

**HIGH COURT OVERTIME RULING SEEN BENEFITING WIDE RANGE OF EMPLOYERS / PAGE 3**

**KAISER PERMANENTE, AETNA RECEIVE HIGH RANKINGS ON SATISFACTION / PAGE 3**

**EMERGING RISK EXPOSURES TEST INSURERS' ABILITY TO SHOW VALUE / PAGE 4**

## inBrief

### LIABILITY & LITIGATION

# Finite reinsurance case settled

*Execs admit fraud, agree to pay fines, but no jail time*

By **MARK A. HOFMANN**

**HARTFORD, Conn.**—The federal government and five former insurance executives accused in a sham reinsurance deal sealed over a decade ago agreed to settle the matter, with the executives admitting that aspects of the deal were fraudulent.

In a motion filed Friday in U.S. District Court for Connecticut in Hartford, the federal government said that “the parties have reached agreements to resolve this matter.”

“If these agreements are approved by the court, it would obviate the need for the filing of



In an agreement reached with federal prosecutors last week, five former insurance executives accused in a sham reinsurance deal more than a decade ago—Ronald E. Ferguson, Christopher P. Garand, Robert Graham, Elizabeth Monrad and Christian M. Milton—are to pay fines, but the charges against them are to be dropped in 12 months.

the pretrial motions as well as any other pretrial and trial proceedings in the case, thus saving the parties and the court significant resources,” according to the motion.

The retrial of Ronald E. Ferguson, former General Reinsurance Corp. CEO; Christopher P. Garand, former Gen Re senior vp

in charge of U.S. finite underwriting; Robert Graham, former Gen Re senior vp and assistant general counsel; Elizabeth Monrad, former Gen Re chief financial officer; and Christian M. Milton, former American International Group Inc. vp for reinsurance, had been slated for Jan. 22, 2013.

But earlier this year, U.S. Dis-

trict Court Judge Vanessa L. Bryant agreed to a series of delays in pretrial motions, during which the parties continued to discuss a resolution of the case.

Under the agreements, which were made individually with each defendant and announced Friday,

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### WORKERS COMPENSATION

# Date confirms obesity ups claims duration

By **ROBERTO CENICEROS**

A study that shows a more than fivefold increase in the duration of workers compensation claims when the claimants are obese will help employers and insurers better manage related costs, experts say.

To date, limited statistical analysis has been conducted on the correlation between increased claims costs and obese claimants, although payers have watched their medical expenses rise along with treating more injured worker comorbid ailments stemming from their growing waists.

“It’s just not an area where data has been collected (over) a significant period of time,” said Bruce Hockman, executive vp and workers comp practice leader in

Philadelphia for Towers Watson & Co.

In research released last week, NCCI Holdings Inc. said the duration of workers comp indemnity benefits paid to the most severely obese workers is more than five times greater than claimants who are not obese but filed comparable claims.

The research and rating organization examined claims provided by insurers operating in 40 states to reach its conclusions.

“The study shows that, based on temporary total and permanent total indemnity benefit payments, the duration of obese claimants is more than five times the duration of nonobese claimants,” NCCI found in the analysis. “When permanent par-



The duration of obese claimants' workers comp indemnity payments is more than five times that of nonobese claimants, NCCI says.

higher medical costs and miss more workdays due to job-related injuries than do their nonobese counterparts.

The Duke University study is widely cited today in discussions and articles on the impact of obesity on workers compensation claims.

While he respects the Duke University study, which was conducted with a “very high-quality” data set, workers comp observers have noted that its findings were based only on claims filed by Duke employees, said Frank Schmid, a director and senior economist for NCCI in Boca Raton, Fla.

NCCI’s findings are based on a much more comprehensive data set that confirmed the Duke University results, said Mr. Schmid, one author of the NCCI study.

NCCI reached its conclusions by culling 4.8 million claims, although only 6,435 of those were compared with similar claims with nonobese claimants.

It is important to note that NCCI’s results apply to employees who are among the most severely obese, which is similar to the

See **OBESITY** page 21

Cyber attack deemed ‘single largest threat’

Cyber attacks represent “probably the single largest threat” facing the United States, the chairman of the U.S. House of Representatives Intelligence Committee said last week. Rep. Mike Rogers, R-Mich.—author of the Cyber Information Sharing and Protection Act, which would encourage greater participation by the private sector in cyber security efforts—said the “threat changes by the day.” By the time mandatory cyber security standards are devised and implemented, the cyber attackers already are ahead of the defenders, he said. The bill—HR. 3523—passed the House in April, but it has yet to be taken up by the Senate.

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## SPOTLIGHT

### INDUSTRY DEEP DIVE: HOSPITALS & HEALTH CARE

Higher medical malpractice rate push tempered by other factors; risks rise with hospital M&As; simulations avoid mistakes; a look at Loma Linda’s efforts. **PAGE 9**

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tial benefits are counted toward duration as well, this multiple climbs to more than six.”

NCCI’s findings on the effect of obesity on indemnity duration are close to those in a landmark 2007 Duke University Medical School study. The research by the Duke team determined that obese workers file more claims, have

# Business Insurance

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## 2012 Business Insurance's WOMEN TO WATCH

**ACCEPTING NOMINATIONS:** *Business Insurance* is now accepting nominations for its annual spotlight on women doing outstanding work in commercial insurance, reinsurance, risk management, employee benefits and related fields. This year's nomination deadline is July 13. Profiles will run in the Dec. 3 issue of *Business Insurance*. Get all the details at [www.BusinessInsurance.com/Women2012Nominate](http://www.BusinessInsurance.com/Women2012Nominate).

### LAST WEEK'S TOP FEATURES [www.BusinessInsurance.com/BI10](http://www.BusinessInsurance.com/BI10)

1. Insurers struggling to maintain relevance for policyholders
2. GALLERY: Looking back at the career of Patrick G. Ryan
3. Cyber attack is 'single largest threat' to U.S.: Committee head
4. Obesity affects duration of workers comp benefits
5. Judge rejects former Marsh execs' claims of collusion
6. Five-year limit on comp benefits to older workers upheld in Fla.
7. U.S. health insurers to pay \$1.1B in rebates: HHS
8. Travelers pays \$10.5M to settle premium overcharge allegations
9. Chartis boosts property capacity to \$1.5B per risk
10. Chartis finds microinsurance success with tailored programs

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## EMPLOYMENT PRACTICES

# Overtime ruling favors employers

Outside sales representatives exempt: Supreme Court

By MARK A. HOFMANN

**WASHINGTON**—A Supreme Court decision that pharmaceutical sales representatives are not entitled to overtime pay could have ramifications far beyond that industry, employment law experts say.

In last week's 5-4 ruling in *Michael Shane Christopher et al. vs. SmithKline Beecham Corp.*, the Fair Labor Standards Act of 1938 holds that workers employed "in the capacity of outside salesman" are not entitled to overtime.

In the high court's decision, Associate Justice Samuel Alito noted that Congress did not spell out the meaning of "outside salesman" and instead delegated that authority to the Department of Labor.

The Labor Department set out a multifaceted definition, which Justice Alito pointed out includes guidance "stressing that an employee is an 'outside salesman' when the employee 'in some sense, has made sales.'"

The plaintiffs were employed by SmithKline Beecham for about four years starting in 2003. "Their primary objective was to obtain a nonbinding commitment from physicians to prescribe" their employer's pharmaceuticals in appropriate cases. Each spent about 40 hours a week in the field and an additional 10 to 20 hours attending events or performing other tasks. The court noted that Mr. Christopher made more than \$70,000 a year.

The prescription drug industry is subject to "extensive federal regulation, including the requirement that prescription drugs be dispensed only upon a physician's prescription," the court ruled. That means drug manufacturers have focused marketing efforts on physicians in an effort to persuade them to prescribe their products, Justice Alito wrote.

Mr. Christopher and another salesman sued on behalf of a class of plaintiffs in federal court in 2008. They argued that because they did not actually sell anything, they were not outside salesmen covered under the exemption and therefore were entitled to overtime.

While the lower court granted summary judgment to SmithKline Beecham, Mr. Christopher and the other plaintiffs asked the court to change its ruling because it failed to



Employment experts say the Supreme Court ruling on overtime pay could extend well beyond the pharmaceutical industry.

give deference to an amicus brief the Labor Department filed in a similar case elsewhere, in which the department said there is no sale unless employees actually "transfer title to the property at issue."

The district court and a three-judge panel of the 9th U.S. Circuit Court of Appeals rejected the plaintiffs' argument, as did the Supreme Court last week.

The plaintiffs "invoke the DOL's interpretation to impose potentially massive liability on (SmithKline) for conduct that occurred well before the interpretation was announced," Justice Alito wrote for the majority. "To defer to the DOL's interpretation would result in precisely the kind of 'unfair surprise' against which this court has long warned."

"The DOL's current interpretation—that a sale demands a transaction of title—is quite unpersuasive," Justice Alito wrote, noting that the department's interpretation was "flatly inconsistent" with the FLSA.

Employment experts say the ruling could extend well beyond the pharmaceutical industry.

"It is important in two respects," said Richard Alfred, chair of Seyfarth Shaw L.L.P.'s national wage and hour litigation practice in Boston.

First, the high court's holding in respect to deference "undermines the Department of Labor's very expansive regulation-by-amicus-brief program. That program has been used by the department to change the law on a wide variety of wage-and-hour issues that affect almost all businesses," he said.

The second way the decision will affect employers in other industries was in the court's analysis of Labor Department regulations. Mr. Alfred said the court used a "functional and practical interpretation" of the regulations to reach its conclusion. "This approach, which was the first time the Supreme Court has ever considered any of the white-collar exemptions, is the framework that the Supreme Court intends the lower courts to use in determining the applicability of all of the FLSA white-collar exemptions, including the administrative, executive and professional exemptions. All of those exemptions are defined in the DOL's regulations in reference to 'capacity' of employees, which is a linchpin of the court's *Christopher* decision on outside sales."

"It should have a huge impact beyond the pharmaceutical industry," said Robin Conrad, executive vp of the National Chamber Litigation Center in Washington, which filed an amicus brief in the case. "This is a very important and sweeping decision in terms of the type of industries affected."

"It was a wonderful decision from the standpoint the pharmaceutical companies, and I think that Alito's opinion made sense because of the heavy federal regulation of the industry that the drug company representatives cannot complete an actual sale," said Robin Shea, a partner at Constangy Brooks & Smith L.L.P. in Winston-Salem, N.C.

George Voegelé, member of Cozen O'Connor in Philadelphia, also said the ruling could extend beyond pharmaceutical sales. "Whenever you have a lead person, an initial contact person, who really is in the role of making the initial contact with a client or potential client but really hands off the actual nuts and bolts of signing the contract or transporting the goods to an underling, it creates more confidence that those initial contact people will still be considered exempt."

## HEALTH CARE COVERAGE

## HEALTH PLAN SATISFACTION

On a 1,000-point scale, health insurer Kaiser Permanente received the highest ranking among fully insured employers and Aetna Inc. received the highest ranking among self-funded employers.

## FULLY INSURED

Kaiser Permanente	716
HCSC Health Care Service Corp. plans	694
Humana Inc.	686
Cigna Corp.	685
Aetna Inc.	665
UnitedHealthcare	661
WellPoint Inc./Anthem Insurance Cos. Inc.	655

## SELF-INSURED

Aetna Inc.	680
UnitedHealthcare	660
Cigna Corp.	641
WellPoint Inc./Anthem Insurance Cos. Inc.	629

Source: J.D. Power & Associates  
2012 Employer Health Plan Study

## Survey ranks satisfaction with insurers

Some health insurers question findings

By MATT DUNNING

A recent survey of more than 6,500 employers ranked Oakland, Calif.-based Kaiser Permanente highest among large U.S. health insurers in terms of overall satisfaction with fully insured plans.

The survey results, released in limited fashion last week by Thousand Oaks, Calif.-based J.D. Power & Associates, also ranked Hartford, Conn.-based Aetna Inc. highest among self-insured plan providers for employer satisfaction.

Out of a possible 1,000 points, employers awarded Kaiser Permanente a score of 716 based on its performance in the six key areas of overall service experience, account servicing, program offerings, benefit design, problem resolution and cost.

Kaiser Permanente scored more than 40 points above the industry average mark of 672, and received top ranking in every category among fully insured plan providers except in benefit design.

In an interview, Kaiser Permanente Senior Vp Christine Paige said she believes the organization's blending of insurance services and medical care delivery was a key consideration in employers' evaluations of its services.

"The integrated approach that we have really does enable our

## RISK MANAGEMENT

## Certification eyed for risk managers in Europe

By STUART COLLINS

**LONDON**—European risk management associations are looking at ways to put the status of risk managers on a par with other professionals such as lawyers and accountants.

The Federation of European Risk Management Assns. has embarked on a project to certify risk managers in Europe, while London-based Airmic Ltd. is seeking chartered status for risk managers in the United Kingdom.

Airmic and FERMA say they want to put risk managers on a level footing with other professions, and the New York-based Risk & Insurance Management

Society Inc. says it is watching developments in Europe and continues to explore similar moves to raise the profile of risk managers in the United States.

There are several qualifications widely held by U.S. risk managers, but, while there is a chartered status for underwriters, there is nothing that would elevate risk managers to the same level as lawyers and accountants, said Richard J. Roberts, a RIMS board member and board liaison for RIMS' professional development group.

"RIMS looks continuously at

how we can get to the point of a chartered risk manager, much like professions like accountants," said Mr. Roberts. "The debate continues as to

whether chartered status adds value, and we are reaching out to member companies to see if it would be recognized by senior management.

If you build a program, you will want members to see value in it," he said.

Mr. Roberts said RIMS wants to see how the efforts of European associations pan out, including Airmic's partnership with the London-based Chartered Insurance Institute, the U.K.'s profes-

sional organization for insurers and financial advisers.

RIMS is not a certified body and does not have the resources to administer and test a certification process, said Mr. Roberts. "It would be a big undertaking, so partnering with another organization (as AIRMIC has done) is likely to be the best way forward, but we have not investigated that yet," he said.

Brussels-based FERMA says it has established a working group to consider a pan-European certificate of professional competence for risk managers. The working group will present a plan



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## INTERNATIONAL

# Emerging risks testing insurers

*New approach required: IIS panelists*

By GAVIN SOUTER

**RIO DE JANEIRO**—Insurers are fading in relevance for many corporate policyholders as they fail to offer solutions for their emerging risks, according to one insurer executive.

And as they seek to expand their own businesses, insurers need to readjust their view of emerging markets, the insurer executive said.

Insurers should adopt different strategies for the various markets they want to enter rather than treating emerging markets as a homogeneous group, a reinsurer executive added.

Both were speaking during the 2012 International Insurance Society Seminar, held last week in Rio de Janeiro.

Michael McGavick, CEO of XL Group P.L.C., said that with the insurance premium share of worldwide gross domestic product shrinking over the past 10 years, “we’ve been losing relevance.”

And only by adjusting their approach will insurers be able to offer the services and coverage businesses need in the changing global economy, he said.

In the three most important areas of evolving risks—technology, energy and supply chain—insurers are not providing businesses with the services they need, he said.

“If you look at the role of insurance in technology, we are practically not present,” Mr. McGavick said during a panel session. While insurers do offer some cyber liability coverage, they are failing to offer coverage for risks such as privacy, intellec-



Mr. McGavick

tual property and business interruption related to technology problems, he said.

For energy risks, the 2010 Deepwater Horizon disaster in the Gulf of Mexico illustrated how insurance has decreased in value for energy companies because the well’s operator, BP P.L.C., was largely uninsured. Insurers were not large enough to match BP’s own balance sheet and did not offer enough insight into the risk to provide risk management assistance, he said.

But “what happened to BP exposed the flaw in the thinking” of energy companies, he said. When companies are so confident in their own risk management that they fail to have anyone “looking over their shoulder,” it sets up an inherent risk.

Regarding supply chain risks, the Thai floods and the Japanese earthquake last year showed the huge contingent business interruption exposure that businesses face, Mr. McGavick said. Insurers

## IIS SEMINAR DRAWS 400 TO RIO DE JANEIRO

**RIO DE JANEIRO**—More than 400 delegates attended the 48th annual International Insurance Society Seminar in Rio de Janeiro on June 17-20.

Topics ranged from the challenges facing insurers and reinsurers and utilizing mobile technology to selling insurance in developing nations to regulatory developments in Brazil and China.

The centerpiece of the conference was the official launch of the Principles for Sustainable Insurance, which was signed by 27 insurers and reinsurers. The four principles are:

- Insurers will embed in their decision-making environmental, social and governance issues relevant to the insurance business.
- Insurers will work together with their clients and business partners to raise awareness of environmental, social and governance issues, manage risk and develop solutions.
- Insurers will work together with governments, regulators and other key stakeholders to promote widespread action across society on environmental, social and governance issues.
- Insurers will demonstrate accountability and transparency in regular public disclosures of their progress in implementing the principles.

The conference coincided with the Rio+20 United Nations Conference on Sustainable Development. The next IIS Seminar will be at the Grand Hyatt Hotel in Seoul, South Korea, on June 16-19, 2013. For more information, visit [www.iisonline.org](http://www.iisonline.org).

—By Gavin Souter

were surprised by the size of the losses even though “we’ve been talking about just-in-time inven-

tory for a full decade,” he said. Insurers responded by inserting exclusions into policies to limit their exposure to future supply chain losses—a response that will push businesses to find solutions outside of insurance and push themselves further away from the industry, he said.

To overcome these challenges, insurers need to ensure that their best people are addressing emerging risks rather than using them for the most profitable lines of business, Mr. McGavick said.

Another challenge that insurers face as they seek to expand their businesses is how to address emerging markets, Mr. McGavick said. Several speakers at the seminar noted that many insurers are aggressively seeking to expand in emerging markets as organic growth opportunities stall in their home markets.

“To use the term ‘emerging markets’ is to admit to ignorance. These are the markets of opportunity and growth,” Mr. McGavick said.

As insurers expand into new markets, they should be aware of the often-significant differences between the countries they are moving into and not treat them as generic emerging markets, said Denis Kessler, chairman and CEO of Paris-based SCOR S.E.

Closer examination of the exposures insurers face in emerging markets will reveal the differences between the markets and the level of catastrophe risk they are taking on, which often is greater than insurers may think, he said.

“Emerging markets are not clones,” and each market requires a different strategy and approach, Mr. Kessler said during the panel session. Different legal systems, different family sizes, different religious beliefs and different attitudes to risk create specific characteristics for each market, he added.

Insurers often find it difficult to assess their exposures in emerging markets because data is

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## HEALTH CARE REFORM

# Young adults gain cover from reform

By JERRY GEISEL

**WASHINGTON**—More than 3 million young adults have gained health insurance due to a health care reform law provision that requires employers to extend coverage to employees’ adult children up to age 26, the Department of Health and Human Services said last week.

Since the provision first took effect on Sept. 23, 2010, 74.8% of young adults 19 through 25 years old were insured through December 2011, up from 64.4% in September 2010. That increase represents 3.1 million additional young adults who now have health insurance, HHS said in releasing the survey by its National Center for Health Statistics unit.

The increase is directly attributable to the young adult coverage provision in the health care reform law, federal researchers said.

For example, in the next age bracket—26 through 35—the percentage with health insurance during the same period was virtually unchanged at about 72%, HHS said.

“Today, because of the health care law, more than 3 million more young adults have health insurance,” HHS Secretary Kathleen Sebelius said in a statement. “This policy doesn’t just give young adults and their families peace of mind, it also gives them freedom. It means that as they begin their careers, they will be free to make choices based on what they want to do, not on where they can get health insurance.”

The young adult provision, which began Jan. 1, 2011, for employers with calendar year plans, was one of the first Patient Protection and Affordable Care Act mandates to go into effect.

Under the reform law, the only eligibility requirement that employers can impose is that the employee’s child be younger than 26, putting an end to common coverage requirements such as college enrollment, financial dependency or residency with a parent.

While definitive statistics are not available, consultants and employers said earlier that cost increases resulting from covering more young adults have been modest, typically ranging from just less than 0.5% to 1.5%.

The expansion has been extremely popular among employees. For example, if the health care reform law is overturned, 59% of benefit professionals responding to a survey released earlier this month by the International Foundation of Employee Benefit Plans said employees would want Congress to pass legislation reinstating the age 26 coverage mandate.

## SAFETY

# Safety professionals need to learn risk financing

*Communication with insurers, execs can help prove value*

By ROBERTO CENICEROS

**DENVER**—More environmental health and safety professionals need to learn risk financing concepts to take advantage of opportunities that result from communicating with the C-suite and insurance underwriters.

That’s the advice of leaders, speakers and attendees at the American Society of Safety Engi-

neers’ Professional Development & Exposition held June 3-5 in Denver.

They said safety engineer roles are shifting, requiring those in their profession to communicate with insurance underwriters to help reduce their employer’s cost of risk. Learning risk financing concepts also helps safety professionals communicate in a language that upper management comprehends. Expanding their knowledge in such a way will help safety professionals garner greater visibility and increase their value.

“The safety professional has to

be able to communicate to decision-makers in the business,” said Mark D. Oldham, senior loss control consultant for Lockton Cos. L.L.C. in Denver. “If the safety professional says, ‘Our total incident rate is (fill in the) blank,’ it doesn’t mean anything. But if you can say, ‘Our lost cost consumes 4% of gross profit margin on this plant and 8% on that plant,’ that is something they can relate to. They can measure it” in financial terms.

That level of communication will elevate safety engineers from professionals who mostly are thought of as wearing hard hats

and promoting safe work practices to professionals who are seen contributing to their company’s profitability, said Mr. Oldham, who spoke during a session on loss control.

Understanding insurance terms also helps safety engineers conduct effective risk evaluations and explain their findings so insurance underwriters are more likely to provide their employers with preferable rates and conditions, Mr. Oldham said.

ASSE President Terrie S. Norris said that helping the Des Plaines,

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# Mid-Market EXECUTIVE

Helping C-level executives at midsize firms overcome critical risk and benefits challenges

## Irene teaches tough lessons

*Flooding, power outages found many unprepared*

By JOANNE WOJCIK

While small and midsize businesses in the Southeast and along the Gulf Coast generally know what their property insurance will cover when a hurricane heads their way, experts say many businesses in the Northeast were caught off guard last summer when Hurricane Irene stormed up the East Coast.

Perhaps the biggest surprise was the amount of water damage that occurred as far north as Vermont, where many businesses had no flood insurance, they note.

Losses from extended business interruptions after Irene also went largely uninsured because many small and midsize businesses either had time deductibles for service interruption or had limits on ingress/egress coverage under their business owners or commercial property policies, the experts say.

While small and midsize businesses can't prevent hurricanes and other catastrophic events, they can mitigate their exposure to such risks through comprehensive planning, said Victor J. Sordillo, vp and global technical services manager, loss control services, at Chubb & Son Inc. in Whitehouse Station, N.J. (see story).

"Even some big clients had some, 'Oops!' moments" following Hurricane Irene, said

Duncan Ellis, New York-based U.S. property practice leader for brokerage Marsh Inc. "The issue we found was: Where was storm surge covered?" he said. "Was it covered under flood, which is almost always sublimited, or was it covered under wind, which is sublimited much fewer times?" In cases where it was covered under flood, businesses often found they had less coverage, he said.

"Most commercial policies are pretty stingy on coverage in flood zones, usually no more than \$1 million" in coverage, said Al

Tobin, New York-based managing principal in Aon Risk Solutions' property practice.

"Typically, insurers will attach (in) excess of (National Flood Insurance Program) coverage, whether purchased or not, for critical flood zones," which include coastal areas and land along inland waterways, said Eric Nikodem, executive vp and prop-

erty division executive at Lexington Insurance Co. in Boston. So "unless the client went out and bought the NFIP coverage, that becomes the deductible."

Unfortunately, "NFIP doesn't provide a great deal of coverage, and it excludes business interruption," Mr. Nikodem noted.

While most business owners property and commercial property policies cover civil and military authority disruptions, such as when the government orders a business to vacate or not enter a particular area, that coverage was limited in many cases because of policy waiting periods, Mr. Tobin said.

"When Hurricane Irene was coming, authorities shut New York City down for two days because of the pending storm. That triggered a clause in policies called 'civil authority,'" he said. Many policies have civil authority waiting periods ranging from 24 to 72 hours. "So if you had a 48-hour waiting period, then you didn't have a loss," he said.

For many small and midsize businesses in the Northeast, ingress/egress coverage was even more limited, Mr. Ellis said.

"These types of coverage, depending on how they are written, sometimes will require damage to your own property. Other times, it will require damage in the area that is the type insured by your policy," Mr. Ellis said.

For example, if a business didn't have flood coverage, but it was not accessible because a neighboring business was flooded, the first business very likely wasn't covered for the lack of ingress/egress, he said.

Service interruption coverage also was limited for many small and midsize businesses left without power following Hurricane Irene. "There are often limitations as far as mileage around your property," Mr. Ellis noted.

In some cases, flooding added to the power outages, with businesses in New Jersey, Vermont and upstate New York hit hard.

"Some of them were without power for two weeks," said Dave Finnis, property practice leader for Willis North America Inc. in Atlanta. "For the most part, Irene affected the Northeast as a water event as opposed to a wind event."

In many cases, coverage for such service

interruptions was limited depending on whether the business owners policy contained a "time deductible" vs. a "waiting period," Mr. Ellis said.

For example, if the policy contained a 24-hour waiting period for service interruption losses, coverage would apply to the first minute of power loss after that waiting period. However, if the policy has a 24-hour time deductible, coverage doesn't begin until the 25th hour of service interruption, he said.

While all of these policy nuances may seem like "old hat" to small and midsize businesses along the Gulf Coast or Southeast, businesses in the Northeast were not as familiar with them, said Mr. Finnis.

Fortunately, Hurricane Irene weakened by the time it hit the Northeast. Had it remained even a Category 3 storm, it would have had a devastating effect on businesses, according to a recent report by data analysis firm CoreLogic, which found New York City to be the U.S. metropolitan area at greatest risk from hurricane damage, both in the number of properties affected and the potential value of damage.

"It's been a long time since a hurricane hit the Northeast, so it's not on your mind every day," Mr. Finnis said.

In the aftermath of Hurricane Irene, Alice V. Edwards, a partner in the Atlanta office of forensic accounting firm Dempsey Partners L.L.C., advises clients to "read carefully" the storm and flood coverage sections of their property insurance policies so "people are not blindsided."

"The language in some of these policies can be a little difficult for the layman to understand. So if you see that you've got a percentage deductible...ask for an example with a deductible calculated showing how it would work," she suggested.

## Mitigate losses with a solid contingency plan

By JOANNE WOJCIK

Even though small and midsize businesses may not have the same resources as large companies to finance and implement extensive emergency response and business continuity plans, neglecting to put basic precautions and procedures in place to protect against hurricanes can mean crippling financial losses, experts warn.

"You have to look out for all contingencies," said Victor J. Sordillo, vp and global technical services manager, loss control services, at Chubb & Son Inc. in Whitehouse Station, N.J.

For example, following Hurricane Irene, "the power loss had a huge impact. Millions were without power for more than a week. That was one of the most easily predictable scenarios, but the one for which most small businesses were the least prepared," Mr. Sordillo said.

In addition, "most businesses learned that the government can, in fact, impose limitations on your ability to conduct day-to-day operations," he said, referring to

the extended period during which local authorities ordered businesses to shut down before the hurricane made landfall. "So many global companies are located in the Northeast. The hurricane may be hitting New York, but you still have obligations around the world."

Loss mitigation is especially important for catastrophes that cover a large geographic area, such as Irene, since it can take days or even weeks before claims adjusters will reach affected properties, said Alice V. Edwards, a partner in the Atlanta office of Dempsey Partners L.L.C., a firm that provides post-catastrophe forensic accounting services to businesses.

"In Hurricane Irene, it took days for adjusters to get out to some people's businesses," she said.

"Regardless, you have to do the best you can to protect your business. For example, coverage for mold is quite restricted. So it's important to have a contractor come out and prevent mold from growing" following flood or water damage. "If you and your insurer have already agreed on a local

restoration contractor or roofer, it's going to save you a lot of heartache on the back end," Ms. Edwards said.

Small and midsize businesses often "haven't thought about who in the business is going to take charge of a claim, especially if they don't have a risk manager. One of the most important things you can do is to put a team together and decide the roles and responsibilities of the team" before a storm occurs, Ms. Edwards advised. The team should include someone with project management expertise, which is important to meet timelines.

"These are the types of things people in Florida know, but we haven't had enough practical experience in the Northeast to take these things for granted," Ms. Edwards said.

"Flooding and loss of utilities were the two biggest issues" that businesses confronted, said David H. Gluckman, senior risk control consultant in the strategic outcomes practice of Willis North America Inc. in Morristown, N.J., who spoke last November at the Morris County Chamber

of Commerce's "Lessons from Irene" conference that was designed to educate local businesses on disaster preparedness.

"Businesses came to a halt. There was no planning in place for backup generators, emergency response and communication with employees to tell them not to come to work," Mr. Gluckman said. With the power out, cellphones could not be recharged and there was no Internet access. "Generators weren't readily available after the event. It was just like trying to buy snowblowers after a snowstorm."

But at least one midsize business in Hurricane Irene's path was adequately prepared, said Mike Lebovitz, senior vp of Affiliated FM, the division of Johnstown, R.I.-based Factory Mutual Insurance Co. that serves the middle market.

"We had a retail client with a number of locations exposed to the area of Hurricane Irene who prepared in advance of the hurricane by providing emergency generators for their locations...and trained employees how to ring up purchases without all of the usual electronic cash registers and communication in place." As a result, the retailer "had very minimal damage" and "very little loss," said Mr. Lebovitz, who declined to identify the business.

## Market Moves

### Chartis launches practice for hospitality, leisure

**NEW YORK**—Chartis Inc. has announced the launch of a hospitality and leisure industry practice group and has named Lance J. Ewing as the practice's regional leader, the insurer said in a statement.

The practice, which will be scattered throughout North America, will offer coverage for hotels, casinos, cruise lines, resorts, and other amusement and gaming industries.

Mr. Ewing, a former *Business Insurance* Risk Manager of the Year® and 2003-2004 president of the Risk & Insurance Management Society Inc., previously was vp of national accounts for Chartis. He is based in Cordova, Tenn.

For more information about the new practice, contact Mr. Ewing at [lance.ewing@chartisinsurance.com](mailto:lance.ewing@chartisinsurance.com).

### MMA buys benefits broker serving Raleigh, N.C.

**NEW YORK**—Marsh & McLennan Agency L.L.C., a subsidiary of New York-based Marsh Inc., has acquired Progressive Benefit Solutions, a Raleigh, N.C.-based benefits broker with \$5 million in revenue. Terms of the transaction were not disclosed.

PBS will operate as a division of Rutherford, an MMA subsidiary based in Richmond, Va., expanding Rutherford's employee benefits capabilities and resources in the Raleigh market, the company said.

PBS offers a wide range of health, wellness, compliance and executive compensation products and services to middle-market employers. Members of the PBS team will continue operating out of PBS' existing Raleigh office.

The transaction is the fourth complementary acquisition for Rutherford/MMA. Last year, Rutherford/MMA picked up two other employee benefits brokerages: KSPH L.L.C., a \$5 million brokerage firm in Glen Allen, Va.; and Alpharetta, Ga.-based Strategic Benefit Solutions Inc., a \$4 million benefits brokerage and consulting firm. In addition, it acquired Hampton Roads Bonding, a Virginia Beach, Va.-based surety bonding agency with \$3 million in revenue.

MMA, created in 2008, operates independently from Marsh to offer commercial property, casualty, personal lines, and employee benefits to midsize clients across the United States.

### Towers Watson launches Europe reinsurance unit

**MUNICH**—To service reinsurance clients in Germany, Austria and Switzerland, New York-based risk and financial management firm

Towers Watson & Co. has created Towers Watson (Re)Insurance Brokers GmbH.

The German-incorporated business unit will be based in Munich and led by Herbert Sedlmair, who joined from New York-based Guy Carpenter & Co. L.L.C., where most recently he was executive director in its Munich-based operation.

Richard Denniston, director for Continental Europe at Towers Watson (Re)Insurance Brokers, said the new unit is part of a planned expansion into continental Europe.

"By setting up in Germany, we aim to mirror the creation of a regional platform such as we have done in Paris in the last few years,

with close working relationships between brokerage, actuarial consultants and software," Mr. Denniston said in a statement.

### ACE acquires Indonesian insurer

**JAKARTA, Indonesia**—ACE Ltd. announced that it has entered into a definitive agreement to acquire Jakarta, Indonesia-based insurer PT Asuransi Jaya Proteksi for approximately \$130 million in cash.

Established in 1963, Asuransi Jaya Proteksi—or JaPro—offers commercial insurance such as liability and marine cargo as well as personal lines and health insurance. In addition to its network of

offices located throughout the Indonesian archipelago, JaPro also maintains relationships with local brokers and agents, the company said.

"There is a good strategic fit between our companies," Damien Sullivan, regional president, ACE Asia Pacific, said in a statement. "JaPro is complementary to ACE's existing business in Indonesia, which includes life insurance, commercial property/casualty, and accident and health, and together we will build a sustained business for growth in this attractive, fast-growing market."

Contingent on regulatory approval, the transaction is expected to be completed of during the third quarter of 2012.

### Brit Insurance sold to RiverStone Resources

**LONDON**—Brit Insurance Holdings B.V. has sold Brit Insurance Ltd. to Manchester, N.H.-based RiverStone Resources L.L.C. for an undisclosed sum as part of a restructuring.

RiverStone is the runoff unit of Toronto-based Fairfax Financial Holdings Ltd.

Under terms of the deal, Brit Insurance Holdings will retain the liabilities and claims handling for certain business currently within London-based Brit Insurance Ltd. relating to the group's ongoing core business now being written into Brit Holdings' Lloyd's of London syndicate 2987.

SEPTEMBER 5TH, 1:45 A.M.

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# Opinions

## EDITORIAL

### Overtime ruling right on target

**T**he U.S. Supreme Court prevented a potential flood of litigation with last week's ruling in a case involving eligibility for overtime pay.

As we report on page 3, at issue in *Michael Shane Christopher vs. SmithKline Beecham Corp.* was whether a pharmaceutical sales representative was entitled to overtime pay. Under the Fair Labor Standards Act—a Depression-era law designed to prevent the exploitation of workers—employers are exempt from paying overtime to certain classes of employees. One of those classes consists of workers employed “in the capacity of outside salesman.”

The plaintiffs in the case had argued that since they actually don't close sales when trying to persuade physicians to prescribe their employer's products, they weren't actually salesmen. Both a district court and an appeals court rejected that reasoning. But matters grew more complicated when the U.S. Department of Labor filed an amicus brief in a different case in a different court maintaining that pharmaceutical sales representatives were not outside salesmen as defined by the act.

The high court rejected the idea that it should grant deference to the department's interpretation of its own rules issued long after the conduct at issue occurred. And by doing so, we believe the high court ruled correctly in its 5-4 decision.

Until that DOL amicus brief, filed in 2009, pharmaceutical companies had no reason to believe that their practice of treating the sales representatives as exempt from overtime was wrong. And the conduct at issue occurred over about four years in the middle of the decade. It is simply a matter of fairness that employers not be subject to what Associate Justice Samuel Alito called “unfair surprise” in the opinion he wrote for the court.

We couldn't agree more.

Perhaps more importantly, though, had the court ruled in favor of the plaintiffs, other exemptions in the FLSA probably would have come under fire as well. The result would no doubt have been a flood of litigation by other currently exempt workers attempting to secure overtime pay. The decision may have been by the narrowest of margins, but its impact should be broadly felt indeed.

## LETTERS

*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

### Ruling complicates injury disputes

**A** California appellate court dealt a significant blow last week to a practice employers have come to rely on to control rising workers compensation medical expenses.

The court ordered the publication of its May 29 decision allowing reports from doctors who are not part of an employer's work comp medical network to be admissible evidence for determining benefits.

The ruling in *Elayne Valdez vs. Workers Compensation Appeals Board* was seen by some observers as a victory for injured workers and claimant attorneys.

It comes as insurers and employers are already experiencing increased workers compensation cost pressures.

Recall that California Insurance Commissioner Dave Jones recently approved an 8.25% advisory pure premium rate hike for policies renewing on or after July 1. He cited rising medical utilization as a main driver of workers comp costs.

He also said that while system costs were increasing, there has been little change in the premiums insurers are charging for workers comp policies because of underwriter competition.

But it's well known that work comp insurers are experiencing lousy combined ratios, exerting pressure on them to raise their pricing, which appears to be occurring nationwide.

Against that backdrop, last week's ruling by California's 2nd District Court of Appeal is particularly unwelcome news and will add to calls that it is

once again time for California to implement work comp reforms.

Due to 2004 reforms, California employers and insurers that established medical provider networks, known as MPNs, gained the right to select doctors to treat their injured workers.

That gave them a significant measure of cost control, and last year the California Workers' Compensation Institute reported that use of the

MPNs had become widespread since 2005, with workers typically channeled to network providers at the outset of their claims.

Meanwhile, claimant attorneys reportedly looked for technicalities that would allow their clients to go outside of the network in hopes of obtaining greater benefits.

That is why last week's ruling, which annulled a Workers' Compensation Appeals Board en banc decision favoring employers and insurers, is a substantial blow for payers.

The appellate court essentially said in May that injured workers have a right to present evidence from their treating physicians, whether or not those physicians are in an employer's network.

But that decision was not published, meaning its application was of limited or no use in other cases.

That changed last week when the court ordered its ruling published. Now it can be cited in other worker injury disputes.

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**ROBERTO CENICEROS**  
SENIOR EDITOR



# STABLE CONDITION

*Push for higher medical malpractice rates tempered by other market forces*

By **ROBERTO CENICEROS**

**U**nderwriters providing medical malpractice insurance for hospitals and doctor groups are trying to raise their prices, but competitive market pressures are working against them, brokers and insurers report.

As a result, they say, rates are flat—in contrast to decreases during the past several years—for the excess layer medical malpractice coverage that hospitals typically buy and the primary layer insurance usually purchased by physician groups.

“This year, there is more push (on the part of insurers) for rate than there was last year or the year before,” said Brenda Osborne, senior vp and chief underwriting officer for Lexington Insurance Co.’s health care business in Boston.

But they are pushing against competitive market forces favoring insurance buyers, particularly those with risk management strategies that are preventing losses, several sources said. Additionally, new medical malpractice underwriters have entered the market within the past few years, adding capacity that is making it challenging for insurers to obtain price increases, Ms. Osborne added.

“It appears there is some success in the industry to get rate,” Ms. Osborne said. “Now brokers are happy with flat as opposed to pushing for rate decreases.”

Insurers holding rates flat does represent a shift, said John Colosimo, senior vp and a health care practice expert in Philadelphia for Lockton Cos. L.L.C.

“It’s interesting, because we are really beginning to see some rate pressure from the carrier side,” Mr. Colosimo said. “Everybody is trying to get rate. On good risks, it’s very difficult for those markets to get rate even though they are trying.”

Accounts with favorable risk profiles “are

still able to hold (their costs) pretty close to flat, but if you have had some loss penetration into your excess layers...carriers are trying to make up for that now,” he said.

Insurers are focusing on attempts to increase rates, making it beneficial for hospitals and physicians wanting favorable pricing to demonstrate to underwriters that they have patient safety initiatives that work, said Sarah Pacini, vp of risk management and insurance at Oak Brook, Ill.-based Advocate Health Care Network.

During her Jan. 1 renewal, Ms. Pacini said she obtained 2011 pricing. She also sought a multiyear contract, which she was able to negotiate during renewals in prior years. But her insurers said they would want rate increases for the second year and any subsequent years.

“So we chose to do a single year,” Ms. Pacini said. “I continue to be concerned that it does seem to be threatening to be a hard market in the near future.”

Hospitals often purchase excess coverage rather than primary insurance, because they typically maintain large retention levels, self-insure, form a captive or other alternative programs, sources said.

Doctor groups, in contrast, tend to buy primary coverage because they are usually much smaller entities. But some doctor groups also transfer risk through alternative arrangements such as risk retention groups. Interest in alternatives also is adding to the competition faced by traditional underwriters.

A significant trend of hospitals acquiring doctor groups also impacts the medical malpractice insurance market, said John H. Mize, a medical professional liability expert and managing director for Towers Watson & Co. in Atlanta.

Large hospitals acquiring the physician groups often pull their new employee doctors into the hospitals’ self-insurance

arrangements, Mr. Mize said, so those doctors are being removed from the pool of clients demanding coverage from traditional underwriters.

“If you are a physician insurer, you are seeing more of your marketplace being taken away by a brand new competitor, with that new competitor being the self-insured programs of physicians’ new employers,” Mr. Mize said. “So you are seeing a smaller percentage of the physician marketplace actually being in the market to buy commercial coverage.”

And hospitals are not the only ones buying physician groups.

A health care market report published by Lockton in April said that during the past 12 to 18 months, private equity groups and health systems also have increased their acquisition of physicians and other hospitals.

This reduction in physician groups is a major factor impacting specialty insurer business, with the trend expected to continue, said Michael Kubik, vp of marketing for Coverys, a Boston-based medical professional liability insurer.

To help offset the loss of physicians to insure, specialty insurers are developing new products. For example, specialty insurers are capitalizing on the mergers and acquisitions activity by offering stand-alone tail policies at a lower cost than those offered by the insurer the physician or hospital is leaving, according to the Lockton report.

Hospital risk managers would like acquired physician groups to purchase tail coverage for losses accumulated before the hospital bought them, sources said.

But the cost for such coverage may make selling their business less appealing for the doctors, so it is not always possible for hospitals to acquire the physicians without also acquiring their tail liability, the sources added.

INDUSTRY DEEP DIVE:  
Hospitals and  
Health Care

# SPOTLIGHT

**HOSPITAL MERGERS  
RISING AS DO RISKS  
FOR ACQUIRERS**

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**UNPRECEDENTED  
CHALLENGES:  
UNUM EXECUTIVE**

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**SIMULATIONS  
AVOID MISTAKES  
ON LIVE PATIENTS**

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**CASE STUDY: TRUST,  
CAPTIVE FUND  
LOMA LINDA EFFORT**

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# As hospital M&As rise, so do acquirers' risks

Due diligence focus includes practices, equipment, staff

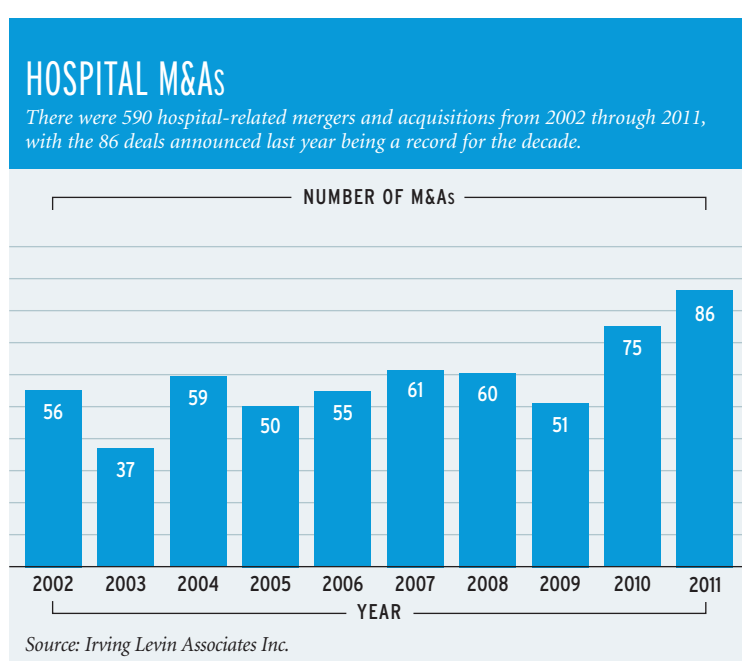
By SUSAN WELCH

The pace of hospital mergers and acquisitions has accelerated in recent years as health care facilities look to reduce their costs, but experts say risks posed by the entity being acquired require a thorough investigation before completing such a deal.

Challenges for hospitals include reimbursement pressures from all payers, pressure to maintain a hospital's tax-exempt status, changes in health care delivery methods, the need to update technology, regulatory and compliance changes, and the ongoing need to gain greater delivery efficiencies, according to a March report by Moody's Investors Service Inc.

Last year, there were 86 hospital M&As—the highest number of deals in the past decade, according to Irving Levin Associates Inc. However, the value of those deals, \$7.94 billion, was a fraction of the \$35.53 billion in hospital-related M&As in 2006, the record in the past decade, according to the Norwalk, Conn.-based company (see chart).

Hospital risk managers need to investigate a series of potential liability and compliance risks on the entity being acquired, said Madelyn Quattrone, senior risk man-



agement analyst with the Plymouth Meeting, Pa.-based ECRI Institute.

"The acquiring organization must be aware of liability risk, claims and regulatory compliance risks and history of the to-be-acquired providers and their corporate organizations," Ms. Quattrone said.

Identifying and closing insurance coverage gaps is another priority. For example, "employing physicians who lack tail coverage for prior acts could expose the acquiring organization to future potential liability for prior acts of the physician," she said (see story,

page 15).

Doug Mitchell, a principal at Phoenix-based consulting firm David Douglass L.L.C., cited the need to monitor "claims made against an insurance policy where coverage is written on a claims made basis," as well as risks associated with human resources-related issues at the acquired entity.

Significant Medicare-related risks also could be involved, said Todd Swanson, a principal in the business transactions department of Los Angeles-based law firm Hooper, Lundy & Bookman P.C.

"Common areas of focus are those associated with compliance

with federal and state fraud and abuse laws," Mr. Swanson said in referring to anti-kickback laws and physician self-referral restrictions. In addition, there is "possible exposure for past overpayments from, or false claims to, governmental and other third-party payers. Violations of these laws can lead to substantial recoupments by governmental payers, civil and criminal sanctions and possible exclusion of the provider from the right to participate in Medicare and Medicaid," he said.

"Past improper billing practices by the selling facility could result in Medicare withholding such overpayments against the purchaser's future Medicare payments," he said.

Examining hospital-acquired infections, such as methicillin-resistant *Staphylococcus aureus* or Vancomycin-resistant enterococci, is another concern as are outbreaks of other infectious diseases.

Dr. Joseph Perz, Atlanta-based epidemiologist and team leader with the Centers for Disease Control and Prevention, advised monitoring the entity being acquired and taking a close look at a few key areas, including its injectable medication preparation and administration, the extent to which a facility combines medica-

tions and its equipment reprocessing practices.

While it may be uncommon for facilities to engage in poor practices such as reusing syringes, "you do want to tease that out," Dr. Perz said. "Bad practices expose the (acquiring entity) to a lot of risk. It could be catastrophic. Retrospective notification of patients may be required."

In short, poor health practices "could be a deal breaker," he said.

Likewise, "there is more risk if a facility is doing a lot of manipulation of medicines on-site, such as compounding" or mixing medicines for a particular patient, Dr. Perz noted. "Then you need to adhere to CDC and pharmacy standards."

Validating effective equipment reprocessing for items such as an endoscope also is critical. Poor practices that may lead to unsanitary conditions or risk of infection also can require retroactive notification of patients, he said.

The numerous, complex risks associated with acquiring a health care bring far-reaching implications (see box).

As the Patient Protection and Affordable Care Act comes into play, Ms. Quattrone urged all

See M&As page 15

## Risks to consider, mitigate in a hospital-related M&A

Several risks need to be monitored during health care industry M&As.

Risk management support often begins with conducting due diligence, said Madelyn Quattrone, senior risk management analyst with the ECRI Institute in Plymouth Meeting, Pa. This typically takes place prior to the acquisition, and involves researching the acquisition to understand its liability risk, its claims scenario, regulatory and compliance concerns, and its overall history.

Particularly true in acquiring a physician practice, but relevant in any health care merger, is the need to ensure appropriate underwriting practices and closing any gaps, said Todd Swanson, a principal in the business transactions department of Los Angeles-based Hooper, Lundy & Bookman Inc.

Comparing and meshing the merged entity's risk and safety culture is another priority, observers said.

Monitoring a facility's injectable medicine preparation and administration, on-site manipulation of medications and equipment reprocessing procedures ensure safe, healthy practices and can

avoid catastrophic outcomes, said Dr. Joseph Perz, Atlanta-based epidemiologist and team leader with the Centers for Disease Control and Prevention. As needed, hiring an infection control professional to ensure appropriate procedures is a good measure.

A growing concern involves remote sites, said Ms. Quattrone. When a physician practice or health care entity includes remote sites, the ideal scenario includes an on-site assessment of risks and potential concerns. This cannot always be achieved; outside experts and consultants can help.

Likewise, outpatient facilities must be monitored as well, said Dr. Perz.

Compliance with fraud and abuse laws is often worth an extra look, since violations can be costly, said Mr. Swanson.

In short, hospital risk managers involved in M&As should be prepared for anything. According to Dr. Perz, there can be some "jaw-droppers" when it comes to acquiring an entity, mostly concerning what an organization may have done to remain operational.

—By Susan Welch

IN A WORLD OF COMPLEX DECISIONS

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# WHAT'S REALLY AT RISK?

FAILURE TO PROTECT PRIVATE INFORMATION\* FROM CYBER THREATS CAN RESULT IN LOSSES TO:

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BUSINESS OPPORTUNITIES • INTELLECTUAL PROPERTY**

## A STRATEGIC APPROACH TO LOSS PREVENTION

Take proactive steps to address vulnerabilities arising from:

### PEOPLE, PROCEDURES, TECHNOLOGY



#### PEOPLE

##### RISKS ...

- Hackers, hacktivists targeting company
- Rogue administrator hired without background check
- Company laptop stolen or lost by traveling employee
- Employee mistakenly posts sensitive information online
- Untrained employee victim of phishing, malicious code attack
- Employee unaware of ban on storing info on cloud services
- IT personnel not trained to respond to security breach
- Lack of support by organization leadership
- Risk manager excluded from cyber security effort

## PROCEDURES

##### RISKS ...

- Security procedures are not widely known or communicated
- Ignorance of where sensitive information is collected and stored
- Customer data unavailable when cloud-based server is attacked
- Vendor inadvertently given access to customer data
- Terminated employee retains access to systems, information
- Employee picks up malware downloading free game on company PC
- IT team not aware of state, federal data governance regulations
- No budget for consistent, effective cyber security procedures

## ... PREVENTIVE MEASURES AND RESPONSE STRATEGIES

- Classify data according to privacy, security needs
- Know where data is stored: electronic vs. paper, internal vs. external
- Set clear policy about storing data on cloud-based servers

## ... PREVENTIVE MEASURES AND RESPONSE STRATEGIES

- Establish cross-disciplinary team to set cyber policies
- Designate a chief privacy officer
- Provide companywide education on cyber-related threats
- Communicate security policies and enforce them
- Segregate and restrict access to sensitive data
- Conduct background checks on staff with access to data
- Establish user control, password protection procedures

## \* PRIVATE INFORMATION WHERE ARE THE EXPOSURES?

### ANY INFORMATION THAT CAN BE USED TO IDENTIFY AN INDIVIDUAL, INCLUDING:

- Credit card information of customers
- Social Security numbers of employees, job applicants
- Patient health information, medical claims records
- Date of birth information
- Customer user names and passwords
- Customer or employee contact information
- Customer or employee account information
- Financial records and account number
- Driver's license number
- Biometric information



## TECHNOLOGY ... RISKS ...

- Failure to detect data breach
- Anti-virus software outdated, does not recognize threat
- Firewall not managed and monitored
- Sensitive information not encrypted at rest
- No limits on electronic transmission of confidential info
- Critical information is corrupted or lost without backup
- Private information is not encrypted on laptop computers
- Social media allows information to be spread outside company's control

## ... PREVENTIVE MEASURES AND RESPONSE STRATEGIES

- Apply intrusion detection software, systems
- Maintain active anti-virus patch management
- Review infrastructure, hardware, software
- Encryption of private data on database, laptops, mobile
- Upgrade access control, authentication requirements
- Implement and maintain Internet firewall
- Introduce social media guidelines for employees and monitor sites
- Test website and e-commerce for penetration vulnerabilities
- Establish backup and recovery procedures for mission critical data

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**Andrew M. Miller, President & CEO  
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## M&As: Vet purchases

CONTINUED FROM PAGE 10

parties involved to “understand the competitive policies that underpin the Affordable Care Act and be clear about why they want to merge.”

She also noted that the Federal Trade Commission has stepped in to block or even undo some mergers, and that FTC monitoring of M&A activity will only increase.

In his experiences in negotiating hospital acquisitions as part of due diligence teams, Mr. Miller said potential “risks all required a workup to determine whether the acquisition would transfer the risk, risk finance cost and unwanted risk to our organization.”

Risks associated with HR processes, compliance or insurance claims are more common to monitor, but a risk manager also must be on the lookout for unusual risk, Mr. Mitchell said.

During an acquisition of a physician practice, one of the acquiring entity's principals died suddenly. “When the risk management squad of the due diligence team lost this historian, it created additional work in order to replace this valuable information,” he said. “In essence, we had

## Make sure practice healthy when buying a physician group

Alongside the steady stream of hospital consolidations runs another steady flow: hospital acquisitions of physician groups.

Uncertainty around the Patient Protection and Affordable Care Act, increasing regulation and declining reimbursements are nudging physician practices to become employees of hospitals.

For hospitals, the risks of acquiring a physician practice are similar to hospital mergers, but with some unique twists.

Concerns about compliance, false claims and overpayments exist for hospital M&As of physician groups, said Todd Swanson, a principal in the business transactions department of Los Angeles-based law firm Hooper Lundy & Bookman P.C. These risks tend to be more severe for hospitals, which “typically have a greater number of, and more complex, agreements with physicians and other referral sources, each of which should be vetted for legal compliance.”

On the other hand, Doug Mitchell, principal at Phoenix-based consulting firm David Douglass L.L.C., said, “Acquiring physician groups can be a challenge for the risk manager. Remember, the physician practice being acquired is likely in questionable health if it is in the process of entertaining acquisition opportunities. That

might indicate record-keeping hasn't been in place, or the folks risk managers are dealing with may be self-employed and have emotional reactions to the questions posed by risk managers.”

Madelyn Quattrone, Plymouth Meeting, Pa.-based senior risk management analyst with the ECRI Institute, said, “Risk managers must assess the insurability of physicians and midlevel providers who would become employees. Self-insured organizations need to develop and implement disciplined underwriting standards for all to-be-acquired physician practices. Underwriting criteria might require physicians to agree to actively participate in the organization's risk management and quality improvement initiatives.”

Personal involvement is more likely for physician groups being acquired, ratcheting up the potential for culture clash. “It is in the acquisition of physician practices where risk managers will have to use all of their assessment and communication skills to get accurate information,” Mr. Mitchell said.

Malpractice concerns also remain a consideration for physician and outpatient practices being acquired. Dr. Joseph Perz, Atlanta-based epidemiologist and team leader with the Centers for Disease Control and Prevention, described a scenario in

which an outpatient clinic reused saline IVs. “Almost 100 patients suffered through hepatitis C as a result,” said Dr. Perz.

Ensuring a facility is using correct, sanitary and safe procedures is critical. Unsafe or high-risk practices could leave the acquiring entity exposed to ongoing risk if the unsafe practices are not discovered and corrected.

Another risk often not considered when acquiring physician practices is resource constraint among risk managers themselves.

“Acquisition of physician practices can occur rapidly,” Ms. Quattrone said. Practices acquired at the same time may range from large, multispecialty groups with hundreds of physicians to solo and small primary care practices that may lack familiarity with even basic risk management principles. Risk management resources are likely to be spread thin.”

One solution? Include risk managers early in the acquisition process.

“Involving risk managers in discussions about practice acquisitions before they occur allows risks to be identified and prioritized so that limited risk management and patient safety resources can be directed effectively,” said Ms. Quattrone.

—By Susan Welch

to do quite a bit more research.”

For risk managers about to embark on an acquisition process,

Mr. Mitchell said, “Look at everything, and then look at it again; and when you're carrying out due

diligence reviews, make sure your notes, tools and reports are categorized in an organized fashion. You

want to be able to quickly lay your hands on your findings for the due diligence team.”



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# Perspectives

With 24/7 operations and diverse staffs, hospitals need to be as fully staffed as possible at any given time. So when it comes to handling employee absences—especially those of nurses—due to disability, a transitional return-to-work program is essential. Kristin Tugman, senior director of health and productivity development for disability insurer Unum, discusses best practices for developing a program that succeeds.

## Boosting hospital productivity with return-to-work programs

By Kristin Tugman



Ms. Tugman

**A return-to-work program should never force employees to come back before they are ready.**

**H**ealth systems and hospitals are facing unprecedented challenges—including uncertainty surrounding health care reform, shortages in skilled staff, and increases in operating costs against declining revenues—while still working to fulfill their mission of delivering quality patient care.

Hospitals also face unique operational challenges, as they are 24/7 operations with a diverse workforce comprising a wide range of occupations and skills.

A key focus for hospital administrators is ensuring they are fully staffed around the clock with the right employees. Employee absences can translate into lost productivity and higher costs, and they also impact the quality of patient care. As a result, the ability to effectively manage lost time due to disability and other absences is a critical need.

As hospitals look for ways to maximize productivity while managing employee absences due to disability, a transitional return-to-work program can be a key element in their overall disability and absence management strategy.

For a typical large hospital, the price tag for disability and lost time is staggering. Based on Unum's experience with more than 1,500 hospitals in the United States, a hospital with 5,000 employees could have as many as 62 employees out of work every day, including 22 nurses. Assuming a typical patient load of four patients per nurse, this level of absenteeism could impact the health care of 90 patients. Over the course of a year, this level of disability can cost up to \$4.5 million in lost productivity and wage replacement.

Absent employees create some hard choices for hospitals. Do they overstaff to make up for absent workers? Do they draw on a nurse pool and incur overtime expenses? Do they increase nurse-patient ratios, potentially affecting patient

care? Do they limit the number of beds that can be filled, reducing revenue?

This potential cost illustrates why disability and absence management is so important to hospitals, why hospitals are focused on absence management strategies, and why their choice of a disability and absence management partner is so important.

Unum's data in 2010 shows that the incidence of disability in the health care industry is consistently higher than other industries. In hospitals, the incidence of family and medical leave under the Family and Medical Leave Act is 40% higher than other industries for two key reasons. First, virtually every disability, by definition, qualifies for job-protection under FMLA; so if disability is higher, then the FMLA incidence is automatically higher as a result. Second, employee demographics, specifically the female population, play a key role because we tend to see more women taking time off to care for family members.

Age also is a key driver of disability. The average age of employees trends higher in hospitals than in other industries. The average age of employees in other industries is 42, compared with 44 for all hospital employees and 48 for nurses. In addition, the nature of hospital work—being physically challenging, requiring long hours and including exposure to illness—also increases the incidence of disability for hospital workers.

On average, hospitals also typically see longer claim durations, driven by hospital workforce demographics and the nature of the work. As the average age of working nurses continues to increase, hospitals are likely to see a related increase in the complexity and severity of the disabilities they face. One factor that comes into play is chronic conditions, such as heart problems, low back problems and diabetes. These conditions increase with age and, when they are not addressed, drive longer leave durations.

According to Unum's internal

data, musculoskeletal problems are the leading cause of long-term disability for nurses, accounting for 32% of long-term disability leaves, compared with 26% in the company's overall block of business.

When it comes time to return to work, transitional return to work, or RTW, programs should be structured and predictable.

An effective transitional return-to-work program recognizes that disabled employees do not regain 100% of their original work capacity instantly. Recovery is incremental. So it is essential to understand the point at which a disabled employee has recovered enough to begin transitioning back into a productive role at work, as well as reasonably understand when the person will be able to return to full capacity.

It is a common misconception among employers that "return to work" means simply coming back to the workplace on light duty—and therefore being unproductive—for an extended period of time. An effective return-to-work program is much more than simply bringing an employee back to the workplace. Instead, it requires close cooperation between hospital management and the disability insurance carrier to understand what kinds of job modifications can be used to facilitate a return to work well in advance of anyone becoming disabled. Manager buy-in is a key component to any effective and successful RTW program.

### Early intervention

The cornerstone of an effective RTW program is the creation of a series of transitional RTW pathways before any individual becomes disabled. These early intervention pathways are a planning tool and a structured method of reducing lost time using a series of agreed-upon options. RTW pathways also serve as a communication guide between the employer, the disability insurer and the employee's physician. All diagnoses, with the exception of maternity, would be considered candidates for an early interven-

tion program.

When an employee actually goes out on disability, the insurer's vocational consultants use these pathways as guidelines to talk with the employee's physician about any physical restrictions and limitations the employee may have. It is also helpful to begin talking with the employee about ideas for how they can return to work as soon as is physically possible after the onset of disability. As the person recovers enough to begin the pre-designed program, the vocational consultant will use the transitional pathways to draft a personal recovery plan.

Typically, a return-to-work plan covers no more than 30 days. It is important to make sure the employee is incrementally improving so he or she can return to their original position. An end date helps to avoid a prolonged transition. The transition period may be extended if necessary, but usually lasts for a maximum of approximately 45 days. In rare instances, if we see the person is not performing the tasks as expected beyond the specified maximum timeframe, then the manager should be able to access either a return to work resource within the employer organization or the disability vendor who can determine the next best step. It's important to note that if the transition period extends beyond the specified maximum timeframe frequently in an organization, then it's recommended that the return-to-work program structure be re-examined to determine if it is capturing the right candidates at the right time.

Patient safety and quality of patient care also play an important part of an effective RTW program. It's important for any organization, especially hospitals, to have an employee back to work only after they are up to the job. And in the case of hospitals, patient safety is top of mind when developing transitional RTW programs. Targeted and safe return to work practices can effectively reduce the duration of short-term disability leave by helping employees through their recovery.

It's important to remember that no matter how well designed the RTW pathways are, there are some people who should not be at work

Continued on next page

# Simulators help reduce medical errors

CONTINUED FROM PREVIOUS PAGE

because they are still sick or haven't recovered enough. A return-to-work program should never force employees to come back before they are ready.

Coupled with typical RTW restrictions—such as reduced lifting, reduced sitting/standing and reduced work hours—a hospital-tailored transitional return-to-work program might include accommodations such as reduced patient load, partnering with a co-worker, taking on a special project, taking a temporary assignment in the same area (like conducting chart audits rather than patient care) or working in an alternate location.

Alternative work locations are frequently the foundation of a successful return-to-work plan because most times nurses need to be close to 100% physically to work back on the floor.

A typical transitional RTW plan for a nurse might begin with a week or two of less strenuous work in another department, perhaps making ambulatory surgery pre-procedure phone calls. The work is more sedentary than floor nursing but allows the employee to begin using his or her clinical skills. Then the individual might spend another week in ambulatory surgery admissions, doing work that requires more movement and clinical tasks but is still less strenuous than regular duties.

Finally, with the employee back to 90%-95% of pre-disability capacity, he or she would return to their original floor with two or three days of reduced workload before resuming original duties. Unum's experience shows that this process helps an individual feel more prepared for a full return if they can transition for a couple of days back into full duty on their original floor.

By planning transitional-work pathways before employees become disabled and intervening as early as possible to create customized plans for employees, a transitional return-to-work program helps managers and employees understand what to expect and it can create a sense of accountability.

Having a structured plan takes the guesswork out of absence management and helps hospitals maximize productivity in a challenging environment.

*Kristin Tugman is senior director of health and productivity development for Unum, where she works with large employers, including hospitals, on transitional return-to-work programs. She can be reached via email at ktugman@unum.com.*

## Underwriters take note as hospitals improve outcomes

By MIKE TSIKOUKAKIS

The growing use and sophistication of medical simulation centers by universities, hospitals and other health care systems can potentially reduce medical errors on patients and is getting positive response from liability underwriters.

Simulation centers provide education using simulated patients, events and scenarios that are used by nurses, technicians, physicians, residents, medical students, emergency responders and others in the medical field.

"We look at this as a risk aversion tool more than anything," said Peggy King, assistant vp of risk management and legal affairs at NorthShore University HealthSystem in Evanston, Ill.

The NorthShore Center for Simulation and Innovation opened May 2011 with two facilities totaling 16,000 square feet. Since January, the center has provided medical simulation courses to more than 1,500 users and surgical simulation courses to more than 400 users.

"We prefer to anticipate what the challenges may be, train in the sim lab for them, then move to the actual situation," Ms. King said.

Simulation centers "absolutely" reduce risks for health care organizations and professionals, said Nancy Towne, senior consultant manager at IMA Consulting in Syracuse, N.Y.

While physicians in residency traditionally learned many hospital and medical procedures while working with patients, "now they have the option to go into the laboratory setting," she said. "Because mistakes are inevitable, they can make those mistakes without hurting the patient."

Simulation centers are ideal for high-risk, low-volume procedures, Ms. Towne said. "We could throw any kind of unique situation from the past and they would be able to practice that in a safe setting instead of coming about it in a real patient care situation."

In the past four years, a growing number of health systems have invested in simulation centers to train new employees as well as update the credentials of experienced physicians, said Holly D. Meidl, managing director and national health care practice leader for Marsh Inc. in Nashville, Tenn.

"We're seeing patterns of change across most medical schools in the country as well as nursing schools where they're trying to do more role-playing or simulation of the patient experience," she said.

Though there are hundreds of simulation centers across the United States, "there's varying degrees of sophistication," said Linda E. Jones, managing director of the health care practice for Rig-

gs, Counselman, Michaels & Downes Inc. in Baltimore.

Simulation training includes everything from Resusci Anne, the popular training mannequin for cardiopulmonary resuscitation, to 3-D simulations, Ms. Jones said, noting that some computer-driven mannequins can cost \$25,000 to \$50,000 each and that sim centers can cost well into the millions depending on the size and equip-

ment used.

order to try and reduce medical errors."

The best use of simulation centers is when a health system examines its claims data and potential compensable amounts and then focuses on those areas, Ms. Meidl said.

At NorthShore, Ms. King and the risk management department work with physicians and technologists to design scenarios to manage certain risks.

"As they build a scenario that they're going to program into the computer that an individual or a

team may be faced with, we can use not only our own claims experience but publicly acknowledged claims experience from other organizations to say, 'Why don't you train for this or train for that?'" Ms. King said.

For instance, an obstetrics team's response to the condition of shoulder dystocia during birth is critical to the outcome of the infant, Ms. King said.

"We train for the presentation of shoulder dystocia in our labor and delivery simulation area so that the team gets very good at identification and response," she said. "We find that outcomes have improved, and we can only assume that it's from the team training in the sim lab."

As the complexity of medical procedures has increased, simulated training for all the medical professionals involved is essential, said Kevin Lachapelle, director of the Arnold and Blema Steinberg Medical Simulation Center at McGill University in Montreal.

Medical errors often result from teams not working well together and poor communications, he said.

"That's where you're going to be having a lot of impact on issues that have to do with communication, teamwork, leadership (and) collaboration that, in the end, probably have a larger component on patient safety than pure knowledge and skill of an individual," Mr. Lachapelle said.

**'We look at this as a risk aversion tool more than anything. We prefer to anticipate what the challenges may be, train in the sim lab for them, then move to the actual situation.'**

Peggy King, NorthShore University HealthSystem

ment used.

To address those costs, large health systems with a mature captive insurer often use surplus capital from the captive to fund simulation programs, experts say (see story, next page).

While insurers have not specifically applied a quantifiable credit for health systems that use simulation centers, underwriters do take them into account in some fashion, experts said.

Ms. Jones said a Lloyd's of London syndicate asked its client to provide six measurable areas

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## REQUEST FOR PROPOSAL



The Delaware River Port Authority (DRPA) is requesting a Technical Proposal and a Price Proposal for Broker/Consultant Services and the Administration of the Owner Controlled Insurance Program. Interested parties can find the Request for Proposal documents by going to the DRPA web site [www.drpa.org](http://www.drpa.org), clicking on the "Working with DRPA" link, and then clicking on "Bids and Contracts."

## REQUEST FOR PROPOSAL



The Delaware River Port Authority (DRPA) is requesting a Technical Proposal and a Price Proposal for Broker/Consultant Services for Bridge Property & Excess Liability. Interested parties can find the Request for Proposal documents by going to the DRPA web site [www.drpa.org](http://www.drpa.org), clicking on the "Working with DRPA" link, and then clicking on "Bids and Contracts."

## REQUEST FOR PROPOSAL



The Delaware River Port Authority (DRPA) is requesting a Technical Proposal and a Price Proposal for Loss Control & Safety Services Consultant for the Authority's construction projects. Interested parties can find the Request for Proposal documents by going to the DRPA web site [www.drpa.org](http://www.drpa.org), clicking on the "Working with DRPA" link, and then clicking on "Bids and Contracts."

## LEGAL NOTICE

IN THE SUPREME COURT OF BERMUDA  
COMPANIES (WINDING-UP)  
COMMERCIAL LIST  
NO. 217 OF 2008  
IN THE MATTER OF  
**LEHMAN RE LTD.**  
(IN LIQUIDATION)

AND IN THE MATTER OF THE COMPANIES ACT 1981  
AND IN THE MATTER OF THE INSURANCE ACT 1978  
Date of Winding-Up Order 18th May 2012  
NOTICE TO CREDITORS TO PROVE

TAKE NOTICE that all creditors of Lehman Re Ltd., (In Liquidation) are required to prove their debts by sending proofs of debt to the Joint Provisional Liquidators no later than 5.00 pm Bermuda time on the 7th day of August 2012 at the address below.

Proofs of debt have been mailed with copies of this Notice to all known creditors. Blank forms can also be obtained by emailing a request to [lehmanreclaims@bm.pwc.com](mailto:lehmanreclaims@bm.pwc.com)  
Dated this 22nd day of June 2012

**Garth Calow Joint Provisional Liquidator**  
c/o PricewaterhouseCoopers, Dorchester House, 7 Church Street, PO Box HM 1171, Hamilton Bermuda HM EX  
Tel: (441) 295 2000 Or by fax: (441) 295 1242  
Or by email to [lehmanreclaims@bm.pwc.com](mailto:lehmanreclaims@bm.pwc.com)

## LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF  
**COLONIAL COOPERATIVE INSURANCE COMPANY**  
Supreme Court County of New York  
Index No.: 400236/10  
NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of New York ("Court"), entered October 4, 2010 ("Liquidation Order"), the then-Superintendent of Insurance of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Colonial Cooperative Insurance Company ("CCIC") and, as such, has been directed to take possession of CCIC's property, liquidate its business and affairs, and dissolve its corporate charter pursuant to Article 74 of the New York Insurance Law ("Insurance Law"). The Superintendent of Financial Services of the State of New York has now succeeded the Superintendent of Insurance as Liquidator of CCIC. The Liquidator has, pursuant to Insurance Law Article 74, appointed Jonathan L. Bing, Special Deputy Superintendent ("Special Deputy"), as his agent to liquidate the business of CCIC. The Special Deputy carries out his duties through the New York Liquidation Bureau, 110 William Street, New York, New York 10038. The Liquidator has submitted to the Court a verified petition ("Verified Petition") seeking an order ("Order"): (i) approving the Liquidator's report ("Report") on the status of CCIC's liquidation proceeding ("Liquidation Proceeding"); (ii) establishing December 31, 2012 as the Bar Date ("Bar Date") for presentation of all claims other than claims for administrative costs and expenses; (iii) authorizing and directing the Liquidator to consider only those claims for actual losses arising under policies issued by CCIC that are presented to the Liquidator on or before the Bar Date; (iv) barring and discharging all claims for losses reported after the Bar Date; (v) authorizing the continued payment of administrative costs and expenses; (vi) authorizing the Liquidator to distribute CCIC's assets, consistent with this Court's orders and the priorities of Insurance Law Section 7434, to those creditors of CCIC with allowed claims, to the extent that, in the Liquidator's discretion, sufficient funds are available; (vii) extending judicial immunity to the Superintendent in his capacity as Liquidator of CCIC, his successors in office and their agents and employees, for any cause of action of any nature against them, individually or jointly, for any act or omission when acting in good faith, in accordance with the orders of this Court, or in the performance of their duties pursuant to Insurance Law Article 74; and (viii) providing for such other and further relief as this Court may deem just and proper.

A hearing is scheduled on the Verified Petition on the 13 day of September, 2012, at 9:30 a.m., before the Honorable Judith J. Gische, JSC, at the Courthouse, IAS Part 10, Courtroom 232, 60 Centre Street, New York, New York 10007. If you wish to object to the Verified Petition, you must serve a written statement setting forth your objections and all supporting documentation upon the Liquidator and Clerk of the Court, at least seven business days prior to the hearing. Service on the Liquidator shall be made by first class mail at the following address:

Superintendent of Financial Services of the State of New York as Liquidator of Colonial Cooperative Insurance Company  
110 William Street  
New York, New York 10038  
Attention: John Pearson Kelly,  
General Counsel

Should the Court issue the Order, all claims, with all supporting documentation, must be presented to the Liquidator on or before the Bar Date, which is the last date set by the Court to present claims in this Liquidation Proceeding.

The Verified Petition and Report are available for inspection at the above address. In the event of any discrepancy between this notice and the documents submitted to Court, the documents control.

Requests for further information should be directed to the New York Liquidation Bureau, Creditor and Ancillary Operations Division at (212) 341-6665.

Dated: June 8, 2012

Benjamin M. Lawsky  
Superintendent of Financial Services of the State of New York as Liquidator of Colonial Cooperative Insurance Company

## REQUEST FOR PROPOSAL



The Delaware River Port Authority (DRPA) is requesting a Technical Proposal and a Price Proposal for Broker/Consultant Services for Traditional Property & Casualty Insurance and Pollution Legal Liability. Interested parties can find the Request for Proposal documents by going to the DRPA web site [www.drpa.org](http://www.drpa.org), clicking on the "Working with DRPA" link, and then clicking on "Bids and Contracts."

## REQUEST FOR PROPOSAL



The Delaware River Port Authority (DRPA) is requesting a Technical Proposal and a Price Proposal for Health & Welfare Benefits Broker/Consultant Services. Interested parties can find the Request for Proposal documents by going to the DRPA web site [www.drpa.org](http://www.drpa.org), clicking on the "Working with DRPA" link, and then clicking on "Bids and Contracts."

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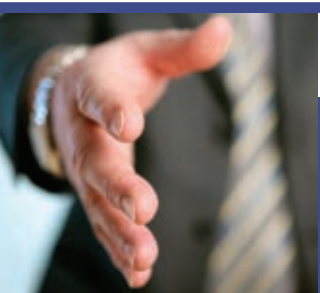
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# Ounce of prevention lowers med mal costs

*University utilizes medical simulations to prevent errors*

By MIKE TSIKOUidakis

The Loma Linda University risk management department has committed part of its budget to fund the university health system's medical simulation center



to back its belief that the training it provides to a wide range of clinical professionals reduces medical errors.

Loma Linda established its SIM center in 2005 to train medical students using technology that reproduces realistic human physiology in real time.

Since 2007, Loma Linda's risk management department has contributed more than \$900,000 in surpluses from its budget to support the SIM center, said Mark L. Hubbard, senior vp of risk management for the Loma Linda, Calif.-based health system.

Loma Linda's primary source of gains in its self-insurance program has been effective claims management and loss prevention, Mr. Hubbard said.

The SIM center is partially funded by its captive, University Insurance Co. of Vermont, and the self-insurance trust, which Loma Linda views as one budget.

The captive writes the first layer of excess liability insurance, which includes professional and general liability, with a self-insurance trust that assumes the primary layer of coverage.

The risk management department has funded a number of simulators and helped develop specific training scenarios addressing high-risk areas such as obstetrics and emergency room procedures, Mr. Hubbard said, noting that this year's efforts include four new simulators.

"In comparison to the budgets that we have for professional liability—and any institution of our size is required to put up pretty substantial funding to support medical malpractice funding—the SIM center's budget is relatively modest compared to what we spend on medical malpractice," Mr. Hubbard said.

Since the SIM center's inception, the program today offers training on 16 human simulators in an 8,000-square-foot facility that can be transformed into various emergency and clinical settings, said Dr. Kent Denmark, the director of Loma Linda's SIM center.

"The thought process behind that was to be able to take one simulator and move it all the way through the continuum of care so that we can work not just on the clinical procedures, which there are quite a few we could do, but also look at the teamwork, communication and the handoffs between the different disciplines, which is where a lot of the medical errors occur," Dr. Denmark said.

"Based on our loss experience, we certainly have identified common areas for potential errors or scenarios that we know represent significant risk to the patient," Mr. Hubbard said.

An early simulation effort focused on cesarean sections.

"We discovered some things in our system that were not very smooth, to say the least," Dr. Denmark said. "We were able to proactively correct things" before they



Loma Linda University Health System's medical simulation center offers training on 16 human simulators.

became an issue in patient care.

While quantifying results from the program is difficult, Dr. Denmark said there have been significant advances in communication among clinicians. "Fortunately, we work in an environment where claims are so low to begin with it would take years of data to show the claims have dropped lower," he said.

"We do know anecdotally that if we were successful in eliminating one patient injury, it could potentially pay for the simulation training program for the year," Mr. Hubbard said.

"We know that the potential injury to the patient and the loss associated with that is so significant in some of these high-risk areas that, even if we can't immediately measure the results, we still believe it's the right thing to do because we know that we have better-prepared clinicians, and we believe that ultimately it is going to reduce the risk of patient injury," Mr. Hubbard said.

# UP COMINGS & GOINGS CLOSE

## RITU MALHOTRA



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The continued rise in cost for prescription drugs, especially specialty drugs. And the major issue of prescription drug abuse and the barriers to solving some of these problems, which result from the industry's lack of data sharing.

**INDUSTRY OUTLOOK:** The consolidation of the industry's pharmacy benefit managers continues to change the industry dynamic. These newly created PBMs have distinct business models that allow clients to partner with the vendor that can meet their needs.

**BEST THING ABOUT A BAD ECONOMY:** Plan sponsors are looking for cost savings opportunities; this allows us to work with them to find outside-the-box solutions.

**FIRST EXPERIENCE IN JOB MARKET:** A post-doctoral residency in pharmacy benefits consulting.

**COLLEGE MAJOR:** Biology as an undergraduate and pharmacy in graduate school.

**ADVICE:** Loyalty and generosity are the keys to a happy life and career. Loyalty to your company, family and beliefs and a generosity of spirit to everyone you encounter is a recipe for success.

**OUTSIDE THE INDUSTRY, A DREAM JOB:** A sommelier. I love experiencing new wines as I travel around the world with my husband.

**HOBBIES:** Photography and traveling.

**CAN'T-MISS TELEVISION SHOW:** "Smash." I love still feeling connected to Broadway even though I'm now living in the Midwest.

**FAVORITE MEAL:** Home-cooked Indian food.

**ON A SATURDAY AFTERNOON:** Spend time playing with my 4-month-old daughter.

**EMAIL OR PHONE, AND WHY:** Email or text because my friends or colleagues can read it and respond when they have time. Unfortunately with everyone's busy lives, long phone call conversations usually need to be scheduled.

**FAVORITE BOOK:** "Interpreter of Maladies" by Jhumpa Lahiri and "Haroun and the Sea of Stories" by Salman Rushdie.

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INSIGHTS TODAY FOR THE RISKS OF TOMORROW

## Designation: European efforts under way

CONTINUED FROM PAGE 3

at the 2012 FERMA Seminar in Versailles, France, on Oct. 22-23.

FERMA plans to issue two certificate types: professional and specialist. The professional certification would be aimed at senior risk managers and based on evidence of the risk manager's previous professional development and education. The specialist certification is aimed at newcomers and would involve formal education and examination by accredited organizations.

It is still early in the process, but FERMA is looking at how it can best deliver such certifications, which could see the organization partner with other groups to provide an internationally recognized accreditation, said Julia Graham, London-based chief risk officer at law firm DLA Piper UK L.L.P. and member of the FERMA

working group.

Risk management has reached a level of "maturity" that deserves professional recognition, in particular given the increasingly complex risk environment and the developing role of insurance and risk managers, said Ms. Graham.

Independently, Airmic has been talking to the Chartered Insurance Institute about developing a chartered risk manager designation.

Airmic has turned to the institute because it already has chartered status and has the scale to police the profession, as it already does for insurers and brokers, said John Hurrell, the association's chief executive. Airmic is acting only as the "catalyst" for the discussions and is not seeking to become the professional designation body for risk managers, he said.

Recognized, consistent qualifications and standards should help improve the profile of risk man-

agers at the board level, said Mr. Hurrell.

The institute is empowered by the Privy Council—the governmental body that grants chartered status to a professional organization in the United Kingdom—to award chartered status to insurers and brokers, and has now requested to add chartered risk manager.

If successful, only a risk manager who meets minimum qualifications and commits to a code of ethics and appropriate continuing professional development would be able to use the title chartered risk manager, said a spokesman for the institute.

It is likely to take 18 to 24 months to receive approval from the Privy Council. A positive outcome is not assured, however, the spokesman said.

Qualifications and standards of member associations and professional bodies in individual Euro-

pean countries, such as the United Kingdom, could be recognized by FERMA's accreditation process, said Ms. Graham.

"We are all looking at the same issue," said Ms. Graham of the work of FERMA, AIRMIC and RIMS to seek professional status for risk managers. Ultimately, the International Federation of Risk & Insurance Management Assns., of which RIMS and FERMA are both members, could be the forum for discussions on international recognition, she said.

The moves by Airmic and FERMA, should they succeed, would fill a gap, said Elaine Heyworth, London-based risk management consultant and director at Heyworth Risk Consulting Ltd. and former risk manager at banking group Barclays P.L.C.

"As a risk manager, I have found that credibility is lacking in our environment. Chartered status would raise risk managers status and profile. Professional recognition brings credibility," she said.

## Gen Re: Fraud admitted, but charges to be dropped

CONTINUED FROM PAGE 1

the government agreed to defer prosecution of all of them for 12 months.

If at that point the government finds they are in compliance with all material aspects of the agreement, it "shall seek dismissal with prejudice" of the indictment within five days of completing the 12-month period.

As part of the agreement, each defendant acknowledged that aspects of the transaction were "fraudulent," that the transaction itself was "highly unusual" and raised "red flags" that suggested that that transaction would be "improperly accounted for."

Each defendant must also pay a fine.

Messrs. Ferguson and Milton were fined \$200,000 each, which has been paid. Ms. Monrad was fined \$250,000. Mr. Garand was fined \$150,000 and Mr. Graham was fined \$100,000. All are to be paid within 30 days of the court's approval of the agreement.

Among other things, the defendants must inform their supervising pretrial service officers if they plan to leave the country or change their residence. They also must "refrain from violation of any law" other than minor offenses, such as speeding.

Neither the attorneys for the defendants nor the U.S. attorney's

**Each defendant acknowledged that aspects of the transaction were 'fraudulent,' that the transaction itself was 'highly unusual' and raised 'red flags' that suggested that the transaction would be 'improperly accounted for.'**

office responded immediately to requests for comment.

A jury in 2008 convicted the five former executives on charges

of conspiracy, securities and mail fraud, and making false statements to the U.S. Securities and Exchange Commission stemming from a loss portfolio deal in 2000 and 2001.

Prosecutors alleged the defendants devised the deal to artificially bolster AIG's loss reserves, costing AIG investors as much as \$597 million as word of the SEC investigation emerged and the stock price declined.

The executives all received prison sentences and fines.

Last August, however, the 2nd U.S. Circuit Court of Appeals overturned the convictions and said U.S. District Court Judge Christopher Droney erred in allowing prosecutors to use a line graph tracing AIG's stock price, which the three-judge panel said was prejudicial.

In March, Judge Bryant set the retrial for 2013.

## Survey: Some question methodology

CONTINUED FROM PAGE 3

high performance on cost and quality of service," Ms. Paige said, adding that Kaiser Permanente was also ranked highest in employee satisfaction among fully insured plans.

"All of the physicians and caregivers that members might encounter are linked together in a system that has a unified incentive structure and drive toward preventive care, as well as a common electronic medical records system that enhances the coordination of care," Ms. Paige said. "That drives service, it drives quality and we feel makes for a much better patient experience."

Ms. Paige said the company also emphasizes responsiveness and transparency in its relationships with benefits managers as they seek greater clarity and context on employee health trends.

"Employers have a huge con-

cern around that these days, and we think we're a leader in the kind of reporting that provides insight for our customers," she said.

### Lowest rankings

At the other end of the spectrum, employers ranked the two largest U.S.-based publicly traded health insurers last in overall satisfaction. Indianapolis-based WellPoint Inc. placed lowest among rank-eligible fully insured plan providers with a satisfaction score of 655, more than 20 points below the industry average.

WellPoint also ranked last in employer satisfaction among self-insured plan providers with a score of 629, 33 points below industry average.

Minnetonka, Minn.-based UnitedHealth Group Inc., the nation's biggest publicly traded health insurer, ranked second to last among fully insured plan providers with a score of 661. The

company placed second among rank-eligible self-insured plan providers, but still scored two points below the industry average of 662.

A spokeswoman for WellPoint said the company does not believe the study accurately reflects the sentiments of the employers it serves because the study did not factor network breadth and wellness support into its evaluations.

"WellPoint has a proprietary research program that we believe is more robust and is used to drive process improvements that directly benefit members in its affiliated health plans," the spokeswoman said. "Every year WellPoint surveys almost 4,700 employers to evaluate their overall satisfaction with its affiliated health plans, and those results drive our continuous improvements. In fact, one of the areas where our affiliated health plans have excelled and

outperformed competitors is in network breadth."

Despite its objections to the study's methodology, WellPoint's spokeswoman said the company takes all feedback seriously and is regularly looking "for ways to improve."

A spokeswoman for UnitedHealth Group said the company's internal research indicated that member satisfaction, measured through post-call surveys, is currently 93.5% and "continues to climb."

The company also cited several external evaluations and awards—including the 2011 and 2010 *Business Insurance* Readers' Choice Award for "Best Health Plan in the U.S."—as evidence of satisfaction among its customers.

"The J.D. Power study is one of many snapshots of a health plan's performance," the spokeswoman said. "A variety of third-party sources have validated a high degree of member, employer and care provider satisfaction with UnitedHealth."

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## IIS: Insurers tested by new markets

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not always available and underwriting models usually cover only developed regions, Mr. Kessler said.

An overview of the catastrophe exposures of the so-called BRIC countries—Brazil, Russia, India and China—illustrates the difficulty of assessing natural catastrophe exposures.

Brazil traditionally has been viewed as a country with few catastrophe exposures because it has not been exposed to hurricanes and it is not in an earthquake zone, he said. However, in the past several years, flooding in Brazil has led to significant landslides.

In addition, Tropical Storm Catarina made landfall in Brazil in 2004. While Atlantic hurricanes and tropical storms traditionally occur in the North Atlantic, climate change may lead to hurricane exposures for the South Atlantic, Mr. Kessler said.

Russia also has been viewed as being largely unexposed to catastrophe risks, he said. But in 2010, it experienced a severe heat wave that had far-reaching consequences, including an increase in the death rate during the summer and an outbreak of wildfires. The heat wave also led to lower crop yields, which affected countries that rely on Russia's cereal production.

In India, the catastrophe exposure has long been recognized, with insurers experiencing 21 catastrophes in India since 1999. But as the Indian economy has grown so rapidly in the past several years, insurers need to be aware that the catastrophe exposure is growing at a similar rate, he said.

The catastrophe exposure also is large in China, with four Chinese earthquakes being among the most deadly since 1900, Mr. Kessler said. As the Chinese economy grows, so do the catastrophe and business interruption exposures. "There are 250 industrial parks in China that are like those affected by the Thai floods," he said.

For insurance growth to be sustainable, insurers need to invest in training and education and carefully analyze the risks they are exposed to as they expand globally, Mr. Kessler said.

## ASSE: Safety meets risk

CONTINUED FROM PAGE 4

Ill.-based organization's members learn risk financing concepts that are commonly used by risk managers and CEOs is an ASSE strategic-plan objective.

"When we did a survey several years ago, CEOs said the problem is that the safety person doesn't know how to talk to them in their language and it's difficult to understand what the safety person is saying," Ms. Norris said.

So ASSE must work to help educate corporate CEOs and directors as well as help safety engineers sell their potential contribution to upper management.

"They need to be able to translate what they do into" a return on investment, Ms. Norris said.

That can be contrary to the way safety personnel think, especially when they are new to their profession and eager to focus on reducing injuries and saving lives.

It would help if more university safety engineer training focused on insurance industry practices, said Steve M. Miller, a conference attendee and regional loss control manager for insurer Harleysville Group Inc. in Worcester, Mass.

In his experience, graduating students are learning Occupational Health and Safety Administration regulations "inside and out," Mr. Miller said, but they lack insurance company experience or an understanding of property and liability issues from an insurance perspective, he added.

There also is a lack of profes-

sionals with that understanding because insurers that once trained their employees in loss-control practices no longer do so due to a lack of resources or the insurers no longer exist because of mergers

### OVER 4,000 ATTEND ASSE CONFERENCE

The American Society of Safety Engineers' Professional Development Conference & Exposition held June 3-6 in Denver, drew 4,243 paid attendees from the United States and 35 other countries.

More than 500 companies exhibited their products and services during the conference, which included several sessions aimed at helping safety professionals expand their knowledge from safety compliance to insurance and risk management principles.

ASSE's 2013 Professional Development Conference & Exposition will be held June 24-27 in Las Vegas. For more information, visit [www.asse.org](http://www.asse.org).

—By Roberto Cenicerros

and acquisitions, Mr. Miller said.

That has made it challenging to hire loss control experts with the necessary experience, Mr. Miller and others at the conference said.

Ms. Norris said she requires her

new hires to study course material for the Associate in Risk Management designation "so that they understand the difference between risk financing and risk control."

Understanding risk financing helps safety engineers garner management support and financing for new safety programs they want to introduce, said Ms. Norris, who also is a risk control manager for Bickmore and Associates Inc., which does business as Bickmore Risk Services in Long Beach, Calif.

While a segment of safety engineers use risk financing concepts in their work, more need to do so, conference attendees agreed.

"The safety side needs to evolve into the risk side," said Steven NyBlom, who manages loss control, occupational health, and the office of the risk management inspector general for Los Angeles County.

"As somebody new to the field, you get in from the safety perspective, but until you embrace the risk side you are missing out on a lot of opportunity," Mr. NyBlom said.

Much like many risk managers traditionally were limited to purchasing insurance, safety engineers traditionally have been limited within corporate silos separating safety from risk management, said Mr. NyBlom, who is a former administrator for the ASSE's Risk Management/Insurance Practice Specialty.

But that has been changing, Mr. NyBlom added. "There are a lot more safety people expanding to take on risk management responsibilities."

## inBrief

CONTINUED FROM PAGE 1

### Proposed IRS rule may aid American

A newly proposed Internal Revenue Service regulation will move American Airlines Inc. one step closer to freezing rather than terminating its pension plan covering the airline's current and retired pilots. The regulation would allow employers in bankruptcy to remove lump-sum options as a way for plan participants to receive their accrued benefits. American Airlines parent company AMR Corp. of Fort Worth, Texas, filed for Chapter 11 bankruptcy in November. Pilots and the PBGC would benefit. That is because the maximum annual benefit—\$54,000—that would be guaranteed by the PBGC is significantly less than the benefits many pilots have earned. For the PBGC, a plan freeze would mean the agency, which last year reported a \$26 billion deficit, would be spared another multibillion-dollar loss.

### Public company M&A, bribery exposures

Executives at public companies underestimate their exposures in mergers and acquisitions as well as anti-bribery laws, according to survey by Chubb Group of Insurance Cos. The Chubb Public Company Risk Survey found that more than 80% of the respondents believe that lawsuits stemming from M&A activities against directors and officers are unlikely, the Warren, N.J.-based insurer said. "This general lack of concern is disconcerting especially in light of the fact that the directors and officers of nearly one in four (23%) of the public companies we surveyed already have been sued," Evan Rosenberg, senior vp and global specialty lines manager for Chubb, said in a statement.

## Obesity: Data shows higher claims

CONTINUED FROM PAGE 1

Duke findings, Mr. Schmid said.

The information will help insurers better understand how to accelerate claim reserves when obesity is a factor, Mr. Hockman said.

He also expects it will help employers and insurers better manage medical care at a time when more payers are relying on predictive modeling to point to potential complexities early in the life of a claim.

While data on the impact of obesity on workers comp claims is limited, NCCI's results are not surprising given what is known about its impact on medical care overall, said Dr. Bernyce

Peplowski, medical director of California's State Compensation Insurance Fund in San Francisco.

"If we go back to 1997, most hip and knee replacements (nationwide) occurred in the 65- to 84-year-old age group," Dr. Peplowski said. "But by 2004, we had a 71% increase in hip replacements among 45- to 65-year-olds and an 83% increase in knee replacements in the 45- to 65-year-old age group." She said that data reflects the growth in obesity.

At the current growth rate, the number of knee replacements could mushroom to 1.4 million by 2015 from 430,000 in 2004, while hip replacements could jump to 600,000 by 2015 from 225,000 in 2004, she said in cit-

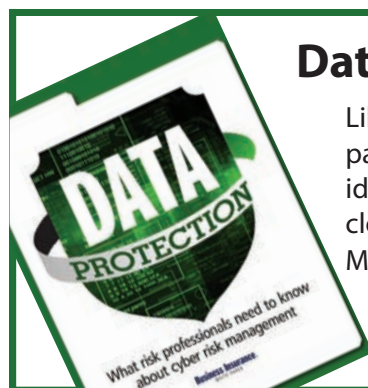
ing various nationwide sources.

"Our two medical icebergs...are obesity and advancing age," Dr. Peplowski said.

Twisted knees are just one example of injuries that may not have occurred had the claimant not been obese, said Tammy Moore, claims manager for third-party administrator Alternative Service Concepts L.L.C. in Nashville, Tenn.

"I would say it's not uncommon at all," Ms. Moore said.

In addition, she also is witnessing expenses rise as obese patients require weight loss programs prior to surgeries, larger wheelchairs, specialized beds as well as new injuries occurring during the recovery process.



### Data Protection: What risk professionals need to know about cyber risk management

Like it or not, your company is exposed to a growing number and array of cyber risks. This Business Insurance white paper identifies the different types of cyber threats that organizations face and what companies need to do to proactively identify, approach and manage these risks. In addition, the paper explores the unique risks created by the growing use of cloud-based computing solutions. The white paper also reviews the results of Business Insurance's proprietary 2012 Risk Manager Cyber Risks Survey. (\$199/\$149 for subscribers)

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## Suit alleges iPhone isn't so smart

A New York man is not enamored with Siri, Apple's voice-operated digital assistant.

In a suit filed last week in the U.S. District Court of Northern California, San Jose Division, Frank Fazio alleged negligent and intentional misrepresentation by Apple Inc. over the much ballyhooed search feature found on the iPhone 4S.

Mr. Fazio's suit contends that Siri is not as functional as the commercials featuring actors John Malkovich and Samuel L. Jackson would make people believe. Fazio purchased his phone from a Best Buy located in Brooklyn in November 2011 for \$299. The suit claims that when Fazio subsequently asked Siri for directions to a certain place or to locate a store, the service was "unable to understand what Plaintiff was asking, or, after a very long wait time, responded with the wrong answer."

The suit seeks class action status and seeks compensatory and statutory damages, as well as restitution.

"Through an extensive and comprehensive nationwide marketing campaign, defendant has conveyed the misleading and deceptive message that the iPhone 4S' Siri feature, a so-called voice-activated assistant, performs useful functions and otherwise works as advertised."

Apple could not be reached for comment.



Mr. Jackson consults Siri while preparing dinner in a TV spot for the Apple iPhone 4S.

CONTRIBUTING: Sheena Harrison, Bill Kenealy, Rodd Zolkos, Mike Tsikoudakis

# End Page



## TRUMP THREATENS TRASH TALKING BEAUTY QUEEN

Questioning the integrity of the Miss Universe Organization has riled "The Donald." Calling in to NBC's "Today" show earlier this month, Donald J. Trump indicated that he and the organization would sue Miss Pennsylvania USA over her allegations that this year's Miss USA competition was fixed. Mr. Trump's reaction followed Sheena Monnin's announcement on her Facebook page that she was resigning as Miss Pennsylvania USA 2012 because she considered the Miss Universe Organization L.P. L.L.L.P. "fraudulent, lacking in morals, inconsistent, and in many ways trashy."

In another post, she alleged that this year's top five Miss USA finalists were selected before the pageant even began. A statement from the Miss America Organization characterized Ms. Monnin's assertions as false and said that the former Miss Pennsylvania told pageant officials that she was resigning over the pageant's decision to allow transgendered contestants to participate.

This year's Miss USA, Olivia Culpo, a cellist from Rhode Island, expressed her support of transgendered beauty pageant contestants.

The Miss Universe Organization is a jointly owned by Mr. Trump and NBC Universal.

Sheena Monnin announced on her Facebook page that she was resigning as Miss Pennsylvania USA 2012.



## INSURERS PLUGGED-IN TO HIGHER LOSS COSTS AS LIGHTNING STRIKES

Lightning strikes and a video gamer cries could be one conclusion resulting from an Insurance Information Institute Inc. study of insurance claims.

While the number of insurance claims from lightning strikes fell 13% to 186,000 claims in 2011 compared with 2010, insured losses still were nearly \$1 billion last year, the III said in a statement.

The average cost per claim increased 93% from 2004 to 2011, partly because of the increased use of consumer electronic devices within households, the III said.

"The number of paid claims is down, but the average cost per claim continues to rise, in part because of the huge increase in the number and value of consumer electronics in homes," Loretta Worters, vp of the III, said in the statement. "Plasma and high-definition television sets, home entertainment centers, multiple computer households, smart phones, gaming systems and other devices that be destroyed by power surges continue to have a significant impact on claims losses."

Electronic products also may have increased in value due to shortages caused by supply chain disruptions last year in Japan and Thailand.

To prevent such damage and protect other electronic equipment when storms threaten, the III recommends having certified lightning protection systems installed in homes and businesses.

## REALITY BITES: BRISTOL PALIN SUED FOR TV TAUNT

A man who got into a verbal dispute with Bristol Palin at a Los Angeles bar is suing her for alleged defamation of character for airing video of their argument during a promotion for the reality television star.

Stephen Hanks was having drinks last fall at the Saddle Ranch Chop House in West Hollywood, where Ms. Palin was riding a mechanical bull, according to a complaint filed in U.S. District Court in Los Angeles last week.

Several patrons yelled at Ms. Palin regarding their dislike of her mother, onetime Republican vice presidential hopeful and former Alaska Gov. Sarah Palin. According to the suit, Ms. Palin then approached Mr. Hanks, and told him in a "condescending and demeaning tone" that she believed he did not like her mother because "you are a homosexual."

The exchange was filmed by A&E Television Net-

works L.L.C. for "Bristol Palin: Life's a Tripp" on Lifetime Television, which premieres June 19.

Video of the argument posted online shows Mr. Hanks calling the former Alaska governor "evil" and "the devil," as well as calling Bristol Palin an expletive.

Mr. Hanks alleges he was unaware that he was being filmed and that A&E did not obtain permission to use his image. He also says Ms. Palin "falsely blamed" him in a magazine interview for prompting her to move from Los Angeles back to Alaska.

Mr. Hanks reportedly works as a talent manager and alleges that the footage, which aired in marketing promos for the upcoming show, caused harm to his profession and occupation. He is seeking unspecified compensatory, punitive and emotional distress damages against Ms. Palin and A&E for defamation, invasion of privacy and other counts.



Ms. Palin, daughter of onetime Republican vice presidential hopeful and former Alaska Gov. Sarah Palin, has been slapped with a defamation suit in connection with her new Lifetime Television reality series.

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Photo: Deborah Feingold

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