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inBrief

Treasury to sell $4.5B shares of AIG stock

The U.S. Treasury Department said it intends to sell $4.5 billion worth of shares of common stock it holds in American International Group Inc. through a public offering. The department said several banks, including Citigroup Global Markets Inc., Deutsche Bank Securities Inc., Goldman, Sachs & Co., and J.P. Morgan Securities L.L.C., had been selected to underwrite the share offering. The government still maintains ownership of 1.06 billion shares of AIG common stock, approximately 61% of the shares outstanding, as a result of the bailout of AIG during the financial crisis. According to the Treasury Department, AIG indicated that it intends to purchase up to $3 billion of the shares when they are offered.

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SPOTLIGHT

PHARMACY BENEFIT MANAGEMENT

Pharmacy benefits competition stiffens; doctor-dispensed drugs drive comp prices; registry targets abuse; M&As give pricing power. PAGE 9

WORKERS COMPENSATION

Residual market the last option

Workers comp prices, insurer refusal force employer decisions

By ROBERTO CENICEROS

An increasing number of U.S. employers seeking workers compensation insurance coverage are getting pushed into their states' markets of last resort as insurers walk away from riskier, less profitable accounts.

The size of employers forced to turn to the workers comp residual market also is growing, experts said.

Employers are turning to the residual markets as insurers raise their workers comp prices—particularly for less desirable accounts—in the face of insufficient investment income and rising medical and indemnity costs.

For example, a California manufacturing company with about 125 employees recently had little choice but to buy coverage from the market of last resort, the State Compensation Insurance Fund, said Stephen Paulin, senior vp at broker SullivanCurtisMonroe Insurance Services L.L.C. in Irvine, Calif., speaking about one of his clients.

> 'We are standing our ground, we need to get more money, and we may lose some business as a result.'
>
> Stephen Paulin, SullivanCurtisMonroe Insurance Services L.L.C.

The manufacturer's workers comp insurer sought a renewal price increase exceeding 40%, Mr. Paulin said. The premium increase was driven by a rise in the employer's experience modification rating, an overall rate increase and the underwriter cutting back on credit deductions it previously made available, he said.

"We were not able to get another private carrier interested, and the state fund was able to do it for 15% less" than the underwriter, Mr. Paulin said. Insurers "are basically saying, 'We

See **RESIDUAL** page 17

RISK MANAGEMENT

AP IMAGES

About 600 million people in India were left without power last week, causing widespread travel problems, as well as disrupting the operations of businesses and their suppliers.

Insurance cover unlikely in India power outages

By RODD ZOLKOS

Loss information from business and supply chain disruptions caused by last week's power outages in India will take time to emerge, but many experts foresee a major effect similar to last year's Japanese earthquake and tsunami and floods in Thailand.

Similar to the experience of many companies that had supply chain disruptions after the Japan and Thailand disaster, many companies that suffered disruptions of outsourced services such as call centers or information technology providers because of the India blackouts may well be mistaken in thinking their losses are covered, many supply chain insurance experts said.

The power failures that hit much of India on July 30 and 31 left hundreds of millions of people without power. The July 31 outage was considered one of the world's worst blackouts, stranding miners and interrupting train travel in addition to leaving much of the country in

See **INDIA** page 20

HEALTH CARE REFORM

Medicaid a 'sleeper' health reform issue for employers

By JERRY GEISEL

WASHINGTON—Employers could be liable for stiff financial penalties as a result of a portion of the U.S. Supreme Court's health care reform law ruling that invalidated massive federal sanctions against states that fail to expand eligibility for their Medicaid programs.

In addition, the Medicaid part of the ruling could result in a much smaller reduction in the number of uninsured U.S. residents compared with earlier projections, according to estimates by the Congressional Budget Office.

If those projections hold true, the effect of one of the big positives of the Patient Protection and Affordable Care Act for employers—a reduction of uncompensated care costs, which providers now shift to employer health plans—could be much smaller than employers had hoped.

"Hospitals could have more uncompensated care than anticipated, and there will be cost-shifting to those who have coverage," said Barbara Gniewek, a principal with PricewaterhouseCoopers L.L.P. in New York.

Until recently, there has been little direct employer focus on the Medicaid part of the health care reform law ruling.

"It has been a sleeper issue," said J.D. Piro, a senior vp with Aon Hewitt in Norwalk, Conn.

But that has begun to change.

"People are now talking about it, and we have been doing a lot of modeling for affected employers," said Tami Simon, managing director-knowledge resources with Buck Consultants L.L.C. in Washington.

As part of its decision upholding the health care reform's law core requirement that, starting in 2014, subjects most Americans to

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solution arc

ATTRACTING TALENT: This *Business Insurance* solution arc shows insurers and related companies how to attract and retain the best employees, including recruiting recent college graduates. *www.BusinessInsurance.com/TalentArc*

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gallery

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Watch for *BI*'s Buyers Choice Survey in your inbox

CHICAGO—*Business Insurance* invites buyers of commercial property/casualty insurance and related services to participate in its second annual Buyers Choice Survey.

The survey—conducted on behalf of *Business Insurance* by Blackstone Group Inc., an international market research firm—is in its final stages, and the final round of invitations to risk managers and other qualified buyers of commercial insurance is being emailed now.

Please watch your inbox for an email invitation from *Business Insurance* signed by Editor Gavin Souter and use the embedded survey link to participate.

We know that life and work can get very busy, but we hope qualified respondents will take the time to participate in this survey. Your responses provide meaningful insights about which service and expertise qualities buyers value most in their risk and insurance service providers. The survey also is designed to measure your preferences, priorities and recommendations to determine the best-in-class commercial property/casualty insurers, brokers and third-party claims administrators.

Business Insurance's mission is to provide insights and analysis that directly help readers do their jobs better. The Buyers Choice research is designed to help buyers benchmark their preferences against their peers and provide the market with better information on customer needs. This helps providers deliver improved service and more targeted expertise.

The survey should take about 20 minutes to complete; participants are able to leave the survey and come back as many times as needed in order to finish.

Upon completion of this survey, in appreciation of your time and input, we will send respondents a free copy of one of our offerings from a list of selected *Business Insurance* white papers on pressing risk management issues.

In addition, respondent names will be entered into a raffle to win one of five prizes valued at $600 each, including an iPad, Kindle or cash. Five winners will be chosen at random.

The Buyers Choice Survey results will be reported in the Nov. 26 issue of *Business Insurance*, and companies that receive the highest number of recommendations for service and expertise will be honored at a Nov. 15 awards event in Chicago.

Your responses provide meaningful insights about which service and expertise qualities buyers value most in their risk and insurance service providers.

LIABILITY & LITIGATION

Retaliation a growing liability

When an employee complains, supervisory reaction may violate federal law

By JUDY GREENWALD

Retaliation by supervisors and company executives against employees for making discrimination, harassment, whistleblower or other complaints is an expanding liability for employers that shows no signs of waning.

A U.S. Supreme Court ruling six years ago has had the unintended effect of encouraging such claims in the workplace, and the difficulty of defending these claims often confounds employers, experts say.

Employers can take steps to avoid and defend themselves against retaliation claims, including being wary of taking any quick action against an employee who files a claim and bringing in objective third parties, such as human resources, to monitor the situation (see story, page 18).

Retaliation claims filed with the U.S. Equal Employment

See **RETALIATION** page 18

WORKERS COMPENSATION

Fla. cracks construction comp scam

Unreported payroll in check-cashing ring reaches $70 million

By SHEENA HARRISON

Florida officials are cracking down on a scheme that uses check-cashing businesses as part of a plan to avoid paying workers compensation insurance premiums.

The Florida Workers' Compensation Fraud Task Force arrested eight people last month in a check-cashing ring that included

$1 billion

Check-cashing is one of the most prevalent schemes to defraud the workers comp system in Florida and could be diverting up to $1 billion a year from the state's economy.

$70 million in unreported payroll from construction contractors. The arrests were made in Broward, Miami-Dade, Palm Beach and Polk counties.

The task force, formed last year, includes representatives from the Florida Department of Financial Services' Division of Insurance Fraud and the Broward County Sheriff's Office.

Check-cashing is one of the most prevalent schemes to defraud the workers comp system in Florida and could be diverting

See **CHECKS** page 7

PROPERTY/CASUALTY INSURERS

Property/casualty industry await fed rules on systemic risk

By MARK A. HOFMANN

WASHINGTON—Although the property/casualty insurance industry still has some concerns about the implementation of the Dodd-Frank Wall Street Reform and Consumer Protection Act two years after its enactment, industry experts say their worst fears haven't been realized.

In fact, two provisions of the law, which President Barack Obama signed on July 21, 2010, draw considerable praise from the industry. Those are the creation of the Federal Insurance Office and reform of the regulation of the surplus lines insurance market. There are still lingering concerns over how federal regulators will treat property/casualty insurers, as they attempt to decide what nonbank financial institutions present systemic threats to the economy and are thus subject to enhanced regulation.

> 'I think the industry fared extremely well as a relative matter in Dodd-Frank.'
>
> Joel Wood, Council of Insurance Agents & Brokers.

Still, the situation is much better than some experts expected in 2008 as the federal government rescued American International Group Inc. as it stood on the brink of collapse.

"If someone had told me in September of 2008 in the aftermath of the federal intervention on AIG that Dodd-Frank would not have led to the imposition of a redefining new federal regulatory authority, I would have said, 'You're crazy,'" said Joel Wood, senior vp at the Washington-based Council of Insurance Agents & Brokers.

"I think the industry fared extremely well as a relative matter in Dodd-Frank," Mr. Wood said.

Unlike the act's effect on the banking sector, property/casualty insurers have felt "a light touch," said Wes Bissett, senior counsel-government affairs for the Alexandria, Va.-based Independent Insurance Agents & Brokers of America. "That's a good thing for us," he said.

Mr. Bissett said the surplus lines reform provision was particularly significant. The provision holds that no state other than the home state of a policyholder can require premium taxes on nonadmitted insurance, leaving it to the states to determine how to allocate taxes among themselves. In addition, it subjects placement of nonadmitted insurance only to the regulation of the policyholder's home state under most circumstances.

"The surplus lines forms clearly have been a net positive for the industry. Have they produced the ideal reform? No. But are we better off? The answer is a clear yes on that. The nice thing is we've gone to a single-state system of regulation," he said.

"It's less of mishmash," said Mr. Wood. Before the reform "it was very, very difficult if not impossible to reconcile competing state rules on multistate risks. Now

See **DODD-FRANK** page 21

CAPTIVES

First Conn. captive covers Thomson Reuters

Revamped law, infrastructure back state's active courtship

By RODD ZOLKOS


AP PHOTO

HARTFORD, Conn.—With Connecticut licensing its first captive insurer last week, many see its revised captive law and its established insurance industry infrastructure positioning the state for success as a captive domicile.

Thomson Reuters Corp.'s captive, Thompson Reuters Risk Management Inc., became Connecticut's first captive when it relocated from Delaware.

It will write workers compensation, general liability, auto liability, property, terrorism, errors and omissions, and personal accident/travel coverage in the United States. Thompson Reuters also has had a Bermuda-domiciled captive since 1978.

Michael Warren, vp of risk management at Thomson Reuters in Stamford, Conn., said changes to Connecticut's 2008 captive law that were included in jobs legislation promoted by Gov. Dannel P. Malloy and signed into law in October made the state an attractive choice for the New York-based company's captive.

> 'We've committed money, personnel. We've changed our rules. We're actively pursuing the relocation of captives to Connecticut and the formation of new captives.'
>
> Dannel P. Malloy, Governor of Connecticut

"I don't think, prior to that, Connecticut was a particularly captive-friendly jurisdiction," Mr. Warren said.

"We were looking for a feasible venue onshore and Connecticut was a logical choice," he said in noting that he and the Thomson Reuters Risk Management Inc. captive's two other directors all are based in Connecticut.

"Let's be honest. We had companies who were based here or who had large operations here who were forming their captives in other states," Gov. Malloy said. "We've committed money, personnel. We've changed our rules. We're actively pursuing the relocation of captives to Connecticut and the formation of new captives."

"I think they will do reasonably well even though the field is pretty crowded," said Brady Young, president and CEO at Strategic Risk Solutions Inc., a Concord, Mass., captive manager. "Obviously, there are a lot of sizable companies based in Connecticut that either have captives or could have a captive."

The state's existing insurance industry intellectual capital will serve as a strategic advantage for the domicile, Mr. Young said.

"There's a lot of infrastructure right there to support captives," he said. "That being said, I don't expect wholesale movement of captives from other domiciles to Connecticut. New captives, they'll win their share."

"I think the prospects for the domicile are terrific," said Gregory V. Serio, partner and managing director at consultant Park Strategies L.L.C. in Albany, N.Y., and a director of the Connecticut Captive Insurance Assn. "I think it has a built-in infrastructure that you just don't find in a lot of other domiciles or prospective domiciles."

See CONNECTICUT page 21

QUESTIONS & ANSWERS

David J. Bresnahan was named president of Lexington Insurance Co. in July 2011, having worked his way up through various management positions since joining the surplus lines unit of American International Group Inc. in 1999. He took on the leadership position after a tumultuous three years for the parent company and after losses from AIG's financial products unit required a government bailout. The problems took a toll on its insurance operating units and resulted in the loss of Lexington's then-leadership team. All through the trauma, however, Lexington maintained its position as the largest U.S. surplus lines insurer. Mr. Bresnahan recently spoke with Business Insurance Editor Gavin Souter about changes at the insurer and its future direction.

Lexington president sees global business

Q: How is Lexington different from the company that it was four years ago?

The first thing is that we are much more team-oriented company today than we were four years ago. A big part of that was born out of the AIG crisis that we all went through. To get through that crisis, our employees really needed to have each others' backs. They had to recommit to one another and recommit to their customers. Today, I think we enjoy that team environment and we have a real esprit de corps that is very difficult to replicate. It's a big differentiator for us today.

The other big difference is how transparent we are and how communicative we are with our customers. It was born out of necessity during the fall of 2008 and 2009, but it's something we have stuck with and we continue to do today.

Q: What areas do you see as having the best growth potential for Lexington?

An unqualified growth opportunity for us is in the international business, which is interesting. When you think about Lexington's focus on U.S. surplus lines, you may not think international business, but our customers have multinational needs as well. When I think about the benefits our clients are going to see as a result of the reorganization at Chartis (Inc.), this area of international capability is top of the list. Lexington, through Chartis' global resources, is now better equipped to issue policies overseas. That's a big new tool for Lexington's customers.

The rest of the growth opportunities really revolve around, and are qualified by, the profitability in the business—and some examples would be noncat property, the high-limits business—and there are pockets of casualty and professional liability that we also want to grow.

Q: What's the pricing outlook for commercial lines?

The outlook is for price increases, but that's not so prophetic because it's what our customers have been dealing with for over a year now. In most of 2011 and all of 2012, we could give you examples of property price increases that were double-digit on average and even pockets in casualty that were double-digit. When I think about the future—not just what customers should expect from us but what they should expect from the marketplace in general—I would expect pricing to be less volatile but more variable from account to account. The reason for that is I think most underwriters are taking a fresh look at each client's risk and evaluating price. There is recognition that some clients have adequately priced programs and may not need an increase, but some carriers may be looking to charge more.

The other big driver on the pricing outlook is these historically low investment yields. In order to get acceptable returns, underwriting performance will have to get much better in future periods. That means customers should be prepared for prolonged price adjustments, not simply a one- or two-year event.

PENSIONS

NCR offers lump sum to trim pension risk

Like Ford and GM, move would limit liability, volatility

By JERRY GEISEL

DULUTH, Ga.—NCR Corp. will give 23,000 former employees who are eligible for but not yet receiving monthly pension payments the opportunity to convert their future annuity to a lump-sum benefit payable in December.

The action will help meet the company's objective of "permanently reducing NCR's pension liability and supporting our profitable growth strategy," Bill Nuti, NCR's chairman, president and CEO, said in a statement last week announcing the transaction.

80%
Fixed-income asset allocation at NCR Corp. increased from 39% at the end of 2009 to 80% in 2011.

NCR's action follows those by Ford Motor Co. and General Motors Co. to give certain former employees the option to take their monthly annuity as a lump-sum payment. For participants remaining in its pension plan, GM is purchasing a group annuity from Prudential Insurance Co. of America to cover their benefits and is terminating the plan.

More employers are expected to follow in the paths blazed by Ford, GM and NCR, benefits experts say. Through such pension "de-risking" strategies, employers no longer will be exposed to factors such as interest-rate fluctuations and investment results that can cause big changes in their pension plans' costs and contributions.

In addition, employers can reduce certain fixed costs, such as the payment of premiums to the Pension Benefit Guaranty Corp., associated with offering a defined benefit plan.

Giving deferred vested plan participants the opportunity to take their future benefit as a lump sum is the latest step NCR has taken in recent years to control the growth of pension plan liabilities and reduce volatility.

In 2004, the Duluth, Ga.-based technology giant closed off its pension plan to new employees. Then, effective Jan. 1, 2007, NCR completely froze the plan while beefing up its 401(k) plan match.

On the investment side, NCR in 2009 began to reallocate plan assets away from equities and into fixed-income investments. As a result, fixed-income asset allocation increased from 39% at the end of 2009 to 80% in 2011 and is expected to be 100% fixed income by the end of this year, the company said.

NAVIGATING THE UPS AND DOWNS OF SURPLUS LINES

For more than 20 years *Business Insurance* has reported on unusual or difficult to place risks not covered by the standard P/C insurance market , and has profiled the leading solution providers to those coverage problems.

2012 Surplus Lines Issue

Issue: October 8 Advertising Close: September 26

This year, *Business Insurance* will look at the state of the surplus lines market, how it is responding to the firmer pricing in the standard P/C market, and what solutions the new specialty risks are looking for in the excess and surplus lines market.

This issue also includes these annual charts:

- Leading Surplus Lines Insurers
- Leading Managing General Agents
- Leading Wholesalers
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Middle market leans to captives

More midsize companies showing interest in alternative risk financing

By JOANNE WOJCIK

Interest in captive insurer arrangements among middle-market insurance buyers is booming as the traditional insurance market hardens for certain lines of casualty coverage, captive experts say.

While middle-market insurance buyers typically have been drawn to group captive arrangements that enable them to pool their risks with other like-minded companies, a growing number are exploring rent-a-captives, protected cells as well as microcaptives that are formed under Section 831(b) of the Internal Revenue Code.

In addition, many midsize companies considering self-funding in response to the federal health care reform law are looking at group captives to help fund medical stop-loss coverage as a hedge against potentially catastrophic claims, captive experts say (see related story).

"There is significantly more interest in captives this year than last year," said Art Koritzinsky, managing director of Marsh Inc.'s Captive Solutions Group in Norwalk, Conn. Increasing premiums are being funneled into group captives as well as new formations by smaller, middle-market companies, he said. "The insurance markets are hardening, and a lot of companies have been through what happened in the hard market 10 years ago and are preparing."

"We're definitely seeing an increase in the use of group captives, rent-a-captives and microcaptives by middle-market companies," said Chad Kunkel, division senior vp and group captive strategy leader at Artex Risk Solutions Inc., the captive management unit of Arthur J. Gallagher & Co. in Itasca, Ill. "I'd say we've seen a 100% increase in new business to existing captives over last year."

Mr. Kunkel said the last time he saw this big a surge in captive use by middle-market companies was in 2003, the start of the last hard market. Unlike that year, when new group captives had to be formed to accommodate that business, many middle-market clients coming to Artex today are joining existing group captives, he said.

Multiple captives

In some cases, companies are using more than one alternative risk transfer vehicle, funding their workers compensation exposure in a group captive or a rent-a-captive and then placing other risks, such as warranty risk, pollution risk or directors' and officers' liability risk, in a microcaptive, he said.

In fact, the bulk of new captive formations by Artex involve microcaptives, the small, single-owner captives whose annual premiums are limited to $1.2 million under the IRS code. "We did 60 new microcaptives last year and we're looking to do the same again this year," Mr. Kunkel said.

Doug O'Brien, national casualty and alternative risk practice leader at Wells Fargo Insurance Services USA Inc. in New York, said his firm has formed about 15 new group captives this year mainly "driven by workers compensation issues" in California, Florida and the Gulf states.

In addition, "we're seeing a lot of interest in 831(b) captives for risks that have low frequency and moderately high severity like product warranty, product recall, loss of key customer, loss of key supplier, insurer bad faith, and to fund some property deductibles," Mr. O'Brien said.

Steve Paulin, senior vp at Irvine, Calif.-based broker SullivanCurtisMonroe Insurance Services L.L.C., said many California-based middle-market clients are turning to captives in response to the hardening workers comp rates in that state. "We've seen businesses get 65% to 80% rate increases, and it will probably repeat itself next year," he said.

While many businesses hit with major workers comp premium hikes are considering loss-sensitive, large-deductible plans as an alternative to higher-priced guaranteed-cost coverage, Mr. Paulin said he is introducing some privately held middle-market companies with good loss experience to the captive insurance concept.

"Before 2004, the only option most middle-market companies had to guaranteed-cost workers compensation was large deductibles. Some went well, some didn't," he said. "Then, about two and a half years ago, I was introduced to the 831(b) concept, which fascinated me. I saw opportunities to use it for workers comp, perhaps providing a middle layer of coverage. Six to nine months later, I saw that captive managers were becoming more assertive and aggressive with their marketing" to middle-market companies.

Learning curve

While interest in captive solutions among middle-market buyers is definitely greater than recent years, "it's more a push than a pull," Mr. Paulin said. "Most businesses have heard of captives, but they need to be educated. So we have been taking select clients and prospects and enrolling them in webinars." Aside from microcaptives, "we have been touting the group captive concept primarily in the traditional areas: work comp, general liability and auto liability."

George Rusu, co-founder, chairman and CEO of Schaumburg, Ill.-based Captive Resources L.L.C., said group captives the consultant established on behalf of middle-market clients have reached combined premium volume exceeding $1 billion, with more than $220 million of the new premium added in the past 24 months.

Mr. Rusu attributed part of this growth to some improvement in economic conditions.

"If you look at the (profit and loss statement) of a midsize manufacturer, the third or fourth item is insurance, and that's one cost they can never really control," he said. "Captives enable them to control and predict these costs. People who have been in our captives for a while understand the loss model and can almost tell to the dollar what their costs will be in a year or two."

In some cases, these captive members even lower their costs because the programs emphasize loss control, Mr. Rusu added.

"When you go into a group captive, you're joining a club. You're not just buying insurance coverage. You should be very focused on claims and loss control and willing to participate," said Les Boughner, executive vp and managing director of the global captive practice at Willis Group Holdings P.L.C. in Burlington, Vt.

As such, "a lot of middle-market companies that look at group captives see it as a way to get more competitive insurance. They have confidence that their claims experience will remain good or get better," Mr. Boughner said.

"If a client has been buying guaranteed-cost coverage and their loss experience is such that they really haven't had a lot of adverse loss experience, that's the first candidate that should look at a group captive," said Lisa Wall, senior vp and director of risk finance at Lockton Cos. L.L.C. in Kansas City, Mo. "They want to see another option."

CAPTIVE GLOSSARY

ASSOCIATION CAPTIVE: A captive insurance company that has two or more owners that typically are members of an industry trade association.

GROUP CAPTIVE: A captive insurance company with more than one owner.

MICROCAPTIVE: A captive insurance company formed under Section 831(b) of the Internal Revenue Code, which allows captive insurers with less than $1.2 million in annual premiums to elect to have their federal taxes based only on their investment income.

PURE CAPTIVE: A captive insurance company with one owner. Also called a single-parent captive.

PROTECTED CELL COMPANY: A captive insurance company that contains multiple segregated accounts, or "cells," each of which is legally protected from the liabilities of the company's other accounts. Also called segregated cell company.

RENT-A-CAPTIVE: A captive insurer or reinsurer that rents its capital, surplus and legal capacity to client users.

Source: Towers Watson & Co.

Health care reform contributes to captives interest

The Patient Protection and Affordable Care Act has increased middle-market employers' interest in captives to fund medical stop-loss for their self-funded health benefit plans, captive experts say.

Similar to captive property/casualty programs, medical stop-loss captives allow self-funded employers to pool part of their excess medical claims costs with other like-minded companies and then purchase commercial stop-loss coverage at higher attachment points.

"The Affordable Care Act is driving more organizations to look at becoming self-insured; and when you become self-insured, you are more interested in loss control," a hallmark of a good captive insurance strategy, said Art Koritzinsky, managing director of Marsh Inc.'s Captive Solutions Group in Norwalk, Conn.

For example, Well Health Ltd., a member-owned group captive formed by Schaumburg, Ill.-based Captive Resources L.L.C., helps members manage their health care expenditures with health care risk management tools, said Sandra Duncan, vp of operations.

Similarly, a medical stop-loss captive organized by Orland Park, Ill.-based Horton Group will require members to implement health risk assessments and wellness programs, said Ken Olson, division president. The captive, intended for self-funded employers with 50 to 200 group members, is set to launch Jan. 1, 2013, he said.

Les Boughner, executive vp and managing director of Willis Group Holdings P.L.C.'s global captive practice in Burlington, Vt., said he has received numerous inquiries about using captives to fund medical stop-loss and is conducting a feasibility study on behalf of one employer.

Chad Kunkel, division senior vp and group captive strategy leader at Artex Risk Solutions Inc. in Itasca, Ill., said his firm is in the midst of launching a group captive to fund medical stop-loss for self-funded midsize employers.

—By Joanne Wojcik

Checks: Fla. legislation aims to reduce schemes, lower comp costs

CONTINUED FROM PAGE 3

up to $1 billion a year from the state's economy, said Maj. Geoffrey Branch, chief of the Florida Bureau of Workers' Compensation Fraud in West Palm Beach, Fla.

The fraud is leaving other Florida businesses to pay higher workers comp rates as the state copes with uninsured injured workers, Maj. Branch said.

"The claims don't stop coming in, but the premiums aren't being collected to offset that," he said.

Insurers are concerned that similar plots could be used by contractors in other areas of the country, said Trey Gillespie, Austin, Texas-based senior workers compensation director for the Property Casualty Insurers Assn. of America.

"The one thing that we always find with regard to workers comp fraud is what starts in one state spreads to another," Mr. Gillespie said. "It's not going to be surprising if something similar is detected and prosecuted in other states."

In check-cashing schemes, a "facilitator" often uses a fake identity to register a shell company that has no employees or operations. Many times, these businesses are billed as performing drywall work or other construction tasks that have relatively low injury risk, according to a report last year by the Florida Workers' Compensation Fraud Work Group.

The group, convened by Florida Chief Financial Officer Jeff Atwater, included state insurance and financial regulators, the Florida attorney general's office, insurers, representatives of the construction and check-cashing industries and other stakeholders.

The facilitator buys a basic workers comp policy for the shell company to cover a small number of employees. The shell company's workers comp certificate then is rented to subcontractors, which pose as the shell company and use the certification to qualify for contracts.

Workers comp certificates often are rented out dozens or hundreds of times weekly by a shell company, according to the work group's report.

Because subcontractors involved in the scam are not buying workers comp coverage for their employees, they are able to secure contracts by underbidding competitors by as much as 30%, said Matthew Capece, representative of the general president for the Washington-based United Brotherhood of Carpenters and Joiners of America.

"It skews the playing field and makes it near impossible for law-abiding construction companies to compete in the industry," said Mr. Capece, who participated in last year's work group.

When the subcontractor is paid, the check is taken to a money-services business for cashing. The subcontractor pays for the check-cashing fee as well as a fee to the facilitator that bought the workers comp policy.

The fees for such schemes are relatively cheap for subcontractors, Maj. Branch said. Businesses paid about 10% to 12% of their payroll for check-cashing schemes several years ago, he said. But the down economy and increased competition among participants in the schemes has lowered total fees to about 3% to 5%.

Check-cashing businesses involved in such scams are usually complicit in the crime rather than being unwitting participants, said Corey Mathews, CEO of Financial Service Centers of Florida, a Tallahassee, Fla.-based trade association for money-services businesses.

"It reflects badly on the overall perception of an industry," said Mr. Mathews, who participated in the workers comp fraud work group.

Despite low costs for subcontractors, check-cashing schemes are big business for participants. The Florida Workers' Compensation Fraud Task Force said its investigations since last August have taken down 12 shell companies that conducted more than $140 million in fraudulent transactions.

Mr. Capece and Maj. Branch said check-cashing schemes to defraud workers comp insurers can be found throughout the Southeast.

Florida enacted legislation in July that aims to cut down on check-cashing schemes through increased regulations for money-services businesses.

The new law increases penalties for check cashiers that possess fake identification materials to commit fraud, and allows authorities to investigate check-cashing businesses without advance notice if fraud is suspected, among other rules.

The Florida Chamber of Commerce in Tallahassee thinks the legislation will reduce check-cashing schemes and help lower workers comp costs in the state, a chamber spokeswoman said.

Maj. Branch said the state's fraud task force so far has focused on check-cashing schemes in Broward County. The department hopes to expand the program statewide.

"There are many, many more people...that are running these exact same schemes," he said.

Opinions

EDITORIAL

Insurers pose no systemic risk

It could have been far, far worse. That sums up the effect of the Dodd-Frank Wall Street Reform and Consumer Protection Act on the property/casualty insurance industry two years after the law's enactment.

With the near-collapse and federal rescue of American International Group Inc. fresh in everyone's—especially lawmakers'—minds, the property/casualty insurance sector had every reason to think that it would be in for heavy-handed regulation as Congress began considering financial reform legislation.

Fortunately, that hasn't happened—at least not yet. And there are good reasons to believe not only that it won't happen, but that the law itself has benefited insurers in some ways.

Establishment of the Federal Insurance Office and the reform of surplus lines marketplace regulation are examples of how the law improved the lot of insurers. Although we wish the FIO had been given greater regulatory authority, the office provides the U.S. insurance industry with an advocate in international regulatory matters.

The surplus lines reforms streamline the regulation of nonadmitted insurers and require that premium taxes be paid only to the home state of the policyholder. It's up to the states to decide how to allocate premium taxes. The fact that the states haven't figured that out yet is their problem, not the policyholders'.

There remains, however, one major concern—and that is whether property/casualty insurers can present a systemic risk to the economy as a whole, and whether they thus should be subject to heightened regulation. We agree with insurers that they do not present a systemic risk. After all, AIG's problems did not stem from the holding company's property/casualty operations, but rather from a financial products unit. The insolvency of even the biggest insurer wouldn't bring down the economy; instead, it would lead its erstwhile competitors to scramble for its business.

We hope the intent of the law's drafters prevails and that property/casualty insurers avoid additional costly and unnecessary regulation, particularly regulation appropriate for banks and not underwriters. That would be in keeping with the law's relatively benign effect on the industry in the two years since it took effect, and that's to be desired.

LETTERS

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SCHILLERSTROM

COMMENTARY

Building code plan a bargain

Sometimes, even in the often-surreal world known as official Washington, an idea will pop up that makes so much sense that the only question that demands an answer is why hasn't this idea already become reality?

That's the case with the Safe Building Code Incentive Act, which was the subject of a hearing before a House of Representatives panel last month. The idea behind the act is simple: Effective building codes save lives and money—in this case, federal money. In other words, the measure is designed to save taxpayers' money.

MARK A. **HOFMANN**
SENIOR EDITOR

If the bill becomes law, states would get a little extra post-disaster federal funding if they enacted and enforced nationally recognized building codes for businesses and residences before the disaster struck. In the world of carrots and sticks, that is called a carrot.

There is no stick. This is not a mandate, unfunded or otherwise. No state has to adopt and enforce effective building codes, if its leaders choose not to do so. Those states simply wouldn't be eligible for the enhanced relief.

As Julie Rochman, president and CEO of the Tampa, Fla.-based Insurance Institute for Business & Home Safety, told the panel, about 20 states would either qualify immediately for the added help or would be able to do so with minor changes to their laws and standards as things stand right now. That's a pretty good start.

And that start should be followed up. Admittedly, the odds of this bill becoming law during the current session of Congress are negligible. There's next to no legislative time left and, despite the bipartisan support this bill has drawn, there's not a lot of good will on Capitol Hill. As the election approaches, few lawmakers want to do anything with which they'll have to share credit with their colleagues on the other side of the aisle.

Still, the very fact that this measure was the subject of a hearing—and that no objection was raised to the bill during that hearing—is encouraging. Holding out the carrot of increased federal aid for those states that implement and enforce comprehensive building codes ultimately should result in fewer federal dollars being spent after a disaster. In other words, it's a bargain.

There's widespread agreement that well-designed building codes, backed by meaningful enforcement, are the foundation for mitigating catastrophes whether natural or man-made. This year's brief spotlight on the Safe Building Code Incentive Act should form a foundation upon which supporters can build to get the bill through the next Congress and on to the president's desk for a signature.

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Pharmacy Benefit Management

SPOTLIGHT

Pharmacy benefits competition stiffens

Self-funded employers unbundle to save costs

By JOANNE WOJCIK

While carving out pharmacy benefits management to a specialty provider generally lowers costs for self-funded employers, those seeking such unbundled arrangements are meeting resistance from the insurers that administer their health benefit programs.

Meanwhile, pharmacy benefit managers are intensifying their courtship of self-funded employers as competition escalates in the PBM market after the most recent wave of mergers and UnitedHealth Group Inc.'s decision to handle pharmacy benefit administration inside, experts say(see story, page 10).

Today, more than half of self-funded employers contract separately for pharmacy and medical benefit administration, usually with a pharmacy benefit manager for pharmacy benefits and an insurer for medical benefits, said Scott Hengst, a pharmacy consultant at Lambertville, N.J.-based Health Strategies Group Inc.

To keep from losing pharmacy benefits administration business, some insurers, such as Hartford, Conn.-based Aetna Inc. and Indianapolis-based WellPoint Inc., have partnered with PBMs to provide those services at a more competitive price than they could if

See **PBMs** next page

PBM sector shakeup boosts competition

By JOANNE WOJCIK

Pharmacy benefit managers are intensifying their courtship of self-funded employers in the wake of recent industry consolidation and other developments, including a decision by UnitedHealth Group Inc. to sever its ties with Medco Health Solutions Inc.

Once the nation's largest pharmacy benefit manager, Franklin Lakes, N.J.-based Medco lost a contract serving some 12 million members of Minnetonka, Minn.-based UnitedHealth the same day St. Louis-based Express Scripts Inc. announced its acquisition.

Now, UnitedHealth is providing PBM services internally via its OptumRx Inc. subsidiary, a rebranding of the former Prescription Solutions, a firm that UnitedHealth picked up when it acquired Cypress, Calif.-based PacifiCare Health Systems Inc. in 2005. OptumRx also is competing for self-funded employer business, sources said.

> 'PBMs are definitely going after the self-funded business, but that's not new.'
>
> William A. Schlag, Willis Group Holdings P.L.C..

"OptumRx is capturing a lot of business," said Susan Hayes, a principal at Pharmacy Outcomes Specialists L.L.C., a Lake Zurich, Ill.-based pharmacy benefit consulting firm. She said that UnitedHealth is taking a "write-off" on its PBM business to reduce its profit margin so it can better meet the new minimum medical-loss ratios for its insured business set under the Patient Protection and Accountable Care Act beginning this year.

UnitedHealth did not respond to a request for comment.

Meanwhile, Catamaran Corp., the nation's fourth-largest PBM based on prescription volume created by the merger of Lisle, Ill.-based SXC Health Solutions Corp. with Rockville, Md.-based Catalyst Health Solutions Inc., promises to be a "disruptive model" in the marketplace by offering better service and greater cost savings to self-funded employers, sources said.

"PBMs are definitely going after the self-funded business, but that's not new," said William A. Schlag, a Boston-based senior vp in Willis Group Holdings P.L.C.'s human capital practice. "There's renewed energy because of consolidation. There's increased competition in the PBM world."

"The PBM marketplace is a buyers' market for self-funded employers," said Robert Kalman, a principal in Buck Consultants L.L.C.'s national pharmacy practice in Washington. "Over the past five years, there's been rapid consolidation in the PBM industry starting with CVS Inc. buying Caremark in 2007, the Express Scripts acquisitions, culminating with Medco last year to produce the largest PBM in the country with over 100 million lives.

"With the consolidation, there has been intense competition among PBMs for self-funded employer business. To get that business, they either have to buy other PBMs or take away business in competitive bidding situations. This puts the employer in an enviable position to achieve very, very aggressive pricing and other terms," Mr. Kalman said.

PBMs: Rivalry stiffens

CONTINUED FROM PAGE 9

they were administered in-house, he said.

For example, WellPoint sold its PBM subsidiary NextRx to St. Louis-based Express Scripts Inc. in 2009 and then signed a 10-year pharmacy benefits administration contract with Express Scripts. Similarly, Aetna in 2010 entered into a 12-year contract with Woonsocket, R.I.-based CVS Caremark Corp., but kept its in-house PBM to manage clinical programs, protocols and oversight of its pharmacy benefits business.

Conversely, Minnetonka, Minn.-based UnitedHealth Group Inc., which had contracted for more than a decade with Medco Health Solutions Inc. to provide PBM services to its plan members, severed ties last year with the Franklin Lakes, N.J.-based Medco on the same day Medco's takeover by Express Scripts was announced. UnitedHealth is taking pharmacy benefits management back in-house under OptumRx Inc., a rebranding of the former Prescription Solutions, a PBM that UnitedHealth picked up when it acquired Cypress, Calif.-based PacifiCare Health Systems Inc. in 2005.

Other insurers, concerned about losing revenues and rebates paid by pharmaceutical manufacturers for dispensing large amounts of certain drugs, are increasing the administrative-services-only fees charged for managing medical benefits if an employer attempts to contract separately with a PBM, sources said.

"Activity regarding jacking up ASO fees if you carve out isn't new, but insurers are a little bit more aggressive now than in the past," said David Dross, managed pharmacy practice leader for Mercer L.L.C. in Houston. He said insurers "want to keep the pharmacy business because it's a source of revenue and a source of profit." Frequently, "they retain the rebates as part of the arrangement and then say to the plan sponsor they are using the rebates to defray the administration fee, but the rebate is a good bit larger than the defrayed administration fee," Mr. Dross said.

Allan Zimmerman, national pharmacy practice director at PricewaterhouseCoopers L.L.P. in New York, said insurers are reluctant to unbundle the pharmacy benefit component from an ASO contract because it weakens their ability to purchase large volumes of prescription drugs at a discount.

"The PBM contract might have some sort of component based on volume, and unbundling and allowing spinoff of significant portions of the pharmacy benefit out of their scope and influence could have an impact on the tier or discount that they get. So if they lost another 1 million lives, they might fall a tier," he said.

A few years ago, when Dan Pikelny, director of health benefits and productivity at Navistar Inc. in Lisle, Ill., attempted to carve out pharmacy benefits for a small group of employees Navistar attained through an acquisition, its insurer attempted to increase ASO fees. Instead, Mr. Pikelny moved the medical plan and pharmacy benefits administration away from that insurer.

"When we tried to pull it away to consolidate under our main PBM contract, the carrier threatened to increase ASO fees by 30%. We moved both the PBM and ASO away from that carrier, consolidating it with the Navistar program," he said.

More recently, when bidding out separate contracts for medical and pharmacy benefits for 70,000 Navistar benefit plan members, CVS Caremark offered better pricing on a carved-out arrangement than Navistar could obtain in a bundled arrangement with its insurer, Mr. Pikelny said.

"Many employers, if they went to their health insurer and said they wanted to carve out prescription drugs, of course the insurer balked," said Nadina Rosier, North American practice leader for pharmacy benefits at Towers Watson & Co. in New York. Insurers said they would have to replace the lost revenue by increasing ASO fees anywhere from 10% to sometimes double, she said.

> 'When we tried to pull it away to consolidate under our main PBM contract, the carrier threatened to increase ASO fees by 30%.'
>
> Dan Pikelny, Navistar Inc.

However, with pharmacy being the fastest-growing component of health benefits for many employers, "many self-insured employers have looked at the carve-out value proposition. On the financial side, there's the attraction of being able to negotiate more transparency and savings," she said.

Moreover, because PBMs specialize in pharmaceutical management, they have better track records than insurers in addressing that component of self-funded employers' rapidly escalating health benefit costs, she said.

"You're hiring a company that only does pharmacy. By concentrating volume within a PBM, they have the best purchasing rights to negotiate the best deals with manufacturers," said William A. Schlag, Boston-based senior vp in Willis Group Holdings P.L.C.'s human capital practice. "Second, they are able to build therapeutic resource centers with specially trained pharmacists to measure and monitor medication adherence. Health plans can do all those things. However, very few do because pharmacy is not the major part of their business."

Docs driving work comp costs

State drug price caps seen as best way to reduce spending

By ROBERTO CENICEROS

Pharmacy benefit managers have limited ability to help workers compensation payers address rising costs caused by the steady increase of doctors dispensing repackaged medicines from their offices.

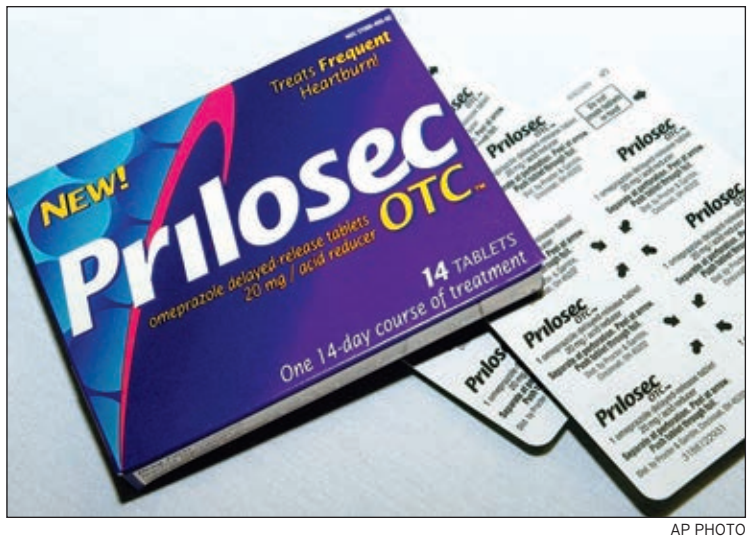
Experts say that's why introducing price caps through state medical or pharmaceutical fee schedule reforms is the only surefire way to stop workers comp cost increases that are driven by doctors dispensing prescription drugs at higher prices than retail pharmacies.

The price caps already introduced in several states, including Arizona, California, Georgia and Tennessee, limit the price doctors can charge when they dispense prescription drugs.

The caps bring the price physicians charge in line with lower prices typically charged for the same prescription medications at retail pharmacies, said Jim Andrews, senior vp of pharmacy services at Healthcare Solutions Inc., a Duluth, Ga.-based pharmacy benefit manager specializing in workers comp.

"In my opinion, (a fee schedule price cap) is the best, immediate, most far-reaching solution states can do to create economic parity between repackaged and non-repackaged drugs," Mr. Andrews said.

See **DISPENSING** next page



AP PHOTO

Prilosec bought at a retail chain cost 64 cents per pill vs. $5 to $8 per doctor-repackaged pill, the Workers Compensation Research Institute said.

N.Y. registry aims to curb drug misuse

Aside from fraud, state law also battles 'doctor shopping'

By ROBERTO CENICEROS

States seeking to deter the abuse and diversion of controlled narcotic prescription pain medications should look to New York state's efforts to implement a "real-time" drug-monitoring registry with teeth.

Beginning next year under New York's recently adopted reforms, doctors will have to check a registry for a patient's prescription history and enter information about any narcotic prescriptions they write for patients.

Pharmacists, in turn, will have to check the database to verify that a legitimate doctor-ordered prescription exists before filling a patient's order. They also will have to input information when they provide a prescription for Schedule II, III, IV and V narcotics.

And by December 2014, electronic prescribing will be required for controlled substances, according to the office of New York Attorney General Eric T. Schneiderman.

Regulations governing how the law will be carried out still must be developed, but the law will affect prescription pharmaceuticals paid for by various forms of insurance, including workers compensation and group health plans, according to several sources.

The database will prevent patient "doctor shopping" and the filling of the same prescription at multiple pharmacies, said Joe Paduda, president of CompPharma L.L.C., a workers comp pharmacy benefit management company consortium that supports New York's effort.

New York's Internet System for

See **REFORM** next page

Dispensing: Docs driving workers comp costs

CONTINUED FROM PREVIOUS PAGE

Repackaging refers to physicians' practice of dispensing prescription medications after the drugs have been bought in bulk.

Data show doctor dispensing is more expensive in states without price caps. The price per pill for medications most commonly dispensed by doctors was often 60% to 300% greater, on average, than the price for the same drug dispensed at a retail pharmacy, according to a study released in June by the Cambridge, Mass.-based Workers Compensation Research Institute.

The study, Physician Dispensing in Workers' Compensation, relied on data from 5.7 million prescriptions paid under 758,000 workers comp claims in 23 states from 2007 to 2011. For example, the price of a Prilosec OTC pill at a well-known retail pharmacy chain was 64 cents per pill, on average, but the WCRI study found doctors were charging $5 to $8 per pill.

The study concluded that the prices of doctor-dispensed pharmaceuticals increased rapidly along with the practice of doctor dispensing in states allowing it. Researchers found that in Illinois, for example, the share of doctor-dispensed prescriptions for injured workers rose to 43% from 26% during the four-year period studied. Meanwhile, the dollar share for those medications increased even more, to 63% from 22% of all workers comp prescription payments in Illinois.

In Florida, meanwhile, doctors' share of drugs dispensed for injured workers grew to 45% from 35%, while their share of prescription payments rose to 62% from 43% during the study period.

Nonetheless, WCRI's study of physician drug dispensing has come under fire.

"The so-called study is no more than a whitewash manufactured by the insurance industry, and it's not surprising that this unscholarly work was the vehicle being used to deliver a self-serving message," said a spokeswoman for Miramar, Fla.-based Automated HealthCare Solutions, which provides doctors with pharmaceutical dispensing technology.

Controversy aside, measures that pharmacy benefit managers can take to help workers comp payers control repackaging charges require the cooperation of the pharmacy benefits managers' customers and medical providers, Mr. Andrews said.

In one growing trend, what are know as electronic bridges can be set up between a doctor and a payer's pharmacy benefit manager so the doctor's billing for the drugs reaches the pharmacy benefit manager directly, Mr. Andrews said. A pharmacy benefit manager then can apply its electronic claims review process to analyze a doctor's billing to assure the physician complies with existing state billing regulations and formularies that "support medical treatment guidelines," he said.

This automated billing and claims review process also lessens a payer's administrative workflow, taking thousands of paper transactions off of an adjuster's desk, Mr. Andrews said.

However, taking advantage of an electronic bridge is limited to payers who contract with a doctor network in which participating physicians agree to certain concessions.

"Unfortunately, PBMs are hamstrung by regulation, and the solution to the physician dispensing issue relies on regulation and legislation," said Joe Paduda, president of CompPharma L.L.C., a workers comp pharmacy benefit manager consortium. "There is really not much of anything PBMs can do. In many cases, the PBMs don't even see the (doctor) bills."

In cases when pharmacy benefit managers do see a doctor's billing for repackaged medicines, they can work with payers and claims adjusters in an attempt to educate patients about the advantages of using a pharmacy benefit manager and retail pharmacies, said Beth Kuschner, a clinical pharmacist for Progressive Medical Inc., a Westerville, Ohio-based PBM.

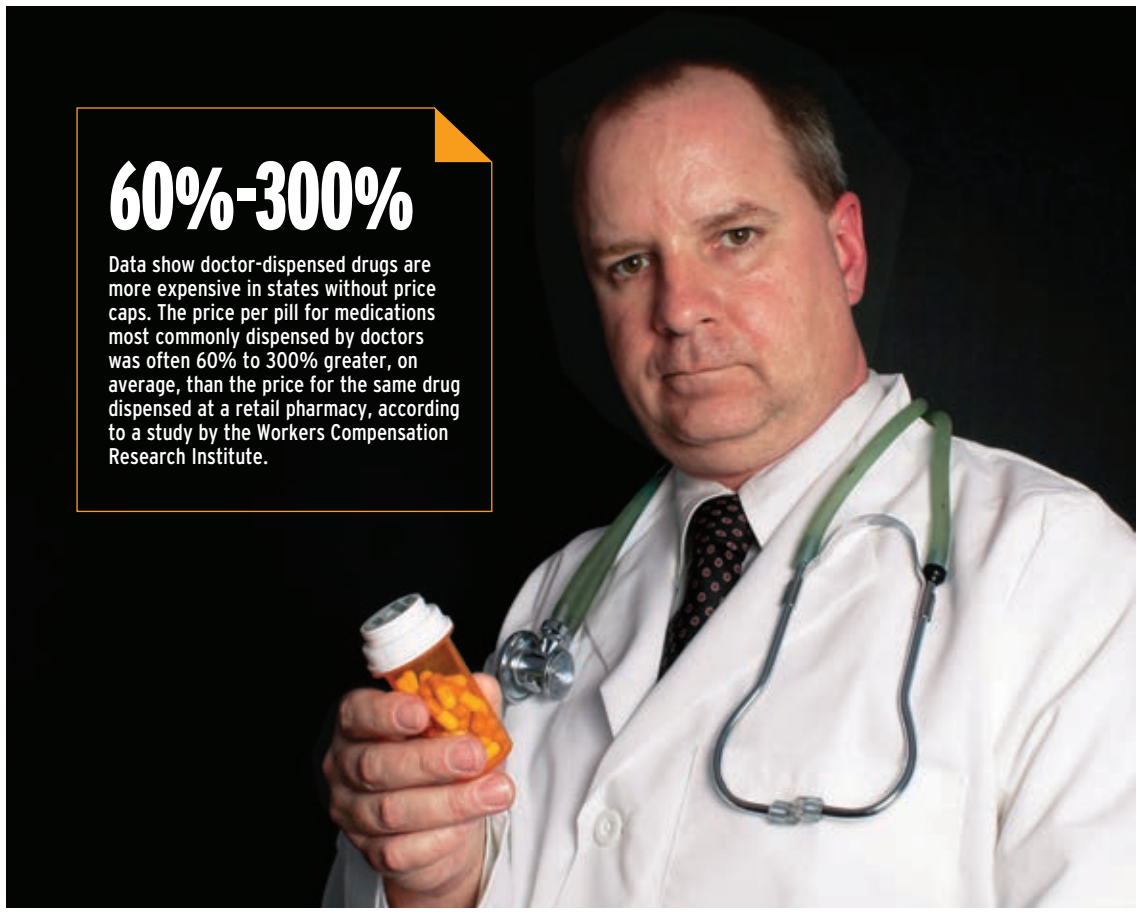
For example, retail pharmacies can provide safety checks, such as assuring that a prescribed drug does not negatively interact with other medications prescribed for patients.

Pharmacy benefit managers also can attempt to encourage doctors to join cooperating networks, Ms. Kuschner said. But those options are limited, she said.

Therefore, Progressive Medical and other pharmacy benefit managers are representing claims payers and pharmacies in lobbying state legislators nationwide to limit physician reimbursements for repackaged medications, said Brian Allen, Progressive Medical's vp of government affairs.

"Payers are being harmed by physician dispensing," Mr. Allen said.

"It's not so much that physician dispensing of medications is bad. It's just the pricing for repackaged medications they are passing on to payers is extraordinarily high compared to what happens in a pharmacy."



Reform: N.Y. aims to curb prescription drug misuse

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Tracking Over-Prescribing, or I-STOP, also will help identify multiple doctors prescribing to a single customer, said Mr. Paduda, who also is principal of workers comp managed care consultant Health Strategy Associates in Madison, Conn.

In addition, the mandate to electronically prescribe narcotics will eliminate diversion through forgery and theft, according to the CompPharma.

Most states already have prescription data monitoring programs, referred to as PDMPs, or prescription monitoring programs, called PMPs, experts said.

But many of those programs are "useless" because compliance is voluntary, Mr. Paduda said.

The programs "vary wildly from state to state," he said. "I would say New York's is probably the most effective, the most clearly thought-through, the most targeted."

Bruce Wood, Washington-based associate general counsel and director of workers compensation for the American Insurance Assn., said he agrees that many other state PDMPs are "useless."

If they were effective, the United States would not be facing a prescription pain medication crisis, Mr. Wood said.

The programs 'vary wildly from state to state. I would say New York's is probably the most effective. The most clearly thought-through, the most targeted.'

Joe Paduda, CompPharma L.L.C.

Death from prescription painkillers has reached epidemic levels, causing more overdose deaths than heroin and cocaine combined, according to the U.S. Centers for Disease Control and Prevention.

The agency reported last year that enough prescription painkillers were prescribed in 2010 to continuously medicate every U.S. adult for a month.

The Washington-based Coalition Against Insurance Fraud, meanwhile, says "insurance fraud is the main financier and enabler of drug diversion."

Improving the way prescription painkillers are prescribed can reduce the misuse and abuse of prescription pain medications, according to the CDC.

Prescribing of narcotic pain medications is particularly common under workers comp insurance programs because of the nature of workplace injuries, said Kevin Tribout, executive director of government affairs for PMSI Inc., a pharmacy benefit manager in Tampa, Fla. Therefore, New York's new law "will definitely have a big impact on comp," he said.

Unlike New York, most other state PDMPs lack enforcement teeth because they do not require the real-time reporting of drug dispensing, Mr. Tribout said. Some states require the reporting only within a certain number of days, weeks or even monthly.

Many states with PMPs do not have the resources to continually analyze the reports they receive, he said.

Meanwhile, the list of drugs that will require reporting in New York is much broader than the list of prescriptions many other state PDMPs require be reported, Mr. Wood said.

Additionally, some states allow only law enforcement authorities with a subpoena to access their databases, Mr. Wood said.

But in contrast, New York state will allow workers comp insurers to access the database, he said.

"It's saying that payers have a legitimate interest in (accessing) this information," Mr. Wood said.

Other states have taken steps recently to bolster their prescription drug monitoring programs, he said.

In January, for example, Oklahoma began requiring all pharmaceutical dispensers to report the dispensing of scheduled narcotics within five minutes of delivery to a customer.

But New York's efforts stand out, he said.

"New York's legislation—not only for the significance of what it provides, but that it happened in a major state—makes a real statement about policymakers understanding the importance and gravity of (the opioid abuse) issue," Mr. Wood said.

The adoption of I-STOP also makes New York the first state in the nation to mandate that physicians consult a database of a patient's prescription history before prescribing a Schedule II, III, or IV controlled substance, Mr. Schneiderman said.

The I-STOP legislation that Mr. Schneiderman introduced last year reformed New York's existing pharmaceutical tracking system, which had weaker enforcement capabilities.

Drug benefit manager mergers yield mixed results

By SHEENA HARRISON

Recent mergers and acquisitions among pharmacy benefit managers have created larger companies that could have greater negotiation power for prescription pricing.

But some experts say employers are leery that consolidation could present them with fewer and less flexible pharmacy benefits options.

Jeff Jonas, a research analyst with Gabelli & Co. Inc. in Rye, N.Y., said pharmacy benefit managers such as Woonsocket, R.I.-based CVS Caremark Corp. and St. Louis-based Express Scripts Inc. appear to have passed along savings to clients, as they have acquired competitors and leveraged their economies of scale.

"I think it's actually fairly positive for the employers," Mr. Jonas said. "For the member, I don't think they really see much of a change. (PBMs) try to minimize disruption in the mergers, but they're not reshaping the industry or reshaping the way it operates."

However, Larry Boress, president and CEO of the Chicago-based Midwest Business Group on Health, said deals may be limited to the largest or most sophisticated employers that know how to effectively negotiate pricing and service with growing pharmacy benefit managers.

"Any time you reduce competition, you're at risk as a purchaser if you're not large enough to be able to get the kind of relationship you want," Mr. Boress said.

Several mergers and acquisitions have occurred among the sector's-largest in the past few years. Express Scripts Inc., formerly the third-largest pharmacy benefit manager, closed on a deal this year to buy Medco Health Solutions Inc. of Franklin Lakes, N.J., the nation's largest, for $29.1 billion. And CVS Caremark Corp. became the nation's second-largest pharmacy benefit manager after CVS Corp. bought Caremark Inc. for $21.2 billion in 2007. Those rankings are according to *Business Insurance*'s 2011 list of the 10 largest pharmacy benefit managers, based on unbundled revenues.

Lisle, Ill.-based SXC Health Solutions Corp. bought Rockville, Md.-based Catalyst Health Solutions Inc. for $4.4 billion early this year. The merged company, now dubbed Catamaran, claims it is now the fourth-largest in the nation based on prescription volume.

While the largest pharmacy benefit managers have been consolidating, they have bought smaller competitors, too. For instance, Express Scripts acquired WellPoint Inc.'s NextRx subsidiaries in December 2009. And SXC has completed four acquisitions, including the Catalyst purchase, since January 2011.

A spokesman for Catamaran said the company's merger combined SXC's information technology model with Catalyst's customer service strengths. The result, he said, has been a "flexible" larger company that has been able to win new contracts with major and middle-market employers.

"While scale is important, skill is even more important," the Catamaran spokesman said. "And we have the right people on board to drive the costs down for clients and employers."

Express Scripts said in a statement its acquisition of Medco has "proven to be very competitive in the marketplace."

Gabelli's Mr. Jonas said recent mergers have been driven by the companies' desire to have more negotiation power for prescription pricing and the ability to attract business from large employers. Wall Street also has looked favorably upon such deals, he said.

> 'Whether it's your IT systems or whether it's purchasing the drugs, especially on the generic drug side...there are huge synergies when you combine these companies.'
>
> Jeff Jonas, Gabelli & Co. Inc.

"Whether it's your IT systems or whether it's purchasing the drugs, especially on the generic drug side...there are huge synergies when you combine these companies," Mr. Jonas said.

Mr. Jonas said employers seem to be receiving lower prices despite having fewer pharmacy benefit manager competitors to choose from.

"You always worry if (they are) going to abuse their market position and not share any savings with the client," Mr. Jonas said. "We haven't seen that in their profit margins."

Mr. Boress said the biggest firms tend to offer pricing deals and customized plan structures for the largest employers or for "squeaky wheels" that are vocal about their pharmacy plan needs.

However, Mr. Boress said that many employers are opting to work with smaller firms because they offer more pharmacy plan flexibility in order to compete with larger pharmacy benefit managers.

Houghton Mifflin Harcourt Publishing Co. has contracted with its group health carrier, Cigna Corp., for pharmacy benefits in the past several years, said Carl Cudworth, Austin, benefits director for the textbook company.

He said larger firms seem to have flexible drug plans that fit the needs of a company like Houghton Mifflin. But lower costs have been the main selling point.

Mr. Jonas expects the mergers and acquisitions trend to slow because companies are "starting to run out of targets" to buy.

Perspectives

Unlike the simple timing element required by occurrence-based liability insurance policies, claims-made liability policies are triggered when an insured receives notice of a claim. Insurers then often dispute whether the notice-triggering event constitutes a "claim" at all. And there is no nationwide consensus in the courts. James R. Murray and Jared Zola of the Dickstein Shapiro L.L.P. law firm explain how claims are defined under these circumstances.

Claims-made judgment calls

By James R. Murray and Jared Zola

Mr. Murray

Mr. Zola

Frequently, policies do not define the term 'claim,' in which case courts may look to dictionary definitions to determine the common meaning.

An issue frequently raised in coverage disputes involving claims-made liability insurance policies is determining whether certain pre-lawsuit events or disputes constitute a "claim" sufficient to trigger coverage.

Unlike occurrence-based liability policies that respond in the policy year or years during which the coverage-triggering event occurred (e.g. the years in which third-party property was damaged in an environmental coverage claim), a claims-made liability insurance policy is triggered upon the insured's receipt of a claim.

Upon an insured's providing notice of a claim, its insurers may dispute whether the notice-triggering event constitutes a "claim" at all, or whether some earlier event constituted a "claim" of which the insured was obligated to provide notice to its insurer.

While there is no consensus among courts across the country, in the absence of a clear answer, courts overwhelmingly accept the policyholder's business judgment of what event constitutes a claim to maximize coverage.

A potential policy definition of "claim" may include a civil proceeding for monetary or nonmonetary relief commenced by service of a complaint or similar pleading. Some policies include receipt of written demands for money in the "claim" definition.

Frequently, policies do not define the term "claim," in which case courts may look to dictionary definitions to determine the common meaning. Dictionary definitions of "claim" are exceedingly broad, e.g., "a demand for something due or believed to be due"; or "something that is claimed," as defined by the Merriam-Webster Dictionary.

Given significant variations in policy "claim" definitions and the lack of defined terms in many instances, the point at which a dispute ripens into a "claim" that triggers coverage is frequently disputed.

A Delaware court in *AT&T Corp. vs. Faraday Capital Ltd.* was called upon to decide the number of "claims" presented in two lawsuits under a directors' and officers' policy. Explaining the crux of the issue, the *AT&T* court held that: "The policy definitions of 'claim' include 'a written or oral demand for damages…' and a 'civil…proceeding initiated against any of the assureds.'"

The *AT&T* court stated: "Thus, here, as in (*Home Insurance Co. of Illinois [New Hampshire] vs. Spectrum Information Technologies Inc.*), there may be a 'claim' that is not a civil proceeding (where, for example, there is simply a written demand for money damages) and a civil proceeding that is not a 'claim' (where, for example, the civil proceeding seeks relief for the same wrongs that were presented in a prior written demand). The term 'claim' means a demand for money damages or other relief, regardless of the form in which that demand is presented."

In a prior case decided under Illinois law, the court in *Minuteman International Inc. vs. Great American Insurance Co.* was faced with determining whether a U.S. Securities and Exchange Commission subpoena served together with a formal SEC order of investigation constituted a claim. There, the SEC order made specific allegations of wrongdoing, stating: "SEC staff had reported information indicating that, in connection with securities transactions, Minuteman officers and others may have made false or misleading statements, failed to keep accurate records and accounts, and failed to implement and maintain a system of internal accounting controls."

Ultimately, the *Minuteman* court determined that the "investigative proceedings at issue in the present case constituted a claim as that term is used in the policy."

Juxtaposed to *Minuteman* is the federal district court's decision in *St. Paul Mercury Insurance Co. vs. Foster*. There, St. Paul argued that the insureds breached their duty to give it notice of the claims as soon as practicable, thus invalidating coverage. Specifically, the insurer contended that a pre-lawsuit letter sent on behalf of the soon-to-be underlying plaintiffs to the insured seeking information and inquiring about certain breaches of fiduciary duties constituted a claim under a D&O policy.

The policy defined "claim" as: "1. a written demand against any insured for monetary damages or other relief; 2. a civil proceeding against any insured commenced by the service of a complaint or similar pleading; 3. a criminal proceeding against any insured commenced by a return of an indictment; or 4. a formal civil administrative or regulatory proceeding against any insured commenced by the filing of a notice of charges, formal investigative order or similar document; for a wrongful act, including any appeal therefrom."

St. Paul argued that the request for information constitutes "other relief" within the meaning of a "claim" under the terms of the policy. The court disagreed, stating that the "standard urged by St. Paul would be bad public policy" and would create uncertainty with regard to the notice requirement, "as well as result in a flood of notices of 'claims' based on requests for information or efforts at intimidation by attorneys that may never materialize into demands against any insurance policies."

The court in *Minuteman* addressed the different outcome from the *St. Paul* case by reaffirming the widely accepted proposition that in determining whether a demand for information constitutes a claim, any doubts should be resolved in the insured's favor. The *Minuteman* court, in distinguishing *St. Paul,* found: "Also, unlike the present case and the other cases that have been cited, in *St. Paul*, finding that there was not a claim favored the insured, not the insurer. Thus, unlike the present case, any doubts should have been resolved in favor of finding no claim."

Accordingly, even though *St. Paul* held that a pre-lawsuit investigatory demand was not a "claim" and *Minuteman* held that a subpoena and accompanying SEC order of investigation was a "claim," both courts agreed on one critical point—the insured's determination was correct, which led to decisions in favor of maximizing coverage.

Other cases include *Polychron vs. Crum & Forster Ins. Cos.*, which found coverage under the "ordinary meaning test" of "claim" and read the policy in favor of the policyholder; *Richardson Electronics Ltd. vs. Federal Insurance Co.*, which found service of a subpoena constituted a claim because "it would frustrate the point of an executive risk insurance policy to require (a demand for money) unless it were expressly indicated in the policy language"; and *MBIA Inc. vs. Federal Insurance Co.*, which found that an investigative subpoena constituted an "investigative order," which was included in the policy's "claim" definition.

These cases recognize the realities of an insured's business by deferring to the insured's judgment. The insureds involved in everyday business disagreements and disputes are better-positioned than an insurer in determining when such a matter rises to the level of a "claim" for which the insured will seek coverage.

Also inherent in this line of cases is the recognition that insurers frequently argue both sides of this issue in an effort to avoid their coverage obligations to the insureds. If an insured provides notice of a pre-lawsuit event, its insurer frequently contends that the event does not constitute a "claim." However, if an insured determined that the same pre-lawsuit event did not yet rise to the level of a "claim" under the policy and later gives notice of a lawsuit arising from the same factual nexus, for example, its insurer frequently contends that coverage does not exist for the subsequent lawsuit because the insured should have provided notice of the earlier event because it was a "claim."

In an attempt to avoid this untenable position, courts frequently defer to the insured's judgment by finding in favor of maximizing coverage.

James R. Murray is the deputy leader of Dickstein Shapiro L.L.P.'s Insurance Coverage Group in Washington. A nationally recognized trial lawyer with more than 25 years of courtroom experience, he has represented corporate policyholders on matters involving nearly every line of insurance. He can be reached at (202) 420-3409 or murrayj@dicksteinshapiro.com.

Jared Zola is a New York-based partner and deputy practice leader in Dickstein Shapiro L.L.P.'s Insurance Coverage Practice. His practice focuses on representing corporate policyholders in insurance coverage litigation, as well as negotiating settlements with prominent property and casualty insurers. He can be reached at (212) 277-6684 or zolaj@dicksteinshapiro.com.

Market Moves

Gallagher benefits unit offers exchange platform

ITASCA, Ill.—Gallagher Benefits Services Inc. is offering a private insurance exchange platform for its employee benefits clients, the company announced.

In a statement, Gallagher Benefits—the employee benefits consulting arm of Itasca, Ill.-based brokerage Arthur J. Gallagher & Co.—said the exchange would help employers set predictable budgets for their employee benefits programs, as well as provide employees with a consolidated marketplace for health care, dental, vision, life and disability coverage from several national and regional underwriters.

Anthony Hernandez, chief information officer at Gallagher Benefits, said the Bright Choices Exchange is "easy to deploy, easy for the employee to use, and built on outstanding technology."

The Bright Choices Exchange is operated through a partnership with platform's designer, New York-based Liazon Corp.

Arthur J. Gallagher & Co. is the world's fourth-largest insurance brokerage by brokerage revenues, according to *Business Insurance*'s 2012 rankings.

"There will be many different private exchange models, and organizations will be interested in them for different reasons," Gallagher Benefits President James Durkin said.

"Some organizations may be focused on simplifying a complex benefits administration process, while for others this may be a key piece in helping execute their total rewards strategy."

Marsh combines energy practices

HOUSTON—Brokerage Marsh Inc. is uniting its U.S. and Canadian energy practices under the leadership of one individual, the company announced.

Bertil Olsson has been named North American energy practice leader, Marsh said in a statement. Previously, Mr. Olsson was U.S. energy, mining and power practice leader, responsible for U.S.-based energy hubs. With this new appointment, he now oversees Marsh's Calgary, Canada-based operations, too.

"U.S. and Canadian energy companies are often at the vanguard of innovation to meet the increasing demands for energy all over the world. As such, they face similar risk profiles," Mr. Olsson said. "With closer coordination between our Canadian and U.S. energy hubs, Marsh will be in a better position to stay abreast of the ever-changing energy landscape and offer more seamless, world-class risk solutions to our North American clients, many of which have cross-border operations."

Mr. Olsson reports to Andrew George, Marsh's global energy practice leader. Jody Draude, who leads the Canada energy operations, now reports to Mr. Olsson, a Marsh spokeswoman said.

Mr. Olsson continues to be based in Houston.

RiskMeter Online partners with EQECAT

BOSTON—RiskMeter Online, a real-time natural hazard risk reporting service from Boston-based CDS Business Mapping L.L.C., and Oakland, Calif.-based catastrophe risk modeling firm EQECAT Inc. have announced an expanded partnership.

The companies said users of RiskMeter Online now are able to include site deductibles when running EQECAT's hurricane and earthquake average annual loss and probable maximum loss reports.

Additionally, underwriters using RiskMeter will be able to feed factors such as standard deviation, coefficient of variation and demand surge into EQECAT's models.

"By expanding our hurricane and earthquake capabilities with EQECAT, a leader in catastrophe modeling, we're providing our users with a much clearer picture of their risk exposure, so they can make better underwriting decisions," RiskMeter Online founder Daniel Munson said in a statement.

"By expanding our offerings through the RiskMeter Online, we will help insurance professionals set rational expectations about risk," EQECAT President Bill Keogh said.

Amlin establishes U.S. reinsurance unit

LONDON—Amlin P.L.C. says it will establish a U.S.-based casualty reinsurance entity called Amlin Reinsurance Managers Inc.

Starting Oct. 1, the business will focus on general and professional liability business and be sourced directly from U.S.-based brokers, Amlin said in a statement. The underwriting team will be led by Paul Brauner, formerly a managing director at Alterra Reinsurance USA Inc. Mr. Brauner will report to Duncan Dale, head of Amlin London's property/casualty business.

"With some signs of conditions in the U.S. improving, we believe this team will be well-positioned to take advantage of rate hardening over the coming few years," Mr. Dale said in a statement.

"Our aim is to provide access to risks from U.S. intermediaries that do not come to Lloyd's and provide further diversification to our existing casualty portfolio."

Amlin Reinsurance Managers Inc. will be based in northern New Jersey.

U.S. captives strained by soft market

A.M. Best report describes pressures faced in 2011

By RODD ZOLKOS

The performance of U.S. captive insurance companies in 2011 reflected pressure from traditional insurance market competition, as well as the effect of global events, an A.M. Best Co. Inc. analyst said last week.

Speaking during a webinar previewing findings from Best's upcoming State of the Captive Insurance Market 2012 report, Steven Chirico, assistant vp at Oldwick, N.J.-based A.M. Best, said the 209 U.S.-based captives that Best rates had $8.5 billion in net premiums in 2011, and finished the year with $50 billion in net assets, a $22.7 billion surplus and $2 billion in net income.

The Best-rated captives had a combined ratio of 92.9% in 2011.

27%

Steven Chirico, assistant vp at Oldwick, N.J.-based A.M. Best Co. Inc., said that for the 209 U.S.-based captives included in Best's upcoming State of the Captive Insurance Market 2012 report, net income fell 27% in 2011 from 2010, and net underwriting income fell 32%.

Net income for that group of captives fell 27% in 2011 from 2010, and net underwriting income fell 32%, Mr. Chirico said.

Net premiums, however, were up $691 million, or nearly 9%, in 2011 compared with 2010.

Mr. Chirico attributed the rated group's drop in underwriting income particularly to medical professional liability, though most other lines of business performed better in that statistic in 2011 than in 2010.

Competition in the medical professional liability market has led to a flattening of premiums, he said.

"The other lines of business written by other types of organizations tended to have good years in 2011, not necessarily compared to 2010, but compared to the five-year average," Mr. Chirico said.

Fred Eslami, senior financial analyst in the alternative risk transfer group at A.M. Best, said that the company maintains a stable outlook for single-parent captives' ratings.

"In our opinion, single parents maintain a relatively stable rating due to their parents' commitment to the captives' mission," Mr. Eslami said.

Public Notices

To place your ad, contact Monique Murray 212.210.0129 • E-mail: mmurray@BusinessInsurance.com

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LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF ASPEN U.S. INSURANCE COMPANY
Supreme Court County of New York
Index No.: 401644/11

NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of New York ("Court"), entered August 24, 2011 ("Liquidation Order"), the then-Superintendent of Insurance of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Aspen U.S. Insurance Company ("Aspen") and, as such, has been directed to take possession of Aspen'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 Aspen. 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 Aspen. 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: (i) approving the Liquidator's report ("Report") on the status of the Aspen liquidation proceeding ("Liquidation Proceeding"); (ii) authorizing the continued payment of administrative costs and expenses, including such costs and expenses pertaining to the closing of the Liquidation Proceeding; (iii) authorizing the Liquidator to distribute Aspen's assets, to the extent assets are available after payment of administrative costs, expenses and other obligations of Aspen, to Aspen U.S. Holdings, Inc. ("Aspen Holdings"), as the immediate parent and sole shareholder of Aspen; (iv) terminating and closing the Liquidation Proceeding; (v) authorizing the Liquidator to continue to receive and disburse any future receivables to Aspen Holdings after the termination of the Liquidation Proceeding, without further application to this Court, and to continue to pay all administrative costs and expenses in connection with any such distributions; (vi) releasing and discharging the Liquidator, his predecessors and successors in office, and their agents, attorneys and employees, from any and all liability arising from their acts and omissions in connection with the Liquidation Proceeding; (vii) authorizing and directing the Liquidator, in his discretion, to destroy or otherwise dispose of any and all of the books, files, records and other property of Aspen without further order of this Court; 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 4th day of September 2012, at 9:30 a.m., before the Court at the Courthouse, IAS Part 15, 80 Centre Street, in the County, City and State of New York. 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
Aspen U.S. Insurance Company
110 William Street, New York, New York 10038
Attention: John Pearson Kelly, Esq.
General Counsel

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 Claims Department at (212) 341-6809.

Dated: July 12, 2012

Superintendent of Financial Services of the
State of New York as Liquidator of
Aspen U.S. Insurance Company

REQUEST FOR PROPOSAL

Investment Management Services

The WTC Captive Insurance Company is seeking proposals for investment management services. The Captive is a not-for-profit corporation created by the City of New York, licensed by the New York State Department of Financial Services and domiciled in New York State. The company is insuring the City and its contractors from their work performed on the City's FEMA funded debris removal site. Investment assets to be managed pursuant to this Request for Proposal are on the order of $350 million.

Respondent must:

1. Affirm that it satisfies all requirements necessary to conduct business in the State of New York with regard to the scope of services required.
2. Affirm current involvement as the investment manager for at least four captive insurance companies and/or casualty insurance companies, with total assets under the respondent's management on behalf of all such client companies in excess of $250,000,000.

Please contact clasala@wtccaptive.com or jschoenbeck@wtccaptive.com to request a copy of the Request for Proposal. Proposals are due by Thursday, August 30, 2012 at 12 noon.

UP CLOSE COMINGS & GOINGS

SUSAN KENNEY COTTER

NEW JOB TITLE: Neptune, N.J.-based senior vp and chief product officer for AIG Benefits Solutions, the group benefits division of American International Group Inc.

PREVIOUS POSITION: Columbia, S.C.-based vp of marketing and products for Colonial Life & Accident Insurance Co., a subsidiary of Unum Group.

LOOKING FORWARD TO: Creating a business, AIG Benefit Solutions, built for the marketplace not only of today but of the future, and being part of the AIG turnaround.

GOALS FOR NEW POSITION: Building a product organization that is the market leader in innovation with a keen focus on the consumer and innovation across what we do in product design, services, portfolio diversity, packaging and flexibility.

CHALLENGES FACING INDUSTRY: At a high level, the biggest challenge the industry faces is the frenetic pace of change, be it competition, the legislative and regulatory environment, technology, distribution.

INDUSTRY OUTLOOK: Bullish. The needs we serve in the marketplace around financial well-being are not going away; they are only becoming larger and more immediate.

BEST THING ABOUT A BAD ECONOMY: It creates an opportunity, an obligation, to rebuild stronger than before. It necessitates that business and policy leaders view the world through a new lens, and that we innovate and change.

COLLEGE MAJOR: International studies and Spanish.

ADVICE: Work hard, and always do the right thing.

HOBBIES: Travel, entertaining, reading.

CAN'T-MISS TELEVISION SHOW: I rarely watch television.

FAVORITE MEAL: Filet migno and cabernet at home on Friday nights is a favorite tradition.

HOW YOU LIKE TO SPEND A SATURDAY AFTERNOON: Running errands and doing chores.

EMAIL OR PHONE, AND WHY: Definitely phone. Communication is nuanced, and so much can be lost over email.

Comings&Goings

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

TO SUBMIT ITEMS

Business Insurance would like to report on senior-level changes at commercial insurance companies and service providers. Please send news and photos of recently promoted, hired or appointed senior-level executives to:

Anna Gaynor
Business Insurance
150 N. Michigan Ave.
Chicago, Ill. 60601-7524

agaynor@businessinsurance.com

POSTING THIS WEEK

INSURERS
- Arch Capital Group Ltd.
- XL Group P.L.C.
- XL Group Insurance (Bermuda) Ltd.

BROKERS
- Lockton Cos. L.L.C.
- Poms & Associates Insurance Brokers Inc.
- Aon Risk Solutions

OTHER
- Aon Infrastructure Solutions
- CBIZ Stoltz
- Alvarez & Marsal Holdings L.L.C.
- Aon Hewitt

Residual: Work comp prices force employer decisions

CONTINUED FROM PAGE 1

are standing our ground, we need to get more money, and we may lose some business as a result.'"

To guarantee insurance availability for employers turned down by voluntary-market insurers, some states require all workers comp insurers underwriting coverage to participate in a residual market pool. Those employers are then assigned to individual pool participants.

States, like California, rely on their competitive state funds or a single insurer to provide residual or market-of-last-resort coverage. California's state fund prefers to think of itself as the "available market," rather than the market of last resort, said Tom Clark, the San Francisco-based fund's chief financial officer.

Nationally, new accounts and existing business assigned to the residual market increased 31% during the first half of 2012 over the prior-year period in the 21 states where Boca Raton, Fla.-based NCCI Holdings Inc. functions as the residual market plan administrator.

The residual market growth during the first half of the year accounts for an 89% increase in premium volume, said James R. Nau, NCCI's general manager for residual markets.

After shrinking for six straight years, the turning point in residual market growth came during the second half of 2011, then accelerated with January 2012 renewals, according to NCCI.

"It came quickly starting in January, but for me it appears as just part of the normal cycle that we see with residual markets growing and shrinking as the voluntary market changes," Mr. Nau said.

In California and other states, more employers are turning to the state fund as firming in the overall workers comp insurance market narrows their choices, experts said.

"We started (seeing) a trend around the beginning of this year," Mr. Clark of the California fund said. "Since January, (the state fund is) up 34% on new business."

That does not include renewal business seeking state fund coverage, he said. While the California market is transitioning from a "very soft market into a less soft market, it's certainly not anywhere close to a hard market yet," he said.

In other states, a hard market already has arrived for certain employers.

Meanwhile, NCCI's first-half report shows the percentage of larger company accounts entering the residual work comp markets also is up, Mr. Nau said.

The incidence of new and existing accounts generating at least $100,000 each in annual premiums turning to the residual market for insurance increased by 80% during the second quarter of 2012, compared with the same period in 2011, Mr. Nau said.

An employer generating $100,000 in premium may not seem like a large account to some workers comp experts. But about 80% of accounts that participate in NCCI-administered residual markets generate premiums of less than $25,000 annually.

"For us, it's big when you have an over-$100,000 account," Mr. Nau said.

California's state fund is experiencing a similar growth trend of larger employers—those generating annual premiums ranging from $25,000 to $250,000—turning to the state fund, Mr. Clark said.

However, some states are lagging in the trend of a hardening insurance market, and therefore employers there aren't being driven into their market of last resort.

In Kentucky, for example, enough workers comp underwriters continue to seek cash flow rather than focusing on underwriting discipline, so the market remains soft, said Roger Fries, president and CEO at Lexington-based Kentucky Employers' Mutual Insurance.

While Kentucky Employers is a competitive, mutual insurer, it also acts as the state's workers comp market of last resort, and Mr. Fries said he has not seen an increase in residual market business.

"There are some parts of the country where the market is hardening somewhat right now," Mr. Fries said. "And there are other parts of the country where it hasn't changed a bit, and I believe we are in that category."

Reform: Medicaid a 'sleeper' issue for employers

CONTINUED FROM PAGE 1

a financial penalty if they don't enroll in a qualified health care plan, the Supreme Court struck down a provision that would have denied all federal Medicaid funding to those states that did not expand their programs to cover those with incomes of up to 133% of the federal poverty level. State Medicaid programs now typically cover those with incomes up to 100% of the federal poverty level.

With the threat of a takeaway of federal funds removed, governors in about half a dozen states, including Florida and Texas, say they will not expand their Medicaid programs, even though the federal government initially will pay 100% of the cost of the expansion.

"I will not be party to socializing health care and bankrupting my state in direct contradiction to our Constitution and our founding principles of limited government," Texas Gov. Rick Perry wrote last month in a letter to U.S. Department of Health and Human Services Secretary Kathleen Sebelius.

If states like Texas—which at about 25% had the highest uninsured rate of any state in 2010, according to the U.S. Census Bureau—refuse to expand Medicaid, employers, especially those with many low-wage workers, would feel that effect and face a much greater exposure to stiff health care reform law fines.

That is due to the interaction of two health care reform law provisions. Under one provision, employers are liable for a $3,000 penalty for each full-time employee who is not offered "affordable" health insurance coverage. Coverage is considered affordable under the health care reform law if the premium for single coverage does not exceed 9.5% of household income.

The Internal Revenue Service has proposed a safe harbor under which the 9.5% premium affordability test would be tied to employees' wages rather than household income. In addition, the IRS has asked for public comment on whether the 9.5% affordability test also should apply to premiums for family coverage.

The $3,000 penalty for flunking the affordability test, though, is triggered only if affected employees are eligible for federal premium subsidies to buy coverage in a state health insurance exchange and use the subsidy to buy the coverage.

However, the health care reform law stipulates, if an employee is eligible for Medicaid, the employee cannot receive a subsidy to buy coverage in a state insurance exchange.

As a result, employers—regardless if premiums paid by employees fail the 9.5% affordability test—can't be liable for the $3,000 penalty if affected employees are eligible for Medicaid.

If governors carry out their threats not to expand Medicaid, employers—to avoid the $3,000 penalty—will have to keep employee premiums below 9.5% for employees whose incomes fall in the range of 100%-133% of the federal poverty level.

"For some companies, this is going to be a big deal," said Jane Jensen, a consulting actuary with Towers Watson & Co. in Denver.

"This will put pressure on employers to offer" affordable coverage, Buck Consultants' Ms. Simon said.

Alternatively, employers could cut back employees' hours or hire more part-time employees. Health care reform coverage penalties only affect full-time employees; those working an average of 30 hours a week.

Still, at this point, it is unknown how many states, if any, will decline to expand their Medicaid programs.

"States would be losing billions of federal dollars. It is really hard to fathom that would happen," said Helen Darling, president of the National Business Group on Health in Washington.

"At this point, no one knows how many states will say no," said Kathryn Wilber, senior counsel-health policy with the American Benefits Council in Washington.

On the other hand, one factor that could drive states to decline to expand their Medicaid programs is the fear that federal lawmakers could later reduce funding, leaving states stuck with the tab. Under the law, the federal government is to pay 100% of the cost from 2014 through 2016 of the expansion cost, with federal funding then gradually dropping to 90%.

Congress can "turn the spigot on and off. Ninety percent could become 50%, and then states are stuck with an additional unfunded benefit. That is a legitimate concern," said Rich Stover, a Buck Consultants principal in Secaucus, N.J.

Retaliation: Growing risk for employers

CONTINUED FROM PAGE 3

Opportunity Commission increased 3% in fiscal 2011 to 36,344 and accounted for the greatest portion—37.4%—of overall claims filed. The total number of claims filed with the EEOC across all categories remained basically flat.

What's more, the number of retaliation claims filed by employees has more than doubled since 1997, while the amount of settlements more than tripled during that period (see chart, page 19).

Another factor that helps explain why retaliation claims are so prevalent can be gleaned from a survey released in January by the Arlington, Va.-based Ethics Resource Center, which found that 24% of whistle-blowers said they experienced workplace retaliation in 2011, up sharply from 15% in 2009.

Gerald L. Maatman, a partner with law firm Seyfarth Shaw L.L.P. in Chicago, said retaliation is a problem "because it's low-hanging fruit that's readily available to plaintiffs lawyers."

Mr. Maatman cited the U.S. Supreme Court's 2006 ruling in *Burlington Northern & Santa Fe Railway Co. vs. Sheila White* in which the plaintiff alleged she was reassigned to a different job and temporarily suspended in retaliation for her sexual harassment complaint.

The court's ruling redefined retaliation as actions that are "harmful to the point that they could well dissuade a reasonable worker from making or supporting a charge of discrimination." And the ruling said retaliatory actions are not limited to those affecting the terms and conditions of employment.

> **'It's one of the most difficult things to navigate with an employer because usually there's a lot of antipathy towards that employee.'**
>
> Anthony J. Oncidi, Proskauer Rose L.L.P.

Mr. Maatman said the ruling "lowered the bar" of proof required to establish retaliation. "Whenever an employer makes an employment decision short of termination that's adverse to an employee, (it) creates the opportunity for the worker to claim retaliation," he said.

"You don't have to get fired or demoted" to allege retaliation, said Kelly H. Kolb, a shareholder at Fowler White Boggs P.A. in Fort Lauderdale, Fla. Transferring a worker to a different shift or branch or denying a worker's previously approved requests to attend his child's soccer games also could result in retaliation charges, he said.

"There's also a perception among the plaintiffs' bar that retaliation charges are more likely to succeed than the underlying discrimination charge," said Richard D. Tuschman, a shareholder with Akerman Senterfitt L.L.P. in Miami.

In fact, experts say that retaliation charges are sometimes upheld when the underlying charge is dismissed.

Burlington "established that a ruling is dependent upon the facts and circumstances of each case," Mr. Maatman said. "Employers have a harder time beating (these claims) short of going through a full trial," and plaintiffs attorneys use that as leverage to reach settlements.

Patricia Eyres, an attorney with Scottsdale, Ariz.-based Eyres Law Group L.L.P., said a wide range of federal and state laws have retaliation provisions, including Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act and the Americans with Disabilities Act.

Philip M. Berkowitz, a shareholder at law firm Littler Mendelson P.C. in New York, said employees also file claims under provisions of the Sarbanes-Oxley Act of 2002, which established new financial reporting standards for U.S. businesses. "Courts are recognizing more frequently that employees have the right to complain about ethical violations," he said.

Furthermore, the U.S. Department of Labor under the Obama administration has reversed a prior position that limited the scope of whistle-blower retaliation claims under Sarbanes-Oxley, Mr. Berkowitz said.

Christopher W. Olmsted, a shareholder at Barker Olmsted & Barnier A.P.L.C. in San Diego, said he also sees retaliation claims made in connection with complaints about overtime, breaks, safety violations "or any matter that you might call whistle-blowing."

Anthony J. Oncidi, a partner at Proskauer Rose L.L.P. in Los Angeles, said there is often an inverse relationship between the frivolousness of the underlying discrimination or harassment claim and the strength of the

Continued on next page

Ways employers can defend against retaliation claims

By JUDY GREENWALD

An adequate policy, detailed record-keeping and having someone objective to deal with the issue are among the strategies employers should deploy to avoid and defend retaliation claims.

"You can't prevent someone from bringing a claim," but company executives can "manage the workplace in a way that creates the maximum defense," said Gerald L. Maatman, a partner with Seyfarth Shaw L.L.P. in Chicago

Firms "need to have in place policies that prohibit retaliation and discrimination, and follow up on any claims of this nature," said Philip M. Berkowitz, a shareholder at Littler Mendelson P.C. in New York

"Deal with (complaints) in a proactive way, and promptly root out any perceived wrongs," said Christopher W. Olmsted, a shareholder with Barker Olmsted & Barnier A.P.L.C. in San Diego.

"Be consistent," said plaintiff attorney Frederick M. Gittes, a principal at the Gittes Law Group L.L.C. in Columbus, Ohio. "You're asking for trouble" when one person is fired, but others who do the same thing are reprimanded or not disciplined at all, he said.

"Make sure that (human resources) is involved in the complaint process as quickly as possible" to monitor the situation, said Kelly H. Kolb, a shareholder at Fowler White Boggs P.A. in Fort Lauderdale, Fla.

It is a "fairly common and natural reaction to someone whose been accused of being a bigot, racist or misogynist to be fairly upset about it, and lashing out at the person who's accusing them," Kolb said.

"By involving HR in the process, then you've got somebody who's objective," said Martha J. Zackin, of counsel at Mintz Levin Cohn Ferris Glovsky & Popeo P.C. in Boston.

Good training is important as well, said Patricia Eyres, an attorney with the Scottsdale, Ariz.-based Eyres Law Group L.L.P. "Most people who get into a supervisory position have been promoted because of good work and don't necessarily know the nuances of the law and the (company's) policies."

Experts recommend that employers train managers to set aside the issue if they are accused of wrongdoing or, if feasible, do a transfer so someone else supervises the complaining worker.

"Having a clear record of alleged misconduct or performance shortcomings that connect the employee's conduct to the consequence, be it some sort of discipline up to and including termination," is always important, Mr. Olmsted said.

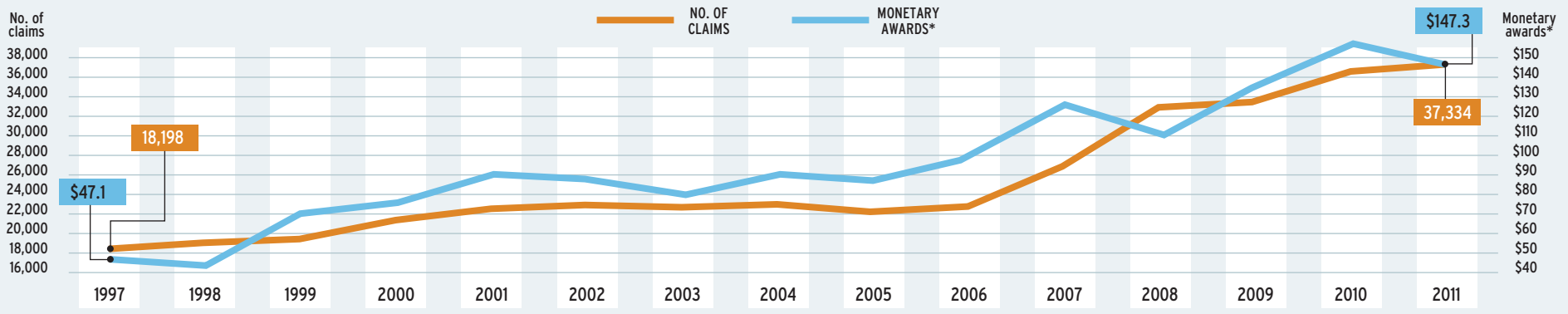
"Unfortunately, a lot of supervisors are so busy managing work, they don't take the time to document effectively the performance or behavioral issues involved," Ms. Eyers said.

Richard D. Tuschman, a shareholder with Akerman Senterfitt L.L.P. in Miami, recommended that an employer considering taking an adverse employment action document the activities through an email to precisely establish timing.

"You can't run away from making tough employment decisions just because someone has engaged in a protected activity, but…you need to be aware those decisions are potentially going to be scrutinized in a lot more detail, so you really need to make sure your T's are crossed and your I's are dotted," said Michael W. Fox, a partner at Ogletree Deakins Nash Smoak & Stewart P.C. in Austin, Texas.

RETALIATION CLAIMS

Since 1997, the number of retaliation claims filed has more than doubled, and the amount of monetary awards has more than tripled.



**In millions*
Source: Equal Employment Opportunity Commission

CONTINUED FROM PREVIOUS PAGE

retaliation claim.

"When you've got genuine harassment or discrimination, I think most employers are savvy enough to know they're not going to be in any position to terminate" that employee after he has made a claim, he said. But a false employee allegation distracts and undermines management, and an employer that is not "well counseled" may decide to terminate or take an adverse job action against the worker, Mr. Oncidi said.

"It's one of the most difficult things to navigate with an employer because usually there's a lot of antipathy towards that employee," Mr. Oncidi said. "It's almost an insuperable challenge for an employer to act as though nothing has happened."

Plaintiff attorney Frederick M. Gittes, a principal at the Gittes Law Group L.L.C. in Columbus, Ohio, said he thinks retaliation is common among employers.

"Maybe it's true in some cases that the manager who's accused wasn't trying to discriminate … but the manager nevertheless is insulted, affronted, angry at being accused" and having to defend himself, he said.

Martha J. Zackin, of counsel at law firm Mintz Levin Cohn Ferris Glovsky & Popeo P.C. in Boston, said a retaliation claim is "much harder to defend than a discrimination claim."

"Juries don't really think that employers discriminate as much as they used to," said Michael W. Fox, a partner with Ogletree Deakins Nash Smoak & Stewart P.C. in Austin, Texas. "But I think juries really do believe that when someone pushes back against an employer, that employers tend to strike back."

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India: Cover not likely

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darkness during the scorching summer heat.

Given the acknowledged fragility of the country's power grid, many businesses in India have backup generators in place.

"It's sort of a good news/bad news scenario," said Clark Schweers, managing director and leader of the insurance claims service practice at BDO Consulting in Washington. "It's not unusual in India to have a lack of reliable power. So many companies have risk management and risk mitigation strategies in place, generators and backup batteries to deal with a situation like this."

Despite the availability of backup power supplies, factors such as transportation disruptions likely caused supply or service disruptions.

"I think there are businesses that are going to have losses, obviously," said Duncan Ellis, U.S. property practice leader at Marsh Inc. in New York. "We haven't really heard of anything yet."

"There are going to be companies that have been impacted," Mr. Schweers said. "I am aware of clients that have been impacted."

Absent physical damage at providers' facilities, however, companies that have traditional business interruption or contingent business interruption insurance won't be covered for disruptions, numerous industry sources said.

"The big issue here is going to be the need for physical damage," Mr. Ellis said.

"Most companies, when they look at their supply chain, if they're focusing on risk, it's very much just focused on property damage," said Tom Teixeira, life sciences and enterprise risk management practice leader at Willis Group Holdings P.L.C. in London.

Many businesses forget that disruptions can come from causes other than property damage, Mr. Teixeira said. "Things like power outages can have a massive effect," he said.

Supply chain disruptions stemming from the Japan and Thailand catastrophes exposed the limitations of suppliers' extension clauses, which cover losses resulting from damage to suppliers' premises, he said.

While many suppliers in Japan and Thailand did not sustain property damage, transportation disruptions that kept personnel from getting to the workplace still interrupted supply chains. "That was a huge problem that came out of Japan and Thailand," he said.

"I could see the same problem happening we've seen in Japan and Thailand, particularly because there's been a strong nondamage aspect to it," Mr. Teixeira said. "You're going to have a lot of people thinking they have cover. No, they do not."

Many likened the India outages to the power outage that hit much of the Northeast United States and portions of Canada in August 2003. In that case, many companies that experienced business interruptions were left uncovered because of the lack of physical damage.

"I think what happened in India is very similar to what happened to us in August 2003," Mr. Ellis said. In that case, "There were very few situations where any type of cover came into play."

Randy Nornes, executive vp at Aon Risk Solutions in Chicago, said that while the 2003 U.S. blackout created considerable confusion over what was covered, many companies that kept detailed records were able to pursue recoveries from third parties in litigation, even if they weren't covered by insurance.

For companies that experienced disruptions because of last week's power outages, "The coverage is what the coverage is, but they should definitely be documenting their losses now," said Frank Russo, managing director at Aon Global Risk Consulting in New York. "Timelines of events are important, too."

Many experts said the Indian power outage highlights the need for businesses to consider risks that power interruptions might pose wherever they do business.

AP PHOTO

A maze of electrical wires illustrates the fragility of India's power distribution system, which left about 600 million without power last week.

While the U.S. power grid is stronger than India's, blackouts like the one that occurred in 2003 are a risk, as are exposures such as terrorist attacks, said Linda Conrad, director of strategic business risk at Zurich Financial Services Ltd. in New York. "So the India power outage could be considered a dress rehearsal for what could happen in the U.S."

In addition, Ms. Conrad said, the power outages in India are another example of the risk of geographic concentration of companies' overseas providers. "India shows the impact of a geographic concentration of suppliers just like Thailand did," she said. While the Thai floods demonstrated the concentration risk of the world's hard drive manufacturers, India has a high concentration of service providers such as call centers and information technology providers.

Ms. Conrad said that companies need to go deeper in assessing potential supply chain risks, gauging vulnerabilities, triggers and consequences and developing mitigation strategies such as business continuity plans and arrangements with backup suppliers. "These events keep happening and, hopefully, the message starts getting through a little bit," she said.

The disruptions are likely to create additional insurance market pressure on buyers for better quality information about their suppliers, experts said.

"One of the things that we are seeing already is that there's been an impact on the contingent business interruption market," Ms. Conrad said. "What has happened as a result of Japan and Thailand, the reinsurers have informed insurance companies…they gave us 18 months from last November to start providing additional information about third-party suppliers or they would not be reinsuring what were called 'unnamed and unspecified' suppliers."

Those new information requirements will pressure contingent business interruption capacity and price, she said. "We're already seeing the impact on some of our submissions, that there's just not capacity there for unnamed and unspecified anymore," she said.

"In the absence of real granular information, you're going to have a hard time getting quality cover," Aon's Mr. Nornes said.

Obstacles hold back stand-alone buyers

While many companies that had supply or service disruptions during power outages in India last week might find their losses uncovered because of a lack of physical damage, stand-alone supply chain policies could address such exposures, brokers said.

However, there is little takeup of such coverage due to the cost and challenges of identifying exposures along the length of the supply chain.

"There are products out there that have a much broader trigger and, of course, are underwritten to those triggers as well," said Duncan Ellis, U.S. property practice leader at Marsh Inc. in New York. However, with a cost of approximately 3% to 4% of the policy limit, many buyers find the stand-alone coverage too pricey, he said.

Providing the supplier risk information required to underwriters also can be an obstacle. "That's becoming challenging in itself," said Tom Teixeira, life sciences and enterprise risk management practice leader at Willis Group Holdings P.L.C. in London. With stand-alone supply chain coverage, "the challenging bit is the amount of information insurers require," he said.

Randy Nornes, executive vp at Aon Risk Solutions in Chicago, said he's seeing some clients trying to make the process more manageable, starting with key suppliers, and recognizing it will be a multiyear process to do a thorough supply chain risk assessment.

"When we get more data out of what's happening in India in terms of the size of these risks, I think the interest in these stand-alone policies will no doubt increase," Mr. Teixeira said.

Mr. Ellis was less sure the India outages would affect business interest in the stand-alone coverage.

"We were hoping post the Iceland volcano we would see more interest. We didn't," he said. "We thought the Japanese earthquake and tsunami would generate more interest. They didn't. We thought the Thai flood would generate interest. It hasn't."

—By Rodd Zolkos

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Connecticut: Committed to captive insurance

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"The other part of this—and I learned some of this firsthand doing some of this in New York—is you need the support of government from the top down," said Mr. Serio, a former New York superintendent of insurance. He cited Vermont's success as demonstrating the value of a consistent commitment to captive insurance.

Connecticut's new captive law, which took effect July 1, includes a $7,500 first-year tax credit for new captives and allows the formation of pure captives, association captives, industrial insured captives, risk retention groups, sponsored captives, special purpose financial captives, branch captives and segregated cell companies.

Thomas B. Leonardi, commissioner of the Connecticut Insurance Department, said that while the state enacted a captive law in 2008, "the problem was the prior administration passed the law but didn't fund it. What we're excited about is this was a high-priority item for the governor."

The law also authorized a 20% increase in the insurance department's staff, including several positions earmarked to regulate captive insurance. "As part of those 28 jobs, I believe five or five-and-a-half positions were set aside for the captive market," Mr. Leonardi said.

"One of the key elements of a successful domicile is having the intellectual infrastructure, which Connecticut clearly has," said Nick Pearson, a partner at Edwards Wildman Palmer L.L.P., a New York law firm that provided legal assistance with the Thomson Reuters captive's Connecticut formation.

"Another thing you need for a serious captive domicile is a regulator who understands captives differ from other types of insurance companies and has a desire to attract captive formations," Mr. Pearson said. "Our experience with the Connecticut Insurance Department gave us every reason to believe the department embraces that."

Mr. Pearson suggested that Connecticut benefited from using Vermont's law as a model. "They looked to a great model, which is Vermont, and basically took that as the model for Connecticut," he said. "Vermont has had decades to perfect its law, so it is a good template. I think that was wise on the part of Connecticut."

Marsh Captive Solutions manages the Thomson Reuters captive. Michael Serricchio, senior vp at Marsh Captive Solutions in Norwalk, Conn., said Connecticut's captive regulatory climate offers "strict oversight, but there's also pragmatic regulation and understanding of captive business plans."

Mr. Leonardi said other captive prospects are considering the state.

"This is the first of what we hope will be several (applicants) in the next few months," he said. "We want to look at good candidates," he said, indicating that Connecticut will focus on financially stable companies that might have hard-to-place risks but a good exposure management history, rather than licensing potentially riskier captives simply to promote the domicile's growth.

Dodd-Frank: Tailor rules for insurers

CONTINUED FROM PAGE 3

there's one standard, the standard of the home taste of the insured."

The FIO draws praise, too.

"FIO has done a good job," said J. Stephen Zielezienski, senior vp and general counsel at the Washington-based American Insurance Assn. "It has been what we have expected. I think FIO Director Michael McRaith has taken an authoritative role where Dodd-Frank gives him responsibility."

Mr. Zielezienski said AIA hopes the global process for determining systemically important financial institutions "will play out and will align itself with the rulemaking under Dodd-Frank. I have every confidence the FIO will right that ship."

"There's a lot obviously that has yet to be concluded," said David Snyder, vp-international policy for the Property Casualty Insurers Assn. of America in Washington. "One positive is the international role of FIO in being part of the U.S. team now in international negotiations. The clearest example of that is the discussions between the European Union and U.S. on how our regulatory systems compare and trying to avoid a non-equivalence determination."

"The biggest remaining concern comes from the sheer scope and size of Dodd-Frank," said Jimi Grande, senior vp in the National Assn. of Mutual Insurance Co.'s Washington office.

"There are any number of unintended consequences and implementation issues that still remain."

AIA's Mr. Zielezienski said that this year the Federal Reserve issued proposed rules announcing enhanced prudential standards and early remediation standards that it would apply to large banks and nonbanks that are designated systemically significant financial institutions. He called it a "one-size-fits-all" approach.

"That's OK if it's only banks, but if an insurance company is unfortunate enough to be designated, it should have rules that are tailored to its business model," he said.

"You just can't take a bank-centric approach and apply it to insurers. It just doesn't work," Mr. Grande said.

inBrief

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Commercial P/C prices continue to rise

Commercial property/casualty insurance prices continued their upward trend, increasing an average of 4.3% in the second quarter, according to the Council of Insurance Agents & Brokers. Midsize accounts experienced the largest increase at 4.9%, while small accounts increased by 4.3% and large accounts by 3.7%, according to the survey.

Chevy replacing Aon as shirt sponsor

Chevrolet will replace Aon P.L.C. as shirt sponsor of British football club Manchester United, beginning with the 2014-2015 season. Chevrolet, a division of General Motors Co., is the official car partner of the club. The deal, which was signed for an undisclosed amount, will run for seven years. Meanwhile, Aon P.L.C. will become the title sponsor of Manchester United's Manchester United Business Network and the Manchester United Foundation.

SunAmerica to buy Woodbury Financial

American International Group Inc.'s SunAmerica Financial Group Inc. has signed a definitive agreement with Hartford Financial Services Group Inc. to acquire Woodbury Financial Services Inc., Hartford and AIG announced. Woodbury Financial is an independent broker-dealer that Hartford had said it would divest itself of this year to concentrate on core operations. Upon finalization of the transaction, Woodbury Financial Services will become part of the SunAmerica Financial Group's Advisor Group, a large network of independent broker-dealers.

Zurich to transfer book to Brown & Brown

Zurich Insurance Co. Ltd. said it would transfer its book of automobile aftermarket business to program administrator Brown & Brown Inc.'s Arrowhead General Insurance Agency Inc., effective Oct. 1. As part of the deal, approximately 170 Zurich employees from sales, underwriting, operations and customer service will switch employment to Arrowhead.

AIG reports higher first-half profit

American International Group Inc.'s net income for the first six months of this year rose 76.8% to $5.54 billion, the insurer reported. Chartis Inc. generated pretax income of $1.87 billion during the first six months of the year, a 313.9% increase over that of a year earlier. However, Chartis' net premiums dropped 2.3% to $17.92 billion during the first half. The unit's combined ratio improved to 102.3% from 111.1% a year earlier. For the second quarter, AIG's net income rose 27% compared with a year earlier to $2.22 billion. Chartis' pretax income for the period rose 16.3% to $961 million while net written premiums declined 0.8% to $9.10 billion. Chartis' combined ratio improved to 102.4% from 104.0% a year earlier.

Pension funding deficit hits record low in July

Funding levels of large corporate pension plans slumped in July, hitting a record low as falling interest rates boosted the value of plan liabilities, according to Mercer L.L.C. The average funding level of pension plans sponsored by companies in the S&P 1500 fell to 70%, down from 74% as of June 30 and 76% as of May 31. The prior record low funded ratio—71%—was set in August 2010.

Chubb to cull professional liability line

Chubb Corp. plans to cull its professional liability business, according to its top executive. "We're getting rid of accounts where we can't make money," said John D. Finnegan, Chubb president, chairman and CEO. Chubb last week reported a first-half net income of $910 million, a 1.9% drop from net income reported during 2011's first half. Professional liability premiums decreased 4.6%, to $1.09 billion. The combined ratio for the professional liability business was 98.2% vs. 85.6% for the comparable period a year ago.

Wellness program for NFL players

The National Football League has created a wellness program that it says will provide mental health support and other assistance for current and former NFL players, thousands of whom are suing the league over concussion-related injuries. The league said the NFL Total Wellness program "will help empower players to make positive health decisions; promote support-seeking behaviors in connection with behavioral and mental health issues; and provide health and safety education for players and all members of their support network." The program includes NFL Life Line, a 24/7 service that allows players to connect with mental health professionals by phone or online. The NFL is being sued by thousands of former professional football players who say the league misled them about the dangers of concussions. The athletes say they suffer from various neurological and cognitive problems related to head injuries they received while playing pro football.

Mo. med mal damage cap overturned

A $350,000 cap on noneconomic medical malpractice damages required by Missouri state law is a violation of residents' constitutional rights, according to the Missouri Supreme Court, which overturned the state Legislature's cap. A divided Supreme Court in Jefferson City, Mo., ruled that the 20-year-old decision to uphold the caps violated a citizen's right to trial by jury. Deborah Watts, the mother of Naython Watts, who suffered disabling brain injuries as a result of allegedly negligent care provided by doctors at Cox Medical Center in Springfield, Mo., was awarded $1.45 million in noneconomic damages by a jury, according to court documents. After a trial court judge reduced the amount to $350,000 as required by state law, Ms. Watts appealed, arguing that the caps violated Missouri's constitution.

Calif. work comp claim frequency still elevated

California workers compensation indemnity claims frequency remains elevated after experiencing its first increase in more than a decade during 2010, according to the Workers' Compensation Insurance Rating Bureau of California. The 2010 rise in claim frequency occurred "at a magnitude that had not been seen in over two decades," and 2011 and 2012 claims frequencies "are emerging at levels comparable to 2010," the WCIRB said.

On-site wellness programs see growth

While a majority of employers offering on-site health services to their employees still struggle to calculate their programs' worth, an even larger majority says senior managers support the programs, according to a Towers Watson & Co. study. In a survey of 74 midsize-to-large employers sponsoring biometric screenings, urgent and primary care, physical therapy and other health services in on-site centers, 53% said they either don't know or haven't attempted to measure the actual return-on-investment of those services.

Wash. plans to rebuild workers comp fund

The Washington Department of Labor & Industries is looking to build its reserve fund for workers compensation claims, but it's not yet clear whether the plan will result in a rate hike next year, the department said. Labor & Industries department is the state's monopoly workers comp insurer. Vickie Kennedy, chief policy adviser for the department, said the state has discussed about 24 workers comp rate scenarios for 2013 that would allow the fund to increase its workers comp contingency reserves. A report by the Seattle Times said those options include a possible workers comp rate increase between 7.8% and 28.6% next year.

Purdue allegedly knew about Tecumseh's "Smart Chicken" trademark before rolling out its own "Simply Smart" marketing campaign, according to a lawsuit filed by Tecumseh.

SLOGAN SUIT SMART ENOUGH TO GO TO TRIAL

A Nebraska-based poultry farmer's lawsuit against industry giant Purdue Farms Inc. has enough meat on it to proceed to trial, a federal judge ruled last week.

In a lawsuit filed in February 2012 in the U.S. District Court of Nebraska, Waverly, Neb.-based Tecumseh Poultry L.L.C. accused Purdue of copying trademarked packaging and marketing concepts. According to the complaint, Purdue allegedly knew about the "Smart Chicken" trademark Tecumseh uses on some of its products before rolling out its own "Simply Smart" marketing campaign.

Tecumseh also claimed that Purdue's slogan, "Taste the Purdue Difference," is suspiciously similar to—and too-easily confused with—its tagline, "Taste the Air Chilled Difference."

On July 24, U.S. District Court Judge John Gerrard denied a motion by Purdue to dismiss the lawsuit. However, his ruling was far from a ringing endorsement of Tecumseh's case.

"The Court finds that Tecumseh's allegations of likely confusion, while far from compelling, are plausible on their face," Judge Gerrard said in his ruling.

CONTRIBUTING: Matt Dunning, Judy Greenwald, Mike Tsikoudakis

End Page

AP PHOTO

Humphrey Bogart's heirs and the Burberry Group P.L.C. have called a truce over the use of the actor's trench coat in advertising.

Not the beginning of a beautiful friendship

Humphrey Bogart's heirs and the Burberry Group P.L.C. have ended a squabble over the use of the actor's iconic trench coat in advertising.

According to news reports, Burberry, which uses an image from the film "Casablanca" of the actor wearing one of its trench coats, has dropped a lawsuit it filed in Manhattan in May, in which it asked for a declaration that the use of Mr. Bogart's name and photo did not infringe Bogart L.L.C.'s trademark.

Bogart L.L.C., which is primarily owned by Mr. Bogart's children, had responded to the lawsuit by filing a trademark-infringement suit in state court in California, claiming that Burberry "designed, manufactured and sold numerous apparel and accessory products" as well as created marketing materials making use of its intellectual property.

They said the use of the actor's photo gave the public the false impression of an endorsement of the company's coats.

The children's lawsuit sought damages, including punitive damages, and an injunction to keep Burberry from suing Mr. Bogart's name or image, and estimated one claim alone would be for at least $1 million, according to the reports.

But despite the apparent settlement, it's probably a fair bet that, to quote Casablanca's closing line, neither party is saying to the other, "I think this is the beginning of a beautiful friendship."

Lighting company says Peete is a Grinch

'Tis not the season to be jolly after a Christmas lights company sued a former National Football League star for not paying his bill.

A California company called Christmas Light Guys has sued "Best Damn Sports Show Period" host and former NFL star Rodney Peete for not paying his Christmas lights bill in 2009.

According to court documents, Christmas Lights Guys claim that Mr. Peete agreed to pay $4,150 to install the holiday lights on his home in Los Angeles but never paid up.

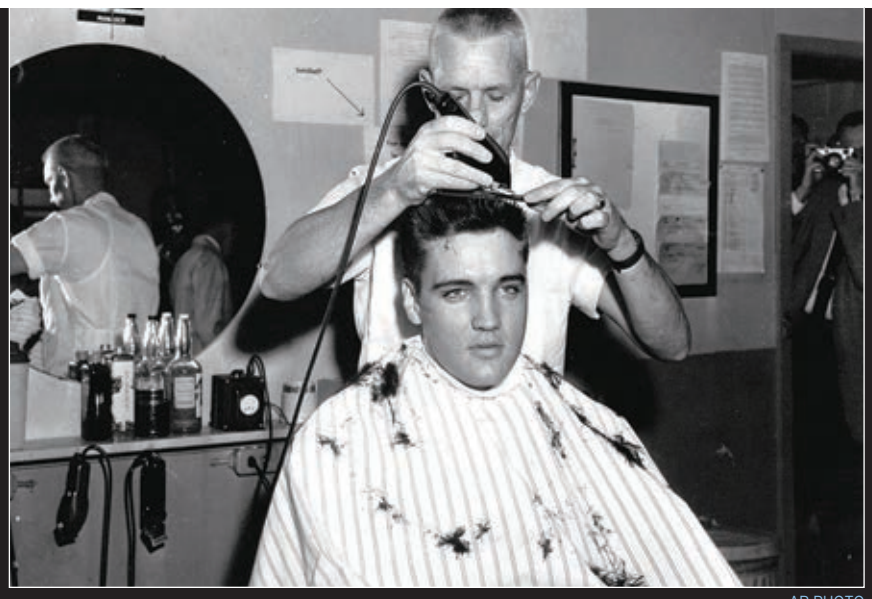
Mr. Peete is a 1988 Heisman Trophy finalist and played in the NFL for 16 years, retiring in 2004.

Calls for comment to Mr. Peete's representative were not been returned, according to news reports.

With the holiday season months away, it seems as though Mr. Peete got his lump of coal early.

AP PHOTO

Mr. Peete



AP PHOTO

A clump of hair cut off when Elvis Presley went into the Army fetched $15,000 at an auction of the legend's personal items.

FANS FIGHT TO GET THEIR HANDS ON A HUNKA HUNKA ELVIS MEMORABILIA

Thirty-five years after his death, there's still scrambling going on over Elvis' effects.

But the stakes are high, at $218,000, according to news reports. That's the amount raised from a group of collectors' items that allegedly belonged to Elvis Presley's friend and fan club president, Sterling Gary Pepper.

Mr. Pepper's heirs, John Tate and Norma Deeble, filed suit in 2009 on behalf of their late cousin, charging Mr. Pepper's former caretaker, Nancy Pease Whitehead, stole the collection.

An Iowa district court refused to block the auction, stating the relatives had waited too long to file the case. But last week after an appeal, the 8th Circuit Court of Appeals in St. Louis sent the case back for trial to determine who is entitled to the funds. The money stays in escrow.

As to the items sold, an Elvis-worn red suede shirt sold for $28,000, a clump of hair cut off when he went into the Army fetched $15,000 and two dried white roses from his funeral raised $1,400.

No blue suede shoes, though. And Elvis was not spotted leaving the auction.

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Photo: Deborah Feingold

Suzy Welch, the best-selling author, popular television commentator, and noted business journalist will be the keynote speaker at the Leadership workshop.

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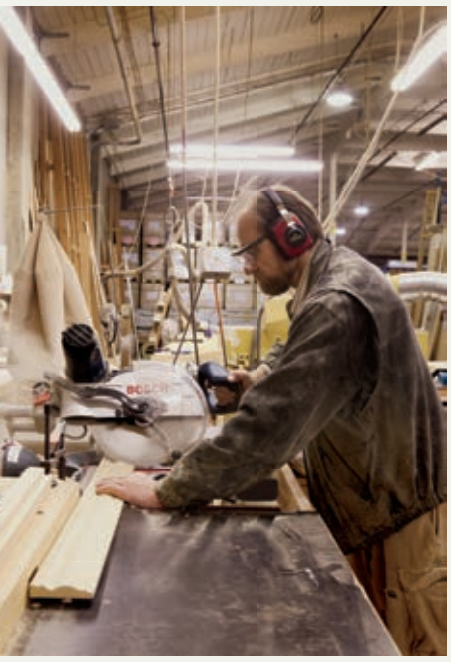

YOU CAN'T PREDICT ACCIDENTS, BUT YOU CAN SEE COMPLICATIONS COMING A MILE AWAY.

INDUSTRY:

MANUFACTURING

CUSTOMER:

FURNITURE DESIGNER

CASE OBJECTIVE:

MANAGE UNRELATED COMPLICATIONS OF AT-WORK INJURY

CASE SPECIFICS:

While working, an employee at one of our customers' furniture factories recently had an accident. What seemed like a fairly straightforward claim changed when our VantageComp™ predictive model alerted us early that the man had key triggers for type 2 diabetes. We were able to get our doctors and other medical staff involved early to craft a plan that treated the injury and helped the employee manage his diagnosis. By combining innovative data analytics with experienced talent, VantageComp led us to the best solution for today and tomorrow. To learn more, contact your agent or broker, or go to **libertymutualgroup.com/factory**

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