allowing the oil and gas to flow out of the formation and be collected.

According to the National Institute for Occupational Safety and Health, the kinds of technology the energy industry can use to limit silica exposure include the application of liquid dust suppressants to keep particles from becoming airborne, mobile dust-collecting particulate air vacuums, to personal protective gear such as respirator masks.

“There are excellent engineering controls that companies can now take advantage of,” said Rick L.



SILICA EXPOSURES

The Centers for Disease Control and Prevention says breathing in crystalline silica, which is used in several industries, can result in silicosis, a progressive, untreatable illness that causes shortness of breath and can be fatal.

- Some 2 million U.S. workers are exposed annually to respirable crystalline silica.
- Silicosis deaths declined from 164 in 2001 to 101 in 2010.
- However, the CDC expects that number to grow with industries that use the ground form of quartz.

Ingram, Victoria, Texas-based member of the National Advisory Committee for Occupational Safety and Health and OSHA voluntary protection programs technical adviser for BP America Production Co. “The technology is becoming more prevalent and more efficient.”

Moreover, field studies conducted by NIOSH in 2012 identified some of the primary sources of silica dust exposure during hydraulic fracturing operations which include when sand is first delivered to a site via truck, when the sand is loaded into dedicated sand movers, and when the sand is

transferred via conveyer belt into a blender, where it is mixed with liquid fracturing fluids.

Sam Henselijn, San Antonio-based business development specialist at fracking storage system provider SandCan L.L.C., said his company has recently developed a storage and unloading technology that significantly reduces airborne silica at fracking sites by putting the fracking sand in a hopper that is housed inside a frame in the shape of a standard shipping container.

“There are a lot of inefficiencies

See **SILICA** page 28

REINSURANCE

London looks to cash in on cat bond craze

BY SARAH VEYSEY

The London reinsurance market, which has been hit by a shift of business to alternative risk transfer vehicles, could regain some of that lost ground by becoming a domicile for insurance-linked securities.

Industry observers last week welcomed U.K. Chancellor of the Exchequer George Osborne’s pledge earlier this month to enable ILS offerings to be domiciled onshore in the United Kingdom.

In his budget statement, Mr. Osborne said he considers ILS to be a key growth opportunity for



the U.K. reinsurance sector, and that he will work with the industry and regulators “to develop a new corporate and tax structure” to allow ILS to be domiciled in the United Kingdom.

The idea is “a boost for the insurance sector and should stimulate growth,” said Colin Graham, U.K. insurance tax leader for PricewaterhouseCoopers L.L.P. in London.

“We hope this will prove a positive first step in a long-term project for our industry to work collaboratively” with the government “to explore more ways of attracting international business,” said Dave Matcham, CEO of the London-based International Underwriting Association, which represents underwriters.

Steve Hearn, deputy CEO of

See **ILS** page 28

CORRECTION

A Q&A interview on page 12 with Christopher J. Swift, chairman and CEO of Hartford Financial Services Group Inc., omits his job title. The page went to press last week before the omission was discovered.

WORKERS COMPENSATION

Physician dispensing a moving target

Repackaging firms find loopholes to rules

BY SHEENA HARRISON

State efforts to restrict prices for physician-dispensed prescriptions have helped lower drug spending for workers compensation claims, but experts say future reforms likely will need to limit or ban physician dispensing in order to prevent prices from rising again.

Those projections are based partly on recent research from the Cambridge, Massachusetts-based Workers Compensation Research Institute, which found that some drug repackaging firms are developing pill formulations that dodge state price caps for medications and are almost exclusively dispensed by doctors.

Those new drug strengths — which are neither more powerful nor more effective than previous formulations — have allowed repackagers and dispensing doctors to continue charging a premium for those pills, according to WCRI data.

For instance, Illinois workers comp payers have typically paid 99 cents to \$1.74 per pill for 5- and 10-milligram cyclobenzaprine, a common muscle relaxant, the WCRI said. However, after Illinois implemented drug repackaging controls in 2012, the injured workers in the state began receiving more prescriptions for 7.5-milligram cyclobenzaprine — a strength that was “rarely seen” previously — at an average wholesale price of \$3.79 a pill.

“They’ve been able to game the system by coming up with these ‘novel’ drugs, thereby circumventing the rules regarding repackaged drug pricing,” said Joseph Paduda, president of Madison, Connecticut-based pharmacy benefit manager consortium CompPharma L.L.C.

Sources say states such as Pennsylvania and Indiana are leading the way in passing legislation that limits the overall ability of doctors to dispense medications directly to patients. Still, they say employers should educate their injured workers about filling prescriptions through pharmacies rather than doctors to avoid higher costs and dangerous drug interactions while waiting for states to act.

See **DISPENSING** page 28

ONLINE  
FEATURES

GALLERY

Relive the Risk Management Summit in pictures

U.S. and European risk managers attended the annual networking and educational summit in New York. [www.BusinessInsurance.com/RMSGallery](http://www.BusinessInsurance.com/RMSGallery)

VIDEO



Workplace wellness programs

Our video report looks at how workplace wellness can improve both health and the bottom line. [www.BusinessInsurance.com/InFocus](http://www.BusinessInsurance.com/InFocus)

TOP STORIES

Top 10 stories of the week

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NEWS

EMPLOYMENT PRACTICES

# High court ruling widens scope of accommodating pregnant workers

BY JUDY GREENWALD

The U.S. Supreme Court's revival of a part-time worker's pregnancy discrimination suit against UPS puts employers on notice that they should review their light-duty programs with respect to pregnant women.

One expert said the ruling could result in more such cases making it to the jury trial phase and that more clarity is needed on what constitutes equal accommodation.

In *Peggy Young v. United Parcel Service Inc.*, the part-time driver for Atlanta-based UPS alleged discrimination after she became pregnant in 2006 and was told by her doctor she could not lift more than 20 pounds during the first 20 weeks of her pregnancy, even though UPS requires drivers to be able to lift 70 pounds.

UPS told Ms. Young she could not work under a lifting restriction. She stayed home without pay during most of her pregnancy and eventually lost her employer-provided medical coverage.

She subsequently sued, alleging UPS acted unlawfully in refusing to accommodate her lifting restriction while it had accommodated other drivers who were unable to work for other reasons.

UPS responded that other workers it had accommodated were drivers who had become disabled on the job, lost their U.S. Department of Transportation certificate or had a disability covered under the Americans with Disabilities Act.

In affirming a Greenbelt, Maryland, federal judge's ruling dismissing the case, the 4th U.S. Circuit Court of Appeals in Richmond, Virginia held in 2013 that UPS had a "pregnancy-blind policy" that

was a "neutral and legitimate business practice" on its face.

The Pregnancy Discrimination Act "requires courts to consider the extent to which an employer's policy treats pregnant workers less favorably than it treats non-pregnant workers similar in their ability or inability to work," according to the Supreme Court's ruling. "It requires courts to consider any legitimate, nondiscriminatory, nonpretextual justification



AP PHOTO

Peggy Young, left, a part-time driver for Atlanta-based UPS, alleged discrimination after she became pregnant in 2006.

for these differences in treatment."

In remanding the case to the 4th Circuit, the 6-3 majority of the nation's highest court said "there is a genuine dispute as to whether UPS provided more favorable treatment to at least some employees whose situation cannot reasonably be distinguished from Young's."

In a dissent, Justice Antonin Scalia wrote the majority crafted a "new law that is splendidly uncon-

nected with the text and even the legislative history of the ADA."

Responding to the ruling, UPS in a statement said it voluntarily introduced a policy in January that makes temporary light-duty work available to all pregnant employees with medically certified or other physical restrictions.

The court "split the baby" and took a middle approach, said Lucretia C. Clemons, a partner with law firm Ballard Spahr L.L.P. in Philadelphia who was not involved in the suit.

"The rule isn't that you always get accommodated or never accommodated," but if an employer is accommodating others who have a similar inability to work, denying the pregnant woman's request for accommodation is discrimination, Ms. Clemons said.

"The court pretty clearly says if you can accommodate all these other people for all these other reasons, why can't you add pregnant women?" she said. "The employer has to explain that, and it has to be a really good reason."

The court reminded employers that "in some circumstances, pregnancy discrimination can be inferred from the way you treat other workers," said Barry A. Hartstein, a shareholder at Littler Mendelson P.C. in Chicago.

The ruling "means that a lot more of these cases are going to survive summary judgment and are going to be tried to a jury," said Camille A. Olson, a partner at Seyfarth Shaw L.L.P. in Chicago.

"It will impact employers who are trying to grapple with the issue" of dealing with workers who do not have on-the-job injuries but need accommodation to perform essential functions of their job, she said.

CLAIMS MANAGEMENT

## Building better physician relationships

### Personal touch combats growing comp costs

BY STEPHANIE GOLDBERG

Building relationships with physicians can help workers compensation payers improve the outcomes of claims and combat rising medical costs.

Third-party administrators such as Helmsman Management Services L.L.C. and Sedgwick Claims Management Services Inc. have measured physician and clinic performance for several years. They're among payers using the data to build relationships with highly rated health care providers, and working with low-scoring providers to improve outcomes.

Sources said building relationships with physicians is done by a small number of payers — perhaps as low as 5%. But with medical expenditures always rising, it's considered a best practice in workers comp managed care.

Cost concerns are real. Medical claim severity increased 6.7% from 1995 to 2012, the latest data available from the National Council on Compensation Insurance Inc. Meanwhile, indemnity benefits, which replace lost income based on an injured worker's average weekly wage, increased 4.8% during the same time period.

"The most costly thing from my avenue is when (workers) get misdiagnosed and mistreated, and then I have to go back and start all

See **PERFORMANCE** page 29

### WHAT PHYSICIANS WANT



Physicians want help with a "cacophony" of regulatory requirements and a "plethora" of alternative payment models designed to improve the quality of health care and reduce costs, according to a recent study by Rand Corp. and the American Medical Association. The study's findings include:

- Physician practices are joining other practices or hospitals to allow increased investment in data technology and staff to better track treatment, outcomes and compliance.
- Payers should consider "investing in the capability" of physician practices to make the best use of technology and data, when drug pricing and performance feedback are incomplete.
- Payers should consider ways to harmonize "hundreds of different performance measures" in alternative payment models.

HEALTH BENEFITS

## Job climate a factor in worker health, productivity

BY MATT DUNNING

SAN FRANCISCO — Employees working in poor job climates are more than twice as likely to miss work due to common ailments, but embracing all factors in an employee's well-being is twice as effective in curbing productivity losses — an approach several employers have used successfully. "We can see from the research

that not only are bad work climates associated with both higher rates of absences and poorer job performance, they also exacerbate the negative effects of mental and physical health symptoms," said Kim Jinnett, executive vice president of the Integrated Benefits Institute.

She was commenting on IBI research, released at the IBI Annual Forum, held March 16-18 in San

Francisco, that employees who had poor perceptions of jobsite safety, respect and trust among staff and managers, job engagement and satisfaction, and overall workload spent more than twice as much time off the job due to chronic pain, fatigue and difficulty sleeping, among other maladies.

Managers and supervisors who

See **IBI** page 28

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Source: Internal analysis of 2013 data published by SNL Financial.



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# Property/casualty insurers enjoyed calm 2014

## Benign domestic catastrophe losses offset continued low interest rates

BY MARK A. HOFMANN

Stable is the best way to describe commercial property/casualty insurers' performance during 2014.

It was a year without huge domestic catastrophe losses, which meant many underwriters continued to post underwriting profits. Insurers did well with their equity portfolios as well, but the continuing paucity of interest income did affect insurers' balance sheets.

In addition, insurers were able to get rate increases last year. However, the size of the increases decelerated as the year went on, a trend that appears to be continuing this year.

Net income for the 10 largest commercial property/casualty insurers that report quarterly results dropped 12.3% in 2014 vs. 2013 (see chart). In their financial statements, most reported disappointing investment income even though the relatively small portion of their portfolios consisting of equities performed well.

Net written premiums grew only 2.6%, but the group's collective combined ratio continued to improve, declining to 93.5% from 94.5% the previous year.

Only American International Group Inc. posted a combined ratio above 100%.

Of course, results varied greatly by company. At one extreme, Hartford Financial Services Group Inc.'s 2014 net income grew more than 380% to \$798 million, reflecting better underwriting results as well as low-

ered losses associated with discontinued business, notably its Japanese annuity business. At the other extreme, XL Group P.L.C.'s net income dropped more than 80% year-over-year, reflecting a large loss stemming from the sale of its life reinsurance business.

Industry analysts generally liked what they saw.

"It was a pretty stable year compared to 2013," said James Auden, managing director of insurance at Fitch Ratings Inc. in Chicago. "Underwriting results for most companies were pretty much on par with 2013."

"2013 and 2014 were very similar," said Joshua Shanker, New York-based analyst at Deutsche Bank Securities Inc. There were no major domestic catastrophes, and there was "a generally benign loss-cost trend in both years."

In fact, 2014 turned out better than some observers expected, said Mark Dwelle, an insurance analyst at RBC Capital Markets, a unit of RBC Dominion Securities Inc. in Richmond, Virginia.

"Pricing held up better, margins held up better and reserves held up better," he said.

But "interest rates continued to be a drag," Mr. Dwelle said. Some insurers also sustained slightly higher-than-normal non-catastrophe-related weather losses.

Interest rates could be one key factor affecting insurers this year.

"The prevailing view last year was interest rates were going up, and they didn't,"

### INSURERS

## PROPERTY/CASUALTY INSURERS' 2014 RESULTS

Largest U.S.-based or listed commercial property/casualty insurers that report quarterly results. Ranked by net premiums written, in millions of dollars.

Insurer	Net premiums written 2014	% increase (decrease)	Net income	% increase	Combined ratio
Liberty Mutual Insurance Co.	\$36,275	3.3%	\$1,833	5.2%	97.5%
American International Group Inc.	\$33,432	(0.4%)	\$7,529	(17.1%)	102.2%
The Travelers Cos. Inc.	\$23,910	5.0%	\$3,692	0.5%	89.0%
Ace Ltd.	\$17,799	4.5%	\$2,853	(24.1%)	87.7%
The Chubb Corp.	\$12,592	3.0%	\$2,100	(10.4%)	88.3%
The Hartford Financial Services Group Inc.	\$10,244	3.2%	\$798	380.7%	93.4%
CNA Financial Corp.	\$6,535	(3.8%)	\$691	(26.3%)	97.7%
W.R. Berkley Corp.	\$5,997	9.0%	\$649	29.8%	93.8%
XL Group P.L.C.	\$5,767	(2.3%)	\$188	(82.2%)	88.2%
The Hanover Insurance Group Inc.	\$4,810	5.6%	\$282	12.4%	96.9%
Cumulative	\$157,361	2.6%	\$20,615	(12.3%)	93.5%

\*Include dividends

Source: Company reports



said Mr. Dwelle.

As a result, Fitch's Mr. Auden said insurers are contending with maturing bonds

with higher interest rates than those borne by the new bonds that are replacing them in the underwriters' investment portfolios, leading to lower investment income.

But Mr. Shanker had a different perspective. He said higher interest rates could cause problems for insurers that have benefited from strong equity markets.

"In a rising interest rate environment, the amazing bull market we had in equities comes to a halt," he said. Investment income takes would take a step down "almost immediately," he said.

Another challenge insurers faced last year that's likely to become more of an issue this year is premium rate increases that are getting smaller.

See **INSURERS** page 26

# Acquisitions, better economy drive revenue growth at large brokers

BY MATTHEW LERNER

The largest publicly traded insurance brokers posted modest organic growth in 2014 as a slowly improving U.S. economy helped offset ongoing soft insurance rates amid an active year for mergers and acquisitions.

Marsh & McLennan Cos. Inc., Aon P.L.C., Arthur J. Gallagher & Co., Willis Group Holdings P.L.C. and Brown & Brown Inc. increased their 2014 revenue, with Gallagher seeing the largest percentage rise and Aon the smallest (see chart).

Gallagher, through a series of acquisitions, also became the world's third-largest broker, sur-

passing Willis.

Profitability varied, however.

Marsh & McLennan, Aon and Gallagher increased their profit in 2014 with respective organic growth rates of 5.0%, 6.0% and 5.6%.

Willis and Brown & Brown, while still profitable, turned in year-end 2014 figures that were less than 2013 and respective organic growth rates of 3.6% and 3.3%.

Overall, analysts said, the results were positive.

"On average, brokers have been profitable, consistently generating double-digit consolidated pretax operating margins," said Gretchen Roetzer, Chicago-based director at Fitch Ratings Inc.

"The brokers continued to gen-



## 2014 BROKER RESULTS

Results for the largest publicly traded insurance brokers, ranked by total revenue. Figures in millions of dollars.

Broker	2014 revenue	% increase (decrease)*	2014 net income <sup>1</sup>	% increase (decrease)*
Marsh & McLennan Cos. Inc.	\$12,951	5.6%	\$1,465	8.0%
Aon Corp.	\$12,045	1.9%	\$1,397	25.5%
Arthur J. Gallagher & Co.	\$4,627	45.5%	\$303	13.0%
Willis Group Holdings P.L.C.	\$3,802	4.0%	\$362	(0.8%)
Brown & Brown Inc.	\$1,576	15.6%	\$207	(4.7%)

\*Percentage change reflects unrounded figures. <sup>1</sup> Includes impact of acquisitions or discontinued operations  
Source: Company reports

erate healthy organic growth through the past year, helped by an improving economy in the U.S.

and by greater penetration in some international markets," said Bruce Ballentine, vice president

and senior credit officer at Moody's Investors Service Inc. in New York. "Economic growth is an important driver of insurance premiums, which in turn drive broker commissions and fees."

Organic growth is "reflective of the economy, in part," said Tim Cunningham, managing director at Chicago-based investment banking and consulting firm Optis Partners L.L.C. "We've seen some modest improvement quarter over quarter, and broker revenue moves a little bit in lockstep with the economy."

"On the retail brokerage side, it seems like organic growth is kind of slipping a bit, and I think it's kind of reflective of the market,

See **BROKERS** page 26



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**OLD REPUBLIC**

## ■ **AIG investors' settlement wins approval of the court**

American International Group Inc. shareholders won approval of a \$970.5 million settlement resolving claims that they were misled about its subprime mortgage exposure, leading to a liquidity crisis and \$182.3 billion in federal bailouts. U.S. District Judge Laura Taylor Swain in Manhattan granted final approval at a hearing to what lawyers for the investors call one of the largest class action settlements to come out of the 2008 financial crisis. The U.S. Justice Department and U.S. Securities and Exchange Commission closed related probes involving AIG in 2010. Judge Swain noted that no potential class member had objected to the terms of the deal, which she said was strong evidence that it was "fair, reasonable and adequate" and should be approved. She added that the amount was "very substantial" and that shareholders would face significant risk if they continued to litigate instead of settling. The settlement covers investors who bought AIG securities between March 16, 2006, and Sept. 16, 2008, when the company received its first bailout.

Reuters

## ■ **Judge OKs proposed settlement in Target data breach litigation**

A federal district judge has approved a proposed settlement agreement in the Target Corp. data breach consumer litigation, under which Target will pay up to \$10 million to settle litigation filed by consumers in connection with 2013's massive data breach in which 100 million customers' payment card members were exposed. Judge Paul A. Magnuson of U.S. District Court in St. Paul, Minnesota, has set Nov. 10 for a final approval hearing on the settlement. In his order, in which he approved a class action for settlement purposes only, Judge Magnuson said that upon preliminary review, the court finds the settlement is "fair, reasonable and adequate" to warrant providing notice of the settlement to class members. The order says that a settlement administrator will begin sending notice by email to all class members for whom Minneapolis-based Target has an email within 45 days. Litigation filed by payment-card issuing financial institutions, which is also being heard by Judge Magnuson, continues.

## ■ **Health exchanges attracting low-income participants**

Participation in public health insurance exchanges is heavily skewed in favor of those with very low incomes, according to a new analysis by Washington-based consultant Avalere Health L.L.C. While 76% of eligible individuals with incomes between 100% and 150% of the federal poverty level enrolled in plans offered in the federal health insurance exchange, just 20% of those with incomes between 251% and 300% of the federal level opted for coverage. The reason for the decline in the exchange participation rate as individual income rises is basic, says Avalere: The amount of the federal premium subsidy provided to buy exchange coverage declines with higher income. A 25-year-old living in the District of Columbia suburb of Arlington, Virginia, who earns \$12,000 a year and opts for single coverage would be eligible for a premium subsidy of just over \$200 a month, for example. However, if the same individual earned \$25,000 a year, the premium subsidy would be only about \$91 a month, according to a plan premium calculator available on the

HealthCare.gov federal exchange website. "Exchanges will need to attract higher-income individuals to ensure enrollment continues to grow over time," Caroline Pearson, an Avalere senior vice president, said in a statement.

## ■ **Settled workers comp claim doesn't bar death benefits**

A Kentucky man's settlement of his workers compensation claim prior to his death doesn't bar his wife from seeking death benefits, the state Court of Appeals has ruled. Stephen Baytos suffered a torn thoracic aorta in February 2006 while working for Charlotte, North Carolina-based Family Dollar Stores Inc., according to court records. Before he died in December 2009, he accepted a lump-sum payment from Family Dollar and agreed not to pursue any future claims, records show. However, his wife, Mamie Baytos, didn't sign the settlement, which did not include references to any future rights she might have. In 2011, Ms. Baytos filed a motion to reopen her husband's claim and seek death benefits. An administrative law judge ruled in February 2014 that Mr. Baytos died as a result of his work-related injury and awarded Ms. Baytos death benefits, according to records. Family Dollar appealed to the Kentucky Workers' Compensation Board, which reversed the judge's order in June 2014. However, the Kentucky Court of Appeals vacated the order of the board and remanded the case for further proceedings. Surviving spouses are eligible to receive death benefits if the injured worker dies within four years of a work-related injury, the court of appeals ruled. The law "makes no mention of prior agreements reached between the employer and the injured employee."

## ■ **FAA streamlines approval for commercial drone use**

U.S. aviation regulators unveiled a new policy to speed up approval for the use of commercial drones in the United States under certain conditions. The Federal Aviation Administration said it would award "blanket" certification allowing companies exempt from a U.S. ban on commercial drones to begin using the aircraft at altitudes of up to 200 feet during daylight hours and within the operator's visual line of sight. Up to now, companies exempt from the ban have had to seek certification for new drone use, a process that could take up to 60 days for each project. "The agency expects the new policy will allow companies and individuals who want to use (unmanned aerial systems) within these limitations to start flying much more quickly than before," the FAA said in a statement.

Reuters

## ■ **Employers sweetening the wellness pot**

More employers are offering financial incentives through wellness program to improve employees' health, while many are boosting the value of those incentives. Seventy-nine percent of employers participating in the National Business Group on Health and Fidelity Investments survey — up from 74% in 2014 — said they now offer financial incentives to encourage employees to participate in wellness programs. Employers said they expect to spend an average of \$693 per employee on wellness incentive programs this year, up from \$594 in 2014 and \$430 five years ago. "It's extremely encourag-

ing to see an ever-increasing number of companies embrace corporate wellness programs as a way to promote a healthy workforce," Washington-based NBGH President Brian Marcotte said in a statement. The survey, conducted in December and January, is based on the responses of 121 employers.

## ■ **Willis taps Marsh exec as alternative risk transfer chief**

Willis Group Holdings P.L.C. has named Marc Paasch to the newly created position of global head of alternative risk transfer solutions. Based in New York, Mr. Paasch reports to John Merkovsky, Willis' global head of risk and analytics, Willis said in a statement. Mr. Paasch joins from Marsh Ltd., where he was managing director, head of analytics and co-head of risk consulting in Europe. "The addition of Marc to our risk and analytics team will enable Willis to leverage the risk insights gained through our cutting-edge analytics to deliver alternative techniques to hedge and transfer risk," Mr. Merkovsky said in the statement.

## ■ **Health care reform credited with drop in uncompensated care**

Hospitals' uncompensated-care costs in Medicaid expansion states were reduced by \$5 billion in 2014, according to a U.S. Health and Human Services Department report. The costs of uncompensated care declined \$2.4 billion in states that did not expand the program, resulting in a total drop of \$7.4 billion, down 21% from 2013. In these states, the uninsured populations dropped as some residents gained insurance through the law's insurance exchanges and others who were already eligible for Medicaid enrolled as a result of the intense enrollment efforts tied to the coverage expansions, a dynamic known as the woodwork effect. Still, HHS estimates hospitals could have saved an additional \$1.4 billion if the remaining states had raised Medicaid eligibility. To date, 28 states and the District of Columbia have expanded Medicaid eligibility to people with incomes up to 138% of the federal poverty level under the reform law. Medicaid enrollment has grown 19.3% to 70 million enrollees as of January this year, up from 57.8 million enrollees in September 2013.

Modern Healthcare

## ■ **D&O liability premiums down 7.4% in 2014 fourth quarter**

Companies' directors and officers liability premiums for both primary and excess layers dropped 7.4% in the fourth quarter of 2014 from the prior-year period, driven by continuing rate decreases in the excess layers, according to Aon Risk Solutions' latest D&O index report. Meanwhile, primary D&O policies that renewed in the fourth quarters of 2013 and 2014 with the same limit and retention decreased by an average of only 0.2%, according to the report. The number of Aon clients receiving decreases on the primary layer grew to 26% in the fourth quarter, which was the highest level since 2012's first quarter, according to the report. For the full year, the average primary premium increased 1.4%, the report said. "Remembering that D&O programs are most often built on a layered basis, basic math would indicate that excess pricing continues to decrease more than enough to compensate for the increase in primary pricing," said the report.

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## Lloyd's of London profit stable in 2014

■ Lloyd's of London posted a pre-tax profit of £3.2 billion (\$4.99 billion) for 2014, the same amount as for 2013, the market announced. Lloyd's reported a combined ratio of 88.1% for 2014, compared with 86.8% for 2013. Gross written premiums for 2014 were £25.3 billion (\$39.42 billion), Lloyd's said, down from £25.6 billion (\$42.39 billion) in 2013. The market posted an investment return of 2.0% for 2014, up from 1.6% in 2013. Lloyd's said the stable profit had been helped by a benign year for large natural catastrophe losses and an improved investment return. This, it said, was set against a backdrop of falling rates for many classes of insurance and reinsurance business as well as low interest rates. "In the face of global challenges, an abundance of capital and the low-interest-rate environment, Lloyd's is being proactive in seizing the opportunities out there for growth and diversification," Lloyd's CEO Inga Beale said in a statement. "We will continue to engage with our global network of syndicates and brokers, to ensure Lloyd's remains at the forefront of innovation in the industry."

## Allianz leads cover on Germanwings crash

■ Allianz S.E. is the lead insurer of the coverage for the Germanwings GmbH plane that crashed in the French Alps last week, sources said. All 144 passengers and six crew aboard the Airbus A320 flight from Barcelona, Spain, to Dusseldorf, Germany, died. Sources said London-based brokerages Jardine Lloyd Thompson Group P.L.C. and Willis Group Holdings P.L.C. placed the insurance program for Germanwings, a budget airline operated by Deutsche Lufthansa A.G. Lufthansa also operates a captive insurance broker, Albatros Insurance Services GmbH. Besides Munich-based Allianz, insurers in London and the international market also are on the program, sources said.

## U.K. doubles down on cyber risk

■ The U.K. government has announced a set of joint initiatives with the insurance sector aimed at improving the suitability and availability of cyber insurance and risk management against cyber attacks. A report published by the Cabinet Office and Marsh L.L.C., "U.K. Cyber Security: The Role of

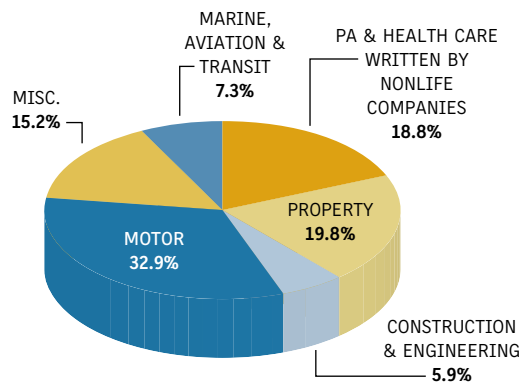
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**\$211.8**  
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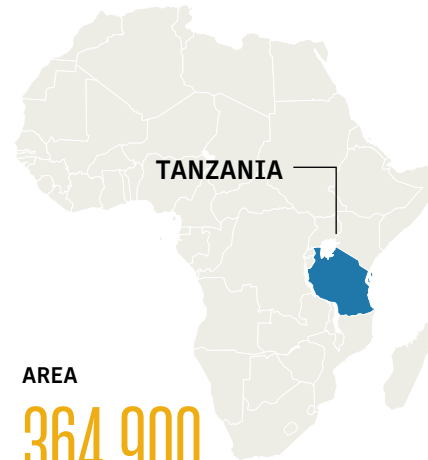
The small Tanzanian property/casualty insurance market continues to struggle. Eleven of the 25 insurers reported underwriting losses in 2013, the latest data available. Overall, the sector reported a market loss of \$2.2 million that year, a 68% decline from 2012. The market has been harmed by stiff competition, poor underwriting standards and risk pricing, and a dearth of qualified insurance professionals. Also, many policyholders pay premiums late or not at all.

◀ 2013 P/C gross premiums

### MARKET SHARE



Source: Axco Global Statistics/Industry Associations and Regulatory Bodies



### AREA

**364,900** square miles

### POPULATION

**47.7** million

### GLOBAL P/C MARKET RANKING

**102**

### 2015 GDP CHANGE (PROJECTED)

**7.3%**

### MARKET DEVELOPMENTS

UPDATED MARCH 2015

- In July 2014, the Workers Compensation Fund was established. Private-sector employers are required to contribute 1% of their annual payroll to the fund, while public-sector entities must contribute 0.5% of annual payrolls.
- In July 2014, the Tanzania Insurance Regulatory Authority announced plans to establish a fund to pay victims of hit-and-run motor accidents.
- In April 2014, Tanzanian insurance regulators said the nation is on track to move from compliance-based supervision to risk-based supervision by December 2018.
- In August 2013, the government ordered the insurance regulators to be sure energy insurance policies contain a clause requiring coverage of hydrocarbons. This came after the discovery of gas fields in Tanzania.
- In February 2013, the insurance authority issued a code of conduct and ethics for the Tanzanian insurance industry.

### COMPULSORY INSURANCE

- Automobile third-party bodily injury
- Workers compensation
- Shipowner liability for marine oil pollution
- Cargo liability
- Professional indemnity for insurance agents and brokers
- Fidelity guarantee for brokers

### NONADMITTED

The nation requires that insurance must be bought from locally authorized insurers or brokers. Therefore, nonadmitted placements of coverage issued abroad is prohibited, unless permission is granted by Tanzanian financial regulators.

### INTERMEDIARIES

Agents and brokers have to be authorized to sell insurance. Intermediaries given permission to place nonadmitted business must be registered with Tanzanian regulators. Brokers involved in nonadmitted placements don't have to warn buyers that their insurers are not subject to local supervision.

### MARKET PRACTICE

The insurance industry generally follows regulatory procedures. Regulators strictly apply the rule that prior approval must be obtained for a nonadmitted placement. A violator can be fined up to \$3,000 for noncompliance of insurance regulations.

Information provided by Axco Insurance Information Services.  
[www.axcoinfo.com](http://www.axcoinfo.com)

Insurance in Managing and Mitigating the Risk," found that 81% of large companies and 60% of small companies in the United Kingdom suffered a cyber security breach in the past year. But while 52% of CEOs believe that their companies have insurance coverage for cyber attacks, less than 10% of U.K. companies have purchased cyber insurance coverage, according to the report. A lack of data pooling has hampered insurers' ability to develop pricing models and coverage, the report said, while the potential for the aggregation of losses affecting a large number of companies is also a concern for insurers. The report recommends the establishment of a forum between the government and the insurance sector, including the Association of British Insurers and Lloyd's of London, on "data and insight exchange for policy discus-

sions," among other things. The report also said the insurers that participated in the report would agree to include a government-backed industry accreditation, known as Cyber Essentials, as part of their risk assessment in a bid to encourage more small and medium-sized companies to actively manage cyber risks.

## Crawford names head of European operations

■ Kieran Rigby will lead Crawford & Co.'s European operations, the Atlanta-based claims management firm said. Mr. Rigby replaces former CEO Mark Harman, Crawford said in a statement. U.K.-based Mr. Rigby was most recently CEO of GAB Robins U.K. Ltd., a role he has held since 2005, according to

the statement. He will lead Crawford throughout Europe, excluding the United Kingdom, the firm said.

## Broker names CEO of underwriting agency

■ Australian insurance brokerage Steadfast Group Ltd. said Bobby Lehane will lead its CHU Underwriting Agencies Pty Ltd. unit as CEO, effective April 1. He replaces David Hampton, who resigned as CEO from CHU Underwriting earlier this month, according to a Steadfast spokeswoman, joining from Zurich Financial Services Australia Ltd., where he worked the past seven years, most recently as executive general manager of the commercial insurance segment, Sydney-based Steadfast said in a statement. Steadfast agreed to

buy CHU Underwriting, along with Corporate Underwriting Agencies Pty Ltd. and Underwriting Agencies of Australia Pty Ltd., from Sydney-based QBE Insurance Group Ltd. for as much as \$290 million in February. The deal is expected to close March 31, the spokeswoman said.

## Berkshire Specialty names Asia energy head

■ Berkshire Hathaway Specialty Insurance, a part of Warren Buffett's Berkshire Hathaway Inc., has appointed Min Ong regional head of energy for Asia. Ms. Ong, based in Singapore, joins from Zurich Insurance Co Ltd., where she was most recently the regional energy underwriting manager. Ms. Ong has 20 years of experience

in the energy underwriting and management field, and she has worked with Ascot Underwriting Asia and Allianz Global Risks in London and Singapore.

Reuters

## Disaster losses down in 2014

■ Insured losses from natural catastrophes and man-made disasters in 2014 totaled \$35 billion, while economic losses reached about \$110 billion, Swiss Re Ltd. said in a new sigma study. Natural catastrophes accounted for \$28 billion of the year's insured losses and \$101 billion of the economic losses in 2014, according to the study. This is lower than 2013, when natural catastrophes and man-made disasters caused total economic losses of \$138 billion, of which \$129 billion were the result of natural catastrophes, the study showed; insured losses from natural catastrophes in that year were \$37 billion, while man-made

disasters caused insured losses of \$8 billion. A snowstorm in Japan in February caused insured losses of \$2.5 billion, according to the study, while wind and hail storm Ela, which affected parts of Belgium, France and Germany in June, caused insured losses of \$2.2 billion. "The frequency of catastrophic events appears to be increasing, with a record number of catastrophes last year," Kurt Karl, Swiss Re's chief economist, said in a statement.

## Solvency II rules to be proportional

■ The Bank of England said it would apply new European Union Solvency II insurance regulations "proportionately" following industry fears that the central bank might seek to add extra rules for companies based in Britain. The rules, which take effect in 2016, aim to ensure that insurers such as Prudential P.L.C. and Aviva P.L.C. hold enough capital to honor poli-

cyholder commitments even when markets turn sour. In a statement about how he intended to police the rules, Bank of England Deputy Gov. Andrew Bailey said the U.K. insurance industry already manages risks in the way the rules intended, unlike elsewhere in Europe. "Solvency II must be applied proportionately, with the emphasis on substance over form, if we are to maintain our focus as a forward-looking and judgment-based regulator," he said.

Reuters

## Allianz hedges stake in Chinese insurer

■ Allianz S.E. struck a deal with Goldman Sachs to help the German company hedge part of its stake in China Pacific Insurance Group and lock in profits from two rounds of investments that Allianz made in China's third-largest insurer. Under the deal, Allianz agreed to a future sale of 147.7 million Hong Kong-traded shares of

CPIC at HK\$36.77 (\$4.74) each to Goldman in a \$700 million transaction. That price is equivalent to a 4.2% discount. Allianz said the sale would leave it with a 1% stake in CPIC, which it called its "preferred partner in China." Allianz's stake in CPIC means it can lock in profits from an investment in 2009 and another stake purchase in 2011. CPIC shares are up 31.3% from when Allianz made its first investment and up 18% from the time of the second deal. Allianz currently owns 243.2 million CPIC shares, according to Hong Kong stock exchange data. Allianz will continue to own a 22.95% stake in a health insurance joint venture with CPIC that was unveiled in December 2014.

Reuters

## Ping An Insurance profit jumps 39%

■ Ping An Insurance Group Co. of China Ltd., posted a better-than-expected 39.5% rise in annual prof-

its as investment income soared on the back of China's rising stock markets. Ping An made a net profit of 39 billion yuan (\$6.23 billion) in the year ended Dec. 31, the company's highest profit since 2003. The gains were largely due to the fact that Chinese insurers can book gains in their investment portfolios as profits. China's benchmark Shanghai Shenzhen CSI 300 index has risen 75% in the last year. The company also said that its life insurance unit, which accounts for 40% of overall profits, saw the value of new business increase by 20% year on year. Analysts see the value of new business, which measures expected profits from new policies, as a more indicative measure of Chinese insurers' success than net profit figures which can be distorted by fluctuations in their investment portfolios.

While the group's insurance unit posted bumper profits on the back of the investment gains and strong sales of insurance policies, analysts remain concerned about rising bad loans at its banking unit.

Reuters



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## SLIMMED-DOWN HARTFORD HAS SHARPENED FOCUS

**Q** How is The Hartford different today from the company you joined five years ago?

**A** Five years ago, The Hartford was still a multiline company — property and casualty, life and annuity. The organization was coming out of the financial crisis, and Liam joined with the view, the mindset and the passion to turn around the company and restore it to glory.

Initially, the vision was to keep the multiline together, but as we got further into studying the business, we concluded that we needed to focus the organization. That culminated in the March 2012 announcement of getting out of the life insurance business, the retirement business, putting the variable annuity business into runoff and really focusing on the property/casualty business, both commercial and personal lines, along with group benefits and mutual funds. We thought those businesses could produce the best returns over a longer period of time. We thought those businesses would consume less capital, would actu-

### Q&A

ally generate capital to allow us the financial reengineering that we had to do.

Our strategy largely is intact, and now we're getting more refined and tactical about where we want to grow.

**Q** Where would that be?

**A** If you look back 20, 30, 40 years ago, The Hartford was, and still is, a national carrier, but we probably lost something in the last 10 to 15 years as far as risk-taking

and risk appetite in broad property/casualty capabilities. We focused on our workers compensation product probably too much the last 10 years.

So really what we're trying to be is a broader product line player. In comp, we have wonderful capabilities, but we want to be a bigger property player, we want to be a bigger general liability player, we want to be a bigger commercial auto player, we want to be a larger and more competitive E&O and D&O player, and we have some other specialty businesses that we feel good at. We want to be more broad-based in those product lines, and we want to serve a more meaningful part of the real economy here in the U.S. — manufacturing, real estate, construction, hospitality, transportation. We have this national footprint, a great brand and wonderful distribution relationships.

**Q** Are there any other businesses you are looking to dispose of?

**A** The last sale we accomplished was the big Japanese variable



**CHRISTOPHER J. SWIFT**

**HARTFORD FINANCIAL SERVICES GROUP INC.**

Christopher J. Swift joined Hartford Financial Services Group Inc. as chief financial officer in 2010 from American International Group Inc. As part of the senior executive team led by the late Liam E. McGee, he was instrumental in Hartford's turnaround from TARP-funds recipient back to a profitable but slimmed-down insurer. He recently spoke with *Business Insurance* Editor Gavin Souter. Edited excerpts follow.

annuity operation. What's left in the U.S. is still a sizable variable annuity platform that we're running off for the time being, but eventually we want to be completely out of it, and we'll look opportunistically at market participants and pricing and see if selling it is a good strategy.

**Q** You chose not to replace Foundation Re III, the insurance-linked security protection you bought previously.

**What was the thinking behind that decision?**

**A** We're always interested in what our traditional reinsurance parties can bring to us, and we will continue to explore what the capital markets can bring, but this renewal season we just felt that we got everything we wanted and then some from our traditional marketplace. But our thinking would not change about using capital markets going forward.

### COMINGS & GOINGS

## UP CLOSE: KELLY BOYER

**PITTSBURGH-BASED SENIOR RISK ADVISER**  
Hanover Stone Partners L.L.C.

**PREVIOUS POSITION:** Pittsburgh-based treasurer and vice president for investor relations for TMS International Corp.

**LOOKING FORWARD TO:** Helping companies efficiently manage their risks. I bring the internal corporate viewpoint to the Hanover Stone practice.

**GOALS FOR NEW POSITION:** My focus is to help risk managers, treasurers and (chief financial officers) understand the resources at Hanover Stone that could help in lowering their risk and costs.

**CHALLENGES FACING INDUSTRY:** Inadequate market capacity for catastrophic risk and cyber risk. These are new, emerging risks people are facing.

**INDUSTRY OUTLOOK:** I'm positive for the U.S. economy. Insurance will continue to be exciting and dynamic. There's new capital, new product, and we have to stay on top of innovation.

**FIRST INDUSTRY JOB:** A business development analyst in a multinational mining company.



**WHAT SURPRISED ME:** It's constantly changing. It's a wonderfully challenging and fascinating business.

**ADVICE:** Always be open to learning.

**OUTSIDE THE INDUSTRY, A DREAM JOB:** Sports photographer.

**THING MOST PEOPLE DON'T KNOW ABOUT ME:** I'm a twin.

**WHEN I RETIRE:** Travel internationally. I absolutely love seeing new places.

**FAVORITE MEAL:** I'm Canadian, and I'm from Calgary so a steak dinner is No. 1.

**FAVORITE BOOK:** "Gone with the Wind" by Margaret Mitchell. It's a study in different personalities.

**CAN'T-MISS TELEVISION SHOW:** I'm not a huge TV watcher, but I do like the new version of "Elementary."

**BEST CITY:** New York City. I've spent a lot of time there. It's got so much to offer. Every single block is its own little zone.

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# Find out what to do, before they find you

Put up your defenses before you're breached. And if you're hacked, how do you recover? The experts and the answers are here at this can't-miss event.

## AGENDA AT A GLANCE:

### DAY 1

Evening networking reception

### DAY 2

Networking breakfast

Welcome remarks

Opening keynote

#### **You're not a retailer, but you're still a target**

No business is safe from cyber attacks. This session will give risk managers the tools to perform a cyber risk self-assessment by exploring today's latest threats.

#### **Legislative and regulatory landscape**

In the wake of the large-scale theft and destruction of data at Sony Pictures Entertainment Inc., President Obama has proposed new federal legislation to combat cyber attacks. This session will help risk managers navigate the data privacy and security requirements with which their organizations must comply.

# CYBER RISK SUMMIT 2015

COMING SEPTEMBER 2015

### DAY 2 (cont.)

Networking luncheon

#### **Quantifying the impact of a cyber incident**

Using data analytics and modeling scenarios derived from actual events, this session will examine the vast array of potential costs to organizations when their systems are hacked.

#### **Addressing cyber risks:**

##### ***Sometimes insurance isn't enough***

The potential scope of cyber risk exposure is reaching \$2 trillion. Yet the market for cyber risk insurance is estimated at just \$85 billion. This session will report on the latest advances in coverage, provide a market update on new players and available coverage limits, costs, terms and conditions.

#### **Cyber Challenge**

In this session, "Jeopardy" meets "Who Wants to Be a Millionaire," as four risk managers test their knowledge of cyber risk terminology. All attendees will be invited to participate using electronic polling, which contestants can use as "help from the audience."

#### **Track The Hacker**

Months leading up to the Cyber Risk Summit, attendees and BI subscribers have been following clues in the "Track The Hacker" Sweepstakes for a chance to win valuable prizes. The location of the tracker will be revealed and a winner will be announced.

#### **Closing keynote**

Closing remarks and cocktail reception

For more details visit: [BusinessInsurance.com/cyberrisksummit](http://BusinessInsurance.com/cyberrisksummit)

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EDITORIAL

## TIME TO ACT ON CYBER

**R**epeated cyber security breaches finally have focused congressional attention on how best to deal with this exploding exposure. As we report on page 1, a Senate panel recently held the first-ever hearing on cyber insurance. It was an event void of partisan fireworks. Lawmakers are seriously considering private insurance as a market-driven way to encourage companies to take steps to mitigate their risk.

We certainly welcome the congressional focus on the issue, and the fact that legislators are looking to the market for some solutions. Now it's time to transform that focus into action.

We think there are two things Congress should move on quickly that would help companies better manage their cyber security risks and by doing so, could encourage the expansion of the cyber insurance marketplace.

The first is simple. Right now, there are about 50 different state and other governmental requirements for reporting cyber security breaches. The sheer number both slows down reporting and adds to costs. This situation begs for a single federal reporting standard. After all, cyber criminals don't respect international borders, let alone state lines. Adopting a single standard is nothing less than common sense.

The second action is more complicated, but nonetheless doable. Congress needs to agree on a system whereby private entities can share cyber breach information with each other and the federal government without fear of being subject to unwarranted liability. Crafting such a system also must take into account legitimate privacy concerns. Nobody wants personally identifiable information or trade secrets to be disclosed.

Fortunately, several bills designed to accomplish those goals already have been introduced in Congress. While no bill will satisfy everyone entirely, getting something reasonable on the books should allay both privacy concerns and corporate fears of expanded liability.

There appears to be growing bipartisan support for tackling the issues surrounding cyber security. The time to act is long overdue. There's no reason to put off action until the next major cyber security breach. Such a breach is inevitable, but having a framework in place to allow quicker reporting of the incident and easier sharing of information about it only can make the risk more manageable.

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SCHILLERSTROM



COMMENTARY

## VIRTUAL REVOLUTION SPAWNS NEW RISKS

**B**ack in 1999, the late management philosopher Peter Drucker wrote an article in the *Atlantic Monthly* about the Internet called “Beyond the Information Revolution.” In the article, he wrote that the “truly revolutionary impact of the Information Revolution is just beginning to be felt.” That revolutionary impact? E-commerce, says Mr. Drucker.

“E-commerce is to the Information Revolution what the railroad was to the Industrial Revolution — a totally new, totally unprecedented, totally unexpected development,” Mr. Drucker wrote.

Of course, the revolutionary impact went far beyond e-commerce per se. Consider something you use every day that didn't exist in its current form until 2007. That's when Apple introduced the iPhone, which was followed very quickly by the Android. Here was yet another truly revolutionary impact of the Information Revolution. Within a couple of decades, we went from a mysterious and quite limited Internet to something that started as a gadget and became a necessity.

Remember, it took close to 50 years to get from the first steam engines used in manufacturing — where they were used to run looms — to steam-powered railroads. It took less than a generation to get from the early Internet to the smartphone.

Mr. Drucker may have foreseen something like this when he wrote, “It is likely that other new technologies will appear suddenly, leading to major new industries. What they may be is impossible even to guess at. But it is highly probable — indeed, nearly certain — that they will emerge, and fairly soon.”

What does seem to be certain is that nearly every



**MARK A. HOFMANN**  
SENIOR EDITOR

new technology has served to speed things up even as the new technologies spring up ever more quickly. But unfortunately, that acceleration of adaptive technology has been accompanied by an acceleration in risk itself.

For example, during a panel discussion of the virtual workplace at *Business Insurance's* Risk Management Summit in New York earlier this month, panelists

discussed how virtual workplaces — including mobile ones — have changed the nature of workplace risks for employers. Workers compensation exposures and reputational risks that would not have been imagined two decades ago during the infancy of the Internet now present clear and present dangers for employers.

Maybe we should call what's happening a risk revolution. Exposures that weren't even on science-fiction writers' radar 30 years ago are commonplace. Defining those risks and managing them can seem like a full-time job.

As Mr. Drucker wrote, it is “impossible even to guess at” what new industries will arise, yet nearly certain they will arise. It's also certain — with no need for a ‘nearly’ — that they will be accompanied by new exposures requiring new applications of risk management if an enterprise is to survive and prosper. And those applications will be required at an ever faster speed.

# Regulatory overreach puts U.S. insurers on defensive

Despite a stable marketplace, U.S. insurers and their regulators face an unprecedented threat of scrutiny and intrusion from U.S. and foreign entities. Such efforts could negatively affect the industry they purport to assist, says Dave Snyder, vice president, international policy at the Property Casualty Insurers Association of America.

Property and casualty insurers are capitalized at historically high and safe levels, according to findings earlier this year by the Property Casualty Insurers Association of America and its partners, the Insurance Services Office Inc. and the Insurance Information Institute Inc. These positive findings were consistent with last December's International Association of Insurance Supervisors Global Insurance Market Report, which stated: "During the past year, the global reinsurance sector has proven to remain well-functioning and stable amid an often challenging environment."

Despite this unmatched record of performance, the push for changes in the substance and architecture of insurance regulation, often originating from nontraditional insurance regulatory sources, never has been greater. And, frequently, it's without objectively demonstrated need or cost/benefit analyses. Ironically, the effects of these developments, if not carefully overseen by policymakers, could be higher costs for businesses and consumers, more financial volatility, less competition and diversity in insurance markets, and even the creation of systemic risk in a sector that does not have it today.

Although there have been some promising signs of late, both as to timing and substance on some issues, thoughtful and consistent engagement from insurers, consumer groups, and most importantly lawmakers in Congress and the states, will be critical to assure outcomes that protect consumers and competitive markets, here and abroad.

Last November, Robert Shapiro, an economic advisor to several U.S. presidents and the International Monetary Fund, created a methodology to estimate cost to the average U.S. consumers of imposing the wrong higher capital standards on U.S. internationally active insurance groups. His conclusion was that it would increase automobile premiums and increase homeowners' premiums up to \$100 per year per policy, even as it provides no real consumer benefits and reduces the ability of insurers to provide coverage. Similar findings might apply in the business sector when additional regulatory burdens are imposed.

Beyond capital, decisions about all aspects of insurance regulation are increasingly being made from behind closed doors. We are seeing increased focus on governance, risk management,

remuneration and cyber risk, and so the lack of transparency will have ramifications beyond capital issues. The Financial Stability Board, a group of global banking and consolidated regulators that functions behind closed doors without U.S. state regulators' participation, is increasingly determining international insurance regulation priorities and ordering the insurance regulators to comply. Following suit, the International Association of Insurance Supervisors, which had been functioning openly and similarly to U.S. state regulators, voted to close its doors to insurers, consumers and others. State regulators opposed the scheme, and Congress introduced bipartisan and bicameral resolutions to oppose it. But the U.S. federal representatives did not similarly oppose it, thereby undermining the position of U.S. state regulators

*The push for changes in the substance and architecture of insurance regulation, often originating from nontraditional insurance regulatory sources, never has been greater.*

and resulting in new procedures with far less meaningful participation by U.S. consumers and companies.

Recently, the U.S. Department of the Treasury and the Federal Reserve Board voted to designate another insurer as systemic, thereby imposing regulation by the Fed on another insurer in the face of reasoned opposition by state regulators and the Treasury Federal Stability Oversight Council's independent insurance expert. The dissent of the independent insurance expert pointed out the issue that these agencies had earlier, in closed door meetings with the Financial Stability Board, apparently helped designate that insurer as globally systemic. This apparently carried with it a commitment to do the same in the U.S. While some transparency improvements have been announced for the U.S. systemic risk designation process, they don't remedy the international/domestic due process issue; they do not provide an activities-based approach; and they would apparently not allow a company once designated to take actions to remove the designation.

State regulators and the National Association of Insurance Commissioners are attempting to work in this new environment with the federal agencies in a "Team USA" approach on the capital standards issue. And, the U.S. is undergoing a review by the IMF and World Bank on its compliance with international standards that are increasingly reflecting the activity of banking regulators. Already, changes to U.S. insurance regulation are occurring through model law changes, including new insurance company risk reporting, and additional regulation of holding companies and corporate governance.

In response to some of these developments, especially capital standards and the lack of transparency, state and federal lawmakers have become engaged. During the last session of Congress, there were hearings, resolutions proposed and appropriations language. Even more activity is expected this year.

Representing state legislators, the National Conference of Insurance Legislators has passed resolutions critical of some of the developments. It also has demanded a greater role for state legislators.

As a result of federal and state lawmaker engagement, there has been recent progress on some issues. But the involvement by nontraditional insurance regulatory bodies will continue and will require the continued focus of our legislators.

In sum, we are seeing fundamental changes develop to both the substance and architecture of insurance regulation. In the U.S., that means a hybrid or hydra system of regulation where federal agencies will play a greater role along with the states. Internationally, it means that traditionally bank-centric regulatory agencies also will play a greater role in determining international insurance regulatory standards.

In terms of substance, regulation may resemble more of the top down European model than the bottom up U.S. state regulatory model. While some of these developments will affect large international companies first, once established as standards, there will be both regulatory and market pressure to apply the same standards to all competitors — small as well as large, domestic as well as international. And some of the international standards already are meant to apply to all companies.

The new, complicated, and often nontransparent regulatory environment poses unique challenges to the industry, regulators and legislators. Currently, the two most crucial issues are the capital standards and the growing lack of transparency. But the regulatory changes also will affect all other areas of insurance regulation, including corporate governance, market conduct and even company officer compensation. Technical engagement by the industry, to the extent permitted, is obviously important. But it is also critical that state and federal lawmakers continue to be engaged to assure that the outcomes truly benefit consumers and protect competitive and diverse markets.



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# Health claims data tempts hackers

Rethink needed on sector's cyber security

BY BILL KENEALY

**I**f 2014 was the year that cyber thieves attacked retailers, 2015 has reminded the health care industry that it is a target as well.

And the claims data that health insurers keep in their systems is in some ways more tempting to cyber hackers than the financial data collected by retailers.

The February disclosure by the nation's second-largest health insurer, Anthem Inc., that it had suffered a data breach affecting about 80 million customers and employees has convinced many experts that medical claims and billing data is the top personal information targeted by cyber criminals. In mid-March, Premera Blue Cross said a cyber attack had gained Social Security numbers and dates of birth of 11 million of its customers.

"The reality is that claims data has a lot of information that thieves find useful," said David Lundal, Chicago-based system vice president and chief of information services for

## DATA PROTECTION

Health insurer Aetna Inc. says it "is not aware of any successful data theft" from its systems by hackers, but also says steps it takes to keep its data secure include:

- Reducing the "footprint" of sensitive data such as Social Security numbers by masking the full number in many systems and looking for other ways to identify people.
- Protecting information through encryption and by creating restricted classifications for data including Social Security numbers, passwords, debit and credit card information, and health savings accounts.
- Continually upgrading security of internal systems and closely following technical details of each reported outside data breach to look for opportunities to improve internal security.
- Actively participating in coalitions with other health care providers and security experts to share information about cyber threats.

See DATA next page

**DATA**

Continued from previous page

Presence Health, which has 12 hospitals and other health care facilities in the Illinois-based Catholic health system as a result of the 2011 merger of Provena Health and Resurrection Health Care.

One reason cyber thieves target medical data is that, unlike credit card numbers, Social Security numbers and dates of birth are not likely to change.

“Financial data is generally temporal and can easily be changed,” said Dena Magyar, Charlotte, North Carolina-based national practice leader at Wells Fargo Insurance Services USA Inc.’s technology, privacy and network risk practice. “However, there is great longevity to your personal health information, and that’s what makes it so valuable to criminals. Thieves will hang on to Social Security numbers because they know that they become more useful the farther in time you go from the data privacy event.”

In addition to using the data to open credit cards, thieves can use stolen medical information to receive health care procedures, including expensive surgeries, experts note.

There is a perception among data thieves that health care providers are soft targets, Mr. Lundal said.

Several experts say health care providers have not been as proactive as other industries in adopting technology to battle cyber threats.

Paula Knippa, an Austin, Texas-based attorney at Slack & Davis L.L.P., is representing plaintiffs in

a class action lawsuit filed against Franklin, Tennessee-based hospital operator Community Health Systems Inc., which acknowledged last June that hackers exposed 4.5 million of its patient records.

Community Health owns, operates and leases more than 200 hospitals in 29 states, according to its website.

“There is a concern that the health care industry is not taking cyber security very seriously,” Ms. Knippa said. Hackers are thought to have gained access to Community Health’s data when a server intended for testing was acciden-



tally hooked up to the Internet.

Community Health did not return calls seeking comment.

All stakeholders in the medical claims process from providers to insurers to third-party administrators need to reassess their approach to data security, experts say.

Ann Patterson, Washington-based senior vice president and program director at the Medical Identity Fraud Alliance, said security personnel need to move from protecting data to comply with the Health Insurance Portability and Accountability Act to a more proactive approach.

“Your primary goal may be to

provide health care, but digital protection measures need to be part of the industry’s psyche and fabric,” Ms. Patterson said. “We need to start building this mentality

To better secure data, companies need to assume that thieves are inside a company’s firewall, said Robert Jackson, Memphis, Tennessee-based chief information security officer at Sedgwick Claims Management Services Inc.

“Security professionals really need to rethink the layers of security,” he said, noting that hackers gaining control of an administrative password is believed to have furthered the Anthem breach. “You also have to really rethink the controlling of access. Passwords are not cutting it.”

Though many technologies exist to address data security, companies should also embrace process-driven reforms such as use of two-factor authentication, Mr. Jackson said.

“The financial services industry has been using two-factor authentication for the better part of a decade,” he said. “The health care industry needs to embrace it quickly.”

Ms. Magyar agreed that a data security approach that focuses on technology at the expense of people and processes will not be effective.

“From a non-IT perspective, you can get the most bang for your buck by implementing very simple employee awareness training,” she said.

“Every person in a health care organization from the CEO on down needs to understand that they have a personal responsibility to protect data,” she said.

**HEALTH CARE SECTOR  
VULNERABLE TO ATTACKS**

**D**ata protection challenges that the health care industry faces exceed the challenges other industries face, said Rob Sadowski, Bedford, Massachusetts-based director of technology solutions at RSA, the security division of technology provider EMC Corp.

“In health care, the open exchange of information is really important for the speed and quality of patient care,” Mr. Sadowski said. “However, there are a lot of potential points of vulnerability as this information moves through the health care ecosystem.”

Moreover, the health care sector has not been as aggressive as other industries in investing in the advance security technologies and techniques to detect the most

sophisticated types of cyber fraud, Mr. Sadowski said.

Accordingly, he advises companies to acquire the latest intrusion detection technology and develop a team with the capabilities to neutralize threats.

“You need an intelligence-driven approach to security in order to give you better visibility and help you spot attacks,” Mr. Sadowski said.

“Once you are better at detection, the next step is crafting an incident response plan. The goal has to be to stop attacks before they turn into a business loss, and you need a team or competency in handling those incidents in real time,” he said.

By Bill Kenealy

“There are a lot of potential points of vulnerability as this information moves through the health care ecosystem.”

Rob Sadowski, EMC Corp



AP PHOTO

A flood-damaged car is destroyed so there is no risk of its being sold, highlighting one of the many dangers of supply-chain disruptions.

**Information key  
in complex claims**

Global business interruption losses create need for documentation management strategies

BY MATTHEW LERNER

**INTERRUPTIONS**

**S**uperstorm Sandy, which hit the northeast U.S., and massive flooding in Thailand are among catastrophes that have reshaped the way insurers and buyers deal with business interruption claims.

Aside from Sandy in 2012 and the Thai floods in 2011 that caused widespread supply chain disruptions, the 2011 earthquake and tsunami in Japan, a 2013 fire at an SK Hynix Inc. production plant in Wuxi, China, and Hurricane Katrina’s devastation of the U.S. Gulf Coast in 2005 have driven changes in business interruption claims management and insurance.

“Business interruption and business continuity is a continuing learning process,” said Todd Reed, Boston-based manager of national insurance property operations at Liberty Mutual Insurance Co.

The most important lesson learned is being more proactive in business continuity planning to mitigate potential business interruption and contingent business interruption losses should an event occur.

“We’re talking about something that I think is going through an evolution, and there is more awareness than in the past,” said Monica Ningen, Armonk, New York-based head property underwriter for the U.S. and Canada at Swiss Re Americas.

Business interruption claims are a growing portion of insured losses, a risk heightened by “lean supply chains and globalized manufacturing,” according to a 2014 analysis by Allianz Global Corporate & Specialty S.E. of more than 11,000 of its and other insurers’ claims. Findings include:

- The average business interruption loss of \$1.36 million was 32% more than the average claim for direct property damage.
- A fire at a Chinese computer manufacturer resulted in about \$300 million in contingent business interruption claims by three U.S. computer manufacturers.
- Aside from catastrophes, political risks, power blackouts and outbreaks of infectious disease can trigger contingent business interruption claims.

Source: Allianz Global Corporate & Specialty S.E.

While various catastrophes in the past decade have increased awareness, “it’s still a preliminary awareness to the extent of how big supply chain dependency can be in terms of contingent business interruption,” she said.

“Multinational risks exist with companies small and big, whether the business is in Iowa or London,” said Gerald Kissner, Chicago-based associate vice president of large property and catastrophe claims at CNA Financial Corp. “Global catastrophes, including the Thai floods and Japanese earthquake and tsunami, significantly impacted manufacturers’ supply chains

around the globe.”

“Sandy highlighted and reinforced the need for insureds to understand their exposures, and what can happen when events affect a large, heavily populated area of a country, including energy and transportation infrastructures,” he said.

Sandy-related losses affecting telecommunications companies, housing providers and transportation entities have drawn “awareness to businesses associated with the service economy,” Ms. Ningen said.

The fire at the Hynix plant, reportedly the world’s No. 2 computer chipmaker, “was a large builder of awareness around the interconnection of supply chains,” she said.

“Supply chains are becoming more exposed and more vulnerable” as clients and businesses in general continue to increase their global footprint, said Doug Backes, Johnston, Rhode Island-based manager of staff claims at FM Global.

In response, insurers have developed industry-specific supply-chain footprints to better understand their potential accumulation of risk, Ms. Ningen said.

To help mitigate challenges after a business interruption or contingent business interruption claim has been filed, insurers and buyers are seeking more definitions and specificity in property/casualty policy language.

“There’s been some movement toward clarification of coverages and wording in terms of coverage intent,” Liberty Mutual’s Mr. Reed said.

“Policies are starting to more closely define which expenses will be considered as continuing or discontinuing and are starting to specifically name those expenses,” said Rob Fox, Waltham, Massachusetts-based director of Crawford Forensic Accounting Services, a unit of Crawford & Co.

“Clients are ever more reliant on contract certainty,” FM Global’s Mr. Backes said.

Insurers also have developed a variety of technologies to help them handle business interruption claims.

Solid documentation to support a business interruption claim and having a backup system are essential, sources said.

“If policyholders don’t have their financial information duplicated somewhere in a safe environment, that can lead to challenges,” said Mr. Reed, who said having a backup system should be part of every risk management program’s best practices.

“We recommend the business has a backup for the records off-site away from the risk location,” said Melanie Elias, associate vice president and director of claims at Minuteman Adjusters Inc., a Farmington Hills, Michigan, claims adjuster. Such claims are document-intensive and often involve forensic accounting, she said.

Brian Flynn, Atlanta-based glob-

al chief information officer and executive vice president at Crawford & Co., said he has seen business interruption claims generate up to 80,000 documents.

That prompted CNA to build an in-house claims forensic accounting team to assist buyers calculate a business interruption claim, said Eva Skordilis, Chicago-based director of forensic accounting.

“Having this capability allows for more direct communication with our customers, which helps facilitate resolution. This team may also assist with oversight if a claim is outsourced to an outside forensic accounting firm,” Ms. Skordilis said.

## CLAIMS TECHNOLOGY CATCHES UP WITH THE TIMES

Technology is playing a more important role in business interruption insurance and claims.

“We’ve deployed some new technology that’s very mobile-enabled and social media-focused,” said Brian Flynn, Atlanta-based global chief information officer and executive vice president at claims manager Crawford & Co.

Crawford’s GTS SLM system for global technical services strategic loss management allows buyers, insurers and claims handlers to communicate documentation needs to process a claim, he said.

In addition, off-the-shelf “software has been developed to track the participants’ financial doc-

uments and the analysis needed to resolve a claim,” said Monica Ningen, Armonk-New York-based head property underwriter for the U.S. and Canada at Swiss Re Americas.

Using such a system, businesses can compare their business interruption values against industry averages, she said.

“Technology has changed the nature of many claims,” Gerald Kissner, associate vice president of large property and catastrophe claims at CNA Financial Corp., said of more robust systems that allow sharing and backing up of documentation on business interruption claims.

By Matthew Lerner



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# Return-to-work programs expand beyond workers comp

Action on disability claims can reduce employers' costs

BY SHEENA HARRISON

**R**eturn-to-work programs are getting greater consideration among employers for workers who are on leave because of disabilities that are not related to their job.

Experts say workers compensation and nonoccupational disability return-to-work programs should have consistent approaches, and that corporate leaders' buy-in is necessary to ensure such programs effectively help employees get back to work.

Some 49% of employers with more than 10,000 employees already have a return-to-work program for their disability programs, according to a Prudential Insurance Co. of America survey released in October. Another 22% of employers plan to add such programs in the near future.

Jake Biscoglio, vice president of absence and disability products at Prudential in Roseland, New Jersey, said the survey focused mainly on nonoccupational disability leave, although respondents with integrated occupational and nonoccupational programs may have included workers comp-related leave.

Employers' preoccupation in recent years with implementing health care reforms under the Patient Protection and Affordable Care Act may have allowed return-to-work efforts to fall by the wayside while managing group health concerns, Mr. Biscoglio said.

"There's a lot of competing priorities that everyone's dealing with, so we know it's easy at times to set this aside and put it in the category of something to come back to," Mr. Biscoglio said.

Prudential's results contrast with workers comp experts at broker Willis North America Inc. and third-party administrator Broadspire Services Inc., who say about 90% of large employers with whom they work already have workers comp return-to-work programs.

Return-to-work "started being popular around 25 years ago and it's nothing new to most companies," said Joe Picone, Glen Allen, Virginia-based claim consulting practice leader at Willis' risk control and claim advocacy practice.

Randi Urkov, managing director at Marsh

Risk Consulting's claims consulting practice in Chicago, said it's not surprising that fewer employers have nonoccupational disability return-to-work programs since such disabilities not related to the job are more common and can be more difficult to track than work-related injuries.

"There are just so many (nonoccupational) disabilities that you really need a very formalized program to be able to sustain that over time," Ms. Urkov said.

Kimberly George, Chicago-based senior vice president and senior health care adviser at Sedgwick Claims Management Services Inc., said some employers lack nonoccupational return-to-work programs because they leave it

of the mediocre grades. "They're nervous about confidentiality, and they need that assistance around having a structured program that offers consistent opportunities for employees."

Willis' Mr. Picone said the grade may also reflect many employers' frustration with monitoring the effectiveness of return-to-work programs and implementing changes that can improve results.

"The programs become outdated or stale and lose momentum," Mr. Picone said of companies that fail to measure success metrics or periodically update their metrics.

Despite the challenges, Sedgwick's Ms. George said nonoccupational return-to-work programs can ultimately reduce employers' costs.

"Having people back in the workplace has historically led to faster healing," Ms. George said. "People that tend to be out longer end up having more medical costs."

Companies that want to implement nonoccupational return-to-work programs or improve the ones they already have should make sure senior leaders and stakeholder groups, such as the human resources or risk management departments, support the effort, said Mike Farrand, vice president and director of workers compensation cost containment at Willis in Radnor, Pennsylvania.

"You need upper management to support from the top down to really effect change," Mr. Farrand said.

Erica Fichter, senior vice president of medical management at Broadspire in Sunrise, Florida, said employers can outsource their return-to-work programs if they feel they need additional resources or assistance in making such policies successful.

"Don't think that you have to do everything yourself in-house," Ms. Fichter said. "There are great programs out there that are very cost-efficient (and) can help facilitate return-to-work strategies."

Willis' Mr. Picone also recommends that companies regularly track metrics for their return-to-work programs, such as days employees are off the job due to disability, to determine whether a program is working or should be tweaked to improve its performance.

## PROGRAMS OFFERED

About half of large employers already have a return-to-work program for disabled employees, but less than one-third of small employers have such programs.

Number of employees	Have program	Plan to add program
10,000 or more employees	49%	22%
1,000 to 9,999 employees	39%	23%
Less than 1,000	28%	19%

Source: Prudential Insurance Co. of America

up to their disability insurers or TPAs to handle the process.

"Historically, if you were to ask an employer whether or not they're aggressively managing return-to-work around disability, the historical answer would probably be 'no' in an insured market," Ms. George said.

Ms. Urkov said many companies reduced their risk management and human resources staff during the Great Recession, making it difficult for some to focus on return-to-work outside of workers comp.

But even large companies that do help disabled employees ease back into the workforce are somewhat ambivalent about their success, giving return-to-work programs an average grade of C+, according to the Prudential survey.

"They feel ill-equipped to address disability and return-to-work issues," Mr. Biscoglio said

"Having people back in the workplace has historically led to faster healing. People that tend to be out longer end up having more medical costs."

Kimberly George, Sedgwick Claims Management Services Inc.

# DO HIGHER DOCTOR FEES PAY OFF OVER TIME?

Increased provider payments may get injured workers back to work faster

BY STEPHANIE GOLDBERG

Some state workers compensation systems and payers are increasing provider payments to ensure that injured workers are treated quickly and effectively.

In North Carolina, increased provider reimbursements take effect in July and are designed to “cut down on treatment delays, allow injured workers to recover sooner and facilitate a safe return to work,” North Carolina Industrial Commission Chairman Andrew T. Heath said in an email.

Noting that both payers and injured workers had expressed concerns about access to care, Mr. Heath said delaying treatment often prolongs disability claims.

Under the new rule, maximum reimbursement rates for professional services are between 140% and 195% of the current Medicare base amount. The professional services fee schedule was previously based on the 1995 Medicare reimbursement rates, according to the commission.

Meanwhile, the Industrial Commission of Arizona recently proposed increasing reimbursements to health care providers an average of 4.54%, according to a WorkCompCentral analysis.

In January, the National Council on Compensation Insurance Inc. said potential changes to Florida’s medical fee schedule, which include increasing medical costs related to physician payments by 2.6%, could increase its workers comp costs by \$61 million.

Other states that are currently contemplating changes to medical benefit provisions include Indiana, Montana, New Hampshire, South Carolina, Utah and Virginia, said Raji Chadarevian, manager and associate actuary at Boca Raton, Florida-based NCCI.

While low fee schedules can reduce injured workers’ access to care, the real gauge is how comp rates compare with Medicare and group health plans, said Joe Pagano, Norristown, Pennsylvania-based executive vice president of managed care services at Healthcare Solutions Inc.

In most states, the overall workers comp fee schedule rates for physician services are higher than Medicare rates by 30% or more, Dr. Rebecca Yang, senior public policy analyst at the Workers Compensation Research Institute said in an email. However, workers comp fee schedule rates for certain services in some states do fall below the Medicare rates, Dr. Yang added.

For example, of the 42 states that have workers comp fee schedules, seven states — including Califor-

nia, Florida and New York — have rates for office visits that are lower than the state’s Medicare rates as of July 2011, she said, citing a WCRI study from June 2012.

“Across the board, workers compensation is a much better payer than group health,” said Joe Paduda, principal of Madison, Connecticut-based Health Strategy Associates L.L.C.

When fee schedules dip below Medicare or group health plan rates, providers no longer have a financial incentive to continue treating injured workers, sources said.

“Workers comp is a more complex, cumbersome and difficult process” for physicians, Mr. Paduda said. “There’s a lot more paperwork. You have to deal with return-to-work (issues). You have to deal with employers.”

If states increase their fee schedules but the rates are just comparable to Medicare or group health plan rates, it might not greatly increase access to care, Mr. Pagano said. “If it’s way above (those rates), it’s obviously going to increase access to care because (doctors) are businesspeople as well.”

But fee schedules that reduce provider reimbursement rates may prompt physicians to increase the number of office visits to make

up the revenue, said Mike Farrand, vice president of medical cost containment and director of workers compensation cost containment and area practice leader at Willis North America Inc. in Radnor, Pennsylvania.

For example, if physical therapists now get \$30 per visit and they previously were paid \$50, “they’re going to make up their money,” Mr. Farrand said.

In addition, preferred provider organization discounts that often are applied to fee schedule rates further lower reimbursements, said Darrell Brown, Long Beach, California-based chief performance officer at Sedgwick Claims Management Services Inc.

“We want really good medical outcomes, we want faster return to work, and sometimes that doesn’t come at the cheapest price,” Mr. Brown said.

To maintain access to quality care, Sedgwick pays its highest-rated providers the maximum rates on fee schedules and does not apply PPO discounts, said Kimberly George, Chicago-based senior vice president and senior health care adviser.

Spremo L.L.C., a managed care tool that connects payers such as Marriott International Inc. and CNA Financial Corp. with radiologists, also offers higher reimburse-

ments — “maybe a 30% increase” — to providers who adhere to its quality guidelines, said Spremo CEO Ron Vianu.

Mr. Vianu said most of the payers Spremo works with are willing to spend more on quality radiologists to ensure that patients are diagnosed correctly and promptly so they can get the most appropriate care.

“Their ultimate goal is getting (their employees) better and back to work, and they understand that better physicians may be more capable of doing that,” Mr. Vianu said.

Instead of looking to see if a provider has decreased medical costs, “which they may have done correctly or not,” or decreased disability time, “which could be manipulated,” payers should focus on the quality of care, said Dr. Kathryn Mueller, medical director for the Colorado Division of Workers’ Compensation, president of the American College of Occupational and Environmental Medicine, and a professor at the University of Colorado Denver’s Anschutz Medical Campus.

Payers could reward providers who operate under evidence-based guidelines and whose requests are almost always approved by not conducting unnecessary utilization reviews, Dr. Mueller said.

“That’s a reward that gets money back into the system where it should be,” he added.

A best practice for payers concerned about limited access to care is developing partnerships with quality medical providers.

“Often I see a situation where there’s a manufacturing facility. It’s in a rural area. You have one doctor in town. And the client says the doctor never releases anybody to return to work,” Mr. Farrand said. “I ask, ‘Have you talked to the doctor? Have you had them out (to the facility)?’”

Developing a relationship with the physician can speed return-to-work decisions since the doctor is better informed about the skills needed at a particular business, he said.

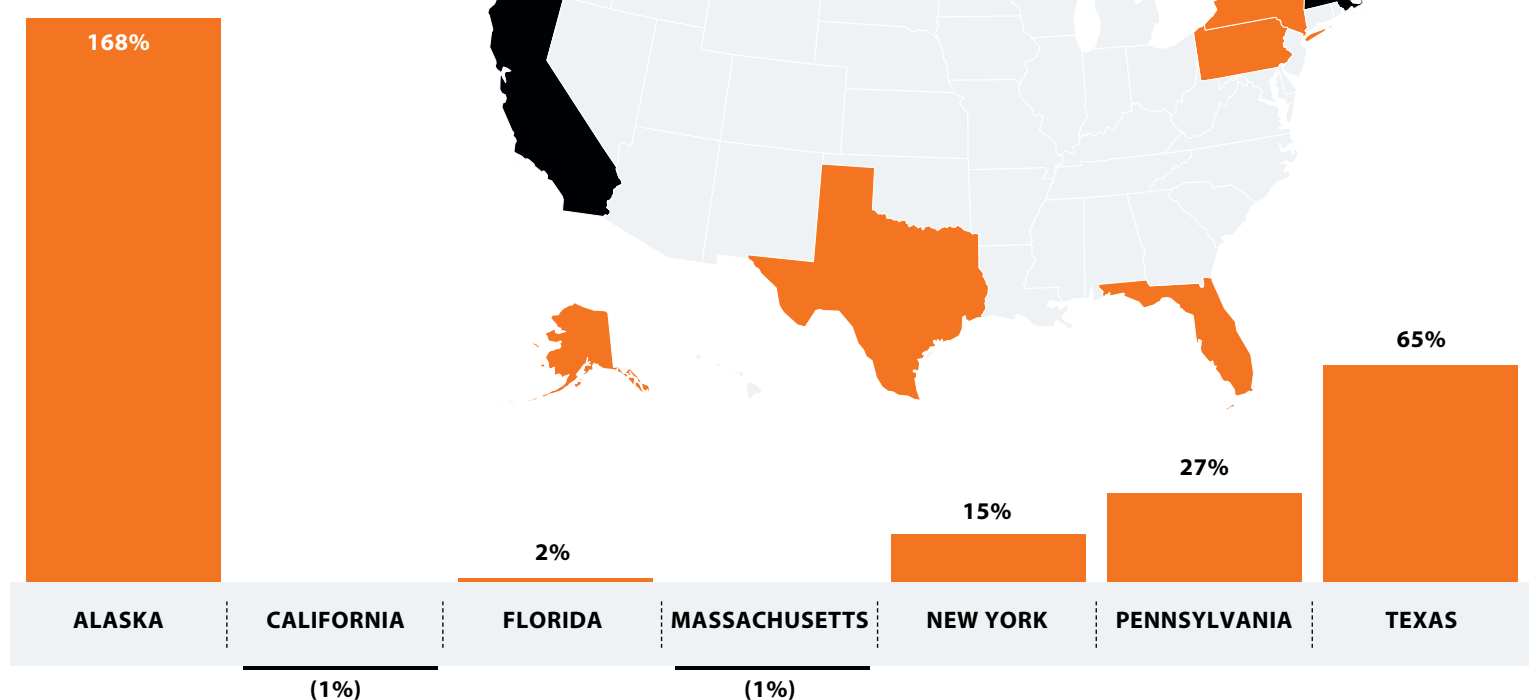
Establishing a relationship with quality medical providers is essential, Mr. Paduda said.

“That involves directing their injured workers to them, not requiring all kinds of utilization review, paying bills promptly, paying them fairly, maybe paying them above the fee schedule,” he said.

In return, payers can demand rapid communication, no physician-dispensed drugs and that providers facilitate the return-to-work process by releasing workers to appropriate light-duty jobs.

## FEE SCHEDULES

In most states, the overall workers compensation fee schedule is higher than the Medicare fee schedule. Alaska pays the highest rates, while California and Massachusetts pay the lowest\*. Select other states include:



\*Rates as of July 2011, the latest data available  
Source: Workers Compensation Research Institute

### LARGEST THIRD-PARTY CLAIMS ADMINISTRATORS

Ranked by 2014 gross revenue

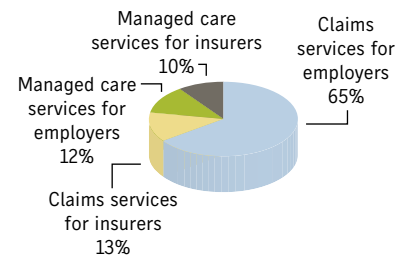
Rank	Company	Headquarters	TPA services provided	Gross revenue 2014	% increase (decrease)	Total claims staff	Officers
1	Sedgwick Claims Management Services Inc.	Memphis, Tennessee	Multiline	\$1,469,427,566	19.0%	11,010	David A. North, president/CEO
2	Crawford & Co. <sup>1</sup>	Atlanta	Multiline	\$1,217,000,000	(2.9%)	7,600	Jeffrey T. Bowman, president/CEO
3	York Risk Services Group Inc. <sup>2</sup>	Parsippany, New Jersey	Multiline	\$705,605,000	36.1%	N/A	Richard Taketa, president/CEO
4	Gallagher Bassett Services Inc.	Itasca, Illinois	Property/casualty only	\$664,300,000	8.7%	4,193	Scott Hudson, president/CEO
5	UMR Inc.	Wausau, Wisconsin	Employee benefits only	\$596,200,000	5.6%	2,600	Jay M. Anliker, CEO
6	ESIS Inc.	Philadelphia	Multiline	\$351,000,000	3.8%	1,196	David Patterson, chairman; Joe Vasquez, president
7	Meritain Health	Buffalo, New York	Employee benefits only	\$294,700,000	19.2%	1,400	Mark Schmidt, CEO
8	HealthSmart Holdings Inc.	Irving, Texas	Multiline	\$224,215,987	22.8%	1,212	Tom Kelly, president/CEO
9	Helmsman Management Services L.L.C.	Boston	Multiline	\$197,379,000	9.7%	1,105	Debbie Michel, president
10	CoreSource Inc.	Lake Forest, Illinois	Employee benefits only	\$176,142,123	9.1%	765	Nancy Eckrich, president

<sup>1</sup> Broadspire Services Inc. is part of Crawford & Co.  
<sup>2</sup> Acquired American Claims Services Inc. in 2014

Source: BI survey

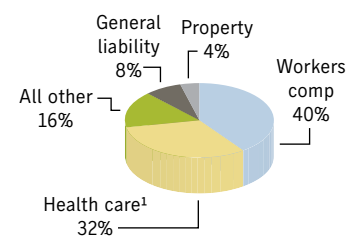
### TPA REVENUE\*

Percentage of 2014 revenue from all services provided



\*Companies listed in BI directory

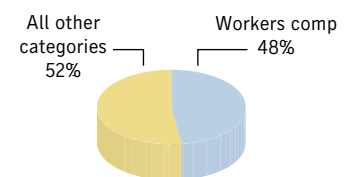
### TYPES OF CLAIMS MANAGED\*



\*Companies listed in BI directory  
<sup>1</sup>Includes medical, vision, dental and prescription drugs

### VALUE OF CLAIMS PAID\*

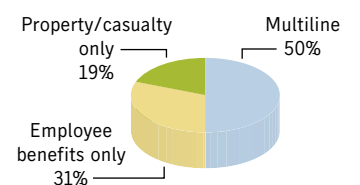
Based on dollar amount of claims paid in 2014



\*Companies listed in BI directory

### TYPES OF SERVICES PROVIDED\*

Percentage of TPAs handling multiline, employee benefits-only and property/casualty-only claims in 2014



\*Companies listed in BI directory

### LARGEST CLAIMS-HANDLING TPAs

Ranked by 2014 revenue from claims handled for employers

Rank	Company	2014 revenue from employers*
1	Sedgwick Claims Management Services Inc.	\$1,043,488,139
2	UMR Inc.	\$596,200,000
3	Crawford & Co.	\$580,000,000
4	Gallagher Bassett Services Inc.	\$545,871,000
5	Meritain Health	\$267,700,000

\*Excludes managed care and medical billing services

### LARGEST MULTILINE TPAs

Ranked by 2014 revenue from direct employer claims managed

Rank	Company	2014 revenue*
1	Sedgwick Claims Management Services Inc.	\$1,043,488,139
2	Crawford & Co.	\$580,000,000
3	York Risk Services Group Inc.	\$243,808,000
4	ESIS Inc.	\$222,000,000
5	Helmsman Management Services L.L.C.	\$124,078,000

\*Excludes managed care and medical billing services

### LARGEST P/C-ONLY TPAs

Ranked by 2014 property/casualty claims revenue from employers

Rank	Company	2014 claims revenue*
1	Gallagher Bassett Services Inc.	\$545,871,000
2	PMA Companies	\$28,202,000
3	Berkley Risk Administrators Co.	\$25,000,000
4	Constitution State Services L.L.C.	\$21,000,000
5	Claims Direct Access	\$1,233,000

\*Excludes managed care and medical billing services

### LARGEST BENEFITS-ONLY TPAs

Ranked by 2014 benefits claims revenue from employers

Rank	Company	2014 claims revenue*
1	UMR Inc.	\$596,200,000
2	Meritain Health	\$267,700,000
3	CoreSource Inc.	\$149,109,625
4	HealthScope Benefits	\$102,630,000
5	Alicare Inc.	\$64,350,000

\*Excludes managed care and medical billing services



## Flood modeling tool targets Canadian risks

Willis Re, the reinsurance arm of Willis Group Holdings P.L.C., has launched tools that allows insurers in Canada to identify potential flood exposures.

In collaboration with catastrophe modeling company KatRisk L.L.C. and analytics firm SpatialKey Inc., Willis Re has introduced a flood modeling tool and flood accumulation application that aims to help develop and enhance underwriting and risk transfer strategy, manage and monitor portfolio accumulations, and calculate probable maximum loss estimations, Willis Re said in a statement.

The SpatialKey Flood Accumulation app gives users the ability to access, accumulate and visualize KatRisk's flood risk data, which models riverine and surface water flood risk, a spokeswoman for Willis Re said.

"With the significant flooding events in both Calgary and Toronto over the past several years, market demand in Canada for a high-quality, high-resolution flood solution has never been greater," Geoffrey Lubert, Willis Re Canada's managing director, said in the statement. "Insurers need to leverage the latest science and analytical methods to evaluate and manage local and regional flood exposure."

## Guide aims to battle social engineering scams

Chubb Corp. has created a free guide to help employers understand and prevent social engineering fraud — the act of influencing others to disclose private company information using various forms of communications, including email, phone, the Internet and in-person interactions.

The "Guide to Prevent Social Engineering Fraud" aims to help employers train their employees on how these tricks occur, and lists measures companies can take to prevent social engineering fraud, such as verifying money transfers via phone or hiring a third party to test employees, Chubb said in a statement.

"Social engineering fraudsters present a growing risk for all businesses, and their trickery is costing some companies as much as \$7 million in a single incident," Christopher Arehart, global product manager for crime insurance at Chubb, said in the statement. "Businesses can train their employees to detect these potentially costly schemes."

Chubb's social engineering fraud endorsement last year, which aims to protect companies against losses from such schemes, launched last year.

## Health data exchange targets claims abuse

Software and technology services provider SunGard Financial Systems, a unit of SunGard Data Systems Inc., has launched a health information exchange communication product that aims to help health care payers identify and mitigate fraud, waste and abuse in health insurance claims.

## PRODUCTS & SERVICES



### Hartford coverage targets private schools

**\*** Hartford Financial Services Group Inc. has launched Educators Professional Choice, a customizable package of management and professional liability insurance products designed for private schools, colleges and universities.

Educators Professional Choice offers three separate, optional coverages, and schools can set individual limits, retentions and retroactive dates for each, the insurer said in a statement.

The package includes employment practices liability insurance with optional coverage for allegations involving third parties, including volunteers, consultants and vendors, and optional defense coverage for wage-and-hour violations, according to the statement.

It also includes errors and omissions insurance for allegations related to the rendering of or failure to render educational services, and directors, officers and entity coverage, Hartford said.

"Protecting a school's reputation and finances is critical to its ability to attract students and donors," Melissa Zaparanick, assistant vice president and head of Hartford's industry practices, said in the statement. Exposures vary widely "from school to school, so they need coverage that can be tailored to fit their specific circumstances."

Health information exchanges allow health care professionals and patients to access and share a patient's medical information electronically, and SunGard's iWorks tool links a health information exchange with a health plan's databases and processing systems, allowing health plans to access and analyze a patient's electronic health records in real time rather than after a claim is processed, Wayne, Pennsylvania-based SunGard said in a statement.

The tool also enables health plans to receive alerts on patient care activity, manage and analyze data, and coordinate workflow with care managers, SunGard said. The tool also could help reduce the length of a patient's stay, duplicative procedures, readmissions, fraud and abuse.

"The demand for electronic health information systems is growing along with nationwide efforts to improve the

quality, safety and efficiency of health care delivery," J.P. James, president of SunGard's insurance business, said in the statement. "SunGard's health information exchange connectivity solution can play an important role in a health plan's overall cost-containment and customer service strategies."

## European recycling firms offered coverage

London-based Solon Underwriting Ltd. has launched a product that serves recycling firms in the United Kingdom and other European markets.

The agency offers property damage and business interruption policies with limits of up to 7.5 million (\$7.9 million), a Solon spokesman said.

The coverage is underwritten by Navigators Group Inc.'s Lloyd's of London syndicate 1221, Solon said in the statement.

Solon is headed by managing director Bill Adamson, previously the director of London-based FCO Intermediaries Ltd., an insurance and reinsurance broker focused on the European recycling industry, according to the spokesman.

"The capacity shortage has seen companies faced with products not specifically designed for the sector, some capacity from poorly rated underwriters, and clients sometimes simply having to self-insure," Mr. Adamson said in the statement. "We work with specialist brokers in the sector, identifying what their clients need, and we provide a range of cover."

Solon, which was launched in conjunction with London-based Ambant Underwriting Services and Guernsey-based Heritage Group Ltd., is developing liability and machinery breakdown coverages, the spokesman said.

## Ironshore boosts cover for kidnap and ransom

IronPro, the professional and management liability arm of Hamilton, Bermuda-based insurer Ironshore Inc., has increased its capacity for stand-alone kidnap and ransom coverage for U.S.-based businesses to \$25 million from \$5 million.

The kidnap and ransom coverage is available for companies in the United States doing business globally, and is meant to protect executives and their families from unexpected and harmful events, Ironshore said in a statement.

Coverage extends to ransom payments, extortion, hijacking and wrongful detention, Ironshore said.

The program also provides professional crisis management services for personal safety guidance, security protection and event resolution through Miami-based Hazelwood Street Consultants L.L.C., a global crisis management and personal security firm, according to the statement.

"Kidnap events, often unreported, have increased in recent years due to heightened turmoil and conflict in regions around the world," IronPro President Greg Flood said in the statement.

## DEALS & MOVES

### Cross Insurance acquires independent agency

Cross Insurance, a unit of Cross Financial Corp., acquired Wellesley, Massachusetts-based independent insurance agency Corcoran & Havlin Insurance Group.

A spokesman for Bangor, Maine-based Cross Insurance declined to comment on terms of the deal.

Corcoran & Havlin will continue to operate under its own name in its current locations, the spokesman said.

According to the statement, Corcoran & Havlin's owners, President Jack Keefe and Executive Vice President George Doherty, will continue to lead the firm.

### Humana selling business unit to private equity firm for \$1 billion

Health insurer Humana Inc. is selling its Concentra urgent care and physical therapy services unit for about \$1 billion to private equity firm Welsh, Carson, Anderson & Stowe and Select Medical Holdings Corp.

Humana, which focuses on providing Medicare Advantage plans to older people, has been reviewing its assets for possible sales, and Wall Street analysts had surmised that Concentra was one of them. Humana said it would use the net proceeds to fund its existing \$2 billion share buyback program and other corporate spending.

Humana expects the sale to the joint venture run by Welsh Carson and Select Medical Holdings to close in the second quarter.

Reuters

### Brown & Brown acquires multiline broker in New York

Brown & Brown of New York Inc., a Rochester, New York-based subsidiary of Brown & Brown Inc., acquired Mahopac, New York-based multiline insurance broker Spain Agency Inc.

A spokesman for Daytona Beach Florida-based Brown & Brown declined to comment on terms of the deal.

Spain provides commercial and personal lines insurance, primarily in New York. The agency generates annual revenues of \$6.5 million, Brown & Brown said.

As part of the deal, Michael Spain, the firm's majority principal, Spain Vice President Brian Miles and their team will continue to operate from Spain's existing office.

### Bermuda reinsurer exits consolidating market

AQR Re Management Ltd., the reinsurance arm of Greenwich, Connecticut-based AQR Capital Management L.L.C., will stop writing reinsurance business April 1.

Pembroke, Bermuda-based AQR Re, which launched in 2011, operates funds holding a global portfolio of reinsurance and manages about \$500 million of assets.

In a statement, a spokesman for AQR Capital Management said that "due to consolidating market dynamics, it will become increasingly difficult to put larger amounts of capital to work to achieve attractive risk-adjusted returns for our investors."

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## MAJOR U.S. HEALTH INSURERS' 2014 RESULTS

Largest publicly traded U.S. health insurers ranked by reported revenue. Dollar figures and enrollment in millions.

Insurer	2014 revenue	% increase (decrease)*	2014 enrollment	% increase (decrease)*	2014 net income	% increase (decrease)*
UnitedHealth Group Inc.	\$130,474	6.5%	45.0	(1.0%)	\$5,619	(1.0%)
Anthem Inc.	\$73,874	5.2%	37.5	5.2%	\$2,570	3.2%
Aetna Inc.	\$58,003	22.6%	23.5	6.1%	\$2,041	6.6%
Humana Inc.	\$48,500	17.4%	13.8	15.5%	\$1,147	(6.8%)
Cigna Corp.	\$34,914	7.8%	14.5	2.7%	\$2,102	42.4%
Total	\$345,765	10.2%	134.3	3.9%	\$13,479	5.4%

\*Percentage change reflects unrounded figures

Source: Company reports

# Health insurers post strong results despite reform law distractions

BY MATT DUNNING

The nation's largest publicly held health insurers met or exceeded most analysts' expectations in 2014 despite the tumultuous rollout of public health insurance exchanges plus new fees and regulations under federal health care reform law.

Collectively, the five largest U.S.-based publicly traded health insurers recorded \$345.77 billion in total revenue in 2014, a 10.2% increase from 2013. Their net income grew to \$13.48 billion in 2014, up 5.4% from the previous year (see chart).

Total medical enrollment also increased, rising 3.9% to 134.4 million lives in 2014.

"In one word, it was impressive," said Vishnu Lekraj, a Chicago-based senior research analyst at Morningstar Inc. "All of the major insurers really performed well, especially given all of the new regulations, fees and taxes in place, and given all of the uncertainty around the exchanges."

Analysts said a key contributor was insurers' relatively conservative approach to participation and/or coverage pricing in public health insurance exchanges established under President Obama's health care reform law.

Two of the five offered coverage through just a handful of state-run or federally operated exchanges in their inaugural year, due largely to concern that their exchange-based products would attract a disproportionate percentage of older and/or less healthy enrollees.

UnitedHealth Group Inc. and Cigna Corp. both limited their participation to just five exchanges for the 2014 plan year, generating roughly 10,000 and 125,00 new members, respectively.

Conversely, Aetna Inc. and Anthem Inc. took more aggressive strategies, offering coverage through 16 and 14 states, respectively, to a combined 13.6 million members. However, the health insurers also were more diligent in pricing their exchange-based plans to guard against the risk of adverse selection, analysts said.

Alongside medical utilization rates that were lower than had been predicted, the exchanges' 2014 enrollment pool showed a more even balance between high-risk and low-risk plan members at midyear last year, prompting insurers to expand their participation in the public exchanges this year.

In particular, UnitedHealth broadened its footprint in the public exchange marketplace from five states to 23 for the 2015 plan year.

"This includes eight of the 10 largest exchange market states, and 15 states where we offer complementary Medicaid plans," UnitedHealth Group CEO Stephen Helmsley said during a recent earnings con-

ference call with analysts.

At year-end, UnitedHealth had more than 400,000 individuals enrolled in coverage through public exchanges, with up to 100,000 more predicted to purchase coverage by the end of the 2015 open enrollment period.

"They'd kept themselves at an arm's length from the exchanges in the beginning, but they've made a really big push into that space for 2015," said Tom Mason, a Charlottesville, Virginia-based senior financial analyst at SNL Financial L.C. "So it looks like they view the exchanges as a pretty significant opportunity."

Aetna, Cigna and Humana Inc. also expanded their participation in public exchanges. Anthem already is participating in public exchanges in all 14 states where it operates, with Cigna expanding its market footprint to three states, and Aetna and Humana each adding one state to their exchange strategies.

But insurers' optimism was far more muted on the short-term opportunities for revenue and membership growth through private health insurance exchanges.

"There (has) been a lot of conversation in the market as we expected," said David Cordani, president and CEO of Cigna.

In addition to participating in several third-party private exchanges owned by benefit broker/consultants, Cigna launched its own exchange platform last year.

"Consistent with our prior dialogues, we did not expect to see a significant amount of movement in the overall landscape in the marketplace in '14 or '15, and that's what manifested for both the industry as a whole, as well as for ourselves," Mr. Cordani said during the company's recent conference call with analysts. "We saw some movement in both directions, but it all nets out to (an inconsequential) amount of activity."

Analysts said one factor potentially impeding broader implementation of private exchanges is the ongoing migration of large and midsize companies to self-funded health insurance programs.

Among the top five publicly traded health insurers, the volume of administrative services-only contracts for self-insured employers grew an average 2.4% in 2014, while the volume of fully insured companies declined an average of 1.6%, according to the companies' filings.

"It looks as though (administrative services-only contracts) actually accelerated a bit in 2014, and it's probably going to continue to be the case moving forward, especially among the larger employers," Mr. Lekraj said. "It's going to reach a floor at some point, but the timing on that is still up in the air. We'll have to see how the small-employer market works out over the next two years."



## BROKERS

Continued from page 6

which appears to be getting mildly soft," said Mr. Cunningham. "That impacts rates, it impacts revenues and therefore it impacts earnings."

"In terms of insured exposures, that's been modestly up, which has helped to offset somewhat the deceleration of pricing," said Julie Herman, New York-based associate director of insurance rating at Standard & Poor's Corp. That pricing deceleration has extended from property to casualty insurance and reinsurance, she said.

One positive aspect for brokers last year was modest but growing revenue related to private health insurance exchanges and advisory services, which Moody's Mr. Ballentine said "have growth potential."

All of the top five brokers operate private exchanges.

"The evolving health care environment could still provide oppor-

tunities for employee benefits and consulting," said Fitch's Ms. Roetzer.

"Employee benefits is generating some traction," said S&P's Ms. Herman, although she also said "overall adoption in the private exchange markets may be a little slower than anticipated and is at this point still a modest source of revenue growth."

Growth by acquisition continues to be a major theme in the industry, rising to a record 321 M&As in 2014, according to Optis Partners.

"I think you're going to see three to five years of pretty robust deal activity," said Mr. Cunningham.

"In 2015, Fitch expects brokers to continue to supplement organic revenue growth through selective acquisitions," said Ms. Roetzer.

"A core skill for all the leading brokers is to source, close and integrate acquisitions," said Mr. Ballentine. "To be one of the biggest brokers, you've probably gotten there through a combination of organic growth and acquisitions, and to remain among the leaders you need to keep doing both."

## INSURERS

Continued from page 6

"Pricing for the U.S. companies tended to peak at about October 2013 at about 5% (increases), and you've been in a creeping deceleration since that time," Mr. Shanker said. "Right now, pricing is about flat compared to where it was a year ago."

Fitch's Mr. Auden said that overall "it's more of a flat-pricing market. We don't see sharp declines in primary rates."

"Our expectation for this year is that rate increases will continue to taper off and likely turn into rare decreases as 2015 unfolds," Mr.

Dwelle said.

Richard Kerr, CEO of Dallas-based electronic insurance exchange MarketScout, said insurers enjoyed rate increases most of the year, and "it took until the very end of the year when it all went flat."

Mr. Kerr noted that rate movement, which MarketScout tracks, has differed state by state and line by line.

"Depending where you are, what line of coverage you're doing, it may be different from the composite," Mr. Kerr said. "We started out up three or four points and bounced down to one (point); and coming into 2015, it actually went negative, but in February, it actually went up a point."

## PROPERTY/CASUALTY RATES BECOMING LESS VOLATILE

While industry observers say rate increases for commercial property/casualty insurance are getting smaller or even flattening, that doesn't mean a true soft market is likely this year.

Continuing low interest rates are making it unlikely that any individual insurer will step out and aggressively compete on price, observers say.

"At this point, I'm optimistic we'll see a plateauing" of commercial rates, said Mark Dwelle, an insurance analyst at RBC Capital Markets, a unit of RBC Dominion Securities Inc. in Richmond, Virginia.

He predicted there would be no strong directional move either way.

Richard Kerr, CEO of Dallas-based electronic insurance exchange MarketScout, also foresees no dramatic changes.

Mr. Kerr said the use of big data and other analytics tools means "I don't think we'll see again the massive market swings like we did eight or 10 years ago." More complete information means management is better equipped to deal with changes, he said.

Instead, "you may have a mini soft market for the primary insurers that lasts six months," Mr. Kerr said. The dramatic hard and soft markets of the past could well be replaced by shorter cycles that are not as deep, he said.

By Mark A. Hofmann

# U.S. reinsurers report growth in competitive market

## National Indemnity boosted by one-time deal

BY MATTHEW LERNER

National Indemnity Co. drove a 78.4% increase in net written premiums among 18 U.S. reinsurers in 2014.

The Berkshire Hathaway Inc. unit's one-time affiliated loss portfolio transfer from Geico Auto Insurance operations and subsequent quota share agreement was a major factor in boosting its net premiums written by \$20 billion to lead reinsurers tracked by the Reinsurance Association of America to \$47.75 billion in net premiums written last year.

Despite ongoing "competitive pressure on reinsurers," the results represented "another really good year" for U.S. reinsurers, said Jim Auden, Chicago-based managing director of insurance at Fitch Ratings Inc.

Underwriting results were also "pretty good in total" with few examples of underwriting losses among the reinsurers sur-

veyed, said Mr. Auden.

Among the top 10 reinsurers (see chart), only QBE North America posted a 2014 combined ratio over 100% and the smallest profit of the group. QBE is still recovering from 2013's \$580 million loss due to higher than expected claims.

"The results, as you would expect, were strong," said Taoufik Gharib, New York-based director of financial services ratings for North American insurance at Standard & Poor's Ratings Services.

"Overall, the reinsurance industry ... performed well in 2014," due mainly to a benign catastrophe year and ongoing reserve releases, Mr. Gharib said.

While still profitable, seven of the top 10 reinsurers reported a smaller profit in 2014 than 2013.

Results for U.S. reinsurers compared favorably with the global reinsurance sector, Mr. Auden said.



## TOP U.S. REINSURERS' 2014 RESULTS

Ranked by net premiums written, in millions of dollars.

Reinsurer	Net premiums written 2014	% increase (decrease)	Net income 2014	% increase (decrease)	Combined ratio*
National Indemnity Co. <sup>1</sup>	\$26,145	404.7%	\$11,956	45.4%	92.6%
Munich Re America Corp.	\$3,248	1.6%	\$822	(2.5%)	87.3%
Transatlantic Reinsurance Co.	\$2,991	0.3%	\$567	(26.5%)	90.4%
QBE North America	\$2,726	(8.8%)	\$5	NM	101.5%
Odyssey Reinsurance Group	\$2,252	(0.2%)	\$276	107.5%	84.5%
Everest Reinsurance Co.	\$2,122	4.8%	\$357	(33.9%)	88.0%
Swiss Reinsurance America Corp.	\$1,882	(4.2%)	\$498	(22.8%)	82.4%
General Re Group <sup>2</sup>	\$1,308	9.3%	\$313	(54.8%)	93.8%
Partner Reinsurance Co.	\$1,204	5.6%	\$237	91.1%	91.8%
Scor U.S. Group/Scor Re	\$899	16.9%	\$83	10.7%	91.4%
Cumulative	\$44,777	88.9%	\$15,114	27.5%	87.0%

\*Includes dividends. NM=Not meaningful

<sup>1</sup> Excludes assumptions from affiliated General Re Group. <sup>2</sup> Includes North American property/casualty segment; excludes certain intercompany transactions, adjustments and cessions to certain Berkshire Hathaway Group members.

Source: Reinsurance Association of America

National Indemnity's loss portfolio and quota share agreements with affiliated Geico companies, all effective Jan. 1, 2014, did have an outsized effect on the overall figures, Mr. Auden said.

Munich Re America Corp. was a distant No. 2 with \$3.25 billion in net premiums writ-

ten last year.

The 18 U.S. reinsurers' 2014 combined ratio deteriorated to 91.1% from 86.8% a year earlier, with a 69.6% loss ratio and an expense ratio of 21.5%, according to the RAA.

Policyholders' surplus increased 2.2% to \$141.8 billion for the year.

## CYBER

Continued from page 1

most recent one last week — to promote more information sharing between public and private entities concerning cyber breaches.

Congressional interest in cyber insurance is a "natural extension" of lawmakers' examination of cyber security issues, said Michael Menapace, counsel in the Hartford, Connecticut, office of Wiggan and Dana L.L.P. and an adjunct professor of law at Hamden, Connecticut-based Quinnipiac University.

Mr. Menapace, who testified before Sen. Moran's panel, said after the hearing the congressional concern over how the costs of cyber breaches will be covered is "naturally going to lead you to insurance. Insurers certainly have influence over their practices that are employed by the insureds."

He added that insurers themselves hold a lot of data, so their own experience in this area is valuable.

Another witness — Ben Beeson, the Washington-based vice president for cyber security and privacy with Lockton Cos. L.L.C. — agreed, saying cyber insurance is an important market force that can drive improved cyber security for companies.

Speaking before the panel, Mr. Beeson said Lockton and "we believe the industry as a whole" would welcome the introduction of legislation that would reduce barriers and encourage organizations to share cyber threat indicators with the government and each other while also protecting individ-

## FEW U.K. FIRMS BOTHER WITH CYBER COVER

U.K. buyers often have very different concerns than U.S. buyers when it comes to transferring cyber risks to insurance, an issue that insurers, brokers, buyers and the U.K. government are looking to rectify.

The rapidly growing risk is an issue for U.K. companies and organizations, according to a report issued last week by the U.K. government, Marsh L.L.C. and insurers. While 81% of large U.K. companies and 60% of small ones suffered a cyber security breach in the past year, less than 10% have bought cyber insurance.

A lack of data pooling has hampered insurers' ability to develop coverage and pricing models. In addition, the potential of aggregated losses affecting a large number of companies is a concern for insurers, according to the analysis.

"This is a call to arms to the insurance sector," said Mark Weil, London-based CEO of Marsh in the United Kingdom and Ireland, as many large companies still do not view cyber coverage as "part of the toolkit" to manage cyber risks.

The joint initiative of the U.K. Cabinet Office, Marsh and 13 insurers that produced the cyber report is "a first step" to help businesses manage their cyber risks, said Natalie Black, London-based deputy director of cyber defense and incident management at the Cabinet Office.

ual privacy.

In an interview after the hearing, Mr. Beeson called the hearing "hugely important for our clients and industry."

"How do you get industry (companies) to raise its game, to improve its resilience against that type of threat?" he said. "I don't think you can legislate minimum security standards. It's about an approach, a culture. It's very difficult to be prescriptive."

Congress would rather see the market try to help solve the prob-

lem, Mr. Beeson said. "It puts the insurance industry in a place perhaps where it didn't expect to be: Congress says, 'We want you at the front of the conversation.'"

Cyber insurance can help address two fundamental cyber security problems, Mr. Beeson said: industry not investing enough in security; and the other of determining the right approach to security, which, he said, is tackling it in an enterprise risk management framework.

"It's a huge opportunity; we're

The report recommends establishing a forum including the government and the insurance sector, such as the Association of British Insurers and Lloyd's of London, on "data and insight exchange for policy discussions," among other things.

"The London market has a long, proud history of finding innovative solutions to insuring large, complex risks that are challenging to underwrite locally," Lloyd's CEO Inga Beale said. "Just as the market has responded to new challenges before, so it needs to again."

John Hurrell, CEO of London-based Airmic Ltd., said cyber coverage developed so far largely responds to a data breach, which is a huge concern for U.S. buyers. However, some U.K. buyers are more worried about theft of intellectual property, disruption of services and reputational damage, he said. Also, there often is insufficient capacity to provide limits large buyers desire, the leader of the U.K. risk management group said.

Sharing information among firms and insurers on cyber incidents could help the U.K. cyber insurance market, said Sarah Stephens, a London partner in the financial lines group at JLT Speciality Ltd., a Jardine Lloyd Thompson Group P.L.C. unit.

By Sarah Veysey

asking the government to do anything they can do to provide more incidence data," Mr. Beeson said.

During his testimony, Mr. Menapace said there's no single standard for private and public entities requiring reporting of data breaches. Instead, each state has its own standard, leading to increased costs and inefficiency, he said.

Mr. Beeson said Congress could follow a precedent in health care reporting and set a federal notification requirement, a good move for consumers and businesses.

Representatives of insurer groups agreed.

"It would be nice to have a single federal standard" for companies regarding data security breach reporting, said Alex Hageli, a director at the Chicago-based Property Casualty Insurers Association of America. "It's been on the wish list for some time, and it seems with all of the recent breaches that it might actually come to fruition."

"Ideas, which all the panelists endorsed, such as federal legislation encouraging sharing of cyber threat data, exploring the creation of a data repository and a pre-emptive federal data breach standard, should help improve underwriting and increase market capacity," a spokesman for the Washington-based American Insurance Association said. "We feel that greater collection of information about the market would be a good thing."

PCI's Mr. Hageli also said that the Federal Insurance Office has been "very interested in developing the cyber insurance market."

"We feel cyber insurance is a key piece of the puzzle of how to best prepare our country to address cyber threats. It was great to see the Senate hold what was the first-ever hearing on this issue," said Jonathan Bergner, federal affairs director in the Washington office of the National Association of Mutual Insurance Cos.

Laura Foggan, a partner in the Washington law firm Wiley Rein L.L.P. who specializes in insurance law, said she thinks there is "pretty broad" insurance industry support for legislation that encourages information sharing about cyber security breaches.

# SILICA

Continued from page 3

in how fracking sand is loaded, stored, transported and unloaded,” he said. “You need to find a way of keeping sand from degrading and the wind from blowing it.”

The energy sector can take some solace in the experiences of the mining industry, which has made strides in combating workers exposure to another harmful airborne particle, coal dust.

The lesson that comes out of the coal industry, is there are known, proven technologies to protect the worker, such as respirators, said Bruce Watzman, Washington-based vice president of the National Mining Association.

The mining industry also is beta testing the use of continuous personal dust monitors, which will give a real-time data feed on airborne dust at worksites, Mr. Watzman said, noting that while the technology has proven itself in the lab, it still has to prove itself in the field.

“Everybody wants a device that can give us real-time dust monitoring results so that we can take actions to protect miners when exposures are occurring,” he said.

Mr. Ingram said he expected wider use of technologies such as gravity-based systems that eliminate the need to force proppant into sand containers as oversight of air quality at extraction sites tightens. “If the proposed silica rule from OSHA becomes law, it is going to be very difficult for companies to meet that standard without proper engineering controls in place.”

The OSHA rule, first proposed in 2013 and due to be finalized in June, would halve the OSHA permissible exposure limit for respirable crystalline silica from 100 micrograms of silica per cubic meter of air to 50 micrograms per cubic meter.

Inhaling silica dust into the lungs causes silicosis, an incurable respiratory disease that can kill, as well as lung cancer and chronic obstructive pulmonary disease, according to the Centers for Disease Control and Prevention.

“Silica exposure is one of the emerging risks that we see, but the fracking industry is starting to take action,” said Pascal Ray, Houston, Texas-based senior vice president and marine and energy program manager for the Southwest region of USI Insurance Services L.L.C. “My energy clients are serious about limiting this risk.”

Despite the progress that has been made in reducing exposure, silicosis can take about 10 or 20 years for the symptoms to develop, Mr. Ray said.

“The issue for the energy industry is the employees that were exposed to silica before much of the new the safety equipment came online,” he said. “We are not yet seeing a lot of silicosis-related claims to the upstream energy sector yet, but it is a concern.”

# IBI

Continued from page 4

champion company wellness and health management programs can make a difference, Oakland, California-based health care provider Kaiser Permanente found via employee surveys.

“Where we have a lot of opportunity for improvement is in the area of what a supervisor can do to support individuals in leading healthy lives,” said Kathy Gerwig, vice president of employee safety, health and wellness at Kaiser Permanente. “We think so much about telling supervisors what they cannot talk to employees about, and we haven’t quite given them the words to have a conver-

sation about health. So that’s some work we have ahead of us.”

Lemont, Illinois-based Argonne National Laboratory noticed a similar problem after polling its employees.

“We found out after a year or so that we weren’t getting through to the employees where we didn’t have the appropriate supervisor support,” said Dr. Jamie Stalker, Argonne’s division director of health and employee wellness.

So Argonne began holding educational boot camps to familiarize its working group leaders and supervisors with the company’s wellness program and train them on communicating the program to employees.

“In the two years since we started the boot camps, the light bulbs are beginning to go on across the

workforce,” Dr. Stalker said. “I think that starts with our group leaders.”

In separate research also presented at the IBI conference, Franklin, Tennessee-based health care consultant Healthways Inc. found that a health management strategy that embraces the full scope of an employee’s well-being is more than twice as effective at curbing productivity losses as a wellness program centered solely on physical health.

“That’s the value difference that (chief financial officers) are going to care about when it comes to offering a traditional wellness program and a program that embraces this broader definition of well-being, whether it’s our definition or someone else’s,” said Jim Purvis, vice president of well-

being improvement at Healthways.

Since integrating Healthways’ well-being assessment into its workplace wellness programs in 2011, the Irvine, California-based St. Joseph Health hospital system, which has 16 facilities in California and Texas, has reduced its number of at-risk employees in nine of 12 categories, including alcohol overuse, high blood pressure, high cholesterol, recreational medication use, low physical activity, stress and tobacco use.

“We feel that the investment is meaningful, because we can see from the data that we are influencing our employees’ health and well-being,” said Elizabeth Glenn-Bottari, St. Joseph’s vice president and chief operating officer of integrative health.

# DISPENSING

Continued from page 3

“There’s a lot of money in” physician dispensing, said Mike Farrand, vice president and director of workers compensation cost containment at Willis North America Inc. in Radnor, Pennsylvania. “It’s a big cottage industry that’s really flown under the radar.”

Eighteen states have passed laws since 2007 to place controls on medications dispensed directly by doctors, rather than retail pharmacies, according to data presented by WCRI at its annual conference early this month. Of those states, 14 based their reforms on limiting reimbursement prices for physician-dispensed drugs — which WCRI says can be priced 60% to 300% higher than pharmacy-dispensed medications — while the remaining states restricted the ability of doctors to dispense medications.

Paul Braun, managing director of casualty claims at Aon Global Risk Consulting in Los Angeles, said such controls have become important since some doctors see prescription dispensing as a way to boost their revenues while serving injured workers who want instant pain relief rather than waiting for a pharmacy.

“It’s all about the money,” he said.

State controls have typically

limited reimbursement for physician-repackaged prescription drugs to an original manufacturer’s average wholesale price. WCRI says some drug manufacturers have begun developing new medications that have signif-

## PILL PROFITS

The average price per pill of physician-dispensed medications continues to be higher than pharmacy-dispensed medications in Illinois despite efforts to control the costs of doctor-issued drugs in 2012.

### Hydrocodone-acetaminophen

	2012	2013
Physician-dispensed	\$1.21	\$1.60
Pharmacy-dispensed	\$0.53	\$0.52

### Cyclobenzaprine HCL

	2012	2013
Physician-dispensed	\$1.58	\$2.51
Pharmacy-dispensed	\$1.02	\$0.98

### Tramadol HCL

	2012	2013
Physician-dispensed	\$1.42	\$3.60
Pharmacy-dispensed	\$0.76	\$0.75

Source: Workers Compensation Research Institute

icantly higher average wholesale prices than previous drugs, allowing dispensers to receive more money for such medications.

In the case of Illinois, because “these new-strength drug products were almost all dispensed by physicians at much higher prices,

we infer that the shift in strength was unlikely to be driven by new evidence about superior medical practices,” said the WCRI study, which noted that similar trends have been seen in California. “Rather, it is likely that financial incentives drove some physicians to choose the strength for their patients.”

CompPharma’s Mr. Paduda said WCRI’s research shows that “price controls just don’t work” in controlling physician dispensing. “They’re very easily circumvented,” he said.

Willis’ Mr. Farrand said it’s likely that states focused on controlling prices for physician dispensed medications, rather than controlling the practice itself, because discussions about the problem have focused on how drug repackaging raises workers comp claim costs.

“I don’t think the legislators really realized this was a possibility,” Mr. Farrand said of loopholes found by physicians and drug repackagers.

Beyond higher prices for repackaged medications, sources contend that such physician dispensing poses safety threats for injured workers. While bills for pharmacy-dispensed medications can be easily reviewed by workers comp claims handlers, claims for physician-dispensed medications often are folded into overall medical bills and are difficult to flag for consideration by pharmacy benefit managers, third-party

administrators or insurers.

“There’s no opportunity to have that comprehensive view of the prescriptions,” said Jennifer Kaburick, vice president of workers compensation product management and strategic initiatives with St. Louis-based PBM Express Scripts Inc.

Sources say they’re hopeful that recent rounds of state reforms will be more effective at addressing physician dispensing and lead other states to consider similar legislation

“We can continue to try to whack the mole, or we can ban physician dispensing, period,” Mr. Paduda said.

In October, Pennsylvania passed H.B. 1846, which caps reimbursement of repackaged drugs at 110% of the average wholesale price, restricts doctors from dispensing Schedule II controlled substances, and prohibits physicians from dispensing more than a 30-day supply of other medications.

Meanwhile, Indiana in March 2014 passed S.B. 294, which says physicians can only be reimbursed for repackaged drugs dispensed during the first eight days of a workers comp injury, among other restrictions.

“They’re addressing the fee schedule issue, or unit per cost, as well as the utilization of the drugs,” said Kim Ehrlich, vice president of workers’ compensation compliance with Express Scripts, of recent reform efforts.

# ILS

Continued from page 3

Willis Group Holdings P.L.C. and chairman of the London Market Group, which already is working to improve the London market’s competitive position, welcomed the proposal that he said was discussed with government officials in February.

“Through insurance-linked securities and other financial

vehicles, there has been a growing prevalence of alternative capital in the global reinsurance market,” said David Ledger, CEO of Aon Benfield U.K., a unit of Aon P.L.C., in London. Domiciling ILS transactions in the United Kingdom would bring some of that business to the London market, he said.

While most ILS activity has been offshore, several ILS funds already are listed on the stock exchange in the United Kingdom, said David Gubbay, a partner at

law firm Reynolds Porter Chamberlain L.L.P. in London.

Establishing special-purpose vehicles in the United Kingdom and retaining the proceeds of the notes they issue would aid the country, but it also would require tax law changes, the attorney said.

“We will watch this space with interest,” Mr. Gubbay said.

“The details matter, and the process matters,” said Rick Miller, New York-based managing director and co-head of insurance-

linked securities at Jardine Lloyd Thompson Capital Markets, an arm of London-based brokerage Jardine Lloyd Thompson P.L.C.

“If the revised regulatory and, more importantly, tax framework encourages more overall reinsurance — ILS and traditional — premiums and risk to flow through London, then it could be significant,” Mr. Miller said. “However, if we are simply building a mimicked version of what is already established in Ireland, Guernsey, Bermuda and the Cayman Islands

# BIAS

Continued from page 1

on the basis of gender.

“I would not be surprised if (the Pao case) is a galvanizing force” in encouraging more litigation, said Paul E. Starkman, a partner at law firm Pedersen & Houpt P.C. in Chicago.

While gender discrimination cuts across all types of businesses, Ms. Pao’s suit highlights issues endemic to professional services firms, experts say.

Gerald L. Maatman, a partner at Seyfarth Shaw L.L.P. in Chicago, said, because of the Pao trial, these issues are being discussed “not only on TV, but around the water cooler.”

Professional services firms’ employees are “really very bright people, but that doesn’t mean that they act rationally,” Mr. Starkman said. The issues in the Pao case are something “that has been haunting professional services for a while,” and include mentoring relationships and how assignments and promotions are doled out.

“You have the interaction between people not wanting to deal with these kinds of troublesome issues and the fact that there is money involved,” he said, which “makes it even more of a kind of hot potato.”

Despite strong efforts by the financial services industry to address gender discrimination concerns, firms’ structure is one reason the problem persists, said Gregg Lemley, a shareholder at Ogletree, Deakins, Nash, Smoak & Stewart P.C. in St. Louis.

For instance, only a minority of employees progress to the partnership track, which may have them wonder whether “something other than merit” led to their failure, Mr. Lemley said. Such claims also can emerge from “that alleged frat boy environ-

ment where the guys are just being guys,” Mr. Starkman said.

The frat boy and good old boy mentality has been a problem in the financial services industry for a long time, said Richard B. Cohen, a partner at FisherBroyles L.L.P. in New York.

The financial services industry “has had more than its share of gender discrimination lawsuits filed by women because it has such a long history of exclusion of women and disparate treatment of women,” Mr. Cohen said. It was the last business sector to embrace minority hiring, and it always has worked to protect its privileges, he said.

The challenge in the technology industry, in particular, is that it draws many employees who are recent college graduates, and studies have shown a high frequency of sexual harassment at universities, said Ingrid Fredeen, vice president of online learning content at Lake Oswego, Oregon-based Navex Global Inc., an ethics and compliance consulting firm.

“Kids are coming up through this environment where it’s tolerable,” while employers mistakenly assume these young people know better, Ms. Fredeen said.

Although apparently not a factor in the Pao trial, Mary-Pat Cormier, a partner with the law firm Bowditch & Dewey L.L.P. in Boston, said there also is an issue with women who spend less time in the office because they care for a child or a parent.

In industries such as private equity where there are high-profile deals, and you must do many “to be able to earn your stripes,” how do you reward or advance somebody who is only billing for 1,900 hours when others are putting in 2,400 hours, Ms. Cormier said. “You’ve got to figure out a way to value diversity.”

Top executives need to act to halt gender discrimination, experts say.

“There’s got to be some oversight. You need to do some auditing,” Mr. Starkman said. “These decisions can’t be driven by assumptions that women may go onto the mommy track and men are there for the duration.”

The best defense is an early warning system, robust compliance procedures and rigorous administration of those systems, Mr. Maatman said. It demonstrates that complaints are not falling on deaf ears, he said.

## GENDER BIAS CASES

■ In a March 19 suit, former Twitter Inc. software engineer Tina Huang accused the San Francisco-based firm of having a “subjective, secretive promotion process that encouraged arbitrary and stereotyped decision making.” Twitter said in a statement Ms. Huang was treated fairly.

■ In a March 16 suit, Chia Hong, a former employee of Menlo Park, California-based Facebook Inc., alleged gender discrimination in *Chia Hong v. Facebook Inc. et al.* Ms. Hong alleged she was belittled at work, including questions about why “she did not just stay at home and take care of her children;” and was replaced after her October 2013 firing by a less qualified male. Facebook said in a statement, “In this case we have substantive disagreements on the facts, and we believe the record shows the employee was treated fairly.”

■ In *H. Cristina Chen-Oster et al. v. Goldman Sachs & Co. et al.*, plaintiffs alleged “at nearly all levels of management ranks,” the company paid its female professionals less than similarly situated male professionals. Magistrate Judge James C. Francis IV recommended March 10 against granting class certification. Plaintiff attorneys asked the court to reconsider.

By Judy Greenwald

# DEDUCTIBLE

Continued from page 1

coverage, said J.D. Piro, a senior vice president with Aon Hewitt in Norwalk, Connecticut.

“HHS is saying that even under a plan covering a family — or any plan covering more than a single individual — no individual can be required to pay more than the \$6,850 out-of-pocket maximum,” said Anne Waidmann, a director at PricewaterhouseCoopers L.L.P. in Washington.

An example illustrates how the HHS-imposed “embedded” limit on out-of-pocket expenses will work:

An employer plan has a \$10,000 out-of-pocket expense limit for employees with family coverage. An employee’s spouse incurs \$15,000 in medical care expenses. The spouse’s out-of-pocket expense will be capped at \$6,850, the same cost-sharing limit that would be imposed if the individual had single coverage.

For many employers, the new cost-sharing limitation for employees with family coverage will be irrelevant. That is because their out-of-pocket limits or deductibles are far below the \$6,850 maximum the HHS rules will allow for any individual plan participant.

For example, in 2014, the median out-of-pocket limit for family coverage in preferred provider organization plans offered by employers with at least 500 employees was \$6,000, according to a Mercer L.L.C. survey.

But smaller employers, especially those with high-deductible plans linked to health savings accounts, could be affected. The Mercer survey found that the median out-of-pocket limit for family coverage offered by employers with between 10 and 499 employees was \$8,000.

The HHS rules “would be a problem for high-deductible plans,” said Andy Anderson a partner

with Morgan Lewis & Bockius L.L.P. in Chicago.

In fact, few employers include embedded cost-sharing limits in their group health care plans. An Aon Hewitt survey found that just 17% of large and midsize employers offering high-deductible health care plans with HSAs had an embedded out-of-pocket limit.

Despite the potential effect the HHS rules would have on plan design, as well as shifting costs from plan participants to employers, there has been little discussion — or even awareness of the new rules.

“This is not very well-known,” said Rich Stover, a principal with Buck Consultants at Xerox in Secaucus, New Jersey.

There is good reason this new cost-sharing limitation has been under employers’ radar: The requirement was included as part of much broader health care reform law regulations issued late last month. The cost-sharing requirement was not in the body of the regulations, but in the preamble to the regulations.

And some think the way the requirement was presented could cause enforcement issues.

The embedded requirement “is described in the preamble to the regulation, not the regulation itself. A court might refer to a preamble for help interpreting a rule, but the preamble typically does not have the force of law on its own,” said Judy Bauserman, a Mercer partner in Washington.

Adding to the uncertainty is that unlike many other health care reform law-related regulations, which have been jointly issued by three federal agencies — the U.S. Department of Labor, the Internal Revenue Service and HHS — the limits on employee health care cost sharing came only from HHS.

“This lack of tri-agency guidance is leading some employers wondering if this is something they have to care about,” Ms. Bauserman said.

# PERFORMANCE

Continued from page 4

over again,” said Loyd A. Hudson, Columbus, Ohio-based integrated disability manager for American Electric Power Co. Inc., which has 18,500 employees in about 20 states.

Providers also are trying to improve outcomes and reduce costs, but face several obstacles, according to a Rand Corp. and American Medical Association study released earlier this month.

The goal of sharing data with physicians is to “make certain that the best providers are only getting better,” and those who “maybe aren’t where they need to be are hopefully upping their game,” said Helmsman President Debbie Michel, who is based in Chicago. “If not, over time, then we would be making modifications to our

network based on that.”

Providers are encouraged to meet with Helmsman’s regional medical directors to discuss their evaluations, which are based on factors that include early requests for MRIs, the amount of physician-dispensed drugs and at what point they prescribe opioids, she said.

Sedgwick’s provider benchmarking program, which scores physicians on litigation rates, billing practices, return-to-work outcomes and other factors, recently started sharing “scorecards” with providers, said Kimberly George, Chicago-based senior vice president and senior health care adviser at Sedgwick.

Many providers are interested in improving their scores, which helps payers since a low-scoring physician might be the only option in a rural area or a state that restricts employers from directing medical care, Ms. George said.

While states such as California

and Florida allow employers participating in a managed care organization, preferred provider organization or coordinated care organization to direct workers comp medical care, states such as Arizona and Massachusetts allow injured workers to choose their providers.

Earlier this month, the Industrial Commission of Arizona said it received complaints of certain entities directing care, which only private self-insured employers can do in the state.

In Pennsylvania, state Rep. David S. Hickernell, R-West Donegal Township, introduced a bill in February that would require an injured worker to receive treatment from providers who are part of an employer’s coordinated care organization for 180 days, rather than the current requirement of only 90 days.

The bill would help ensure “provider quality and integrity,”



**HEAR INTERVIEW**

Visit *Business Insurance's* multimedia web page to hear Kimberly George of Sedgwick Claims Management Services Inc., discuss scoring physicians who treat workers comp patients with *Business Insurance* associate editor Stephanie Goldberg.

“eliminate unnecessary services, excessive or duplicative treatment and overutilization of medication,” while still allowing injured workers to choose a provider, Rep. Hickernell said in a statement earlier this year.

Even in states where employers can’t direct care, sources say making injured workers aware of higher-rated physicians can help

reduce the cost and length of a claim.

“So in states where (employers) can’t direct, we will offer to advise the injured workers (and explain that) we have an understanding of the providers within the area that are delivering the most successful outcomes,” Ms. George said.

But payers don’t need data to build relationships with physicians.

“Over the last 10 years, there’s been a lot of debate about how you would actually measure and quantify who your good physicians are,” said American Electric Power’s Mr. Hudson. “Nobody likes to be measured.”

Mr. Hudson said he looks to forge partnerships with physicians who understand comp and who will help him identify an injured worker’s capabilities so he can offer a light-duty interim assignment until the worker can return to his or her full-time job.



## Hide-and-seekers told to get lost

Ikea is asking customers to please stop playing hide-and-seek in its stores. The craze reportedly began last year when the Swedish furniture retailer allowed a woman to play the game with her friends at a Belgium location, and subsequently crossed the item off her 30th birthday bucket list, an Ikea spokeswoman told media outlets.

Similar events have since been planned via social media for other Ikea locations, with 19,000 people signing up to play in Amsterdam on April 3 and 13,000 people signing up to play in Utrecht, Netherlands, on April 18.

The company has reached out to hide-and-seek enthusiasts through Facebook pages that are dedicated to organizing such events and asked that they play elsewhere.

"We need to make sure people are safe in our stores and that's hard to do if we don't even know where they are," the spokeswoman told media outlets.

Photos of various games have been posted on social media websites. Popular hiding spots seem to include under beds and sofas, inside cabinets and closets, and beneath plastic bins and Ikea shopping bags.

## Actuarial tool adds up to savings

A new book by U.S. actuary Peter Neuwirth could help you buy a car, refrigerator or even save for retirement, by offering a guide to the concept of "present value."

In the book, "What's Your Future Worth?," the retirement actuary at Towers Watson & Co. says

while present value techniques cannot predict the future, they can help simplify and evaluate outcomes that could arise from choosing one path over another.

Mr. Neuwirth describes how when his favorite running shoe was discontinued by the manufacturer and put on a half-off sale, he was faced with deciding how many pairs to buy and went through a five-step process to determine. Mr. Neuwirth bought four pairs of his favorite running shoes — a good decision, he says.

Present value techniques can be used to decide where to book a dream holiday, and even bigger decisions, such as changing jobs or investing in education, Mr. Neuwirth contends.

And the book aims to make the present value concept simple enough for nonactuaries to follow.



# POP STAR SWIFT TO PURCHASE LEWD DOMAIN NAMES



AP PHOTO

Representatives for Taylor Swift have acquired domain names including TaylorSwift.porn and TaylorSwift.adult.

Pop princess is displaying some savvy reputational risk management by purchasing potentially embarrassing Internet domain names before others can do so.

According to CNN, representatives for Taylor Swift have acquired domain names including TaylorSwift.porn and TaylorSwift.adult ahead of June 1, when many new domain suffixes become available. The nonprofit Internet Corporation for Assigned Names and Numbers, which oversees Internet domains, has allowed select brands and celebrities the opportunity to purchase domain names during a "sunrise period" prior to June 1.

In 2011, ICANN voted to expand the number of suffixes far beyond commonly used suffixes such as .com and .net to about 547 possible domain endings.

In addition to Ms. Swift, Microsoft used the sunrise window to acquire potentially risqué site names such as Office.porn and Office.adult, CNN reports.

Other image-conscious businesses and celebrities may want to follow Ms. Swift's lead as one of the other approved domain suffixes set to become available is .sucks.

*Business Insurance* isn't all business all the time, and we know you're not either. So visit [www.businessinsurance.com](http://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.

## Lawmaker pushes pot for pets

pampered pets in the Silver State soon may qualify for a new prescription drug rider on their pet insurance policies.

A Nevada lawmaker proposed a bill in the state legislature that would grant ailing pets access to medical marijuana.



The measure, put forward by Democrat Tick Segerblom, would let owners obtain the drug for their animals if a veterinarian confirmed it "may mitigate the symptoms or effects" of a chronic or debilitating medical condition.

The proposed bill also includes provisions related to medical marijuana use among humans, including new regulations for dispensaries and dropping penalties for motorists found driving with the drug in their system.

The proposal comes as a growing number of U.S. states have relaxed marijuana laws. Nevada is one of 23 states where medical marijuana is legal, and voters have approved the drug for recreational use in four states and Washington, D.C.

Public opinion has also shifted dramatically toward legalizing marijuana in recent years. About 46% of Americans support full legalization of marijuana, according to Reuters/Ipsos polling.

Reuters



TINSELTOWN/SHUTTERSTOCK.COM

David Copperfield

## Pool water does vanishing act

David Copperfield's neighbors probably wish his disappearing swimming pool was just an illusion.

The water in Mr. Copperfield's rooftop lap pool vanished on March 8, flooding his 8,000-square-foot Manhattan penthouse, leaking into apartments more than 20 floors below and causing the building's elevators to stop working for more than a day, according to media reports.

The illusionist, who performs at the MGM Grand Hotel & Casino in Las Vegas, was out of town at the time, reports state.

His lawyer, Ted Blumberg, told the New York Post's Page Six that a pump for the 57th-floor pool malfunctioned, causing water to flow through Mr. Copperfield's four-story penthouse, which is decorated with valuables.

Mr. Blumberg added that the insurance company has been notified, and that no lawsuits have been filed as of yet.

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<b>ISSUE DATE:</b>	June 22	September 14	November 9
<b>AD CLOSE:</b>	May 25	August 24	October 19
<b>MATERIAL DUE:</b>	May 28	August 27	October 22

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<b>ISSUE DATE:</b>	June 29	September 21	November 16
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# Benefits Outlook™



## Research & Data

Facts and figures from the latest research on health care reform including: achievements attributed to the law; sources of coverage; enrollment figures; how the marketplace has changed; and the effects of the groundbreaking legislation on employer benefits packages. **Page 22**

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## *Health care reform five years later*

Starting with its passage in 2010, President Barack Obama's signature law never has been far from controversy, but employers have learned to adapt.

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## Health care reform reaches milestone

The Patient Protection and Affordable Care Act has survived a barrage of attacks since its March 2010 inception, and benefits managers are rolling up their sleeves for the long haul. But the law is still under fire in the courts, and new rules tracking worker hours are employers' latest hurdle.

Page 4



### Health Care

When employers use on-site health care services, lower health care costs often follow, so why don't more organizations offer the services to their workers? **Page 8**



### Retirement & Investment

The Pension Benefit Guaranty Corp. has performed a vital service over the past 40 years, but will it last another four decades? **Page 15**



### Voluntary Benefits

Employers such as Microsoft and Michelin are finding that investing in their employees' financial education can pay dividends. **Page 17**

## More work needed on reform law

It's hard to believe that five years have passed since President Barack Obama signed into law the Patient Protection and Affordable Care Act.

With the stroke of his pen, the president enacted what arguably will be remembered



Paul Bomberger, Managing Editor

decades from now as the most significant health care legislation in the United States. Its purpose was straightforward: provide the vehicle for the tens of millions of uninsured

in this country to get basic health insurance, and to be sure employers with at least 50 workers offer medical coverage to their employees who work a minimum of 30 hours a week or pay a fine.

Of course the landmark law has generated plenty of employer and political responses. The U.S. Supreme Court upheld the law's constitutionality in 2012, and it has survived numerous Republican-led attempts in Congress to repeal it.

Employers, meanwhile, have been adapting their benefits plan designs to comply with the law's provisions, many of which already have gone into effect.

Indeed, in our cover story package in this spring edition of Crain's Benefits Outlook, the national practice leader for the health law group of Aon Hewitt said: "After five years, I think employers are pretty much of the view that this law is here to stay."

Our cover story assesses the law's effectiveness, its shortcomings and how it has and will continue to alter employer health plans. For many, perhaps the biggest shortcoming is that it's still a big unknown if the Affordable Care Act can have a lasting effect on helping to keep employers' health care costs in check. Under the law, employers' health benefits expenses have increased, largely because they have to cover more people, such as employees' dependent children up to age 26.

However, fortunately, the doomsday predictions from naysayers that health care reform compliance will cause companies to abruptly stop offering health benefits to their workforces simply have not happened.

We think at the five-year mark it's time for state and federal lawmakers to make it a high priority to work with health insurers, health care providers and employers to periodically measure the law's effectiveness and devise ways to work collaboratively to improve it. More time and energy spent to try to kill or reverse it is not a productive way forward to achieve world-class health care delivery in this country.

## Questions & Answers

Sharon Cunninghis, leader of Mercer L.L.C.'s private health insurance exchange — Mercer Marketplace — discusses employer interest in this new delivery model, as well as the factors driving growth in private exchanges and Mercer's role going forward. **Page 20**



## International Benefits

The use of captive insurers to transfer pension longevity risk is a relatively new practice, but one that shows potential as an efficient way to access reinsurance capacity. **Page 21**

## Research & Data

Breaking down by the numbers the effect on employers and employees of President Obama's health care reform law. **Page 22**

# Cover Story



*The health care reform law has brought significant changes to the delivery of care since its 2010 inception.*

# Employers settle in to new era

BY KAREN PALLARITO

**S**ince its enactment in March 2010, the landmark Patient Protection and Affordable Care Act has weathered numerous attempts to block, repeal and eviscerate it.

Employers have stayed the course through the law's fits and starts, however, and now that most of the key provisions are in effect, benefits managers and business leaders are rolling up their sleeves for the long haul.

"After five years, I think employers are pretty much of the view that this law is here to stay," said J.D. Piro, a Norwalk, Connecticut, based senior vice president and national practice leader for the health law group of Aon Hewitt.

Indeed, the health care reform law already has begun to revamp health care delivery by ushering in public exchanges, spurring health system and payment reforms and accelerating the adoption of high-deductible account-based health plans, among other pivotal changes.

The primary goal of expanding health insurance coverage to tens of millions is still a work in progress, but early evidence suggests the law is making headway.

In 2014, the number of working-age adults without health insurance dropped to 29 million, or 16% of the population, according to the New York-based Commonwealth Fund's Biennial Health Insurance Survey released in January. That's the lowest level in more than a decade and the first statistically significant decline in uninsured rates since the survey's inception in 2001.

Separately, the Congressional Budget Office released new estimates in January showing that 36 million children and adults under age 65 will be uninsured this year, down from 55 million if Congress had not passed the law.

The health care reform law has been a game-changer for employers, too, beginning with the enormous administrative and compliance burden it imposes. Simply under-

standing the far-reaching law and all its complexities is tedious and time-consuming. Implementing it is even more so, especially as regulatory guidance continues to evolve, and 78% of employers in a 2014 Mercer L.L.C. survey cited the increased administrative burden posed by the health care reform law as a significant or very significant concern.

"We were still working on unanswered COBRA questions 10 years after COBRA was passed, and COBRA was a drop in the bucket compared to ACA," said Christopher Gavigan, president of Charon Planning, an NFP company, a strategic planning and benefits management firm, in Warrington, Pennsylvania.

With the employer shared-responsibility mandate now in play for businesses with 100 or more employees, employers are focusing on the next big task: complying with the law's detailed recordkeeping and reporting requirements.

Whether the law will have a lasting effect on the health-care cost trajectory remains to be seen. In the short-run, it added modestly to employers' health benefit expenses via new patient protections and expanded benefits, such as dependent coverage up to age 26, and more significantly through the extension of health benefits to full-time employees who weren't previously eligible for coverage.

Most employers experienced year-over-year health-care cost increases over the past three years, according to the Society for Human Resource Management's 2014 Strategic Benefits Survey, with 79% saying they are very concerned about controlling health care costs.

After assessing the law's effects, one of Mr. Gavigan's large employer clients considered scrapping its proposed acquisition of another large business. Initial estimates suggested that extending health benefits to workers at the target company and absorbing other health care-related expenses would have cost several million dollars, he said. Ultimately, the 1,000-plus-employee acquirer completed the deal, but switched

## Five years of health care reform law

**March 23, 2010** President Barack Obama signs the Patient Protection and Affordable Care Act in the East Room of the White House.

**March 24, 2010** Attorneys general in 13 states sue the federal government maintaining that the reform law is unconstitutional.

**Sept. 23, 2010** Employers begin to implement new health care reforms, including dependent health insurance coverage up to age 26.

**Dec. 13, 2010** A federal judge in Virginia strikes down the individual mandate, the first successful legal challenge targeting a key provision of the health reform law.

**Nov. 14, 2011** The Supreme Court agrees to hear arguments against the law after numerous state lawsuits and split appeals court decisions.

**June 28, 2012** The U.S. Supreme Court upholds the law's individual mandate and makes state Medicaid expansions optional.

**July 2, 2013** White House delays employer mandate until 2015.

**Oct. 1, 2013** Federal and state health insurance exchanges open for business.

**Jan. 1, 2014** Federally subsidized health insurance coverage takes effect.

**June 30, 2014** The high court, in a 5-4 decision, strikes down the law's mandate requiring family-owned Christian companies to pay for contraception benefits.

**Jan. 1, 2015** Employer mandate for businesses with 100 or more workers takes effect.

**March 4, 2015** Supreme Court hears oral arguments in *King v. Burwell* on legality of using premium subsidies in the exchange run by the federal government.

**“It’s almost like you’re baking in this potential exposure, and the employer has fewer and fewer levers to control.”**

Amy Bergner,  
PricewaterhouseCoopers L.L.P.

to bronze-level health coverage to minimize costs.

For certain employers with large numbers of hourly or low-wage workers, the 30-hour definition of a full-time employee, which determines eligibility for benefits under the law, is packing a wallop.

To provide health benefits to workers earning \$20,000 to \$30,000 a year, “you’re potentially looking at a 20% increase in total labor costs for certain parts of your workforce,” said Christopher Ryan, vice president for strategic advisory services in the Louisville, Kentucky, office of ADP L.L.C.

That is why many employers are choosing between reducing worker hours below 30 hours a week to avoid the additional expense or retaining a smaller number of key employees on a full-time basis with health benefits.

Of the various fees embedded in the law to help fund health reform, the one that strikes fear among benefits and business leaders is the excise tax on high-cost health plans, also known as the Cadillac tax.

Beginning in 2018, a 40% excise tax will be imposed on health care premiums that exceed \$10,200 for single coverage and \$27,500 for family coverage. The tax will be paid by insurers and plan administrators, who then almost certainly will seek reimbursement from employers.

It adds up quickly, and it’s tough to avoid because mandates under the law raise the value of health coverage and because the tax is linked to the overall inflation rate, said Amy Bergner, managing director in the global human resource solutions practice of PricewaterhouseCoopers L.L.P. in Washington.

“It’s almost like you’re baking in this potential exposure, and the employer has fewer and fewer levers to control,” she said.

Dire predictions of employers no longer offering health benefits for their workers due to reform-related pressures have not



materialized, however. Only 1% of employers have eliminated health benefits, and 5% intend to do so over the next three to five years, a recent Aon Hewitt survey found.

Instead of bowing out, employers are scrambling for ways to make benefits more affordable and, in turn, avoid triggering the excise tax. Thirty-three percent of employers in the survey said they were reducing the richness of their plan designs for 2015 through higher out-of-pocket costs, and 31%

are increasing the use of wellness incentives.

Ultimately, if that excise tax were to erode the value of employers’ pretax exclusion of health benefits, it could lead to the broad adoption of health plans with lower actuarial values, Mr. Ryan said. In other words, employers may shift from gold-level health plans to silver or bronze, with the option for employees to “buy up” to a higher-value plan, he said.

Five years after the reform law’s enactment, lots of loose ends remain.

Employers still await crucial regulatory guidance on several matters, including specifics on calculating the Cadillac tax.

“You only know what you know right now, and it’s scary for employers,” said Mike Colarusso, managing director for the Mid-Atlantic region of Charon Planning.

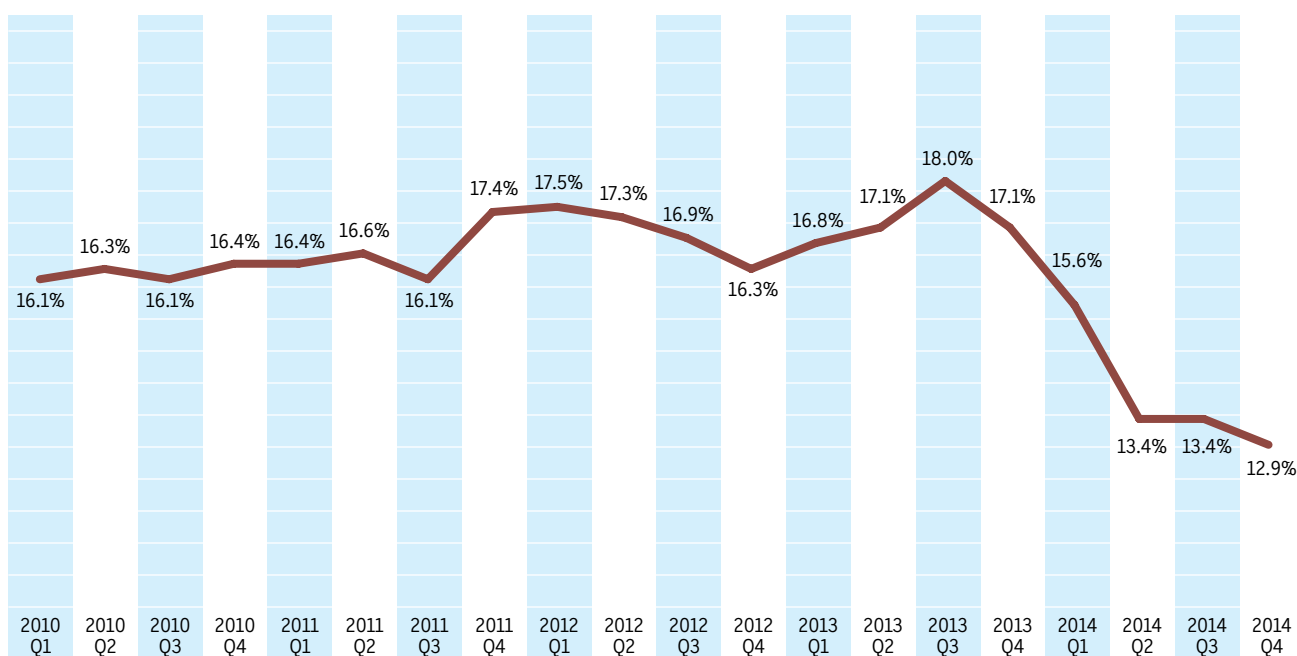
Future legislative attempts to derail the law are unlikely to go very far as long as President Barack Obama wields the veto pen. However, there could be a push to raise the 30-hour work week definition to 40 hours.

It’s also unclear how the U.S. Supreme Court will rule by the end of June on the health-reform law’s premium tax subsidies in the pivotal *King v. Burwell* case. A decision in favor of the plaintiffs could, in theory, derail enforcement of the employer mandate in the 37 states where federally facilitated exchanges operate.

“No subsidy, no penalty. No penalty, no mandate,” Mr. Piro said. It wouldn’t be a “whole new ballgame, but a substantially new one,” he said.

## Percentage of adults without health insurance

The rate of the uninsured in the United States has declined moderately since 2010.



Source: Gallup; Gallup-Healthways Well-Being Index

# Looming reporting rules the latest benefits hurdle

After a temporary reprieve, employers covered by the Patient Protection and Affordable Care Act's shared-responsibility, or "play-or-pay," mandate must begin measuring and reporting worker hours to the federal government or face steep penalties.

Employers with 100 or more full-time workers had to begin tracking worker hours at the start of 2015; the requirement kicks in next year for businesses with 50 to 99 full-time workers.

Complying with the new reporting requirements may be the most unforgiving exercise many of them have ever encountered.

"It's staring them in the face, and they're like a deer in headlights," said Mike Colarusso, managing director for the Mid-Atlantic region of the employee benefits consulting firm Charon Planning, an NFP company in Warrington, Pennsylvania, which represents middle-market employers, large regional companies and multinational corporations. "They're trying to figure out how they're going to get this done."

Under complex federal rules, employers must determine who qualifies as a full-time employee applying the government's 30-hour definition, not employers' historical 40-hour

benchmark.

Counting hours that employees log on the job sounds simple enough. But in reality, employers must figure out what data they need, where that information resides and who will be responsible for culling and compiling it.

They may need to tap benefits administration, payroll, health plan and leave-of-absence data — information that may be siloed in different departments or held by a company's external vendors.

Federal regulations specify two methods for calculating employee hours: month by month or a year-long "look-back." If an employer relies on a monthly measurement period for salaried employees and a look-back for variable-hour workers, the measurement methods must remain consistent for each type of employee.

"You can't be flip-flopping categories," Mr. Colarusso said.

Ryan Moulder, a partner with Health Care Attorneys P.C. in Los Angeles, who represents a number of fast-food franchise owners with several hundred to several thousand employees, said installing compliance software or upgrading existing systems to track employees' paid work hours, enabling employers to determine workers' health

benefits' eligibility, can cost \$10,000 to \$20,000 a year or more, depending on the number of employees.

"One of the problems here is if you have 100 employees, you need the exact same technology as the Wal-Marts of the world nowadays because you need to track your employees in the exact same way," he said.

But botching your employee count is costly, too. Penalties of \$2,000 to \$3,000 per full-time employee, minus the first 30 employees, may be assessed for failing to offer adequate or affordable coverage.

"I think you're going to see a lot of situations where employers don't track their employees properly," Mr. Moulder said.

Even in industries with relatively few part-time workers, calculating and reporting worker hours is "a significant exercise," said Amy Bergner, managing director for global human resource solutions at PricewaterhouseCoopers L.L.P. in Washington.

Employers with stable full-time workforces are generally much better prepared to comply with the new reporting requirements than companies with large numbers of variable-hour employers or multiple operating divisions, Ms. Bergner said.

Karen Pallarito

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# Workplace services



**On-site health care** facilities are popular among only a minority of employers, but those that do use them are broadening the services they offer.

BY MATT DUNNING

**A**s they seek methods of controlling medical costs and improving employees' overall health, many employers are taking a more thoughtful approach to offering on-site and near-site health care services.

The use of on-site primary and acute-care clinics, fitness centers, pharmacies and other health care services continues to be dominated by large employers, with small and midsize firms showing signs of receding from the market, according to several recent studies.

However, those same studies indicate companies of all sizes that do offer health care services on or near their worksites are becoming more ambitious in terms of the range of medical and wellness services they provide and how they administer them. Also, they are getting more sophisticated in the way they measure the success of those services.

### Large employers leading the way

Studies published within the last 12 months show the percentage of employers investing in on-site health services for their employees tend to vary significantly according to staff size, with implementation rates as much as 15% to 20% higher among large employers compared with their small and midsize counterparts.

However, the trend lines those studies reveal also depend heavily on the demographics of the responding employers.

For example, 24% of employers with 3,000 or more full-time employees reported offering on-site health clinics to their employees, compared with 14% of employers with 100 to 2,999 employees and 9% of employers with fewer than 100 employees, according to the results of Eden Prairie, Minnesota-based Optum Inc.'s 2015 Wellness in the Workplace Study.

Similarly, 36% of large employers polled by Optum offered on-site fitness centers, compared with 31% of midsize employers and 17% of smaller employers.

Optum's Wellness in the Workplace survey results — generated from a split between large employers (60%) and small and midsize employers (40%) — indicate a slight rise in the prevalence of on-site health clinics and fitness centers among small and midsize employers.

Conversely, studies weighted more heavily toward employers with fewer employees suggest that the percentage of small and

# Plastics firm molds on-site clinic to fit corporate, employee needs

After just two years, plastics manufacturer Flambeau Inc. says the on-site clinical services it provides to the 500 employees at its plant in Baraboo, Wisconsin, already have had a substantial effect on its overall health care costs.

Last year, the company was able to reduce its medical costs by about \$300,000 from 2013, largely by offering primary and preventive health care services, chiropractic care and massage therapy at its clinic in a leased storefront space across the street from its manufacturing plant, said Mark Reiland, Flambeau's director of human resources.

"That's all in, even throwing in all of the expenses from the clinic, and we still saved \$300,000 in 2014," Mr. Reiland said. "The previous year was similar. Not quite as big, but it was similar."

Mr. Reiland said the clinic — which today boasts an employee utilization rate of between 60% and 65% — has had other positive effects since it opened in 2012, although he admits that those effects are more difficult to quantify.

"To me, the feedback that we get back from employees, and the satisfaction that they have in the services that they receive from the clinic, along with the utilization rate, are enough of an indication that it's been effective," Mr. Reiland said.

Not surprisingly, Mr. Reiland said, Flambeau encountered its share of challenges during the clinic's implementation and early operation. In particular, he said the company's decision to staff and manage the clinic internally, rather than use a third-party vendor, made identifying the right medical personnel for the company's culture quite difficult.

"We think that in a lot of health care systems, there's an

overuse of testing, and we felt that by having our own on-site clinic we could better control those decisions about how much testing and additional services really are needed," Mr. Reiland said. "So finding a physician that shared that mindset and was willing to work in an on-site clinic without a lot of support was definitely a challenge."

Mr. Reiland said the company also took several proactive steps to overcome its employees' early reticence to use the clinic, including educational programs and family events designed to familiarize its workforce with the clinic's services.

"One thing we did was ask the on-site physician and clinic staff to go to the shift meetings and address the associates, talk about the services we were offering and answer their questions," Mr. Reiland said. "A lot of the questions we got were around data privacy, and what we did there was emphasize the fact that the clinic was being run on a completely separate server and that the company has absolutely no access to it."

Mr. Reiland said the company made a deliberate choice to brand the clinic, which operates as Nordic Private Care, separately from its own corporate identity in order to ease employees' concerns over any perceived threat to their private medical information.

"We called it that for a couple of reasons, primarily because we wanted to have at least some separation between the company and the clinic," Mr. Reiland said. "We feel like that separation did help the employees on a psychological level, simply in that it didn't have the Flambeau name attached to it. As subtle a thing as that is, we felt like it was important."

By Matt Dunning

midsize employers offering on-site health services actually has declined in recent years, largely due to constricting budgets and an increased focus on health care reform compliance, experts say.

According to the Alexandria, Virginia-based Society for Human Resource Management's 2014 Employee Benefits Survey — of which, 80% of respondents reported having fewer than 2,500 full time employees — the percentage of employers offering on-site health clinics, fitness centers, seasonal flu vaccinations and other services has decreased by as much as 10% since 2010.

## Expanding on-site clinical services

As employers continue to hone their strategies regarding on-site health services, the scope of services they offer to their employees has broadened substantially.

In addition to traditional on-site clinical services such as acute and urgent care, emergency first aid and occupational health care, many employers today also provide primary physician care, preventive and behavioral health services and pharmacy services through an on-site or near-site clinic, according to survey data published in February by the National Association of Worksite Health Centers, a Chicago-based nonprofit trade organization.

To increase the likelihood that employees will actually use the on-site health programs they provide, experts recommended employers closely examine and tailor their services according to a range of data sets, including past medical and pharmacy claims, health risk assessments and biometric screenings, as well as employee surveys and industry benchmarking data.

"It always comes back to the data," said Beena Thomas, Atlanta-based vice president of health and wellness at Optum. "That's going to drive the selection of services employers ought to be offering."

When it comes to offering on-site health services, employers also are expanding their definition of success beyond a reduction in medical costs, a strategy that experts say typically makes it easier for benefit managers to secure an ongoing investment in those services.

"It really isn't all about cost reduction anymore," said Larry Boress, the worksite health centers association's Chicago-based executive director.

According to the association's 2014 Benchmarking Survey, 70% of employers providing on-site and near-site clinics said the clinics contributed to improvements in employees' overall health, while 75% said their

## On-site health clinics

More firms employing at least 500 people have been adding workplace clinics since 2010.

Year	Currently has in at least one location	Considering clinics
2010	36%	13%
2011	37%	16%
2012	46%	9%
2013	44%	9%
2014	40%	14%

Source: National Business Group on Health

employees had become more engaged in worksite health and wellness programs.

"When you look at employers' priorities in terms of offering on-site health services, we're seeing a lot of companies trying to

deal with health care access issues, productivity, population health and reducing unnecessary emergency room use," Mr. Boress said. "Recruitment and talent retention are becoming a bigger and bigger part

**"It always comes back to the data.**

That's going to drive the selection of services employers ought to be offering."

Beena Thomas, Optum Inc.

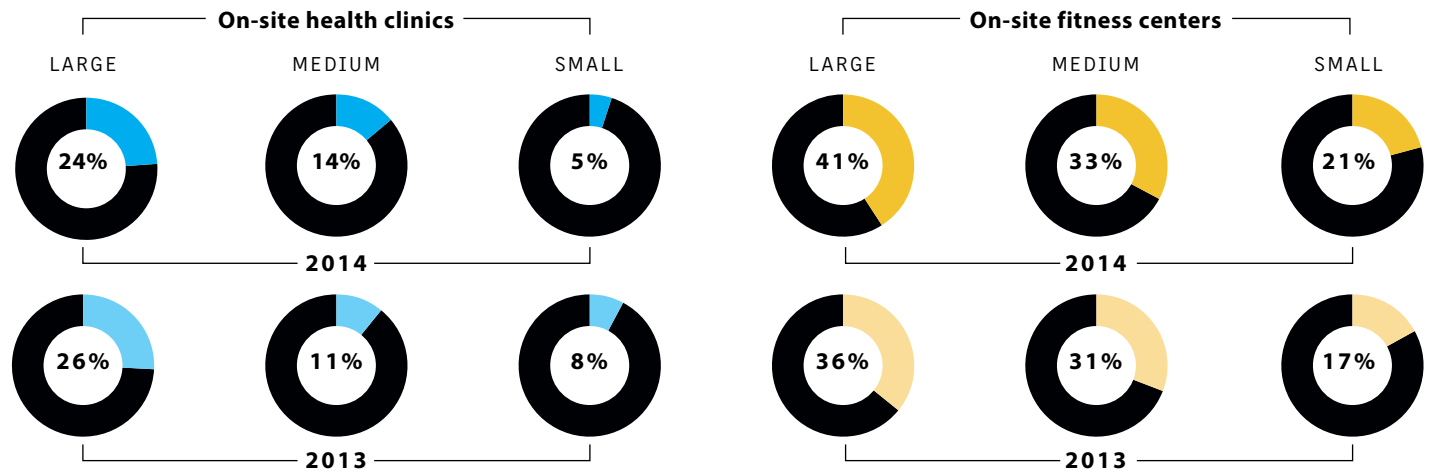
# Health care

## OPTUM SURVEY

40% of employers polled have fewer than 3,000 full-time workers

### Workplace health and fitness

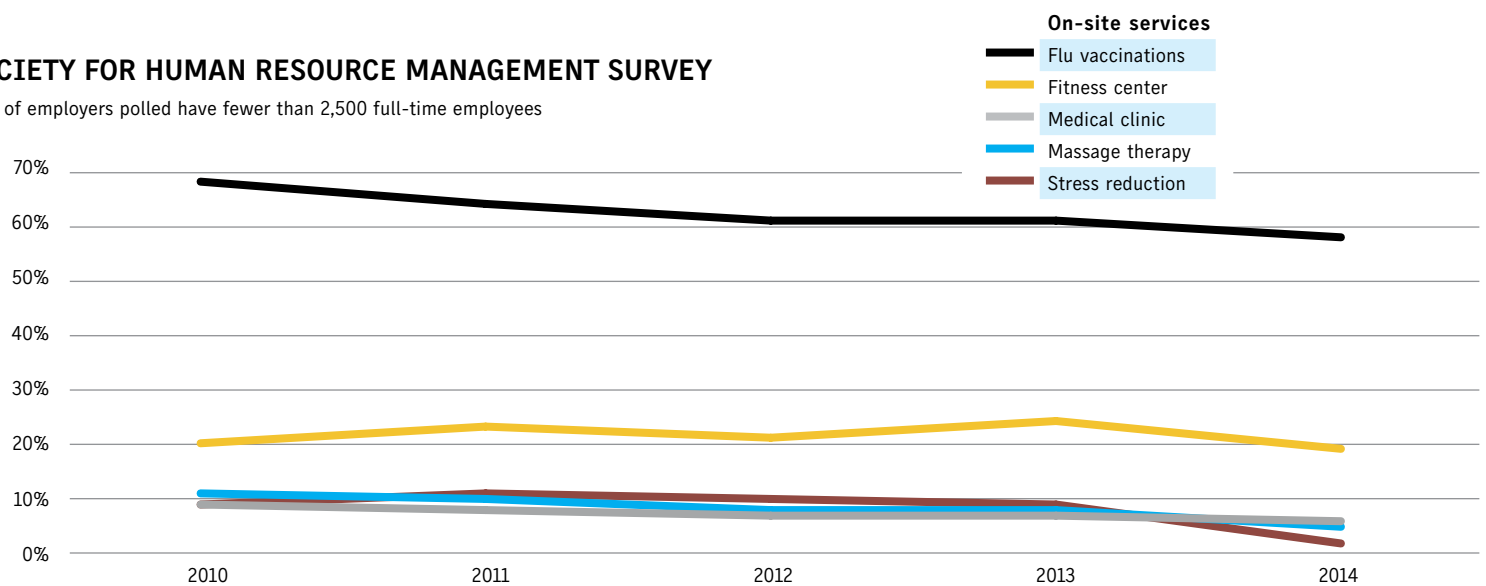
Industry surveys depict the proliferation of on-site health and wellness services differently depending on the average staff size of employer respondents.



Source: Optum Inc.

## SOCIETY FOR HUMAN RESOURCE MANAGEMENT SURVEY

80% of employers polled have fewer than 2,500 full-time employees



Source: Society for Human Resource Management

of this as well.”

Additionally, more than 95% of those employers also said the clinics had at least partially improved employee job satisfaction and productivity, according to the association’s survey.

“We’re struggling a little bit with measuring the overall cost impact at this time, but where we have seen a large impact is on efficiency, productivity and lost work time,” said Kate Schieldt, vice president of human resources at Stoughton Trailers L.L.C. in Stoughton, Wisconsin. “We’re working on adding metrics to determine what the financial gains might be from those improvements.”

### Self-managing workplace clinics

Another way in which employers’ strategies regarding on-site health services has evolved in recent years is the approach they take to administering the services they offer, including how they choose to handle staffing and managing their on-site facilities.

According to worksite health centers association’s survey data, 30% of employers today have implemented some form of cost-sharing for on-site clinical services, compared with 12% in 2012.

Additionally, 38% of employers polled

reported they have elected to self-manage the on-site clinical services they provide to employees, rather than use a third-party vendor or local health care provider.

Experts say that while the majority of employers that staff and manage their on-site clinical services internally tend to be larger firms, some small and midsize firms also have embraced self-management to control the upfront costs of offering an on-site clinic and tailor the services they offer more closely to their employees’ needs and health conditions.

“Doing this work on your own is something that a lot of employers probably can handle, but there’s a big cost-benefit analysis that goes with that,” Ms. Schieldt said. “In our case, we understood what it would cost to bring in a third-party vendor and decided that the best way forward for us in terms of cost savings was to do it ourselves.”

Conversely, experts say a majority of employers — particularly smaller ones — still elect to contract with a third-party vendor or local health care provider to staff and manage their on-site clinics, largely to reduce the administrative burden on their benefits personnel and dampen privacy concerns among employees.

“I actually think data security is one of

the big reasons why most companies shop out the management of their clinics,” said Jill Micklow, a Chicago-based wellness consultant at Schaumburg, Illinois-based Assurance Agency Ltd. “Employees tend to feel more comfortable working with a third-party vendor, even if it’s only because of the perception of greater privacy.”

### What lies ahead

Looking forward, experts say they expect large employers to continue expanding the types of health care services they offer on or near their worksites, as well as a growing preference for in-house administration of those services.

They also expect some manner of rebound in on-site health clinics among small and midsize employers, as they acclimate to new market conditions and administrative processes under health care reform, though some barriers are likely to persist.

“The persistent challenge that I see being a major part of it is the fear of the cost, and a lot of that depends on what kinds of services you’re going to offer, and whether you’re going to build something brand new or just renovate an existing structure,” Mr. Boress said.

**“Doing this work on your own is something that a lot of employers probably can handle, but there’s a big cost-benefit analysis that goes with that.”**

Kate Schieldt,  
Stoughton Trailers L.L.C.



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# 401(k) Investment Lineup Summit

San Fran: Apr 7 | Dallas: Apr 9 | Chicago: Apr 14 | New York: Apr 16

## conference sessions

### panel discussions

Raise your plan to the next level through new, interactive experiences designed to help you retain your conference learnings and easily share with your colleagues after the event. Throughout the day, an artist will create real-time visuals that capture all the key content from the panel discussions. Plus, participate in the “Retirement Inspiration Wall” where you can share your thoughts – from goals to new insights gained – on 401(k) plan design.

#### How to Refresh 401(k) Plan Design to Make the Most Impact

The challenge of enhancing a plan’s design year after year often comes down to cost, particularly when faced with economic factors that can weigh down a plan. Learn how to get around such obstacles with this interactive discussion that will include topics such as:

- Tips for plan design improvements that won’t throw off your budget
- Market practices to optimize plan design
- How to measure retirement readiness and retirement income

#### The Evolving 401(k) Plan through Simplification and Menu Choice Consolidation

The phrase “less is more” has never been more true than when it comes to successfully designing 401(k) plans with simplicity and clarity for the participant. Panelists will discuss:

- Aligning plan objectives with investment structure
- Menu consolidation
- Educating plan participants on the benefits of target-date funds
- Effective communication through uncomplicated messaging

#### Current and Future Trends of Revenue-Sharing in 401(k) Plans

The DOL’s fee-disclosure requirements are meant to ensure that all participants are paying an equal share of plan administrative fees, meaning fiduciaries must evaluate whether the payments cause potential conflicts of interest. Panelists will discuss best practices pertaining to:

- Determining if service provider compensation is reasonable
- Revenue-sharing formula consistency and reporting needs
- Tracking payments using a trust or bookkeeping account
- Establishing payment policy in accordance with ERISA

**networking events and opportunities:** Breakfast | Breaks | Lunch | Cocktail Reception

### keynotes



**Werner DeBondt, Ph.D.**  
Director - Driehaus Center  
for Behavioral Finance  
DePaul University



**Michael Finke, Ph.D., CFP**  
Professor  
Texas Tech University



**John G. Lynch, Jr.**  
Director - Center for Research on Consumer  
Financial Decision Making,  
University of Colorado Boulder

### conference chair



**Sue Walton**  
Director  
Towers Watson

# The evolution of the 401(k): Get your plan to the next level

REGISTER for P&I's 401(k) Investment Lineup Summit, a FREE one-day event aimed to help plan sponsors meet the task of designing a plan which meets the needs of both your organization and employee population. You will learn from industry experts and peers who will present innovative investment approaches for DC plans to help best prepare portfolios and participants for the future.

## workshops

### A Case Study in Plan Design, Participant Behavior and Better Outcomes

This session features an interactive case study on the evaluation, design and execution of a thoughtful program to revamp a company's retirement plan in order to put employees on a positive path to saving and investing and to improve plan participant outcomes. Discussion items will include:

- Understanding participant behavior and working to increase savings rates
- Retroactive automatic enrollment, escalation and a plan investment re-enrollment
- Improving asset allocation for all participants

### Risk Management and Target-Date Funds

DC plan participants are exposed to a broad range of risks that impact their investment outcomes throughout the life of the glidepath. It is important that plan sponsors understand the various types of risks associated with target-date investing because the way in which different managers weigh risks affects the design of the glidepath. Accumulation risk, longevity risk, market risk, interest rate risk and inflation risk are some of the risks that impact TDFs. While not all of these risks can be managed in a TDF, target-date managers need to adopt a dynamic and holistic approach to identifying and prioritizing these risks as they seek to mitigate their effects in portfolio design.

### The New World of Retirement – Alternative Thinking for DC

Until recently, alternative investments have played a limited role in DC plans, most frequently used for risk diversification and inflation protection. Has the time come for alts to play a wider role? Join BlackRock Alternative Advisors, the firm's hedge fund solutions platform, as well as their head of DC implementation for a discussion of how alts can be further used to hedge risk and capture returns as part of specialized funds or within multi-asset class solutions like TDFs.

### Can You Get the Best of DB with the Best of DC? Ideas for "DB'izing" a Defined Contribution Plan

Critics have said that DC plans lack some of the advantages of defined benefit pensions. For example, in pensions, professional managers set the asset allocation and match assets to liabilities. In contrast, in DC plans, participants must forecast their own retirement lifestyle expenses and choose their own investment options. Although the creation of QDIAs and TDFs has introduced some DB-like characteristics in DC plans, more can be done. By seeking to unite the best traits of DC and DB – while avoiding the main pitfalls for each – plan sponsors can take a proactive approach to helping DC participants prepare for retirement. Join Capital Group's Senior DC Specialists as they explore this important topic.

### It's Getting Personal - The Shift to Customized Portfolios

Amazon. Nike. Chipotle. What do these companies have in common? Each of them is leading the charge on creating personalized experiences, services, and products for their customers. And, hundreds of other companies across all industries and sectors are getting in on the act. As consumers, we're not only embracing our new personalized lifestyle, but we've come to expect it. What does this mean for the retirement industry? A top industry expert shares insights on how personalization is impacting the retirement industry and what it means for plan sponsors, participants, and their retirement readiness.

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# PBGC on the rocks?



*The Pension Benefit Guaranty Corp.,* the pension payer of last resort for employees of companies that can't meet their obligations, may need its own safety net in coming years.

BY JERRY GEISEL

**F**orty years after it was created, the future of the federal agency that guarantees employees' and retirees' pension benefits is in doubt.

The Pension Benefit Guaranty Corp., a cornerstone of the Employee Retirement Income Security Act of 1974, was formed so that pension plan participants would have the security of knowing that their vested benefits would not be lost even if their employers failed and had not fully funded promised benefits.

Those benefits are — up to certain limits — guaranteed by the PBGC's single-employer insurance program. In turn, that program is funded by premiums paid to the PBGC by all private-sector employers with defined benefit plans, as well as by the investment income the agency earns on those premiums and on assets in failed plans that the agency takes over.

There is near-universal agreement that the agency has achieved its congressional objective of guaranteeing participants benefits.

Since 1974, the PBGC has taken over more than 4,600 pension plans from employers who failed and went out of business or could prove that they could not continue to operate if they had to continue to fund their pension plans.

Each month, the PBGC sends checks to well over 800,000 participants in plans the agency has taken over, many of them sponsored by employers that filed for bankruptcy and then went out of business.

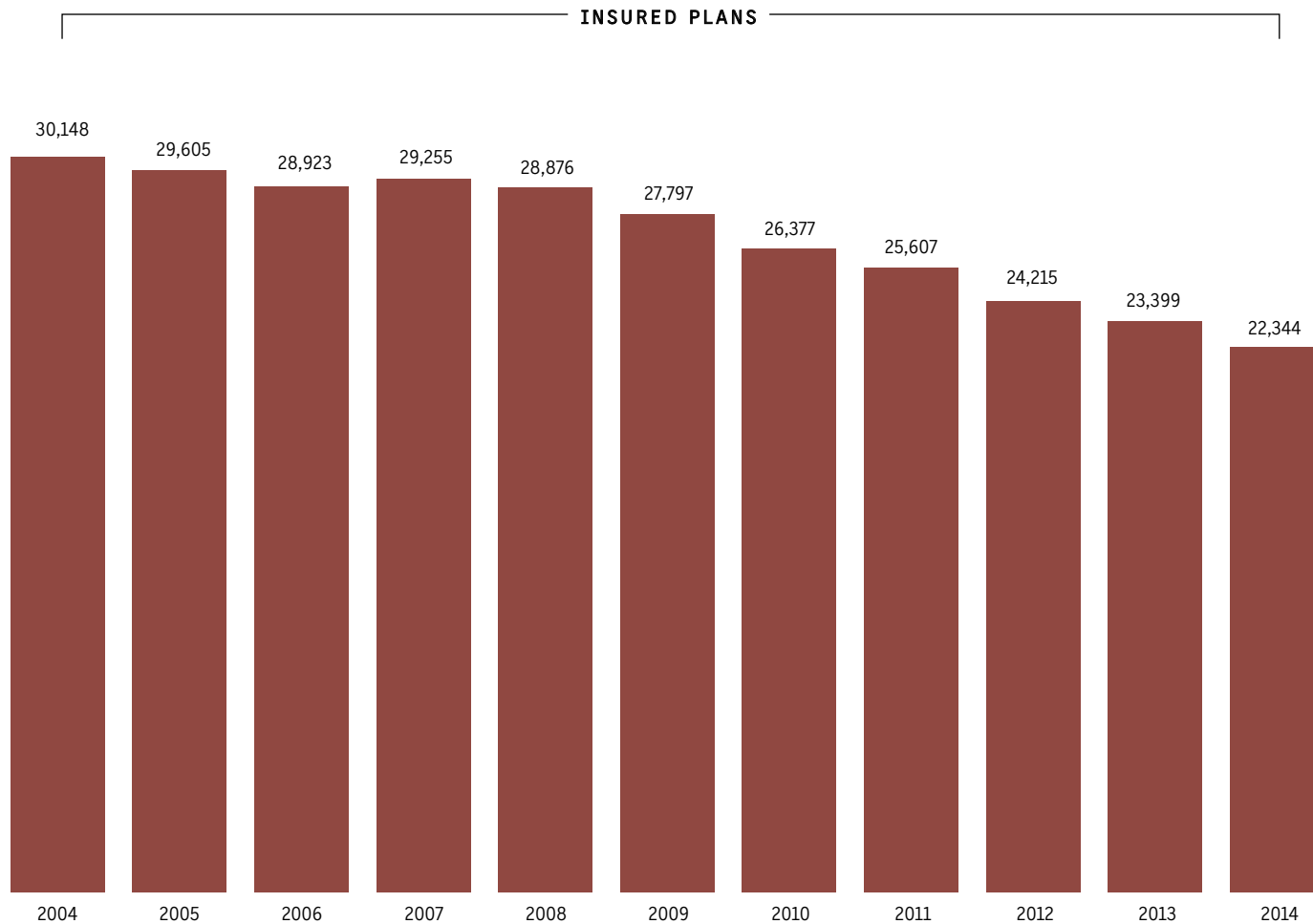
In all, the PBGC last year paid more than \$5.5 billion to participants in those failed plans.

Those figures are more than just numbers. The monthly checks have given many participants the money they need to buy basic essentials.

"It means money for gas and groceries," said Kim Andrews, a 62-year-old retired steelworker in Williamsport, Pennsylvania, referring to the \$165 monthly check he receives from the PBGC. In 2003, the PBGC took over the massively underfunded pension plan of Bethlehem Steel Corp., the failed Bethlehem, Pennsylvania-based steel producer, and assumed responsibility for paying more than \$3.6 billion in benefits Bethlehem promised but did not fully fund to the plan's nearly 70,000 participants, including

## A SHRINKING BASE

The number of single-employer pension plans insured by the Pension Benefit Guaranty Corp.



Source: Pension Benefit Guaranty Corp.

Mr. Andrews.

Providing that pension benefit safety net has been the PBGC's crowning achievement, observers say.

"It is unforgivable to let a person work, earn a pension and not get it. A retiree can't start out all over again. That is what used to happen, but no longer" because of the PBGC, said Frank Cummings, a Washington pension attorney, who as a congressional staffer, helped draft versions of the legislation that later became ERISA.

"The PBGC has a tough and a very important job. Millions of Americans have been able to have a secure retirement because the PBGC has stepped in. Its pension insurance program has been extremely valuable," said James Klein, president of the American Benefits Council in Washington.

"The PBGC has been an extraordinary success," added Karen Ferguson, director of the Pension Rights Center in Washington.

But like many of the employers whose pension plans the PBGC has taken over, the agency's financial condition is shaky.

In 2014, the PBGC reported a \$19.3 billion deficit in its single-employer insurance fund. In addition, the agency puts its potential exposure to future losses from financially weak companies at \$167 billion.

By contrast, the agency last year collected just \$3.8 billion in insurance premiums from

the 22,300 employer plans covered by its insurance program.

With more than \$88 billion in assets, the PBGC is in no imminent danger of running out of money to pay guaranteed benefits to participants in plans the agency has taken over.

"That would not be happening for a very long time," said Alan Glickstein, a senior retirement consultant with Towers Watson & Co. in Dallas.

That said, there is one big worrisome trend: The number of employers who pay premiums to the PBGC and the number of participants in those plans is shrinking.

The 22,300 plans paying premiums to the PBGC is a record low. In just one year, the number of insured plans fell by more than 1,000, with a 25% drop in just a decade.

A key driver of that falling number of defined benefit plans is that few employers have been setting up new plans, preferring to set up defined contribution plans, for which they pay no PBGC premiums and for which, unlike defined benefit plans, investment risk is shifted to employees.

At the same time, long-time big employer sponsors are moving away from the plans. For example, as recently as 1998, 90% of Fortune 100 companies offered defined benefit plans to new salaried employees. In 2013, the last year complete information is available,

just 30% did, according to a Towers Watson survey.

In addition, the PBGC's premium base is being eroded by the biggest current defined benefit trend: pension "de-risking." That is a term used to describe employer efforts to shrink the size of their pension plans, such as by selling off the liabilities to insurers through the purchase of group annuities and giving certain participants, especially former employees, the option to convert their monthly annuity benefit to a cash lump-sum benefit.

By reducing the size of their pension plans, employers face less exposure on how interest rate fluctuations and investment results can affect required contributions to their pension plans.

And a smaller pension plan means a reduction in PBGC premiums, whose base rates, due to hikes approved by lawmakers in recent years, have been soaring. Next year, the base premium will be \$64 per plan participant, up from just \$35 as recently as 2008.

While perhaps not the principal reason for de-risking, escalating PBGC premium rates are a factor moving employers away from defined benefit plans.

Those rates are "a fixed cost that has increased excessively in a short amount of time," said Kathryn Ricard, senior vice president for retirement policy at the ERISA

## Pension payouts

Benefits paid by the Pension Benefit Guaranty Corp. to participants in single-employer plans taken over by the agency now are nearly 85% higher than a decade ago.

2014  
\$5.52 BILLION

2013  
\$5.45 BILLION

2012  
\$5.38 BILLION

2011  
\$5.34 BILLION

2010  
\$5.47 BILLION

2009  
\$4.48 BILLION

2008  
\$4.29 BILLION

2007  
\$4.27 BILLION

2006  
\$4.08 BILLION

2005  
\$3.69 BILLION

2004  
\$3.00 BILLION

Source: Pension Benefit Guaranty Corp.

# Retirement & Investment

## Pension conundrum

The Pension Benefit Guaranty Corp.'s obligations far outweigh the agency's assets.

**“The higher the premium, the harder employers will look to lower that tab.”**

Alan Glickstein,  
Towers Watson & Co.

**“The real concern is the agency's premium base is shrinking.”**

Lynn Dudley,  
American Benefits Council



	2013	2014
People protected in pension plans emerging from bankruptcy	161,000	163,000
People receiving pension benefits today: Single employer plans	851,000	813,000
People receiving pension benefits today: Multiemployer plans	50,000	52,000
People to receive future pension benefits: Single employer plans	596,000	595,000
People to receive future benefits: Multiemployer plans	21,000	23,000
Financial surplus (deficit): Single employer plans	(\$27.4B)	(\$19.3B)
Financial surplus (deficit): Multiemployer plans	(\$8.3B)	(\$42.4B)

Source: Pension Benefit Guaranty Corp. 2014 Annual Report

Industry Committee in Washington. “You start looking at other ways to manage that cost.”

“The higher the premium, the harder employers will look to lower that tab,” Towers Watson’s Mr. Glickstein said.

The implications of pension de-risking on the PBGC financial balance sheets are largely negative.

“The real concern is the agency’s premium base is shrinking,” said Lynn Dudley, senior vice president of global retirement and compensation policy at the American Benefits Council in Washington.

In theory, the PBGC’s exposure to losses are reduced if pension plans are smaller. But so far, many of the employers who have opted for de-risking approaches have been financially healthy, said Bruce Cadenhead, chief pension actuary at Mercer L.L.C. in New York.

The result, experts say, is that de-risking,

over the long run, may be a negative for the PBGC, with little change in its exposure to losses but less premium income.

Still, the outlook for the PBGC and its insurance program is not entirely negative. First, if interest rates rise, that would lower — perhaps significantly — the PBGC’s deficit, reducing if not eliminating the need for future increases in PBGC premiums.

“Low interest rates have created an impression of a bigger problem than there really is,” Ms. Dudley said, referring to the PBGC’s deficit.

In addition, employer interest in offering defined benefit plans could pick up, swelling the PBGC’s premium base, if government regulators become more accepting of allowing employers to offer more innovative benefit designs, said Joshua Gotbaum, a former PBGC director and now a guest scholar at The Brookings Institution in Washington.

## Multiemployer pensions rescue buys federal agency more time

**W**hile experts may disagree on the strength of the Pension Benefit Guaranty Corp.’s insurance program for single-employer pension plans, there is a broad consensus that lawmakers had to act last year to prevent the collapse of big, underfunded multiemployer pension plans, and with that the PBGC’s multiemployer insurance program.

Indeed, the likelihood of such a debacle was so obvious that lawmakers passed a multiemployer pension plan rescue package.

The grim numbers were hard to ignore. As recently as 2008, the PBGC’s insurance program that guarantees a portion of benefits promised to the plans’ participants if the plans are unable to do so was in reasonably decent shape with about \$1.3 billion in assets and \$1.8 billion in liabilities.

But with the looming insolvency of several large multiemployer plans, the deficit in the agency’s multiemployer insurance program ballooned last year to more than \$42 billion, many times the roughly \$120 million in premiums the PBGC collected from the nation’s 1,400 multiemployer

plans, which have about 10.4 million participants.

The U.S. Government Accountability Office warned that the financial drain on the PBGC insurance program from guaranteeing benefits of participants in failed plans would be so great that the insurance program would go broke in the next 10 to 15 years.

To prevent that doomsday scenario from developing, or at least delaying it, lawmakers agreed on a legislative package that would have been inconceivable just a few years ago: allowing trustees of financially troubled plans to cut participants’ benefits. “Lawmakers gave trustees the tools to do this,” said Jack Abraham, a principal with PricewaterhouseCoopers L.L.P. in Chicago.

“Having labor and industry championing a well-crafted proposal that did not require government or taxpayer funding made for the right elements to encourage Congress to act in a timely and in a bipartisan fashion,” said Vince Sandusky, CEO of the Sheet Metal and Air Conditioning Contractors’ National Association in Chantilly, Virginia.

At its core, the new law is basic: Participants’ benefits can be cut if a plan is projected to go

insolvent during a current plan year or any of the next 14 years, or any of the next 19 years if the plan’s ratio of inactive participants to active participants exceed 2-to-1 or if the plan is less than 80% funded. Certain participants would be protected from benefit cuts, such as retirees age 80 and older and those receiving disability from the plan. Retirees between the ages of 75 and 79 would face smaller benefits cuts than younger retirees.

For some plans, “very small benefit adjustments” will enable them to survive, Mr. Sandusky said, while others will “need more drastic action to remain solvent.”

Still, he said, “There is that small number that can’t be saved, no matter what.”

That benefit guaranty burden then would be shifted to the PBGC, which, some believe, eventually could overwhelm the agency even with the legislation passed by Congress last year.

The action taken by Congress so far has not drawn cheers in all quarters. Karen Ferguson, director of the Pension Rights Center in Washington, describes it as “shocking” that Congress chose to allow multiemployer plan trustees to cut benefits to current retirees.

A more sensible and fairer approach, she said, would have been to boost premiums multiemployer plans pay the PBGC. While the new law doubled the premium to \$26 per participant from \$13, Ms. Ferguson says premiums still are “incredibly cheap.”

By Jerry Geisel

# Planning healthy finances



**Financial benefits** are gaining traction as a way for employers to help their employees improve their budgeting, retirement savings and physical wellness.

BY SHELBY LIVINGSTON

**V**oluntary financial benefits, including financial planning at all career stages, have become a popular way to boost employee productivity, satisfaction and retention while reducing their stress and health care costs.

These benefits, such as budgeting sessions, group education seminars, or software applications that help track expenses, aim to help employees deal with financial issues while also helping them manage their spending and savings.

Many employers have offered various forms of financial education for years. What's new is the shift away from the traditional focus of those benefits on retirement and onto a holistic picture of financial health.

It's a trend that shows no sign of slowing. According to a 2015 survey of nearly 250 employers, benefits consulting firm Aon Hewitt found that 93% of companies were very likely or moderately likely to broaden their efforts on financial wellness beyond retirement decisions. In the same survey last year, only 76% of firms said they were likely to do so.

The shift to a focus on financial wellness comes as an improving economy allows companies to offer more voluntary benefits to their employees and also to pick up the tab. It is one of an emerging group of voluntary benefits that companies are offering for free or at a small cost to employees.

"Increasingly, employers are saying, 'There's much more to financial health than just helping our employees be able to retire on time,'" said San Francisco-based Lori Block, principal of Buck Consultants at Xerox.

Instead, particularly when it comes to a young workforce, topics such as credit card debt, student loans, saving for a house and even caring for elderly parents may take precedence over pensions and retirement, Ms. Block said.

That's the case at Microsoft Corp., where the majority of employees are in the early to middle stages of their careers, with many hired straight out of college. The challenge is prompting employees to think "about what their decisions do to their long-term success, and really putting it into meaningful terms for them," said Sonja Kellen, Microsoft's director of global retirement.

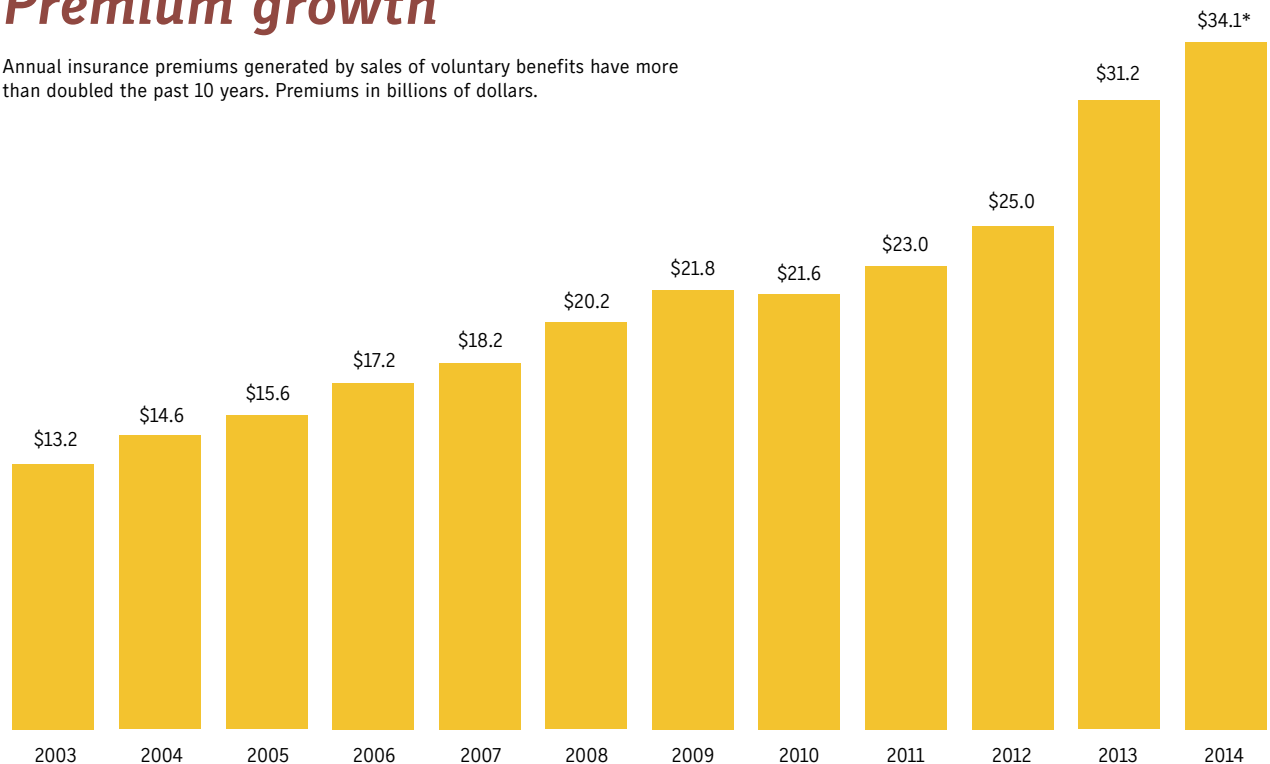
So after years of offering financial education in a "classroom" format, Redmond, Washington-based Microsoft in fall 2013 revamped its financial wellness offerings to include investment advice, managed accounts and a financial planning tool, myFiTage, which helps employees manage spending and track progress toward financial independence.

Supporting employees' financial health helps Microsoft attract and retain its workforce, Ms. Kellen said. Additionally, by help-

# Voluntary Benefits

## Premium growth

Annual insurance premiums generated by sales of voluntary benefits have more than doubled the past 10 years. Premiums in billions of dollars.



\*Estimate

Source: Eastbridge Consulting Group, Inc., U.S. Worksite Sales Report

**“We know that there’s a link between stress and health cost, and we know that financial stress is a big, huge component of stress.”**

Rob Austin, Aon Hewitt

ing to relieve the stress that comes with dealing with complicated financial topics, employees have “more mind power and time to spend working and doing what they’re here for,” Ms. Kellen said.

The benefits of alleviating financial stress in the workforce stretch further than productivity, said Charlotte, North Carolina-based Rob Austin, director of retirement research at Aon Hewitt.

“We know that there’s a link between stress and health cost, and we know that financial stress is a big, huge component of stress,” Mr. Austin said.

He said employers are asking, “If we can help out our financial wellness, doesn’t that translate to better physical wellness, and then hopefully lower claim costs and lower premiums and lower medical expenses overall?”

That’s the thinking at the University of Denver, where 23% of employees on the health care plan account for 49% of the claims costs, said Lynnette Woodbury, the university’s associate director of total rewards.

Much of the university’s financial wellness program is aimed at reducing stress and depression. That way, employees can “alleviate or eliminate some of the physical health issues they might have, like high blood pressure (or) high cholesterol,” which will help reduce claims, Ms. Woodbury said.

In addition to financial workshops, such as Budgeting 101, and individual counseling, the University of Denver offers a financial planning tool called HelloWallet. The tool allows employees to track expenses, manage debt, set budgets and plan for retirement.

What’s more, it helps them figure out how to tackle these goals simultaneously. Ms. Woodbury said 20% of employees use HelloWallet, which the university pays for per eligible user.

Since the university implemented targeted financial wellness four years ago, health claims costs and the severity of those claims have decreased. Also, participation in the 403(b) retirement plan has increased to 86% from 80%, Ms. Woodbury said.

Meanwhile, Greenville, South Carolina-based Michelin North America Inc. is beginning to shift its financial voluntary benefits focus toward comprehensive financial health.

Because Michelin’s employee base skews older, the tire manufacturer has historically focused these benefits on all things retirement, including financial planning workshops, individual counseling and retirement modelers. During the past 10 years, however, the company turned over half of its staff due to a wave of retirements, leaving a younger workforce in need of a different benefits strategy.

Connie Judkins, Michelin’s manager of retirement plans, said the key is finding balance between educating employees about saving for immediate and eventual needs.

Ms. Judkins said talking to employees revealed “an undercurrent of financial stress” at Michelin. It was that revelation that prompted the company to begin looking into tools to help employees with debt management and budgeting, and in turn reduce the amount of loans and hardship withdrawals from

their 401(k) retirement accounts.

Financial wellness opportunities may be hidden within the financial benefits an employer already offers, Buck Consultants’ Ms. Block said. For instance, an employer offering an employee-assistance program may find that debt-counseling services and other education materials already are within the program. In that case, it’s a matter of repackaging or rebranding the benefits, and promoting them to employees.

Sometimes, it requires creative thinking. Chicago-based human resources software company StratEx Partners, which employs about 60 people, offers a 401(k) with a matching contribution. Even though employees are automatically enrolled upon being hired, participation in the 401(k) plan hovered between 25% and 30%.

Confused by the low participation, founder Adam Ochstein asked his employees, most of whom are in their late 20s, why they were “giving away money.”

He found they didn’t understand the importance of financial planning. So he spoke to them in terms they were familiar with: He gave a presentation in which he compared the power of 401(k) savings with the cost of a beer or weekend night out. He broke the numbers down, proving that saving for the future, even contributing as little as \$25 to \$30 before taxes per paycheck, is “not going to impact their beer fund too much.”

It worked. Participation in the company’s 401(k) plan skyrocketed to two-thirds of StratEx’s employees.

# Microsoft offers tool to keep employees financially on track

Microsoft Corp.'s financial wellness program covers a lot of ground for employees. At the center of Microsoft's program is a financial planning tool, myFiTage, which the Redmond, Washington-based technology company began offering in 2013 as a voluntary benefit to its U.S. employees.

The tool, developed by Towers Watson & Co., integrates all of Microsoft's financial benefits, as well as an employee's income, savings and external accounts, to determine how long the user will be able to afford to live without a steady paycheck.

"It allows you to model your behavior and see how those model changes impact your age that you can retire, and help you in an easy, one-click action put some of those changes into effect," said Sonja Kellen, Microsoft's director of global retirement.

After offering employees a small financial incentive to use the tool, Microsoft saw that 47% of its U.S. employees participated. Of those users, 24% increased their 401(k) savings by an average of 2%.

Microsoft also started a college coach program in January to help parents with teenage children plan for college.

"It helps with not only saving for college and paying for college, and how education loans work, repayment strategies and financial aid, but it also helps you navigate the whole application process and admission process," Ms. Kellen said.

Finally, Microsoft launched its total rewards portal last fall, which offers personalized messages based on an employee's savings. For example, if an employee is not saving up to the level Microsoft matches in its 401(k), the portal will send a personal message about the importance of financial planning.

All of Microsoft's financial wellness benefits are provided to employees at no cost.

"Helping people think about the best strategies for saving and investing starting from day one is going to set them up for success, so that at the end of their career, they're not just starting to think about it," Ms. Kellen said. "It's really hard to get on track with your finances and your savings, if you don't start when you're young."

But Microsoft is not going to hold each employee's hand.

"We definitely believe in personal accountability, and we feel our role is more about advancing that culture of (financial) wellness and giving people the right tools and resources, so they can take control of their own finances and do what's right for them," Ms. Kellen said.

Shelby Livingston

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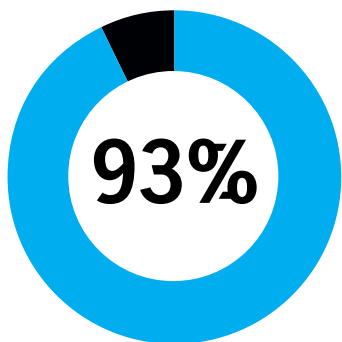
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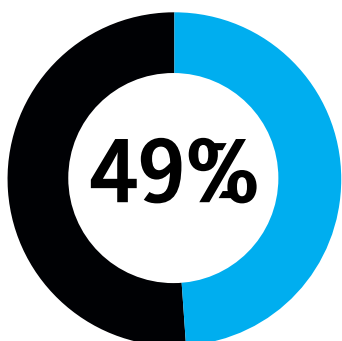
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Employers who are very likely or moderately likely to focus on financial wellness initiatives beyond retirement



Employers who believe financial wellness has become more significant in the past two years

Source: Aon Hewitt

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## Sharon Cunningham Mercer Marketplace



**Sharon Cunningham is the leader** of Mercer L.L.C.'s private health insurance exchange, known as the Mercer Marketplace, which offers coverage to about 500,000 employees and retirees. In an interview with Editor-at-Large Jerry Geisel, Ms. Cunningham, who is based in New York, discussed a wide range of private exchange issues including their growth and appeal. Edited excerpts follow.

# Q

**We know the use of private health insurance exchanges by employers has grown, but do we know roughly how many employers now use the exchanges as a source of coverage for employees, retirees and their dependents; how many enrollees are in the exchanges and how those figures have grown over the last couple of years?**

**A** The numbers are still relatively small but growing, and there's a lot of interest in this new delivery model. According to the Mercer National Survey of Employer-Sponsored Health Plans 2014, among large employers (500-plus employees), 3% use an exchange to provide health benefits to active employees and dependents. Among large employers that provide retiree benefits, 8% use an exchange for pre-Medicare-eligible retirees, and 15% use it for Medicare-eligible retirees. An additional 28% of large employers say they are considering moving to an exchange for active employees within five years. In some industries, that number is significantly higher. For example, 41% of large financial services employers are considering moving to an exchange within five years.

**Q How has employer participation and employee/retiree enrollment grown in the exchanges Mercer operates?**

**A** We are proud of the fact that 247 companies have chosen the Mercer Marketplace exchange for their active and retiree exchange solutions. These relationships cover 500,000 employees and retirees and provide exchange access for more than 1 million lives, including dependents. This represents nearly five times the reach of the marketplace when it covered 52 companies, 110,000 eligible employees/retirees and 220,000 lives a year ago.

**Q What are your expectations for the growth of private health insurance exchanges?**

**A** Through surveys and discussions with many clients, close to half of them tell us that within the next four, five or six years, that they are going to seriously consider moving to some type of private exchange.

**Q What are the factors driving growth in private exchanges?**

**A** There are a number of factors. Many employers are concerned about costs. They recognize that there are cost pressures within the health care system that will continue to grow over the next couple of years. There are certainly added costs that have come to some employers through the provisions of the Patient Protection and Affordable Care Act. There is an added concern — given the public system is actually growing in terms of its membership, such as the expansion of Medicaid in a number of states — that there will be additional cost-shifting to the employer sector.

There is an expectation that unless employers look for new types of solutions, they are going to bear a significant increase in their health care expenses.

At the same time, many employers are struggling with the already large administrative burden that is associated with their health and welfare benefit programs. And that burden is growing.

One other driver is that despite the efforts that are being made by so many employers to put together very good health benefit programs for their employees, employees often neither understand nor appreciate the value of those benefits. Employers believe with the right tools, and the right level of choice, they could increase employee appreciation.

**Q Private exchanges aren't the only exchanges. The health care reform law created public exchanges. The simplest thing for employers to do would be to say to employees: "Here is X amount of money. Use it to purchase coverage in public exchanges." We haven't seen that. Why not?**

**A** The overwhelming majority of employers we have talked to have said they did not plan to terminate their group sponsored plans and send employees to public exchanges.

There are a number of reasons for that. While some employees would be able to qualify for public premium subsidies, others will not, making buying coverage a very expensive proposition for many employees.

The second piece is that today with most health care plans, employees can pay their share of the premium with pretax dollars. With public exchanges, when consumers go in and purchase coverage, they have to pay the full or a share of the premium and do not get that tax break.

The third piece is employers themselves. Any money they provide to employees to purchase coverage in public exchanges would be treated as taxable income to employees. So, there isn't the tax advantage of the group system. In addition, the plans in the exchanges may be very different, such as in some cases having much smaller networks.

**Q How do you see exchanges changing in the future?**

**A** I believe there is a significant opportunity to innovate within an exchange. At its core, an exchange is a very large buying collaborative. With a large number of employers in an exchange, exchanges provide a distribution opportunity for insurance companies, who would like to innovate and offer high quality, lower cost options and that would be a terrific outcome for employers, insurers and consumers.

**There is ample opportunity for growth in private health exchanges.**

**Only 3% of large employers used one last year, a Mercer survey found.**



## Companies turn to captives to tackle pension liabilities

BY SARAH VEYSEY

**T**he use of captive insurance companies or captive cells to transfer pension longevity risk is a relatively new but potentially cost effective and efficient way for employers to access reinsurance capacity to reduce their pension liabilities.

Last year, the British Telecom Pension Scheme — the U.K.'s largest defined-benefit pension plan transferred £16 billion (\$18.47 billion) of liabilities, about 25% of the fund's exposure to longevity — to the reinsurance market via a wholly-owned captive set up in Guernsey specifically for the purpose.

The liabilities in the captive then were reinsured by Prudential Insurance Co. of America.

This landmark deal, which also was unusual because only one reinsurer was involved, likely has sparked interest among other pension plans in the U.K. and Europe that are seeking to reduce their exposure to longevity risks, experts say.

Although no U.S.-based pension funds have yet carried out a transfer of pension longevity liability using a captive, such transactions are expected.

While the British Telecom deal was “an enormous transaction — a one off,” London-based consulting firm Towers Watson & Co. realized that “it is a repeatable transaction” and set up an incorporated cell captive company in Guernsey, known as Longevity Direct, said Martin Best, managing director of Willis Management (Guernsey) Ltd.

In January, the trustee of the U.K.-based Merchant Navy Officers Pension Fund announced that it had hedged £1.5 billion (\$2.31 billion) — about 55% of the fund's total liabilities — via a cell in Longevity Direct, MNOFF IC Ltd.

Those liabilities then were reinsured by Pacific Life Re Ltd.

In February, Artex Risk Solutions Inc., which worked as the insurance manager on the British Telecom deal, announced it had set up a Guernsey-based incorporated cell company, Iccaria ICC Ltd., in conjunction with PricewaterhouseCoopers L.L.P., to enable pension funds with liabilities as low as £250 million (\$385 million) to access the reinsurance market.

The ability to use a captive, or a captive cell, as a vehicle to transfer pension longevity risk can offer the trustees of pension plans an alternative route to reinsurance markets rather than using an insurance company or

investment bank.

“What is driving innovation in the use of captives for pensions is companies' needs to manage the legacy issues of their defined-benefit plans,” said Lorraine Stack, business development leader for the Europe, Middle East and Africa region and for Asia Pacific at Marsh Captive Solutions Group, a unit of Marsh L.L.C., in Dublin.

The sponsoring employers of many defined-benefit pension plans are faced with greater longevity risk as plan members live longer, while many reinsurers have heavy exposure to mortality risk.

Many pension plans, particularly those based in the United Kingdom, have been seeking ways to access the reinsurance market to transfer some of their longevity risk for about the past 10 years. And for reinsurers that have large exposure to mortality risks, taking on risk that people will live longer offers a natural hedge, they say.

Trustees of U.S. defined-benefit plans also are facing a longevity challenge as more retirees live longer.

“We believe it is possible for U.S. pension funds to use captives to transfer longevity risk, as British Telecom has done,” said Amy Kessler, senior vice president and head of longevity reinsurance at Prudential Retirement, part of Prudential Insurance.

Pension plans, however, cannot enter into direct contracts with reinsurers, and reinsurers cannot write contracts of direct life insurance, so there needs to be a vehicle in the middle to transform the risk.

Typically, this role has been taken by an insurance company or investment bank, which has acted as an intermediary in the transaction, as well as offering administration services and credit protection, among other things.

While there are many benefits to using an insurer or a bank as an intermediary in this way, in some cases, notably those where the trustees of the pension plan are comfortable with their calculations and risk tolerance, among other factors, a cost benefit analysis may show that using a captive or captive cell is a viable alternative, said Martin Bird, a senior partner at Aon Hewitt in London, who advised the trustees of the British Telecom plan on its pension risk transfer deal.

While using a captive in this way may reduce some of the fees a pension fund must pay for transferring longevity risk, the trustee assumes different risks in such deals such as management of the captive and

management of the reinsurance contract, Mr. Bird said.

In addition, he said, captives often are set up in offshore domiciles for capital and tax efficiency reasons, so pension plans that set up such captives need “carefully designed governance protocols.”

While many pension plans will continue to go down the intermediary route, using a captive or incorporated cell captive company “gives another option,” said Shelly Beard, a senior consultant at Towers Watson in Bristol, England, who worked on the Merchant Navy Officers Pension Fund deal.

Guernsey was chosen as the location for the Longevity Direct cell captive company because of the ability to set up incorporated cells there but also because of the domicile's capital regime, Ms. Beard said.

Guernsey, which is a U.K. Crown Dependency, is not a member of the European Union and, therefore, not subject to the Solvency II risk-based capital regime for insurers and reinsurers that will be effective Jan. 1, 2016.

This means that in cells where the risk has been reinsured — and there is, therefore, no risk left in the cell — the cell owners are not required to hold large amounts of capital, Ms. Beard said.

Once trustees have a captive in place, it gives them added flexibility to undertake buy-out or buy-in deals using the captive in the future — say in 10 years' time or so when the risk profile of the plan may have changed, said Stewart McLaughlin, account director at Willis Management (Guernsey) Ltd.

Sources say there likely will be more pension transfer deals involving captives or cells in coming years.

“We are convinced that there is further business out there,” Willis' Mr. Best said, noting that “there is no cap on the amount that you can put through an ICC cell.”

“Particularly at the larger end of the scale” — plans with liabilities of above £2 billion (\$2.31 billion) — trustees will be exploring whether this is a route they can take, said Adrian Richardson, head of risk financing at Aon Global Risk Consulting, a unit of Aon P.L.C.

Experts say that pension plans from outside of the United Kingdom also could use captives as a way to transfer pension longevity risk to reinsurers and noted particular interest from plans in Canada and the Netherlands.

“We expect to see many more pension funds from many more countries pursue longevity risk transfer through captives,” Ms. Kessler said. “This solution is a cost effective way for pension funds to gain access to the deep and competitive global reinsurance market for longevity risk, where the largest players use longevity to balance their mortality exposures.”

### Pension risks can be insulated via cell captive

**C**ells within incorporated cell captive structures can provide a useful mechanism for the transfer of pension risk to the reinsurance market.

While trustees wishing to use captives to transfer pension longevity risk can set up wholly-owned captives as in the case of the British Telecom Pension Scheme, incorporated cell captives offer a less expensive, ringfenced route to reinsurance markets, experts say.

In theory, they say, trustees of a pension fund could use an existing captive operated by the sponsoring employer of the plan for a pension longevity deal.

However, they say hurdles such as the need for that captive to have a life insurance license and undesirable effects such as the mixing of property/casualty business with potentially much larger longevity liabilities, mean that separate structures are more likely to be used in such deals.

Setting up a standalone captive company likely would be the most expensive way to enter such a transaction, said Stewart McLaughlin, account director at Willis Management (Guernsey) Ltd., while a cell in a protected cell captive likely would be the least costly.

Incorporated cells offer a greater degree of ringfenced protection of the liabilities within the cell and therefore reduce the risk to other cells within the incorporated cell captive than do protected cell captives, experts say.

This is of particular importance given the relative size of the liabilities that may be placed in a captive, before being reinsured, in longevity swap deals.

While longevity risks could be placed through a protected cell, other cells within the protected cell captive may object to such large liabilities being put through the company, experts say, even though that risk then would be reinsured.

Incorporated cell captives were introduced in Guernsey in 2006. In 2010, Malta also introduced rules to allow such captives.

The number of cells within an incorporated cell captive structure is unlimited. Each cell is a separate legal entity, and all of its assets are segregated from other cells. Cells are able to transact with reinsurers, among other things.

The cell captive structure gives “great certainty of segregation,” said Dominic Wheatley, CEO of Guernsey Finance, the promotional agency for the island's finance industry.

Captive cells can contract with each other, and each cell has its own governance, which gives comfort to the trustees of pension plans and also the owners of other cells, he said.

Using an incorporated cell captive is cheaper than using an intermediary, such as a life insurance company or bank to carry out a pension longevity swap, and setting up a captive cell “can be done in a relatively streamlined way,” said Shelly Beard, a senior consultant at Towers Watson in Bristol, England.

By Sarah Veysey

#### BRITISH TELECOM CAPTIVE PENSION TRANSFER

- The British Telecom Pension Scheme is the largest defined-benefit pension plan in the United Kingdom with about 320,000 members.
- The pension scheme trustee set up a wholly owned captive, based in Guernsey, to cover about 25% of its total exposure to greater pension longevity.
- This was measured at £16 billion (\$18.47 billion).
- This exposure then was reinsured with Prudential Insurance Co. of America.
- The cost of the deal was not disclosed.

# Research & Data

## 2014 PUBLIC EXCHANGE ENROLLMENT

**11+ MILLION**

The number of individuals automatically renewed for 2015 marketplace coverage

**\$268**

The average monthly tax credit for people who qualify for financial assistance in the 37 states using HealthCare.gov through Jan. 30, 2015

**87%**

The percentage of marketplace consumers who qualified for tax credits to make their monthly premiums more affordable in the first two months of open enrollment

**25%**

The increase in insurers competing for business in the 2015 marketplace compared with last year

**40**

The average number of plans consumers can choose from this year

**49%**

The average increase in premiums in 2014 (based on 3,137 counties studied)

**84%**

The percentage of signups who actually enroll in public exchanges

**>4.7 MILLION**

The number of individuals who have received cancellation notices because they do not meet the public exchange's requirements

Sources: U.S. Department of Health and Human Services, Manhattan Institute

## ACHIEVEMENTS ATTRIBUTED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

<b>Quality improvement and reduced health care costs</b>	Free preventive care
	Prescription discounts for seniors
	Protection against health care fraud
	Small-business tax credits
<b>Adoption of consumer protections</b>	Pre-existing conditions
	Consumer assistance
<b>Access to health care</b>	Health insurance marketplace
<b>Greater benefits for women</b>	Providing insurance options
	Covering preventive services
	Reducing costs
<b>Inclusion of young adults in coverage</b>	Coverage available to children up to age 26
<b>Adoption of Medicare preventive services</b>	Annual wellness visit
	Many free preventive services for some seniors with Medicare
<b>Establishment of health insurer accountability measures</b>	To ensure that the benefits listed above are being implemented

Source: U.S. Department of Health and Human Services; Kaiser Family Foundation

## HEALTH INSURANCE COVERAGE IN THE U.S.

Coverage types for enrollees ages 18-64

	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014
Employer	44.2%	42.5%	43.5%	43.4%	43.4%
Self-paid	17.6%	19.3%	20.7%	20.7%	20.6%
Medicaid	6.9%	7.9%	8.4%	8.7%	8.6%
Medicare	6.1%	6.3%	6.9%	7.1%	7.5%
Military/veterans	4.6%	4.8%	4.7%	4.9%	4.7%
Union	2.5%	2.6%	2.5%	2.4%	2.6%
Other (e.g. parent-paid)	3.5%	3.7%	3.8%	3.6%	4.1%
No insurance	20.8%	19.0%	16.2%	16.2%	15.5%

Source: Gallup-Healthways Well-Being Index

## HOW THE INSURANCE MARKETPLACE HAS CHANGED

PUBLIC HEALTH EXCHANGES OPENED

**11 MILLION**

enrolled in 2014

**85%**

qualified for premium tax credits

**76%**

reduction in premium for those who qualified

**65%**

enrolled in a silver health plan (individual pays 30% of the premium)

**\$82**

average monthly premium (after tax credit applied)

**28%**

of enrollees were 18-34 years of age

**15.5%**

of individuals ages 18-64 with no insurance, fourth quarter 2014

PRIVATE HEALTH EXCHANGES EMERGING

**3 MILLION**

employees enrolled in private health exchanges in 2014

**50**

of the largest U.S. brokers offer a private health exchange

**40 MILLION**

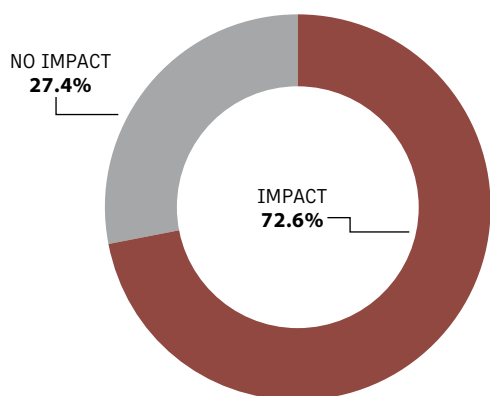
employees expected to be enrolled in private exchanges by 2018

**9**

of the largest health insurance companies are now offering private exchanges

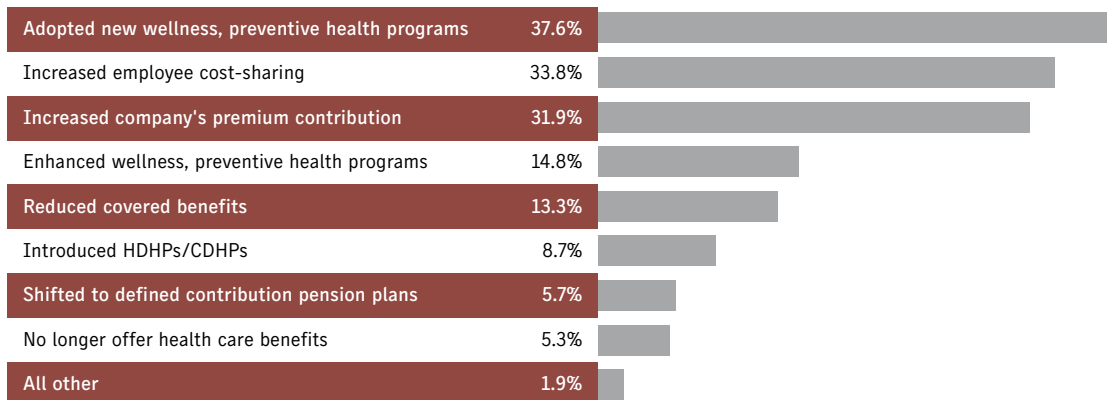
Source: U.S. Department of Health and Human Services; Gallup Inc.; Accenture P.L.C.; BI survey

## 2014 EFFECTS OF HEALTH CARE REFORM ON BENEFITS PACKAGES



Influenced seven out of 10 businesses in 2014.

### Types of effects



Source: Healthcare Trends Institute, sample of 250 human resources, benefits and benefits decision-making executives

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