

DISABILITY DISCRIMINATION

Discrimination as defined by the Americans with Disabilities Act continues to be a major issue for the Equal Employment Opportunity Commission.



FY 2013 FY 2012

| | | |
|-----------------|--------|--------|
| Charges brought | 25,957 | 26,379 |
| Cases resolved | 26,410 | 28,799 |

LIABILITY & LITIGATION

Disability leave ruling conflicts with EEOC stance

Companies have been flexible with ill workers

BY JUDY GREENWALD

A federal appeals court ruling that allows employers to set rigid disability leave guidelines is the first to bump directly against a U.S. Equal Employment Opportunity Commission campaign that promotes more flexible policies for injured or ill workers.

Many employers have already adjusted their leave policies in response to the EEOC's efforts since at least 2009 that support flexible disability leave policies, experts say.

They recommend that despite the ruling by the 10th U.S. Circuit Court of Appeals in Denver in *Grace Hwang v. Kansas State University*, employers that already have flexible policies should stand pat, at least for now.

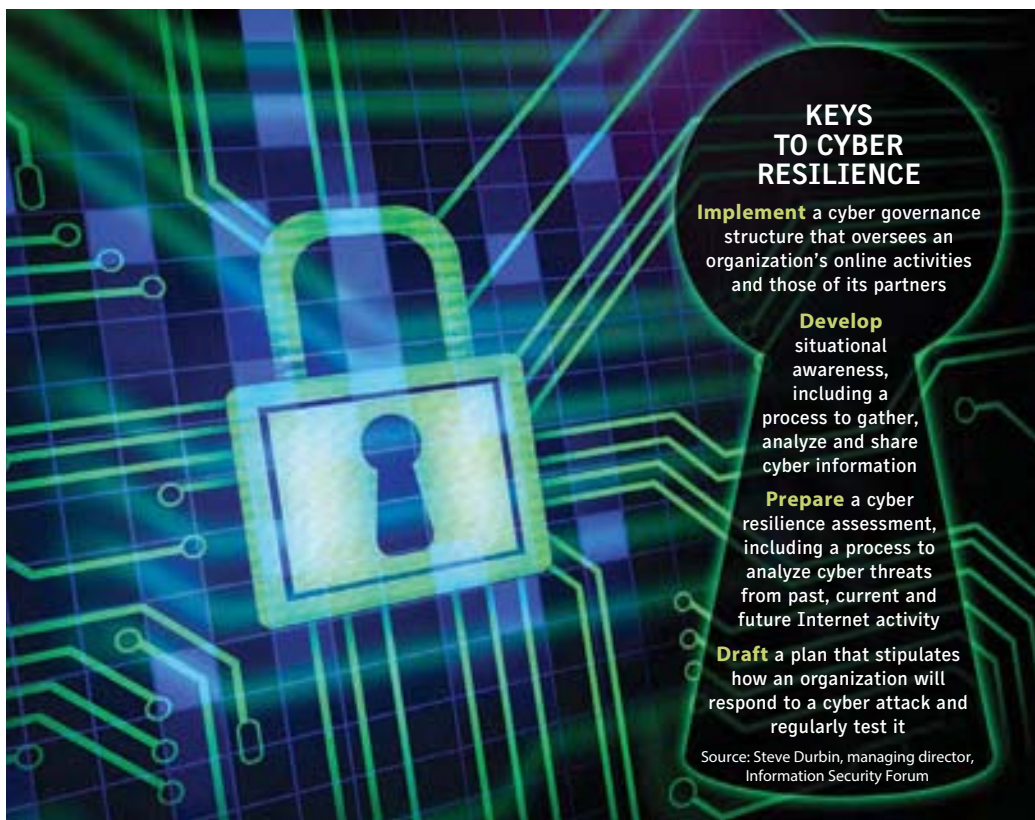
In this case, Ms. Hwang signed a one-year contract to teach classes in the fall, spring and summer

See LEAVE page 29

CYBER RISKS

RESILIENCE CRUCIAL TO COMBAT PERSISTANT CYBER THREATS

Firms urged to consider business risks from attacks



BY RODD ZOLKOS

Confronted with inevitable cyber attacks, organizations should go beyond cyber security to focus on achieving cyber resilience.

In some respects, experts say, the risk management approach is like that taken by many companies in catastrophe-exposed areas crafting business continuity plans and seeking to strengthen

business resilience in the face of a natural disaster.

"The Internet is probably one of the greatest achievements of our lifetime, but it was based on trust," said Daniel W. Riordan, CEO global corporate of North America at Zurich in New York. "Now we're confronted with the issue of how do

See CYBER page 30

P/C INSURERS

Next AIG CEO needs to boost profitability

Peter Hancock taking top job on Sept. 1

BY MARK A. HOFMANN

Peter Hancock will face profitability and other challenges when he becomes CEO of American International Group Inc. in September, but will benefit from Robert Benmosche's turnaround efforts following the insurer's near-collapse six years ago during the financial crisis.

AIG's board earlier this month chose Mr. Hancock — executive vice president of AIG and CEO of AIG Property Casualty — to succeed the retiring Mr. Benmosche. He restored AIG, which received a \$180 billion federal bailout in 2008, to sound financial footing since becoming its leader in August 2009.

But work remains to be done, analysts say. This includes improving the profitability of its property/casualty operations, retaining key executives and coping with heightened regulation by the Federal Reserve, as the result of AIG being designated as a systemically important financial institution by the Financial Stability Oversight Council.

The announcement of Mr. Hancock as Mr. Benmosche's successor came during a week marked by management changes at other major insurers.

Mr. Benmosche, 70, "did a lot to

See AIG page 29

BENEFITS MANAGEMENT

Employers must ensure wellness programs remain within the bounds of the law and their corporate culture

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DEALS & MOVES

Chicago-based Ryan Specialty Group partners with Lloyd's on health care and life science underwriting facility

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RESEARCH & DATA

Benefits consultant ranking: Largest by benefits consulting revenue, annual revenue growth, staff size

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Q&A: DANE DOUETIL

Minova Insurance Holdings Ltd. CEO discusses Minova's growth opportunities in broking and underwriting via BMS Group and Pioneer Underwriting. He explains the lessons the holding company learned from its recent strategic review and explains why the Lloyd's of London, U.S. and Bermuda markets are crucial to the company's operations.

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COMMENTARY

MARK A. HOFMANN
SENIOR EDITOR



Encouraging private insurers to enter the flood insurance market is about the only way flood insurance will remain widely available. The Flood Insurance Market Parity and Modernization Act of 2014 would clarify that private flood insurance, rather than only the policies issued by the National Flood Insurance Program, meets the mandatory purchase requirements of lenders.

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Avoiding religious bias claims

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The Moroccan property/casualty market generates modest growth of 6% per year, but that hasn't

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NEWS

TERRORISM

ADVANCING TRIA BILLS
HIKE INSURERS' FINANCIAL BURDEN

Industry prefers Senate version, expects compromise

BY MARK A. HOFMANN

Differences between House and Senate bills that would reauthorize the federal government's terrorism insurance backstop appear to be resolvable before the program expires Dec. 31.

While industry experts say the legislative differences are significant, they are not insurmountable even for this sharply divided Congress.

One of the biggest issues is the duration of the extension. The TRIA Reform Act of 2014, approved by a 32-27 vote Friday by the House Financial Services Committee, would reauthorize the program for five years.

The Terrorism Risk Insurance Program Reauthorization Act the Senate, Banking, Housing and Urban Affairs Committee unanimously passed earlier this month would extend the program for seven years.

Both bills, now headed to the floor of the respective chambers although no date has been set for consideration, would retain the current program for 2015.

Also, both would require insurers to bear a greater portion of losses from future terrorist attacks.

Insurers' "clear preference is a bill closer to the Senate bill," said



The House bill to renew the terrorism insurance backstop separates conventional terrorist attacks and nuclear and biological attacks.

Peter Lefkin, senior vice president of government and external affairs for Allianz of America in Washington. "I think ultimately any bill that is enacted would be closer to the Senate bill and will accommodate at least some of the House

concerns." Meanwhile, a stark contrast between the measures is the House bill differentiates between conventional terrorist attacks and

See TRIA page 28

HEALTH CARE BENEFITS

COBRA rules bridge exchange coverage gap

BY JERRY GEISEL

Recent federal guidance allows employees who lose their group health coverage when they leave or lose their job to get health insurance through public exchanges sooner and with no gaps in coverage by temporarily enrolling in COBRA.

The COBRA guidance, included in 436 pages of Patient Protection and Affordable Care Act regulations issued last month by the U.S. Department of Health and Human Services, addresses the health care reform law's requirement that those enrolled in COBRA wait until the next open enrollment

period to move to coverage through a public health insurance exchange.

The wait can be costly because COBRA enrollees typically pay the full group premium to continue coverage through former employers. In 2013, for example, the average annual premium for employer plans was \$5,884, or about \$490 per month, for individual coverage and more than \$16,300, or about \$1,350 a month, for family coverage, according to a Kaiser Family Foundation survey.

Coverage through a public exchange, though, can be substantially less.

According to an HHS report last

week, enrollees in 36 states in which the federal government operates exchanges paid an average of \$82 a month for coverage due to federal premium subsidies for lower income individuals. Without the subsidies, the enrollees would have paid \$346 a month.

Exchange coverage "can be a much better deal" than COBRA, said Elizabeth Vollmar, vice president and co-director of compliance services at Lockton Cos. L.L.C. in St. Louis.

But individuals can't get exchange coverage right away.

See COBRA page 30

LIABILITY & LITIGATION

High court stresses patent precision

Ruling may increase infringement litigation

BY MATT DUNNING

A pair of U.S. Supreme Court rulings could improve companies' legal protection against patent-infringement claims brought by competitors as well as nonpracticing entities often called "patent trolls."

The nation's highest court unanimously overturned legal standards that the U.S. Court of Appeals for the Federal Circuit in Washington had used last year to assign patent-infringement liability to Nautilus Inc. and Limelight Technologies Inc.

A three-judge panel of the Federal Circuit Court had rejected Vancouver, Washington-based fitness equipment manufacturer Nautilus' argument that a competitor's patented design for hand-held heart rate monitors failed to meet the legal "definiteness" standard necessary to sustain an infringement lawsuit.

The lower court said patent claims can be invalidated for indefiniteness only if they are "insolubly ambiguous."

On review, the Supreme Court disagreed, noting that the insolubly ambiguous test lacked "the precision that (the statute) demands."

"A patent must be precise enough to afford clear notice of what is claimed, thereby apprising the public of what is still open to them," Justice Ruth Bader Ginsburg wrote in the high court's opinion, which was unanimous. "To tolerate imprecision just short

See PATENT page 28

PATENT-INFRINGEMENT LAWSUITS

Nonpracticing entities, commonly known as "patent trolls," accounted for two-thirds of patent-infringement lawsuits in 2013 and were responsible for an estimated \$12.8 billion in legal expenses, damages, settlement costs and licensing fees incurred by targeted companies.

| Year | NPE suits filed | % of total | NPE-related costs |
|------|-----------------|------------|-------------------|
| 2013 | 3,608 | 67% | \$12.8 billion |
| 2012 | 3,042 | 64% | \$11.2 billion |
| 2011 | 1,547 | 47% | \$9.9 billion |
| 2010 | 744 | 30% | \$7.0 billion |
| 2009 | 640 | 28% | \$5.4 billion |

Source: RPX Corp.

ONLINE FEATURES

TOP 10 STORIES

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VIDEO: IN FOCUS



Hurricane preparedness

Miami-Dade County public schools officials discuss measures they take for the hurricane season.

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VIDEO: BROKER BEAT

Cowan Benefit Services

The president of specialty broker Cowan Benefit Services discusses employee benefits issues.

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WOMEN TO WATCH

2014 nominations now open



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Women to Watch. The deadline for nominations for this annual honor is midnight July 11.

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NEWS

SAFETY

Go beyond 'culture of compliance' to embrace safety as best way to work

BY STEPHANIE GOLDBERG

ORLANDO, Fla. — Companies that acknowledge the difference between safety and compliance are less likely to see workplace accidents caused by complacent employees, according to an official with the Occupational Safety and Health Administration.

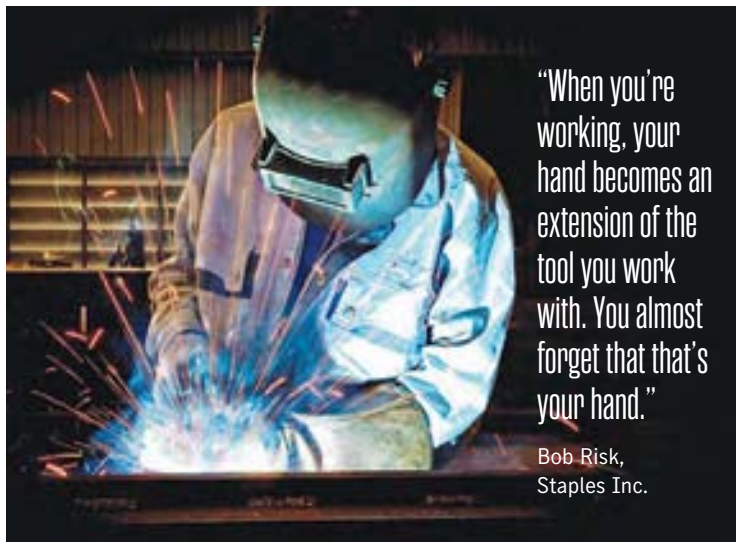
OSHA regulations represent the bare minimum employers can do to keep workers safe, said David Michaels, the U.S. Department of Labor's assistant secretary for occupational safety and health in Washington.

"We want to see employers go beyond what we sometimes call the 'culture of compliance,'" Mr. Michaels said. "There are so many ways people are hurt that are not necessarily covered by a standard, so we want employers to embrace a different approach, and safety culture is one aspect of that."

Bob Risk, Bristol, Pennsylvania-based national sales manager for safety at Staples Facility Solutions, a division of Framingham, Massachusetts-based Staples Inc., said the distinction between safety and compliance affects an entire organization.

"The cost of a hand injury is, on average, about \$50,000," Mr. Risk said. "That's everything involved — the insurance, the lost time, the lost experience."

Just because workers are wearing their protective gear and being compliant doesn't mean they're being safe, Mr. Risk said. A safety culture should stress that "cut-resistant gloves aren't called cut-proof gloves for a reason," he said.



"When you're working, your hand becomes an extension of the tool you work with. You almost forget that that's your hand."

Bob Risk,
Staples Inc.

What some companies with successful safety cultures will do, Mr. Risk said, is rotate the color of their gloves to keep workers alert about using such protective gear.

"When you're working, your hand becomes an extension of the tool you work with," he said. "You almost forget that that's your hand. You're drilling something, you're hammering something, you're seeing what you're doing but you're not seeing your hand. ... You look at (an) orange (glove) for long enough, you don't see it anymore. But if you go from orange to yellow to fluorescent green ... it's always something new. It's kind of odd, but it works."

Mr. Michaels and Mr. Risk were two of several safety professionals in attendance at the American Society of Safety Engineers' Safety 2014 conference in Orlando earlier this month.

During one conference session, Andy Schneider, global manager

of health and safety for Caterpillar Inc. in Peoria, Illinois, said developing a successful safety culture begins with changing the way safety is measured.

"We're changing the focus from the absence of injury to the presence of safety," he said.

The goal is that, when a vice president calls a facility manager to ask about safety, the answer will focus on solutions, such as improvement workshops, he said.

Speaking on a panel at the conference, Trevor Larsen, senior vice president of facilities and operations services at Walt Disney World in Orlando, shared a saying he said has become ingrained in the company's safety culture: "Let legal be legal, and you be safe."

At Disney "we're always using safety as the first lens and letting compliance follow," Mr. Larsen

See SAFETY page 26

CAPTIVES

IRS taking a closer look at captive setup

BY BILL KENEALY

INDIANAPOLIS — Historically a heavily regulated industry, U.S. insurers are facing more scrutiny ranging from an increasingly inquisitive Internal Revenue Service at home to more assertive regulators abroad.

As the use of captive insurers has become more popular, the industry is drawing a closer look from treasury and tax officials, said Brian Kilbane, St. Louis-based senior manager at tax advisory and consulting firm Dixon Hughes Goodman L.L.P.

The IRS is increasingly focused on the issues of risk shifting and risk distribution when assessing the tax status of captive insurance companies, Mr. Kilbane said. Companies that focus on accruing the tax benefits of establishing a captive without demonstrating that a risk has been transferred run the risk of "adverse outcomes" from the IRS, he said.

"If you are a captive, you must prove that the risk transferred for a reasonable premium. Rates have to be actuarially determined. You just can't set arbitrary premiums to max out tax deductions,"

Mr. Kilbane said, during a panel discussion held at this month's Insurance Accounting & Systems Association Inc.'s 2014 Educational Conference and Business Show.

Fellow panelist Douglas Stein, Atlanta-based partner with Strategic Law L.L.C., said a common mistake many companies make when establishing a captive is structuring it in such a way that there is little chance the captive can lose money.

"By definition, insurance requires risk of loss, so if there's no chance of loss it's not really insurance," he said. "There's nothing better-looking to regulators than a captive that's had a claim."

Captives increasingly must pass a "smell test" with regulators, Mr. Stein said. He cited the example of a farmer in Iowa that ran afoul of regulators after he established a captive. In addition to standard coverages, the farmer paid hefty premiums to the captive for kidnapping insurance despite the fact that he didn't hold a passport and

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Still time to nominate star broker

Don't miss the opportunity to nominate an outstanding young broker for the 2014 *Business Insurance* 40 Under 40 Broker Awards. The nomination deadline has been extended to July 1.

This awards program, which is in its second year, recognizes retail commercial insurance brokers younger than 40 who work in five regions of the United States: Northeast, Southeast, Midwest, Southwest and West.

Nominations should highlight the broker's client service skills, leadership skills and market expertise. A panel of *Business Insurance* editors will review the nominations and select the regional honorees.

Anyone can nominate a broker — co-workers, man-

BUSINESS INSURANCE 2014

40 UNDER 40 BROKER AWARDS

agers, clients or insurance industry partners — but each nomination must include client and management/co-worker references. To be eligible, nominees must have worked in the brokerage industry for at least three years and must be under age 40 on Oct. 1, 2014.

The winners will be announced online in late summer and will be profiled in the Oct. 13 edition of *Business Insurance*. Award winners also will be recognized at regional events in the fall.

Nomination forms are available at www.businessinsurance.com/40under40nominate. Please send broker nominations to Gavin Souter, editor of *Business Insurance*, at gsouter@businessinsurance.com.

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Wednesday, October 22

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Thursday, October 23



For additional details about the regional events and how you can participate, please contact Mary Pemberton, Director of Conference Sales at mpemberton@businessinsurance.com.

Visit www.BusinessInsurance.com/40under40

For event details and sponsorship information

After a thorough review by a panel of senior editors at Business Insurance, who will consider various criteria, including recent professional achievements, influence on the marketplace and contributions to their community, eight (8) Brokers will be identified in each region, and the results will be announced on-line prior to the event date for each region - and a compilation of all 40 of the award winners will be in the Oct. 13, 2014 issue of Business Insurance. Honorees are selected from nominations submitted by readers of Business Insurance, and they must be age 40 or under at the time of their nomination. A series of regional receptions will be held in celebration of the achievements of the broker leaders.



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FLEXIBILITY KEY TO AVOIDING RELIGIOUS BIAS CLAIMS

Requests for time off, religious dress should be treated with sensitivity

BY JUDY GREENWALD

ACCOMMODATING WORKERS

Issues to consider with respect to religious accommodation

- Make sure the company's antidiscrimination policy provides reasonable accommodation for religious beliefs.
- Consider religious accommodation requests in developing dress, grooming and scheduling policies.
- Devise appropriate forms and procedures for religious accommodation requests, including the ability to file anonymous complaints with the human resources department.
- Provide training to employees on the issue of religious accommodation.
- Listen to the employee and do not reject any request out of hand.
- Realize employees may not explicitly say their accommodation requests are based on religious reasons.
- Keep in mind that a decision on a religious accommodation request should be determined based on what the individual believes is required of them.
- Take as a given the sincerity of an employee's religious beliefs, without questioning him or her.
- Engage in an interactive process with the employee and try to reach an accommodation.
- Consider whether an accommodation creates an undue hardship for the company.
- Recognize a decision may be scrutinized regarding whether it reflects religious discrimination.



Avoiding religious discrimination claims often is more about accommodating employees' schedules and allowing latitude on head-wear rules as it is about hiring, promotion or harassment issues.

Religious discrimination, which often is combined with national origin claims by the Equal Employment Opportunity Commission, is an ongoing, troubling issue for employers, observers say.

For instance, New York-based Tanenbaum Center for Interreligious Understanding found in a national survey last year that more than one-third of workers report observing religious bias or being subjected to it on the job.

According to the EEOC, 3,721 charges of religious discrimination were filed in fiscal 2013, which was down from 3,811 in 2012 and the 2011 peak of 4,141. While two out of three cases were determined to have no reasonable cause, observers say the issue persists for employers.

"The principal ways you see religion in the workplace coming up is when employees request accommodations so they can observe their religions," such as asking for Friday off to go to the mosque, said Elizabeth Torphy-Donzella, a defense attorney and partner at Shawe Rosenthal L.L.P. in Baltimore.

Grooming that includes beards and dreadlocks, religious headgear and the acceptability of uniforms also can pose religious discrimination issues. In March, the EEOC issued two technical assis-

tance publications on religious dress and grooming under Title VII of the Civil Rights Act of 1964. Included was advice against assigning employees to a noncustomer service position because of their religious garb.

Particularly after the Sept. 11, 2001, terrorist attacks, "there were quite a few cases involving Muslim individuals who wanted to wear their headgear, or their hijabs, and were terminated," Ms. Torphy-Donzella said.

Employees may not specifically say why they want to modify their

uniform or that they want the time off for religious reasons, said Peter J. Gillespie, of counsel at Fisher & Phillips L.L.P. in Chicago.

Managers may "need to step back and try to recognize that could very well be the reason driving" the request, so they avoid the company-should-have-known argument later even though the issue was not raised directly, he said. "The better course is to ask for clarification from the employee" why they are making the request.

Employers "need to revisit" their

anti-discrimination policies, which should bar religious discrimination as well as provide reasonable accommodation of religious beliefs and practices. Although most employers prohibit religious discrimination, few go this "extra step," said Douglas J. Farmer, a shareholder at Ogletree, Deakins, Nash, Smoak & Stewart P.C. in San Francisco.

"If you do have a dress code, then I think you have to recognize there may be a requirement to reasonably accommodate somebody" if they have a bonafide religiously-held belief, said Paul Kehoe, senior counsel at Seyfarth Shaw L.L.P. in Washington.

Employers should be aware that while they have an obligation to engage in an interactive process with the employee, the request must be reasonable without creating an undue hardship on the company, said Richard B. Cohen, a partner at Fox Rothschild L.L.P. in New York. "At times, that's not easy," he said.

Employers should avoid questioning the worker's sincerity or strength of their religious beliefs when a request is made. "They should take that as a given, unless there's evidence to the contrary," Mr. Cohen said.

Accommodations could include asking a Muslim who requires prayer breaks to take a shorter lunch, or work an extra hour a couple of times a week, he said.

Jewish and Christian employees also can raise religious accommodation issues to take time off for the Sabbath, Ms. Torphy-Donzella said.

"You don't have to be (a member of) one of the major religions to invoke the right to practice your religion freely," Mr. Cohen said. As long as an employee has sincerely held beliefs, "that would be sufficient," he said.

Much also depends on where the employer is located, said plaintiff attorney Michael Kraemer, a partner at Kraemer, Manes & Associates L.L.C. in Pittsburgh.

In areas of the country that have less workforce diversity, "you find a lack of the same kind of understanding" as in urban areas, he said. "It's not necessarily discrimination. A lot of folks don't really realize they're doing it."

MANY PATHS TO RELIGIOUS BIAS CLAIMS

Several settlements of Equal Employment Opportunity Commission religious discrimination cases illustrate the wide variety of issues the subject encompasses:

■ Laurinburg, North Carolina-based Scottish Food Systems Inc. and Laurinburg KFC Take Home Inc., which operate a chain of Kentucky Fried Chicken restaurants in the state, agreed to pay \$40,000 last December for allegedly firing a convert to Pentecostalism who refused to wear pants and would wear only dresses or skirts, saying it was against her religious beliefs.

■ Miami-based Dynamic Medical Services Inc. agreed to pay \$170,000 last December in a case in which it allegedly required employees to spend at least half of their work days in courses involving Scientology religious practices, such as screaming at ashtrays or staring at someone for eight hours without moving.

■ Oak Brook, Illinois-based McDonald's Restaurants of California Inc. agreed in December to pay \$50,000 for allegedly refusing a request from a Muslim employee, at a Fresno, California, restaurant it formerly owned, to grow a beard for religious reasons, which led to his being discharged.

■ Albuquerque, New Mexico-based 704 HTL Operating L.L.C. and Investment Corp. of America, which do business as MCM Elegante Hotel In Albuquerque, agreed to pay \$100,000 in November for allegedly terminating a Muslim housekeeper who refused to remove her head covering.

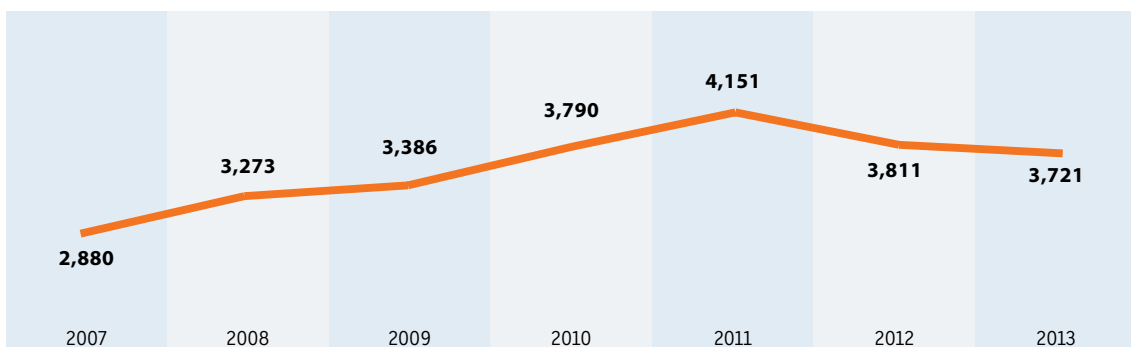
■ Little Falls, New Jersey-based car dealership United Galaxy Inc. agreed to pay \$50,000 last November for allegedly refusing to hire as a sales associate a man whose Sikh faith required him to wear a beard, uncut hair and a turban.

■ Virginia Beach, Virginia-based Landmark Hotel Group L.L.C., which operates Comfort Inn Oceanfront South in Nags Head, North Carolina, agreed to pay \$45,000 last July for allegedly refusing to permit a member of the Seventh-day Adventist Church to have a day off on her Sabbath, from sundown Friday to sundown Saturday, and firing her.

By Judy Greenwald

RELIGIOUS DISCRIMINATION CHARGES

Religious discrimination charges declined in 2013 and 2012 from their 2011 peak, but they remain an ongoing concern for the Equal Employment Opportunity Commission and employers.



Source: Equal Employment Opportunity Commission

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EXERCISE CAUTION CRAFTING WELLNESS PLANS

Various laws curb employers' ability to use incentives, penalties

BY MATT DUNNING

As the wellness industry focuses more on reducing employees' health risks by improving their behavior, employers must ensure their programs remain within the bounds of the law and their own corporate culture.

A host of federal and state laws regulate the extent to which employers can impose a health management strategy on employees, particularly strategies including aggressive wellness programming and incentive structures.

Benefits managers and wellness administrators also must not let their programming take an authoritarian tone, or risk exceeding employees' tolerance of employer-provided health management education and support (see story, below).

Forty-two percent of employers polled in Eden Prairie, Minnesota-based Optum Inc.'s 2014 Wellness in the Workplace Survey offer financial incentives tied to measurable improvements in employees' health outcomes — such as achieving or maintaining a healthy weight, reducing their cholesterol or quitting smoking — compared with 37% in 2013 (see chart).

Additionally, 52% of employers said they offer financial rewards to employees who complete health related activities, and 46% have nonparticipation penalties in their incentive structures.

"It takes quite some time for individuals to change their behavior, and they have to be motivated to do it," said Beena Thomas, Atlanta-based vice president of health and wellness at Optum. "Incentives can play a strong role and we have seen a trend of employers moving away from

incentives based on participation and towards incentives that are keyed on results."

Another study, released in May by Chicago-based benefits consulting firm Bswift L.L.C., found that while only 17% of employers saw participation rates of at least 75% in their wellness programs, up to 39% reached that level if they offered programs with outcome-based incentives of \$250 or more per employee.

Even without incentives, a workplace wellness strategy that expands beyond basic educational

under the Health Information Portability and Accountability Act to offer "reasonable alternative standards" to employees who are unable to meet the initial program objective.

If the first alternative offered is deemed medically inappropriate or unattainable by an employee's personal physician, the employer must offer a second alternative that abides by the physician's recommendations.

Although similar regulations on outcome-based incentives existed under HIPAA prior to finalization

ers not offering required alternative standards for outcome-based incentives in last year's survey.

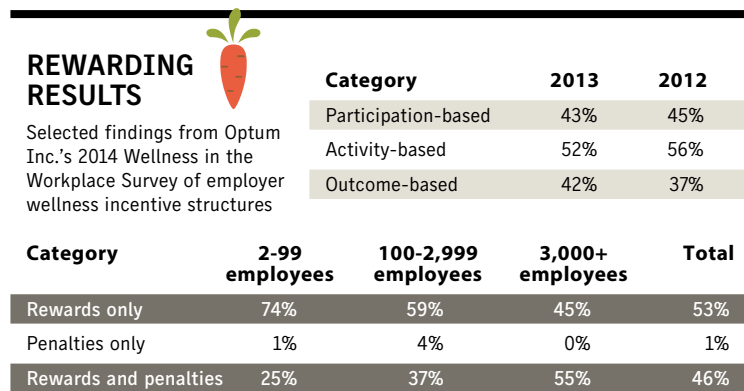
Experts said many employers have expressed even greater confusion over the extent to which incentivized activities such as diet, fitness and smoking-cessation programs, which employers have offered for years but have been subject to HIPAA only since the beginning of this year.

Under the expanded rules, employers must offer reasonable alternative incentive standards using most of the same guidelines that apply to outcome-based incentives, with the exception that the alternatives need be made available only to employees who are medically unable to meet an initial activity-based goal.

"Prior to the rule changes under PPACA, there was no such thing as an 'activity-based' wellness program," said Rachel Cutler Shim, a Philadelphia-based tax, benefits and wealth planning attorney at Reed Smith L.L.P.

Employers also may be required under the Americans with Disabilities Act to provide reasonable alternative incentive standards to employees who cannot achieve initial incentive goals because of a recognized disability, even if the initial goal is only participation-based, experts said.

"It's one of the riskiest areas when you talk about wellness programs, but particularly so when you get into outcome-based programs and incentives," said John McKelway Jr., a Boston-based partner in the labor and employment practice at McCarter & English L.L.P. "This is uncharted water, and there are an infinite number of scenarios that no one ever would have thought of."



programming carries regulatory obligations, experts said (see box, right).

For example, many employers have taken steps to eliminate or strongly discourage smoking among their employees, in some cases limiting health benefit options or penalizing employees who test positive for nicotine. However, several states bar employer discrimination based on employee use of tobacco and other legal products when they are not at work.

Starting this year, employers offering activity- or outcome-based financial incentives are required

of expanded rules under the Patient Protection and Affordable Care Act in March 2013, 24% of employers offering outcome-based wellness incentives still were not providing reasonable alternatives by the end of the year, according to Willis North America Inc.'s 2014 Health and Productivity Survey.

"That probably reflects variations in the level of knowledge and sophistication employers have when it comes to wellness programs," said Ron Leopold, Atlanta-based health outcomes practice leader at Willis, adding that the 2014 results were a marked improvement from 42% of employ-

KEY WORKPLACE WELLNESS REGULATIONS

FEDERAL

Health Insurance Portability and Accountability Act

- Restricts distribution of employees' personal health information.
- Limits incentives or penalties to 30% of an employee's total health care premium, or 50% for smoking-cessation incentives.
- Requires reasonable alternative incentive standards for employees who are medically unable to meet an initial activity-based goal.
- Requires reasonable alternatives for outcome-based incentive requirements for employees that do not meet the initial standard, regardless of medical condition.

Americans with Disabilities Act

- Restricts employer-mandated medical examinations for employees.
- Prohibits discrimination and retaliation against disabled employees.
- Requires employers to provide reasonable alternative incentive standards for employees unable to earn an incentive due to an ADA-recognized disability.

Genetic Information Non-Discrimination Act

- Prohibits employers from requiring employees to disclose genetic information, including family medical history, via health risk assessments/biometric screenings.

STATE

- 18 states prohibit employers from banning off-duty tobacco use.
- 8 states prohibit employers from restricting employees' off-duty use of all lawful products.
- 4 states prohibit employers from restricting employees' engagement in lawful off-duty activities.

HEAVY-HANDED APPROACH CAN DETER WORKERS FROM PARTICIPATING

Even if their wellness programs comply with all state and federal laws, employers that push too hard to improve the health of their workforce still risk violating their employees' personal boundaries.

"Employees don't want to feel like control of their health is being taken away," said Randi Dukoff, a partner at New York-based Vital Advantage Consulting. "When you start preaching to employees about their nutrition or weight or whatever it is you're trying to address, rather than educating them, they're likely to shut down."

Benefits managers and wellness coordinators must be cognizant that employees

may reject wellness strategies — including activities, educational programming, incentives and communications — that ignore the deeply personal nature of their health management decisions.

"So much of doing this right is about positioning it in a way that doesn't make the employee feel threatened, and that makes them feel like it really is about what's best for them," said Ron Leopold, Atlanta-based health outcomes practice leader at Willis North America Inc.

For example, Chicago-based Aon Hewitt's 2014 Consumer Health Mindset Survey found that employees' top reason for not participating in a company's well-

ness program is they didn't find any elements relevant or applicable to their lives.

"You can't force your employees to want to change," said Tracey Saliski, Freehold, New Jersey-based wellness program coordinator at CentraState Healthcare System. "You can provide them with all the resources and opportunities they need to make a change, but if they're not interested, they won't even take the smallest of steps."

Similarly, a wellness program centered on incentivized participation or completion of physical activities could be viewed as indifferent to employee needs if they are not given time during the workday to

partake in the activities. Forty-nine percent of employees in the Aon Hewitt survey said they did not participate in their employer's wellness program because it was inconvenient, not worth the time or their work prevented them from participating.

"The second it starts feeling like an obligation, employees will begin quitting the programs," said Karen Curran, director of health risk management at Denver-based Pinnacle Assurance. "The simpler, easier and more fun employers can make their wellness programming, the more employees are going to keep using it."

By Matt Dunning

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Sponsors pressure FIFA over Qatar claims

■ Adidas A.G., Sony Corp., Visa Inc. and The Coca-Cola Co. have called on soccer's rulers to deal with allegations of bribery to secure the 2022 World Cup for Qatar. Soccer's governing body, the Zurich-based Federation Internationale de Football Association, is conducting an internal investigation into the decisions to hold the 2018 World Cup in Russia and the 2022 Cup in Qatar. Both countries have denied any wrongdoing. Qatar's bid attracted controversy from the outset because of the extreme summer heat during the months when the World Cup is played and the tiny country's lack of domestic soccer tradition. "The negative tenor of the public debate around FIFA at the moment is neither good for football nor for FIFA and its partners," said German sportswear company Adidas, which has signed up as FIFA sponsor until 2030, extending a partnership dating back to 1970. Coca-Cola concurred. "Anything that detracts from the mission and ideals of the FIFA World Cup is a concern to us," the company said in a statement. The signs of unease will raise pressure on FIFA to get to the bottom of the underlying concerns about how it is run. It is unusual for sponsors to say anything publicly, and their comments reflect concern over the knock-on effects on their image. "This underlines that companies need to make sure that any high-profile association enhances their reputation rather than damages it," said Andy Sutherden, global head of sports marketing and sponsorship at communications firm H+K Strategies.

Reuters

PIC insures pension risk with Hannover Re

■ Pension Insurance Corp. and Hannover Re S.E. have assumed a block transfer of £1.6 billion (\$2.69 billion) of pension liabilities from the defined benefit pension plan of Total U.K. Ltd., the London-based arm of Paris-based oil company Total S.A. London-based PIC said it had completed a buy-in deal with the trustees of the Total U.K. Pension Plan. In a buy-in deal, a regulated insurance company assumes responsibility for the pension obligations of a company. In turn, the employer transfers pension plan assets to the insurer, which are used to pay retirees their promised benefits. "This was a complex transaction in which we sought to bring certainty to a large portion of our liabilities," Iain McCombie, chairman of the

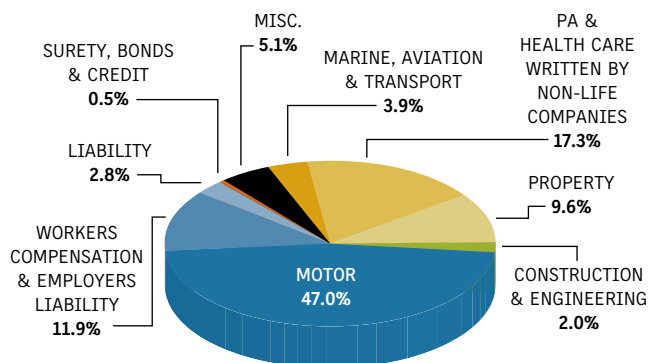
PROFILE: MOROCCO

\$1.64
BILLION

The Moroccan property/casualty insurance market generates modest growth of 6% a year. That has not been robust enough to keep the market players happy. Regulators are working on laws to add new mandatory coverages that would help to expand the market, which ranks No. 49 in the world. Those coverages would include natural catastrophes and terrorism risks. And it's expected that workers compensation coverage eventually will be transferred from the private market to the state.

◀ 2012 P/C gross premiums

MARKET SHARE



Source: Axco Global Statistics/Industry Associations and Regulatory Bodies

COMPULSORY INSURANCE

- Workers compensation
- Marine oil pollution damage
- Clinical trial liability
- Professional indemnity for agents and brokers
- Auto third-party liability

NONADMITTED

Nonadmitted insurance is not allowed to be placed in Morocco because the nation's law requires that insurance must be bought from locally authorized insurers, with some exceptions. The exceptions for nonadmitted placements are unclear. Insurers and brokers in the Moroccan insurance market do understand that marine, aviation and credit risks are excluded if the coverage can't be secured in the country. Also, regulators want imports to be insured in Morocco, but there are several exceptions.

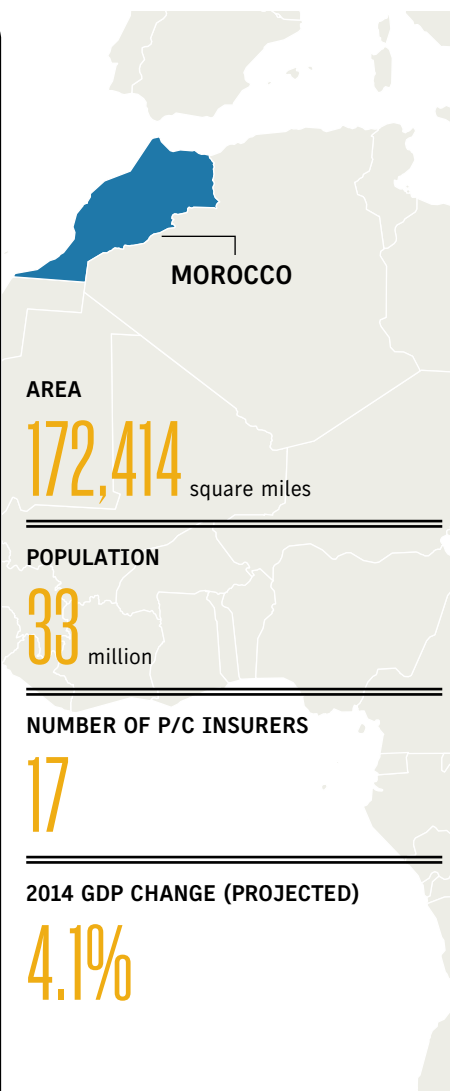
INTERMEDIARIES

Agents and brokers are required by the government to be authorized to place insurance business. They are not permitted to place business with nonadmitted insurers unless regulatory approval is granted. It's encouraged that local brokers get involved in permitted nonadmitted placements to warn insurance buyers their insurers are not subject to local supervision.

MARKET PRACTICE

After passage of a 2002 law, the rules generally loosened in the insurance market. For example, now insurers can make fronting arrangements, particularly if the risk concerned has unusually wide coverage or is excluded from reinsurance treaties in place within the market.

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



MARKET DEVELOPMENTS

UPDATED
MAY 2014

- Construction all risks and decennial liability coverages are expected to be made mandatory later this year.
- Discussion continues among authorities regarding implementation of required coverage for natural catastrophes and terrorism. A proposal is expected to be made to the parliament later this year.
- There is ongoing draft legislation to make insurers responsible for their agents and the range of insurance products Moroccan banks should be allowed to sell.
- The parliament is reviewing a workers compensation reform law that was introduced last year.
- In August 2013, the parliament approved a draft law to establish a financial super-regulator.

trustees of the ICI plan, said in a statement. Hannover Re said that under the terms of the deal, it assumes the biometric risk of the plan, not the investment risk. Hannover Re said in a statement that it would generate total income of about €1.9 billion (\$2.59 billion) from the transaction.

Quebec asks \$377 million for Lac-Mégantic wreck

■ The Quebec government said it is seeking 409 million Canadian dollars (\$377 million) from Montreal, Maine & Atlantic Railway Inc., the insolvent rail operator at the center of the rail disaster in the town of Lac Mégantic, Quebec, last year. The claim is the latest in a growing list against the rail operator and other companies involved in the train shipment of oil from the Bakken fields that derailed and

exploded, killing 47 people in the small town of Quebec and flattening the center of the town. The government, which filed its claim with court officials handling the claims process, said CA\$126 million (\$116.1 million) was for funds already spent, while the remainder was for expenses it expected to incur. The government said the size of its claim may be revised upward, once all its expenses were determined.

Reuters

Moody's downgrades reinsurance outlook

■ Moody's Investors Service Inc. has downgraded its outlook on the global reinsurance sector to negative from stable. "The outlook change was prompted by a number of factors that are pressuring reinsurers simultaneously: an

oversupply of capacity, new entrants in the form of nontraditional capital, more substitute products, low interest rates and greater bargaining power of buyers," said Moody's in a statement. Moody's said the current soft market shows many of the traits of the late 1990s, including an overabundance of capital and a substantial rise in buyers' bargaining power, and predictions of industry consolidation. But the rating agency added that today's situation is not identical to that of the 1990s. "One key difference is that reinsurance buyers today have greater incentives to improve capital efficiency, limiting their need for reinsurance," Kevin Lee, vice president and senior credit officer of Moody's financial institutions group, said in the statement. "Tighter regulatory oversight and the need for better internal governance have pushed insurers to get more mileage out of their capital."

U.K. risk managers get contract guidance

■ Airmic Ltd., the U.K. risk management association, has launched a guide to help risk managers achieve greater coverage, contract and claims certainty. "Efficacy of Business Insurance" aims to help buyers successfully operate within the U.K. legal system and achieve the best possible coverage for their organizations, said Airmic technical director Paul Hopkin. The guide advises risk managers to ensure that terms and conditions are agreed fully and in writing before policies come into force and that wordings be tested before policy inception. Airmic also advises members to demand that their insurance policy be issued on the day of inception or before, Mr. Hopkin said. This will bring insurance contracts in line

with other contracts agreed upon by companies, said Chris McGloin, chairman of Airmic and vice president of risk management and insurance at technology firm Invensys P.L.C. in London. There also is an increasing need for policy wordings to be reviewed by legal experts or insurance class specialists, Mr. Hopkin said.

Nokia blackmail threats revealed on Finnish TV

■ Finnish telecommunications equipment company Nokia Corp. paid several million euros to criminals who threatened to reveal the source code for part of an operating system used in its smartphones some six years ago, Finnish TV station MTV said last week. The police confirmed to Reuters that they were investigating a case of alleged blackmail and that the case was still open. Nokia was not immediately available for comment. MTV said the blackmailers had acquired the encryption key for a core part of Nokia's Symbian software and threatened to make it public. Had it done so, anyone could have written additional code for Symbian, including possible malware, which would have been indistinguishable from the legitimate part of the software, MTV said. After the blackmail attempt, Nokia contacted the police and agreed to deliver the cash to a parking lot in Tampere, central Finland. The money was picked up, but the police lost track of the culprits, MTV said. In 2007, Nokia's smartphone market share was about 50% with the Symbian software also used then by other manufacturers. Nokia later moved to use Microsoft's Windows software in its smartphones and Microsoft bought Nokia's entire mobile phone business earlier this year for €5.6 billion (\$7.58 billion).

Reuters

Big insurers may escape regulators' systemic list

■ Global insurers deemed by regulators as likely to destabilize the financial system should they fail could find a way of removing themselves from the list, such as by simplifying themselves, a German watchdog said. Felix Hufeld, the top insurance supervisor at German financial watchdog Bafin, told Reuters without giving details that the companies would have options to remove their names on the list once the rules are finalized later this year. "It should be possible to get down off the list of systemically relevant insurers," Mr. Hufeld said. "The additional capital requirements are not only there to increase safety but should

also create an incentive to separate from systemically relevant activities," he said. Companies initially identified last July as systemically relevant were Allianz S.E., American International Group Inc. Assicurazioni Generali S.p.A., Aviva P.L.C., Axa S.A., MetLife Inc., Ping An Insurance Co. of China Ltd., Prudential Financial Inc. and Prudential P.L.C. A decision on including any large reinsurers such as Munich Rein-

surance Co. and Swiss Re Ltd. will be taken at a later date.

Reuters

Marsh to buy majority stake in Panama broker

■ Marsh L.L.C. has agreed to acquire a majority stake in Seguros Morrice y Urrutia S.A., an insurance broker based in Panama

City. Terms of the transaction were not disclosed. As of March 30, Semusa had \$2.8 million in assets and more than 75,000 clients, Marsh said in a statement. With a staff of 196 professionals, Semusa has been Marsh's local correspondent broker in the region for 15 years, according to the statement. The combined entity will operate as Marsh Semusa. "Panama is one of the fastest-growing economies in the world," Peter Zaffino, presi-

dent and CEO of Marsh, said in the statement, "The country has seen significant expansion across the financial services, infrastructure, construction, energy, logistics and transportation sectors." Samuel Urrutia, now president of Semusa Group, will become chairman of the board of Marsh Semusa, while Emanuel Abadia, now CEO of Semusa, will become CEO of Marsh Semusa, according to the statement.

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EDITORIAL

TOP BENEFIT MANAGERS RECOGNIZED

Reducing the cost of health care benefits, or at least curbing cost increases, has been an ongoing concern for employers for years. While medical cost increases are slowing, high health care costs are still a major problem for many employers. And the drive to encourage employees to live healthier lives, in an effort to reduce costs over the long-term, can be a painfully slow process.

To implement a benefits management program that successfully addresses these and other benefits issues takes innovation, expertise and tenacity. Such attributes are on full display in the award-winning benefits managers that we profile in this issue.

Dianne L. Howard, director of risk and benefits management at the School District of Palm Beach County in West Palm Beach, Florida, hasn't just slowed her organization's health care cost increases; she's secured significant year-over-year cost decreases with further reductions expected.

She negotiated to secure millions of dollars in prescription drug rebates for the school district rather than let the rebates go to its insurer, analyzed claims data to make sure deductibles and coinsurance requirements were applied correctly and used several strategies to change employees' behavior and improve their health.

By taking a diverse strategy and questioning conventional approaches to benefits management, Ms. Howard has built a better program for the district and for its employees. Recognizing her success, Ms. Howard has been selected by an independent panel of judges as the Business Insurance 2014 Benefit Manager of the Year®.

Sarah Staggs, head of benefits for Zurich North America, also has successfully addressed health care costs and taken a creative approach to solving benefits problems.

Among her successes, Ms. Staggs fostered a grassroots wellness campaign for employees, introduced a consumer-driven health plan that allowed employees to choose coverage levels, boosted participation in the company's 401(k) plan and introduced a risk-reduction strategy for its pension plan.

For her achievements, Ms. Staggs has been named to the 2014 Benefit Management Honor Roll®.

We congratulate both our honorees for their achievements. We hope you enjoy learning more about them and their programs in the profiles that begin on page 13.

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters.

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SCHILLERSTROM



COMMENTARY

U.S. FLOOD BILL MAKES HEADWAY INCLUDING PRIVATE INSURANCE

Sometimes the simplest ideas are among the best. That's the case with a recently introduced piece of legislation involving flood insurance.

The Flood Insurance Market Parity and Modernization Act of 2014 would clarify that private flood insurance, rather than only the policies issued by the National Flood Insurance Program, meets the mandatory purchase requirements of lenders.

Bill sponsors Sens. Jon Tester, D-Montana, and Dean Heller, R-Nevada, say that the drafters of the original National Flood Insurance Act of 1968 intended for private insurers to participate in the market.

"Unfortunately, due to a lack of clarity in existing law, lenders have not accepted private flood insurance as meeting mandatory purchase requirements," according to a statement from Sen. Heller's office.

"This straightforward clarification to our nation's flood insurance market will encourage private-sector participation, increase competition and give consumers more options when shopping for policies," Sen. Tester said in a separate statement.

The bill comes at a particularly opportune time. The National Flood Insurance Program is about \$25 billion in the red. Earlier this year, Congress rolled back some of the provisions of a 2012 law that sought to return the program to some semblance of solvency, thereby making a bad situation even worse.

Encouraging private insurers to enter the flood insurance market is about the only way flood insurance will remain widely available. While commercial policyholders can buy cover from private underwriters, that option doesn't exist for the vast majority of residential property owners.



MARK A. HOFMANN
SENIOR EDITOR

A potential private market exists. As Frank Nutter, president of the Reinsurance Association of America put it in a statement issued after the bill's introduction late last month, "reinsurers have an appetite to underwrite flood risk, and this legislation will facilitate the development of a private insurance market for flood risk." He added that the bill will not only provide more

options for buyers, but "importantly as well, reduce the federal government's role in providing flood insurance through the National Flood Insurance Program."

Developing a private flood insurance market will be no easy task. It's hard to unwind what basically has been a government monopoly for nearly half a century. But the bill provides a straightforward way to begin reducing taxpayers' exposure to flood losses.

Other reforms will be necessary as well before private underwriters jump in — such as requiring actuarially sound rates for the coverage. That means higher premiums, and no sitting lawmaker wants to hear about those from his or her constituents.

The bill has been introduced so late in this Congress — and only months before elections, at that — that it stands little chance of moving this year. But if it can't get the consideration it merits this year, it's such a good idea it deserves action as early as possible in the next session of Congress.

Benefits innovations drive savings



JOSH RITCHIE

**BENEFIT MANAGER
OF THE YEAR**

Dianne L. Howard

SCHOOL DISTRICT OF
PALM BEACH COUNTY

BY JERRY GEISEL

When it comes to their group health care plans, virtually all employers have one thing in common: Costs keep going up. For the past several years, costs on average have risen between 5% and 6% a year, and projections for 2014 fall within that range.

But one big employer — the School District of Palm Beach County in West Palm Beach, Florida — has had an entirely different experience: Its costs actually have gone down.

In 2011, the school district's health care plan costs averaged \$686 per employee per month. Last year, costs averaged \$661 per employee per month. This year the district projects costs will average \$634 per employee per month based on claims through May, said Dianne L. Howard, the school district's director of risk and benefits management.

"My goal is not to exceed what we spent in 2013, and it increasingly is looking like we will come in significantly under that," she said.

For her innovative approach to achieving cost-effective health benefits management for the school district, Ms.

Howard has been named *Business Insurance's* 2014 Benefit Manager of the Year®.

The beneficiaries of the district's health care cost deflation: both employees and the school district.

"Those savings will translate into keeping employee premium contributions stable for all of 2015, as well as allow us not to have to boost funding," Ms. Howard said.

Achieving that remarkable cost stability was not the result of slashing employees' health benefits. Instead, it was achieved through a multiprong approach that includes:

- A broad wellness program that gives employees attractive financial incentives to see providers for a physical or preventive screening to spot medical problems before they worsen, become much more expensive to treat and result in trips to hospital emergency rooms.

- A diabetes management program that has encouraged employees, through lower copayments, to get health care screenings to spot the conditions early and take the appropriate medications to keep the disease in check.

See **HOWARD** next page

THE SCHOOL DISTRICT OF PALM BEACH COUNTY, FLORIDA

Size: Fifth-largest school district in Florida, with 181,205 students as of October 2013 projections and 185 schools

Employees: 21,449, including 12,898 teachers

Budget: \$2.37 billion

Did you know:

- 11,300 graduates received \$100 million in scholarships in 2013.
- Education Week recognized the school district as having the eighth-highest public high school graduation rate in the United States.
- Students speak 146 languages and come from 191 countries and territories.
- 69,311 computers are in schools, along with 6,500 iPads.
- 805 buses transport 60,000 students daily, traveling about 13 million miles per year.

Self-funding health care results in big cost cuts

Networking, enrollment audits also lead to significant savings

BY JERRY GEISEL

While prevention and detection through a sweeping wellness program are at the core of the School District of Palm Beach County's efforts to keep health care costs under control, a variety of other actions also has been pivotal, says Dianne L. Howard, the West Palm Beach, Florida-based school district's director of risk and benefits management.

One of the first cost-saving steps Ms. Howard took was to move the school district to a self-funded health care benefits program in 2007.

Two big reasons — both financial — drove the decision to self-fund.

"We decided to self-fund when we realized the profits the insurer was making every year," Ms. Howard said. "Insurers build in a risk corridor, since they are taking the risk if our claims exceed what they expect. It's probably at least 5% of the premium."

In addition, by self-funding, the school district does not have to pay the premium tax the state of Florida imposes on health insurers, a cost insurers typically pass on to policyholders in the form of high-

er premiums.

Ms. Howard estimates that by self-funding — reaping the risk corridor profits and an exemption from insurance premium taxes — the school district saves about \$10 million a year. In addition, the school district gets "more detailed reporting, since the data is ours," she said.

Networking led to another way for Ms. Howard to reap millions of dollars a year in savings for the school district's prescription drug benefits program.

Through her membership in the Orlando, Florida-based Florida Health Care Coalition, an organization whose employer members have about 2 million enrollees in their health care plans, Ms. Howard became aware of prescription drug rebates.

Under such arrangements, prescription drug manufacturers give rebates to insurers in exchange for positioning their drugs on lower copayment coverage tiers that cost less for plan enrollees, resulting in the sale of more of that drug-maker's prescriptions.

After learning of the rebates, Ms. Howard approached UnitedHealthcare, the administrator of the school district's prescription



JOSH RITCHIE

Dianne L. Howard with Mike Burke, right, chief operating officer, and E. Wayne Gent, superintendent, at the School District of Palm Beach County's administration building in West Palm Beach, Florida.

drug program, and asked it to forward the rebates to the school district. UnitedHealthcare made a counteroffer: It would discount the administrative fees it charged the school district for running the prescription drug benefits program.

The offer was significant: UnitedHealthcare said it would cut its administrative fee by \$5 per employee per month, for a total savings of \$1.2 million.

But Ms. Howard declined. "I said I don't want the \$5 discount because I wouldn't get the data or even know what the rebates actually were. I said we would take 80% of the rebates."

UnitedHealthcare advised there

was a "cash-flow concern" involving the rebates. The insurer told Ms. Howard that the drug manufacturers didn't immediately distribute rebates and, as a result, the school district could have to wait as long as nine months after a plan year began before the rebates would start to roll in if it wanted a share of them.

Ms. Howard didn't find that argument persuasive: "Cash flow was not a problem for us. So receiving rebates would work for us."

Ultimately, UnitedHealth agreed to pass on 80% of the rebates it received from the drug manufacturers, later increasing it to 100%, saving the school district about \$5

million per year.

"They valued our business," Ms. Howard said. "Our challenge is to stay ahead of where the money is hidden" in the health care system.

In other cases, digging through claims data resulted in significant cost savings. For example, in 2012, the school district began to impose deductibles and coinsurance requirements for diagnostic treatment and magnetic resonance imaging.

Digging through claims data, Ms. Howard saw that deductible and coinsurance had not been applied to the MRI claims. "That didn't make sense," she recalled.

A months-long investigation by UnitedHealthcare revealed that claims had not been properly adjudicated. "We were self-funded, so it was our dollars" that were incorrectly being spent, Ms. Howard said.

In the end, the appropriate cost-sharing requirements were administered, and the school district recouped \$4 million in claims that plan participants, not the school district, were responsible for paying.

Other sources of savings have been periodic audits of health care coverage eligibility. At one time, about 1,000 people who were no longer eligible — such as employees' adult children who, because of their age, were not eligible to remain on their parents' coverage or employees who had terminated employment — still had claims being paid.

"We started chipping away at the problem," Ms. Howard said. Ultimately, enrollment audits saved the school district \$4.4 million by detecting those no longer eligible for coverage, she said.

HOWARD

Continued from previous page

■ Collecting millions of dollars in rebates from prescription drug manufacturers that otherwise would have gone to its health insurer.

■ Rigorously digging into claims payments through a data warehouse to uncover payments that should not have been paid to providers.

■ Redesigning health care plans to include cost-sharing requirements that encourage employees to question providers on the need for certain services and become better health care buyers.

■ Giving employees financial incentives to help their peers engage in activities to improve their health.

From the time she joined the school district in 1995, Ms. Howard said she knew she "could change

things for the better. I knew I could make things happen."

Others concur with that assessment.

"She pushes the envelope and insists on excellence from everyone, including herself," Howard S. Gruverman, senior vice president and managing director with Wells Fargo Insurance Services USA Inc. in Fort Lauderdale, Florida, wrote in a statement recommending Ms. Howard for the award. Mr. Gruverman serves as an insurance consultant for the school district.

Ms. Howard "is not afraid to step out there with cutting-edge ideas," said Marilyn Boursiquot, benefits manager for the School District of Palm Beach County. "We are now starting to see the fruits of her labor."

"She is very focused, while passionate and persuasive. While taking very proactive stances, she does everything with grace," said Kimberly Sandmaier, the district's wellness coordinator.

Ms. Howard's cost savings initiatives span a wide range and she's open to new approaches.

For example, the school district fully insured its health care benefits plans for years with UnitedHealthcare. In fact, the school dis-

"We saw the level of profits the carrier was making. We needed to take that money in-house. We can take that risk."

Dianne L. Howard,
School District of Palm Beach County

trict at one point was the beneficiary of a three-year policy in which the insurer guaranteed that its rates would not increase during that period.

Despite that guarantee, in 2007 Ms. Howard beat the drum for the school district to self-insure group

health care coverage.

"We saw the level of profits the carrier was making. We needed to take that money in-house. We can take that risk," she said.

Her openness to new ideas and a willingness to network with colleagues reaped dividends in other benefit areas.

For example, through her membership in the Florida Health Care Coalition, Ms. Howard found out that prescription drug manufacturers will provide health insurers with rebates in exchange for putting certain drugs on a higher coverage tier in which health plan enrollees will have lower copayment or coinsurance requirements.

After learning about the rebates, she approached UnitedHealthcare, which offered to discount its prescription drug plan administrative fee.

Ms. Howard rejected that approach, however, reasoning that the school district would save far

more if it received those rebates directly. UnitedHealthcare gave in, with the school district eventually collecting 100% of the manufacturers' rebates, now amounting to more than \$5 million a year.

"Our challenge is to stay one step ahead of where the money is hidden," Ms. Howard said.

As Ms. Howard approaches her two-decade employment mark with the School District of Palm Beach County, her enthusiasm for finding new ideas that improve employees' health and save money for the school district and its more than 21,000 employees and their families has not waned.

"I enjoy the process of getting to the deal, whether it's with an insurer or broker or even the unions," she said. "I like the preparation and research so that I'm prepared. And then when a deal is done, it is a tangible accomplishment and often times results in cash savings for the district or the employees."

Financial incentive boosts wellness program participation

Workers offered break on premiums in return for regular screenings, health coaching

BY JERRY GEISEL

What can an employer do to get employees to have regular medical checkups and tests to spot problems before they mushroom into very-expensive-to-treat complications?

The School District of Palm Beach County, based in West Palm Beach, Florida, has an answer: Give employees an immediate and financial incentive by providing a significant reduction in their health insurance premiums.

Launched in 2011, the school district's Wellness Rewards program offers employees a \$50 reduction in the monthly premium they pay for health care coverage. To obtain that premium reduction, employees have to earn 300 points during the plan year, or if their spouses

are covered, the employee and spouse each must earn 300 points.

Those points are earned through participation in a variety of health-related activities. For example, 100 points are earned for completing an online health risk assessment, and another 100 points can be earned by having a blood test to measure cholesterol and glucose levels.

The final 100 points can be earned by having a wellness physical, a colonoscopy, a screening mammogram, cervical cancer screening or participating in and completing an online or telephonic coaching program. Subjects in that program include weight loss, nutrition and stress management.

The results, says Dianne L. Howard, the school district's director of risk management and bene-

fits in West Palm Beach, have been "phenomenal."

For example, 85% of employees now get annual physicals, an increase of more than 50% since the launch of the program. Similarly, 16,000 employees now complete an online health assessment each year, compared with just 25 employees in 2008, she said.

In addition, over the past three years, breast cancer screenings rose 12%, colon cancer screenings climbed 13% and cervical cancer screenings increased 7%.

Already, the wellness rewards program is having a positive effect on the school's district's health care costs, due in part to decreases in hospital admission rates and a drop in outpatient surgeries, Ms. Howard said. The hospital admissions rate per 1,000 covered lives

was 69.8 in 2011, but it dropped to 61.1 per 1,000 covered lives in 2013. The overall monthly medical spend per member dropped to \$288.87 from \$309.45 during this same time period.

And the impact of a wellness program for health plan enrollees with diabetes has been especially strong, she said.

Under that program, launched in 2010, diabetics are required to comply with a checklist of seven evidence-based medicine health actions, such as seeing their doctor twice a year, as well as having their cholesterol and blood sugar levels tested. In return, they receive a 50% reduction in copayments for office visits and for medications and supplies.

Over the past two years, the hospital admission rates for diabetic

employees dropped 33% in 2011 and 2012 and another 2% in 2013. In addition, in 2013, health care spending for those enrolled in the program fell 31% per enrollee per month.

"People are taking better care of themselves," leading to a reduction in hospitalizations and ultimately lower costs, Ms. Howard said.

In all, over the past three years, the diabetes program has saved the school district approximately \$6.5 million, Ms. Howard said.

Additionally, about one-third of health plan participants with diabetes have complications, and participants in that subcategory saw a 39% decrease in medical spending, which Ms. Howard attributed to more consistent care and follow-up.



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JOSH RITCHIE

Dianne L. Howard joins benefits manager Marilyn Boursiquot, left, wellness coordinator Kimberly Sandmaier and the rest of her staff at the School District of Palm Beach County's administration building in West Palm Beach, Florida.

SCHOOL DISTRICT BUCKS NATIONWIDE TREND BY STAYING THE COURSE WITH HMOs

Choice between health plans makes employees consider costs of care

BY JERRY GEISEL

One of the biggest health care benefits plan design trends of the past few years has been the decline of employers offering health maintenance organizations to their employees. With that has come the growth of preferred provider organizations and lately consumer-driven health care plans linked to health savings accounts.

Last year, for example, just 31% of U.S. employers with at least 500 employees offered HMOs, a big drop compared with the 43% of larger employers that offered HMOs in 2009, according to Mercer L.L.C. annual surveys.

But the School District of Palm Beach County, based in West Palm Beach, Florida, is one large employer that has stuck with HMOs. In fact, except for a few hundred employees enrolled in a new high-deductible health care plan, nearly all of the school district's 21,450 employees who have opted for coverage have chosen

one of the two HMOs the district offers. Both HMOs are provided by UnitedHealthcare, with one known as the "low-option" plan because of greater enrollee cost-sharing, and the other called the "high-option" plan because of lower enrollee cost-sharing.

"In our area, HMOs work well. The networks are good, and most hospitals and physicians participate," said Dianne L. Howard, the school district's director of risk management and benefits. "We've found that too many choices made it more complicated for employees."

In addition, adding insurers really doesn't give employees more provider choices, since in the Palm Beach County area most health insurers "have all the hospitals and most of the same physicians in their networks, so the only thing differentiating the plans from the employee or member viewpoint is plan design and customer service," she said.

What is especially appealing

about UnitedHealthcare's HMOs is the design of the plans, Ms. Howard said. The insurer offers open-access HMOs, which means health plan enrollees can go directly to a specialist without having to first go to a primary care physician for a referral, saving time for the enrollee.

Another advantage for opting for UnitedHealthcare's HMO network is its size, Ms. Howard said.

"It is a nationwide network, so even though our employees all work in Palm Beach County, their children — who may be away, for example, at college — have access to physicians throughout the country," she said.

The plan design the school district offers employees doesn't follow the traditional HMO format.

"For example, we have copays for office visits, but we also have coinsurance for any diagnostics, even if done during an office visit. We believe that this cost-sharing keeps skin in the game for members," Ms. Howard said. "We want

our employees to care about the cost of an MRI. So, if they have to pay some of the cost, maybe they will check out the cost before they just go to the nearest hospital."

The two HMOs the school district offers differ significantly in terms of enrollee cost-sharing and premium payments.

In the low-option HMO, monthly employee-paid premiums before any offset for participation in the school district's wellness programs are \$50 for single coverage, \$136 for employee plus children, \$178 for employee plus spouse/domestic partner and \$302 for family coverage.

Monthly premiums employees pay for the high-option HMO are more expensive. Those premiums are \$90 for employee-only coverage, \$270 for employee plus children, \$320 for employee plus spouse/domestic partner and \$460 for family coverage.

The more costly premiums for the high-option HMO reflect its richer coverage of health care

expenses. For example, the low-option HMO has a \$500 individual deductible and a \$1,000 deductible for family coverage. That compares with a \$350 individual deductible and a \$700 deductible for family coverage in the high-option plan.

Similarly, in the low-option HMO, a \$40 copay is imposed for an office visit with a primary care physician, while a \$60 copay is charged for an office visit with a specialist. By contrast, in the high-option plan, a \$25 copay is charged for an office visit to a primary care physician and a \$35 copay is required for an office visit with a specialist.

In addition, in the low-option plan, a 20% coinsurance requirement is imposed after the deductible is met, compared with 10% in the high-option plan.

The high-option plan is only available to employees after they complete two years of service. New hires are required to enroll in the low-option HMO or a recently introduced high-deductible health plan linked to health savings accounts. Currently, only 200 employees are enrolled in this plan.

Even though the high-option HMO plan is closed to new employees, overall enrollment is skewed in favor of the high-option plan, with 6,889 employees enrolled in that plan compared with 4,902 employees in the low-option plan.

The appeal to employees of the low-option HMO is the substantially lower monthly premium. "We thought if employees start in that plan, they would stay because of the lower premium they would pay," Ms. Howard said.

And that, in turn, could generate cost savings for the school district. When employees pay a greater share of costs, through higher deductible and coinsurance, they should become more careful consumers of health care services, experts say.

"You want employees to think about costs. If they are going to have an MRI and they have to pay 20% of the cost, maybe they'll go to a place that will save them and the organization money. If there is no cost-shift, it is much harder to get employees to comparison-shop," Ms. Howard said. "Making that copayment can influence employee behavior."

To help employees make informed decisions when deciding in which plans they want to enroll, the school district has developed an interactive chart that lets them compare their total costs in both plans, factoring in premiums and out-of-pocket expenses.

"In most cases, the low option plan is a better financial choice for employees, even for those with as many as 15 doctor visits a year," she said.

Claims-handling experience primed Howard for success

BY JERRY GEISEL

Dianne L. Howard's success in employee benefits has been shaped by what she describes as eye-opening experiences early in her career.

Ms. Howard, 58, director of risk and benefits management at the West Palm Beach, Florida-based School District of Palm Beach County, grew up in Cocoa Beach, Florida, and attended the University of South Florida in Tampa, where she graduated in 1978 with a degree in management and finance.

In her senior year, she interviewed with Travelers Cos. Inc. for a management-trainee position in Miami. "I just wanted to be in management," she recalled.

In fact, the job Travelers offered

Ms. Howard involved adjusting commercial and personal automobile insurance claims. While working at Travelers, Ms. Howard attended Florida International University in Miami, where in 1984 she earned a master's degree in health care administration.

After a while, Ms. Howard asked Travelers if she could add general liability to her claims adjusting

responsibilities. "I wanted to learn," Ms. Howard said.

Conversations with one of Travelers' clients, the restaurant chain TGI Friday's Inc., led to the next stage in Ms. Howard's career.

"The people at TGI Friday's said, 'You have to get into risk management. That is where you can move up. It will be more rewarding financially, and you'll be able to do

more things, and it will be more exciting,'" Ms. Howard recalled.

With that conversation as a trigger and thinking that it was time for a change after seven years with Travelers, Ms. Howard set her sights on getting a job in risk management.

In 1985, she applied for and was



JOSH RITCHE

Dianne L. Howard

See **PERSONAL** next page

EMPLOYEES AS AMBASSADORS FOR WELLNESS

Giving employees a financial incentive — a \$600-a-year discount on the premiums they pay for their health care coverage — is one key way the School District of Palm Beach County encourages employees to take steps to spot medical conditions before they develop into expensive medical complications.

But the West Palm Beach, Florida-based school district has another program to boost employee participation in activities aimed at improving health.

That program, called Wellness Champions, allows employees to volunteer as "ambassadors for wellness," said Dianne L. Howard, the school district's director of risk management and benefits.

As wellness champions, they engage friends and colleagues to participate in wellness programs and create excitement about leading a healthy lifestyle, and are eligible to receive \$500 annual stipends for organizing wellness-related activities such as runs, walks or exercise groups.

Initially, only 30 employees volunteered for the program, but that number has grown to 180.

"The champions have played an integral part in changing our culture to embrace healthy living and wellness in general," Ms. Howard said. "For example, some champions inspired their school staff so much that some have instilled the healthy habits they have learned into programs for students."

"We didn't think we would ever get to this point, but now we have wellness champions at 99% of our locations," she said.

By Jerry Geisel

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PANEL OF JUDGES SELECTED 2014 BENEFITS MANAGEMENT HONOREES

Business Insurance created the Benefit Manager of the Year® award in 2005 to recognize excellence and innovation in employee benefits management. In 2010, the Benefit Management Honor Roll® was added to honor other outstanding benefits professionals. Honorees are selected by a panel of independent judges that includes the previous year's winner and benefits experts. Judges for the 2014 awards are:

Judges

DR. A. MARK FENDRICK, director of the University of Michigan's Center for Value-Based Insurance Design and a professor at the university.

MATTHEW C. HARMON, benefits delivery and retirement director for J.C. Penney Co. Inc. and the 2013 Benefit Manager of the Year®.

CRAIG HASDAY, chief operating officer of Frenkel Benefits L.L.C.

BRIAN KLEPPER, CEO of the National Business Coalition on Health.

JOHN M. WIRTSHAFTER, a member of law firm McDonald Hopkins L.L.C. and immediate past president of the Worldwide Employee Benefits Network.

Methodology

The judges scored each nominee, according to how well he or she:

- Innovatively and effectively applied benefits programs to solve major problems for his or her organization.
- Exhibited leadership in achieving change within his or her organization.
- Skillfully used technology to administer benefits programs and/or identify and address major problems such as health care cost drivers.
- Established and/or led an effective benefits communication strategy to effectively inform employees of benefits program changes.
- Developed in his or her career and promoted the advancement of the benefits profession.

PERSONAL

Continued from previous page

offered a position as risk manager for the city of North Miami. A key reason North Miami offered her the job: "They liked that I could handle claims," Ms. Howard said, an important qualification, as city claims were adjusted internally.

While in North Miami, she gained new insights into the hardball tactics deployed in some cases by commercial insurers. A few months after working for North Miami, the city's property/casualty insurer said it was going to boost the premium on a current three-year policy contract.

Ms. Howard recalled explaining to the insurer that the premium was set for three years. The insurer didn't budge. "They said they would cancel the policy if the city didn't pay the additional premium," Ms. Howard said. "It was an eye-opening experience."

In all, Ms. Howard said, her time in North Miami had both positive and negative aspects. On the one hand, she felt she lacked sufficient authority to make decisions. "You couldn't close a file without the city manager's approval," she recalled. "I found it a bit restrictive."

Still, she acknowledged that she learned a lot in her two years there.

In 1987, she accepted the position of risk manager for the city of Boca Raton, Florida, where for the first time she got heavily involved in employee benefits issues.

Soon after moving to Boca Raton, Ms. Howard had her first big win.

"I remember talking to and negotiating with the city's health insurer trying to get a premium discount. I spent five minutes on the phone and saved \$250,000," Ms. Howard said. That success demonstrated the effect she could have.

Her time in Boca Raton coincided with the rise of preferred provider organizations. She quickly saw a basic problem with early PPO design: the huge financial incentives some employers, like Boca Raton, gave employees to use doctors and health care facilities participating in the PPO.

"Back then, you didn't even have to pay a copayment for using doctors in the PPO. People liked it," but the lack of participant cost-sharing led to overuse of medical services, she said.

After seven years in Boca Raton, Ms. Howard was again ready for a change.

"I wanted to move up. I reported to the director of finance, and didn't think I would be going anywhere there," she said.

In 1995, Ms. Howard accepted the position as director of risk and benefits management for the

School District of Palm Beach County.

"I knew there were things I could get done here," Ms. Howard said.

And she did. Aided by her experience in Boca Raton — and facing tight deadlines — she implemented a Section 125 plan soon after joining the school district, allowing employees to pay for uncovered health care expenses through pretax contributions to flexible spending accounts, as well as using pretax dollars to pay their share of group health care premiums.

The next problem she tackled was removing from the school district's health care plans about 1,000 enrollees who were still covered even though they no longer worked for the school district.

"There were basic things we needed to fix. We started chipping away at the problems. It was very exciting," she recalled of her early years with the school district.

That enthusiasm remains just as strong 19 years later. "If you work for government, you really can make a difference," she said.

And Ms. Howard never let a childhood accident interfere with her drive to succeed. When she was 14 years old, she dove into her middle school's swimming pool, hitting her head on the bottom. The accident left her a partial quadriplegic, with some paralysis in her arms and legs.

While the accident resulted in Ms. Howard having to use a wheelchair, "I always can figure out a way to get something done — maybe not the way everyone else does it, but some way — so I guess that transfers to my job. I don't want my disability to define me," she said.

"Yes I use a wheelchair, but that is just a part of me. My goal has always been to live as normally as possible and experience as much as possible," she said.

Indeed, Ms. Walker says, "I've gotten on a jet ski," but concedes that she hasn't yet tried skydiving.

Off the job, she enjoys reading, cooking, baking and swimming. "I also enjoy games like Scrabble and canasta. I'm pretty competitive," she said.

Ms. Howard's husband, Brian, retired in 2011 after a 33-year career in program management with IBM Corp. He now works as a substitute school teacher with the Palm Beach County school district.

The Howards have four children, including Kevin, 28, an aviator with the U.S. Navy in Jacksonville, Florida, and 24-year-old triplets: Travis, a third-year student at Georgetown University School of Medicine in Washington; Danielle, a helicopter pilot with the U.S. Navy in Jacksonville; and Dominique, a concierge working out of her home in Jacksonville for The Breakers Hotel.

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**BENEFIT MANAGEMENT
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Sarah Staggs
ZURICH NORTH AMERICA

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Did you know:

- Zurich North America has helped to shape America by insuring iconic infrastructure projects such as the Hoover Dam in Nevada and Madison Square Garden in New York.
- Franklin Delano Roosevelt, the 32nd president of the United States, served as vice president and as a board member of Fidelity & Deposit Co. (now a Zurich-owned company) from 1920 to 1928.
- To commemorate its 100th anniversary in 2012, Zurich Insurance Group donated the desk used by Mr. Roosevelt during his employment at Fidelity & Deposit Co. to the Franklin D. Roosevelt Presidential Library and Museum.

BY JOANNE WOJCIK

Using a strategic yet humanitarian approach to addressing benefits challenges, Sarah Staggs, head of benefits for Zurich North America, has slowed the rate of health care spending at the property/casualty insurer from an annual rate of 20% at the beginning of the decade to just 4% in each of the past four years.

Ms. Staggs also has led a pension risk-reduction strategy that included changes in investments and offering a temporary lump-sum window to a select group of terminated, vested plan participants, resulting in a significant one-time reduction in Zurich's pension liabilities and long-term savings in administrative costs.

For her employee benefits achievements, Ms. Staggs has earned a place on *Business Insurance's* 2014 Benefit Management Honor Roll®.

By fostering a grassroots wellness campaign led by volunteer "wellness champions," Ms. Staggs also has enabled Schaumburg,

Illinois-based Zurich North America, a unit of Swiss insurer Zurich Insurance Group Ltd., to be named one of the nation's Best Employers for Healthy Lifestyles by the Washington-based National Business Group on Health for two consecutive years.

And to help Zurich North America employees achieve financial wellness, Ms. Staggs instituted

"Sarah's very good at taking the data that comes out of the various firms that we work with and translating that into opportunities for us to think about."

Brian Little, Zurich North America

automatic enrollment in the company's 401(k) plan starting with a 6% payroll contribution so employees could maximize the company's matching contribution of 6%.

She also helps employees maximize their retirement savings by trimming administrative costs for the company's 401(k) plan participants through unbundling and

reallocating fees, which enabled their investments to transition to the lowest-cost share classes available from their plan administrator, The Vanguard Group Inc.

"When we define what we do as a company, Zurich's mission is to help our customers understand and protect themselves from risk. And you only have to change one word in that to describe what I feel

like our department's mission is: To help our employees understand and protect themselves from risks," said Ms. Staggs. "Those risks can be health care risks; they can be financial risks; they can be lifestyle risks."

After identifying the risks facing Zurich North America employees, as well as the organization that

keeps them employed, Ms. Staggs developed and implemented a multiyear strategy that continues to evolve as conditions and laws change, such as the passage the Patient Protection and Affordable Care Act in 2010.

"Sarah was talking about this change a long time ago, before health care reform was enacted," said Brian Little, head of human resources for Zurich North America and Ms. Staggs' supervisor. "With Sarah's strategic approach to plan design, we will be able to stay on course without being subject to the Cadillac tax and still be able to have robust benefits," he said, referring to the excise tax on benefits that exceed a certain threshold beginning in 2018.

"Like most companies, you have to sell leadership on the cost benefit for what you're doing, and Sarah's very good on the mathematical end of the equation — helping people understand that if you spend money, you're going to get a return on your investment," Mr. Little said. "But sometimes the return isn't immediate; it's not

next quarter. It may be next year or a couple of years after that. So understanding trends is really important, as is being able to translate that into strategic actions over a longer period of time. Sarah's very good at taking the data that comes out of the various firms that we work with and translating that into opportunities for us to think about."

"Sarah is always thinking ahead and about potential downstream effects," agreed Kristin Bajorat, benefits consultant at Zurich North America and a member of Ms. Staggs' team responsible for health and welfare benefits. "Sometimes you go to seminars where they ask how many companies actually have a strategic plan. We're one of the companies that actually has one."

Ms. Staggs also seeks input from the team she has assembled since joining Zurich North America in 2002, all of whom are subject-matter experts in their own right.

"It's definitely a collaborative

See **STAGGS** next page



MICHAEL MARCOTTE

Sarah Staggs' staff: (from left) Lisa Anderson, benefits consultant; Susann Greco, administrative assistant; Dawn Carthan, benefits consultant; Ms. Staggs; Kristin Bajorat, benefits consultant; Carey Shogren, benefits analyst.

MULTIMEDIA BENEFITS COMMUNICATIONS STRATEGY KEEPS ZURICH EMPLOYEES ENGAGED, INFORMED

BY JOANNE WOJCIK

Zurich North America's benefits communications are carefully crafted, using multiple mediums to appeal to all employees.

An electronic magazine with links to presentations and interactive planning tools enabled the Schaumburg, Illinois-based North American unit of Swiss insurer Zurich Insurance Group Ltd. to "go green" this year while enhancing the annual benefits enrollment experience for its employees at the same time.

A full suite of online tools and resources from UnitedHealthcare, the company's health plan administrator, allows employees to find doctors and compare the cost of plans and treatment, as well as track their health care spending and health savings account balances.

Meanwhile, employees can take an online health risk assessment, enroll in health coaching, or track and redeem their wellness incentives via Zurich North America's branded wellness portal.

The company's volunteer "wellness champions" also produce their own newsletters in each of the company's seven corporate locations in the United States, and the 1,000 employees who work from home receive "Fit Bites," which are snippets of health information, every Friday via email.

In July, the company will introduce Wisser Health, an online interactive decision-support tool that gives employees who have been diagnosed with a particular condition or who are facing surgery the ability to compare and contrast the full range of treatment options available to them, as well as their costs.

For example, "this tool will help an employee diagnosed with carpal tunnel syndrome to decide whether to have surgery, physical therapy or just take two aspirin and rest their wrist," said Sarah Staggs, head of benefits for Zurich North America.

The company's 401(k) plan administrator also produces personalized profiles showing how much an employee's paycheck might change if he or she contributed various

amounts to the plan. These electronic statements are sent to employees who are not maximizing the company match.

Also in July, the benefits department is launching one-click enrollment in the 401(k) plan that will make it easier for current employees not subject to automatic enrollment to enroll immediately in the plan, said Dawn Carthan, benefits consultant at Zurich North America responsible for overseeing the company's 401(k) plan.

In addition to all this electronic communication, the benefits department still disseminates some information, such as employees Total Rewards Statements and periodic home mailers, in print, in response to survey responses citing employee preference and other benefits communication research.

For example, one home mailer that had to be torn open to reveal a prize — a cell phone cleaning cloth — informed employees about health screenings, coaching and other health promotion opportunities.

Pension de-risking helps maintain benefits, contain employer's costs

A pension de-risking strategy that included offering a temporary lump-sum payment window in 2012 to a select group of terminated vested participants resulted in a significant one-time reduction in pension expenses and an ongoing reduction in administrative costs for Zurich North America.

And a change to a more conservative investment mix in response to an asset liability study following the recent economic downturn will further help to protect the assets of the company's defined benefit pension plan going forward, according to Zurich North America Benefits Consultant Lisa Anderson.

Over the next few years, the target allocation of Zurich North America's pension fund assets will gradually transition from 55% equities and 45% bonds to 30% equities and 70% bonds, according to Sarah Staggs, head of benefits for the Schaumburg, Illinois-based North American unit of Swiss insurer Zurich Insurance Group Ltd., who added that she and her team are continuing to explore other de-risking opportunities.

"Unfunded pension liabilities do affect what an insurance company can do with its capital expenditures," she said.

But Zurich North America has no intention of terminating its cash balance plan, because the company's leadership views it as a competitive necessity since approximately 60% of large property/casualty insurers continue to offer defined benefit pension plans, according to Ms. Staggs.

Still, with a large number of terminated vested employees still among its plan participants, many of whom had fairly small balances in the plan, it made sense to offer lump-sum distributions to reduce the amount Zurich North America was paying in premiums to the Pension Benefit Guarantee Corp., she said.

Of the 6,324 terminated vested plan participants eligible for the special lump-sum distribution, 2,415, or 38.19%, accepted the offer. This resulted in a 19% reduction in PBGC premiums, a 12% reduction in administrative costs, and a 9.2% reduction in the company's pension obligations, Ms. Staggs said.

"The goal around de-risking was containing costs and maintaining benefits," Ms. Staggs explained. "And with the costs around pension administration, paying PBGC premiums and costs of searching people down, there's this question: Does someone who worked here 30 years ago still have a vested interest in Zurich, and do we have a vested interest in them? We wanted to make sure that this was seen as spending benefits dollars wisely."

By Joanne Wojcik

STAGGS

Continued from previous page

partnership. That's what makes Sarah a good leader. She listens to what we have to say and asks us to share our ideas," Ms. Bajorat said.

Trained as a teacher, Ms. Staggs also encourages members of her benefits team to pursue continuing education and attend benefits management conferences, where they can gain knowledge to help

Zurich North America foster its culture of health and wealth. The company's business strategy is "to deliver sustainable, profitable growth" while remaining committed to shareholders, customers, employees and the communities in which they live and work.

"I've been in benefits for a long, long time, but I'm still learning from her," said Lisa Anderson, the benefits consultant responsible for Zurich North America's defined benefit pension plan. "I'm just so proud of us as a team."

Ms. Staggs also "is very empa-

thetic when it comes to work/life balance, which for me is critical," said Dawn Carthan, the benefits consultant responsible for Zurich North America's 401(k) plan administration and the mother of a special-needs child.

"Because we're a large company, even small changes in cost potentially impact revenue," Mr. Little noted. "At the same time, it's not simply about how much it costs. It's about how you spend your dollars and what kind of value you get from that, because you really want to have competitive benefits. If you

don't, then you won't have the talent that you need to be successful as an organization. So even though costs are really important, it's not the only decision-making factor we use. It's more about for every dollar we spend, what do we get in return?"

"In her leadership role, Sarah is responsible for implementing a strategy focused on driving change and meeting the needs of Zurich's employees. This strategy has empowered employees to become better health care consumers by providing them with

consumer-centric tools coupled with the appropriate financial incentives. The results of this work are evidenced through the marked reduction in the number of employees displaying high health risks and the market-competitive medical benefits program that has operated at an average cost 15% below industry benchmarks for the past four years," said Scott Ziemba, health and group benefits consultant at Towers Watson in Chicago who has worked closely with Ms. Staggs in developing and implementing Zurich's strategy.

Cost increases slide after introduction of consumer-driven plans

BY JOANNE WOJCIK

Sarah Staggs, head of benefits at Zurich North America, implemented a multi-year consumer-driven strategy to put the brakes on the insurer's health care spending, which had been careening out of control with annual increases of more than 20%.

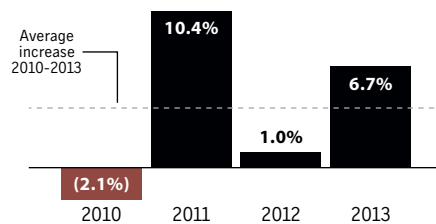
By gradually reducing health care plan offerings to just three levels of consumer-driven health plans administered by a single insurer, and by emphasizing consumerism and wellness, Ms. Staggs has whittled those annual increases down to an average of just 4% over the past four years for the Schaumburg, Illinois-based North American unit of Swiss insurer Zurich Insurance Group Ltd.

"When we first looked at introducing consumer-driven health plans in 2002, we were experiencing 20% to 21% annual increases in medical costs when the rest of the world was probably more like 10% or 11% and moving down. But we weren't moving down, so we realized there was something we had to do relatively quickly," Ms. Staggs recalled.

"I think we were experiencing part of the

TOTAL MEDICAL COSTS

Total medical plan spend by percentage increase year over year.



Source: Zurich North America

problems of what was happening in some of the smaller companies, trying to unify them into a larger program," she said. "We had just merged five companies together to form Zurich North America and had a combination of different health plans and providers."

"We also realized we needed to move to the concept of 'Your health care doesn't cost that \$20 copay. Your doctor's visit cost the company the other \$80 you didn't have to pay.' And we need to make sure that people are getting the right care at the right time in the right place. People were using emergency rooms for basic health care when a doctor's office visit could handle it,"

Ms. Staggs said.

Ms. Staggs' first step was to consolidate health plans, which enabled her to negotiate a better deal with one health plan vendor: United Healthcare.

"We gained some efficiencies there. It made our job of communicating internally easier. We weren't spending so much time explaining the difference between three different vendors. We were explaining what does the plan cover, how should you use it, and here are the tools that can help you make the best decision for you to meet your health care needs," she said.

Her next steps were to introduce a CDHP with a health savings account as an option in 2005, and then to gradually eliminate the plans with lower deductibles, adding two other options with even higher deductibles, all with HSAs. Today, Zurich North America offers just three CDHPs: Choice Plus HSA, with a \$1,250 single/\$2,500 family deductible; Choice Max HSA, with a \$2,000 single/\$4,000 family deductible; and Choice Premier HSA, with a \$2,800/\$5,600 deductible, Ms. Staggs said.

Zurich North America also contributes \$500 to HSAs for single coverage if an

employee contributes at least \$100 of their own money, and \$1,000 for HSAs linked to family coverage if an employee contributes at least \$200. The funds are deposited annually on Jan. 1 so that employees who need to pay for health care expenses within their deductibles early in the year have access to them.

Since the middle-level CDHP has become the most popular benefits option, with 44% of Zurich North America's benefits-eligible employees enrolled, and with the average HSA account balance at the end of 2013 being \$3,396, the consumerism strategy appears to be working, according to Ms. Staggs.

"We have done a lot on the design side with going to full-replacement high-deductible health plans to push the button as far as we can on design, realizing that we've actually reaped some benefits as a company for that because our per capita spend is lower than the national average," Ms. Staggs said. "Part of the benefit of that is employees are responsible for a little bit more of the first dollar, but we look at it also that people have become better consumers. They ask more questions."

News changes. Principles don't.

Since 1916, the world has seen countless changes.

What's news one day is history the next.

One thing remains unchanged- the editorial excellence of Crain Communications. Dependable, accurate, fact-based journalism readers have relied upon for nearly 100 years.

Today, Crain Communications is a business media company that publishes more than 25 trade and consumer newspapers and magazine worldwide as well as websites, events, research and data products that helps readers to succeed.



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Auto-enrollment, transparent fees increase employee retirement savings

More workers take advantage of company's 401(k) plan match

BY JOANNE WOJCIK

By unbundling 401(k) administration fees to make them more transparent and reallocating them more equitably among plan participants, Zurich North America was able to transition to the lowest-cost mutual fund classes available, ensuring employees maximize their retirement investment returns.

And by implementing automatic enrollment for new hires, participation in the insurer's 401(k) plan has grown from 80.21% at the end of 2013 to 85% as of April 2014.

Since the beginning of the year, the North American unit of Swiss insurer Zurich Insurance Group Ltd. has added 658 new employees, 160 of whom were automatically enrolled in a retirement savings plan if they took no action after 45

days. Another 247 employees enrolled on their own, while 36 opted out of the company's 401(k) plan.

When employees are auto-enrolled in Zurich North America's 401(k) plan, 6% of their salaries are automatically withdrawn from their paychecks and deposited into the target date mutual fund closest to their retirement date. The company matches that contribution up to 6% of a contributing employee's salary.

To comply with U.S. Department of Labor regulations requiring greater fee transparency in 401(k) plans, last summer the insurer "stripped out" the percentage-based investment fees that had been included in certain investments and converted them to per-participant fees, said Dawn Carthan, a company bene-

fits consultant.

As a result of this change, Zurich North America was able to transition to the lowest-cost mutual fund classes available, with the target date fund annual fees falling between 5 and 7 basis points and fees on actively managed funds dropping by 5 to 40 basis points, she said.

"We are continuously looking at any savings in fees, whether it's from the administrative cost savings side or a reduction in the expense ratios," Ms. Carthan said.

Implementation of auto-enrollment at 6% of an employee's salary was designed to ensure that employees save adequately for retirement, she said.

"We did an analysis of what the new hires who made an affirmative election were setting aside, and more often than not they were

going in at 6%," she said. "So it just made sense if people who were making that election on their own are going in at 6%, why would we start new hires as part of the auto-enrollment process at a lower percentage?"

Moreover, she said, "being new employees, if it's their first paycheck, they haven't really gotten the chance to say, 'I can't do 6%; it's such a large amount.'"

In addition to auto-enrollment, Zurich North America's 401(k) plan has an annual voluntary escalation feature increasing the employee contribution by 1% each April, which is when pay raises typically take effect.

However, employees can set it up for any month they choose. In addition, employees can defer up to 85% of their annual bonuses into their 401(k) accounts.



MICHAEL MARCOTTE

Sarah Staggs

STAGGS ALWAYS LEARNING, TEACHING

While Sarah Staggs, head of benefits at Zurich North America, can explain the "big picture" impact of benefit costs on the insurer's bottom line, she has the ability to also get "granular" when it comes to explaining minute details to her team members and other employees.

Ms. Staggs said she learned both techniques from her training as a teacher in the Chicago Public Schools system, where she worked after graduating from the University of Illinois at Urbana-Champaign in 1975 with a Bachelor of Arts in social studies.

She said she was later attracted to benefits management because of its focus on education.

Ms. Staggs has two adult daughters, both of whom are pursuing doctorates in their respective fields. Her daughter Emily is living in Montana studying infectious diseases among large mammals, while her daughter Kirsten is studying epidemiology, focusing on the effect of the environment on human health.

Meanwhile, Ms. Staggs says she and her husband, Mark Almborg, consider themselves to be "social scientists."

"We appreciate science, the concept of making a hypothesis and testing it to find out whether it's right or wrong, and then looking at the data and evidence to see where it takes you," she said.

The couple, who live in the Lincoln Square neighborhood on Chicago's north side, also recently became grandparents when their daughter Emily and her husband, Michael O'Connell, gave birth to a daughter, Maeve, on Feb. 10.

"Sometimes when you work with benefits people, they just don't really think about the company impact as much. But Sarah does," observed Brian Little, head of human resources for the Schaumburg, Illinois-based North American unit of Swiss insurer Zurich Insurance Group Ltd. and Ms. Staggs' supervisor. "Sarah's also good at explaining to leadership that 'It's not just about numbers; it's about people and employees.'"

By Joanne Wojcik

Wellness program encourages workers to be health 'champions'

BY JOANNE WOJCIK

Zurich North America has been named one of the nation's Best Employers for Healthy Lifestyles by the National Business Group on Health two years in a row for its grassroots wellness efforts.

The wellness activities of the Schaumburg, Illinois-based North American unit of Swiss insurer Zurich Insurance Group Ltd. are spearheaded by volunteer "wellness champion" committees that coordinate wellness activities locally in each of the company's seven U.S. locations, as well as by a wellness champion committee that inspires the insurer's 1,000 telecommuters "virtually" by sending weekly "Fit Bites" to encourage them to get up from their desks and move.

Although Zurich has a paid wellness coordinator in Overland Park, Kansas, who oversees corporate-led initiatives, "we decided we needed a 'bottom-up' approach to get more people involved," said Sarah Staggs, head of benefits for

Zurich North America.

For example, on May 23, the day of Ms. Staggs' interviews by *Business Insurance* for the 2014 Benefit Management Honor Roll®, Zurich North America's Schaumburg office held a lunchtime walk led by Chief Underwriting Officer Mary Merkel, who also serves as one of the company's wellness champions. The evening before, 122 Zurich North America employees had participated in the 33rd Annual J.P. Morgan Corporate Challenge in downtown Chicago.

"The wellness piece is huge for us," said Brian Little, head of human resources for Zurich North America and Ms. Staggs' supervisor. "Not only does it help our folks stay healthy, the engagement that it causes is really neat. Just to give you an example, three years ago, we had 50 people participate in the J.P. Morgan Corporate Challenge. Yesterday, we had 122. That has a lot to do with the wellness champions program that Sarah created to get people excited about their own personal health and to be an advocate for others."



MICHAEL MARCOTTE

Zurich North America's head of benefits Sarah Staggs (left) helps lead a lunchtime walk at the insurer's headquarters in Schaumburg, Illinois.

Zurich North America also offers outcomes-based incentives to encourage employees to take steps to mitigate their health risks. Employees can earn up to \$200 annually in *HealthFirst* dollars including a \$50 incentive for completing a health risk assessment and biometric screening and \$150 additional dollars for meeting three out of four biometric measures: body mass index less than or equal to 27.5; total cholesterol less than or equal to 200; blood pressure less than or equal to 140/90; and glucose levels less than or equal to 100. Employees who don't meet the measures can also qualify for the incentive if they enroll in health coaching. *Health-*

First is Zurich's branded corporate wellness program.

The incentive is paid in the form of gift cards rather than cash or a premium discount, because the benefits department thought that would get more employees' attention, according to Kristin Bajorat, benefits consultant at Zurich North America.

"That was a thoughtful decision, because we used to give it back as cash in the paycheck," Ms. Bajorat said. "But when it's cash in the paycheck, it tends to be forgotten about, especially with direct deposit. Employees don't always look at their paychecks. But when you have a gift card, you remember, 'I did something for wellness.'"

LARGEST BENEFITS SERVICE PROVIDERS

Ranked by 2013 total benefits services revenue*

| Rank | Company | Headquarters | Website | 2013 total revenue | % increase from 2012 | Total staff | Principal officer |
|------|---------------------------------|------------------------|--|--------------------|----------------------|-------------|---|
| 1 | Mercer L.L.C. | New York | www.mercer.com , www.imercer.com | \$4,241,000,000 | 2.3% | 20,124 | Julio A. Portalatin, president/CEO |
| 2 | Aon Hewitt | Lincolnshire, Illinois | www.aonhewitt.com | \$4,100,000,000 | 5.1% | 30,000 | Kristi Savacool, CEO |
| 3 | Towers Watson & Co. | New York | www.towerswatson.com | \$3,596,784,000 | 5.2% | 14,000 | John Haley, CEO |
| 4 | PricewaterhouseCoopers L.L.P. | New York | www.pwc.com/us/hrs | \$1,599,000,000 | 0.0% | 7,000 | Michael Rendell, global leader-human resource services |
| 5 | Gallagher Benefit Services Inc. | Itasca, Illinois | www.ajg.com | \$564,188,000 | 19.9% | 2,465 | James W. Durkin Jr., president of employee benefit consulting and brokerage |

*Includes benefits consulting, benefits outsourcing and benefits brokering
Source: BI survey
Researched by Angelina Villarreal

EMPLOYEE RESPONSE

Employees who work for a company that has a strong health and well-being orientation feel they have more control, less stress and exercise more than workers at companies with a weak health and well-being orientation.

| Employee response | Strong company orientation | Weak company orientation |
|-------------------------------------|----------------------------|--------------------------|
| Feel in control of their health | 75% | 63% |
| Stress negatively affects work | 25% | 49% |
| General happiness | 66% | 32% |
| Underwent a physical in past year | 72% | 64% |
| Exercise at least three days a week | 62% | 49% |
| Participate in a wellness program | 77% | 46% |

Source: Aon Hewitt, National Business Group on Health 2014

LARGEST EMPLOYEE BENEFITS CONSULTANT SPECIALISTS*

Ranked by 2013 benefit consulting revenue

| Rank | Company | Headquarters | Website | 2013 benefit consulting revenue | % increase from 2012 | % from benefit consulting | Benefit consulting staff | Principal officer |
|------|---------------------------------|------------------|--|---------------------------------|----------------------|---------------------------|--------------------------|---|
| 1 | PricewaterhouseCoopers L.L.P. | New York | www.pwc.com/us/hrs | \$979,000,000 | 0.0% | 61% | N/A | Michael Rendell, global leader-human resource services |
| 2 | Gallagher Benefit Services Inc. | Itasca, Illinois | www.ajg.com | \$519,053,000 | 19.8% | 92% | 1,275 | James W. Durkin Jr., president of employee benefit consulting and brokerage |
| 3 | Buck Consultants L.L.C. | New York | www.buckconsultants.com | \$405,820,000 ¹ | 3.0% | 100% | 1,500 | Fraser Smart, group president |
| 4 | Segal Group Inc. | New York | www.segalgroup.net | \$201,400,000 | 0.5% | 91% | 843 | Howard Fluhr, chairman |
| 5 | Hays Group Inc., dba Hays Cos. | Minneapolis | www.hayscompanies.com | \$65,930,000 | 8.8% | 95% | 253 | James Hays, president/CEO |

*Derive more than 50% of benefits services revenue from benefit consulting services.
¹ BI estimate
Source: BI survey
Researched by Angelina Villarreal

PREFERRED SOURCE

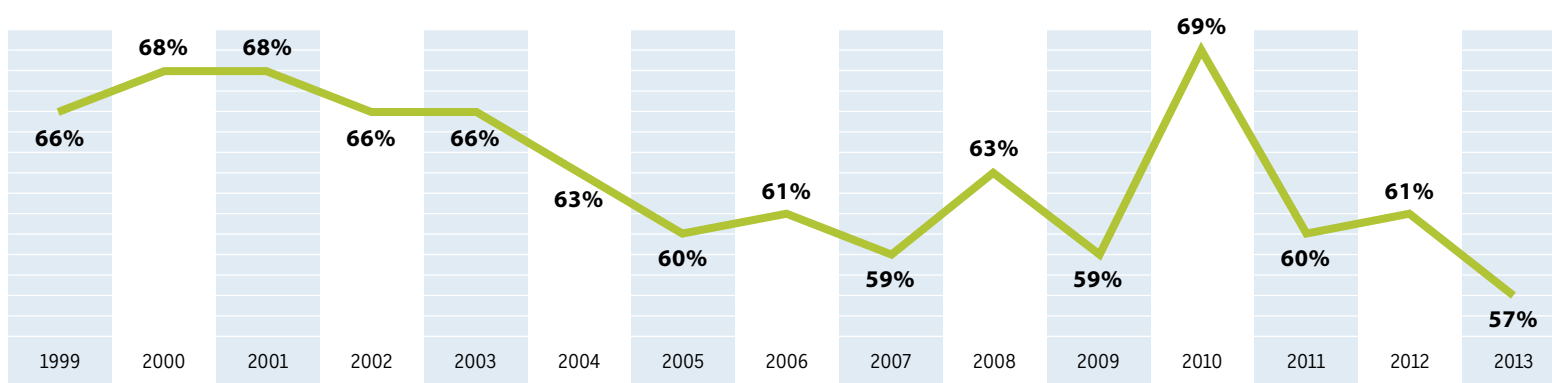
Three of four employers with 500 or fewer employees prefer to buy group health insurance through their existing broker*.

| Source | % using* |
|--|----------|
| Existing broker | 76% |
| Directly from the insurer | 12% |
| Trade or membership association | 9% |
| Small-business health options program ¹ | 8% |
| Individual exchange | 6% |
| All others | 6% |

*Multiple responses permitted.
¹ Offered through the federal government
Source: National Small Business Association 2014

HEALTH BENEFITS OFFERED*

Since 1999, the estimated percentage of U.S. employers that offered health benefits to their employees declined to its lowest level in 2013.



*Firms with 200 or more employees
Source: Kaiser Family Foundation and Health Research & Educational Trust

Cyber certification to bolster U.K. businesses

The U.K. government has launched a cyber security certification framework for businesses to demonstrate they have taken steps to improve their security against cyber threats.

The Cyber Essentials plan, launched by U.K. Universities and Science Minister David Willetts, is backed by American International Group Inc., the British Insurance Brokers' Association, the International Underwriting Association, Marsh L.L.C. and Swiss Re Ltd., the U.K. Department for Business, Innovation & Skills said in a statement.

The plan offers two levels of certification: Cyber Essentials, which is awarded on a self-assessment basis and then verified by an independent certification body; and Cyber Essentials Plus, which includes external testing of a company's cyber security.

It focuses on five main areas of cyber security controls: boundary firewalls and Internet gateways; secure configuration of systems; access control; malware protection; and patch management.

The plan, now open and available to organizations of all sizes in the United Kingdom, uses several accreditation bodies depending on the type of company seeking certification, as well as certification bodies who will be in competition with each other, which means prices for certification will vary, the Department for Business, Innovation and Skills said in the statement.

U.S. Risk Pros upgrades specialized coverage

U.S. Risk Pros, the professional liability division of U.S. Risk Underwriters, has launched an enhanced architects and engineers insurance program.

The program includes the ability to write primary and excess limit options for classes including residential and commercial design/build, construction managers, residential and commercial architects and structural engineers, Dallas-based managing general agency U.S. Risk Insurance Group Inc. said in a statement.

The new policy form includes professional liability, contractor's pollution liability, technology errors and omissions, technology projects, computer network security and multimedia, and advertising liability insurance, according to the statement.

The coverages are available in all 50 states.

Berkshire Specialty launches surety unit

Berkshire Hathaway Specialty Insurance Group, the Boston-based commercial insurance arm of Berkshire Hathaway Inc., said it has added contract surety to its portfolio of specialty insurance products designed for construction companies.

Geoff Delisio has been named senior vice president of its surety business, the company said in a statement.

"With Geoff on board, we will be building a multidisciplinary team of surety



Ironshore Canada enters commercial property market

* Ironshore Canada Ltd., a unit of Ironshore Inc., has entered the commercial property market, adding coverages to its existing suite of specialty products available in the Canadian market.

Toronto-based Ironshore Canada now has licensed approvals to provide property coverage products to specialty sectors in every Canadian province except Quebec, the insurer said in a statement.

Products are available for general commercial property, energy property and builder's risk property, with capacity limits of \$25 million to \$45 million, according to the statement.

The general commercial property offering provides coverages on a primary, quota share, excess of loss or full value basis. It focuses on property and business interruption exposures and catastrophic risks, including earthquakes and floods, the insurer said.

The energy property product provides coverages for property damage, machinery breakdown and business interruption across almost all classes within the specialty sector, including refining and power, the statement said.

The builder's risk property team underwrites the construction of civil engineering projects, and mechanical engineering risks for oil and petrochemical facilities, utilities and heavy manufacturing plants.

underwriting, claims and legal professionals to serve the needs of our construction customers and brokers for the long term," David Bresnahan, executive vice president of Boston-based Berkshire Hathaway Specialty Insurance, said in the statement.

Mr. Delisio will be based in Boston and report directly to Mr. Bresnahan. Previously, he served as senior vice president of surety at Zurich North America.

Broadspire addresses work comp drug costs

Third-party administrator Broadspire Services Inc. has started a physician-dispensing program to reduce workers compensation medication costs and improve safety for injured workers.

The program addresses safety concerns associated with physician dispensation of medications directly to injured workers, the Atlanta-based Crawford & Co. unit said in a statement.

Under an original pilot program, letters were sent to dispensing physicians in states that permit direction of care, telling them about the safety risks and higher costs associated with the practice and giving them information about Broadspire's pharmacy network benefit, which allows the provision of medications associated with the injured worker's compensable condition without any expense to the worker, according to the statement.

Broadspire saw a 46% decrease in costs associated with physician-dispensed medications, the statement said.

Hub starts online crisis management center

Middle-market broker Hub International Ltd. has launched an online crisis management center to inform and prepare its risk management clients for disasters, including cyber, natural, civil unrest and pandemics.

The Hub Crisis Management Center, a product of Chicago-based Hub International's risk services division, provides information, resources and access to risk management and claims experts and to businesses, to help reduce the effect of these disasters, Hub said in a statement.

"Implementing an effective plan before a catastrophic event occurs is the best approach to safeguarding a company's future and keeping families safe," Todd Macumber, president of Hub's international risk services division, said in the statement.

"Being prepared, especially for disasters like hurricanes, makes a tremendous impact in limiting business operation disruptions and profit losses, not to mention that it saves lives."

Since June 1 was the official start of the North American hurricane season, the site is focused this month on hurricane-specific content including pre- and post-preparedness tips, checklists for ensuring business continuity and first-response claim protocols.

Ace offers executive risk cover for multinationals

Ace Ltd. has started selling a global directors and officers liability insurance proposition for multinational organizations. Ace 2488 Global D&O allows Ace to issue policies on behalf of its syndicate 2488 at Lloyd's of London directly in the U.S. and Bermuda, the insurer said in a statement.

The new product streamlines the need to manage multiple global policies, according to the statement.

The addition of Lloyd's coverage through Ace syndicate 2488 to Ace's existing suite of D&O insurance allows Ace to provide coverage in more jurisdictions.

Ace also has service company coverholder status with Lloyd's, which gives Ace binding authority to issue policies on behalf of Ace's syndicate 2488 directly in the U.S. and Bermuda, the insurer said.

DEALS & MOVES

Ryan Specialty partners with Lloyd's on health care underwriting

Chicago-based Ryan Specialty Group L.L.C. has unveiled RSGUM Healthcare, a health care and life science underwriting facility that will offer limits up to \$25 million for professional, general and products liability coverage.

RSGUM Healthcare was created in partnership with RKH Insurance Brokers and features support from Lloyd's of London syndicates Amlin P.L.C., Chaucer P.L.C., Catlin Group, Hiscox Inc., Atrium Underwriters Ltd., RenaissanceRe Holdings Ltd. and Dale Underwriting Partners.

To create RSGUM Healthcare, RSG combined two existing underwriting units: its medical professional liability business, Sapphire Blue, and its medical products liability business, LifeScienceRisk. The overall facility will be managed by Kieran Dempsey, newly appointed Chicago-based CEO of RSGUM Healthcare.

Wholesaler All Risks purchases entertainment broker Alive Risk

Independent wholesale brokerage All Risks Ltd. said it has acquired Alive Risk, a division of Encino, California-based NAS Insurance Services L.L.C. that specializes in insurance for live music and sports events.

Terms of the transaction were not disclosed.

The Alive Risk team is based in Los Angeles and Minneapolis and will continue to operate under this name as a division of Hunt Valley, Maryland-based All Risks.

Integro acquires California benefits broker

Integro Ltd. has acquired the Newport Beach, California-based employee benefits broker and consultant Lugo & Associates Insurance Services Inc.

Terms of the sale were not disclosed.

Lugo & Associates will be rebranded as a unit of New York-based Integro and continue operating from its offices in Newport Beach.

Xerox closes buyout of workers comp firm

Xerox Corp. has completed a deal to acquire workers compensation services provider ISG Services Inc. for \$225 million, adding to the corporation's presence in what it sees as a "growing" workers comp market.

Norwalk, Connecticut-based Xerox and ISG closed the deal last month that will help Xerox substantially expand its workers comp business.

ISG includes StrataCare L.L.C., a medical bill review firm based in Irvine, California, and Bunch CareSolutions, a medical cost control firm based in Lakeland, Florida. The firms have retained their names and continue to be lead by ISG Chairman and CEO Paul Glover.

Xerox also owns Santa Ana, California-based CompIQ, a medical bill review company.

"The workers' compensation industry generates \$60 billion in medical payments each year — that equates to approximately 75 million bills in need of financial validation," Bob Zapfel, president of Xerox's Xerox Services division, which does business process outsourcing, said in a statement.

MINOVA TARGETS GROWTH IN U.S., SOUTH AMERICA, AFRICA

Q Minova has just undergone a strategic review and, as part of that process, received a capital injection from Capital Z Partners L.L.P. to help finance the company's growth. What lessons were learned from that review and what are the next steps?

A The review enabled me and the senior management team to take a really good health check of the business. And we also did a lot of benchmarking against others. One of the key things we found is that because we have been investing in people, for both the broker (BMS Group) and for Pioneer, we did not have enough money available to buy back shares from people who are no longer part of the company. The capital we raised from Capital Z will enable us to buy back those shares and to invest in new people.

Another thing that we learned was that we need to be efficient as we scale up.

What we are building within BMS is the capability to go out around the world and serve bundles of complex risk and match them with capital, whether that be in London, the United States,

Q&A

Bermuda or wherever. With Pioneer, we source that business from other brokers and then provide the expertise to underwrite it.

Q Minova operates broking and underwriting businesses. Why is it important for the company to be active in both areas?

A The announcement about the change of name of the holding company from BMS to Minova is very much about this. We are not a broking business and we are not an underwriting business; we are a holding company that invests in insurance businesses. It is very important that we operate the two

separately, so they have separate boards. For example, the Pioneer board is chaired by former Lloyd's Chairman Max Taylor. BMS is also run and regulated separately. Each of these businesses needs to do the best for its clients. Pioneer cannot lead business from BMS; it is following capacity. And BMS clients have to sign a form to say that it is clear that it is placing business with a company also owned by Minova. There are obviously synergies between the two companies: insurance expertise, management and information technology expertise.

Q The Lloyd's market is clearly an important one for Minova. What are the major attractions of the Lloyd's market? How do you hope to see the market adapt and modernize?

A Why is the Lloyd's market still a success 300 years later? Because of technical ability matched with capacity and licenses to operate. It has a brand and franchise. It has expertise. We place business that is large, technical and has complex insurance requirements, and we can find that



DANE DOUETIL

MINOVA INSURANCE HOLDINGS LTD.

Since last September, Dane Douetil has been group CEO of Minova Insurance Holdings Ltd., which this month changed its name from BMS Associates Ltd. Minova owns a brokerage business, BMS Group Ltd., and an underwriting business, Pioneer Underwriting Ltd. He was CEO of Brit Insurance Holdings P.L.C. from 2005 until 2011. He was selected a commander of the British Empire in 2007 for his services to the insurance industry. He recently spoke with *Business Insurance* Senior Editor Sarah Vesey about Minova's growth strategy. Edited excerpts follow.

expertise better at Lloyd's than anywhere else in the world. But it is important for us to also access capacity elsewhere, so we have offices in Bermuda and in the United States. And we also have a capital market capability.

Q Are there any other areas, either geographically or by business line, that you target for growth?

A Pioneer is predominantly U.K.-based, but we will build out our

presence in the United States. That is very much the focus for Pioneer over the next 12 to 18 months. BMS has offices in Australia, Canada, the United States, London and Bermuda.

We have already started to expand in South America. And there are certain areas of Africa where there are growing insurance needs — a growing middle class, more construction projects. We will grow there through relationships with local brokers.

COMINGS & GOINGS

UP CLOSE: GREG MARTENS

CHICAGO-BASED EXECUTIVE VICE PRESIDENT AND HUMAN CAPITAL PRACTICE LEADER, MIDWEST REGION
Willis North America Inc.

PREVIOUS POSITION: Chicago-based senior vice president and Chicago consulting market leader for Aon Consulting

LOOKING FORWARD TO: Driving growth and continuing to build the human capital brand in the region. As we continue to grow, I am looking forward to connecting the talent at Willis to the region.

GOALS FOR NEW POSITION: This is a newly developed role. The goals are around growth and talent development. It's a way to leverage the talent we have in each of those offices that are somewhat operating in silos on a state-by-state basis.

CHALLENGES FACING INDUSTRY: We continue to see rising health care costs. The Affordable Care Act has created a lot of opportunity and challenges. We will need to continue to navigate the new landscape for our clients, while keeping the costs down. We've seen double-digit growth over the past few years. The Affordable Care Act has added to the costs.



ON A SATURDAY AFTERNOON: Golfing in the morning; pool in the afternoon. Not in January though.

FIRST INDUSTRY JOB: Hewitt & Associates as a compensation consultant.

OUTSIDE THE INDUSTRY, A DREAM JOB: It might be fun to be a high-end tour guide.

ADVICE: Develop an area of expertise and develop your skill set in that area.

THING MOST PEOPLE DON'T KNOW ABOUT ME: I played a couple of sets with Kid Rock when I was in college. I played the bass guitar.

FAVORITE MEAL: Sushi.

BEST CITY: Of course Chicago. But beyond Chicago, I would say Rome.

THOUGHTS ON SMARTPHONES: They are great, but the problem is you can never get away from it.

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U.K. RISK MANAGERS CITE AS TOP CONCERN INSURERS' LACK OF INNOVATION

As rules, risks evolve, collaboration is key to keeping coverage relevant

BY SARAH VEYSEY

BIRMINGHAM, England — Risk managers must work with their brokerages and insurers to devise innovative insurance to cover the changing risks their companies face.

While buyers decry a lack of innovative insurance to address the complex risks they face in areas such as cyber, reputation and supply chain risks, brokers and insurers say they need more data and transparency from risk managers to devise new products.

A lack of innovation was the top concern cited by U.K. risk managers in a recent survey, said Chris McGloin, outgoing chairman of U.K. risk management group Airmic Ltd. and vice president of risk management and insurance at London technology firm Invensys P.L.C.

Twenty-six percent of 110 risk managers, who were asked to rank their biggest concerns in the May and June study by Airmic cited lack of innovation by the insurance market as a major concern.

Helen Pope, incoming chair of Airmic and head of insurable risk at London-based supermarket chain Tesco P.L.C., said the upcoming Solvency II risk-based capital regulations for insurers and reinsurers in Europe may stifle innovation.

She said the rules, which are to go into effect in 2016, will restrict insurers' ability to underwrite policies that span several classes of insurance. "Solvency II is very restrictive on the way insurers can write bespoke policies," she said.

In some cases, however, changes in law and regulations may drive innovation, said Thomas Keist, Zurich-based head of specialties for the Europe, Middle East and Africa

region at Swiss Re Corporate Solutions, a unit of Swiss Re Ltd.

For example, he said rules that went into effect in February in the United Kingdom allow companies that admit a breach of regulations to reach a settlement and indefinitely defer prosecution may alter the way that directors and officers policies are written.

This change may require underwriters to reshape directors and officers coverage to make sure it is applicable, he said. Any increase in defense and claims costs may test policy limits and result in underwriters offering separate limits for each category, he said.

"This may be a driver of the much-sought-after innovation in the industry," he said, as separate limits would effectively enable larger limits.

Experts who gathered at Airmic's annual conference June 16-18 in Birmingham, England, agreed that risk managers, brokers and underwriters must work together if there is to be innovation in the industry.

"It is simplistic to suggest that all the responsibility for innovation rests with the insurer," said George Davies, U.K. chief client officer at Marsh Ltd. in London. "It needs to be three-way. The industry evolves through client need and client understanding.

"The challenge for the broker is to facilitate the relationship between client and underwriter." Then the parties can work together to drive innovation, he said.

"Some of the issues that buyers are facing are so new and so pervasive that we do need to come together to try to build products and services" such as cyber, said Mike Hammond, CEO of Lockton Cos. L.L.P.'s international operations based in London.



Greater collaboration is needed within the industry and with other parties that have particular expertise, he said.

Insurers need quality data from buyers to be able to innovate, said Charles Beresford-Davies, U.K. risk management practice leader at Marsh in London.

"If we are going to start to write more innovative coverage, we need more transparency from clients," said Nigel Bamber, U.K. country manager for XL Group P.L.C. in London. "There is a real benefit from having that dialogue."

For certain risks, historical data that underwriters typically might require to begin underwriting a risk might be limited, XL CEO Mike McGavick said.

"Because the pace of change is so

fast, we will not as an industry be able to innovate at the correct pace if we are asking (buyers) for 10 years' worth of data, so we cannot work in the old way," he said. Insurers need to look for "adjacencies in terms of data," as well as "learn to work more flexibly" and be less restrictive about who "owns solutions," he said.

For example, Mr. McGavick said cyber risk underwriters need to work with experts in that field to come up with coverage that matches clients' needs.

Collaboration is needed for innovation, said Philippe Rocard, CEO of Axa Corporate Solutions, a unit of Paris-based Axa S.A. "Historically, we have not been good at forecasting" future risks and trends, she said.

SAFETY

Continued from page 4

said, adding that Disney views safety as a value. "It's the way we do things," not "something else to do."

"Our parks are clean," Mr. Larsen said. "We don't put people through cleanliness training. ... People develop that lens on their own. It's a value — picking up trash that's a certain size. We try to do some of that with safety."

One way that value is instilled in workers is through "the power of storytelling," Mr. Larsen said, adding that "it's more powerful to share stories than metrics."

Once upon a time, Mr. Larsen said he ended up in the emergency room after mulch flew into his eye while he was edging a lawn without wearing safety glasses. Mr. Larsen said he shares this story with employees, including one who later visited his office holding a pair of chipped safety glasses. The man said a bolt flew up while he was edging, and that it was Mr. Larsen's story that encouraged him to wear the glasses in the first place.

If nothing else, experts say, a safety culture should obliterate the attitude that new workers are at risk, that workers in a dangerous industry are going to get hurt, or even that injuries are going to occur.

ASSE President Kathy Seabrook, who is also president of Mendham, New Jersey-based safety firm Global Solutions Inc., said ideally there should be no distinction between a company's overall culture and its safety culture.

"What we advocate is really looking at an organization holistically, and that's where this culture piece comes in," Ms. Seabrook said.

"An organization that has a process in place to identify and manage safety and health risks ... this is the culture of the organization, where safety is in their DNA and all employees are incented to choose the safe way to work. It is an organization where safety is a value at every level of the organization."

Safety isn't just about commitment or compliance, Ms. Seabrook said. "It's engagement."

INSURERS

Continued from page 4

had never left Iowa.

"How likely is that person to be kidnapped?" Mr. Stein asked. "That's a good example of an insurance transaction that won't pass regulatory muster."

Moreover, Mr. Kilbane said a January ruling by the U.S. Tax Court saying that subsidiaries of Rent-A-Center Inc. are entitled to deduct premiums paid to the company's captive insurer from feder-

al taxes, should provide only limited reassurance to captive owners.

In the case, the IRS accused the rental company of using "sham transactions" and questioned whether a real risk transfer was taking place between the company's subsidiaries and its Bermuda-based captive. While the court ultimately ruled in the company's favor, the IRS still may appeal the ruling, and not all captive owners may be willing to fight a protracted legal battle as Rent-A-Center did, he said.

"The IRS has said not to construe the recent ruling as a safe harbor,"

Mr. Kilbane said. "The IRS will look at specific facts of each case and rule accordingly."

On the world stage, James Morris, Baltimore-based senior manager and director at advisory firm ParenteBeard L.L.C., said all insurers, regardless of size or line of business, are operating in an evolving regulatory environment.

Mr. Morris said that while the Dodd-Frank Wall Street Reform and Consumer Protection Act left the state-based system of insurance regulation untouched, the United States is not entirely

removed from the influence of international regulatory bodies such as the International Association of Insurance Supervisors and the Financial Stability Board of the G-20.

Given the FSB's stated goal of addressing "too big to fail" financial institutions, insurers need to be leery of bank-centric rules being applied to the insurance industry, Mr. Morris said, noting that the Basel, Switzerland-based FSB designated nine global insurers "systemically important."

"The FSB is really starting to flex their muscles," he said.

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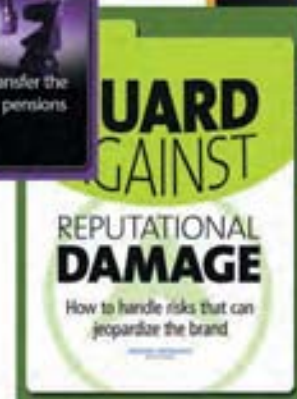
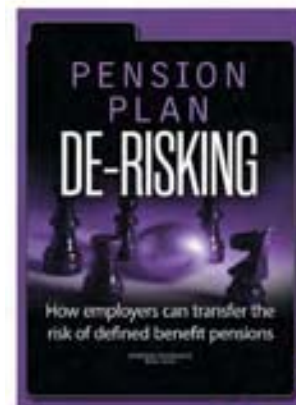
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PATENT

Continued from page 3

of that rendering a claim ‘insolubly ambiguous’ would diminish the definiteness requirement’s public-notice function and foster the innovation-discouraging ‘zone of uncertainty.’”

Wayne Bolio, senior vice president of law and human resources at Nautilus, said the Federal Circuit’s previous standard for determining indefiniteness encouraged patent applicants to draft their patents as broadly as possible to maximize their enforceability against other companies.

“That breeds excessive litigation and encourages patent trolls, which basically are in business to extract licensing fees through agreements, and use the threat of litigation to do it,” Mr. Bolio said.

The Supreme Court, in its June 2 ruling, ordered the Federal Circuit Court to apply a higher standard of “reasonable certainty” to the definiteness of the patent Nautilus is accused of infringing.

The high court also overturned an August 2012 Federal Circuit Court decision against Tempe, Arizona-based software developer Limelight Networks, where the lower court ruled companies can be liable for indirect or “induced” patent infringement even if there has been no direct violation.

“Liability for inducement must be predicated on direct infringement,” Justice Samuel Alito wrote in the court’s opinion. “The Federal Circuit’s contrary view would deprive (the statute) of ascertainable stan-

HISTORY OF LIMELIGHT AND NAUTILUS PATENT CASES

Limelight Networks Inc. v. Akamai Technologies Inc., filed June 2006

Akamai Technologies accused Limelight Networks of infringing on its patented method of delivering electronic data via a content delivery network.

U.S. District Court: Ruled Limelight could not be held liable for direct infringement of Akamai’s method patent because one or more steps in the patent were performed by Limelight’s customers.

U.S. Court of Appeals for the Federal Circuit: Reversed the lower court, ruling Limelight could be held liable for induced infringement if it performed some steps contained in Akamai’s method patent and encouraged others to perform the remaining steps.

U.S. Supreme Court: Overturned the Federal Circuit Court, ruling that induced patent infringement cannot occur if there has been no direct infringement.

Nautilus Inc. v. Biosig Instruments Inc., filed October 2010

Biosig accused Nautilus of infringing on its design patent for hand-held heart rate monitors.

U.S. District Court: Granted Nautilus’ motion for summary judgment and declared Biosig’s patent invalid due to indefiniteness.

U.S. Court of Appeals for the Federal Circuit: Reversed the lower court, ruling that a patent is indefinite only if it is insolubly ambiguous.

U.S. Supreme Court: Overturned Federal Circuit Court ruling, instead saying a patent is invalid if its claims fail to inform the scope of the invention with “reasonable certainty.” Remanded with instructions to re-examine Biosig’s patent against the higher “reasonable certainty” standard.

Did you know?

The Supreme Court’s ruling in *Nautilus* marks the first time the court has reviewed the standard for determining “indefiniteness” since 1942.

dards and require the courts to develop two parallel bodies of infringement law. The notion that conduct which would be infringing in altered circumstances can form the basis for contributory infringement has been rejected, and there is no reason to apply a different rule for inducement.”

Philip Maynard, chief legal officer at Limelight Networks, said the Federal Circuit Court’s ruling

would have been dangerous for industries that rely heavily on patented methods of providing services electronically, such as financial services and online retailers.

“It’s a bullet dodged for the business and innovative communities,” Mr. Maynard said. “It would have exposed a much broader range of companies to infringement claims brought by (nonpracticing entities), as well as create

greater uncertainty as to whether companies’ activities will expose them to liability for patent infringement.”

By emboldening patent trolls to pursue litigation, Mr. Maynard said the Federal Circuit Court’s decision also likely would have exacerbated rapidly escalating costs of defending infringement lawsuits.

Those defense costs “divert resources away from research and development for the purpose of funding these stunningly expensive patent lawsuits,” Mr. Maynard said.

Although the companies pursuing litigation against Limelight and Nautilus are competitors, patent attorneys and consultants said their clients’ interests in the short- and long-term ramifications of the Supreme Court’s rulings have been focused primarily on lawsuits brought by nonpracticing entities.

A recent report by San Francisco-based patent consultant RPX Corp. found that nonpracticing entities accounted for 67% of new patent infringement plaintiffs in 2013 vs. 47% in 2011.

Ironically, experts said the Supreme Court rulings may increase the volume of patent infringement litigation rather than reduce it, at least in the near term, as companies become more optimistic about their chances of invalidating a nonpracticing entity’s competing patent even before the Federal Circuit Court of Appeals develops new definiteness and indirect infringement standards. The circuit court has exclusive jurisdiction over patent appeals.

“Both of these decisions could

give companies one more reason to consider going to court vs. paying the licensing fee,” said Shawn Ram, national technology practice leader at Aon Risk Solutions in San Jose, California. “For those companies that are purchasing patent insurance, that would impose more claims for defense costs against those policies.”

In time, experts said the ruling in *Nautilus* ultimately could dampen nonpracticing patent owners’ efforts to assert infringement against practicing firms.

“Frankly, there are a lot of terms that might have multiple meanings,” said Scott Doyle, the Washington-based chair of Shearman & Sterling L.L.P.’s intellectual property practice. “If it’s unclear what a certain term means within the context of a patent, that patent will probably be found to be indefinite and, therefore, invalid.”

“I think it’s going to motivate a lot of companies to rethink their position, whether they’re defending or prosecuting an infringement claim,” said Jura Zibas, a New York-based partner at Wilson Elser Moskowitz Edelman & Dickler L.L.P.

Experts said the Supreme Court’s ruling for Limelight likely is more immediately beneficial, but only for limited industries.

“There are a lot of software- and Internet-based method patents where you don’t have a single entity performing all of the elements of the method,” said Harold Wegner, a Washington-based partner at Foley & Lardner L.L.P. “Suddenly, under the Limelight ruling, those patents are no longer considered infringing.”

TRIA

Continued from page 3

nuclear, biological, chemical or radiological attacks. Beginning Jan. 1, 2016, the trigger for tapping the program following conventional attacks would increase \$100 million per year up to \$500 million. Meanwhile, the trigger for nuclear, biological, chemical and radiological attacks would remain at the current \$100 million. The Senate bill makes no change to the trigger regardless of the nature of the terrorist attack.

Also starting Jan. 1, 2016, the House legislation would reduce the federal share of payments for losses from conventional terrorist attacks to 80% of insured losses by 2019, the same percentage included in the Senate bill. Under the House bill, though, the federal share for nuclear, biological, chemical and radiological terrorist attacks would remain at 85% of insured losses.

The House bill also seeks to clarify and streamline the terrorism certification process. Beginning on Jan. 1, 2015, the U.S. Treasury secretary would be required to consult with the secretary of Home-



land Security and the U.S. attorney general and issue a preliminary terrorism certification within 15 days of an event. A final determination would be made within 90 days. The bill also would remove the existing \$5 million threshold for certifying acts of terrorism.

Joel Wood, senior vice president of government affairs at the Washington-based Council of Insurance Agents and Brokers, said the House bill was “much improved” from earlier discussion drafts of the measure. “We hope the House acts on it very soon. There are a lot of sensitivities in the differences

HOW THE HOUSE AND SENATE DIFFER ON TRIA

The TRIA Reform Act of 2014 passed by the House Financial Services Committee last week differs significantly from the Terrorism Risk Insurance Program Reauthorization Act of 2014 approved earlier this month by the Senate Banking, Housing and Urban Affairs Committee. Key differences include:

- The House bill would extend the program for five years; the Senate bill would extend it seven years.
- The House bill gradually would increase the response trigger to \$500 million in covered losses from conventional terrorist attacks; the Senate bill would keep the trigger at \$100 million.
- The House bill includes a separate \$100 million trigger for losses stemming from nuclear, biological, chemical or radiological attacks; the Senate bill would make no differentiation.
- The House bill calls on the federal government to consider requiring insurers to pay upfront premiums to participate in the program; the Senate bill is silent on the issue.

Sources: Thomas.gov; House Financial Services Committee

between the House and Senate bills, but we don’t think they’re irreconcilable.”

Industry experts expect Congress to succeed in negotiating a legislative compromise before the program expires at year-end. Since the program was established under the Terrorism Risk Insurance Act of 2002 as a result of the Sept. 11, 2001, terrorist attacks, Congress already has extended it twice.

With the bills, “the key difference is the number of years,” said Thomas J. Santos, vice president of federal affairs at the American

Insurance Association in Washington. “The trigger issue will be an issue that needs to be negotiated. The bifurcation issue will be something that has to be worked on” plus a few smaller issues.

“At the beginning of this Congress, there were questions whether TRIA would be taken up at all” by the House Financial Services Committee, said Nat Wienecke, senior vice president of federal government relations at the Property Casualty Insurers Association of America in Washington. It would have been easy for opponents to stop last week’s House

markup of the bill, but they decided to move the process forward and “I think that’s very important.”

“What bodes well for TRIA is there are primarily five issues and the important thing is they’re easily understood,” he said, noting the program trigger, the duration, differences in recoupment and the bifurcation issue.

“I suspect they could hammer out a deal in a couple of days because the differences between the two bills aren’t too hard to understand,” Mr. Wienecke said.

Jimi Grande, senior vice president of federal and political affairs at the National Association of Mutual Insurance Co.’s Washington office, said, “I think there’s going to be renewal and there appears to be much greater consensus around the Senate bill.

“If you put the Senate bill on the House floor tomorrow, you’d get more than 300 votes, whereas the House bill still needs a lot of improvement so it doesn’t create new burdens for taxpayers through less availability and higher prices,” Mr. Grande said.

Senior Editor Rodd Zolkos in Chicago contributed to this report.



PETER HANCOCK

Age: 56

Job: CEO of AIG Property Casualty since March 2011

Previous financial services experience: executive vice president of finance, risk and investments at AIG; vice chairman, KeyCorp.; chief financial officer and chief risk officer, JPMorgan Chase & Co.; president, Integrated Finance Ltd.

Education: graduate of Oxford University, with bachelor of arts degree in politics, philosophy and economics

AIG

Continued from page 1

get the company back on a sound footing,” said James Auden, managing director at Fitch Ratings Inc. in Chicago. “The company’s a lot different today than it was in 2009.”

Mr. Hancock, 56, was the “natural heir apparent” because of his experience in the broader financial services field, particularly his 20-year stint at JPMorgan Chase & Co., said Gloria Vogel, senior vice president at Drexel Hamilton L.L.C. in New York. Although “some have criticized him for not having enough insurance experience,” Mr. Hancock has run AIG’s property/casualty operation since early 2011, the year after he joined the company, she said.

“I think he’s inheriting a company that’s no longer in crisis, but he’s also inheriting a company with a lot of things that need to be fixed and improved,” said Paul Newsome, managing director at investment banking firm Sandler O’Neill & Partners L.P. in Chicago. “Expenses

are too high in the property/casualty business.”

AIG’s property/casualty side had “some issues on underwriting and they’ve focused the book quite a bit, and they’ve shrunk the book,” Mr. Auden said. But AIG’s combined ratio was above 100% last year, “so they’re still lagging peers in underwriting profitability,” he said.

The big focus for AIG “is to increase the profitability on the property/casualty side and to build on what they’ve done on the life (insurance) side already,” he said.

With softening rates and perhaps a slowing of the global economy, making the property/casualty business profitable will be a challenge, Ms. Vogel said.

However, Mr. Hancock has invested in new technology and science to write the business more efficiently, Ms. Vogel said. “Part of the reason the combined ratio is so high is that the expense ratio has been high. At some point, those investments have to pay off.”

Retaining talent also may be a challenge for Mr. Hancock.

Ms. Vogel said the other contender to succeed Mr. Benmosche was Jay Wintrob, who heads AIG’s life insurance operation, which has been growing.

“Jay’s been with the company a lot longer,” she said. “Anytime there are several people in contention to succeed the CEO and one gets chosen, often the other contenders leave. One of the challenges is making sure Mr. Wintrob doesn’t leave and, if he does, making sure that operation stays intact.”

But another analyst played down the issue. “CEO successions always imply some risk of

additional senior management turnover, but Mr. Hancock’s experience with the current team, the apparently prevalent expectation of his eventual appointment and Mr. Benmosche’s previously announced retirement plans should minimize disruption risk,” Meyer Shields, managing director at Keefe, Bruyette & Woods Inc. in Baltimore, said in an analysis.

Mr. Newsome said AIG’s strategy in repaying the federal assistance was to sell off noncore units, a strategy that continued even after the repayment was completed. Units sold include AIG’s personal lines automobile insurance business, its Japanese life insurance subsidiaries and its aircraft leasing company.

“Broadly speaking, they still have business in both property/casualty and life they need to run off,” Mr. Newsome said. “There are a lot of pieces that need to be run off.”

Mr. Newsome also cited future regulation as a challenge for Mr. Hancock. AIG declined to make Mr. Hancock available to be interviewed for this story.

“There’s uncertainty about how AIG will be regulated. We just don’t know what will happen,” Mr. Newsome said.

“They are still a SIFI regulated by the Fed, and there’s still a lot of uncertainty about what that ultimately means and what sort of capital standards that they’ll have to manage to,” Mr. Auden said.

Managing AIG under whatever regulations are forthcoming will be a challenge, Ms. Vogel said, because SIFI rules “aren’t yet written and the Fed doesn’t have much bench strength in insurance.”

“CEO successions always imply some risk of additional senior management turnover, but Mr. Hancock’s experience with the current team, the apparently prevalent expectation of his eventual appointment and Mr. Benmosche’s previously announced retirement plans should minimize disruption risk.”

Meyer Shields, Keefe, Bruyette & Woods Inc.

HARTFORD AND TRAVELERS MAKE CHANGES

One day before American International Group Inc. named Peter Hancock to be its next CEO, Hartford Financial Services Group Inc. said that Liam McGee, who is credited with turning around the insurer, would step down as president and CEO effective July 1, but will remain as executive chairman until next year.

Christopher J. Swift was promoted to CEO of Hartford from executive vice president and Douglas G. Elliot was promoted to president of the parent from president of commercial markets.

Also on June 10, Travelers Cos Inc. said in a statement that Bill Cunningham, who served as executive vice president of business insurance, “decided to leave the company to pursue other opportunities.”

“Bill has been a great asset to the organization and a big reason why business insurance is a market leader in the United States today,” Travelers Chairman and CEO Jay Fishman said in the statement.

“We would like to thank him for his many significant contributions over his nearly three decades at Travelers and wish him well in his new endeavors.”

By Mark A. Hofmann

LEAVE

Continued from page 1

academic terms at Kansas State University. But before the fall term began, she learned she had cancer. She sought and received a six-month leave from the university to undergo treatment.

On her doctor’s advice as the end of the leave neared, Ms. Hwang asked for an extension of her leave, but the university refused and said it had an inflexible policy that allowed no more than six months’ leave.

Ms. Hwang sued, alleging the university violated the Rehabilitation Act, the equivalent of the Americans with Disabilities Act for publicly funded entities.

A Wichita, Kansas, federal judge dismissed the case, which a three-judge panel of the 10th Circuit upheld unanimously in a late May ruling.

An employee incapable of working more than six months “isn’t an employee capable of performing a job’s essential functions,” the appeals court ruled. Requiring an employer to keep a job open for so long “doesn’t qualify as a reasonable accommodation.”

While Ms. Hwang alleged the university’s policy is inherently discriminatory, the appeals court

MAJOR DISABILITY LEAVE SETTLEMENTS

The U.S. Equal Employment Opportunity Commission has reached several settlements with employers over disability leave policies that allegedly violated the Americans with Disabilities Act. Among them are:

- New York-based Verizon Communications Inc., which paid \$20 million to settle charges in July 2011 for refusing to make exceptions to its “no fault” attendance plans to accommodate employees with disabilities.
- Hoffman Estates, Illinois-based Sears Roebuck & Co., which paid \$6.2 million in a September 2009 consent decree on charges it maintained an inflexible workers compensation leave exhaustion policy and terminated employees instead of providing reasonable accommodations for their disabilities.
- Tacoma, Washington-based Interstate Distributor Co., which paid \$4.85 million in

November 2011 to settle EEOC charges that it automatically terminated workers who needed leave of more than 12 weeks, rather than determining if it would be reasonable accommodation to provide additional leave.

- Eden Prairie, Minnesota-based Super Valu Inc. and its American Drug Stores L.L.C. and Jewel Food Stores Inc. units, which paid \$3.2 million in a January 2011 settlement of charges that the Jewel-Osco supermarket chain terminated employees with disabilities at the end of medical leaves, rather than bringing them back to work with reasonable accommodations.
- Chicago-based United Airlines Inc., which paid \$600,000 in a December 2010 settlement on allegations it refused to allow employees with disabilities to work reduced schedules as a reasonable accommodation.

By Judy Greenwald

disagreed.

“To the contrary, in at least one way an inflexible leave policy can serve to protect rather than threaten the rights of the disabled — by ensuring disabled employees’ leave requests aren’t secretly singled out for discriminatory treatment, as can happen in a leave system with fewer rules, more discretion and less transparency,” the appeals court ruled.

Ms. Hwang’s attorney, Luanne C. Leeds of Leeds Law L.L.C. in Topeka, Kansas, said she has requested

a rehearing before the full appeals court.

The EEOC had no comment on the ruling.

Debbie Norris, vice president of human resources at Greenwood Village, Colorado-based Merrick & Co., said, “We’ll be taking a look at our own policies” for the engineering and architectural design and consulting firm’s 500 employees in 18 offices as a result of the appeals court ruling.

“We have gone beyond what is probably required,” which “makes

it really difficult to run a business if you have people on leave for a year,” Ms. Norris said. “I actually welcome this direction” from the 10th Circuit Court.

While other appeals courts have ruled that a maximum of six months of disability leave is reasonable, “this goes one step further and says there is a time period” of six months, beyond which such leave is too long, said Darren E. Nadel, a shareholder at law firm Littler Mendelson P.C. in Denver.

The ruling reflects an understanding of “the practicalities of the work world when it came to the conclusion that six months is a reasonable amount of time to hold jobs open,” said Judith Biggs, a partner at Holland & Hart L.L.P. in Denver.

“It’s an interesting decision because the conventional wisdom,” given the EEOC’s stance, is that “employers shouldn’t maintain rigid leave policies” and “have an obligation under the ADA to engage in the interactive process to determine whether or not leave is a reasonable accommodation,” said Jonathan T. Hyman, a partner at Kohnman, Jackson & Krantz, P.L.L. in Cleveland.

Some experts think the ruling will be influential.

It will give other appeals courts “something to point to and to recognize” that a six-month leave limit can be considered reasonable, Ms. Biggs said.

It is too soon to say whether the U.S. Supreme Court will take up the matter, because experts say there is no clear split on the issue among the appeals courts.

For now, experts advise employers that already have flexible disability leave policies to keep them.

“It’s always a smart move” to evaluate any employee request, even if it is turned down later, Mr. Nadel said.



HEAR INTERVIEW

Access *Business Insurance's* interactive digital edition to hear Senior Editor Rodd Zolkos talk with William Gouveia of SunGard Availability Services in Jersey City, N.J., about the need for organizations to establish cyber resilience in the face of ever more frequent and more sophisticated cyber attacks.

CYBER

Continued from page 1

we build resilience to protect that value that's there."

With a resilience approach to a cyber breach, companies can get the business up and running, communicate effectively and immediately start a forensic investigation, said Steve Durbin, managing director of the Information Security Forum Ltd. in London.

"The fundamental issue is that there is no way that you ever create 100% security," Mr. Durbin said. "As we look forward, the unexpected is going to become

more frequent. So the challenge for organizations is how do we plan for the unexpected. That's where you get into a resilience approach."

Matthew Goche, director of security consulting at SunGard Availability Services Ltd. in Wayne, Pennsylvania, said, "We think that disaster recovery events are going to be more and more caused by cyber security issues ... as the Internet of all things starts rolling out in a greater way."

Typically, no matter how much is spent on cyber security infrastructure, "events still happen," Mr. Goche said. "Looking at the business risks that you absolutely can't afford to have happen," the

solution is to develop resilience to cyber attacks, "much as you would with a general business continuity or disaster recovery plan."

The risk goes beyond an individual company's walls to cyber attacks affecting suppliers, financial institutions, business partners and others. In fact, widespread reliance on the Internet creates systemic risks with the possibility of "cyber-shock," according to an April report by Zurich and the Washington-based think tank Atlantic Council.

"Risk managers, regulators and organizations with systemwide responsibility all need to focus more on resilience and agility rather than simply prevention,"

according to the report. "In an increasingly interconnected world, risks can strike quickly and from any direction — so, too, it is equally critical that those affected are able to respond rapidly to ride out the shocks."

Mr. Riordan said companies "need to be thinking outside of their four walls." While a company might protect its own operations, how does it guarantee that its suppliers are addressing cyber exposures? With cloud computing growing, how are companies "looking at the rest of the providers in the cloud?" he said.

"You may have the best defenses within your enterprise, but that doesn't mean that some of the entities that you do business with" have equally strong defenses, Mr. Durbin said.

With security and prevention, historically the way that's been approached has been from a readiness and a compliance perspective. "If I've got the best bells and whistles in place, I'm protected," said Randy Hayes, vice president and leader of the predictive intelligence business at Booz Allen Hamilton Inc. in McLean, Virginia.

"The cyber resilience mindset includes all of that, but it goes further," Mr. Hayes said. "Cyber resilience makes the assumption that you can't prevent" cyber attacks.

"The goal is to be able to operate in an environment of these persistent attacks without having your data stolen, without having your trade secrets stolen, without having your money stolen," he said. "What you need with cyber resilience is a war fighting mindset."

William Gouveia, vice president of consulting services at SunGard A.S. in Jersey City, New Jersey, said one important element of achieving cyber resilience is aligning security measures with business objectives.

Chief information security officers focus on protecting organizations against technology risk, but he said it's "very unclear" who should focus on the business risk.

"Too often, we've talked with CISOs and other security leaders who take sort of a one-size-fits-all approach," Mr. Gouveia said. "What we see is technology driving the conversation, not risk driving the conversation."

Mr. Hayes of Booz Allen offered several key steps for companies and organizations to build cyber resilience.

"Understand and know your adversary," he said. "This is really human intelligence. Who are these people, these nation states, these hacktivists and what are they planning to do? What are their objectives and what methods have they used?" Knowing the answers to those questions provides "actionable threat intelligence."

It's also necessary to know what assets a company has and where they are located, like 24-hour network monitoring "with actual trained intelligence analysts and cyber security experts," Mr. Hayes said. "What's needed is a statistics-based approach where you're looking for anomalies across the enterprise vs. a baseline which is normal."

When incidents do occur, "what most incident-response teams do is they go in blind," he said.

COBRA

Continued from page 3

Federal rules say for people who lose employment-based coverage, public exchange coverage cannot begin until the first day of the month following enrollment — resulting in a coverage gap, which the HHS guidance eliminates.

Under the regulations, individuals who lose employment-based coverage could opt for COBRA and, within 60 days, enroll in a public exchange plan. Once the exchange plan goes into effect, HHS said the individual could end COBRA coverage.

An example, provided by Buck Consultants L.L.C., illustrates how this interplay can work:

An employee loses group coverage on Aug. 1. On Sept. 10, he or she enrolls in an exchange plan, with coverage to start on Oct. 1. On Sept. 10, he or she also opts for COBRA, with coverage retroactive to Aug. 1. Retroactive coverage is permitted under COBRA. Then on Sept. 30, the individual drops COBRA, with the exchange coverage starting Oct. 1 and avoiding a gap.

"This gives individuals an addi-

tional window for coverage," said Rich Stover, a Buck Consultants principal in Secaucus, New Jersey.

The approach also could be appealing to those who already have met their health plan deductibles for the year, or want to ensure they can stay with their current doctor. Those individuals could keep their COBRA coverage for a limited period and then move over to an exchange plan.

Meanwhile, the availability of the federal premium subsidies for exchange coverage could lead to curtailment of a plan design in which employers, as part of a severance package, pay COBRA premiums for several months for employees they let go.

Instead, Andy Anderson, a partner at Morgan, Lewis & Bockius L.L.P. in Chicago, said an employer would give those individuals a cash lump sum, which could be used to pay for COBRA or exchange premiums.

That approach could be cost-effective for employers if the individuals opt for exchange plans, since COBRA beneficiaries tend to be heavier users of health care services than other individuals. A rough rule of thumb, consultants say, is that for every dollar COBRA enrollees pay in premi-

PUBLIC HEALTH INSURANCE EXCHANGE ENROLLMENT

Among individuals who enrolled in a public health insurance exchange plan that complies with the health care reform law:

57% Previously uninsured

14% Previously covered by an employer/COBRA

16% Previously covered by a different nongroup health care plan

COST

Among individuals who switched from a nongroup health plan that did not comply with the health care reform law to a compliant nongroup plan:

46% Paid a lower premium

39% Paid a higher premium

Source: Kaiser Family Foundation, June 2014

ums, they incur \$1.50 in health care costs.

"This deals with the adverse selection issue," Mr. Anderson said.

While some experts had said public exchanges under the health care reform law would lead to the end of COBRA coverage, that view is fading.

"COBRA will continue to be a health coverage alternative," said Bruce Richards, individual insurance exchange leader at Mercer

L.L.C. in Richmond, Virginia, noting, for example, that exchange premium subsidies are available only to those with incomes of up to 400% of the federal poverty level.

"COBRA will not disappear," Mr. Anderson said.

"The rumors of COBRA's demise are somewhat overstated. It still will have a role in filling gaps in coverage," said Steve Wojcik, vice president of public policy at the National Business Group on Health in Washington.

"The rumors of COBRA's demise are somewhat overstated. It still will have a role in filling gaps in coverage."

Steve Wojcik,
National Business
Group on Health

Labor Department to extend FMLA benefits to same-sex couples

■ Married same-sex couples nationwide will soon have access to emergency leave benefits under the Family and Medical Leave Act, according to the U.S. Labor Department, which has issued a proposed rule that would expand the definition of “spouse” under the FMLA to include all legally married gay and lesbian couples, regardless of their state of residence. The revision would expand eligibility for spousal FMLA leave benefits to include same-sex couples lawfully married in a U.S. state or territory, or a foreign country, even if the state the couple lives in does not permit or recognize same-sex marriages. “No one should have to choose between succeeding at work and being a loving family caregiver,” Labor Secretary Thomas Perez said in a statement.

Pace of insurance rate hikes slowing in 2014: Moody's

■ Rate increases for U.S. commercial property/casualty liability insurance should continue throughout this year, but at a slower rate than in 2013, according to a Moody's Investors Service Inc. analysis. In “U.S. P&C Insurance Survey: Slowing Commercial Rate Increases as Insurers Shift Toward Growth,” Moody's said the insurers it rates are expecting rate increases of about 6% for liability insurance policies written this year, down from 7.5% last year. Covered liability lines include workers compensation, commercial general liability, professional liability, commercial auto liability and commercial multiple peril. Commercial property rate increases also are expected to drop, to 3% this year from 4.5% last year. Given falling reinsurance prices, Moody's said pricing increases could fall even further during 2014 if there are no major catastrophes. “We expect commercial casualty insurers' combined ratios to decline to about 99% for accident year 2014 and 96.5% for accident year 2015 compared to 103% for accident year 2013,” Moody's said.

Retiring couple needs \$220,000 for future health care costs: Fidelity

■ A 65-year-old couple retiring in 2014 without employer-provided retiree health insurance will need about \$220,000 to pay future medical-related expenses, Fidelity Investments said in an analysis. That's unchanged from last year, with that stability in costs driven by a decrease in utilization of discretionary health care services, such as elective surgeries, and a provision in the 2010 federal health care reform law that has expanded Medicare coverage of brand-name prescription drugs once retirees' drug costs hit a certain level. Of the \$220,000 needed to cover a retired couple's health care expenses, Boston-based Fidelity estimates 32% will go toward paying Medicare Part B and Part D premiums, 45% will be needed for expenses not covered by Medicare, and 23% will be spent on out-of-pocket prescription drug expenses.

Ohio governor signs captive insurer bill

■ Ohio Gov. John Kasich has signed into law a measure allowing the formation of captive insurers and special purpose financial captive insurers in the state. The law requires captives to have a minimum of \$250,000 in capital and

surplus, with the minimum set at \$500,000 for protected cell companies. Ohio captives are required to pay an annual fee of 0.35% on net direct premiums and 0.15% on revenue from assumed reinsurance premiums with an annual minimum fee of \$7,500 and an annual maximum fee of \$250,000. The law requires Ohio-domiciled captives to hold at least one board meeting annually in the state and that their manager be an Ohio resident.

Details emerge about GM plan to pay ignition-switch victims

■ General Motors Co. may end up compensating many more people than the families of 13 victims it has linked to a faulty ignition switch as it considers waiving key legal defenses in order to resolve injury and death cases out of court. Details of the compensation program, while still not final, began to emerge during congressional testimony by GM CEO Mary Barra and in subsequent interviews with plaintiffs lawyers. Ms. Barra said the program, expected to be announced by July, will not reject claims based on a previous settlement with GM or the company's bankruptcy status at the time of the accident. Rep. Diana DeGette, D-Colo., suggested during the hearing there could be as many as 100 deaths linked to the faulty switch, which has prompted a recall of 2.6 million vehicles since February. GM has so far acknowledged 13 fatalities in connection with the defect. A spokesman for Rep. DeGette said her estimate comes from private interviews with GM employees and other individuals close to the matter, conversations with investigators from the National Highway Traffic Safety Administration and access to GM documents given to her staff and the House committee.

Reuters

Massachusetts repeals play-or-pay health care rules

■ The board of directors of the Massachusetts Health Connector, which regulates key provisions of the state's 2006 health care reform law, has formally repealed regulations to the statute that required employers to either offer health care coverage to their employees or pay a fine. The unanimous vote by the board brings to an end a provision in that law that required employers with at least 11 full-time employees to either offer coverage or pay an annual \$295-per-employee fine. Massachusetts Gov. Deval Patrick had sought repeal of the mandate, saying that it was no longer necessary to have such a requirement because of the subsequent passage of the Patient Protection and Affordable Care Act in 2010, which authorized a federal employer health care coverage mandate.

Judge concerned about Apple, Google hiring case settlement

■ A U.S. judge said she had concerns about approving a \$324.5 million settlement involving Apple Inc., Google Inc. and two other tech companies in a lawsuit accusing them of conspiring to avoid poaching each other's workers. Tech employees filed a class action lawsuit against Apple, Google, Intel Inc. and Adobe Systems Inc. in 2011. The four companies agreed to settle with the plaintiffs in April for a total of \$324.5 million. The plaintiffs had planned to ask for about \$3 billion in damages at trial, which could have tripled to \$9 billion under antitrust law. U.S. District Judge Lucy Koh in San Jose, California, must approve the deal. At a court hear-

ing, Judge Koh said the plaintiffs had leverage going into trial against the defendants, given the strength of the evidence in the case. Several emails showed late Apple co-founder Steve Jobs, former Google CEO Eric Schmidt and some of their Silicon Valley rivals hatching plans to enforce their no-poaching agreement. “I just have concerns about whether this is really fair to the class,” Judge Koh said, adding that she had not made a decision about whether to approve the deal.

Reuters

Medtronic reveals 2013 cyber attack

■ Medical device maker Medtronic Inc. said in a regulatory filing released last week that it was the victim of a cyber attack last year. “Medtronic, along with two other large medical device manufacturers, discovered an unauthorized intrusion to our systems that was believed to originate from hackers in Asia,” the company said in a 10-K filing with the U.S. Securities and Exchange Commission. “We concluded that the intrusion did not breach any of the databases where we store patient data.”

Reuters

Lump-sum pension benefit offered to 20,000 NCR retirees

■ NCR Corp. will give about 20,000 pension plan participants now receiving benefits the opportunity to convert their monthly annuity to a lump-sum benefit. The offer is being made to former employees or beneficiaries who began receiving pension benefits between Jan. 1, 1994, and April 1, 2014. The latest lump-sum offer is the second the Duluth, Georgia-based technology company has made in recent years. In 2012, the company gave 23,000 former employees who were eligible for but not yet receiving monthly pension payments the opportunity to convert their future annuity to a lump-sum benefit. The offers are “part of our pension transformation and” are “consistent with our overall de-risking strategy,” NCR Treasurer John Boudreau said in a statement.

Feelings of employment security help injured workers heal faster

■ Workers who are concerned they may be fired after filing a workers compensation claim have longer disability durations than workers who feel secure in their employment, according to a series of reports released by the Workers Compensation Research Institute. Workers who were concerned with losing their jobs after a workplace injury experienced a four-week increase in disability duration, compared with workers who did not have such concerns, WCRI said. Lack of trust in an employee's job security after a work accident also correlated with claimant dissatisfaction with workers comp medical care. Cambridge, Massachusetts-based WCRI interviewed 3,200 injured workers last year in Indiana, Massachusetts, Michigan, Minnesota, North Carolina, Pennsylvania, Virginia and Wisconsin. Among that group, 47% of workers in North Carolina said they were somewhat or very concerned that they would be fired or laid off when they were injured, the highest percentage of the states studied by WCRI. “Among workers who were concerned about being fired, 20% reported big problems getting the services that they or their provider wanted,” WCRI said in the North Carolina report.

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AP PHOTO

Robert Plant and Jimmy Page perform.

Rocker claims Zep stole 'Stairway'

Most fans of rock music have a whole lotta love for the band Led Zeppelin, and the group's iconic hit "Stairway to Heaven" — all eight minutes and two seconds of it — is widely regarded as a classic.

But, 43 years after the track was recorded, a suit has been filed alleging that the song was plagiarized from a guitar player named Wolfe — real name Randy California.

The suit filed late last month in U.S. District Court in Philadelphia on behalf of the estate of Mr. California, who died in 1997, claims that one section of the song was copied from a track called "Taurus" released in 1968 by Spirit, a band of which Mr. California was a founding member.

The complaint seeks statutory damages, defendants' profits, punitive damages and equitable relief in the form of an order that will state that Wolfe is credited as the writer of Stairway to Heaven.

Led Zeppelin guitarist Jimmy Page reportedly has described claims that he copied sections of the song as "ridiculous."

Whiskey standards too stiff in Tennessee

Legislators in Tennessee say a year-old law establishing certain production standards for whiskey bearing the state's name is too stiff.

In order to use the term "Tennessee Whiskey" in their product labels and advertising, liquor companies must produce and store their whiskey in Tennessee, as well as age the liquor in newly made charred oak barrels, according to a law enacted in May 2013.

The requirements outlined in the law closely resemble the distilling and aging process used by the owners of Jack Daniel's, the world's most famous brand of Tennessee whiskey, according to several media reports.

But London-based liquor firm Diageo P.L.C. — the makers of Jack Daniel's closest rival brand, George Dickel — has argued requiring the use of new barrels for every batch of "Tennessee Whiskey" puts smaller whiskey makers at competitive disadvantage, since the new barrels can cost upward of \$600 apiece.

Tennessee lawmakers had hoped to pass an amendment to the 2013 statute earlier this year that would permit liquor companies to reuse oak barrels, according to the Associated Press.

MONEY NOT BUYING FIRST-ROUND WORLD CUP WINS



AP PHOTO

Germany, which tops the money rankings with players worth \$1.08 billion in insurable value, beat ninth-ranked Portugal.

If you want to see more evidence that money doesn't buy success, look at the return on investment for players in the World Cup soccer tournament. According to an analysis by Lloyd's of London of the collective insurable value of the players in each of the 32 national teams playing in the tournament taking place in Brazil this month and next, numbers do lie.

The analysis, which is based largely on the players' salaries and endorsement income, estimates that the collective value of all teams in the tournament is \$10.5 billion.

Given that we know how all of the teams have fared in their early round matches, it's interesting to see how well the investments in soccer talent add up in terms of tournament success.

The ranking starts well enough — Germany, which tops the money rankings with players worth \$1.08 billion in insurable value, had a convincing early win against ninth-ranked Portugal, regardless of the individual talent/insurable value of Portugal's Cristiano Ronaldo.

But below the top ranking things start to go wrong.

According to the money stakes, the second most valuable team and reigning world champion, Spain, should easily have overcome the Netherlands, given that Spain's insurable value at \$997.2 million is more than double that of their opponents. Instead, Netherlands trounced Spain 5-1.

And while the margin of victory may not have been so large, third-ranked England should comfortably have beaten 10th-ranked Italy, based on player value, rather than losing 2-1.

The failure of money to translate into tournament success is good news for the U.S. national soccer team: Team USA came in at number 19 on the insurable value list but still managed to beat the odds and history with its defeat of 14th-ranked Ghana, who knocked out the U.S. in 2006 and 2010.

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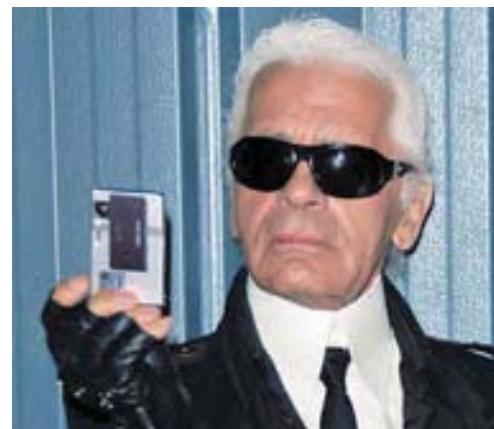
Double dipping as dancing hamster

One of the dancing hamsters from a Kia Motors Corp. commercial — or rather, a dancer who dressed in a hamster costume for the ad — has been charged with insurance fraud for allegedly spinning off with ill-gotten workers compensation and disability benefits, according to the California Department of Insurance.

Leroy Barnes, 27, was struck by a piece of ceiling that fell on him during a sound check for a John Cossette Productions job in June 2010, and received \$51,000 in disability and comp benefits from September 2010 to September 2011, the insurance department said in a statement.

While Mr. Barnes said he was not working while receiving disability benefits, he starred as a dancing hamster in a 2011 commercial for South Korean carmaker Kia, the department said. He allegedly also worked as a backup dancer for Madonna and other stars during the time he was receiving disability payments.

Mr. Barnes has pleaded not guilty to the fraud charges. If convicted, he faces up to five and a half years in jail and restitution of nearly \$74,300, the insurance department said.



S_BUKLEY/SHUTTERSTOCK.COM

Karl Lagerfeld faces copyright lawsuit.

Lagerfeld accused of sneaky move

Karl Lagerfeld, the iconic head designer and creative director of Chanel, has been accused of stealing a design from an unlikely source, Boston-based sportswear company New Balance Athletic Shoe Inc.

New Balance filed a copyright-infringement lawsuit, obtained by TMZ, against Mr. Lagerfeld for allegedly designing a shoe for his eponymous Karl Lagerfeld label that is nearly identical to a New Balance shoe.

The shoe in question allegedly features a block letter "K" logo instead of New Balance's signature "N" logo, copying a design that New Balance has been using since the 1970s, according to TMZ.

There's a big difference in price between the sneakers: The shoe from Lagerfeld's eponymous label is \$360, and the New Balance version is \$112, according to E! News.

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Benefits Outlook™



Research & Data

Facts and figures from the latest research on voluntary benefits, including: trends in sector from life insurance to cancer insurance; emerging voluntary benefits employers plan to offer in 2015; voluntary benefits as part of employers' total rewards programs; and enrollment trends. **Page 22**

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State of the union: Same-sex marriage benefits

How employers are reacting to the changing legal and legislative landscape. **Page 4**

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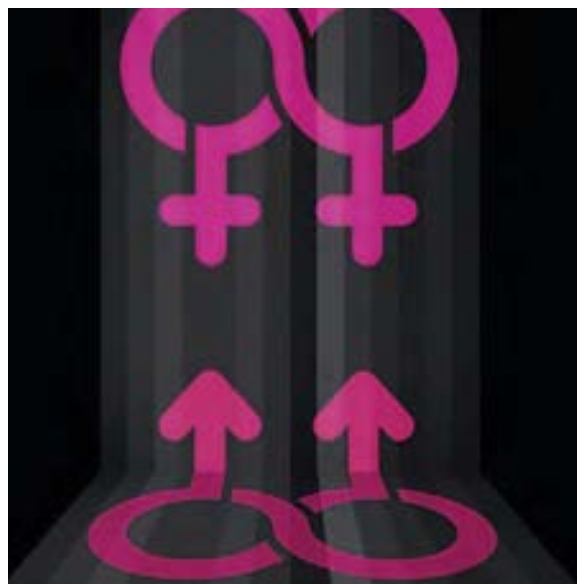
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Benefit options for same-sex couples

The unprecedented expansion of marriage rights for gay and lesbian couples during the past year has put added pressure on employers to review the health care benefits they extend to employees' same-sex spouses and domestic partners.

Page 4



Health Care

Effective wellness programs can lead to significant cost savings but changing behavior of employees is easier said than done. Successful programs can take time. **Page 8**



Retirement & Investment

Hybrid pension plans offer advantages to employers that want to provide more than a savings plan but need to contain their liabilities. **Page 14**



Voluntary Benefits

Products such as critical illness, accident and hospital indemnity can help fill gaps in coverage created by high-deductible health plans. **Page 17**

Questions & Answers

Brian Klepper, CEO of the National Business Coalition on Health, columnist, speaker and adviser to the Lundberg Institute speaks with Senior Editor Joanne Wojcik about mechanisms underlying America's health care cost crisis. **Page 20**



International Benefits

U.S. companies expanding into Asia need to develop international benefits offerings to employees transferred overseas. **Page 21**

Research & Data

Tracking trends in voluntary benefits programs: enrollment, projected future offerings, importance among total rewards **Page 22**

Benefits expansion at the fore

Since the U.S. Supreme Court's landmark decision a year ago to strike down Section 3 of the 1996 Defense of Marriage Act, regulatory agencies, courts and legislators have been moving quickly to expand married gay and lesbian



Paul Bomberger, Managing Editor

couples' access to spousal rights and benefits.

The trend is expected to continue, as 13 states have legalized same-sex marriage or had their state-level prohibitions of the practice overturned in the last year. At the same time, employers have been forced to hastily review, and in many cases, revamp their health care benefits for employees' gay spouses and domestic partners.

Our cover story package in this summer edition of *Crain's Benefits Outlook* provides employers with a comprehensive overview of the evolving regulatory requirements and pending litigation regarding same-sex spousal rights, as well as best practices for ensuring that their benefit plans remain compliant, effective and attractive to their employees.

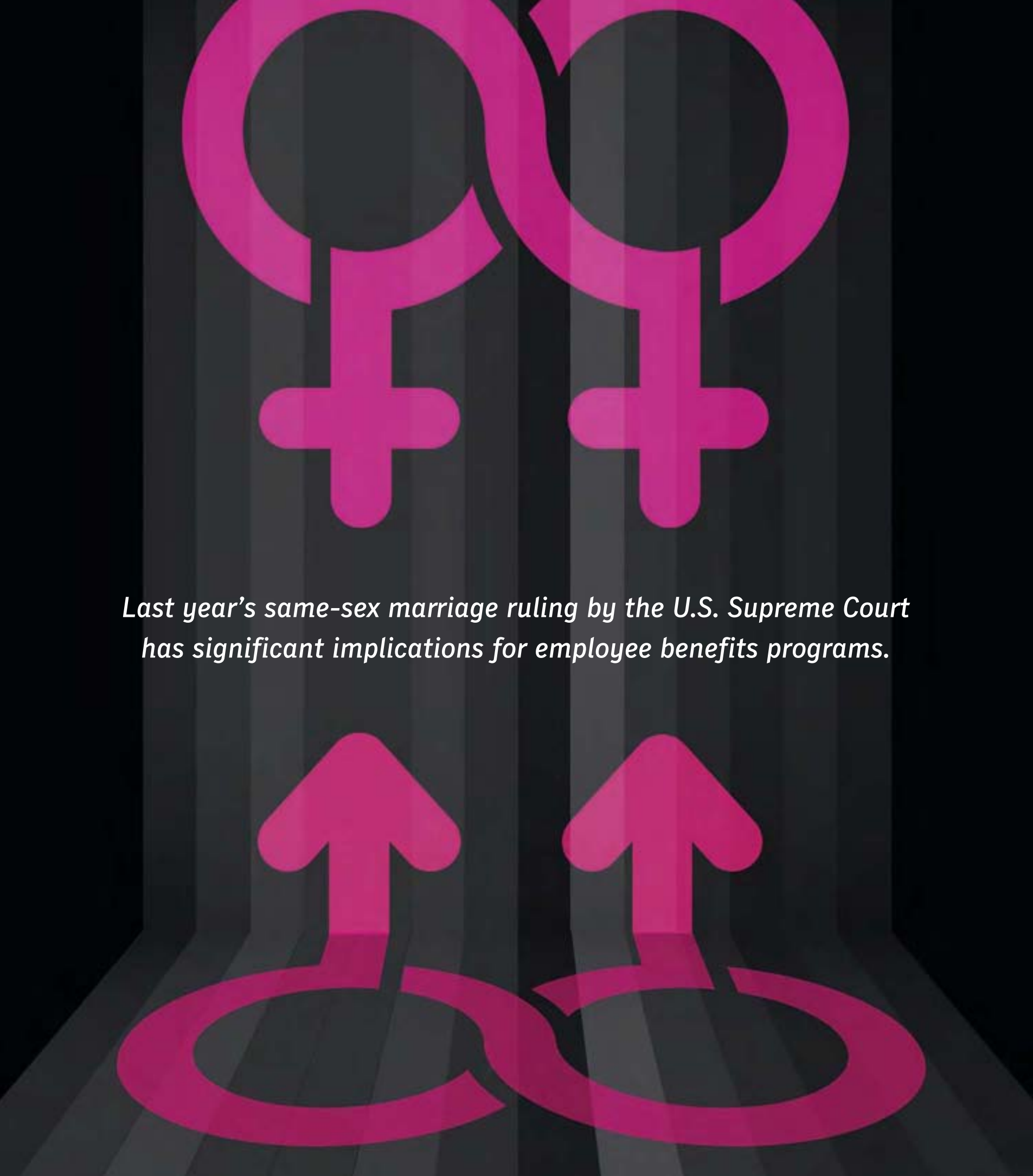
Looking ahead, our story points out that it remains uncertain whether employers will continue offering health benefits to same-sex domestic partners or heterosexual domestic partners. We hope employers indeed will afford domestic partners, whether same-sex or opposite-sex, the same health benefits offered to comparable married couples.

It would be disconcerting if employers eventually react to this spreading national trend of recognizing same-sex marriage by curtailing benefits for same-sex or heterosexual domestic partners — even if they do so to alleviate difficult tax issues or potentially reduce the risk of a gender discrimination challenge under federal law.

Of course, there are costs to consider, as employers' health care expenses keep increasing every year. Still, it's troubling that an employer poll conducted last summer after the court's landmark decision by the International Foundation of Employee Benefit Plans found that nearly 50% of employers offering benefits to same-sex domestic partners were not planning to extend matching coverage to opposite-sex partners in 2014.

The high court's ruling enables our country to take a quantum leap forward with marriage equality. In the same progressive vein, more employers could seize the moment and finally offer health care coverage to domestic partners of their employees, be they gay or straight.

Cover Story



Last year's same-sex marriage ruling by the U.S. Supreme Court has significant implications for employee benefits programs.

Employers adjust health benefits for gay marriage

BY MATT DUNNING

The unprecedented expansion of marriage rights for gay and lesbian couples in the past year has exerted added pressure on employers to review the health care benefits they extend to employees' same-sex spouses and domestic partners.

A year ago, the U.S. Supreme Court struck down a core provision of the 1996 Defense of Marriage Act that excluded married same-sex couples from recognition under federal law.

The high court's June 2013 ruling in *United States v. Windsor* touched off a series of revisions and updates to federal statutes under which married gay and lesbian couples were previously denied the same rights and protections afforded to opposite-sex married couples, including preferential tax treatment, eligibility rights and other spousal benefits via an employer-sponsored health insurance plan.

"The Windsor decision does, I think, make things simpler for employers in the long term," said Todd Solomon, a Chicago-based partner at McDermott Will & Emery L.L.P. "In the short term, though, there's obviously been a lot of upheaval and changes made in the last year."

Additionally, the Supreme Court's verdict has lent considerable strength to the dozens of pending lawsuits seeking to overturn the remaining state-level statutory and constitutional prohibitions against gay marriage, several of which have already been struck down in federal and state district courts.

And while the seismic shifts in the legal landscape for married same-sex couples has only a limited bearing on employee health benefits provided to domestic partners from a compliance perspective, the changes have raised substantive strategic questions about employers' intent to continue providing domestic partner benefits for same-sex or opposite-sex couples.

Where employers' health benefit programs are concerned, the broadest and most immediate regulatory change resulting from the

BEFORE AND AFTER HIGH COURT'S DOMA RULING

Health care coverage strategies for same-sex spouses and domestic partners among U.S. employers polled in August 2013, two months after the U.S. Supreme Court's decision overturning provisions of the Defense of Marriage Act that barred federal recognition of legal same-sex marriages.

Coverage provided pre-DOMA ruling

Same-sex spouses: 61.4%

Same-sex domestic partners and/or civil unions: 54.9%

Opposite-sex domestic partners: 45.0%

Coverage strategies post-DOMA ruling (employers not covering domestic partners/civil unions)

Offering coverage to ...

Same-sex domestic partners: 16.6%

Same-sex civil unions: 15.0%

Opposite-sex domestic partners: 10.5%

Coverage strategies post-DOMA ruling (employers covering domestic partners/civil unions)

Continue covering ...

Same-sex domestic partners: 82.3%

Same-sex civil unions: 77.5%

Opposite-sex domestic partners: 39.9%

Source: International Foundation of Employee Benefit Plans

ruling was the extension of equal recognition and protection for legally wed same-sex couples under the U.S. Tax Code, regardless of their state of residence.

"That's probably the closest the federal government can get to a national definition of spouses that includes married same-sex couples without taking the next (legislative) steps," said Rachel Cutler Shim, a Chicago-based tax, benefits and wealth planning attorney at Reed Smith L.L.P.

That rule change, which went into effect Sept. 16, 2013, likely provided a considerable measure of administrative relief for the 61% of employers that already offered health care coverage to their employees' same-sex spouses at the time of the Supreme Court's ruling, according to an August 2013 survey by the International Foundation of Employee Benefit Plans.

With married same-sex and opposite-sex couples on equal tax footing with the IRS, employers no longer are required to pay federal payroll taxes for medical, dental and vision insurance provided to same-sex spouses, nor are gay and lesbian employees required to pay federal taxes on contributions made toward their spouses' coverage.

The U.S. Department of the Treasury and Internal Revenue Service further ruled that employers and employees can seek refunds for taxes paid on same-sex spousal health care coverage in plan years between 2010 and 2013.

Under the agencies' revenue ruling, employers cannot collect refunds or credits for employment or Social Security and Medicare tax overpayments until they have repaid or reimbursed over-collected taxes to their employees. It remains unclear as to whether

"The Windsor decision does, I think, make things simpler for employers in the long term. In the short term, though, there's obviously been a lot of upheaval and changes made in the last year."

Todd Solomon,
McDermott Will & Emery
L.L.P.

Same-sex marriage litigation

31
1

Of the 31 states that prohibit same-sex marriage, all but one — North Dakota — is facing lawsuits in state and/or federal courts.

52
28

All told, 52 lawsuits challenging states' same-sex marriage bans are pending in federal district and appeals courts, and another 28 lawsuits are pending in state courts.

employers are required to fulfill employees for corrected earnings statements if the company has no intention of seeking a refund for itself.

"In my experience, almost every employer is forgoing the refund opportunity because it's just not that much money and it's a very complicated process," Mr. Solomon said. "It's not clear to me whether that employer has an obligation to issue a corrected W-2 to employees if asked for one, and I think a lot of employers will be asked as people work through this."

Spending accounts, cafeteria plans

The Supreme Court's partial overturn of DOMA also led the IRS to revise its rules regarding cafeteria health plans. Prior to the ruling, employers could not allow married gay and lesbian employees to elect accident and health care coverage on a pretax basis under a cafeteria plan unless the spouse also qualified as a tax dependent.

The IRS said in a December 2013 guidance document that employees would be permitted to enroll their same-sex spouses for pretax coverage under a cafeteria plan retroactively to the beginning of whichever plan year includes the date of the *Windsor* ruling.

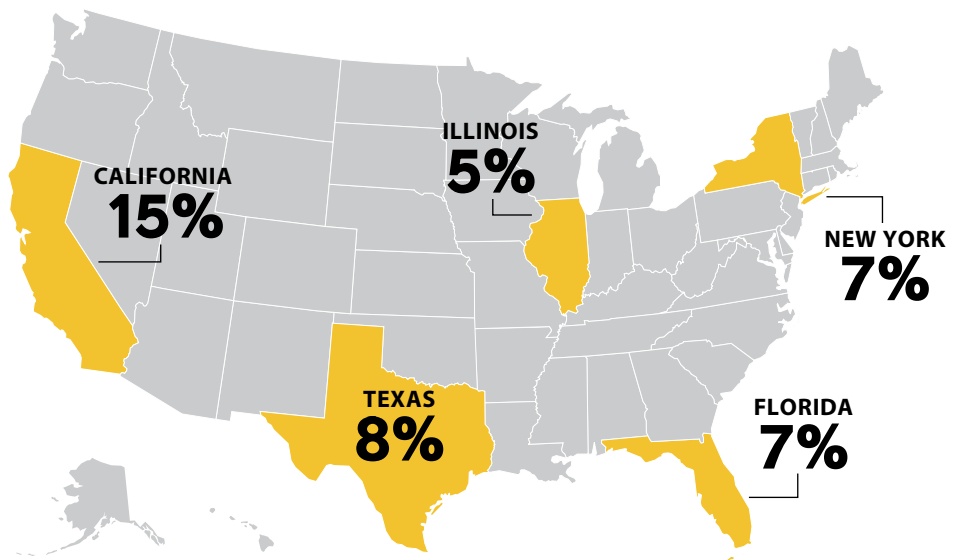
Additionally, employees now are permitted to use tax-favored spending accounts — including health, dependent care, adoption assistance and flexible spending accounts — to reimburse covered expenses incurred by their same-sex spouses or their spouses' dependents, as long as those expenses were incurred within the plan year that includes the date of the Supreme Court's decision or the date of their marriage, whichever is later.

Group health eligibility

Legally speaking, the *Windsor* verdict and the subsequent regulatory updates have done relatively little to change the extent to which employers are required by federal law to offer health care benefits to their employ-

U.S. SAME-SEX HOUSEHOLDS

The five states with the highest percentage of same-sex households, according to a 2012-2013 Prudential research report.



Source: Prudential Financial Inc.

ees' same-sex spouses.

Under the Consolidated Omnibus Budget Reconciliation Act, or COBRA, employers must now offer continual health care coverage to same-sex spouses as a result of the Supreme Court's ruling. Same-sex spouses also have been extended special enrollment and nondiscrimination rights under the Health Insurance Portability and Accountability Act.

Additionally, the U.S. Health and Human Services Department clarified in March that the nondiscrimination provisions of the Patient Protection and Affordable Care Act prohibit health insurers from offering group health care plans that include disparate coverage for opposite-sex and same-sex spouses.

However, employers' obligations to provide spousal health care coverage remain governed primarily according to their funding structure and only secondarily by the

states in which they operate.

Employers that provide fully insured health care plans in the 19 states and District of Columbia that have legalized same-sex marriage are generally required to offer spousal coverage to same-sex and opposite-sex couples in equal measure.

Meanwhile, despite the U.S. Department of Labor's expanded definitions of "spouse" and "marriage" under the Employee Retirement Income Security Act, employers that self-insure their group health benefit plans still have discretionary authority to define eligibility for spousal coverage as they see fit, regardless of state laws.

Experts have warned that although federal law does not necessarily require self-insured employers to extend their health plan to gay and lesbian spouses, the broader protections now afforded to married same-sex couples could lead to civil litigation under federal and/or state nondiscrimination laws.

Continuing to offer spousal health benefits to opposite-sex married couples without extending equal benefits to married gay and lesbian couples could expose self-insured employers to accusations of gender-based discrimination under Title VII of the Civil Rights Act of 1964, particularly employers located in states that have legalized same-sex marriage, experts say.

"That's becoming more and more likely, given some of the litigation and opinions that have come out so far (on states' same-sex marriage bans)," said Jay Kirschbaum, St. Louis-based national human capital practice leader at Willis North America Inc. "It might depend on the state that the employer operates in, but I would think that if there's no protection for making the distinction between opposite-sex spouses and same-sex spouses at the state level, then accordingly there would be no protection for that kind of distinction at the federal level."

Ruling undercuts states' defense

The U.S. Supreme Court's June 2013 ruling in *United States v. Windsor*, while not invalidating any state laws banning same-sex marriage, appears to have substantially undermined states' efforts to defend those laws in court.

Since October of last year, federal and state judges in Arkansas, Idaho, Michigan, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia and Wisconsin have struck down those states' bans on same-sex marriage, relying heavily on the *Windsor* ruling alongside previous Supreme Court decisions establishing marriage as a fundamental right protected by the U.S. Constitution.

However, state governments have been permitted in most cases to postpone issuing marriage licenses to gay and lesbian couples or updating their laws and regulations related to spousal benefits until after their separate appeals to higher courts have been exhausted.

For some state governments, that process is already well underway. Federal judges in the 4th and 10th U.S. Circuit Courts of Appeals were expected to decide by the end of June whether

they uphold previous U.S. District Court decisions legalizing same-sex marriage in Oklahoma, Utah and Virginia, potentially setting the stage for another landmark ruling by the Supreme Court on the issue of same-sex marriage.

"I think it's very likely that this question will eventually reach the Supreme Court, but it's probably going to take a while," said Todd Solomon, a Chicago-based partner at McDermott Will & Emery L.L.P. "If you look at where we were a year ago, the idea that we'd see the ruling that we have in some of the states was pretty unfathomable."

If states' same-sex marriage bans are ultimately struck down en masse by the Supreme Court — or gradually by the U.S. Circuit Courts, in the unlikely event that they all separately rule in favor of overturning the bans — the practical implications on state laws regarding spousal eligibility for group health care coverage would primarily be the concern of fully insured employers, since self-insured employers are largely not subject to state insurance laws.

By Matt Dunning

Same-sex marriage rules may affect coverage for domestic partnerships

Though none of the recent regulatory updates regarding health care benefits for legally married same-sex couples apply directly to couples in domestic partnerships, the rule changes could substantially affect employers' decisions to cover such arrangements under their health benefits plans in the long term.

So far, very few employers have indicated plans to discontinue their benefit offerings for gay and lesbian domestic partnerships as a result of U.S. Supreme Court's June 2013 ruling on the Defense of Marriage Act of 1996 or the subsequent regulatory changes for same-sex spouses.

More than 78% of employers polled in August 2013 by the International Foundation of Employee Benefit Plans were offering health care benefits to their employees' same-sex domestic partnerships prior to the Supreme Court's ruling.

Two months after the decision was issued, more than 82% of those employers said they intended to continue to offer benefits to same-sex domestic partners.

However, with same-sex spouses now able to access the same tax benefits and other protections available to married opposite-sex

couples, some employers have recently signaled an interest in dropping coverage for domestic partners from their health care plans beginning in the 2015 plan year.

"To the extent that the relevant state law allows them to do it, I've spoken with a few employers that just for administrative reasons want to eliminate the domestic partnership coverage altogether, largely so they don't have to continue dealing with some of the difficult tax issues," said Jay Kirschbaum, St. Louis-based national human capital practice leader at Willis North America Inc. "It's one less administrative and political hurdle for human resource managers to contend with."

A key factor in many employers' decisions about whether they will continue to offer benefits to same-sex domestic partners could be the extent to which they already cover — or are willing to cover — opposite-sex domestic partners.

Fifty-five percent of employers polled by the IFEBP were not covering opposite-sex domestic partners at the time of the Supreme Court's ruling, but one in five of those employers said they were considering offering the coverage going forward.

Conversely, employers that were covering

opposite-sex domestic partners last year were about half as likely to consider ending those benefits in 2014.

Similar to the risk borne by self-insured employers who offer spousal health care coverage to married opposite-sex couples but not married same-sex couples, experts say an employer that continues to exclude opposite-sex couples from the domestic partner coverage it offers to same-sex couples could potentially be sued for gender discrimination under federal law. A sexual orientation discrimination claim also might be possible, but only if the target of that lawsuit is a fully insured employer in one of the 21 states plus the District of Columbia that have passed such protections.

"A sexual orientation discrimination claim would seem like the obvious way to go, but that kind of discrimination isn't actionable under federal law," said Todd Solomon, a Chicago-based partner at McDermott Will & Emery L.L.P. "There's enough background guidance from the (U.S. Equal Employment Opportunity Commission) to suggest that they're going to view sexual orientation discrimination as a form of gender bias."

By Matt Dunning

A key factor in many employers' decisions about whether they will continue to offer benefits to same-sex domestic partners could be the extent to which they already cover — or are willing to cover — opposite-sex domestic partners.

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Healthy workplaces



Wellness programs have taken on
increasing importance as health care costs
balloon, but changing employees' health
behaviors can be challenging.

BY MATT DUNNING

Employers increasingly are focusing their workplace wellness efforts on modifying their employees' health management behaviors and habits, recognizing their inextricable link with the development of costly conditions and diseases.

Sixty-one percent of employers polled in Willis North America Inc.'s 2014 "Health and Productivity Survey" said their employees' poor health habits were among their top impediments to managing health care costs, up from 48% of employers polled in the previous year.

"Employers today are really looking at what's driving their employees' behavior when it comes to managing their health," said Dr. Ron Leopold, Atlanta-based national practice leader for health outcomes at Willis North America. "What that says is employers are putting a greater level of scrutiny on whether a wellness program actually gets employees to change their behaviors and, thusly, improve their health outcomes."

Accordingly, employers are now designing wellness programs aimed at curbing employees' high-risk health behaviors and, in some cases, seeing marked reductions in their population health risks (see story, page 10).

Designing and implementing a workplace health management strategy — or reconfiguring an existing one — in a way that motivates employees to make substantive changes to their health behaviors is no easy undertaking, even for the most sophisticated employers.

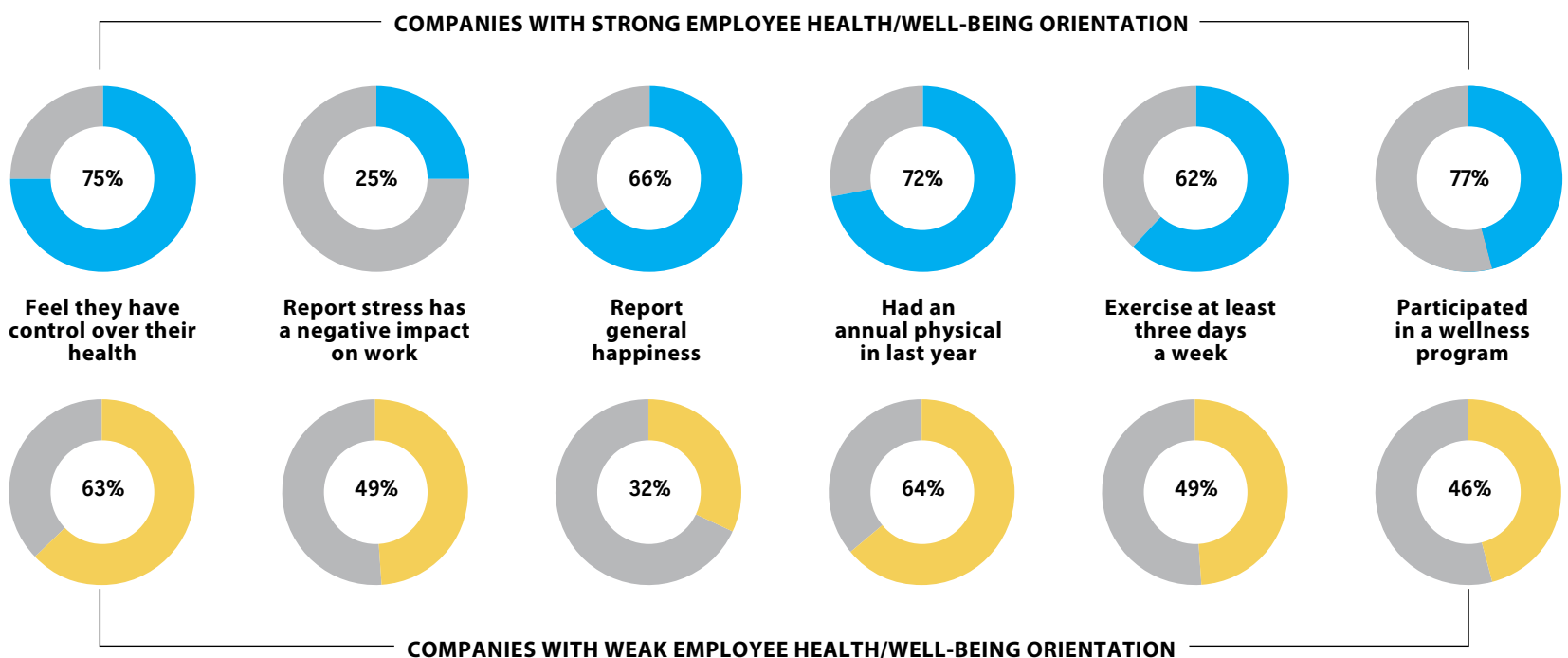
At its core, a workplace wellness or health management program aimed at improving employees' health behaviors must recognize the complex and often sensitive nature of those habits.

"In health, changing a behavior has to be something that employees decide on their own to do, no matter what the goal is," said Randi Dukoff, a partner at New York-based Vital Advantage Consulting.

Because health management is by its nature a deeply personal issue, employees are likely to reject an employer's attempt to enforce adherence to certain health behaviors, particularly if the program's messaging implies, however subtly, that the

HEALTH-ORIENTED WORKPLACES

There's a positive link between healthy employees and firms with a strong employee health orientation.



Source: Aon Hewitt

employer knows better than they do when it comes to their health management choices.

“When employees feel like they’re being saddled with a program, that’s where you run into feelings of mistrust and resistance,” Ms. Dukoff said. “There’s a big difference between being

told what to do and figuring out for yourself what you want to accomplish and how to do it based on the information and opportunities provided to you.”

Perhaps the most critical element underpinning an effective workplace wellness strategy, particularly one that aims to drive behavioral change, is the

extent to which an employer’s culture not only promotes a sense of responsibility among employees for managing their own health, but also equips them with the resources and opportunities to do so.

However, while a majority of employers recognize the value of establishing a health-conscious organizational culture,

relatively few have actually done so (see chart).

“There has to be a culture of health within your organization,” said Karen Curran, director of health risk management at Denver-based workers compensation insurer Pinnacle Assurance. “If your company’s culture doesn’t support

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Health care

a healthy lifestyle for your employees, I don't care what you put into your program. It's probably going to fail."

One approach many employers have taken to weave health management into their company's organizational culture in recent years has been blending their wellness initiatives with existing worksite safety and absence management programs.

Nearly one-third of employers polled in Aon Hewitt's 2013 "Employee Health Benefits Survey" said they have already combined elements of their worksite safety and health management strategies, while 25% of employers polled said they have integrated their employee health management and absence management programs.

Integrating workplace wellness with normal operational activities provides a natural context in which employers can insert health management discussions and activities into the relationships employees already share with their co-workers and direct supervisors, a crucial step toward naturally motivating employees toward better health behaviors.

Another key component of an organizational "culture of health" is the degree to which the workplace affords employees the opportunity to improve their health behaviors.

According to Eden Prairie, Minnesota-based Optum Inc.'s 2014 "Wellness in the Workplace Survey," 39% of employers have made environmental changes to their worksites designed to influence healthier nutritional habits, reduce stress and improve opportunities for physical activity.

Among the most popular changes were conversions to smoke-free campuses and healthier food and beverage options in vending machines, cafeterias and catering menus.

"Every employer with a wellness program can and should be doing a 'wellness walkthrough' of their worksite," Ms. Curran said. "There are all kinds of things you can change in your employees' workspace to make it easier for them to make health-

ier choices, some of which can be done at little or no cost."

Regardless of their objective, workplace

"If your company's culture doesn't support a healthy lifestyle for your employees, I don't care what you put into your program. It's probably going to fail."

Karen Curran, Pinnacol Assurance



wellness and health management programs are typically most effective when employees feel as though they have been given some degree of control in designing the program's activities and educational resources, and are satisfied with its incentive structures and communication strategies.

Employee input and satisfaction are all the more imperative when employers' objectives turn from addressing specific health conditions to influencing health behaviors.

To that end, employers can maximize their wellness offerings' potential to effect lasting improvements to their employees' health habits by tailoring their programs according to demographic studies and internal attitudinal surveys conducted during the initial planning stages and periodically throughout the course of the program.

"Beyond health care claims, you need to know what it is your employees actually want and need," said Janet Nardo, Jersey City, New Jersey-based vice president and wellness executive at Covidien P.L.C. "If you're not addressing those things, that's a huge gap."

Employers also must realize that their workers' health behaviors and habits are typically rooted in decisions made outside the workplace, particularly if they are married or have children.

As improving health behaviors has become a primary wellness objective among employers over the years, the percentage of companies extending wellness offerings to employees' family members has also grown.

"An employee can be 100% on-board with your wellness program while they're in the workplace, but if they get home and their spouse or significant other doesn't know or understand the information that employee is getting at work, their progress is going to hit a wall," Ms. Dukoff of Vital Advantage said. "If an employee can't maintain all of the things they're doing at work once they get outside the building, those changes are never going to stick."

MOTIVATING WELLNESS

Employers' attitudes and actions regarding workplace wellness programs that motivate behavioral change, according to an Optum Inc. survey conducted in November 2013.

Establishing a culture of health ownership

| | |
|-----------------------|-----|
| Think it's important | 59% |
| Have actually done it | 22% |

On-site facilities

| | |
|-------------------------|-----|
| On-site fitness centers | 31% |
| On-site health clinics | 19% |

Top wellness success metrics

| | |
|-----------------------|-----|
| Health risk reduction | 94% |
| Claim/cost reduction | 91% |
| Participation | 90% |
| Quality of life | 90% |
| Productivity | 89% |
| Employee satisfaction | 88% |
| Return-on-investment | 85% |

Employees' family members

| | |
|--|-----|
| Extended wellness programming to employees' family members | 56% |
| Extended wellness incentives to spouses | 23% |

Source: Optum Inc.

Successful programs reduce workers' health risks

By designing their workplace wellness programs to address risky health behaviors in addition to chronic conditions and diseases among their workforces, two employers have seen demonstrable reductions in their employees' health risks.

When CentraState Healthcare System, a nonprofit medical center in Freehold, New Jersey, introduced its workplace wellness program in 2005, initial health risk assessment and biometric screening results placed 18% of participating employees at high health-risk levels, 55% at moderate risk levels and 27% at low risk levels, according to documents supplied by CentraState.

Seven years later, the percentages of participating employees in the high-risk and moderate-risk categories fell dramatically — to 5% and 27%, respectively, in 2012 — while the percentage of employees in the low-risk category increased to 68%.

The sharp reduction in high- and moderate-risk employees has translated to substantial cost savings for CentraState, with the hospital system's gross medical plan costs increasing at an average annual rate of 4.2% since 2008.

Similarly, since introducing its wellness program in 2011, New York-based social services agency Odyssey House Inc. has

seen the percentage of participating employees whose initial biometric screening results placed them at or above a high-risk threshold fall by nearly one-third.

"It's been interesting to see, just since I started here (in May 2013), some of the behavior changes among our employees," said Kelly Ahearn, wellness coordinator and nutritionist at Odyssey House. "They're influencing each other, which is nice to see."

In both cases, the companies credit their programs' success in reducing their workers' health risks in large part to their respective efforts to tailor the programs to employees' needs and interests, as well as provide employees with as many opportunities as possible to improve their health management habits and behaviors.

"The most important thing is to really listen to your employee population and provide them with a lot of different options," said Tracey Saliski, wellness program coordinator at CentraState.

"There is no one-size-fits-all solution. Any wellness program needs to be built to the specific needs of your employees," Ms. Saliski said.

By Matt Dunning

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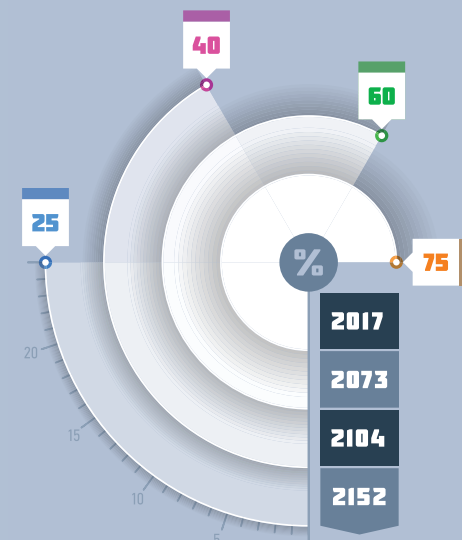
Finding the right fit for your plan participants

Custom target-date funds are fastly becoming more prevalent than traditional TDFs as they address the varied, individualized needs of plans that aren't attuned to the "one-size-fits-all" mold. For many participants, plan flexibility outweighs the simplicity found in off-the-shelf target-date products. But fully understanding the packaged approach vs. the various custom options is important to consider when constructing, implementing and managing a custom target-date solution.

P&I's 2014 Custom Target-Date Strategies Summit will explore the critical considerations plan sponsor executives need when determining if a customized solution is ideal for their plan. The conference's unique case-study format provides a valuable, educational arena in which plan sponsors share their custom implementation experiences and advice on the best ways to evaluate the process.

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Pension alternatives



Hybrid pension plans have emerged after a series of court challenges to be an attractive option for employers seeking to offer workers a secure retirement.

BY JERRY GEISEL

Nearly three decades ago, Bank of America Corp. launched what became a revolution in pension plan design.

In July 1985, the Charlotte, North Carolina-based financial services company replaced its old-style final average pay plan, then the dominant corporate defined benefit plan design, with a hybrid design — so named because the plan combined aspects of both defined benefit and defined contribution plans.

Like all defined benefit plans, Bank of America's plan promised employees a specific guaranteed benefit. But the plan earned its hybrid moniker because embedded in it were numerous defined contribution plan features. For example, when employees left, they could take the vested portion of their benefit as a lump sum or leave it in the plan until retirement, when they would have the option of a lump sum benefit or a monthly annuity.

Also, like a defined contribution plan, the benefit earned each year was expressed as a percentage of pay. As a result, employees at all times knew the exact value of their benefit.

While Bank of America called its plan BankAmeraccount, it immediately became known as a cash balance plan, an apt description with employees' benefits expressed as a cash lump sum.

That made the plans strikingly different than final average pay plans, in which employees had to project their retirement benefit based on their guesses about how long they would work for an employer and what their salaries would be in their final years of employment. By contrast, in cash balance plans, employees would instantly know the current value of their benefit.

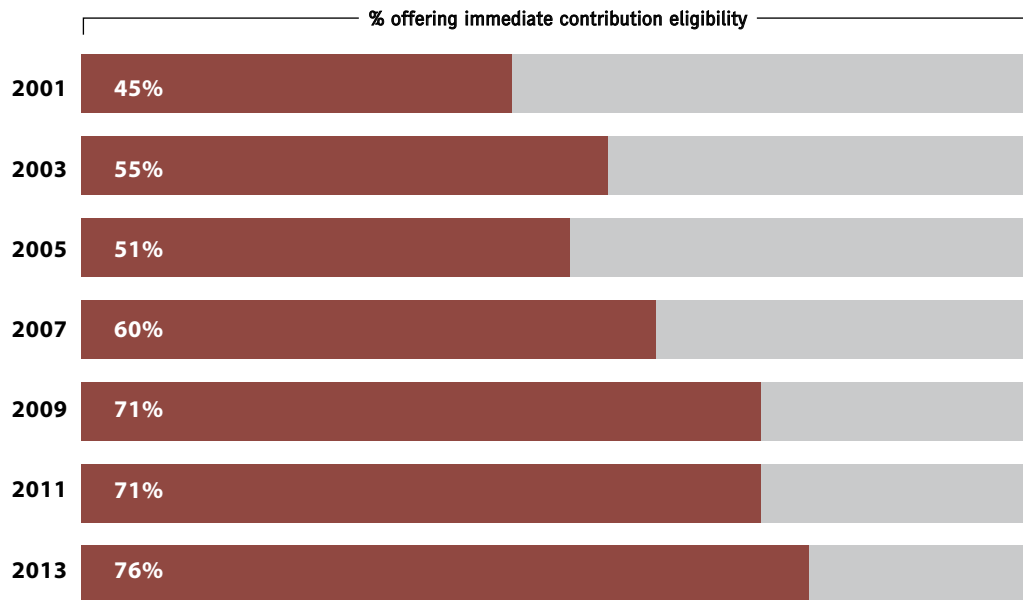
That easy-to-understand benefit formula and the smooth earning of benefits was a key reason Bank of America adopted a cash balance plan, corporate executives said at the time.

"We wanted a plan that would be easy to understand and that would provide more benefits to more employees. We believe the cash balance plan is it," said Paul Nordine, a benefit consultant at Bank of America at the time Bank of America launched the plan in 1985.

Hundreds of other employers, including

OPENING THE DOORS SOONER

More employers offering 401(k) and other defined contribution plans are giving new employees the opportunity to make pretax contributions immediately after hire.



Source: Aon Hewitt

nationally known corporate heavyweights such as AT&T Inc., American Express Co., BP America Inc., Cigna Corp., IBM Corp. and Wells Fargo & Co., had similar thoughts as they, too, adopted cash balance plans, typically converting their old final average pay plans to the new design.

But storm clouds in the form of lawsuits were to come. Led by an aggressive plaintiffs bar, the suits charged that the basic plan design discriminated against older employees.

Eventually, the suits came to naught, with five U.S. appeals courts rejecting the age discrimination charge. In addition, Congress, as part of a broader pension measure it passed in 2006, made clear that going forward the basic design of cash balance plans did not violate age discrimination law.

Those twin developments have given a lift to cash balance plan formations. Big-name employers, including The Coca-Cola Co., Dow Chemical Co. and MeadWestvaco Corp., all adopted cash balance plans in the wake of the new law.

On the other hand, many other employers, including cash balance plan pioneer BankAmerica, froze their plans as part of a broader corporate move away from defined benefit plans.

Still, more employers have hung on to their cash balance plans compared with other defined benefit plans.

A 2013 Towers Watson & Co. survey found that 23% of Fortune 100 employers offer

hybrid plans, mostly cash balance, to new employees, more than three times compared with those who offer traditional plans.

And that percentage should hold steady. “Many employers who have moved to cash balance plans will keep them,” said Kevin Wagner, a senior retirement consultant with Towers Watson in Atlanta.

One such employer sticking with its cash balance plan is North Shore-LIJ Health System in Lake Success, New York.

“This allows us to offer a benefit to employees that they could better understand than a traditional defined benefit plan,” said Gregg Nevola, the health care system’s vice president of total rewards.

“Employees are used to seeing everything in dollars,” and that is what this plan does, Mr. Nevola said.

And in some business sectors, such as small professional firms, cash balance plan formation is on the rise.

For example, a forthcoming report by retirement plan administrator Kravitz Inc. found that of the 9,648 cash balance plans operating in 2012, 86% of the plans had fewer than 100 participants.

“There has been a lot of activity in the small employer market,” said Jack Abraham, a principal with PricewaterhouseCoopers L.L.P. in Chicago.

“There is no better way to reduce tax liabilities and increase savings than a cash balance plan,” said Dan Kravitz, president of Kravitz in Los Angeles.

The additional benefits that employers can provide to employees through offering a cash balance plan compared with providing just a 401(k) plan are striking.

Employees can contribute up to \$17,500 — or \$23,000 if they are age 50 and older — annually to a 401(k) plan, and their employers can match those contributions up to a total of \$51,000. By contrast, employers can fund an annual benefit of more than \$210,000 in a cash balance plan.

The cash balance plan gave Southwest Diagnostic Imaging Ltd., a 650-employee radiology provider, “a vehicle to enable employees to save additional funds for their retirement,” said Mike von Kolen, director of finance at Southwest affiliate Valley Radiologists Ltd., in Phoenix. Southwest set up a cash balance plan late last year.

And more large companies that have frozen their cash balance or other defined benefit plans and moved to a defined contribution plan-only approach could one day embrace cash balance plans.

The drivers of that move are employees who haven’t saved enough through their 401(k) plans for their retirement and are staying on the job longer than their employers would like.

“I can see a scenario where five years from now, if baby boomers don’t retire, some employers might unfreeze their plans to address workforce management issues,” said Art Noonan, a senior partner with Mercer L.L.C. in Pittsburgh.

“We wanted a plan that would be easy to understand and that would provide more benefits to more employees. We believe the cash balance plan is it.”

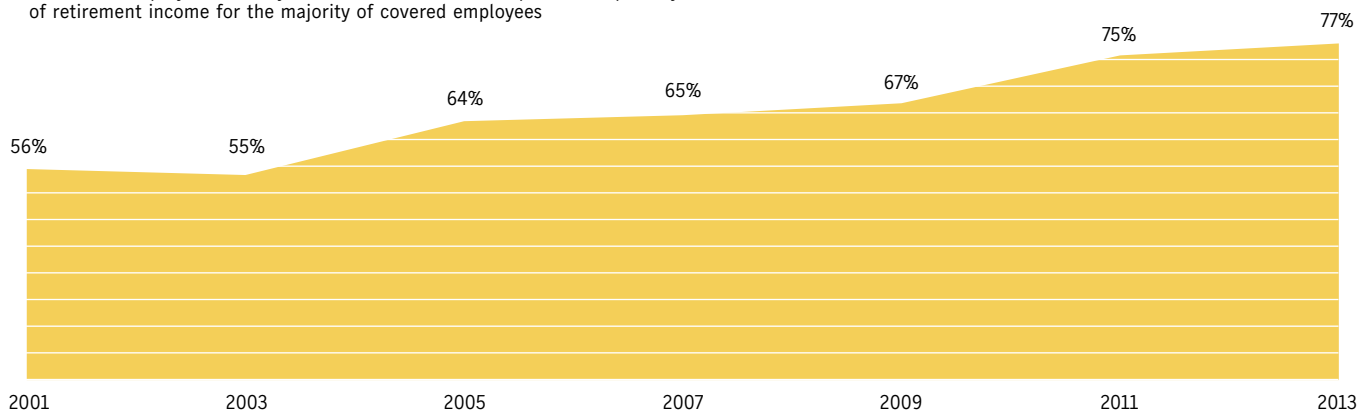
Paul Nordine, formerly at Bank of America

“I can see a scenario where five years from now, if baby boomers don’t retire, some employers might unfreeze their plans to address workforce management issues.”

Art Noonan, Mercer L.L.C.

RISING IN IMPORTANCE

Percent of employers who say their defined contribution plan is the primary source of retirement income for the majority of covered employees



Source: Aon Hewitt



New hybrid plan limits downside risk for firms

BY JERRY GEISEL

A new defined benefit pension plan design is on the horizon that could rekindle employer interest in the plans, benefit experts say.

The design has both defined benefit and defined contribution plan elements.

On the defined benefit side, the plan would provide a minimum pay-related amount contributed by the employer.

Employers would decide the plan's design in allocating investment income to participants' account balances. For example, the interest credit could be based on the yield of a target date fund.

On the defined contribution side, the plan would shift investment risk entirely to employees.

If a target date fund did badly, for example, employers would not be liable beyond providing the promised minimum benefit. On the other hand, if a selected investment did well, the employee would receive the entire gain. Regardless, the employee's account balance never would be less than the amount generated by the plan's pay-related credits.

Benefit experts say the new design, which would have to be approved by the U.S. Treasury Department, is a middle ground between conventional defined benefit plans in which employers carry all the investment risk and defined contribution plans, such as 401(k) plans, in which employees bear the investment risk.

"We need more options," said Richard Shea, a partner with law firm Covington & Burling L.L.P. in Washington.

"The beauty of this plan is it would eliminate much of the financial volatility of defined benefit plans, yet provide more retirement income security than defined contribution plans," Mr. Shea said.

Experts view the risk-sharing design as a positive contrast to defined contribution plans, where employees shoulder the risk, and defined benefit plans, where employees bear the risk.

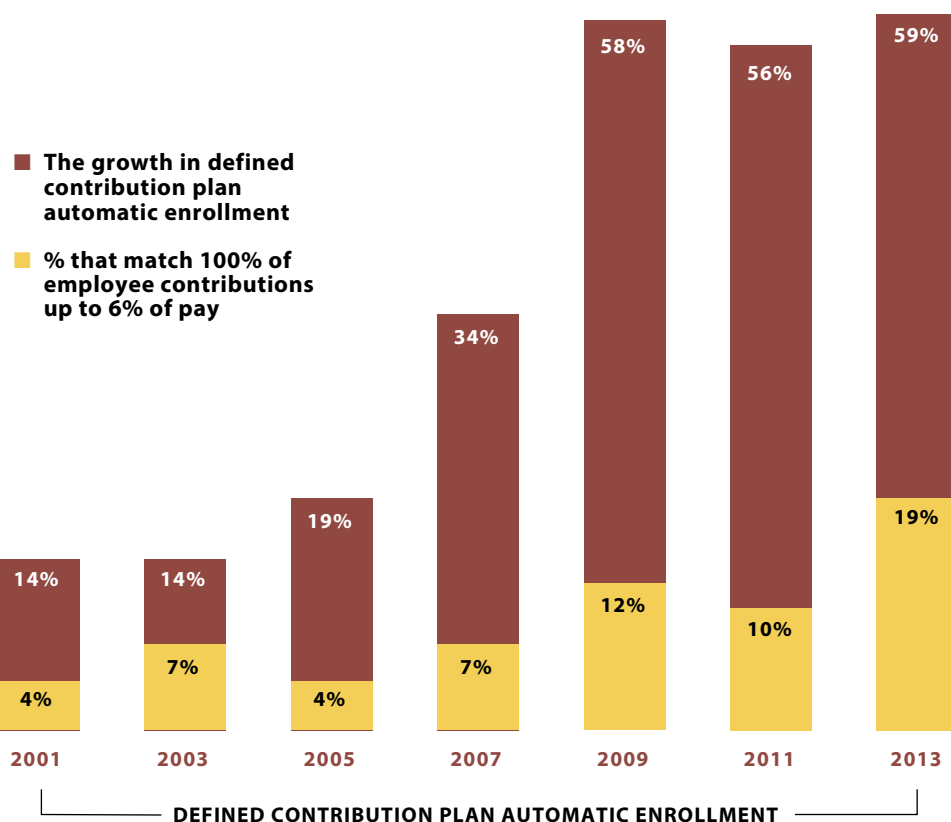
For example, bearing all of the investment risk is a key reason why employers have moved away from defined benefit plans.

On the other hand, moving to a defined contribution plan-only approach also poses problems.

If employees invest poorly, they may stay on the job longer than either they or their employers want because they will not have earned enough retirement income, leading to productivity issues and blocking the advancement of younger employees.

Matches, automatic enrollments grow

How employers are sweetening their defined contribution plan matches



Source: Aon Hewitt

Filling in the gaps

BY JOANNE WOJCIK

Voluntary benefit products such as critical illness, accident and hospital indemnity can help to fill gaps in health care coverage that are created when employees enroll in high-deductible health plans.

However, employers often hesitate to offer these gap-filler products out of concern that introducing additional product offerings at the same time they are implementing a new health plan may be overwhelming for their employees.

“Many employers have historically viewed voluntary benefits as kind of an afterthought,” said Bruce Sletten, senior vice president and national practice leader for elective benefits at Aon Hewitt in Dallas. “In years past, you’d have to make your decisions about medical, dental, vision, your 401(k) and all of these kind of core benefits first. Then at the end, if you had any energy left, there was a list of voluntary benefits. The problem is by that time, employees are often suffering from ‘decision fatigue.’”

However, “If you put them on the ballot in the enrollment flow with the medical decision, employees can better connect the dots, putting together how a hospital indemnity plan would help them potentially mitigate the risk of a high-deductible medical plan,” he said. “So when properly designed and positioned, voluntary benefits can really help employers in their health care strategy.”

“As employers add more high-deductible health plans, they are absolutely adding more voluntary benefits,” said Barbara Gniewek, a principal at PricewaterhouseCoopers L.L.P. in New York. However, “employers are more likely to do voluntary if they do full-replacement HDHP,” she said.

Beth Grellner, health and group benefits leader at Towers Watson & Co. in St. Louis, said she usually recommends employers consider adding voluntary benefit offerings whenever they implement an HDHP.

“They are usually intrigued if it’s not something that they have ever considered before,” Ms. Grellner said. “Often we find they may not really understand how the products work. So we have to spend some time educating them around why their employees might find the offer valuable and then speak to how, especially with a (health savings account), there are some compliance requirements with the types of voluntary benefits that can and cannot be offered.”

For example, “sometimes employers really want more of a ‘gap filler’ to say that someone could get reimbursed for outpatient care as well, but that’s not allowed under the HSA guidelines,” Ms. Grellner said.

Under Internal Revenue Service rules



Voluntary benefits products can be used
to replace benefits curtailed by the
introduction of high-deductible health plans
and improve employee satisfaction

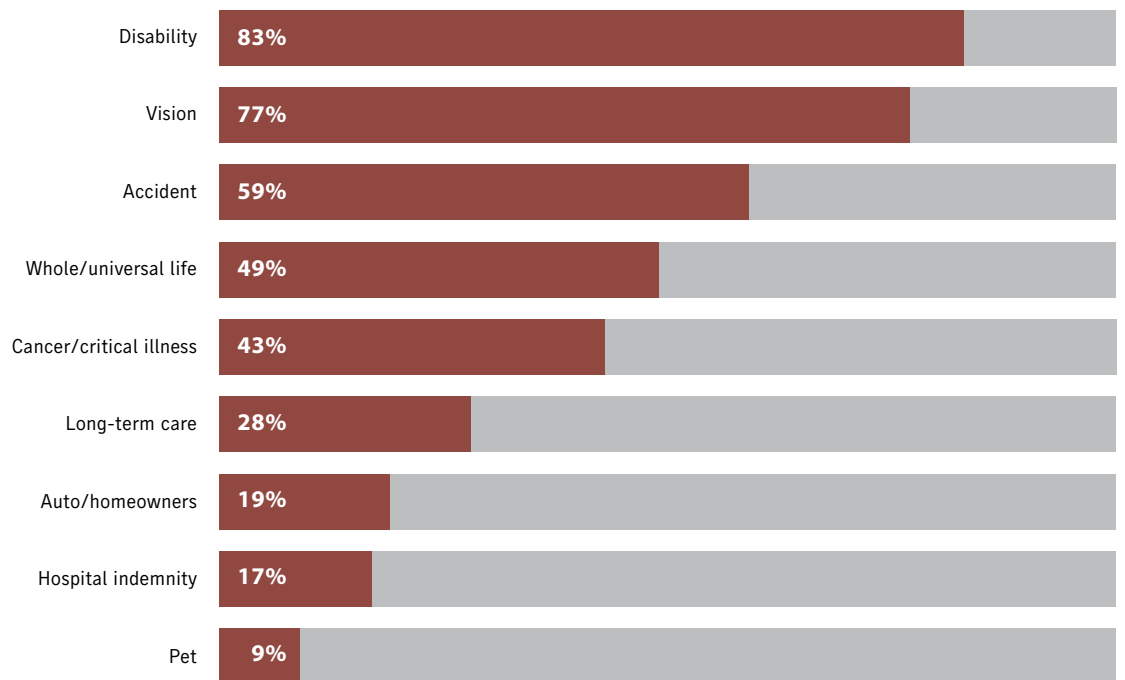
Voluntary Benefits

Hardship one major medical event away



Top voluntary insurance products

Products most offered in 2013 by large employers with at least 500 workers



Source: Mercer L.L.C.

Many employees today are just one serious medical event away from financial hardship, according to the “2014 Aflac Workforces Report,” which found 49% of employees have less than \$1,000 available to pay for unexpected out-of-pocket medical expenses, even though high-deductible health plans have deductibles significantly higher than that.

Voluntary benefits such as critical illness, hospital indemnity and accident — which pay a fixed benefit when an employee is diagnosed with a covered critical illness, are hospitalized or sustain an injury requiring emergency room treatment — can offset high deductibles and coinsurance.

For example, for as little as \$3 to \$5 per week, an employee can purchase a critical illness benefit that pays up to \$10,000 if they are diagnosed with any of the policy’s specified diseases, a sum that can go a long way toward meeting the minimum \$1,250 deductible for an HSA-qualified HDHP, said Bruce Sletten, senior vice president and national practice leader for elective benefits at Aon Hewitt in Dallas.

And since these are indemnity payments not connected to the cost of medical services, they can be used to pay for other items related to the individual’s illness, such as transportation costs or the cost to hire help in the home when an individual is incapacitated, said Beth Grellner, health and group benefits leader at Towers Watson & Co. in St. Louis.

“Since many workers are not equipped to pay for high deductibles and other expenses not covered by their major medical policies, it’s important for insurance professionals to start conversations with employers about how supplemental plans can create a financial safety net in case of an unexpected medical crisis for employees,” said Teresa White, Aflac Inc.’s executive vice president and chief operating officer.

By Joanne Wojcik

governing the tax-deductibility of contributions to HSAs, employees generally cannot have any other health coverage that is not an HDHP with at least a \$1,250 deductible for individual coverage and \$2,500 deductible for family coverage.

However, critical illness, accident and hospital indemnity policies that pay a fixed amount per day of hospitalization are permitted.

The cost of the coverage varies based on the ages of individuals purchasing them and the amount of coverage they buy.

For example, Portland, Maine-based Unum offers “low, medium and high plans,” said Marilyn Finley, the company’s director of

product and market development based in Chattanooga, Tennessee. As such, a \$5,000 critical illness policy would start at about \$270 a year, she said.

Most employers that aren’t interested in offering voluntary benefits in conjunction with an HDHP “see concerns around the education component,” Ms. Grellner said. “They wonder how much information their employees can take in at one time. If they’re already moving them to a high-deductible health plan, potentially with an account-based model, they are concerned they might overwhelm them with the additional products that might come into play.”

Helping employees understand the value

of the voluntary benefit products is essential to their ability to make decisions, acknowledged Bob Love, vice president and head of group distribution at New York-based The Guardian Life Insurance Co. of America (see story, page 19).

“There are a number of products that historically have been confusing. We’re making sure we’re building products that are simple to use and easy to understand. There’s a lot of opportunity for education during the enrollment process,” he said.

Voluntary benefits evolve

Meanwhile, many employers that had offered voluntary products in the past and are hesitant to do so now — even in conjunction with an HDHP — are concerned about their administrative complexity, especially since these products historically were individually underwritten and not integrated into group benefits platforms, according to Alyssa Williamson, a voluntary benefits consultant at Mercer L.L.C. in Atlanta.

“But voluntary benefits have evolved. They look and feel a lot more like group programs. Administration is easier today, and they can be payroll-deducted,” she said.

About two-thirds of employers have successfully integrated voluntary benefit offerings on the same administrative platform as core benefits, up from 60% in 2012, according to Mercer’s “National Survey of Employer-Sponsored Health Plans 2013.”

In some cases, to soften the impact of a high-deductible plan, employers will provide a base level of critical illness, hospital indemnity or accident coverage at no cost to employees and then give workers the option of buying higher levels of voluntary benefits coverage for an additional premium, according to Mercer’s survey. In these cases, insurers underwriting the voluntary benefits

LINKS TO JOB SATISFACTION

Voluntary benefits increase job satisfaction and help to improve employees’ peace of mind.

| Satisfaction | Employer does not offer voluntary benefits | Employer offers voluntary benefits | Enrolled in voluntary benefits |
|---|--|------------------------------------|--------------------------------|
| Believes employer is a great place to work | 46% | 55% | 58% |
| Believes employer takes care of its employees | 44% | 52% | 55% |
| Satisfied with current job | 56% | 62% | 66% |
| Likelihood to recommend workplace | 55% | 64% | 67% |

| Confidence | Employer does not offer voluntary benefits | Employer offers voluntary benefits | Enrolled in voluntary benefits |
|---|--|------------------------------------|--------------------------------|
| Confident in financial future | 29% | 37% | 37% |
| Have a financial plan | 39% | 49% | 49% |
| Health insurance is an important part of financial plan | 39% | 47% | 52% |
| Have peace of mind | 42% | 50% | 52% |
| Have more than \$1,000 in savings | 49% | 62% | 64% |

Source: Aflac Inc.

Online survey conducted with 5,299 U.S.-based employees; conducted by Research Now

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Ease into plans to avoid confusion

To prevent information overload from introducing voluntary benefits in combination with a move to a high-deductible plan, some benefits consultants recommend that employers add benefits in stages, coupled with a concerted communication and education campaign.

"When we sit down with the client and customize a strategic plan for them, usually over a three- to five-year period, we usually recommend adding two or three new voluntary benefits products at a time based on their employee population's needs," said Ron Agypt, chief sales officer of employee benefits at Hub International Ltd. in Chicago.

Then, when introducing these additional benefits offerings to employees, "what we're really finding to be extremely valuable is the communication-education process," he said. "You've really got to think about the consumer — the employee. We've found that employees have started to feel the pinch of higher premiums and in many cases lower benefits. Voluntary benefits can buffer employees' anxiety from greater uncertainty; they just feel better when they have the voluntary product."

Beacon Health System, a Hub client, used this staged strategy when it introduced an HDHP earlier this year as an option beside a preferred provider organization plan, according to Annette Vota, benefits manager for the hospital system with locations in South Bend and Elkhart, Indiana. Using financial incentives including significantly lower employee premium contributions and depositing seed money into HSAs, 40% of Beacon's 4,500 benefits-eligible employees enrolled in the HDHP, she said.

Employees who elected the HDHP with either a \$2,000 single deductible, \$3,000 employee-plus-one deductible, or a \$4,000 family deductible received \$400, \$600 or \$800, respectively, in their health savings accounts. Premium contributions for the HDHP were approximately 40% lower than for the PPO plan, which offered deductibles of \$600 for single coverage, \$1,200 for employee-plus-one coverage and \$1,800 for family coverage.

Later this year, Beacon will offer those employees the additional options of accident coverage with a sickness confinement rider, critical illness with a cancer rider, and permanent life insurance with a long-term care rider.

"We're giving our employees these different options because we're finding that benefits are not one-size-fits-all," Ms. Vota said, adding that in addition to benefit communications, employees will receive individual counseling so they can "craft their benefits portfolios to match their individual needs."

"One-on-one provides the best opportunity to educate, because people can ask questions," Mr. Agypt said.

By Joanne Wojcik

products will often shave a few percentage points off of the cost of the coverage purchased by employees because they are guaranteed higher voluntary benefit participation rates.

"We do see opportunity to provide more competitive pricing on critical illness and hospital indemnity when there's an employer-paid basic level of \$5,000 or \$10,000 of coverage," said Lydia Jilek, vice president and head of voluntary products and private exchange

strategy at Voya Financial Inc., formerly ING U.S. Inc. She said she sees this strategy used most often when employers offer more than one plan choice as an incentive to drive employees to select an HDHP.

Guardian Life's Mr. Love agreed. "Anytime you have a transition from a fully employee-paid product to a fully employer-paid product, you're eliminating adverse selection. You have more stable risk, and you can provide a discount," he said.

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Brian Klepper was named CEO of the Washington-based National Business Coalition on Health in March. He also is a columnist and speaker and serves as an adviser to the Lundberg Institute and the Patient-Centered Primary Care Collaborative. He recently spoke with *Business Insurance* Senior Editor Joanne Wojcik about mechanisms underlying America's health care cost crisis and what employers can do to address them. Edited excerpts follow.

Q

Q The Patient Protection and Affordable Care Act has been criticized for not doing enough to control the rising costs of health care. How is the ACA affecting employers' decision to self-fund health care benefits?

A Some of the ACA's market reforms, like coverage of essential benefits, modified community rating and limits on cost sharing, will likely encourage some small employers to transition to health plan self-funding for the first time. Not only will their costs probably be significantly lower, but they'll have more data and more control over the benefit design.

Q What is NBCH's strategy to help employers control costs in a post-ACA environment?

A First, I think it's important to understand that the health care industry contributed \$1.2 billion in 2009 when health reform was formulated, so the limitations on cost control were pushed hard by the health care industry itself, and they got their way. I think that the delivery of value through the coalitions is a big topic, and one of the things that I'm very actively doing right now is identifying high-value next-generation risk reduction mechanisms in health care, truly transparent pharmacy benefit managers, truly advanced third-party administration firms,

musculoskeletal management firms, vascular and surgical and oncology management — all functions that can sit in front of the health plan and drive high value, improvements in health outcomes and reductions in cost.

The core principle is if you belong to a business health care coalition, your costs should be lower and your outcomes should be better. This is a very different model than the coalitions have pursued in the past, but that's where I think they need to go. There are some purchasing coalitions that have pursued this very heavily: The Alliance in Madison, Wisconsin, or the Savannah Business Group in Georgia. This needs to be a more uniform approach throughout the coalitions.

We need to be able at the next level to roll up and leverage the members of the coalition ... in a way that leverages their purchasing heft in the market.

Q Private exchanges are reporting significant growth. How are your coalition members responding to the availability of these exchanges?

A A portion of them have set up independent review of these exchanges. I think that's a good thing. A lot of the consulting firms are very conflicted. To be a consultant and at the same time to offer an exchange to an employer can be construed as a conflict of interest. There need to be independent advisers.

If your benefits consultant is advising you on your long-term benefits strategy, and if your benefits consultant is offering a private exchange option, they are not likely to be objective and to encourage you to take advantage of their exchange. That's the rub. And so if you are an employer and you are using, let's say, a Towers Watson & Co. as a consultant and you are seriously considering using a private exchange, you may want to consider someone else's private exchange, like Aon Hewitt's. You don't want to be in a situation where your adviser has a vested interest in the counsel that they provide.

Q What are some employer-led initiatives NBCH has identified to drive value-based purchasing and quality improvement efforts?

A If you look at some of the programs going on, The Alliance in Madison, Wisconsin has a new effort called Quality Path that gets purchasers to make commitments to quality in a new and substantial way. The Savannah Business Group is partnering with health care systems and physician groups, bringing substantial savings to members. And Pacific Business Group on Health has an Employers Centers of Excellence Network program. There are others too numerous to name that are sprinkled throughout the country.

Part of the task is to identify existing programs that have been successful in communities, scale them and then make them available to other coalitions and purchasers around the country.

One way to think about this is purchasers are acting on behalf of purchasers, and the health care industry has figured out and institutionalized many mechanisms at all levels of the system to make costs more than they need to be. These efforts are about disrupting those mechanisms while driving appropriate care, and the results can be very powerful. We need to find those programs wherever they exist and promulgate them.

Q Do you see NBCH working with any other employer groups to drive greater change?

A We're interested in working with anybody who has aligned interests around enhanced health care value. In a system that costs double what all of our competitors on the international stage cost, and in a system that RAND Corp. has shown eats up \$4 out of every \$5 in household economic growth, there's a lot of room for change. We have allowed health care to crowd out investments in education and infrastructure replacement and a lot of other things. So anybody who is after the same goal of higher-value health care, we ought to be aligned with — that's for unions and local government and firefighters. I think our goal at this moment ... is to stabilize and strengthen the organization and get some wins. But going forward, we will absolutely be focused on getting as much clout as possible, working with other players to make the kind of things happen that we know can happen for a healthier economy, healthier business environment and a healthier country.

The core principle is if you belong to a business health care coalition, your costs should be lower and your outcomes should be better.



PLACES, EVERYONE

Top Eastern work destinations for U.S. expatriates

1. China
2. Singapore
3. Australia

Assignments to Asia present foreign benefits challenges

BY KAREN PALLARITO

As more U.S. employers seize growth opportunities in Asia, they must develop international benefits packages for the employees they send there on assignment.

Most employers with international operations have global policies for providing core benefits and services, assuring that benefits are doled out in a consistent manner, whether employees are working in Bangkok or Brussels.

Still, it's important to customize policies to conform with country-specific conditions.

China's traffic gridlock and Singapore's expensive drivers' licenses, for example, make public transportation or hired drivers better options than providing employees an automobile allowance. In cities shrouded in air pollution, employers sometimes pick up the cost of air-quality testing or pay for high-end air purifiers for employees' apartments.

To stretch benefits dollars, many employers also maintain a suite of benefits policies that differ by type of assignment, and the cost of benefits and services varies depending on the roles that need to be filled and available talent.

While long-term expatriates continue to play a significant role in Asia, they require a large investment. U.S. employers will spend roughly three to five times base salary to send someone on a work assignment for a three- to five-year period, said Ed Hannibal, Mercer L.L.C.'s global mobility

practice leader for North America in Chicago. If an employee earns \$100,000 annually, it costs the employer \$300,000 to \$500,000 a year, depending on the length of the assignment in Asia.

"Over the course of their assignment, that can run the company \$1.5 million," Mr. Hannibal said.

To attract talent and reduce some of these costs, companies increasingly are deploying staff on short-term stints, using local hires in the country where the company is doing business or permanently transferring employees to the host country. Some employers tap junior-level workers to perform tasks overseas, helping them gain valuable on-the-job training for future assignments.

"The complexity of it is significant. It's not as simple as it being a U.S. expat living abroad anymore," said Bill Nelligan, CEO for the U.S. at Philadelphia-based global assistance company International SOS.

Some employers tier benefits and services according to an assignee's pay grade or job title and the number of family members tagging along. As a result, corporate executives often enjoy, say, better accommodations than middle-managers.

Corporate culture and spending appetite also play into employers' global benefits designs. Investment bank and financial firms tend to offer more lavish packages. In the hospitality industry, unlimited recreation, laundry and restaurant privileges may be offered.

Americans bound for Asia usually don't see sharp spikes in base pay, unless an assignment represents a promotion. Employers tend to keep assignees on their home-country salary. Other benefits, like life and disability insurance and retirement plans, remain the same as well.

However, assignees may receive a cost-of-living adjustment to cover the difference in the cost of food, transportation and other living expenses between home and host country.

In some instances, employers may switch certain workers to a so-called local plus arrangement in which salaries are based on host-country pay levels but employees receive some traditional expat benefits ad services.

Taxes represent the largest expense for U.S. employers with assignees abroad, including Asia, according to Mercer research. Many global companies have tax equalization policies whereby an employee pays no more or less than he would have paid had he stayed in the U.S. As a result, the employer absorbs the cost of any taxes assignees incur in the host country plus any U.S. taxes on foreign income above a certain threshold.

Because expatriate taxes are complicated, employers usually provide the services of a global accounting firm specializing in international tax planning and preparation

to handle expatriates' U.S. and host-country filings.

Housing is another enormous expense. Renting an apartment in Tokyo can cost \$8,000 a month, while in Hong Kong, rentals go for \$8,000 to \$9,000 a month, said William Sheridan, vice president of international human resource services at the National Foreign Trade Council in Washington.

Typically, employers provide an allowance toward housing, with employees paying part of the cost, although some companies provide accommodations free-of-charge. It's often the employee's responsibility to sell, rent or maintain payments on their home in the U.S.

Sometimes employers tack on a hardship allowance to compensate assignees for rough living conditions due to political instability, crime, disease, health conditions and other factors. Papua, New Guinea, is considered a high-risk destination due to serious crime and violence and the incidence of cholera and malaria.

To manage the risks of international travel, employers typically retain global assistance companies to brief assignees on local conditions ahead of a move and aid them in the event of a medical emergency, natural disaster or travel snafu, like a stolen passport.

Support services, like relocation and help settling in, are common offerings, as are language courses, culture training and assistance enrolling children in schools. But again, what employees receive may depend on the assignment type, their seniority and other factors.

In places like Hong Kong, with long wait lists for top international schools, some multinational employers purchase debentures, costing as much as \$130,000 per debenture, before tuition, to secure priority placement for children of top executives coming into the region, said Jenny Castelino, director of intercultural and language solutions in the Asia-Pacific region of Cartus Corp., a global relocation services provider.

Despite written policies, companies sometimes bend the rules. A valuable assignee with an ill family member in the U.S., for example, may get more frequent paid travel to his home country.

"A lot of companies want to stay fair and consistent and all that, but the reality is, you've got a key position, a hole to fill, and you really need that person," so companies do accommodate special requests, said Jill Taylor, vice president of consulting services at Brookfield Global Relocation Services L.L.C. in Burr Ridge, Illinois.

Very few, though, want to tip their hand. "The truth is, there are a lot of exceptions," said a senior executive at a Fortune 500 manufacturer with extensive operations in Asia who did not want to publicize the company's benefits policies or accommodations.

"It's not one-program-fits-all," he said.

Expatriate workers benefit from local health care options

Employers have a couple of options for providing health care benefits to expatriates in Asia.

Keeping employees on the company's domestic health plan may be the simplest route, and that may be fine for employees on short-excursion work assignments.

But employers need to ask themselves whether that coverage is a good fit for employees stationed in a foreign country for several years.

Expats aren't likely to know which doctors and hospitals they can trust when living in Asia, or whether the care they receive from those providers is covered under their home-country plan. They may have to deal with bills in the local language and currency.

In many countries, providers demand payment up front. Otherwise, "you can get denied access to treatment," said Cliff Caldwell, senior vice president with Ascende Inc., a Houston-based provider of global employee benefits consulting services.

Plus, many providers lack electronic claims capabilities, he said.

Given the enormous investment required to deploy workers on overseas assignments, experts say opting for a global health benefits plan tailored to meet the needs of international assignees and their families is often a better choice, even if it costs a bit more.

"You don't want health to be a distraction factor," said Howard Gough, CEO for the Middle East & Asia-Pacific Region of Cigna Corp.'s global employer segment.

With the exception of multinational employers with very large expat populations, self-insuring usually isn't an option. Employers mostly buy coverage for expats on a fully insured basis.

Global expatriate benefits plans underwritten in the U.S. typically provide the same level of benefits that employees receive at home. The big difference is "how simple do you make it?" said Jim Peiffer, senior vice president of global employee benefits for Metlife Inc. in New York.

Look for plans that provide 24/7 global service centers with multilingual staff to handle questions and claims, assistance in an emergency and access to credentialed hospitals and physicians that can bill the insurer directly.

To keep things simple and equitable for all, employers usually opt to provide one health plan for their expatriates, no matter what country they reside in. However, employers with significant numbers of expats in Asia may choose to add customized benefits such as acupuncture and herbal medicine, for example.

By Karen Pallarito



SOLID BENEFITS PLANNING LEADS TO HAPPIER LANDINGS

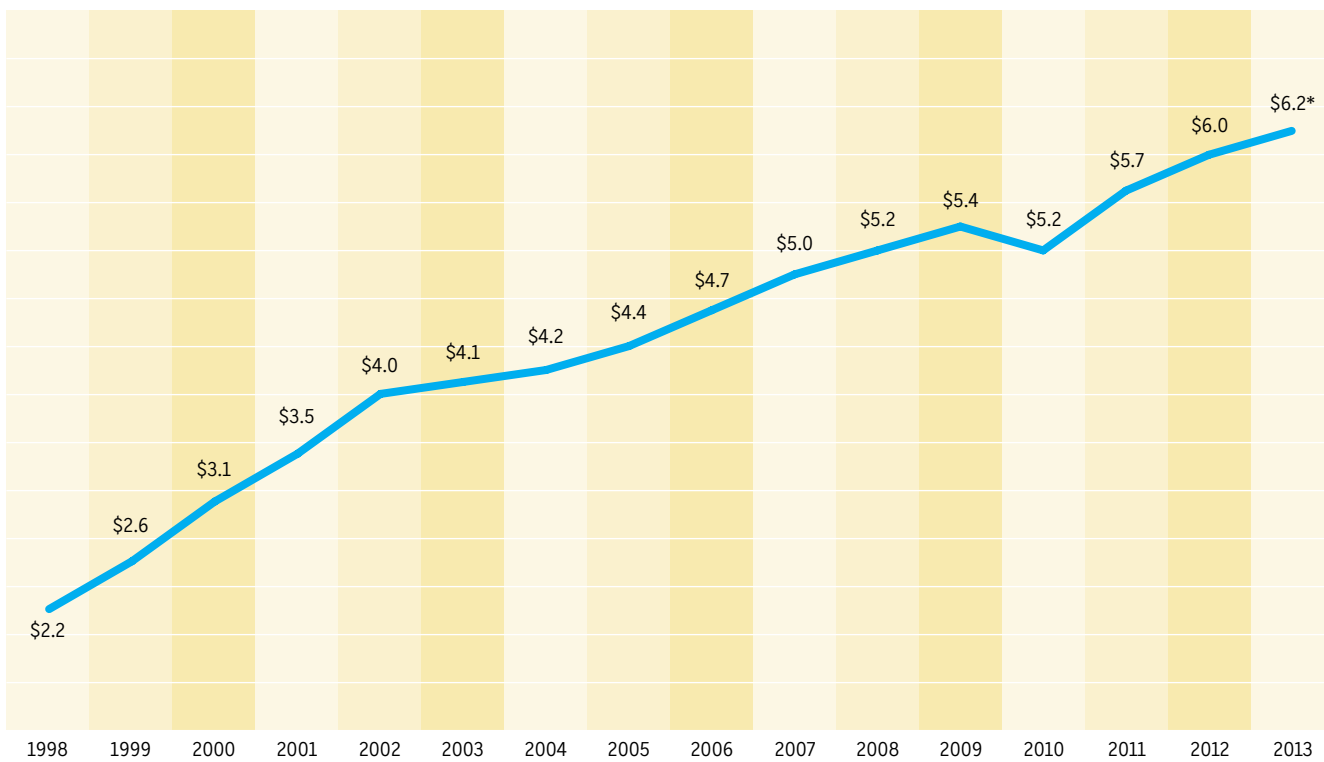
Employee benefits planning tips before U.S. firms expand into Asia

- **Develop** a global benefits strategy aligning employee benefits and services with business goals and talent options.
- **Customize** benefits policies by country of assignment.
- **Consider** a flexible plan that allows expatriate work assignees to select optional benefits and services to fit their needs.
- **Use** plan design to control costs.
- **Clearly** communicate benefits and services to work assignees.

Research & Data

VOLUNTARY BENEFITS TREND

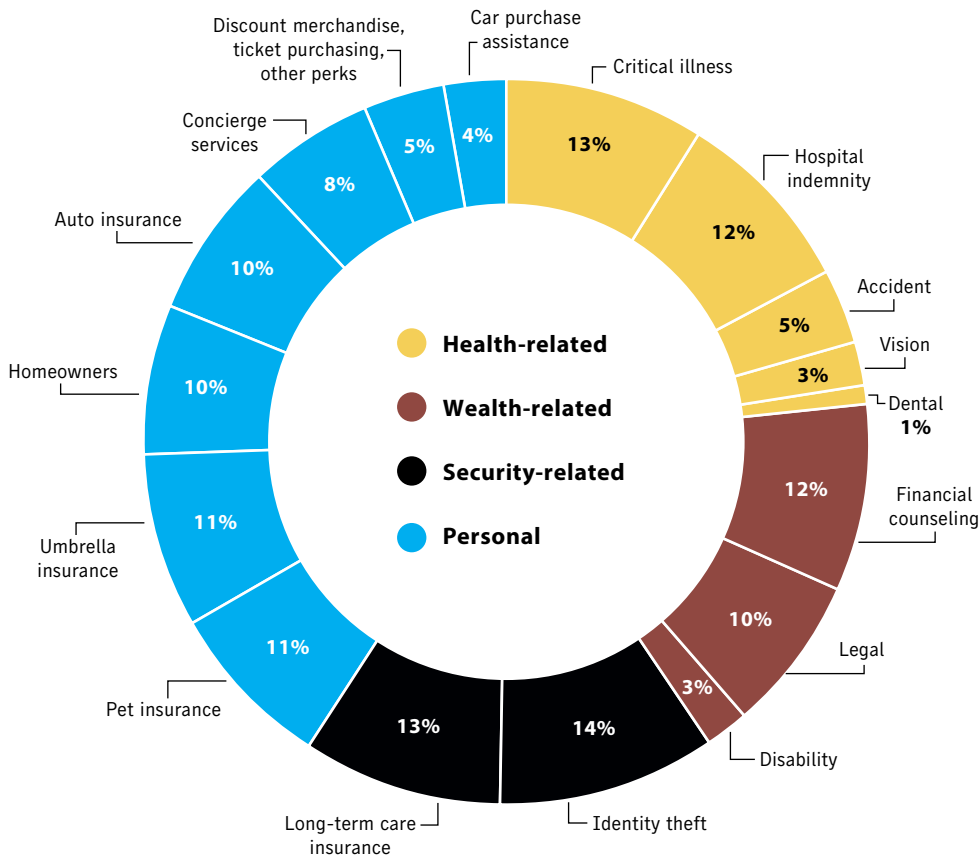
Premiums generated from these policies have increased threefold since 1998 (voluntary new business annualized premium in billions).



*BI estimate
Source: Eastbridge Consulting Group Inc.

EMERGING VOLUNTARY BENEFITS

What companies are planning to offer in 2015



Source: Towers Watson & Co.
Sample: 320 companies ranging from 540 to 345,000 employees, online survey

VOLUNTARY INSURANCE PRODUCTS

Most appealing to middle-income employees, the percentage who own a voluntary insurance product by household income

32%
Under \$25,000

46%
\$25,000 - \$49,999

49%
\$50,000 - \$74,999

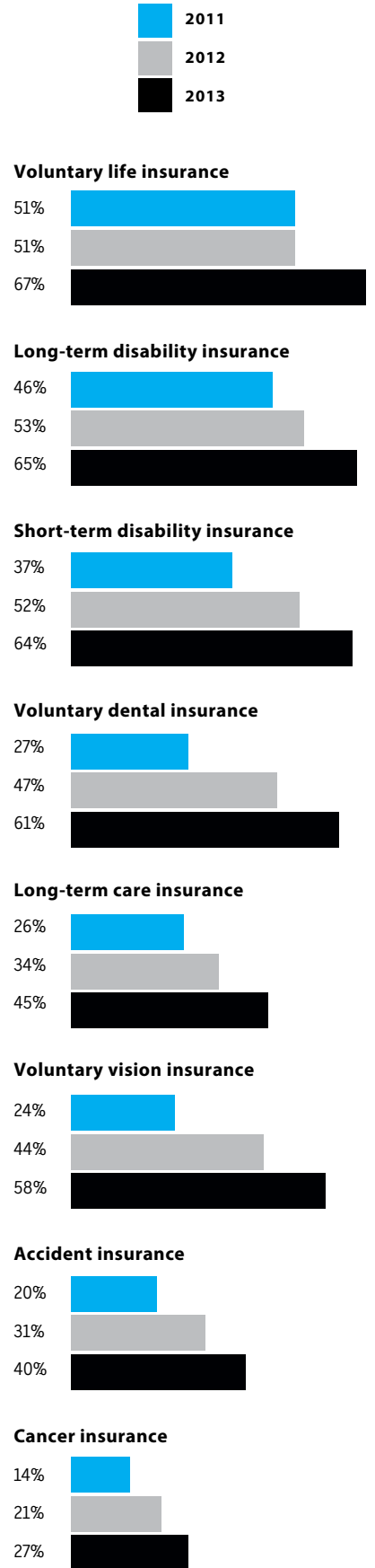
48%
\$75,000 - \$99,999

36%
\$100,000 or more

Sample: 770 U.S.-based employees, 2013 survey
Source: Eastbridge Consulting Group Inc.

VOLUNTARY INSURANCE ENROLLMENT

There's strong growth in employee enrollment the past three years across all product lines.

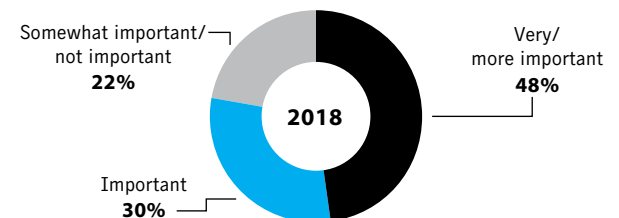
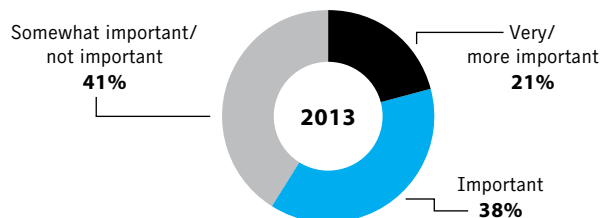


Source: Aflac Inc.
Online survey conducted with 5,299 U.S.-based employees by Research Now Inc.

TOTAL REWARDS

Voluntary benefits as part of companies' total rewards. These policies are expected to gain more importance.

Source: Towers Watson & Co.
Sample: 320 companies, online survey



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