

## THE BIGGER THEY ARE . . .

The larger the company, the more likely it is to offer health care coverage to retirees who are not yet eligible for Medicare.

Employees	% offering health plans
20,000 or more	48%
10,000-19,999	35%
5,000-9,999	27%
1,000-4,999	23%
500-999	22%
10-499	3%

Source: Mercer L.L.C.

## RETIREMENT BENEFITS

# Employers mull health cover for early retirees

Some might shift them to insurance exchanges

BY JERRY GEISEL

Many employers that offer health insurance plans to retirees who are not yet eligible for Medicare are exploring potential savings of directing them to plans offered through soon-to-be launched public insurance exchanges.

"A lot of employers are exploring this option. They have come to the conclusion that certain of their retiree population may be better off in exchanges," said Susan Nash, a partner with law firm McDermott Will & Emery L.L.P. in Chicago.

A foundation of the Patient Protection and Affordable Care Act is establishment of 51 public health insurance exchanges; some will be

See **RETIREES** page 35

## RISK MANAGEMENT

# DRASTIC MEASURES TO AVOID MORE STORM SURGE LOSSES

New York transit agency buys \$200 million cat bond



AP PHOTO

Joseph Leader, vice president and chief maintenance officer of the Metropolitan Transportation Authority, surveyed the floodwaters after Superstorm Sandy hit New York last October.

BY BILL KENEALY

The recent announcement that New York's Metropolitan Transportation Authority bought a \$200 million catastrophe bond demonstrates the challenges faced by large insureds to secure adequate insurance coverage in catastrophe-prone regions, as well as the ability of insurance-linked securities to augment or even replace traditional insurance and reinsurance coverages.

When Superstorm Sandy barreled onto the East Coast last October, no entity bore the brunt like the MTA, which owns a network of train, bus and subway network infrastructures in New York City and surrounding areas. With tunnels and subway stations flooded, the MTA estimates it will cost \$4.75 billion to repair the damage caused by Sandy's deluge of wind and rain.

See **SURGE** page 34

## WORKERS COMPENSATION

# Meadowbrook downgrade aftermath

Excess workers comp clients assess options

BY ROBERTO CENICEROS

Companies that buy monoline excess workers compensation policies are considering alternatives, after one of the few national underwriters of the coverage was dealt a recent financial warning.

Purchasers of Meadowbrook Insurance Group Inc.'s excess workers compensation policies and their brokers are evaluating whether to obtain coverage arrangements elsewhere, after the insurer's recent loss of its A- financial strength rating from A.M. Best Co. Inc., several sources said.

Whether policyholders move, however, will depend on Southfield, Mich.-based Meadowbrook's efforts to shore up its financials and whether the limited number of competing underwriters now offering stand-alone excess workers comp insurance provide acceptable coverage terms and prices.

Only six underwriters nationwide, including Meadowbrook, provide excess workers comp coverage on a stand-alone basis because of the line's significant long-tail challenges, said Duke Niedringhaus, an excess workers comp specialist and vice president at broker J.W. Terrill Inc. in Chesterfield, Mo.

Employers' purchasing options

See **MEADOWBROOK** page 37

## CATASTROPHE BOND SALES

About \$4 billion in catastrophe bonds were sold globally during the first half of 2013, the most since the first half of 2007. Strong issuance is expected the rest of this year, with total sales projected to be \$7 billion to \$8 billion.

Sales, in millions of dollars, since 2009

2009

\$3,471

2010

\$5,275

2011

\$4,601

2012

\$6,251

2013\*

\$3,973

\*First-half of year  
Source: Aon Benfield Securities Inc.



## Q&A: ROGER EGAN

Roger Egan of Risk Strategies Co. discusses his plans to help expand the company's services

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## U.S. MID-MARKET

Employers are showing increased interest in total absence management programs

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## RESEARCH & DATA

M&A activity of agents and brokers slows after 2012 sees most deals since before 2008

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## TRENDS IN WORKERS COMPENSATION OPT OUT, OK?

Oklahoma comp law seen as alternative model; limits on drug dispensing by doctors; patient contracts to cut opioid abuse; stops on dollar leakage; utilization management. PAGE 14

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Two different federal statutes provide remedies for marine worker injury claims, which can confuse middle-market employers.

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Workers comp: Back to basics



To evolve in a positive direction, workers comp should narrow its focus and return to its original

intent, Mark Walls of Marsh Inc. says.

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OFF BEAT

A dispute worth watching



A watch worn by Sandra Bullock is at the center of an insurance dispute. Ms. Bullock is suing a watchmaker that she claims used her image in advertising without her permission.

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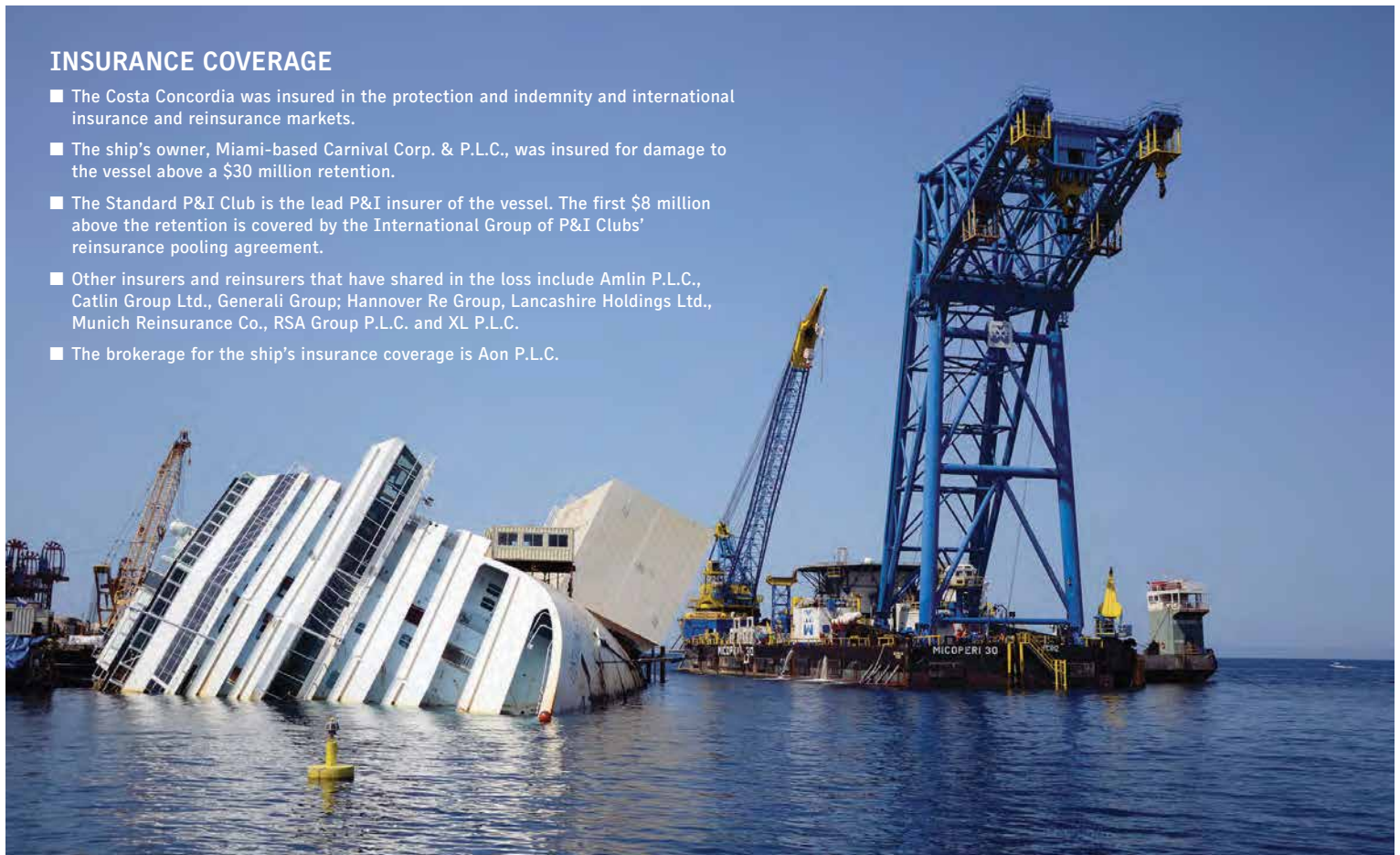
MARINE INSURANCE

SALVAGING THE WRECKAGE OF COSTA CONCORDIA

Efforts to protect environment lead to \$1 billion marine loss, costliest ever

INSURANCE COVERAGE

- The Costa Concordia was insured in the protection and indemnity and international insurance and reinsurance markets.
- The ship's owner, Miami-based Carnival Corp. & P.L.C., was insured for damage to the vessel above a \$30 million retention.
- The Standard P&I Club is the lead P&I insurer of the vessel. The first \$8 million above the retention is covered by the International Group of P&I Clubs' reinsurance pooling agreement.
- Other insurers and reinsurers that have shared in the loss include Amlin P.L.C., Catlin Group Ltd., Generali Group; Hannover Re Group, Lancashire Holdings Ltd., Munich Reinsurance Co., RSA Group P.L.C. and XL P.L.C.
- The brokerage for the ship's insurance coverage is Aon P.L.C.



AP PHOTO

Salvage crews are working against time to right and remove the shipwrecked Costa Concordia, which ran aground off the Tuscan island of Isola del Giglio.

BY SARAH VEYSEY

A technique intended to reduce the environmental effect of recovering the wreck of the Costa Concordia is boosting insurers' and rein-

surers' costs, making the cruise ship disaster the costliest marine loss of all time.

Owned by an Italian unit of Miami-based Carnival Corp. & P.L.C., the Costa Concordia sank in January 2012 near the coast of Tuscany, Italy,

causing 32 fatalities. It is a large passenger vessel at 951.5 feet and weighing 145.6 tons, and it was carrying 4,200 passengers when it hit rocks

See COSTA page 33

CAPTIVES

IRS puts captives under microscope

BY RODD ZOLKOS

Internal Revenue Service scrutiny of captive insurance arrangements is increasing, and much of it is aimed at small captives utilizing the 831(b) tax election, say many in the captive industry.

MICROCAPTIVES

826 in 2012

1,016 in 2011

The number of small captives operating under Section 831(b) of the Internal Revenue Code, according to a *Business Insurance* survey. Such captives are taxed only on their investment income if they write \$1.2 million or less in premiums a year.

Large or small, captives must be formed for the right reasons, their premiums must be appropriate and their business plans must

See CAPTIVES page 34

AGENTS & BROKERS

Hub sale signals end to spate of private-equity broker deals

BY BILL KENEALY

Last week's sale of Hub International Ltd. to San Francisco-based private-equity firm Hellman & Friedman L.L.C. likely completes the recent cycle of ownership changes among private-equity-owned insurance brokerages.

Hub is the 10th-largest broker of worldwide business and the 11th-

largest broker of U.S. business with \$632.8 million in U.S. revenue, according to the 2013 *Business Insurance* ranking.

The \$4.4 billion purchase of Chicago-based Hub came within nine months of Briarcliff Manor, N.Y.-based USI Holdings Corp. and Newport Beach, Calif.-based

See HUB page 33

8/12/13

ONLINE  
FEATURES

## SOLUTION ARC

How to protect against theft  
of intellectual property

Employee theft is a problem among U.S. businesses; it can hurt income and lead to a company's demise.

[www.BusinessInsurance.com/EmployeeTheftArc](http://www.BusinessInsurance.com/EmployeeTheftArc)

## VIDEO



## Strategic risk management

The latest *Business Insurance* video focuses on SRM and its effects on reputational and supply chain risks.

[www.BusinessInsurance.com/video](http://www.BusinessInsurance.com/video)

## VIRTUAL CONFERENCE

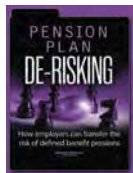
## Sign up for online comp event

Registration is open for *Business Insurance's* fourth annual Workers Compensation Virtual Conference on Aug. 22. The event is free.

[www.BusinessInsurance.com/2013wccconference](http://www.BusinessInsurance.com/2013wccconference)

## WHITE PAPER

## Cutting pension risks



Many companies are reducing risk in their pension plans. This white paper explains how pension risk reduction works,

outlines the advantages of the strategy and reviews its outlook.

[www.BusinessInsurance.com/PensionDeriskingWP](http://www.BusinessInsurance.com/PensionDeriskingWP)

**BUSINESS INSURANCE** (ISSN 0007-6864)  
Vol. 47, No. 16, is published biweekly by Crain Communications Inc., 150 N. Michigan Ave., Chicago, IL 60601-7620. Periodicals postage is paid at Chicago and at additional mailing offices.

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

## NEWS

## LIABILITY &amp; LITIGATION

EMPLOYERS GET A BOOST AS  
WAL-MART WINS ANOTHER ROUND

Judge rejects class-action attempt in gender bias case

BY JUDY GREENWALD

Employers' efforts to dismiss, settle or discourage class-action litigation gained ground with a federal judge's rejection of a smaller group of workers still alleging gender discrimination by Wal-Mart.

In the most recent ruling in the 12-year-old case, this month U.S. District Court Judge Charles R. Breyer in San Francisco ruled in *Betty Dukes et al. v. Wal-Mart Stores Inc.* that the proposed class of 150,000 plaintiffs faces the same problems that led the U.S. Supreme Court in 2011 to reject a 1.5 million-member class: They did not identify a "common mode of exercising discretion that pervades the company," as the high court had ruled two years ago.

The smaller group of women that worked in the California area, as did the larger group, alleged they were paid less and promoted less often than men.

In the ruling, Judge Breyer basically said that while there may be a certifiable class in the group of 150,000, "it has to be a whole lot smaller," said Michael W. Fox, a shareholder at law firm Ogletree, Deakins, Nash, Smoak & Stewart P.C. in Austin, Texas.

Charles W. Pautsch, a partner with Arnstein & Lehr L.L.P. in



AP PHOTO

Betty Dukes, right, and fellow plaintiffs in *Betty Dukes et al. v. Wal-Mart Stores Inc.* suffered a setback in court this month.

Chicago, said the plaintiffs may have been successful had they restricted the suit to the Sacramento, Calif., area, for example, with one particular vice president who "had a discriminatory bent."

"The days of courts certifying class actions without taking a good look at the evidence are over," Kenneth Sulzer, a partner with Proskauer Rose L.L.P. in Los Angeles, said of Judge Breyer's ruling in light of the earlier Supreme Court decision.

Meanwhile, the high court's 2011 ruling in *Dukes* has significantly

affected similar federal and state court cases.

Attorney Gerald L. Maatman Jr., a partner at law firm Seyfarth Shaw L.L.P. in Chicago, said in 2010, the year before *Dukes*, the 10 largest settlements of private plaintiff employment discrimination class actions totaled \$346 million, according to the law firm's Annual Workplace Class Action Litigation Report.

In 2012, the 10 largest settlements totaled about \$45 million. Post-

See **WAL-MART** page 30

## RESEARCH &amp; DATA

## M&amp;A activity slows after record-setting 2012

BY TIMOTHY J. CUNNINGHAM  
AND DANIEL P. MENZER

Announced mergers and acquisitions of insurance agents and brokers in the United States and Canada finished 2012 with the largest number of deals in one month and for one quarter since before 2008.

The number of announced deals early this year continued last year's trend, and likely were deals that closed in December but were not announced until this year.

Since February, however, every month has had only modest deal activity. Given the record-setting

2012, the falloff in mergers and acquisitions this year should not be a surprise.

With the capital gains tax increasing from 15% to 20% effective January 1 and a new Patient Protection and Affordable Care Act surtax of 3.8% on investment gains for certain high-income individuals, the robust pipeline was drained as principals considering selling were strongly motivated to get it done last year.

The most active buyer groups this year continue to be privately owned brokers and private equity-backed firms. They were responsible for nearly 70% of the

announced transactions in the first half of this year, up from 60% for the same period last year. Publicly traded brokers dropped to only 15% in the first half of this year from 23% of the total in the first half of 2012, with nearly half of their announced deals in January. Thirty-seven different privately owned buyers announced deals during the first half of 2013, while there were 13 different private equity buyers during the period.

Private brokers and bank-owned agencies were the only groups that increased their reported acquisi-

See **MERGERS** page 26

## WORKERS COMPENSATION

Humana seeks  
repayments  
from Farmers

Insurers legal clash tied to rules for Medicare reimbursement

BY SHEENA HARRISON

A series of federal lawsuits filed by Humana Inc. against Farmers Insurance Group of Cos. seeking reimbursement under Medicare Secondary Payer rules is being watched closely by Medicare experts, who say the litigation is an example of hurdles they face in reaching workers compensation and liability settlements.

Humana argues in the suits that the Medicare Secondary Payer Act entitles it to reimbursement from Farmers for benefits that Humana paid for Medicare Advantage and Medicare Part D plan beneficiaries.

In its suits, Humana is seeking nearly \$80,000 from Farmers and related entities for claims that Humana paid in Kansas, Missouri, Tennessee and Texas. The company also is seeking unspecified "restitution for all claims under no-fault, medical payments or other" cases in which Humana paid a claim when Farmers was the primary payer.

A Farmers spokesman said the company does not agree with the premise of the lawsuits, but did not provide additional comment.

While Medicare compliance experts agree that Medicare Advantage plans have some right to reimbursement from workers comp and liability settlements, they say it can be tricky to determine whether a claimant owes money to a private provider, rather than the Centers for Medicare and Medicaid Services.

Cases such as Humana's could open the door for Medicare Advantage plans to seek reimbursement long after a claim has closed — and possibly seek double damages in court for delayed repayment — even if settlement parties didn't know money was owed to a Medicare Advantage plan that paid for the care, said Michele Adams, chairwoman of the Medicare Advocacy Recovery Coalition in Washington.

"It's going to slow down recovery to (CMS), as well as to the Medicare Advantage plan and ultimately to the beneficiary in the final resolution of their case," said Ms.

See **HUMANA** page 31



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# AFTER A SPINAL INJURY, SHE FEARED SHE MIGHT NEVER WORK AGAIN. BUT WE HAD HER BACK.

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# MARINE FIRMS DOUBLE DOWN ON COMP

Two federal laws, plus state laws, often prompt multiple worker claims

BY JOANNE WOJCIK

Because two different federal statutes provide remedies for marine worker injury claims, middle-market employers with maritime operations often are confused about what types of insurance coverage to purchase.

Longshoremen and other types of shore workers are covered by the U.S. Longshore and Harbor Workers' Compensation Act, a federal workers compensation program that serves as the exclusive remedy for injured marine workers.

But seamen and other crew members are covered by the Merchant Marine Act of 1920, known as the Jones Act, which provides a personal-injury negligence remedy within the tort system.

Although these two statutes define which types of workers fall under each law, there are some "gray areas," marine liability experts say, which often lead injured marine workers to file claims under both laws, setting up the need for marine employers to have work comp coverage under the Longshore Act and maritime employer liability coverage for Jones Act claims. And in some states, such as California, it also may be necessary to buy statutory workers compensation coverage, experts said.

Because of the nature of their work, "marine workers are constantly walking in and out of coverage during the course of the workday," said Jack Martone, senior vice president at Washington-based American Equity Underwriters Inc., which administers a self-insured group workers comp program for maritime employers.

For example, most U.S. courts have considered workers who spend 30% or more of their workday on a vessel, such as fishermen, to be Jones Act employees, while those who spend the majority of their time on shore, such as stevedores, to be covered by the Longshore Act, Mr. Martone said.

But because a Jones Act recovery can be significantly greater than one under the Longshore Act, injured workers often file claims under both, Mr. Martone said. As such, "an employer has to have coverage for the right remedy or suffer the consequences," he said.

"We've got several cases right now where dock builders are claiming to be seamen," said Tom Lan-



## INJURY SOURCES

Marine workers suffer similar injuries to that of workers in other industries. While the U.S. government does not compile data into a single marine worker category, it does track data for injured water transportation workers, who are generally covered by the Merchant Marine Act, known as the Jones Act, and longshoremen and stevedores, who are generally covered by the Longshore and Harbor Workers' Compensation Act.

\*Includes workers involved in marine cargo handling, port and harbor, and deep sea coastal and Great Lakes transport operations  
Source: U.S. Bureau of Labor Statistics

## TOP INJURY SOURCES

### WATER TRANSPORTATION WORKERS

1. Vehicles
2. Parts and materials
3. All other
4. Person, ill or injured worker
5. Floors, walkways, ground surfaces

### LONGSHOREMEN AND STEVEDORES\*

1. Containers, furniture, fixtures
2. Parts and materials
3. Tools, instruments, equipment
4. Vehicles
5. Structures and surfaces

gan, corporate risk manager at Weeks Marine Inc., a Cranford, N.J.-based dredging, marine construction and stevedoring firm. The employees sued arguing they are covered by the Jones Act, relying in part on the U.S. Supreme Court's 2005 decision in *Willard Stewart v. Dutra Construction Co.* "that basically found anything that floats is a vessel," he said.

"The Supreme Court has wrestled with the dividing line between longshoremen and seamen for a long time," said Jim McMullen, a partner at Gordon & Rees L.L.P. in San Diego, who was involved in the 1991 precedent-setting *Southwest Marine Inc. v. Byron Gizoni*.

In that case, Southwest Marine, a San Diego-based ship repair operator, was sued by Mr. Gizoni, a rigging foreman who broke his foot when it went through a wooden sheet covering a hole in a platform being used to transport a rudder

from the shipyard to a floating dry dock. He applied for, and received, medical and compensation benefits under the Longshore Act and later filed suit under the Jones Act, alleging that he was a seaman injured as a result of his employer's negligence. While the district court dismissed his claim, finding that Mr. Gizoni was not a seaman as defined by the Jones Act, the appellate court reversed, and the U.S. Supreme Court upheld, finding that "a maritime worker whose occupation is one of those enumerated in the USL&H may be a seaman within the meaning of the Jones Act."

"If you have exposures on the waterfront, you've got to entertain the possibility that you will need USL&H and/or maritime employers liability coverage, or both," said Jeffrey Gieseler, Metairie, La.-based area vice president at Gallagher Marine, a unit of Arthur J. Gallagher Risk Management

Services Inc.

He said there are three ways for marine employers to obtain coverage: "You can buy a U.S. Longshore Act policy," which is akin to statutory workers compensation except that it crosses state lines, covering workers as they traverse all U.S. jurisdictions; "you can be self-insured, but you have to satisfy the financial responsibility requirements set by the Department of Labor; or you can belong to a group self-insurance fund."

Some employers buy maritime employer liability cover from protection and indemnity clubs, said Nadine Stillifant, senior vice president in the marine group at Marsh Inc. in Seattle.

"When you're looking for a P&I placement, you need to make certain it includes crew. In part of the country, it's customary to provide bodily injury and property damage under the P&I coverage and have

## SEAMAN DEFINITION STILL UNCLEAR

Congress enacted the Longshore and Harbor Workers' Compensation Act in 1927 in response to a 1917 U.S. Supreme Court ruling in *Southern Pacific Co. v. Christen Jensen* that said the Maritime Clause of the U.S. Constitution prohibits state workers compensation laws from covering workers employed over navigable waters.

The act, administered by the U.S. Department of Labor, operates similarly to state workers comp laws, providing no-fault, prompt payment of benefits and medical treatment to injured workers.

While the Merchant Marine Act of 1920, also known as the Jones Act, similarly provides for "maintenance and cure" of injured seamen, it also gives them the right to use the tort liability system to file negligence claims and seek damages from their employers.

Though the Jones Act allows only workers defined as "seamen" to seek such remedies, it doesn't thoroughly define the term. Since then, numerous U.S. courts have attempted to interpret the term, resulting in uncertainty over whether employees are covered by the Longshore Act or the Jones Act.

By Joanne Wojcik

separate MEL cover. There are certain underwriters that will provide all three coverages, but it depends on how their reinsurance coverage is structured," she said.

In some states, maritime employers also may require statutory workers compensation cover, said Mr. McMullen, citing *CNA Insurance Co. v. Workers Compensation Appeals Board, Navigators Insurance Co., et al.*, a 1997 case involving a bartender on a Catalina ferry who was injured while running down the gangway after disembarking.

Even though Cella Baker spent more than 80% of her workday aboard the vessels to which she was assigned, the California appellate court ruled that because "she tripped on the bottom of the gangway and fell onto her knee onto the floating finger pier" belonging to the city of Avalon, Calif., she "was entitled to state workers comp benefits," Mr. McMullen said.

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# TOTAL ABSENCE MANAGEMENT HELPS EMPLOYERS CONTROL COSTS

Integrating employee leave programs can result in fewer injuries



## STARTING AN ABSENCE PROGRAM

Companies that want to create a total absence management program should start by tracking the amount of leave that their employees take each year and analyzing the cost of such absences, said Tom Parry, president and CEO of the San Francisco-based Integrated Benefits Institute. This can help executives understand the business case for leave integration.

“Employers often get stuck because they don’t have the data to demonstrate they’ve got a problem and, therefore, there is a solution needed,” Mr. Parry said.

“I think the first order of business would be to understand what kind of data you want out of that integration, and understand what your current partners can bring to the table and what they’re doing for others,” said Jim Blaney, Radnor, Pa.-based CEO of Willis North America Inc.’s human capital practice. Secondly, employers should bring all of their stakeholders together to discuss how they can combine their data for integrated leave management and provide that data to the employer in the company’s preferred format, he said.

Such talks should include group health, workers comp and disability insurers, wellness program providers and any other firms that manage employee health.

By Sheena Harrison

BY SHEENA HARRISON

Mid-market employers are expressing increased interest in total absence management programs to help them administer different types of occupational and nonoccupational disability leave while using integrated data to create healthier workplaces.

Integrated disability management programs developed by large employers many years ago are starting to be modified for mid-market companies, driving smaller employers to consider such programs as an option, sources say.

Meanwhile, the economy has amplified the importance of eliminating excessive employee leave time, particularly among mid-market firms in blue- and gray-collar industries, experts say.

“Larger employers tend to have what we might call more ‘slack’ in their systems,” said Tom Parry, president and CEO of the San Francisco-based Integrated Benefits Institute. “They have more people that might be able to fill in and do jobs and that kind of thing. Smaller employers don’t have that luxury, so absence and poor health really hit small employers big time.”

Experts say the definition of total absence management varies from employer to employer.

Many integrated programs tie in short- and long-term disability leave and absences under the federal Family and Medical Leave Act, while some include programs such as workers compensation and sick leave.

FMLA typically serves as the common thread for programs that employers want to integrate since the law operates concurrently with various types of occupational and nonoccupational leave.

Terri L. Rhodes, San Diego-based executive director of the Disability Management Employer Coalition, said about 60% of FMLA-related leaves are connected to short-term disability claims.

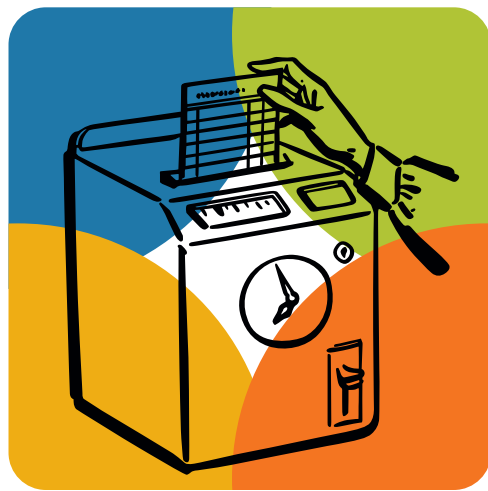
FMLA “has created more protected job time for different reasons, and so it has increased absences for many employers,” said Denise Fleury, Orange, Calif.-based senior vice president of disability and absence management for Sedgwick Claims Management Services Inc.

Companies haven’t linked such programs in the past because they’ve traditionally been han-

dled by different departments that often don’t collaborate, said Mark Walls, St. Louis-based senior vice president and workers compensation market research leader at Marsh Inc.

“You’ve got the nonoccupational (leave) being handled by human resources and being paid under group benefits, whereas the occupational (leave) is being handled under risk management and coming out of workers compensation,” Mr. Walls said.

It also has been difficult for employers to integrate data from various providers that handle group health, workers comp and disability coverage, said Jim Blaney, Radnor, Pa.-based CEO



of Willis North America Inc.’s human capital practice.

Employers may work with third-party administrators, insurers, brokers and other providers to administer such services, and sometimes find it difficult to get them to collaborate on leave integration, Mr. Blaney said.

Companies with integrated leave programs “have disability and wellness right, but they can’t loop in workers comp effectively,” Mr. Blaney said. “Or they’ve got workers comp looped in effectively with the health management vendor, but disability’s still a problem.”

Still, experts say the advantages of total absence management outweigh the challenges of such programs. They note that consolidating programs can reduce costs compared with

operating several leave programs through various providers.

Data from integrated leave programs can be analyzed to determine health and disability cost trends that employers should target for intervention, said DMEC’s Ms. Rhodes.

“Employers are more likely to be able to see those red flags when someone’s absence is exceeding what the doctor’s guidelines are or they have those patterns of absence,” Ms. Rhodes said.

Employees who take time off for workers comp-related injuries are prone to being reinjured, which could result in a later disability-related absence, Sedgwick’s Ms. Fleury said. By linking data on employees who have taken such absences, employers can help those employees participate in wellness initiatives that could keep them at work down the road, Ms. Fleury said.

By combining leave programs, employers also can make the leave experience easier for employees to navigate, sources say. For instance, some programs establish one phone number that employees can call to report different types of absences. Integration also can allow employees to receive correspondence from one provider when their leave falls under two or more categories, such as short-term disability and FMLA.

“To them it feels like it’s one voice and one piece of information to deal with,” Ms. Fleury said about the employee experience.

There are several steps employers can take to establish a total absence management program (see related story).

Experts recommend that employers shop around for providers with total absence management programs that are customized to the employer’s needs. This can be particularly important for mid-market employers, they say, since outsourcing absence management can be a time- and labor-intensive endeavor for companies that attempt to create such programs in-house.

DMEC’s Ms. Rhodes said companies should be prepared to commit to the program and their leave management partners for some time to see the most benefits. “It usually takes between 12 months and 18 months to ... put a program together when you’re integrating,” she said.

### LEAVE ISSUES

According to a survey of 238 employers released in January by the Disability Management Employer Coalition and Spring Consulting Group Inc.:

58%

of respondents centralize the administration of their various leave programs.

84%

believe their leave management programs are somewhat or highly successful.

32%

said they struggle with applying the Family and Medical Leave Act consistently across their organizations.

32%

said their leave management program has decreased associated costs in the past two years.

33%

said their leave program has decreased lost employee time in the past two years.

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## IG says still in deal talks with Chinese group

U.S. insurer American International Group Inc. said it was still in talks with a Chinese consortium regarding the sale of its International Lease Finance Corp. aircraft leasing unit for about \$4.8 billion. AIG CEO Bob Benmosche said on a post-earnings conference call that the company also was open to an initial public offering of the unit if a deal does not go through. The Chinese buyers' consortium, which has missed earlier deadlines, includes P3 Investments, New China Trust Co., one-fifth owned by Barclays P.L.C., and China Aviation Industrial Fund. It struck a deal with AIG late last year to buy its ILFC unit for \$4.8 billion.

Reuters

## Third Point IPO expected to raise at least \$277.5M

Third Point Reinsurance Ltd. will offer 22.2 million shares on the New York Stock Exchange for its initial public offering, the Pembroke, Bermuda-based reinsurer said. Founded in October 2011 with funds from New York-based hedge fund Third Point L.L.C., the reinsurer said it expects the IPO price to be \$12.50 to \$14.50 per common share. That would raise \$277.5 million to \$321.9 million. Third Point Re announced its intent to go public in July.

## Bermuda registers 10 captives in first half

The Bermuda Monetary Authority reported registering 10 new captive insurers among the 34 insurance companies it registered during the first half of 2013. The authority had registered five new captives and 13 insurers total during the year's first quarter. The first-half registrations also included 12 new special-purpose insurers, four of them registered in the second quarter and eight during the first quarter, according to a statement from the authority.

## Firm in Quebec rail crash was subcontractor

Canadian Pacific Railway Ltd., hired to transport oil from North Dakota to New Brunswick, Canada, subcontracted part of the job to the small railroad involved in the deadly crash in Lac-Mégantic, Quebec, the company that chose the Canadian railroad said. CP Rail, which had not until now been

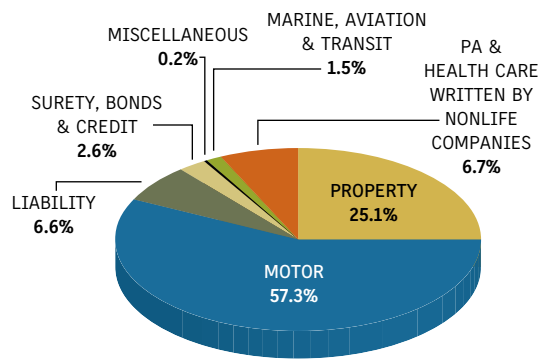
## PROFILE: SLOVAKIA

**\$1.38 BILLION**

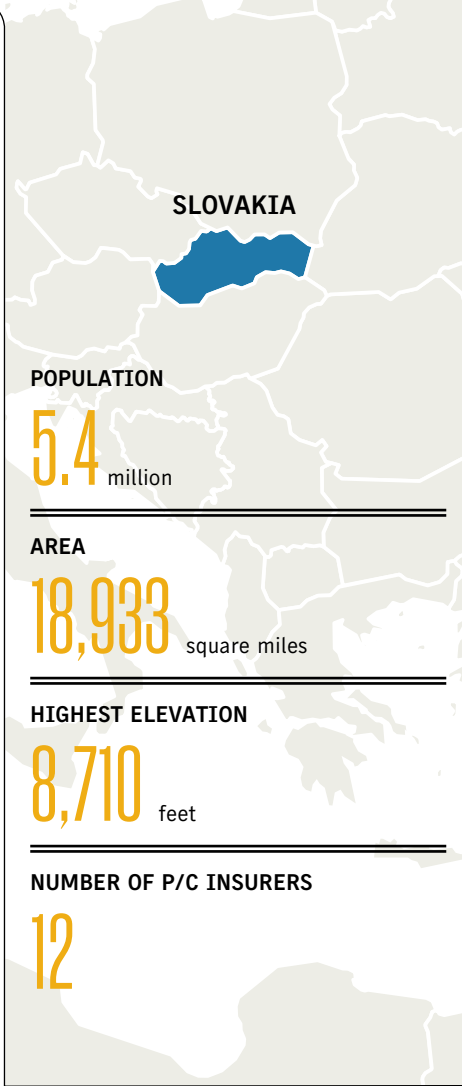
The commercial insurance market in Slovakia is competitive due to the international nature of the country's export-related industrial base. At least 80% of the top 300 companies in Slovakia are foreign-owned and are insured under global programs. As a result, many insurers target personal lines insurance for expansion. The insurance market is dominated by the five largest companies, which write more than 85% of gross written premiums.

◀ 2011 p/c premiums

### MARKET SHARE



Source: Axco Global Statistics/Industry Associations and Regulatory Bodies



### MARKET DEVELOPMENTS

UPDATED JUNE 2013

- Brokers and insurers are attempting to develop liability business, but buyer attitudes reflect a low-claims environment. For example, insurers expected increased activity after the E.U. Environmental Pollution Directive was introduced in 2012, but instead potential polluters set aside relatively small amounts of cash as financial guaranties.
- Effective Jan. 1, 2013, the Slovakian government increased corporate tax to 23% from 19%. In addition, the government introduced a special levy to help reduce the public deficit. The levy applies to companies in regulated sectors, including insurance and reinsurance, that make an annual profit of more than \$3.9 million. The profit is subject to a levy of 0.0363% per month between Sept. 1, 2012, and Dec. 31, 2013.
- Astra, Romania's largest insurer, entered the automobile insurance market in Slovakia in 2013 with the intention of expanding into property insurance.
- Previously expected merger and acquisition activity in the run-up to the implementation of Solvency II has not materialized, except for the merger of two small companies, ERGO and CSOB.

### COMPULSORY INSURANCE

Several classes of insurance are compulsory, including:

- Auto third-party liability
- Railway operators liability
- Professional indemnity for numerous professions
- Liability for river vessels and road carriers
- Aviation liability
- Hunters public liability

### NONADMITTED

There is nothing in Slovakian legislation to prevent insurance buyers from placing their business with nonadmitted insurers abroad, with a few exceptions — compulsory auto, employers liability and clinical trials liability.

### INTERMEDIARIES

Intermediaries have to be authorized to conduct insurance business. Brokers involved in nonadmitted placements do not have to warn buyers that their insurer is not subject to local supervision. Insurance is sold mainly through agency and branch networks, but brokers are becoming increasingly important in the commercial sector.

### MARKET PRACTICE

Market players seldom diverge from the legal parameters enforced. Slovakia is ranked No. 53 in the world in terms of nonlife gross written premiums.

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

named in connection with the accident, subcontracted a section of the route to Montreal, Maine and Atlantic Railway (MMA), World Fuel Services said.

Reuters

## London-based IUA sets up political risk committee

The International Underwriting Association, which represents insurers and reinsurers in the London company market, has established a political risk committee. The group, which will meet every other month, is made up of underwriting and claims practitioners from IUA member companies and will consider "both technical underwriting and claims aspects of doing business across different jurisdictions and industries," the IUA said in a statement.

## Greenberg, others to buy Tokyo building for \$1B

A group including former U.S. insurance magnate Maurice R. Greenberg and an Abu Dhabi sovereign fund have agreed to buy a prominent Tokyo office building for \$1 billion, the biggest property deal in Japan since February, people with direct knowledge of the transaction said. The decision by the foreign and Japanese investors to acquire the aging but distinctive structure in central Tokyo highlights expectations that real estate values will revive as Prime Minister Shinzo Abe's pro-growth economic policies boost investor sentiment and risk appetite. The group, led by property investor Asia Pacific Land, includes the Abu Dhabi Investment Council, Japan's Secured Capital Investment Management Co. and C.V. Starr & Co. Inc., which

is run by Mr. Greenberg, the billionaire former chief executive of American International Group Inc. For the purchase for more than 100 billion yen (\$1.01 billion) of the 14-story Shiba Park Building, the investors will inject about 10 billion yen (\$101.1 million) in cash, according to sources.

Reuters

## Cayman Islands licensed 24 captives in first half

The Cayman Islands licensed 24 new captives in the first half of 2013, up from 20 licensed during the same period last year. The domicile ultimately licensed 53 captives in 2012. A statement from the Insurance Managers Association of Cayman said that most of the newly licensed captives were formed by North American companies, with 31% of them providing

medical malpractice coverage and 21% covering workers compensation. According to IMAC, the Cayman Islands had 412 pure captives and 134 segregated portfolio companies as of June 30, with Cayman captives writing \$13.5 billion in total premiums, a 52% increase from a year earlier.

## Energy mutual group adds four new members

Hamilton, Bermuda-based mutual Oil Insurance Ltd. has signed four new members this year, the company announced. OIL said it now has 56 energy company members. The new members are Dallas-based Alon USA Energy Inc.; Anadarko Petroleum Corp. and Arena Energy L.P., both based in The Woodlands, Texas; and Calgary, Canada-based Cenovus Energy Inc.

## Billion-dollar disasters hit Canada, China

■ Canada experienced its second billion-dollar natural disaster loss of the year as record rainfall in the metropolitan Toronto area during July caused significant flooding and power outages, according to an analysis by Impact Forecasting L.L.C., the catastrophe model development arm of reinsurance intermediary Aon Benfield. Strong July 8 thunderstorms caused \$1.45 billion in economic losses with about half of that total — \$730 million — covered by insurance, according to the July 2013 Global Catastrophe Recap report. While the storms caused widespread damage to personal and commercial properties, vehicles and infrastructure, no deaths were reported.

## Lancashire to acquire Lloyd's insurer Cathedral

■ Lancashire Holdings Ltd. will acquire Lloyd's of London insurer Cathedral Capital Ltd. from private-equity firm Alchemy Partners and the management of Cathedral for £266 million (\$406.6 million). Cathedral underwrites property reinsurance, direct and facultative property business, aviation and satellite, contingency and cargo insurance and reinsurance. Lancashire, which is headquartered in London but registered in Bermuda, focuses on short-tail lines of insurance, mainly aviation, energy, marine and property.

## Guernsey licenses 46 entities in first half

■ The Guernsey Financial Services Commission said it has granted licenses to 46 international insurance entities during the first half of 2013. There were 766 international insurers based on the island compared with 737 at the end of 2012, the commission said. The new companies licensed during the first half of this year were three limited insurance companies, two protected cell captives, 37 protected cells and four incorporated cells.

## \$1.3M reward for recovery in jewel heist

■ A loss adjuster working on behalf of Lloyd's of London syndicates that insured diamonds and other gemstones stolen in an armed robbery in Cannes, France, offered a reward up to €1 million (\$1.3 million) for information that leads to recovery of the jewels.

Paris-based loss adjuster S.W. Associates SARL said it would pay a reward up to €1 million "to the first person who provides information which leads to recovery of the goods." The offer is subject to "certain conditions," S.W. Associates said in a statement. The jewels were seized July 28 from an exhibition by jeweler Lev Leviev at the Carlton Hotel in Cannes and are estimated to be worth about €103 million (\$1.4 million).

## Brazil enacts anti-bribery law required by OECD

■ Bribing a public official in Brazil could become an onerous mistake for local and foreign businesses under a new law that for the first time makes companies liable for bribes paid by their employees. Companies found guilty of bribery will face fines of up to 20% of their gross annual revenue for the previ-

ous year or a maximum of 60 million Brazilian reais (\$26.6 million). They also could be suspended from operating, have assets confiscated and even face possible dissolution. Brazil's Congress passed the law in record time in the wake of sweeping protests that shook the country's political establishment in June, fueled by widespread public anger with corruption and bad government. The law proposed by President Dilma Rousseff's govern-

ment covers bribery of foreign officials by Brazilian companies and bribery of local officials by any company. The legislation was required by the Organization for Economic Cooperation and Development. While not a member, Brazil is a party to the OECD's Anti-bribery Convention and was asked in a peer review in 2007 to speed up steps to make companies directly liable for bribing foreign officials.

Reuters



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EDITORIAL

## GOP EXERCISES IN FUTILITY NEED TO STOP

**H**ow many times will Republicans in the House of Representatives vote to repeal all or part of the health care reform law? That's a fair question in light of the series of repeal votes House GOP leaders have led — the most recent one this month to try to bar the Internal Revenue Service from enforcing provisions of the law under its jurisdiction.

How these votes play out is always the same: A vote is scheduled. The Obama administration makes a veto threat. Then impassioned oratory, from Republicans and Democrats alike, precedes the vote on the House floor. The House, where Republicans hold the majority, then approves the bill on near-party-line votes. Of course, the repeal bills then all die in the Senate, which Democrats control.

Republicans and Democrats know the outcome before a single vote is cast. So a reasonable question to be asked is why do Republicans in the House continue to bring up these dead-on-arrival bills for votes?

One reason might be for the American people to hear GOP arguments on why the Patient Protection and Affordable Care Act should be repealed.

But after the umpteenth vote to repeal, the arguments have been heard often enough and are unlikely to significantly affect public opinion.

Both sides know how the votes will play out and what the result will be. So why is the GOP taking so much of legislators' time with floor votes on these dead-on-arrival repeal bills?

A much better use of lawmakers' time would be to work together to try to improve the law, a suggestion made last week by White House Press Secretary Jay Carney.

Maybe, as we have suggested before, the law too broadly defines full-time employees as those working as few as 30 hours a week to determine if employers are liable for a penalty for not offering coverage.

Or perhaps more small employers, especially new firms struggling to earn profits, should be exempt from the requirement of offering coverage or paying a stiff financial penalty.

These are issues — and there are no shortage of others — for lawmakers to consider. How to improve the law seems a far better use of senators and representatives' time than futile repeal votes.

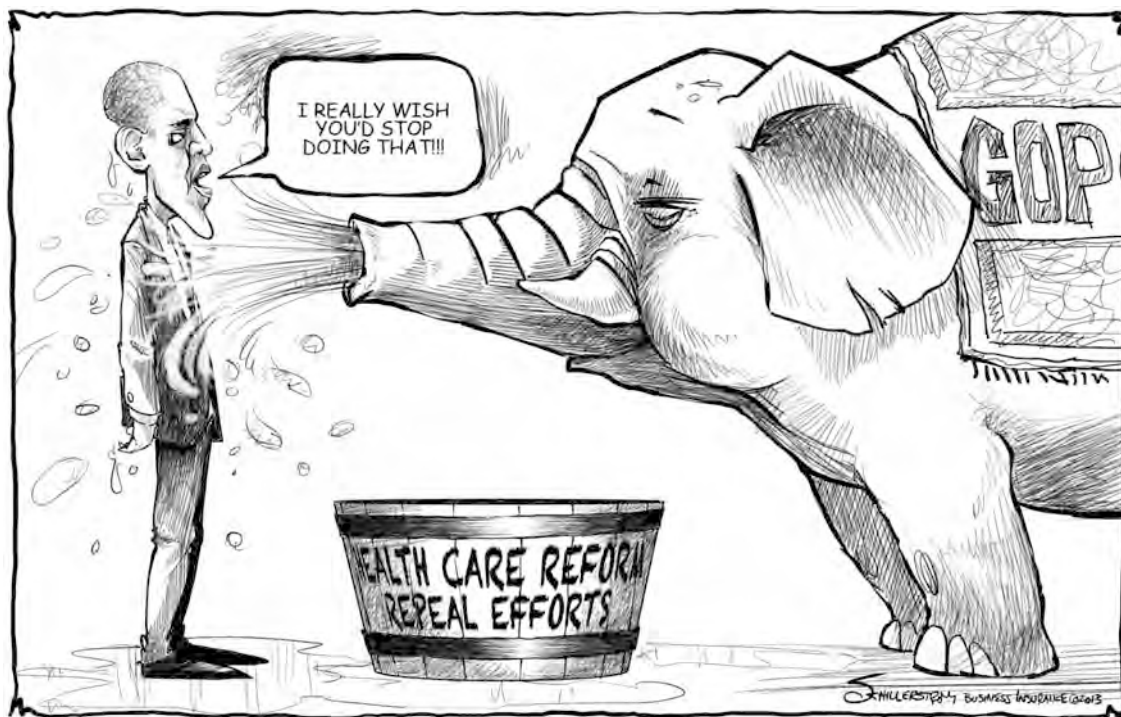
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SCHILLERSTROM



COMMENTARY

## DEADLIEST OCCUPATION NEEDS BETTER COMP SYSTEM

**W**hile sitting back comfortably in my La-Z-Boy recliner watching recorded episodes of “Deadliest Catch,” I often wondered whether there’s not a bit of hyperbole in this reality TV show’s portrayal of the perils of crab fishing.

But fishing is, in fact, the most deadly occupation, according to the U.S. Bureau of Labor Statistics.

The risk of suffering a fatal job injury is 50 times greater for those engaged in this line of work than for all other occupations. In 2009, the most recent year for which data is available, the fatality rate for fishermen was 203.6 per 100,000 workers, compared with a fatality rate of just 3.5 per 100,000 for all other occupations. The shellfish industry accounts for almost half of all fishermen killed on the job over a seven-year period ending in 2009, government statistics show.

As a reporter who has covered risk management for more than two decades, I also wondered what the workers’ compensation experience was like for employers of the fishermen featured on the “Deadliest Catch.” But while doing research on maritime worker injuries for this week’s middle-market risk management section, I discovered that none of these workers are covered by workers compensation. Rather, they are covered by the Merchant Marine Act of 1920, more commonly known as the Jones Act.

If these workers are injured, their employers generally provide something called “maintenance and cure,” including emergency medical care and compensation for lost wages. If their injuries result in permanent disability, or if their maintenance and cure doesn’t cover all of their injury-related expenses, these workers must file lawsuits alleging negligence on the part of their



**JOANNE  
WOJCIK**

SENIOR EDITOR

employers to obtain damages. And if they die, their families must take their loved ones’ employers to court to obtain death benefits.

It was explained to me that these workers are not covered by state workers compensation systems because their place of employment is on the “navigable waters” of the United States, which often cross state and/or international borders.

By contrast, longshoremen — the maritime workers who load and unload these ships and work primarily in seaports — are covered by a no-fault system that makes treating their injuries easier. The Longshore and Harbor Workers’ Compensation Act is a federal workers compensation program that works much like state work comp systems, serving as the exclusive remedy for injured land-based maritime workers.

Given the inherent dangers of this work and the friction caused by litigation, Congress should extend the Longshore Act to include fishermen. A no-fault system like workers comp would be a more appropriate and user-friendly venue than the tort liability system to resolve maritime worker injury claims.

Using a single system for all maritime workers also could eliminate confusion over which act applies to which type of worker, making it possible for maritime employers to obtain a single insurance policy to cover all of their occupational injury risks.

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# SPECIAL REPORT

## Trends in Workers Compensation

State laws limit drug dispensing by doctors

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Patient contracts seen as way to cut opioid abuse

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Seal comp programs from dollar leakage with range of tools

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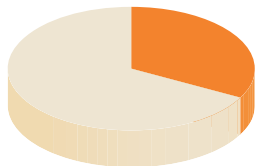
How utilization management can rein in PT costs

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## WORK COMP OPT-OUT

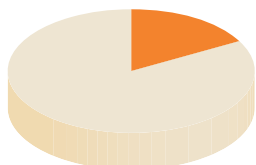
# OK?

### BIG CHANGES IN TEXAS



33%

An estimated 113,000 Texas companies — 33% of the state's employers, employing 19% of the state's workforce — opted out of Texas' workers compensation system in 2012, according to a Texas Department of Insurance report.



17%

Of large Texas employers, defined as those with 500 or more employees, 17% opted out of Texas' workers comp system in 2012.

### Oklahoma law seen as alternative model to Texas' nonsubscriber system

BY ROBERTO CENICEROS

Oklahoma will emerge as a testing ground for the insurance policies employers will need should more states allow companies to opt out of traditional workers compensation systems, observers predict. In May, Oklahoma Gov. Mary Fallin signed into law legislation allowing employers to implement injured employee benefit plans as alternatives to the state's existing workers compensation coverage requirements.

The law is expected to generate demand for new insurance policies that help employers provide health benefits and compensate Oklahoma employees for occupational injuries, several sources said.

Those policies could serve as prototypes and may help lay groundwork for allowing employers in other states to manage injury benefit plans as alternatives to purchasing workers comp coverage, they added.

See OPT-OUT page 16

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## OPT-OUT

Continued from page 14

"I most definitely believe that Oklahoma's new law will produce a new standard (insurance) product," said Becky Robinson, assistant vice president of risk management at Oklahoma City-based retailer Hobby Lobby Stores Inc. "The freedom to be creative with the new insurance product will provide competition, and indeed a test, on how other states may move forward with similar legislation."

For now, underwriters that currently provide insurance products for employers opting out of Texas' workers comp system — called nonsubscribers — are evaluating how they might structure forms for neighboring Oklahoma employers who will manage their own occupational injury benefit plans as alternatives to the state's traditional system for compensating injured workers, insurers and brokers said.

"There is great interest" among underwriters providing employer liability and employee health benefit products for Texas nonsubscribers, said Jerry Murphy, Dallas-based executive vice president for wholesaler AmWINS Brokerage of Texas.

National employers with nonsubscriber programs in Texas will be among policyholders demanding products for their injured employees in Oklahoma, Mr. Murphy said.

"There is a pressure from (insurers') existing customer base to be responsive," he added.

But Oklahoma's new law and Texas' decades-long practice of allowing employers to entirely opt out of its workers comp system are significantly different, observers say.

Texas employers who opt out, for instance, do not have workers comp exclusive remedy protection, so they can face open-ended civil lawsuits for employee injuries. And Texas nonsubscribers are not required to provide workers with any injury benefits, although many large employers prefer to do so.

To help injured employees with medical treatment, those Texas employers establish health plans governed under the federal Employee Retirement Income Security Act, sources said.

They typically purchase policies providing the health coverage for occupational accidents coupled with employer liability protection should an employee sue for negligence after a workplace injury, sources said.

Under Oklahoma's new law, in contrast, employers who implement their own occupational injury benefit programs still will be subject to several traditional workers comp system protections and mandates.

They will retain exclusive remedy protection and will be required to provide statutory — meaning unlimited — benefits to injured workers, several sources said.

That means Oklahoma's new alter-

*"Broadly speaking, I think it will be in line with Texas (coverage) with an occupational accident form (coupled) with an employer's liability or employer's indemnity component, but with significant differences."*

Keith Rosenblum, Lockton Cos. L.L.C.

native more closely resembles a traditional workers comp system than does Texas' opt-out alternative, said Dick Hinch, senior regional business development manager for Safety National Casualty Corp. in San Antonio.

"It looks and smells a lot more like workers comp than does the Texas (nonsubscriber model), because in Oklahoma they are saying, 'You must provide statutory benefits,'" Mr. Hinch said.

Yet observers expect the insurance coverage that will emerge in Oklahoma will share similarities with products now sold to Texas nonsubscribers.

"Broadly speaking, I think it will be in line with Texas (coverage) with an occupational accident form (coupled) with an employer's liability or employer's indemnity component, but with significant differences," said Keith Rosenblum, senior risk consultant in Kansas City, Mo., for Lockton Cos. L.L.C.

Policies sold in Oklahoma may have to provide more encompassing coverage containing fewer exclusions than forms sold in Texas, Mr. Rosenblum said.

Those now sold in Texas, for example, may exclude coverage for psychological or psychiatric care and occupational disease.

But Oklahoma's new law requires employers to purchase insurance and mandates that employers provide workers with broader protections, sources said.

So illnesses excluded from Texas policies may not be excluded in Oklahoma, Mr. Rosenblum said.

Insurers will weigh such differences — and their liability implications — before deciding whether to engage in Oklahoma, observers said.

Other underwriters will want to provide coverage in Oklahoma to gain momentum should other states allow employers to adopt alternative, opt-out-style plans, Mr. Murphy said.

"I do believe it will be the future to some degree," he said.

REASONS  
FOR OPTING  
OUT OF  
THE SYSTEM

A survey of large Texas employers (those with 500 or more employees) conducted by the Texas Department of Insurance and Texas A&M University found that those large employers' primary reasons for opting out of the work comp system in 2012 included:

- Workers comp insurance premiums were too high, according to 23% of the employers.
- They felt they could do a better job of delivering appropriate benefits to injured workers than the workers comp system could, according to 20%.
- Medical costs in the workers comp system were too high, according to 24%.
- Texas law does not require them to purchase workers comp insurance, according to 14%.

# Virtual event to show employers how to minimize workers comp injury exposure

Experts will advise employers how to reduce their workplace injury exposures by improving their workers compensation programs during an upcoming free virtual conference presented by *Business Insurance*.

*Business Insurance's* Fourth Annual Workers Compensation Virtual Conference will begin at 10 a.m. EDT Aug. 22.

Because of the event's virtual format, travel is not required; it can be accessed from a laptop, desktop or a tablet from any location.

In addition to online presentations, such as a keynote speech by Dr. Richard A. Victor, executive director of the Workers Compensation Research Institute, the virtual conference also will allow registrants to participate in live chats with the speakers and pose questions immediately following each presentation.

Participants also can join colleagues from across the workers

comp industry for informal online chats on current trends during the virtual conference.

Panel presentations will include a discussion on "Getting the Best Results from Workers Compensation Claims Management."

The panelists are Mark E. Field, risk manager for Raley's Family of Fine Stores; David North, president and CEO at Sedgwick Claims Management Services Inc.; and David Donn, president of David Donn Consulting Inc.

Another panel, "How to Avoid Complications in Medicare Sec-

ondary Payer Act Compliance," will discuss legislation and recent changes as companies attempt to comply with Medicare rules.

The panelists are Roy Franco, principal at Franco Signor L.L.C.; Aaron Frederickson, director, Medicare secondary payer compliance at Allsup Inc.; and Craig Storey, business development executive at Rising Medical Solutions Inc.

Kimberly George, senior vice president of managed care practices and client services at Sedgwick Claims Management Services Inc., will discuss health

advocacy as a powerful claims management tool in a panel, titled "Relying on health Advocacy for Improved Results."

Conference registrants can visit exhibitor booths and interact with the conference's sponsor, Sedgwick, and other exhibitors Safety National Corp. and Gallagher Bassett Services Inc.

This *Business Insurance* virtual conference is aimed at anyone who is involved in workers compensation.

More information and registration are available at [businessinsurance.com/compcosts](http://businessinsurance.com/compcosts).

The Fourth Annual Workers Compensation Virtual Conference will begin at 10 a.m. EDT Aug. 22.



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# STATES TAKE ACTION TO RESTRICT DISPENSING OF DRUGS BY PHYSICIANS

Higher costs, medication coordination top concerns as legislative efforts continue

BY LOUISE KERTESZ

States are taking steps to rein in the repackaging of drugs by doctors who are dispensing them to injured workers at higher costs than pharmacies charge.

By banning or restricting physician dispensing the states hope to push prescription dispensing back to pharmacies and reduce disability periods.

Eight states have banned the practice, while 13 states have implemented pricing and other restrictions, according to CompPharma L.L.C., a consortium of pharmacy benefit managers (see map).

A 2012 Workers Compensation Research Institute study found that before California changed a fee schedule in 2007, physicians charged nearly double the price for the same drug obtained at a retail pharmacy.

But a February 2013 report by the California Workers' Compensation Institute found that as a result of the 2007 change, which made the prices doctors charged comparable to retail pricing, the volume and the cost of physician dispensing in California declined by 90%.

The CWCI report also showed that in 2011, the state's doctors still dispensed more than half of all prescriptions under workers compensation and that California's use of physician-dispensed drugs remains among the highest in the country.

That is problematic because physician dispensing is associated with higher medical and indemnity costs and longer periods of disability, according to the CWCI report.

"We don't know whether the injury is worse, but the data is clear that where the patient is getting medicine from the doctor, the cases are lasting longer. Clearly, it's not a process that's saving the system money," said Salt Lake City-based Brian Allen, vice president of government affairs at Westerville, Ohio-based Progressive Medical Inc., a workers comp pharmacy benefit manager.

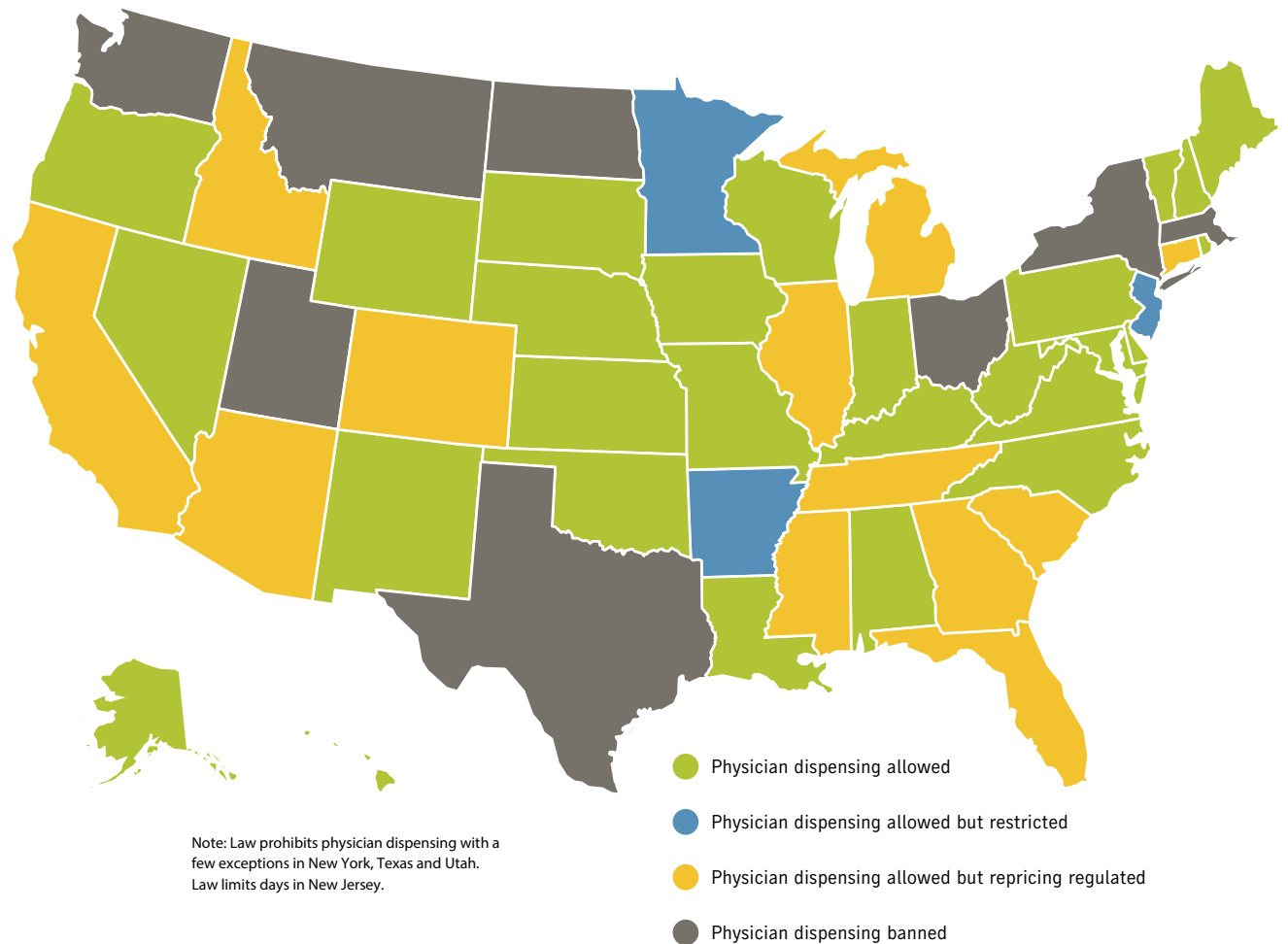
Michelle Weatherston, Fresno, Calif.-based director of the claims medical division at the California State Compensation Insurance Fund, the state's workers comp insurer, said the 2007 change "significantly improved the situation in California."

In an analysis this year of its 2012 data, the insurer found that physicians dispense a relatively small percentage of medications prescribed to injured workers, and that 40% of that amount is the "first fill" — an initial 72-hour supply — given to the patient. First-fill prescriptions can improve compliance because they allow a one-on-one conversation with the doctor and get the medicine to the patient as soon as possible, providing support and potentially contributing to a good outcome, said Ms. Weatherston.

State Fund's analysis showed for the first

## LAWS GOVERNING DOCTORS' ABILITY TO DISPENSE DRUGS IN COMP CASES

As of July 2013



Source: CompPharma L.L.C.

fill and beyond, medical costs "were virtually the same" for State Fund, regardless of whether the drugs were physician-dispensed, but "it's a trend we're keeping an eye on because of past problems," she said. The analysis focused on medical expense, the largest portion of costs in workers comp, and not total claims costs, she said.

In a recent effort focused on costs, the National Council of Insurance Legislators adopted a model law that ties reimbursement for physician repackaged prescription drugs to an original manufacturer's average wholesale price. Proposed amendments would cover the repackaging of over-the-counter products.

The model law is designed to limit pricing differentials between physician dispensing and retail pharmacy dispensing.

"Any state not currently limiting repricing would be helped by the model law," said Progressive Medical's Mr. Allen.

The model law is similar to laws already adopted in several states to regulate repricing, said Kimberly George, senior vice president of managed care and client services at

Sedgwick Claims Management Services Inc. in Chicago. With the support of the model law, "we are hopeful more states will regulate physician dispensing, but the states are slow to change," she said.

But the model law has its limitations, said Joseph Paduda, principal at Health Strategy Associates L.L.C. in Madison, Conn.

"The model law doesn't do anything to stop physician dispensing, nor address the patient safety issue or the impact of physician dispensing in terms of impact on claims outcomes. It attacks the smallest part of the problem," he said.

"What should happen is that physician dispensing should be banned unless it's for medications necessary to start immediately such as, potentially, antibiotics or life-saving drugs. None of the top physician-dispensed drugs falls into those categories," Mr. Paduda said.

Mr. Allen said the model law "is really just directed at the cost of the medication. It's part of the battle but not the whole battle."

Another issue that needs to be addressed is keeping prescriptions in a managed net-

work, where they can be monitored for compliance, safety and effectiveness, which is what PBMs do, he said.

"Medications dispensed from a physician office are not part of the pharmacy benefit management program and, therefore, there is no cross-reference to other medications the patient may be taking," Ms. George said.

But physician dispensing can have its medical and cost benefits for the patient and the health care system, if done properly, she said.

"Sedgwick and our PBM partners created a physician-dispensing medication formula-ry to address medications that are safe and convenient for the patient to receive in the physician office. Physician outcomes are scored in Sedgwick's five-star provider benchmarking program and, as deemed appropriate, we will enroll an occupational health physician into the pharmacy network as part of our outcomes-based quality care program and allow limited physician dispensing. Medications dispensed, quantities and price are agreed to within the network contracting," Ms. George said.

# Effective Narcotics Management: A Stitch in Time

No one debates the wisdom of darning a sock at the first sign of a hole. In an environment where prescription drugs represent 19% of the increasingly high cost of medical services for workers' comp claims—and when narcotics account for about 21% of the total pharmacy spend—it makes sense to step in sooner rather than later, before the whole claim unravels.

## Early narcotics use leads to prolonged use

Medical services now constitute almost 60% of workers' compensation claim costs, up from about 40% in the early 1980s.<sup>1</sup> With prescription drugs—specifically, narcotics—driving a significant percentage of those costs, solving the narcotics epidemic needs to be a top priority. A 2012 NCCI study confirmed that early narcotic use predicts prolonged narcotic use. Individuals who receive higher doses of narcotics in the first quarter after injury are more likely to receive narcotics in subsequent quarters.<sup>2</sup> These results indicate that involvement at the point-of-injury is critical if carriers, TPAs and employers are to achieve the best possible outcomes for injured workers.

## Nurse triage provides education at the soonest point possible

With a goal of guiding and educating injured workers on necessary and appropriate treatment options, employers are implementing symptom-based triage at the point-of-injury. These services provide 24/7/365 access to nurses experienced in triaging injuries as they occur. Coventry's nurse triage program, NT24, is designed to get the claim on the right path from day one.

### An NT24 client experienced the following first year results:

- **37% decrease in number of claims**
- **28% reduction in workers' comp medical costs**

When an injury occurs, the injured worker or the supervisor places a call to NT24. The nurse collects information about the employee and the injury, makes an assessment, and recommends the most appropriate course of action, including self-care or seeking medical attention.

Happening when it does, this proactive point-of-injury assessment helps avoid claims. If a claim is filed, triage helps set the tone by providing guidance and establishing expectations with the injured employee about treatment alternatives, network providers, and considerations regarding prescription drugs, including narcotics. This assessment also allows the nurse to identify early predictors of complex or high-dollar claims, including the presence of co-morbidities.

## Network providers deliver more than cost savings

Nurse triage kick-starts claim management in the most positive direction possible for the injured worker and the employer. Once treatment is deemed necessary, the benefits of integrating with provider networks, pharmacy benefit management (PBM) solutions, and case management

become clear. Giving injured workers information on network providers helps ensure that the injured worker is evaluated by a provider with experience in treating work-related injuries. Without this information, the injured worker is likely to seek care in an emergency room or from a group health provider.

For injuries where pain could be a concern, the NT24 nurse helps establish the injured worker's expectations regarding appropriate pain relief and provides information on network pharmacies. This support ensures that the injured worker obtains prescriptions within the PBM network from the very first fill, so the PBM can apply utilization management protocols and identify narcotic use immediately. Out-of-network prescriptions bypass these point-of-fill clinical interventions, which prevents narcotics management from making an immediate impact.

## Proactivity pays off

When a network pharmacy processes a narcotic prescription, the PBM is in a position to limit the amount of short-acting narcotics dispensed to the injured worker. This early narcotic management can make a significant positive impact on the employee's recovery, ability to return to work and overall claim outcome. More importantly, it gives the PBM the ability to quickly monitor narcotic fills and educate the prescriber on evidence-based medically appropriate use of opioids. At the same time, it opens the door for the PBM to discuss the activities necessary when continuing to prescribe opioids, such as:

- Prescription drug monitoring programs (PDMPs)
- Patient/prescriber agreements
- Random periodic drug screens
- Adjunct pain management therapies beyond opioids

The PBM can also share claim-specific utilization concerns with the case manager so that he or she may further coordinate care with both the injured employee and the prescriber. The goal of this outreach is to influence future prescribing habits and decrease narcotic utilization before it spins further out of control. For optimal results, ongoing communication between nurse case management and the PBM is critical.

### Claims enrolled in the Early Narcotic Intervention program demonstrated:

- **18% decrease in MED the first year**
- **37% decrease in year two**

## Steps in the right direction

Narcotics management that begins with education at the point-of-injury, includes early PBM drug monitoring programs, and engages case management when barriers are identified, can be the stitch in time that saves the bottom line—by decreasing narcotic utilization and reducing average claim costs.

1. [www.ncci.com/documents/Med\\_Svc\\_Size\\_Claim\\_Nov\\_2011.pdf](http://www.ncci.com/documents/Med_Svc_Size_Claim_Nov_2011.pdf)  
2. [www.ncci.com/documents/narcotics-wc.pdf](http://www.ncci.com/documents/narcotics-wc.pdf)

## About Coventry

### WHAT WE DO

Coventry Workers' Comp Services offers cost and care management solutions to the workers' compensation, auto, and disability industries. With roots in both clinical and network services, we leverage more than 30 years of industry experience, knowledge and data analytics. We offer an integrated suite of solutions, powered by technology to enhance network development, clinical integration and operational efficiencies at the client desktop, with a focus on total claims cost.

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Managed care executives and risk managers of:

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- Insurance carriers
- Third-party administrators

### CLINICAL SOLUTIONS

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- Case Management
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- Facilities
- Occupational Medicine Clinics
- Physical Medicine
- Diagnostic & Radiology
- Outcomes-based Networks
- State Certified Networks

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- 275,000+ Utilization Reviews annually
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- 17 MCO jurisdictions supported including California, Texas, New York and Illinois

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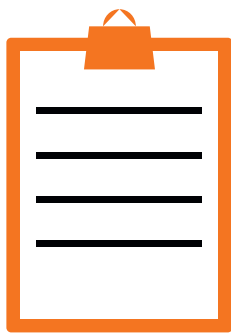
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**GUIDELINES  
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Urine testing at Veolia ES Technical Solutions, a hazardous waste management company, follows the stringent protocols of the federal Substance Abuse and Mental Health Services Administration, said Michael Richter, director for health and safety with Veolia's hazardous waste division in Flanders, N.J.

Under the guidelines, the urine specimen is collected at a clinic and sent for analysis to a certified lab, which sends a report to a medical review officer, a licensed physician.

The MRO then reports positive tests for illegal substances to the appropriate corporate staff person.

The SAMHSA guidelines are the "gold standard" because they are "thoroughly vetted," said Mr. Richter.

At Veolia, they are used for pre-employment testing and also are administered at random to commercial drivers and employees who work with hazardous materials.

Injured workers who may be on prescribed narcotics or opioids may be selected at random for the same testing procedures, he said.

AllOne Health of Wilkes-Barre, Pa., an occupational health company, provides the computerized random selection service.

Workers are trained on the seriousness of working with hazardous waste and are made aware that if they test positive for drugs or alcohol, they are terminated, Mr. Richter said.

"We infrequently have positive test results in our random program, and very infrequently in post-accidents of any type," said Mr. Richter.

The keys to the success of the program are pre-employment testing, which screens out those who test positive, and offering "amnesty" to workers who come forward before testing and admit to drug use. Those workers enter into an agreement to accept help, including counseling and rehab, he said.

If the MRO gets a positive test result for an injured worker, he will ask the worker's permission to speak with his or her doctor to verify that the drug is being prescribed.

"We don't do any compliance testing (to verify that the drug is being taken appropriately) — that's between the doctor and the patient," Mr. Richter said.

By Louise Kertesz

# Curbs on doctor dispensing have unintended result

## Costs grow as physician-conducted urine tests increase dramatically

BY LOUISE KERTESZ

When states began placing limits on physician dispensing of drugs to injured workers in 2007, that squeezed the health care balloon, creating another problem: More physicians are conducting urine tests, primarily for opioids, in their offices rather than using accredited labs, which is driving up the volume of tests and their cost, industry sources say.

A California Workers Compensation Research Institute study released in May 2012 "confirms a viral-like growth rate in the volume of drug testing and in the amounts billed and paid for these services." The study showed a 315% increase in the average cost of a test from 2004 to 2011.

"Our data shows that physician billing varies from \$17 a test to \$2,000 a test, which is a 125% increase, on average, in the past year," said Kimberly George, senior vice president of managed care and client services at Sedgwick Claims Management Services Inc. in Chicago.

"It's a lot like physician dispensing was five years ago," said Dan Gifford, executive vice president of product development at Progressive Medical Inc., a workers comp pharmacy benefit manager in Westerville, Ohio. "I think we're on the tip of the iceberg," he said, noting that testing companies are advertising to install testing equipment in physician offices to gener-

ate revenue. The CWCRI report is "a cry for regulation around" urine testing, said Mr. Gifford.

Only Colorado and Washington state have stringent urine testing guidelines, sources said. Delaware has proposed legislation that limits the number of tests but contains "nothing in the line of medical management," said Tron Emptage, chief clinical officer at Progressive Medical.

The CWCRI study also shows that the cost increases "coincide with the dramatic growth in the use of opioids to treat work injuries."

Workers comp experts have long held that overprescription and inappropriate prescription of opioids are a significant factor in driving up workers comp costs. Workers can quickly develop a dependence on the powerful narcotics, which leads to other medical conditions and prolongs their absence from work.

Progressive Medical has created a network of labs on behalf of their clients and payers to address inappropriate testing and combat "egregious billing," Mr. Gifford said.

In the process Progressive Medical has developed with payers, the physician usually has a conversation with the patient stressing that opioids won't be prescribed if the urine test is not compliant. The first baseline sample is collected at the doctor's office and sent to a network lab with Clinical Laboratory Improvement Amendments certification and College of American Pathologists accreditation. Urine is then collected at the doctor's office at random in six months.

The labs send test results to the physician and to Progressive, which routes it to the insurer or

the third-party administrator. If compliant with the prescribed drug regimen, the test is generally done at least twice a year. If noncompliant, it's done every 30 days until compliance is achieved.

"We pass the lab reports electronically to the carrier so they have the injured worker's information quickly and can use it as a tool to reach out to the physician," said Mr. Emptage.

"It depends on the doctor and how they want to influence the patient. There's no regulation, there's guidelines — that's the challenge," Mr. Gifford said.

"We designed our program to look for criteria that could suggest high narcotic use and claimants that are potentially at risk for long-term use," Mr. Emptage said. "The doctor should be looking for triggers. Are (patients) asking for early refills? Are they getting prescriptions filled at multiple pharmacies, and is there a pattern that can indicate diversion" of the drug for sale? Mr. Gifford said.

"It's not 'let's test everybody' as often as possible, but test those at the trigger points," said Mr. Emptage.

Sedgwick has developed an opioid risk assessment that "evaluates substance abuse history and tendencies with predictive analytics that score an injured worker's risk. Based on the risk score, we determine if the patient has a low, moderate or high risk and is appropriate for testing," Ms. George said.

Sedgwick "partners with the physician regarding the appropriate testing to be conducted, how to address testing results and next steps," she said.

### NARCOTICS USAGE

Prescription drugs accounted for 19% of workers compensation costs in 2009, and narcotics accounted for 21% of prescription drug costs. Other trends in narcotics usage in treating comp claimants include:

■ Narcotics' cost per claim was **\$35** in 2009, a **14% increase** from 2008.

■ **OxyContin** was the **No. 1** narcotic in dollars spent on comp claimants.

■ **13%** of comp claimants still were receiving narcotics **one year after** their injury.

■ **1%** of comp claimants accounted for **40%** of narcotics used.

Source: 2012 National Council on Compensation Insurance Inc. analysis of 2009 data

# Patients agree to drug regimens through signed contracts

BY SHEENA HARRISON

Opioid contracts that require injured workers to give informed consent to long-term narcotic prescriptions are useful in preventing improper use of pain medications, experts say.

It's unclear whether such contracts have a direct effect in preventing opioid dependency or overdoses, sources say. But they agree that contracts are helpful in informing patients and physicians about the long-term dangers of such painkillers, and can give doctors a legal recourse if a patient appears to be heading toward prescription abuse.

"I think we're seeing it become a much more common practice, partly because providers are seeing the benefits of it and partly because in some states and other jurisdictions they're actually requiring that they be used," said Robert Twillman, director of advocacy and policy for the Sonora, Calif.-based American Academy of Pain Management.

Opioid contracts, therefore, are appearing more often in workers comp-related care as the insurance industry looks to stem addiction and overdoses related to the narcotics.

Minnesota passed legislation in May requiring injured workers to sign written contracts with their providers when receiving long-term prescriptions for opioids or other controlled substances.

Washington state, which has used an opioid contract since 2000, updated the form in July to include several new points, including a section saying that doctors will verify patients' opioid prescription history with the state's prescription monitoring program.

Washington's contract, considered by sources to be one of the nation's leading examples of such documents, includes language saying the patient will take opioids "only at the dose and frequency prescribed," and won't "ask for opioids or any other pain medicine from another provider." A second page informs patients of the risks of opioids, including psychological dependence, tolerance, and "breathing too slowly," which can lead to death if a patient overdoses.

The contract informs patients that their provider can stop prescribing medications or change the patient's treatment plan if they violate various points of the agreement.

The largest benefit of opioid contracts is that they inform patients and providers about the risks of narcotic prescriptions and allow physicians to set boundaries for prescribing such drugs, said

Jaymie Mai, pharmacy manager for the Washington State Department of Labor and Industries, which is the state's monopoly workers comp insurer.

"It sets expectations and lets the worker or the patient know about their responsibility, and it also

See **CONTRACTS** next page



Opioid contracts are appearing as the insurance industry looks to stem addiction related to narcotics.

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## CONTRACTS

Continued from previous page

allows the provider to talk about the benefits,” Ms. Mai said.

Contracts set limits that can help physicians keep patients in line with proper treatment protocols, said Mike Farrand, Radnor, Pa.-based national technical director for workers comp medical cost containment at Willis Group Holdings P.L.C.

For instance, some contracts indicate that patients can be subject to drug testing, and could be refused treatment by their doctor if a test shows that medications are being abused. That scenario could lead to better prescription compliance for patients who don’t want to lose necessary medications, Mr. Farrand said.

“An employee who needs these (medications) or feels as though they need them, they’re risking a lot knowing that this doctor’s going to test them,” Mr. Farrand said.

Though sources could not quantify the effectiveness of opioid contracts, each of them said contacts are part of a cadre of tools that should be used in unison to protect patients who take opioids over a long term.

“They may not be fully aware that the risk is different when you’re taking opioids... for your broken ankle versus when you’re taking it chronically (after) the broken ankle has healed,” Washington’s Ms. Mai said of how contracts combine with other safety measures to help protect patients.

Mr. Twillman of the American Academy of Pain Management said his organization recommends opioid contracts as a best practice in pain management. However, he cautions that the wording in some contracts has the potential to create an adversarial relationship between the doctor and patient.

“Many times, patients who have no history of misusing their medications in any way and are perfectly fine using them will perceive being asked to do one of these as an indication that the doctor doesn’t trust them,” Mr. Twillman said.

Experts agree that doctors should be educated on how to present opioid treatment contracts to patients. Mr. Twillman said that can include giving doctors a script that can help them establish common ground with a patient, rather than making the patient feel they’re receiving a contract because they’re under suspicion.

“I think if you present it in a way that says, ‘This is just so we’re all clear on how we’re going to be using these medications’ ... then patients are very accepting of

that,” Mr. Twillman said.

While many contracts say patient care can be terminated if the agreement is violated, Mr. Twillman said providers should consider contracts that allow care to be modified in a way that helps the patient stay on track with their medications.

“Some people can’t do what they need to do with their medications appropriately when you give them a whole month’s supply,” Mr. Twillman said. “But some people, if you only give them a week’s supply, they’re fine. Sometimes imposing a little bit more structure is really what’s needed to help patients.”

*“Some people can’t do what they need to do with their medications appropriately when you give them a whole month’s supply.”*

Robert Twillman, American Academy of Pain Management



## Sealing comp programs from dollar leakage requires multiple tools

Tech solutions can help efforts

BY ROBERTO CENICEROS

**A**lthough technology can help employers plug the “leakage” of dollars lost from their workers compensation programs, it’s not a replacement for older, proven measures, experts say.

Leakage refers to money needlessly flowing from a workers compensation program when unnecessary services are applied or, conversely, when claims managers fail to effectively employ measures that would have reduced costs by resolving a case sooner.

An adjuster, for example, may assign a nurse case manager when one is not necessary, or may call in one later than is optimal. But leakage can flow from any number of workers comp practices and services, including failure to subrogate, paying claims that are not compensable, failure to reprice medical care, paying ineffective doctors, managing return-to-work efforts poorly and so on.

Employer practices and provider services, including those obtained from insurers and third-party administrators, all can contribute to the problem. Yet reducing

sources of leakage is important today because of rising claims and insurance costs, sources said.

To help stop the drain, service providers have employed various types of technology.

Atlanta-based Broadspire Services Inc., for example, applies predictive modeling technology relying on information gleaned from adjuster interviews with claimants. While that information helps the third-party administrator determine what resources may benefit an individual claimant, it is also mined to find patterns among an employer’s entire claims history or among claims at many employers.

That could reveal, for instance, that claimants from a specific employer would benefit from a particular pain management program, said Joel T. Raedeke, Chicago-based vice president of consultative analytics for Broadspire.

“That is a way of using diagnostics to do an investigation and build a solution,” Mr. Raedeke said.

As another example of available technology, Marsh Inc. offers clients a leakage assessment tool



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called Workers' Compensation Past Performer, said Charles F. Martin, U.S. casualty operations consulting practice leader for Marsh Risk Consulting in Norwalk, Conn. It evaluates a batch of closed claims files looking for leakage trends in four areas including appropriate claims compensability, disability duration, medical management, and claims management and recovery.

The process is statistically valid, so the findings can be extrapolated to a client's entire claims portfolio and used to assess the client's processes and protocols, Mr. Martin said. Marsh has found that slightly more than half of all leakage typically results from the employer's processes rather than from the third-party administrator's practices, Mr. Martin said.

Because the tool quantifies the amount of dollar savings that will result from system improvements, "it's really the next-generation claims audit," Mr. Martin said.

Technological tools provide a good blueprint, guiding employers to appropriate system improvements in general, said Fred Pachón, a risk management consultant and president of Risk-Minds in Ventura, Calif.

But they should be used as a starting point only, and not a substitute for a deep-dive review and analysis conducted by individuals with significant claims experience, said Mr. Pachón, who was *Business Insurance's* 2009 Risk Manager of the Year®.

"They are just one more tool" Mr. Pachón said.

"There is simply no replacement for having an experienced auditor" reviewing claim files to uncover certain leakages, said Rebecca Shafer, a workers compensation consultant and president of Amaxx Risk Solutions Inc. in Hartford, Conn.

It remains difficult to automate some practices, such as medical record reviews, Ms. Shafer added.

She cited the case of a bus company employee who developed pain in the coccyx that was not reported in the worker's initial medical report. A medical file review conducted by a doctor working with Ms. Shafer uncovered notations in an earlier medical report indicating that Paget's disease caused the claimant's pain, not a workplace injury, she said.

"This type of example is not uncommon" Ms. Shafer said.

An "old fashioned" pre- and post-injury program review, without automation, still reveals much about an employer's protocols, or lack of them, and their TPA's practices, added Robin Hendrickson, senior vice president of claims and risk control practice leader at broker ABD Insurance & Financial Services in San Mateo, Calif.

Although leakage evaluations

can be formalized, many facets to a workers comp program remain, particularly on the post-injury side, Ms. Hendrickson said. Therefore, a "live conversation" with the employer remains essential.

"I think the best way is still sitting down with the employer and just saying 'Walk me through the process,'" Ms. Hendrickson said. "I ask (the employer's TPA or insurer) the same thing: 'Walk me through your process.'"

## SOURCES OF LEAKAGE BY CATEGORY

There are many sources of "leakage" when it comes to paying workers compensation claims expenses, but observers generally divide them into two categories.

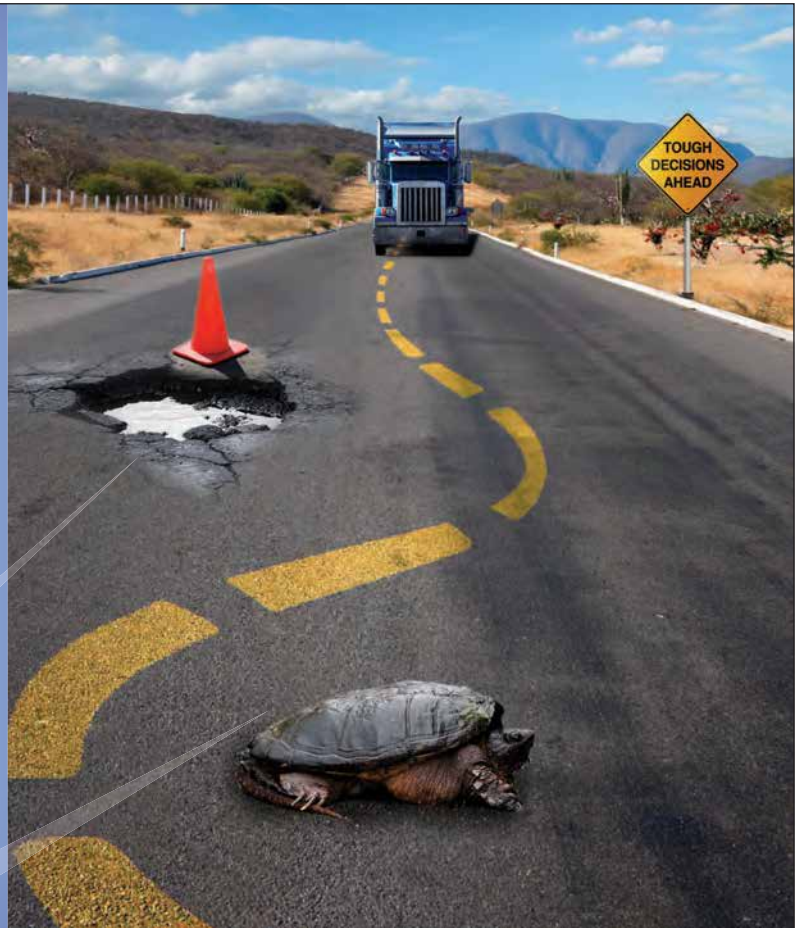
**"Hard leakage"** refers to instances such as paying a claim that should never have been paid in the first place or paying out more benefits than required.

An example of **"soft leakage,"** in contrast, would be paying more for medical care than is necessary, perhaps because the doctor has ordered more treatments than justifiable. Soft leakage is often described as more subjective than hard leakage.

Workers comp experts may also talk of **"vendor leakage,"** referring to the payment of services that are not necessary or do not help resolve a claim faster.

By Roberto Cenicerros

Driving better business decisions means seeing the road ahead clearly.



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# Comp system must get back to basics



Mr. Walls

The workers compensation system has moved significantly away from the idea of providing for employees injured at work while protecting employers from lawsuits, says Mark Walls, Marsh Inc.'s workers compensation market research leader. To evolve in a positive direction, workers comp should narrow its focus and return to its original intent.

BY MARK WALLS

The origin of workers compensation in the United States traces back more than 100 years to a time when working conditions were typically poor and workplace accidents commonplace.

On March 25, 1911, a fire at the Triangle Shirtwaist Factory in New York killed 146 workers. Tragically, many of the factory exits were locked to prevent employee theft, a factor cited as a main cause for the high death toll. The factory owners ultimately were acquitted of criminal charges, but they lost a civil lawsuit in which each deceased victim's family received \$75.

The public outrage over the tragedy was a main rallying point for workers compensation legislation nationwide.

Workers compensation was seen as the "Great Compromise" between labor and business. Employers agreed to provide indemnity and medical benefits without fault, and employees gave up the right to sue, making workers compensation the exclusive remedy for workplace injuries.

## History of workers comp in the U.S.

The earliest workers compensation laws were voluntary. In 1917, the U.S. Supreme Court upheld the constitutionality of compulsory insurance requirements, paving the way for the mandatory workers compensation coverage that now exists in almost every state.

Workers compensation has evolved significantly over the years. Early on, there was little loss-prevention activity, resulting in a high frequency and severity of claims. Workers compensation injuries often were life-changing events, with severe burns, amputations and deaths as the leading cost drivers. The National Safety Council estimated that between 18,000 and 21,000 workers were killed in workplace accidents in 1912, or 61 deaths for every 100,000 workers.

During the construction of the Hoover Dam between 1932 and 1935, 96 of the approximately 21,000 men who worked on the project were killed on the job. That is an astonishing rate of 457 deaths per 100,000 workers.

Workplaces today are the safest they have ever been. Injury frequency rates have held steady or declined for several years. According to the U.S. Bureau of Labor Statistics, in 2011 the fatality rate was 3.5 deaths for every

100,000 workers.

Despite the more than 95% improvement from the fatality rates of 100 years ago, workers compensation costs continue to rise. The evolution of workers compensation has changed the leading injury causes and the cost drivers. Severe burns, amputations and deaths have been replaced as cost drivers by strains and sprains. Material handling and lifting is now the leading cause of accidents in the United States. The biggest cost driver is not indemnity benefits, or even surgical costs, but chronic pain. The use of high-cost opioid pain medications is epidemic in the workers compensation system. Drugs that were designed for end-term cancer patients now are being used to treat non-surgical back strains. Although injuries are less traumatic, the severity rates, or cost per claim, continue to escalate.

## Expansion of workers compensation

Workers compensation injuries typically are no longer traumatic events traceable to a specific date, time and place. Repetitive trauma claims now are extremely commonplace, especially in jurisdictions such as California, where the workplace needs only to be a contributing factor to the disabling condition. Standing, walking and sitting are things people do every day in every phase of their lives. But over time, courts around the country have ruled that these acts accelerated degenerative conditions, which led to workers compensation claims.

Another aspect of the expansion has been so-called "presumption laws" that affect many municipalities. Consider that about half of all Americans have at least one of the risk factors for heart disease, the leading cause of death in the U.S. Despite this, laws around the country create the presumption that diseases of the heart, lung and certain cancers are related to the employment of police, firefighters and other first responders. These laws create a financial burden on public entities entailing billions of dollars in future liabilities, despite numerous studies showing the risk factors for first responders are no higher than for the general public.

The cause of the injury does not even have to be directly related to the employment. In many states, positional risk — simply being at work and being injured — can create a workers compensation claim. A bullet from a shooting that comes through a window,

tripping over one's feet, choking on food, shaking a vending machine, bending over to pick something up — all have been found compensable under workers compensation using the doctrine of positional risk.

## Erosion of exclusive remedy

The exclusive remedy that employers received as part of the "Great Compromise" also has eroded over time. For example, employees in New York who sustain a "grave injury" can file a separate civil liability lawsuit against their employer. New York also has a "scaffold law" under which employees injured in a fall from elevation can pursue additional benefits through civil litigation.

Employers also are exposed to civil litigation for work-related injuries under a variety of federal laws, including the Family Medical Leave Act and the Americans with Disabilities Act. In recent years, courts even have allowed injured workers to pursue litigation under the Racketeer Influenced and Corrupt Organizations Act due to actions

*The evolution of workers compensation has changed the leading injury causes and the cost drivers. Severe burns, amputations and deaths have been replaced as cost drivers by strains and sprains.*

arising from a workers compensation claim.

The expansion of workers compensation and the erosion of exclusive remedy have many employers questioning whether the "Great Compromise" is still beneficial to them.

For years, Texas has allowed employers to "opt out" of the state's workers compensation system and the exclusive remedy it provides. About one-third of employers in Texas have elected to opt out. Despite the threat of civil litigation, their costs have been significantly lower than under traditional workers compensation models.

Oklahoma recently passed legislation allowing employers to opt out, and other states are closely watching the develop-

ments there. Many consider the Oklahoma law — which fully replaces traditional indemnity benefits, gives the employer total medical control and still preserves exclusive remedy — to be a real threat to traditional workers compensation systems.

To evolve in a positive direction, workers compensation needs to get back to the basics. Its focus should be narrowed to something closer to the original intent so that ordinary diseases of life and natural degenerative conditions are not covered under workers compensation. This is what attracts employers in Texas and Oklahoma to opt out. Those employers maintain control over the medical treatment, ensuring that injured workers receive the appropriate medical care from physicians who follow widely accepted occupational medicine treatment guidelines. They avoid the expansion of workers compensation that is prevalent in the traditional system.

Workers compensation also needs to shift its medical management focus from fee-for-service discounts to outcomes. Medical costs continue to climb despite the fact that fee schedules are in place in most states. The focus needs to be on getting injured workers the appropriate care from medical providers who produce superior outcomes. This may cost more on a per-visit basis, but if it produces a faster return to work and ultimately a better medical outcome for the worker, then employer costs will be reduced.

Finally, workers compensation needs to simplify. About 20% of all costs in the system are for claims administration, including litigation, adjusting and other expenses. If the system were more self-executing, with more efficient dispute resolution processes and less bureaucracy, employer costs could be lowered substantially.

Workers compensation has changed significantly over the past 100 years. Workplaces are safer now than they have ever been, but the workers compensation system needs to evolve to ensure that it remains a "Great Compromise" for both employers and workers. If it fails to do so, there likely will be more states looking to follow Oklahoma and allow employers to opt out of their state's respective workers compensation system.

*Mark Walls is Marsh Inc.'s St. Louis-based workers compensation market research leader. He can be reached at 314-342-2648 and at mark.w.walls@marsh.com.*

# Keeping a tab on physical therapy treatment curbs comp costs

Minor expenses can add up to large claims over time if not controlled

BY SHEENA HARRISON

Physical therapy costs can be one of the top medical expenses in the early stages of a workers compensation claim. But such costs can be controlled with utilization management to help physical therapists perform only necessary treatments.

Mike Farrand, Radnor, Pa.-based national technical director for workers comp medical cost containment at Willis Group Holdings P.L.C., said physical therapy costs can account for up to 50% of comp costs in the first 90 to 120 days of a claim.

Experts say physical therapy costs can accumulate quickly because they occur in the acute phase of an injured worker's recovery and include bills that are relatively cheap, but accumulate over time.

"It's seen to a lot of groups as a small incremental cost," said Ian McDaniels, Indianapolis-based vice president of directed care solutions for CorVel Corp., a provider of medical cost containment and managed care services. "It's just a visit here or a visit there. Well, those visits add up."

Additionally, physical therapists sometimes try to make up for the low cost of services they provide by billing for several treatments during each patient visit, Mr. McDaniels said.

"A lot of patients go into therapy and think they're going to go get a massage," Mr. McDaniels said. "And though a massage would probably feel very good, it's not what they need."

Mark Walls, St. Louis-based senior vice president and workers compensation market research leader at Marsh Inc., said treating physicians often prescribe more physical therapy than a patient needs because they're uncertain how long a patient's recovery will take.

"There's a lot of physicians that just write a prescription for physical therapy that says 'evaluate and treat,'" Mr. Walls said. "They'll leave it open and let the therapist dictate" the treatment duration.

The key to keeping physical therapy costs down is to conduct regular reviews of a patient's treatment and end physical therapy sessions once it's clear that a patient has received the maximum benefit from treatment, sources say.

"If they are making progress, then you keep doing it," Mr. Walls said. "When they plateau, you stop."

Medical treatment guidelines can provide a framework for how many physical therapy sessions a patient needs. But insurers and

employers should talk weekly with physical therapists to determine how long therapy should continue, Mr. McDaniels said.

Such discussions ideally should be led by people who have practiced physical therapy and can evaluate a patient's progress, Mr. McDaniels said.

While utilization management can result in fewer physical thera-

py visits, it can also lead to ongoing care if it's determined that continued therapy would help the worker avoid reinjury, Mr. McDaniels said.

"We will fight for more care when appropriate, just as much as we will fight with that therapist to say 'show us why you need more treatment,'" Mr. McDaniels said.

In addition to utilization manage-

ment, Willis' Mr. Farrand says employers should consider using physical therapy specialty networks, which provide physical therapy at a discounted cost.

Marsh's Mr. Walls said physical therapy sessions should focus on using active modalities that strengthen patients rather than passive modalities that only provide pain relief. He also recom-

mends that physical therapists provide patients with home exercises that can be performed without billing for another physical therapy session.

While such steps can reduce the direct cost of physical therapy claims, Mr. Farrand said utilization management can lead to larger savings down the road for employers.

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# MERGERS

Continued from page 4

tions through June of this year compared with the same period last year. Private equity buyers were steady, with 40 announced first-half deals in 2011, 2012 and 2013. Despite the late reporting of 2012 deals, publicly held brokers and the all-other-buyer groups dropped substantially in the first half of this year.

Property/casualty brokers continue to be the primary product-line focus of acquired brokers, followed by benefit brokers and combined property/casualty/benefits brokers. The interesting statistic, however, is the continued popularity of benefits-focused brokers. It appears both sellers and buyers will continue to be motivated by the implications and uncertainty of PPACA. Sellers need the value-added and other resources offered by larger firms to help clients navigate the health care reform law. Buyers need to aggregate volume to spread the cost of the value-added services they have built over a larger client base.

Among private equity-backed firms, there were two major recapitalizations in the first half of this year. Due to the core nature of these deals, they are not treated as traditional acquisitions for this data:

- Genstar Capital acquired GCP Capital Partners L.L.C.'s equity in Acrisure L.L.C. in March.

- Kohlberg & Co. L.L.C. replaced Berkley Capital's investment in Risk Strategies Co. in June.

On a more traditional level, two noteworthy transactions closed in the first half of this year:

- Private equity firm Madison Dearborn Partners L.L.C. announced the acquisition of

National Financial Partners Corp. in April.

- Brown & Brown Inc. in May announced the acquisition of Beecher Carlson Holdings Inc. from Austin Ventures, FSPM and a group of individual equity holders.

Private equity-backed brokers, whether well-established (such as Assured Partners Inc., Hub International Ltd. and USI Holdings Corp.) or those recently entering the insurance arena, may provide much of the capital and demand for opportunities to keep broker valuations relatively stable. As recently reported by several sources, global private equity firms raised more capital during the second quarter of 2013 than any quarter since the fourth quarter of 2008, which would seem to support the continued expansion of private equity into the insurance distribution arena in the near term.

Private equity-backed ventures may be the most active buyer group in the foreseeable future as the number of participants continues to increase and continues to attract funding.

The active publicly traded brokers, Arthur J. Gallagher & Co. and Brown & Brown, have consistently been the most active buyers over the past five years. Brown & Brown closed the acquisition of Beecher Carlson in July, and Gallagher reportedly is close to acquiring a top 25-size firm. This could diminish their deal activity somewhat as they close and integrate these larger acquisitions.

Bank-owned agencies still have not recovered to their pre-recession activity levels, with limited exceptions. There are two banks that have had robust activity this year, led by Peoples Bancorp Inc. (four transactions this year, but none previously) and Canada-based Western Financial Group

Inc. (four acquisitions this year). Wells Fargo Insurance Services USA Inc. has completed 24 deals since 2008, but only one since the start of 2012. Western Financial Group, now the second-most active bank in the broker acquisition space, has announced 18 agency acquisitions across Canada since 2008, half since January 2012. BB&T Corp., the other historically active bank, has announced only one transaction since the end of 2011, and now sits with 16 deals in the past 5½ years.

Privately owned buyers are by far the largest potential group of acquirers, though they are a fragmented group. Since the start of 2008, only four privately owned firms have five or more announced acquisitions, and more than 300 firms have less than five.

The acquisition pipeline may not be restocked until 2014 and possibly into 2015, notwithstanding the need for the buyer-side group to drive growth by acquisition. Certain sellers may want to recover some lost value from the tax increases over the next few years. When all is said and done, however, the acquisition climate looks to be good for the foreseeable future for buyers and sellers alike.



*Timothy J. Cunningham is managing director at Chicago-based Optis Partners L.L.C., an investment*

*banking and financial consulting firm that serves the insurance distribution industry. He can be reached at [cunningham@optisins.com](mailto:cunningham@optisins.com). Daniel P. Menzer is a partner at Optis Partners. He can be reached at [menzer@optisins.com](mailto:menzer@optisins.com).*

## FIRST-HALF M&A ACTIVITY, 2011-2013

Agent and broker deals by type

Type	2013H	2012H	2011H
Private broker	45	40	58
Private equity-owned broker	40	40	40
Publicly held broker	18	30	26
Bank	14	10	18
Other	5	13	4
<b>Total</b>	<b>122</b>	<b>133</b>	<b>146</b>

## MOST ACTIVE FIRST-HALF BUYERS, 2011-2013

The most active buyers of insurance agents and brokers

Company (ownership type)	2013H	2012H	2011H
Hub International Ltd. (private equity-owned)	14	9	18
Arthur J. Gallagher & Co. (publicly held)	9	15	10
Digital Insurance Inc.* (privately held)	7	1	7
AssuredPartners Inc. (private equity-owned)	4	9	1
Confie Seguros Insurance Services (private equity-owned)	4	7	4
USI Holdings Corp. (private equity-owned)	4	6	2
Western Financial Group Inc. (bank-owned)	4	3	3
Brown & Brown Inc. (publicly held)	3	7	11

\*Privately held until December 2012 purchase by publicly traded Fidelity National Financial Inc.

## MOST ACTIVE BUYERS, 2008-2012

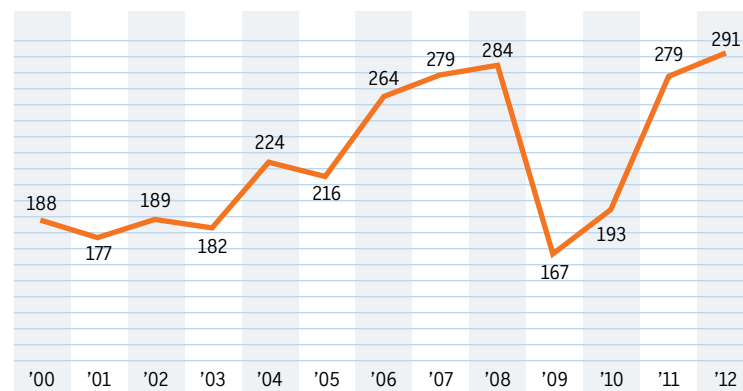
Most active purchasers of U.S. and Canadian agents and brokers

Company (ownership type)	Total	2012	2011	2010	2009	2008
Arthur J. Gallagher & Co. (publicly held)	102	30	21	16	11	24
Brown & Brown Inc. (publicly held)	96	15	17	21	8	35
Hub International Ltd. (private equity-owned)	91	21	32	14	8	16
Confie Seguros Insurance Services (private equity-owned)	32	18	8	3	0	3
USI Holdings Corp. (private equity-owned)	30	10	8	4	1	7
AssuredPartners Inc. (private equity-owned)	23	17	5	1	0	0
Marsh & McLennan Agency (publicly held)	23	9	8	4	2	0
Wells Fargo Insurance Services USA Inc. (bank-owned)	23	0	5	4	6	8
Digital Insurance Inc.* (privately held)	21	9	10	2	0	0
Ascension Insurance Inc. (private equity-owned)	18	2	4	2	6	4
Bollinger Inc. (private equity-owned)	17	3	5	3	2	4

\*Privately held until December 2012 purchase by publicly traded Fidelity National Financial Inc. Source: Optis Partners L.L.C.

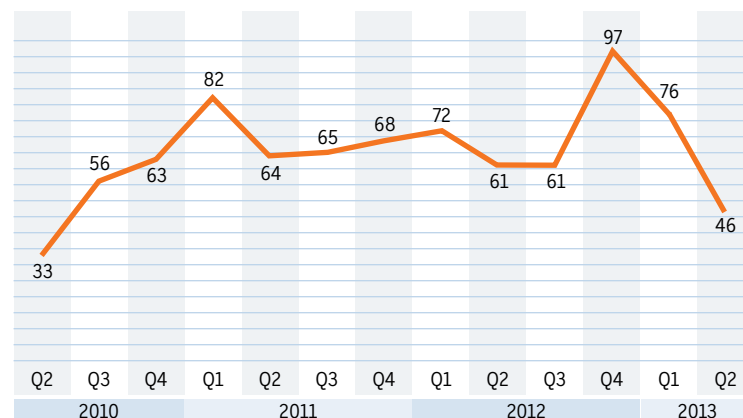
## AGENT/BROKER MERGERS, 2000-2012

Mergers and acquisitions involving U.S. and Canadian insurance agents and brokers



## AGENT/BROKER MERGERS BY QUARTER, 2010-2013

Total U.S. and Canadian insurance agent and broker mergers



## EGAN TAKES ON NEW CHALLENGE BUILDING MIDSIZE BROKERAGE

**Q** What are the near-term and long-term goals for Risk Strategies?

**A** In the near term, we want to grow aggressively, both by acquisition and organically, to flesh out our national footprint; (and) add practices and key hires to become a truly national brokerage firm focusing on upper middle-market, smaller risk management clients with complex risks.

I believe that clients want a choice when selecting a trusted adviser. Upper middle-market and smaller risk management clients are underserved by the large brokerage houses. There is a need for a medium-sized brokerage firm whose hallmarks are quality, client service, knowledge and specialization — both by risk and by industry.

**Q** What attracted you to the opportunity to join Risk Strategies?

**A** I began to work with Kohlberg & Co. early last year, looking for a medium-sized brokerage firm that had a great reputation and tal-

### Q&A

ented professionals — one that could be a U.S. platform for growth. I visited Mike Christian, CEO and founder of (Risk Strategies), in Boston, and we quickly realized that we had a very similar strategic vision and the same ideas about the importance of culture to the success of a professional service firm.

In my mind, culture is the greatest sustainable competitive advantage in the brokerage business. I saw in Risk Strategies a company with a strong entrepreneurial culture — one that emphasizes client service and

technical excellence. The colleagues at RSC are professional and knowledgeable, but they are also collaborative and collegial, smart and nice.

**Q** You have said that you want to establish a greater national presence. Are you targeting specific geographies?

**A** Yes. We have a strong presence in Boston and California. We would like to increase our presence in New York and Chicago right away and eventually open offices in the Southeast and the Southwest. While it is not our immediate priority, we would also like to establish our own office in London to service our clients' placements into that important marketplace.

Geography is important, but so is specialization. As we expand our national footprint and begin to operate as a virtual company, we will also deepen our expertise by risk category, such as professional liability, directors and officers, and by industry, such as the health care and private equity industries.



ROGER EGAN

RISK STRATEGIES CO.

recently spoke with *Business Insurance* Associate Editor Bill Kenealy about his plans to help Risk Strategies expand its services and national footprint.

When Mount Kisco, N.Y.-based private equity firm Kohlberg & Co. purchased the Boston-based privately held commercial insurance and benefits brokerage Risk Strategies Co. in June, industry veteran Roger Egan joined Risk Strategies as part of the deal. Mr. Egan, previously CEO of Integro Ltd. and president of Marsh Inc., agreed to join Risk Strategy's leadership team as executive chairman. He

**Q** Do you think current market conditions are conducive to acquisitive growth?

**A** Yes, if one has the right culture and strategic vision.

There are more than 25,000 agents and small brokerage firms serving middle-market commercial property/casualty, benefits (and) high-net worth individuals. Further consolidation is inevitable. Many of these firms will sell to larger firms in the next five years or so.

**Q** How will Risk Strategies leverage the capabilities of Kohlberg & Co.?

**A** Kohlberg is a very strong financial partner. Of course they add capital, but they add so much more ... They have a reputation as a conservative, disciplined, well-managed private equity firm, second to none. RSC now has the financial wherewithal to fulfill its vision to be the high-quality, specialized, smaller alternative to the big brokerage houses.

### COMINGS & GOINGS

## UP CLOSE: BRIAN MELANSON

GIG HARBOR, WASH.-BASED SENIOR VICE PRESIDENT  
OF STRATEGIC CHANNEL PARTNERSHIPS

Digital Insurance Inc.

**PREVIOUS POSITION:** Mountlake Terrace, Wash.-based director of distribution and ancillary strategy with Premera Blue Cross.

**LOOKING FORWARD TO:** Taking my knowledge of carrier distribution challenges and opportunities and basically marrying it with digital insurance capabilities to modernize the way we look at distribution channels going forward.

**GOALS FOR NEW POSITION:** Creating those partnerships with carriers to thrive in a post-reform world. The second goal is looking at emerging distribution models and implementing in that path.

**CHALLENGES FACING INDUSTRY:** Going into 2014, it's just readiness. It's getting the infrastructure ready to handle the transition of health care reform.

**WHAT I WOULD CHANGE:** How quickly the industry adopts emerging trends. Understanding consumers and what their needs are.

**FIRST INDUSTRY JOB:** A sales rep with Humana Inc.



**WHAT SURPRISED ME:** How tight-knit of a community it is. You run into the same players throughout your career.

**ADVICE:** I think it's really all about customer satisfaction. There is so much focus on technology right now, but it really needs to be making sure people can engage and interact with the system. We need to help people going forward.

**OUTSIDE THE INDUSTRY, A DREAM**

**JOB:** Running a burger stand on a pretty beach somewhere. My family has a decades-old recipe.

**HOBBIES:** I enjoy reading quite a bit. I am also big fan of baseball. I also like teaching my little boy golf. My son is 6.

**THING MOST PEOPLE DON'T KNOW ABOUT ME:** I was able to perform as a (disc jockey) at the Lizard Lounge in Dallas, where I grew up.

**BEST CITY:** Cabo San Lucas (in Mexico). It's where my wife and I first vacationed together. In the United States, it's Seattle. The beauty here is staggering.

### Professional Moves & Promotions

Visit [www.businessinsurance.com/ComingsandGoings](http://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.

#### INSURERS

PMA Companies Inc.	David A. Chandler
Axis Capital Holdings Ltd.	Robert E. Peretti
Liberty Mutual Insurance Co.	Kelly Fusner
Endurance Specialty Holdings Ltd.	Joan deLemps
Endurance Specialty Holdings Ltd.	Catherine A. Kalaydjian
W.R. Berkley Corp.	Timothy F. Galvin

#### BROKERS

Marsh Inc.	Kevin Tobin
National Financial Partners Corp.	Michael N. Goldman
Cooper, Claridge-Ware Ltd.	David Herratt

#### OTHER

Mercer L.L.C.	Tracy Stough Grajewski
Crawford & Co.	Jacob Laudenslager
Hanover Stone Partners L.L.C.	Fred Travis
Hanover Stone Partners L.L.C.	Winifred Baker
Hanover Stone Partners L.L.C.	Craig Nelson

*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: Kate Shepherd, *Business Insurance*, 150 N. Michigan Ave., Chicago, Ill. 60601-7524. [kshepherd@businessinsurance.com](mailto:kshepherd@businessinsurance.com).

## CNA package policy targets midsize businesses

CNA Financial Corp. has launched CNA Paramount, a package policy for midsize businesses that combines property and general liability coverage.

The Paramount suite combines basic and critical property and crime coverage in one package, including lost business income, extra expense, inland marine liability, equipment breakdown and crime, CNA said in a statement.

The package includes coverage for contractual penalties, forgery and alteration, protection of property, restoration expenses, unintentional errors or omissions, expediting expenses and green-insured property.

“The policy responds to the complex needs and risks of today’s modern businesses, such as the expanded digital and global landscape,” Jim Segriff, CNA’s vice president of property, said in the statement.

## Verisk adds data resources to replacement costs tool

Verisk Insurance Solutions Underwriting, a unit of Verisk Analytics Inc., has enhanced the commercial module of 360Value, its replacement cost estimation tool for property insurers.

The tool’s database has 2 million additional records of property-specific building characteristics and the ability to estimate replacement costs for heavy commercial and industrial structures, such as hospitals, museums, airport terminals and manufacturing plants, Verisk said in a statement.

“Innovation is the driving force behind the growth of 360Value,” Scott Amussen, vice president of property solutions at Verisk Underwriting, said in the statement.

## ISO adds media liability to cyber insurance

Insurance Services Office Inc., a unit of Verisk Analytics Inc., has updated its electronic commerce cyber insurance product.

The enhancements add coverage designed specifically for companies with a media liability exposure, ISO said in a statement.

Media liability policies offer eight coverage areas: media liability, security breach liability, programming errors and omissions liability, replacement or restoration of electronic data, extortion threats, business income and extra expenses, public relations expense, and security breach expense, according to the statement.

Claims-made and occurrence versions of the coverage are available. All policies can be written with separate limits and deductibles.

“The alarming frequency and severity of data breaches suggests that, for many businesses, it’s no longer a question of ‘if



## RMS adds storm surge to hurricane model

Risk Management Solutions Inc. has expanded storm surge factors in the latest update of its North Atlantic hurricane model.

Version 13.0 also gives new insight into future hurricane activity levels, the Newark, Calif.-based risk modeler said in a statement.

The model simulates the interaction between wind and storm surge and distinguishes potential losses for residential and commercial lines of business.

Superstorm “Sandy revealed just how real storm surge risk is,” Claire Souch, vice president of model solutions at RMS, said in the statement.

“Our model shows there is a 20% chance that storm surge loss will be greater than wind loss for any U.S. hurricane that makes landfall, which rises to almost 40% along the Northeast coast of the United States; this is a risk the market can no longer afford to ignore,” Ms. Souch said.

The model includes up-to-date data from the Federal Emergency Management Agency’s 2012 flood insurance rating maps as well as National Flood Insurance Program policies in force, RMS said in the statement.

RMS also issued a new five-year forecast that includes scientific findings on how sea-surface temperatures affect hurricanes making U.S. landfall.

“Our forecast gives insurance companies an additional view of the risk that may be more appropriate to future climate conditions, as opposed to using averages of historical activity,” Ms. Souch said in the statement.

but ‘when’ they will suffer a data breach,” Beth Fitzgerald, senior vice president of ISO’s insurance programs and analytic services, said in the statement.

## Wells Fargo launches intellectual property products

Wells Fargo Insurance Services USA Inc. is offering a pair of insurance products designed to protect policyholders’ revenue and royalties from intellectual

property challenges.

The products, RevEnsure and ANDAfend, are underwritten by a dedicated facility at Lloyd’s of London, the Chicago-based brokerage said in a statement.

RevEnsure provides indemnification for companies’ actual revenue shortfall if the intellectual property rights that support its sales are adversely affected by litigation, Wells Fargo said in the statement.

ANDAfend provides similar revenue and market coverage for pharmaceutical companies if they are subjected to successful legal challenges by generic drug-makers filing Abbreviated New Drug Applications with certifications under Paragraph IV of the 1984 Drug Price Competition and Patent Term Restoration Act.

## Starr chooses platform for policy administration

Starr Insurance Holdings Inc., a member of Starr Cos., has selected PolicyWriter as its policy administration platform for its general casualty, energy, environmental and commercial auto lines of business, Starr Insurance and the provider of PolicyWriter, Adaptik Corp., said in a statement.

Starr cited the platform’s rapid configuration and prototyping capabilities for choosing PolicyWriter.

“We needed a highly configurable policy administration platform that would meet our complex commercial business needs,” Ed Myers, director of underwriting systems at Starr, said in the statement.

## PMSI launches flexible PBM program

PMSI Inc., a Tampa, Fla.-based provider of specialty workers compensation products, services and clinical services, has launched a flexible pharmacy benefit management program aimed at excess insurers, third-party administrators and settled claims administrators.

ClaimSelect allows claims to be enrolled in a customized pharmacy benefit management program that will best meet the goals the injured worker’s claim and reduce costs, PMSI said in a statement.

“ClaimSelect addresses the pharmacy needs post-settlement, high-exposure and excess claims,” said Rey Quinones, PMSI’s vice president of strategy and product development, in the statement. “These types of claims require efficient management in order to monitor utilization, maximize medical outcomes, and mitigate cost.”

Claimants can receive medication through PMSI’s network of nearly 65,000 retail U.S. pharmacies and its mail order program.

Claims payers also can use clinical oversight for excess and high-exposure claims through its MedAssess program, PMSI said in the statement.

## DEALS & MOVES

### Hub units buy Unity Group, Vicencia & Buckley assets

Subsidiaries of Chicago-based Hub International Ltd. have acquired assets of The Unity Group Inc. and Vicencia & Buckley Insurance Services Inc.

Hub International Northwest acquired Bellingham, Wash.-based Unity, and Hub International Insurance Services Inc. acquired La Palma, Calif.-based Vicencia & Buckley, both full-service brokerages.

Hub did not disclose the terms of the deals. Unity Group President Barry Hanson will join Hub Northwest as executive vice president and be based in Bellingham, Wash., according to a statement.

Vicencia & Buckley President and CEO Steve Vicencia will join Hub California as executive vice president, and Vicencia & Buckley Chief Financial Officer Michelle Vicencia Jondle will join Hub California as senior vice president. Both will remain based in La Palma, Calif., Hub said in the statement.

Hub is the 10th-largest broker in the world and the 11th-largest broker of U.S. business, according to *Business Insurance’s* 2013 rankings.

### Digital Insurance acquires employee benefits unit

Atlanta-based Digital Insurance Inc. has acquired Massachusetts-based Strategic Employee Benefits Services-Wellesley, Providence and Springfield.

The operation, which had been affiliated with the Milwaukee-based SEBS network, provides employee benefits programs and cost-containment solutions to nearly 950 small and midsize employers in New England.

SEBS Managing Principal Kevin O’Connor and his 14-member team will join Digital Benefit Advisors, a division of Digital Insurance, to establish the company’s first office in Boston.

### XL, Stone Point Capital form ILS investment management firm

XL Group P.L.C. and Stone Point Capital L.L.C. have formed a Bermuda-based investment management firm for insurance-linked securities and XL reinsurance products.

Dublin-based insurer XL will have 75% ownership of the firm, while Greenwich, Conn.-based private equity firm Stone Point will own the remaining 25%, the companies said in a statement.

The companies plan to invest \$135 million in the operation and secure third-party investors for the yet-to-be-named Bermuda-based firm.

### Ironshore provides more capacity to surety market specialist

Hamilton, Bermuda-based insurer Ironshore Inc. and Lexon Surety Group L.L.C., a Mount Juliet, Tenn.-based insurer that specializes in surety bonds, will broaden their alliance by providing additional capacity for Lexon subsidiary Boston Indemnity Group.

Ironshore is set to provide quota share reinsurance capacity for Boston Indemnity and will serve as a primary fronting facility business for U.S. commercial and contract surety risks, Ironshore said in a statement.

Boston Indemnity serves the surety market and focuses on small- to midsize companies. Ironshore purchased a 9.9% equity stake in Lexon this year.

# CLASSIFIEDS

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## PUBLIC NOTICES

### LEGAL NOTICE

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS  
COUNTY DEPARTMENT, CHANCERY DIVISION  
IN THE MATTER OF THE LIQUIDATION OF  
LUMBERMENS MUTUAL CASUALTY COMPANY, ) NO.  
AMERICAN MANUFACTURERS MUTUAL ) 12 CH  
INSURANCE COMPANY AND AMERICAN ) 24227  
MOTORIST INSURANCE COMPANY )

**NOTICE OF CLAIM FILING DEADLINE OF NOVEMBER 10, 2014 at 4:30 p.m. C.S.T.**  
**PLEASE TAKE NOTICE**, that pursuant to orders entered on May 8, 2013, by the Circuit Court of Cook County, Illinois, effective May 10, 2013, Lumbermens Mutual Casualty Company, American Manufacturers Mutual Insurance Company, and American Motorists Insurance Company (collectively referred to herein as the "Lumbermens Companies") were placed into liquidation. The Orders of Liquidation with a Finding of Insolvency (the "Liquidation Orders") were entered pursuant to Article XIII of the Illinois Insurance Code (215 ILCS 5/187, et seq.). Andrew Boron, Director of Insurance of the State of Illinois, was affirmed as the statutory Liquidator (the "Liquidator") of the Lumbermens Companies.

**TAKE FURTHER NOTICE**, that pursuant to the Liquidation Orders, all rights and liabilities of the Lumbermens Companies and their policyholders, creditors and all other persons interested in their property or assets are fixed as of May 10, 2013.

**TAKE FURTHER NOTICE**, that on August 1, 2013, the Circuit Court of Cook County, Illinois, entered an Order providing for the filing of claims and the setting of a claim filing deadline ("Claim Filing Order"). Pursuant to the Claim Filing Order, all persons, companies, or entities who have, or may have claims against the Lumbermens Companies, their property or assets, or against a Lumbermens Company insured or policyholder, shall have the right to present and file with the Liquidator a proof of claim form on or before the claim filing deadline of **November 10, 2014 at 4:30 p.m. C.S.T.**

**TAKE FURTHER NOTICE**, that any insured under an insurance policy issued by the Lumbermens Companies shall have the right to present and file with the Liquidator a proof of claim setting forth a contingent claim on or before November 10, 2014 at 4:30 p.m. C.S.T. No such contingent claim shall be allowed for purposes of participating in any distribution(s) of estate assets that may be made at the fourth priority level, 215 ILCS 5/205(1)(d), unless such claim has been liquidated and the insured claimant has presented to and filed with the Liquidator evidence of payment of such claim on or before the contingent claim date of November 10, 2015 at 4:30 p.m. C.S.T. Any insured's contingent claim for which a proof of claim was received by the claim filing deadline of November 10, 2014, at 4:30 p.m. C.S.T., but which is not liquidated by November 10, 2015 at 4:30 p.m. C.S.T. may be estimated pursuant to Section 209(4)(b) of the Code, 215 ILCS 5/209(4)(b) for purposes of participating in any distribution(s) of estate assets that may be made at the fifth priority level, 215 ILCS 5/205(1)(e), unless otherwise directed by the court.

**TAKE FURTHER NOTICE**, that the form and required contents of all proofs of claim are described in 215 ILCS 5/209. Proofs of claim, along with supporting documents, are to be filed with, and may be obtained from the Liquidator of the Lumbermens Companies, c/o the Office of the Special Deputy Receiver, located at 222 Merchandise Mart Plaza, Suite 960, Chicago, Illinois 60654, OSD website: [www.osdchil.com](http://www.osdchil.com), or by calling OSD at (312) 836-9500. In order for a proof of claim to be timely filed, the liquidator must have physical possession of the proof of claim form on or before the claim filing deadline, or the proof of claim form must have been delivered to the United States Postal service for delivery to the Liquidator and postmarked on or before the claim filing deadline with full postage pre-paid, or the proof of claim form must have been delivered to a private mail courier for delivery to the Liquidator on or before the claim filing deadline with delivery charges fully paid.  
Paul Miller, Special Deputy Receiver

### LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF  
CONSOLIDATED MUTUAL INSURANCE COMPANY  
Supreme Court County of Kings, Index No.: 10402/79  
NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of Kings ("Court"), entered May 31, 1979 ("Liquidation Order"), the then-Superintendent of Insurance of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Consolidated Mutual Insurance Company ("Consolidated Mutual") and, as such, has been directed to take possession of Consolidated Mutual'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 Consolidated Mutual. The Liquidator has, pursuant to Insurance Law Article 74, appointed Michael J. Casey, Acting Special Deputy Superintendent ("Acting Special Deputy"), as his agent to liquidate the business of Consolidated Mutual. The Acting 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 ("Closing Report") on the status of and request to close Consolidated Mutual's liquidation proceeding ("Liquidation Proceeding") and the financial transactions delineated therein; (ii) authorizing the continued payment of administrative expenses, including such expenses pertaining to the closing of the Liquidation Proceeding; (iii) terminating and closing the Liquidation Proceeding; (iv) authorizing the Liquidator, without further application to the Court, to continue to receive and disburse assets, pursuant to Insurance Law Article 74, to those creditors of Consolidated Mutual with allowed claims who are eligible to share in a pro-rata distribution, after the termination of the Liquidation Proceeding (including any portion of the Post-Closing Amount (as defined in the Closing Report) remaining after payment of administrative expenses (including administrative expenses incurred in connection with the collection of such assets; (v) 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 or omissions in connection with the Liquidation Proceeding; (vi) 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 Consolidated Mutual without further order of the Court; and (vii) providing for such other and further relief as the Court deems appropriate and just.

A hearing is scheduled on the Verified Petition on the 20th day of September, 2013, at 9:30 a.m., before the Court at the Courthouse, IAS Part 18, 360 Adams Street, Room 775, Brooklyn, 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 (7) 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 Consolidated Mutual Insurance Company, 110 William Street, New York, New York 10038, Attention: John Pearson Kelly, Esq., General Counsel.

The Verified Petition and Closing 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 17, 2013, Benjamin M. Lawsky, Superintendent of Financial Services of the State of New York as Liquidator of Consolidated Mutual Insurance Company.

### LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE  
CHANCERY DIVISION  
COMPANIES COURT

No. 4987 of 2013  
**IN THE MATTER OF EAGLE STAR INSURANCE COMPANY LIMITED AND HOME & OVERSEAS INSURANCE COMPANY LIMITED AND CITY OF LONDON INSURANCE COMPANY LIMITED AND RIVERSTONE INSURANCE (UK) LIMITED AND IN THE MATTER OF THE FINANCIAL SERVICES AND MARKETS ACT 2000**

NOTICE

NOTICE IS HEREBY GIVEN that on 23 July 2013 Eagle Star Insurance Company Limited, Home & Overseas Insurance Company Limited and City of London Insurance Company Limited (together, "ESI") and RiverStone Insurance (UK) Limited ("RIUK") made an application (the "Application") to the High Court of Justice pursuant to section 107(I) of the Financial Services and Markets Act 2000 ("FSMA") for an Order: (i) under section 111 of FSMA sanctioning an insurance business transfer scheme for the transfer of the general insurance business of ESI to RIUK (the "Scheme"); and (ii) making ancillary provisions in connection with the Scheme pursuant to section 112 of FSMA. The Scheme will result in the general insurance business currently carried on by ESI being carried on by RIUK. Copies of a report on the terms of the Scheme prepared pursuant to section 109 of FSMA (the "Independent Expert's Report") and a statement setting out the terms of the Scheme and containing a summary of the Independent Expert's Report are available free of charge on ESI's website at [www.esitransfer.com](http://www.esitransfer.com). Supporting documents and any further news about the Scheme will be posted on these websites so you may wish to check for updates. You can also request free copies of any of these documents by writing to Eagle Star Insurance Company Limited, 33 Jermyn Street, London SW1Y 6AD (quoting reference ESI Transfer). The Application will be heard on 8 November 2013 by a Judge of the Chancery Division of the High Court at The Rolls Building, Fetter Lane, London, EC4A 1NL. If approved by the Court, it is currently proposed that the Scheme will take effect on 31 December 2013. Any person who believes that he or she would be adversely affected by the carrying out of the Scheme is entitled to either make written representations or be heard (either in person or by a legal representative) at the hearing of the Application on 8 November 2013. Any person who intends to appear at the Court or make representations in writing is requested to notify his or her objections as soon as possible and by no later than 28 October 2013 to the solicitors named below. If the Scheme is sanctioned by the Court, it will result in the transfer of all the contracts, property, assets and liabilities relating to the general insurance business of ESI to RIUK; notwithstanding that a person would otherwise be entitled to terminate, modify, acquire or claim an interest or right or to treat an interest or right as terminated or modified in respect thereof. Any such right will only be enforceable to the extent the order of the Court makes provision to that effect.

**Dated:** 12 August 2013  
Freshfields Bruckhaus Deringer LLP  
65 Fleet Street  
London EC4Y  
1HS Ref: GHFS/DJB  
Solicitors for ESI

### LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF ATLANTIC MUTUAL INSURANCE COMPANY  
Supreme Court County of New York, Index No.: 402424/10  
NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of New York, entered on April 27, 2011 ("Liquidation Order"), the Superintendent of Insurance of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Atlantic Mutual Insurance Company ("Atlantic Mutual") and, as such, has been directed to take possession of Atlantic Mutual'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 Atlantic Mutual. The Liquidator has, pursuant to Insurance Law Article 74, appointed Michael J. Casey, Acting Special Deputy Superintendent ("Acting Special Deputy"), as his agent to liquidate the business of Atlantic Mutual. The Acting Special Deputy carries out his duties through the New York Liquidation Bureau, 110 William Street, New York, New York 10038.

**PLEASE TAKE NOTICE** that the Supreme Court of the State of New York, County of New York, has issued an order, dated July 11, 2013, establishing September 30, 2013, as the bar date for the presentation to the Liquidator of all claims against Atlantic Mutual or its insureds other than the Liquidator's claims for administrative expenses. Requests for further information should be directed to the New York Liquidation Bureau, Creditor and Ancillary Operations Division, at (212) 341-6665. Dated: July 16, 2013, Benjamin M. Lawsky, Superintendent of Financial Services of the State of New York as Liquidator of Atlantic Mutual Insurance Company.

### LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF CENTENNIAL INSURANCE COMPANY  
Supreme Court County of New York, Index No.: 402424/10  
NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of New York, entered on April 27, 2011 ("Liquidation Order"), the Superintendent of Insurance of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Centennial Insurance Company ("Centennial") and, as such, has been directed to take possession of Centennial'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 Centennial. The Liquidator has, pursuant to Insurance Law Article 74, appointed Michael J. Casey, Acting Special Deputy Superintendent ("Acting Special Deputy"), as his agent to liquidate the business of Centennial. The Acting Special Deputy carries out his duties through the New York Liquidation Bureau, 110 William Street, New York, New York 10038.

**PLEASE TAKE NOTICE** that the Supreme Court of the State of New York, County of New York, has issued an order, dated July 11, 2011, establishing September 30, 2013, as the bar date for the presentation to the Liquidator of all claims against Centennial or its insureds other than the Liquidator's claims for administrative expenses. Requests for further information should be directed to the New York Liquidation Bureau, Creditor and Ancillary Operations Division, at (212) 341-6665. Dated: July 16, 2013, Benjamin M. Lawsky, Superintendent of Financial Services of the State of New York as Liquidator of Centennial Insurance Company.

### LEGAL NOTICE

IN THE MATTER OF THE LIQUIDATION OF FRONTIER INSURANCE COMPANY  
Supreme Court County of Albany, Index No.: 000097/2006  
NOTICE

Pursuant to an order of the Supreme Court of the State of New York, County of Albany ("Court"), entered on November 16, 2012 ("Liquidation Order"), the Superintendent of Financial Services of the State of New York and his successors in office were appointed as liquidator ("Liquidator") of Frontier Insurance Company ("Frontier") and, as such, has been directed to take possession of Frontier's property and liquidate its business and affairs pursuant to Article 74 of the New York Insurance Law ("Insurance Law"). The Liquidator has, pursuant to Insurance Law Article 74, appointed Michael J. Casey, Acting Special Deputy Superintendent ("Acting Special Deputy"), as his agent to liquidate the business of Frontier. The Acting 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 an affirmation ("Affirmation") seeking an order: (i) establishing December 31, 2013, as the bar date ("Bar Date") for the presentation to the Liquidator of all claims against Frontier other than the Liquidator's claims for administrative costs and expenses; and (ii) providing for such other and further relief as the Court may deem just and proper.

A hearing is scheduled on the Affirmation on the 6th day of September, 2013, at 10:30 a.m., before the Honorable Richard M. Platkin, J.S.C., Supreme Court of the State of New York at Albany County Courthouse, located at 16 Eagle Street, Albany, New York. If you wish to object to the Affirmation, you must serve a written statement setting forth your objections and all supporting documentation upon the Liquidator and Clerk of the Court, at least 14 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 Frontier Insurance Company, 110 William Street, New York, New York 10038, Attention: John Pearson Kelly, General Counsel.

In order to participate in the Frontier liquidation proceeding, all claims must be presented to the Liquidator on or before the Bar Date, which is the last date set by the Court to present claims in the Frontier liquidation proceeding.

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

Requests for further information should be directed to the New York Liquidation Bureau, Creditor and Ancillary Operations Division, at (212) 341-6241.

Dated: July 9, 2013, Benjamin M. Lawsky, Superintendent of Financial Services of the State of New York as Liquidator of Frontier Insurance Company.

### LEGAL NOTICE

To all persons or entities interested in the affairs of ULLICO CASUALTY COMPANY  
Supreme Court of the State of New York, County of New York, Index No.: 450995/13  
Notice is Hereby Given:

I, Benjamin M. Lawsky, Superintendent of Financial Services of the State of New York, has been appointed by an order ("Order") of the Supreme Court of the State of New York, County of New York ("Court"), filed July 8, 2013, as the ancillary receiver ("Ancillary Receiver") of Ullico Casualty Company ("Ullico") and with all of the rights and obligations granted to and imposed upon him pursuant to Article 74 of the New York Insurance Law ("Insurance Law"). The Ancillary Receiver has, pursuant to Insurance Law Article 74, appointed Michael J. Casey, Acting Special Deputy Superintendent ("Acting Special Deputy") as his agent to carry out his duties as Ancillary Receiver. The Acting Special Deputy carries out his duties through the New York Liquidation Bureau, 110 William Street, New York, New York 10038. II. All persons are permanently enjoined and restrained from commencing or prosecuting any actions, lawsuits or proceedings against Ullico, and all persons are permanently enjoined and restrained from commencing or prosecuting any actions, lawsuits or proceedings against the Superintendent as Ancillary Receiver or the New York Liquidation Bureau, its employees, attorneys or agents, with respect to this proceeding or in the discharge of their duties under Insurance Law Article 74; III. All parties to actions, lawsuits and special or other proceedings within the jurisdiction of the courts of the State of New York in which Ullico, its policyholders or insureds, are obligated to defend a party or to provide a defense of any matter against an insured pursuant to an insurance policy, bond, contract or otherwise, are enjoined and restrained from proceeding with any discovery, court proceedings or other litigation tasks or procedures, including, but not limited to, conferences, trials, applications for judgment or proceedings on settlement or judgment, for a period of 180 days from the date of entry of this Order; V. All persons or entities having possession of information, such as, but without limitation, insurance policies, underwriting data, claims files (electronic or paper) and/or software programs owned by, belonging to or relating to Ullico that is necessary or desirable to permit the Ancillary Receiver to carry out his obligations, shall preserve such information, and immediately, upon the Ancillary Receiver's request and direction, provide and/or make such information available to the Ancillary Receiver; VI. The bar date of June 30, 2014 established in the domiciliary liquidation proceeding shall also be effective in this ancillary receivership proceeding; VII. Immunity is extended to the Superintendent in his capacity as Ancillary Receiver of Ullico, and his successors in office and their agents and employees, for any cause of action of any nature against them, individually or jointly, for any act or omission when acting in good faith, in accordance with the orders of this Court, or in the performance of their duties pursuant to Insurance Law Article 74; VIII. Ullico's license to do business in the State of New York is hereby revoked; IX. The Ancillary Receiver may at any time make further application to the Court for such further and different relief as he sees fit. X. All communications relating to ULLICO and to the Ancillary Receivership Proceeding thereof should be addressed to: **New York Liquidation Bureau, 110 William Street, New York, New York 10038, Attention: Jeanne Pannullo-Anderson, JPannullo@nylb.org.**

MICHAEL J. CASEY  
Acting Special Deputy Superintendent and Agent for the Superintendent as Ancillary Receiver of Ullico Casualty Company

BENJAMIN M. LAWSKY  
Superintendent of Financial Services of the State of New York as Ancillary Receiver of Ullico Casualty Company

### LEGAL NOTICE

NOTICE OF SANCTION AND EFFECTIVE DATE OF SCHEME OF ARRANGEMENT

IN THE HIGH COURT OF JUSTICE

CHANCERY DIVISION

COMPANIES COURT

IN THE MATTER OF

**FOLKSAM INTERNATIONAL INSURANCE COMPANY (UK) LIMITED**

(IN ADMINISTRATION)

and

IN THE MATTER OF THE COMPANIES ACT 2006

NOTICE IS HEREBY GIVEN that, by an Order dated 19 July 2013 made in the High Court of Justice in the matter of Folksam International Insurance Company (UK) Limited (in Administration) (the "Company"), a scheme of arrangement dated 8 May 2013 (the "Scheme") proposed to be made between the Company and its Scheme Creditors (as defined in the Scheme) pursuant to Part 26 of the Companies Act 2006, which was voted on and approved by Scheme Creditors during three meetings held on 20 June 2013, was sanctioned. All capitalised terms in this notice have the same meaning as given to them in the Scheme.

On 6 August 2013, the United States Bankruptcy Court entered an Order granting, amongst other things, permanent injunctive relief pursuant to section 304 of the United States Bankruptcy Code in favour of the Company in respect of the Scheme.

Following the obtaining of these Orders, a copy of the Order sanctioning the Scheme was lodged with the Registrar of Companies on 7 August 2013. Therefore, in accordance with the terms of the Scheme, the Scheme became effective at that time.

Scheme Creditors are required to provide full details of their Claim(s), including outstanding and contingent Claims, and supporting documents by completing and submitting a Claim Form by no later than 5pm (London time) on 7 February 2014. This is the Bar Date for the purposes of the Scheme.

Scheme Creditors who do not return a Claim Form so that it is actually received by the Scheme Administrators by the Bar Date, and who have not elected to have their Proxy and Voting Forms treated as their Claim Form, will be bound by the Scheme. They will still receive payment under the Scheme but only in respect of and in recognition of those Claims set out in the Claim Form made available to them (net of Security Interest and set-off).

Further information and copy documents (including Claim Forms) may be obtained by contacting the appointed Run-off Company, Compre Services (UK) Limited, as follows:  
By phone: +44 (0) 20 3551 6552  
By email: [folksam.uk@compre-group.com](mailto:folksam.uk@compre-group.com)  
Website: [www.folksam.co.uk](http://www.folksam.co.uk)

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# WAL-MART

Continued from page 4

*Dukes*, employers can drive harder bargains with plaintiffs attorneys, Mr. Maatman said.

Mr. Fox said the Supreme Court's ruling in *Dukes* "means we're not going into an era where we're going to take massive classes and sort of bootstrap them into big settlements."

"The courts in general are scrutinizing these class actions, and I think that putative class actions that would have been certified just a few years prior to *Wal-Mart* will not be now," and courts in general

## FEDERAL JUDGE SIDES WITH WAL-MART

This month in *Betty Dukes et al. v Wal-Mart Stores Inc.*, U.S. District Court Judge Charles R. Breyer in San Francisco ruled that:

- Plaintiffs' proposed class of 150,000 members is a "scaled-down version of the same case" that the U.S. Supreme Court rejected in 2011, "with new labels on old arguments."
- Plaintiffs' statistics are "underwhelming" and do not present significant proof of a general policy of discrimination, as required by the U.S. Supreme Court.
- Plaintiffs have not gathered sufficient anecdotal evidence of bias and stereotyped thinking within any management group to establish significant proof of a general policy of discrimination.

"are more mindful as far as looking at the evidence that is available" to satisfy the requirement of commonality among class members, said John B. Lewis, a partner at Baker & Hostetler L.L.P. in Cleveland.

The Supreme Court ruling in *Dukes* is "just another iteration in

the trend of courts curbing class actions," said Proskauer Rose's Mr. Sulzer, who cited the Supreme Court's 2012 ruling in *Stolt Nielsen S.A. v. AnimalFeeds International Corp.* In that 5-3 ruling, the high court said imposing class arbitration on parties, who have not

agreed to authorize it, is inconsistent with the Federal Arbitration Act.

"You would need to have very strong evidence of a corporate policy or practice of discrimination" before taking the leap to say it should be litigated as a class, Kevin M. McGinty, a member of Mintz, Levin, Cohn, Ferris, Glovsky & Popeo P.C. in Boston, said of *Dukes*.

Most employers like Wal-Mart have a written policy forbidding discrimination, Mr. McGinty said. Such a policy suggests when discrimination does happen, it is based on individual factors and does not reflect a corporatewide decision, he said.

# Smaller groups seeking class certification

Since the U.S. Supreme Court's 2011 ruling in *Betty Dukes et al. v. Wal-Mart Stores Inc.* in which the court said a proposed gender discrimination class failed to identify a "common mode of exercising discretion that pervades the company," smaller groups of plaintiffs have filed lawsuits around the United States seeking class certification.

While there has been no final determination in some cases, none has yet been successful.

According to a spokeswoman for plaintiffs attorneys in the California case against Wal-Mart that was rejected this month, case dismissals in Texas and Tennessee are being appealed. The 7<sup>th</sup> U.S. Circuit Court of Appeals in Chicago has refused to reconsider dismissal of a case filed in Wisconsin and it is now back in federal district court. And a ruling is pending in a Florida case.

In a statement on the recent ruling in California, Bentonville, Ark.-based Wal-Mart said it is pleased that the court rejected "the attempt of a few associates to turn their individual complaints into a sweeping and unwarranted class action. As the U.S. Supreme Court recognized in 2011, these claims are unsuitable for class treatment because each individual's situation is so different."

Plaintiff attorney Randy Renick, a partner at Hadsell Stormer Richardson & Renick L.L.P. in Pasadena, Calif., said the plaintiffs plan to appeal.

"We are deeply disappointed in the court's decision regarding what we remain convinced is a strong class-action case against Wal-Mart for wide-scale gender discrimination," Mr. Renick said in a statement. "While this court decision does not in any way negate the merits of the pay and promotion discrimination case against Wal-Mart, it does create yet another hurdle for these women to at long last have their day in court."

By Judy Greenwald

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Adams, who also is director of claims management and business strategies for risk management services for Walt Disney World Resort in Orlando, Fla.

Humana filed suit last month in federal courts in Kansas, Missouri, Tennessee and Texas, court records show. Each complaint argues that Farmers entities used “deceptive practices” to “shift their financial obligations under the Medicare Secondary Payer Act to Medicare Advantage organizations and ultimately to the Medicare Trust Funds.”

The Medicare Secondary Payer Act requires self-insured employers, insurers and others to notify CMS of workers comp and liability settlements or payments that involve Medicare recipients. CMS can use settlement funds to recoup “conditional payments” that it has made on behalf of beneficiaries to medical programs. It also can require insurers, employers and other “primary payers” to set aside funds to pay for future medical costs related to a beneficiary’s injury.

Humana argues in the court filings that Farmers entities served as primary payers, and that Humana and its entities are secondary payers because they acted on behalf of CMS as a Medicare Advantage plan. Therefore, Humana contends, Farmers companies are required to reimburse Humana under the federal law.

As to whether additional lawsuits may be filed, Humana said in an emailed statement that it “will do what is necessary to protect its members and the Medicare Advantage program, a program that has helped seniors across the country improve their health.”

In earlier litigation, Humana sued pharmaceutical firm GlaxoSmithKline P.L.C. in federal court for reimbursement under Medicare Secondary Payer rules. That suit was based on at least \$460 million in settlements that Glaxo paid for patients who suffered complications from using diabetes drug Avandia.

The 3rd U.S. Circuit Court of Appeals ruled in June 2012 that Humana had a right to pursue its claim

against Glaxo. The U.S. Supreme Court declined in April to hear Glaxo’s appeal of that case, which was remanded to the Philadelphia County Court of Common Pleas.

Attorney David Farber, counsel for the Medicare recovery coalition, said most court decisions prior to the Glaxo case found that

## Government loses appeal seeking Medicare repayment

The U.S. 11th Circuit Court of Appeals recently ruled against the federal government after Medicare sought reimbursement from a massive class-action litigation settlement based on the Medicare Secondary Payer Act.

In *USA v. James J. Stricker et al.*, the government wanted repayment from more than 900 Medicare beneficiaries, as well as insurers and plaintiff attorneys, who were part of a \$300 million pollution liability settlement. The 2003 settlement was based on injuries suffered by Alabama residents from exposure to polychlorinated biphenyls manufactured in the state.

A U.S. District Court judge dismissed *Stricker* in 2010, ruling that the government’s case was filed in December 2009, and therefore fell outside a six-year statute of limi-

tations for contract law and a three-year limit for tort cases. On appeal, the government argued in part that the district court miscalculated the time limit.

In a July 26 ruling, a three-judge panel of the 11th Circuit unanimously upheld the district court that the government’s case fell outside the six-year deadline.

Attorney David Farber, counsel for the Washington-based Medicare Advocacy Recovery Coalition, said it is possible the government could file similar lawsuits seeking reimbursement from large settlements while aiming to beat the statute of limitations requirement.

“We may not have seen the end of cases like *Stricker*, even though the next one will probably be brought more timely,” Mr. Farber said.

By Sheena Harrison

Medicare Advantage plans do not have the same recovery rights as CMS. He sees Humana’s lawsuits against Farmers as a continuation of arguments in the Glaxo case.

“I presume that they’re trying to build on that one decision,” Mr. Farber said.

The difficulty in reimbursing Medicare Advantage plans stems from several points.

First, experts say there are numerous Medicare Advantage programs and no centralized way to determine whether money is owed to a particular Advantage plan.

Settlement parties can request reimbursement information from CMS if a claimant’s health care has been paid by traditional Medicare. However, CMS does not provide reimbursement information for private Medicare Advantage programs.

“We just don’t have access to the information that these Medicare Advantage plans are expecting,” Ms. Adams said. “If we don’t know that a beneficiary is a member in a Medi-

care Advantage plan until well after we’ve resolved the case, we don’t know that there’s an obligation out there that we have to pay back the plan.”

Secondly, many claimants are unaware of whether their coverage is provided by traditional Medicare or a Medicare Advan-

tage plan. Without that information, experts say settlement parties often seek reimbursement data from CMS rather than the proper Medicare Advantage provider, leaving them unaware that money is due to a private plan.

“You really need the cooperation of the claimant,” Ms. Jordan said.

“You need them to show you their (Medicare) card because sometimes they really don’t understand that there’s a difference” between Medicare Advantage and traditional Medicare.

Also complicating matters is that Medicare Advantage enrollees often receive coverage from vari-

“We may not have seen the end of cases like *Stricker*, even though the next one will probably be brought more timely.”

David Farber,  
Medicare Advocacy  
Recovery Coalition

ous programs in their lifetime, making it difficult to determine how much should be repaid to various Medicare Advantage plans, said Aaron Frederickson, director of Medicare Secondary Payer compliance for Medicare and Social Security compliance firm Allsup Inc. in Belleville, Ill.

“A plan might start making payments, but 18 months later that plan could conceivably change two or three times,” Mr. Frederickson said.

Though experts say Medicare Advantage plans should be repaid for workers comp- or liability-related medical care, they say it’s unclear whether Advantage programs should have the same recovery authority as CMS and the federal government.

If so, Ms. Adams said Medicare Advantage programs should be held to the same requirements as CMS under the Medicare Secondary Payer Act and the recently enacted Strengthening Medicare and Repaying Taxpayers Act, known as the SMART Act.

Those provisions include a three-year statute of limitations for reimbursement claims, the ability to request precise reimbursement amounts prior to a claim settlement and safe harbor provisions that protect settlement parties from litigation if they acted in “good faith” to follow Medicare Secondary Payer procedures.

“Certainly, if they have a right of recovery, we have an equal right to the information upfront so that we can attempt to resolve the claim,” Ms. Adams said.

“If we don’t know that a beneficiary is a member in a Medicare Advantage plan until well after we’ve resolved the case, we don’t know that there’s an obligation out there that we have to pay back the plan.”

Michele Adams,  
Medicare Advocacy  
Recovery Coalition

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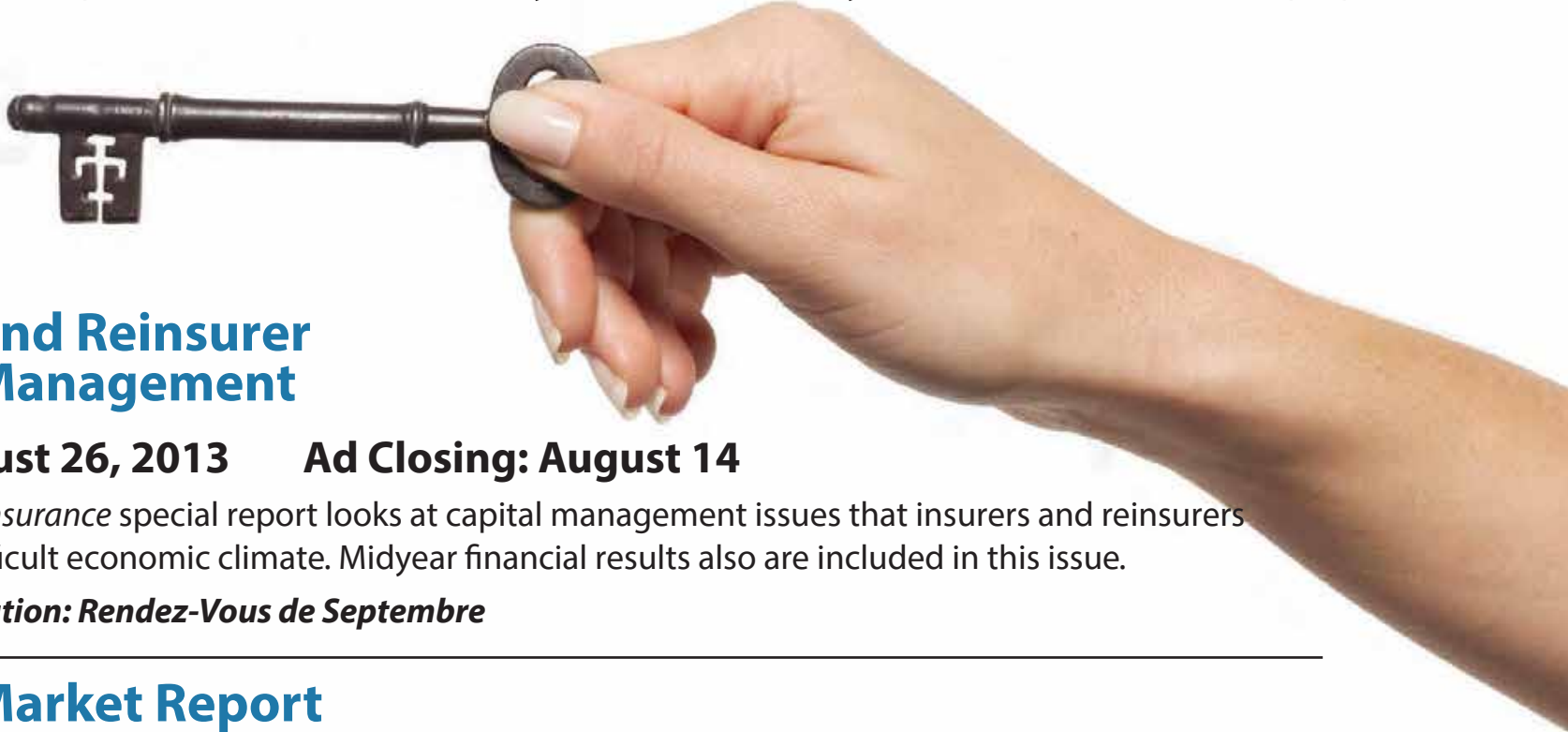
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# COSTA

Continued from page 3

and grounded off the Italian island of Giglio.

Five people already have been convicted for their roles in the disaster, and the ship's captain is accused of manslaughter and abandoning the ship.

The ship was insured in the protection and indemnity and international insurance and reinsurance markets.

The latest estimates suggest the cost of the disaster to insurers will exceed \$1 billion, making it to the most expensive marine loss of all time. The most expensive insured marine loss before the Costa Concordia sank was the Exxon Valdez in 1989, which cost insurers about \$500 million.

Shortly after the sinking, all fuel was removed from the ship to reduce the threat of pollution. Italian authorities later announced that the ship must be removed intact rather than broken up before removal to avoid environmental damage, as would be typical for a ship of such size, experts said.

According to a recent Lloyd's of London report, the Costa Concordia salvage operation is "likely to be the most complex and expensive wreck removal operation of its kind."

While there have been accidents involving ships of a similar size before, this is the first time that such a large ship is to be refloated rather than broken up, and this is pushing up the cost to insurers, said Capt. Rahul Khanna, a marine risk consultant at Allianz Global Corporate & Specialty in London, a unit of Allianz S.E.

"The engineering of the removal of this wreck is unique," Capt. Khanna said. "It's unprecedented."

According to Lloyd's report "The Challenges and Implications of Removing Shipwrecks in the 21st Century," the Costa Concordia demonstrates several key factors that can influence the cost of wreck removal, namely "a mas-



AP PHOTO

Italian authorities say the Costa Concordia must be righted and removed intact to reduce the threat of pollution. This process, called parbuckling, plus ongoing salvage work is estimated to cost insurers more than \$1 billion.

sive vessel wrecked at a difficult location, rocky ground above deeper water, combined with environmental concerns leading the authorities to require a complex,

heavily engineered solution."

In early August, Munich Reinsurance Co. increased its estimate of its share of insured losses from the disaster to €100 million from

€80 million (\$132.8 million from \$106.3 million) and said the industry-wide loss likely would top \$1 billion.

And in late July, Lancashire Holdings Ltd. increased its estimated loss to \$58.7 million, \$24.6 million more than its previous estimate. The company said the increase was due in large part to a \$20 million payout on an industry loss warranty related to the disaster.

Lancashire CEO Richard Brindle expressed disappointment in higher loss estimate and said the company would "monitor the situation closely."

At least 10 insurers underwrote the ship.

Several insurers and reinsurers are annoyed about the extra cost involved and think that the typical process of breaking up the ship would have been quicker, less costly and not harmful to the environment, since the fuel had been removed, one London market source said.

The more complex wreck removal process has resulted in delays, and "delays will mean more cost," one underwriting

## PARBUCKLING TECHNIQUE'S BIGGEST TEST

The Costa Concordia is being raised using a technique, known as parbuckling, never before used on a ship of this size.

The technique, according to the project's website, involves stabilizing the ship; preparing a false bottom under the ship; and fixing watertight boxes — or caissons — to the side of the ship that is above water. Then, undersea platforms are built on which the ship will rest after rotation.

Rotating or "parbuckling" the ship may take days and is a delicate task. Cranes will be used to pull the ship upright, helped by the caissons that will be filled with water. Once the ship is upright, caissons will be fitted to the other side to help stabilize it.

A pneumatic system then will push the ship upwards, the caissons will be emptied and the ship refloated and towed to a port.

The operation to remove the Costa Concordia was 73% complete at the beginning of August, according to the project's website.

By Sarah Veysey

## COSTA CONCORDIA CONVICTIONS

- Five people were convicted and sentenced to jail in July for their role in the disaster.
- The cruise company's emergency manager and the Costa Concordia's hotel manager were found guilty of multiple manslaughter counts and causing personal injury.
- The ship's first mate, third mate and helmsman were convicted of causing a shipwreck or maritime disaster.
- The ship's captain, Francesco Schettino (right), is being tried separately for multiple manslaughter counts and for abandoning the ship. He is seeking a plea bargain, pleading guilty in exchange for a sentence of three years and five months. The next hearing in his case is slated for Sept. 23.



AP PHOTO

# HUB

Continued from page 3

Alliant Insurance Services Inc., the 10th- and 12th-largest brokers of U.S. business, respectively, changing private-equity owners.

With the top 10 brokers in the *Business Insurance* rankings dominated by public companies, Thomas Doran, Atlanta-based principal at Reagan Consulting Inc., said the recent deals are likely to be the largest involving brokerages for the foreseeable future.

"If you look at who would be acquirable, you can pretty much check everybody larger off the list," Mr. Doran said. "There are just not a lot of billion-dollar-revenue operations to buy."

Timothy J. Cunningham, managing director



Hub Chairman and CEO Martin Hughes said the company will leverage the capital provided by its new owners to continue its growth.

of Chicago-based investment banking and consulting firm Optis Partners L.L.C., said the deals are part of the "natural progression" of private-equity ownership of brokerages.

After a wave of leveraged buyouts of insurance brokerages in 2007, private-equity owners need to sell or refinance as the bank loans come due, Mr. Cunningham said.

John Wicher, principal at John Wicher & Associates Inc. in San Francisco, said private-equity owners generally hold on to purchases for five to seven years, irrespective of industry. "Hub, USI and Alliant all chose not to do an IPO," he said. "What that says is that you still have a situation where brokerages believe a higher valuation can be realized in a private transaction."

Despite its predictability, Messrs. Cunningham and Doran agreed that the deal is noteworthy for the amount Hellman &

Friedman paid to acquire Hub from its previous owner, London-based private-equity firm Apax Partners L.L.P. Hellman & Friedman's purchase price is about 3.7 times the \$1.2 billion in overall revenue Hub is estimated to earn in 2013.

"It's a big deal and something that went out at a big multiple," Mr. Cunningham said. "It validates where the pricing is going, because you now have an affirmation that things are going at a premium price."

Mr. Doran said the deal highlights the competition between private-equity firms to acquire large brokers in general and the quality of Hub's underlying economics in particular.

"It speaks volumes to the quality of Hub's operation," Mr. Doran said. "It's not an organization that is going to require a strategic turnaround to fix."

The turnkey nature of brokerage operations from an acquirer's standpoint is seen as keeping the deal wheel turning, even if the deals are smaller, experts say.

From the seller's standpoint, private-equity deals afford brokerages the capital to grow without the added overhead and regulatory scrutiny experienced by public companies, Mr. Wicher said.

For its part, Hub said it will continue to grow through acquisitions, having completed more than 300 buys since its inception in 1998. Just three days prior to announcing that it was being acquired, Hub said it had acquired the assets of Bellingham, Wash.-based The Unity Group Inc. and La Palma, Calif.-based Vicencia & Buckley Insurance Services Inc. for undisclosed sums.

Hub Chairman and CEO Martin Hughes said the company will leverage the capital provided by its new owners, who bought a majority stake in Hub, to continue to grow.

"Partnering with Hellman & Friedman will enable us to build upon our current strategy of enhancing our product and service capabilities and expanding our geographic footprint," Mr. Hughes said in a statement.

# SURGE

Continued from page 1

This tally was no doubt on the mind of insurance underwriters when time came for the transportation authority to renew its property insurance program in the spring.

“Our program expired on May 1 and it was a difficult renewal for us,” MTA Director of Risk and Insurance Management Laureen Coyne said. “We saw contraction in the market and pricing increases, and we were not able to get the same traditional reinsurance that we had.”

This realization forced the MTA’s risk management team to take a look at the catastrophe bond market, Ms. Coyne said. “After Sandy, we realized that we needed another option” for coverage against natural disasters, she said.

The result was a first-of-its kind catastrophe bond, MetroCat Re Ltd., which will benefit the MTA’s captive insurance company, First Mutual Transportation Assurance Co., and deal solely with storm surge and rely on measurements from a collection of tidal gauges surrounding New York City to trigger. The three-year bond was created with the help of New York-based GC Securities, a division of MMC Securities Corp., as well as Newark, Calif.-based catastrophe

risk modeling firm Risk Management Solutions Inc. and St. Petersburg, Fla.-based financial advisory firm Raymond James & Associates Inc.

The novelty of the bond structure, as well as the need to secure the requisite number of investors in the tight time frame between renewal season and the onset of the Atlantic hurricane season in the summer, proved a challenge, MTA Senior Manager of Strategic Initiatives Nora Ostrovskaya said.

“The traditional insurance process is a very well-known process, even if we don’t know exactly what our broker will come back with,” Ms. Ostrovskaya said. “With catastrophe bonds, it was an entirely new process for us, starting with the selection of the firms to advise us.”

Ms. Ostrovskaya said the transparency provided by parametric triggers in the bond, which are based on data received from existing tidal gauges, are run by the United States Geological Survey and the National Oceanic and Atmospheric Administration. They helped assuage fears when the MTA presented the bonds to potential investors.

“This is the first solely storm surge-based parametric transaction in the market,” she said. “So we wanted to make sure the investors knew that the triggers were transparent and not subject to our control.”



AP PHOTO

Water reached the street level of the Battery Park underpass after Superstorm Sandy hit New York last October.

Duncan Ellis, New York-based U.S. property practice leader at Marsh Inc., the MTA’s insurance broker, said the certitude surrounding the triggering of the bonds was attractive to investor and sponsor alike.

“The nice thing about these bonds is that they are either triggered or not triggered,” he said. “You don’t have the grey areas around as you would have around a traditional insurance policy, about whether the damage was caused by wind, flood or surge.”

Indeed, the bonds do not address many of the more contentious issues found in a traditional property policy such as proximate cause of loss, contingent business

interruption and ingress and egress issues, Mr. Ellis said.

This relative simplicity and increased demand for catastrophe bonds from investors leads some to think they will play an increasingly important part in primary insurance programs for large public entities in addition to their traditional role in the reinsurance market.

“We have already been seeing, with regards to reinsurance and retrocession, the use of alternative capacity has continued to grow,” said Cory Anger, global head of ILS structuring at GC Securities. “This transaction demonstrates that it can apply to the insurance market and is a tool for corpora-

tions and governments institutions to hedge their risk.”

William Dubinsky, New York-based head of insurance-linked securities at Willis Capital Markets & Advisory, said that insureds accessing the capital markets directly for coverage is relatively rare.

He called it “the exception rather than the rule.”

Mr. Dubinsky said that the transactional costs for catastrophe bonds have come down, but said that directly accessing the capital markets for insurance coverage makes sense only for the largest or hardest-to-place risks.

For example, he said in a traditional insurance arrangement, the prices you would pay for \$2 billion in limits are proportionately more than what you would pay for \$250 million in limits, if the primary coverage was available at all.

“As the economics of (catastrophe bonds) improve and the cost of doing the deals and the bond spreads come down, those things become more achievable,” he said.

Ms. Ostrovskaya said catastrophe bonds likely will figure in the mix of risk-shifting techniques the MTA uses in the future.

“Cat bonds are a tool,” she said. “We do not feel obligated to use them. But as we move forward, if we find an appropriate use for this tool to replace traditional insurance, we have that option.”

# CAPTIVES

Continued from page 3

involve genuine insurance, captive experts say.

But some “minicaptive” or “microcaptive” formations under Section 831(b) of the Internal Revenue Code lack a genuine insurance purpose and instead provide tax shelters for their owners, experts say. IRS scrutiny drawn by improper use of captives threatens to cast a bad light on the entire captive industry, many fear.

“Supposedly, the word is out of the general counsel’s office that the IRS in the last year or so has taken an increased interest in captives,” said Jay Adkisson, a partner at Riser Adkisson L.L.P. in Newport Beach, Calif., and chairman of the American Bar Association’s committee on captive insurance. “There are more cases against captives than ever before.”

Some people “have their own motivations for getting clients into captives that don’t necessarily involve risk management,” Mr. Adkisson said. “Let’s just call them what they are: They’re tax shelters.”

“If the IRS wanted to make a lot of money, they could go out and audit every one of the 831(b) captives that’s doing terrorism coverage,” he said. Terrorism coverage “tends to be a hallmark of the tax shelter captives. They’re coming up with these ter-

rorism covers and the pricing bears utterly no relationship to any kind of reality.”

Under Section 831(b), property/casualty captives earning less than \$1.2 million in annual premium may elect to pay U.S. taxes only on their investment income.

The provision, part of the Tax Reform Act of 1986, was meant to encourage formation of insurance companies and simplify business for small companies. The rapid growth of small captives taking advantage of the 831(b) election has driven similar rapid growth of several newer captive domiciles such as Utah, Montana and Kentucky as it has added to many captive managers’ rosters of captive clients.

The 831(b) election “has its purpose,” said Thomas P. Stokes, U.S. consulting practice leader at JLT Towner Group L.L.C. in New York. “It also has the potential for abuse.”

Les Boughner, executive vice president and managing director of Willis Group Holdings P.L.C.’s North American captive and consulting practice in Burlington, Vt., said after initially rejecting 831(b) captive proposals, the company has rethought its position on the small captives, recognizing that there are 831(b) eligible captives with legitimate insurance business plans.

“We’ve actually done a 180-degree turn on these,” Mr. Boughner said. “Now we’re putting them together because we realize they’re small captives that have good business plans.”

“It’s a really good thing for the captive industry because it’s suddenly broadened

the market for us,” Mr. Boughner said. “That doesn’t change the fact that they have to be done correctly.”

He said he’s seen no evidence of increased IRS interest in the microcaptives among Willis clients, though “one of the other managers had a number of IRS audits. What they were interested in were 831(b) captives.”

Brady Young, president and CEO of Strategic Risk Solutions Inc. in Concord, Mass., said, given the number of 831(b) captive formations, it’s probably natural that they would draw IRS attention. “I just think there are some aggressive captive promoters out there and some aggressive structures that some people have used that have caught the eye of the IRS and they’re going after those,” he said.

Several experts cite the “Salty Brine” case in which two Texans involved in an elaborate arrangement of corporations and partnerships — including 831(b) captives — sought unsuccessfully in U.S. District Court for the Northern District of Texas to overturn penalties the IRS levied against them for what the federal agency said was an improper effort to avoid taxes.

“Salty Brine, the judge thought it was just a complete sham,” said Charles J. Lavelle, a partner at Bingham Greenebaum Doll L.L.P. in Louisville, Ky. “He said this wasn’t even a captive.”

Mr. Lavelle agreed that the IRS appears to be scrutinizing captives more closely, but said that attention is aimed at large captives as well as smaller ones. “There’s a lot more activity of IRS audits of captive companies, but that includes public companies as well as closely held. I think the IRS is just more active in the captive area now than they have been in the past,” he said.

It’s possible the IRS is looking to the courts to “fill in the gaps” between previous rulings

establishing what captive insurance activities are sufficient to merit favorable tax treatment, Mr. Lavelle said.

According to Mr. Adkisson, the IRS position on captives may become clearer in September at a meeting of the ABA’s Section of Taxation in San Francisco at which John Glover, senior counsel in the office of the associate chief counsel, financial institutions and products of the IRS, is scheduled to participate in a panel on captive insurance.

Thomas M. Jones, a partner at McDermott Will & Emery L.L.P. in Chicago, said the increased focus from the IRS on captives isn’t a recent phenomenon.

“For the last two-and-a-half or three years, the IRS has certainly been more aware of captives and therefore more likely to do a tax audit,” Mr. Jones said.

He cited two recent cases, one brought against the government by Rent-A-Center Inc. that was heard in 2011 and another in which he was involved in recent weeks involving Securitas Holdings Inc.

“Both of the cases involve trying to further define the meaning of risk distribution,” Mr. Jones said.

“I think both the IRS and the taxpayers want a clearer definition,” he said. “It’s not like the IRS is doing the audits to define the term. The IRS is doing audits to raise revenue.”

While saying he has no first-hand knowledge of increased IRS scrutiny of captives, David F. Provost, deputy commissioner of the Captive Insurance Division in the Vermont Department of Financial Regulation, said IRS actions against captives can cast the entire captive industry in an unwanted light.

“Anytime you have a captive tax case, that just sort of perpetrates the idea that captives are just a tax dodge,” he said. “It kind of perpetuates the myth around captives.”



## HEAR INTERVIEW

Access the *Business Insurance* interactive digital edition to hear Jay Adkisson, founding partner of Riser Adkisson L.L.P., talk about IRS scrutiny of certain captive insurance arrangements and what might be prompting it.

# RETIREEES

Continued from page 1

run by states and others, in states that declined to set them up, will be run by the federal government.

The exchanges will be available starting next year, with the federal government subsidizing premiums of low- and middle-income uninsured U.S. residents with incomes between 100% and 400% of the federal poverty level. For example, this year 100% of the federal poverty level for a family of two is \$15,510, while 400% of the federal poverty level for a family of the same size is \$62,040.

While not as well-known — but clearly intended by legislators when they drafted the health care reform law — is that the exchanges and the premium subsidies also would be available to retirees younger than 65, even if they have access to coverage offered by their former employers.

In fact, the law authorized \$5 billion to partially reimburse early retiree health care plan sponsors for claims incurred through the end of 2013.

The chief purpose of the Early Retiree Reinsurance Program was to encourage employers to continue offering coverage until the

exchanges are launched, said Rich Stover, a principal at Buck Consultants L.L.C. in Secaucus, N.J.

“The extension of exchange coverage to early retirees was one of the things envisioned by the health care reform law,” said Steve Wojick, vice president of public policy at the National Business Group on Health in Washington.

Such a move could be financially advantageous for employers, depending on whether they subsidized such coverage, as well as the pre-Medicare-eligible retirees. It also would remove from employers the administrative burden of offering the coverage.

“This could be a win-win for employers and retirees,” said John Grosso, a senior vice president with Aon Hewitt in Norwalk, Conn.

Take the case of a retiree with an annual household income of \$22,980, or 200% of the federal poverty level of \$11,490 for a one-person household. That individual could be required to pay no more than 6.3% of his or her income, or \$121 a month, for the second-lowest cost “silver” health plan offered through an exchange, according to an analysis by consultant Mercer L.L.C.

By contrast, that retiree could pay far more in premiums for coverage from a former employer.

For example, according to a Mer-

cer survey, 39% of large employers — those with at least 500 employees — that extend such coverage require the pre-Medicare-eligible retirees to pay the full premium for individual coverage. When the cost of the premium is shared, retirees pay an average of 37% of the plan premium, according to Mercer.

Given the availability of the federal subsidies, “I would not be surprised if many retirees saw their premiums decline” by getting coverage through an insurance exchange instead of their former employers, said Gretchen Young, senior vice president of health care policy with the ERISA Industry Committee in Washington.

Despite the apparent financial advantages, employers aren’t rushing to terminate their early retiree health care plans, which would force retirees to seek coverage through the exchanges.

“It is definitely on employers’ radar screen,” but for 2015 and beyond, said Derek Guyton, a Mercer partner in Chicago.

In part, that delay is due to the fact that final information is not available on the number of plans and premiums insurers will charge through all the exchanges.

Another uncertainty is how much exchange insurers will boost rates over the next several years. A factor holding down rates — \$25

billion in federal subsidies to partially reimburse insurers for covering high-cost individuals — ends in 2016.

“It isn’t known what will happen to rates over time,” Mr. Guyton said.

Rather than terminating coverage, employers could give pre-Medicare-eligible retirees a choice of staying in the employer-provided health plan or moving to an exchange.

Still, there are risks to that approach, benefits consultants say.

The main concern is adverse risk selection, with retirees in good health opting for low-cost and less-generous exchange plans, while retirees in poor health staying with coverage offered by their former employers.

Whether an employer thinks it would retain retirees who are “less healthy” would be a consideration in deciding if it would keep its plans, Mr. Guyton said.

Yet another issue employers would have to resolve is whether their benefit plan documents make it clear they have the right to make such a change, such as for union employees covered by a collective bargaining agreement.

“The devil will be in the details,” said Andy Anderson, a partner with Morgan, Lewis & Bockius L.L.P. in Chicago.

## EARLY RETIREE HEALTH COVERAGE

# 24%

Employers that offered health insurance to pre-Medicare-eligible retirees in 2012, down from 46% in 1993\* \*\*

# \$11,961

Average cost of coverage in 2012 for pre-Medicare-eligible retirees\*\*

# 49%

Employers that shared the cost of such retirees’ health coverage. Only 12% of employers paid the entire cost.

\*First year of survey.

\*\* For employers with at least 500 employees.

Source: Mercer L.L.C.

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## Fed's Bernanke should testify in AIG bailout lawsuit: Judge

■ Federal Reserve Chairman Ben Bernanke should testify in the lawsuit by American International Group Inc.'s former chief Maurice R. Greenberg against the United States over the insurer's 2008 bailout, a judge ruled. Judge Thomas Wheeler of the U.S. Court of Federal Claims rejected the government's effort to keep Mr. Bernanke from being deposed, saying the Fed chairman was a "central figure" in the decision to bail out AIG. Mr. Greenberg's Starr International Co., which once had a 12% stake in AIG, is suing over the government's taking of a 79.9% stake in the insurer in September 2008 and a separate 1-for-20 reverse stock split in June 2009.

Reuters

## Commercial P/C rates up 4% in July: MarketScout

■ Commercial property/casualty insurance rates increased an average of 4% in July over those of July 2012, MarketScout said. The 4% average increase for July came after four consecutive months of year-over-year increases of 5%. Commercial auto, commercial property, general liability and workers compensation all experienced the greatest average increase at 5%. Business interruption, crime and surety reported the smallest increase at 2% for July. Contracting, service and transportation accounts experienced the greatest increase among classes of business at 5%, while public entity accounts experienced the smallest increase.

## BP ordered to pay \$130 million in fees to Gulf claims program

■ BP P.L.C. must pay \$130 million to a court-appointed administrator overseeing payments to thousands of people who claimed they were hurt by the 2010 Gulf of Mexico oil spill, a federal judge ruled in a fresh legal setback for the oil company. BP had balked at funding the third-quarter operating budget for the administrator, Louisiana lawyer Patrick Juneau, complaining that his bill contained "excessive costs." But U.S. Magistrate Judge Sally Shushan in New Orleans ruled that it was "unreasonable" for BP to halt funding. Fees have topped \$560 million since Mr. Juneau's team started work in June 2012, shortly after BP reached an agreement with businesses and residents to compensate them for spill-related injuries. The fees amount to about 18 cents for each of the \$3.1 billion paid out so far, data from the claims administrator and the settlement show. BP's finance director projected last week that the fees could eventually top \$1.5 billion.

Reuters

## Delay in employer mandate means 1 million fewer covered in 2014

■ Delaying a key health care reform law provision until 2015 requiring many employers to offer health insurance or pay a fine will result in about 1 million fewer people with employment-based coverage next year and cost the government billions of dollars in lost revenue, according to a Congressional Budget Office report. The CBO report is the first to analyze the effect of the Treasury Department's surprise July 2 announcement to delay the employer mandate, which regulators said is necessary

to simplify how employers are to report to the government enrollment in their health care plans. As a result of the delay, about 156 million people next year will have employment-based coverage, or 1 million less than the CBO projected in May prior to the Treasury Department's decision.

## NOAA predicts above-average Atlantic hurricane season

■ This year's Atlantic hurricane season is "shaping up to be above normal with the possibility that it could be very active," according to an analysis by the National Oceanic and Atmospheric Administration. In its update of estimated hurricane activity, NOAA said that this year's season already has produced four named storms. The peak of the season doesn't occur until mid-August through October. In the report, NOAA said there is a 70% chance that 13 to 19 named storms — with top winds of 39 mph or higher — will occur this season.

## Large employers' pension plan funding strong in July

■ The funded status of pension plans sponsored by large U.S. employers rose slightly in July, climbing on strong returns in the equities markets to reach its highest point in nearly five years, according to Mercer L.L.C. On average, pension plans sponsored by companies in the S&P 1500 were 89% funded as of July 31, up from 88% at the end of June and 74% at the end of 2012. Meanwhile, Milliman Inc. said funding levels of pension plans sponsored by large publicly held U.S. employers hit nearly 90% in July. Defined benefit plans offered by the 100 U.S. employers with the largest pension programs were an average of 89.7% funded as of July 31, up from 88.2% at the end of June and 86% as of May 31.

## Workers comp rate changes proposed in Ill. and Calif.

■ The National Council on Compensation Insurance Inc. is seeking to decrease Illinois workers compensation rates by 4.5% for policies incepting on Jan. 1, 2014, the Illinois Workers' Compensation Commission announced. But in Illinois, insurers setting their prices are free to decide whether to adhere to such rate changes, which the state describes as "voluntary advisory insurance rates." The new rate filing follows a recommended 3.8% decrease in Illinois for 2013. Meanwhile, California's Workers Compensation Insurance Rating Bureau proposed a 3.4% increase in advisory pure premium workers compensation rates for 2014. In a statement, the agency said it will seek an advisory rate of \$2.62 per \$100 of payroll as of Jan. 1, 2014.

## AMA obesity classification could spike workers comp costs

■ A recent American Medical Association classification of obesity as a disease may significantly increase workers compensation claims costs, research released by the California Workers' Compensation Institute said. Workers comp claimant obesity historically has been viewed as a co-morbidity issue that is largely unreported and often has not required medical attention before treatment of most work-related injuries and illnesses, according to the CWCI report. Medical providers typically document only the medical issues they intend to treat and

for which they plan to seek reimbursement, the CWCI said.

## Employers plan changes in retiree health care offerings: Survey

■ More than 40% of employers offering health care coverage to Medicare-eligible retirees have decided to change how they provide coverage, according to an Aon Hewitt survey. The most popular approach, planned by 32% of employers, is one in which employers will direct retirees to the individual market. In many cases, employers will partially subsidize coverage by making a fixed contribution, which a retiree could use to help pay premiums, such as for coverage offered through a private insurance exchange. In addition, 6% of employers said they plan to terminate prescription drug coverage, while 3% said they will terminate drug coverage but pay part of the premium for policies that retirees purchase from insurers.

## White House launches website for employers on health reform

■ The Obama administration launched a new "one-stop" website to provide to employers of all sizes educational material on the health care reform law. Among other things, the *Business USA.gov/healthcare* website explains how key provisions of the Patient Protection and Affordable Care Act will work and affect employers.

## Ore. work comp self-insurance trust must increase security deposit

■ Oregon's largest workers compensation self-insurance trust, with about 200 employer members, must increase its security deposit by Aug. 7 or face decertification, potentially leaving its members liable for existing claims. Oregon's Department of Consumer and Business Services warned in a letter mailed to members and former members of the Oregon Employers Trust Inc. that the trust's state-required security deposit must increase from \$3.2 million to \$3.95 million by Aug. 7 or the employers will have to purchase workers comp insurance effective Aug. 8. So far the trust has not been able to meet the requirement, according to the state, which has begun preliminary measures to decertify.

## Noted

**American International Group Inc.** reported second-quarter net income of \$2.73 billion, a 17.1% increase over the same period last year. The property/casualty insurer said net written premiums rose 1.8% to \$9.26 billion in the quarter, while its combined ratio was essentially flat at 102.6% compared with 102.4% in the second quarter of 2012. However, on a first-half basis, AIG's net income dropped 10.9% to \$4.93 billion as net written premiums fell 1.2% to \$17.7 billion. ... **Berkshire Hathaway Inc.**'s insurance operations' net underwriting gains shrank 14.4% during the second quarter to \$530 million, the conglomerate reported. Net income for Berkshire, however, surged 46.1% in the second quarter to \$4.54 billion, driven largely by favorable investment results. ... **A.M. Best Co. Inc.** has placed the A- (excellent) financial strength rating of **SAC Re Ltd.**, whose investment manager is SAC Capital Advisors, under review with negative implications after SAC Capital was indicted on insider trading charges. Best also placed SAC Re's "a-" issuer credit rating under review with negative implications.

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# MEADOWBROOK

Continued from page 1

for stand-alone excess workers comp insurance are further narrowed because the underwriters that provide it have differing appetites for the business classes they accept, sources said.

Additional insurers provide excess workers comp coverage, but typically only for national customers buying their other products.

Mr. Niedringhaus, who tracks excess work comp insurer premium volume, estimates that Meadowbrook writes about 10% of the stand-alone coverage purchased by most self-insured employers. That amount totaled about \$68 million in 2011 premiums.

A.M. Best's financial strength downgrade of Meadowbrook this month from A- (excellent) to B++ (stable) has caused Torrance, Calif.-based broker Keenan & Associates to closely monitor Meadowbrook's excess workers comp underwriter, Star Insurance Co., while simultaneously presenting alternative insurer quotes to clients now insured by Star, said Bill Poland, director of marketing for Keenan's property and casualty practice.

"Anytime a carrier that is on our risks drops below an A rating, ... we immediately react on behalf of the customer, take a deep breath and then figure out a strategic plan of how to work with the situation," Mr. Poland said.

Because self-insured employers typically purchase excess coverage with \$500,000 or \$1 million attachment points, the urgency to move will not be as great as if the coverage were first-dollar, he said. Meadowbrook, meanwhile, hopes established relations with its distributors and policyholders, along with a new arrangement allowing it to use A-rated policies provided by a fronting insurer, will limit any loss of business, said Robert S. Cubbin, Meadowbrook's CEO.

"We like the excess comp business and we intend to stay in it," Mr. Cubbin said.

Stand-alone excess workers comp is among several insurance lines Meadowbrook business units provide. Its six insurer units also underwrite program business and specialty excess and surplus lines coverage.

Other excess workers comp underwriters say a few brokers have asked whether they might provide acceptable terms for certain Meadowbrook customers.

Charles Caldwell, CEO of Midlands Management Corp., an Oklahoma City-based managing general agent that underwrites excess workers comp coverage, said he expects more inquiries and market

*"Anytime a carrier that is on our risks drops below an A rating, ... we immediately react on behalf of the customer, take a deep breath and then figure out a strategic plan of how to work with the situation."*

Bill Poland, Keenan & Associates

movement when current policies expire.

"I am not sure anyone is going to want to move midterm," Mr. Caldwell said. But "at renewal, there will be significant movement."

Safety National Casualty Corp., a Meadowbrook excess workers comp competitor, also has heard from a few brokers inquiring whether it will "accept submissions on certain classes of business and how close we can get to certain terms," said Steve Luebbert, executive vice president for the St. Louis-based underwriter.

Meadowbrook's Mr. Cubbin said he, too, expects to see some of his competitors' business at renewal time.

After the A.M. Best downgrade,

Meadowbrook reached an agreement with Bedford, Texas-based State National Insurance Co., allowing Meadowbrook to write policies using State National's A (excellent) financial strength rating.

Meadowbrook will reinsure those policies so that State National will not assume any of the risk, Mr. Cubbin said. That will provide A-rated paper for certain clients, such as those working under government contracts requiring it.

State National specializes in providing collateral protection insurance, a form of coverage that typically protects property, such as cars, held as collateral by financial institutions. Providing fronting arrangements also is a part of its business, Mr. Cubbin said.

A.M. Best's Meadowbrook downgrade came after the company's second-quarter earnings report was released July 30.

The insurer said it was hurt by a recent, unexpected adverse arbitration outcome concerning ceded losses, storm losses and some Southern California workers comp claims now in runoff after Meadowbrook discontinued writing that block of business in mid-2012.

"In hindsight, we needed to increase prices more than we did in 2009, '10 and '11 in order to achieve an underwriting profit," Mr. Cubbin told securities analysts during a July 31 earnings call.

Meadowbrook began obtaining rate increases in 2010, and 2013 rate increases are averaging 11% across all lines, Mr. Cubbin said in an interview.

"Our core, ongoing business is performing pretty well in a rising premium rate environment," Mr. Cubbin said. Meadowbrook also terminated about \$180 million in various lines of underperforming business during 2012.

"So we have been able to get out of the businesses that were hurting us," Mr. Cubbin said.

"On a go-forward basis, we are showing evidence of a return to profitability. It's just a question of a few more quarters to prove that out."

## Excess comp is tough for buyers and insurers

Excess workers comp insurance is a challenging line to underwrite because it guarantees the payment of catastrophic worker claims that can remain open for decades.

But it's precisely for that reason that self-insured employers want to purchase the excess coverage from an insurer that will be around for decades to come, experts say. It's also why few underwriters offer the insurance as a stand-alone product.

The line's challenges were underscored when American International Group Inc. disclosed in a 2012 Securities and Exchange Commission filing that it had ceased writing stand-alone excess workers comp cover because of its extremely long tail and risks that make it "one of the most challenging classes of business to reserve for."

Issues that escalate costs — such as obesity,

opioid pain medication usage and Medicare set-aside requirements — have pushed excess workers comp underwriters to raise their prices and demand that clients assume greater retentions.

With the recent word that Meadowbrook Insurance Group Inc. has lost its A- rating, "it just further elevates the need (for excess workers comp insurers) to get rates and retentions so they are around when they have to pay the bills on these cat losses," said Duke Niedringhaus, an excess workers comp specialist and vice president at broker J.W. Terrill Inc. in Chesterfield, Mo.

Mr. Niedringhaus said he is pulling for Meadowbrook's long-term success.

"Hopefully, they get their A rating back and get it behind them," Mr. Niedringhaus said.

By Roberto Cenicerros

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## Marvel avenges alleged breach

**T**o some people, a Captain America charm bracelet may be only cheap jewelry, but to comic book publisher Marvel, it's a valuable commodity.

That's apparently the rationale behind recent litigation filed by Manhattan Beach, Calif.-based Marvel Characters B.V. in federal district court in New York against Burbank, Calif.-based JewelM Inc.

Marvel said in its lawsuit that JewelM violated a merchandise licensing agreement between the two stating that within 30 days prior to its expiration in March, it would provide Marvel with a full written statement of any then-existing unsold inventory of licensed products. Instead, the lawsuit says JewelM sold more than 50,000 licensed articles to an affiliate.

Charges against JewelM include breach of contract, copyright infringement and trademark infringement. The jewelry's value is estimated at \$73,691.55.



## No workers comp for falling down drunk

**A**n Oregon longshoreman who drunkenly took a six-foot tumble while urinating from one of his employer's docks cannot receive workers compensation benefits for his fall, a federal court has ruled.

Gary Schwirse worked for Marine Terminals Corp. in Portland, Ore., according to an opinion issued late last month by the U.S. 9th Circuit Court of Appeals.

In 2006, Mr. Schwirse drank two beers before showing up for work one day, drank up to eight more beers by lunch, and drank more than half a pint of whiskey through the end of his shift at 4 p.m. At about 4:30 p.m. that day, Mr. Schwirse decided to urinate from a Marine Terminals dock, where he fell over a rail and landed on concrete six feet below, court records show. He was diagnosed with a severe scalp laceration, as well as a blood alcohol-content level of .25 and evidence of marijuana ingestion.

Mr. Schwirse sought workers comp benefits under the federal Longshore and Harbor Workers' Compensation Act, saying he thought he tripped over a bright orange warning cone prior to his fall, records show. He was denied benefits by an administrative law judge and the Oregon Benefits Review Board. He appealed to the 9th Circuit, which upheld the prior rulings.

## INSURER WATCHING FOR RULING IN BULLOCK DISPUTE



S\_BUKLEY/SHUTTERSTOCK.COM

Actress Sandra Bullock has sued an Italian watchmaker for marketing a watch using her name without her permission.

**A** watch worn by Hollywood star Sandra Bullock in her Oscar-winning role in "The Blind Side" is at the center of an insurance dispute. According to website TMZ, Ms. Bullock is suing a watchmaker that she claims used her image in advertising without her permission.

And the watchmaker reportedly has an insurance policy that may pay out if it loses in court.

In her role as Leigh Anne Tuohy in the 2009 film, Ms. Bullock wore a white ToyWatch watch.

The watch subsequently was marketed online as "the Sandra Bullock watch."

Ms. Bullock last year sued Italy-based ToyWatch for using her name and image in its advertisements.

But in June, TMZ reported, the watchmaker's insurers filed legal documents asking a judge to decide whether it must pay out of Ms. Bullock wins the case.

Only time will tell which side wins.

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

## Drunk trash man gets job back in Portugal

**D**on't be surprised if U.S.-based waste management firms see a spike in worker requests to transfer to Portugal in the wake of a court ruling in favor of a garbage collector fired for working while drunk.

A Portuguese waste management firm must rehire a garbage collector it fired in 2012 after he and a co-worker were found drunk at the scene of a wreck involving their garbage truck and another vehicle, according to a unanimous ruling last month by a three-judge panel of the Portuguese Court of Appeals in Porto.

Both workers were given breathalyzer tests at a nearby hospital, where they were treated for minor injuries. The tests revealed both men had blood alcohol content levels above 0.20, four times the legal driving limit in Portugal. The company fired the driver and co-worker for drinking while working and endangering the public's health, hygiene and safety.

While the truck driver did not contest his firing, the co-worker sued for wrongful termination, arguing that the company had no right to use the breathalyzer test as evidence against him, and that it never established a written policy regarding drinking alcohol during work hours.

On July 10, the appeals court upheld a lower court's ruling that the breathalyzer was inadmissible as evidence because it was obtained from the hospital without his permission.

## Ben & Jerry's draws line on porn

**B**en & Jerry's Homemade Inc. may be famous for its cheeky ice cream flavor names — "Karamel Sutra" springs to mind — but the company has drawn the

line at having its products adapted by the adult entertainment industry.



SPIRIT OF AMERICA/SHUTTERSTOCK

A federal judge has barred Rodax Distributors Inc., a Los Angeles-

based pornography studio doing business as Caballero Video, from releasing a series of X-rated DVDs with titles and packaging based on the Burlington, Vt.-based ice cream makers' registered trademarks, according to court documents.

In a consent judgment filed late last month in U.S. District Court for the Southern District of New York, Judge Lewis Kaplan prohibited Rodax Distributors from manufacturing or selling any products that copy or imitate any of Ben & Jerry's trademarked labels and packaging, including signature elements such as its stylized fonts and clouded backdrop.

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