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Business Insurance

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In Brief

Ted Devine leaving Aon Risk Services

Aon Risk Services President Ted T. Devine is leaving to launch a charitable organization. Mr. Devine, who joined Aon Corp. in 2005 as chief operating officer of Aon Risk Services Americas and head of global strategy, was named president of Aon Risk Services, Aon's large-account operation, in 2008. He will not be replaced, Aon said in a statement, noting that Chairman and Chief Executive Officer Steve McGill and Chief Operating Officer Mike O'Connor will continue to lead the operation. Mr. Devine is launching 1World Sports, a nonprofit entity dedicated to encouraging children worldwide to participate in sports.

Ohio attorney general sues rating agencies

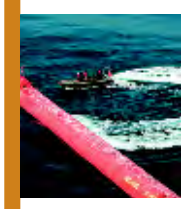
Ohio Attorney General Richard Cordray has sued three national

See **IN BRIEF** page 25

SPOTLIGHT

ENERGY, CLIMATE CHANGE & ENVIRONMENTAL RISKS

Capacity for renewable energy exposures increases as insurers grow more comfortable with risks; executives in the hot seat with global warming suits; greenhouse gas emitters battle public nuisance lawsuits; legal expert urges commercial policyholders to avoid coverage clause. **PAGE 11**



HEALTH CARE REFORM

Senate test looms for health reform

Employers see bill as less threatening than House plan

By JERRY GEISEL

WASHINGTON—Sweeping health care reform legislation is awaiting its toughest test: approval by the U.S. Senate.

Senate Majority Leader Harry Reid, D-Nev., last week completed melding different reform bills passed earlier by the Finance and Health, Education and Labor and Pensions Committee into one measure, moving that test one step closer.

"We have traveled really a long ways to where we are and tonight begins the last leg of this journey that we been on now for some time," Sen. Reid said at a news conference last week when he unveiled the measure.

While the Senate was expected to vote during the weekend whether to begin consideration of the legislation, there was uncertainty late last week whether Sen. Reid had the 60 votes needed to start the debate.

NYT PHOTOS

Sen. Reid

Should he fall short of 60 votes, observers said Sen. Reid likely would make changes to expand support and then bring the measure for a vote on whether to proceed.

The most critical vote—one not expected until after Thanksgiving—will be to limit debate and end an expected Republican filibuster. Supporters also need 60 votes to stop debate and move the legislation to a final vote on the Senate floor.

With House passage of reform legislation this month and Senate action ramping up, "health care reform has moved further than ever before," said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington. "We are now in the home stretch."

Observers say a handful of moderate Democrats will determine the fate of the Senate legislation.

At this point, though, business groups say the Senate plan is preferable to the House-passed bill. In particular, they applaud Sen. Reid for not including a provision in the House bill that would cripple the ability of employers with retiree

See **REFORM** page 25

HEALTH CARE BENEFITS

Mammogram cover changing?

By SALLY ROBERTS

Health insurers last week said they will continue to provide coverage for routine mammograms for women in their 40s despite a government task force's recommendation against the screenings.

And self-funded employers, which often rely on their health plan administrators for such coverage guidelines, are unlikely to start denying such benefits to their female employees due to the backlash that likely would ensue, experts say.

See **EXAMS** page 23

AGENTS & BROKERS

Prosecutors throw in the towel in latest bid-rigging case

By COLLEEN McCARTHY

NEW YORK—Prosecutors may been left reeling in the latest rounds, but they still came out on top in their fight against bid-rigging in the insurance industry, observers say.

Last week a judge dismissed criminal charges against the remaining defendants in New York's bid-rigging case against former brokerage and insurer executives.

The dismissals last week by New York County Supreme Court Judge James A. Yates, which came at the request of New York Attorney General Andrew Cuomo's office, ended a four-year pursuit of charges of misconduct by Marsh Inc. officials and others launched by former New York Attorney General Eliot Spitzer.

The judge dismissed all charges against former Marsh Senior Vps Thomas T. Green Jr. and William L. McBurnie, who were among seven former Marsh executives accused in a 2005 indictment.

Judge Yates also dismissed charges against Geri Mandel, former senior vp at Zurich American Insurance Co., who was indicted in 2006 on similar charges.

The action came just weeks after Judge Yates acquitted three other ex-Marsh executives of all charges in the case, raising speculation that prosecutors would drop charges against the remaining defendants.

"I think the (attorney general) saw the writing on the wall," said James W. Carbin, a partner with Duane Morris L.L.P. in New York, who was not involved in the case. "Given the history and the very

See **MARSH** page 21

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On the Web

BEST PLACES TO WORK

BI goes one-on-one with award honorees

Individual 2009 Best Places to Work in Insurance honorees answer questions about their corporate cultures, talk about how it feels to be honored, and give advice to other firms. *www.BusinessInsurance.com/BestPlaces.*

WOMEN TO WATCH

Special report to honor leading women

Business Insurance will profile all the 2009 Women to Watch honorees in the Dec. 7 edition of the magazine. *BI* also will host a lunch and reception recognizing the honorees Dec. 8 at the Four Seasons Chicago. Register to attend by contacting Event Manager Rebecca Briggs at 212-210-0132 or *rbriggs@BusinessInsurance.com*. To see a list of honorees, go to *www.BusinessInsurance.com/women2009*.

_BI_ BLOGS

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You rely on *Business Insurance*'s editors for the industry news and information you need. Now you can get their unfiltered opinions and observations on the issues and make comments of your own. *www.BusinessInsurance.com/section/blogs.*

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Business Insurance®

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS

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HEALTH CARE BENEFITS

Health care plan costs rise 5.5% in '09: Study

Adoption of CDHPs, other control efforts help limit increases

By JERRY GEISEL

Group health care plan costs rose 5.5% in 2009, the lowest increase in more than a decade, as employers stepped up cost-control efforts, according to a survey.

That 5.5% increase brought costs to an average of $8,945 per employee this year compared with $8,432 last year, according to a survey of nearly 3,000 employers released last week by Mercer L.L.C. in New York.

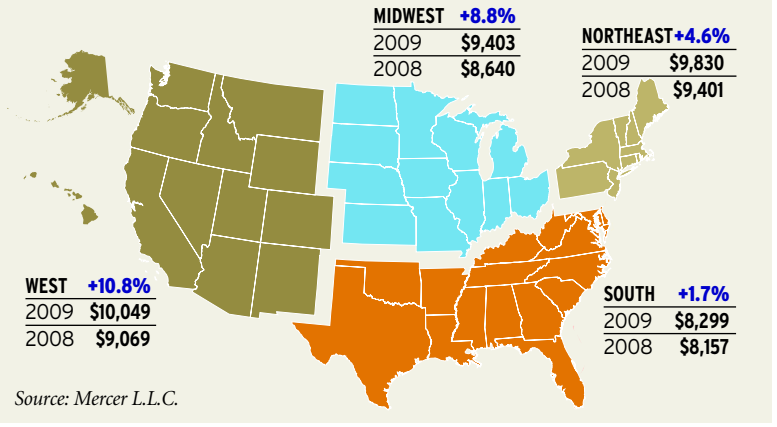
Costs rose an average 6.3% in 2008; from 2005 through 2007, costs increased an average of 6.1% each year. Health care cost increases peaked in 2002 when they jumped 14.7%, with lesser increases since then, according to the consulting firm.

"This is good news and the cost increase is a better number than we might have expected," said Linda Havlin, a Mercer worldwide partner in Chicago. Use of health care services often spikes in recessions as employees, fearful of losing their jobs and coverage, seek more care, she said.

One factor limiting cost increases, especially among smaller employers, was increased adoption of consumer-driven, account-based health care plans that have significantly lower costs than more traditional plans.

For example, 15% of employers

See **MERCER** page 22



INTERNATIONAL

Spain charges big insurers developed construction coverage cartel

Competition regulator fines group $180M for alleged price-fixing

By MICHAEL BRADFORD

MADRID—Spain's competition watchdog says it has extensive evidence to justify €120.7 million ($180.1 million) in fines it levied against six insurers and reinsurers for allegedly fixing prices for construction defect insurance.

The Madrid-based Comisión Nacional de la Competencia says the group of European insurers and reinsurers for more than five years controlled the price of decennial insurance, which provides property developers with 10 years of coverage against flaws or defects in new construction projects.

The companies reacted angrily to the commission's charges, which were leveled earlier this month, and say they will fight the fines in court.

Decennial insurance has been compulsory on new residential construction in Spain since May 2000. The cartel operated between 2002 and 2007, the CNC alleges.

The insurers and reinsurers accused of fixing prices on the coverage were fined varying amounts (see related box).

The CNC says proof that a cartel existed is found in a document dated Dec. 5, 2001, indicating that five of the companies exchanged information on setting minimum premiums on decennial insurance in the Spanish market. Madrid-based Caja de Seguros Reunidos, Compania de Seguros y Reaseguros S.A. joined the arrangement in 2006, according to the CNC, which did not release the document but referenced it in its resolution levying the fines.

"It is a very explicit document," said María Naranjo, chief of staff at the CNC. Not only did the document call for minimum prices for the coverage, it detailed retaliation measures to be taken against insurers in the Spanish market that did not go along with cartel pricing, she said.

"And that's just the beginning," said Ms. Naranjo.

See **SPAIN** page 22

SPANISH FINES

Insurers and reinsurers fined by Spain for allegedly fixing the price of construction-defect insurance are:

ASEFA S.A.
€27.8 million ($41.5 million)

SWISS REINSURANCE CO.
€22.6 million ($41.5 million)

MAPFRE EMPRESAS COMPANIA DE SEGUROS Y REASEGUROS S.A.
€21.6 million ($32.2 million)

SCOR GLOBAL P&C S.E.
€18.6 million ($27.8 million)

MUNICH REINSURANCE CO.
€15.9 million ($23.7 million)

CAJA DE SEGUROS REUNIDOS, COMPANIA DE SEGUROS Y REASEGUROS S.A.
€14.2 million ($21.2 million)

Source: Comisión Nacional de la Competencia

EMPLOYMENT PRACTICES

Employer's DNA test rule raises legal concerns

Genetic checks on job applicants slammed

By JUDY GREENWALD

AKRON, Ohio—The University of Akron is expected to soon rescind a controversial rule that lets the university demand DNA samples from job applicants as part of a criminal background check.

Observers say the requirement—believed to be the first genetic testing rule imposed by an employer—violates the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act, as well as raises significant privacy concerns. Other employers generally have not considered such rules, experts note.

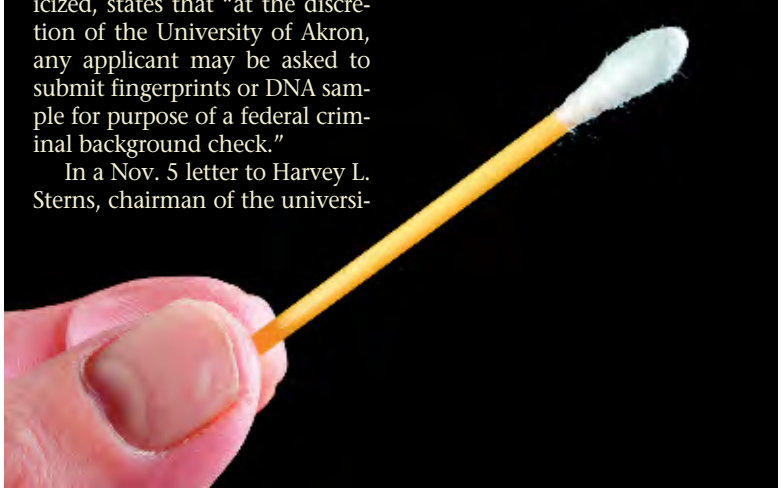
The regulation, which initially was approved by the university's trustees in August but not publicized until late last month, may be rescinded by the trustees at their next meeting Dec. 16, according to a source familiar with the situation. The regulation, which has been widely criticized, states that "at the discretion of the University of Akron, any applicant may be asked to submit fingerprints or DNA sample for purpose of a federal criminal background check."

In a Nov. 5 letter to Harvey L. Sterns, chairman of the university's faculty senate, university Vp and General Counsel Ted A. Mallo calls for the regulation to be changed to read more broadly as: "The candidate may be required by the law enforcement agency to provide additional information which is needed by the law enforcement agency for purposes of conducting the criminal background check."

Mr. Mallo states in the letter that the DNA provision was inserted after discussion among trustees "which centered around the likelihood that future reliance on fingerprinting would diminish and using DNA tests for criminal identification purposes will likely become the more prominent technology."

The letter says the rule's purpose "was to secure a pre-employment criminal background check for applicants selected for employment…not to

See **SWAB** page 22



SAFETY

GAO faults OSHA's workplace injury data collection system

By JEFF CASALE

WASHINGTON—Workplace injury and illness data that the Occupational Safety and Health Administration uses to assess workplace safety may be inadequate, according to a report released last week by the Government Accountability Office.

Underreporting of injuries by employers and employees, and insufficient direct contact with workers by OSHA officials may result in inaccurate data, said the GAO, which is the nonpartisan investigative arm of Congress.

Workplace injuries and illnesses often are unrecorded by employers, according to the report. Some employers avoid reporting workplace injuries and illnesses for fear of jeopardizing workers compensation premium discounts, the report said.

IMPROVING ACCURACY

The GAO recommends that OSHA inspectors:

- Interview workers during records audits.
- Minimize the time between the date injuries and illnesses are recorded by employers and the date they are audited.
- Update the list of high-hazard industries used to select worksites for records audits.
- Increase education to help employers better understand recordkeeping requirements.

Source: Government Accountability Office

In addition, some workers don't report job-related injuries because they fear being fired or don't want to let their co-workers down by losing rewards for maintaining safety.

Employment attorneys acknowledge that underreporting of workplace injuries is an issue for employers and regulators, though the reasons for underreporting vary, they say.

"Sometimes it's not clear what is reportable," said Jeffrey I. Pasek, a Philadelphia-based defense attorney at Cozen & O'Connor P.C. "Many times employees don't report to employers because they figure they have health insurance and there isn't a need to file for workers compensation."

Mr. Pasek added that, given the economic situation and job availability, workers are willing to forgo filing a workers comp claim because they are "trying to get as much work as they can and that they are willing to work through an injury" to stay eligible for overtime.

"There is no reason, other than employer retaliation against an employee who files a workers compensation claim, that an employee who is legitimately hurt on the job should not report it," said Alan Genitempo, an injury and employment-related claims attorney with Nutley, N.J.-based Piro, Zinna, Cifelli, Paris & Genitempo. He noted that labor laws protect an employee from employer retaliation if they file a claim and lose their job.

The GAO report said OSHA annually audits records of a representative sample of about 250 of approximately 130,000 worksites in high-hazard industries to verify the accuracy of workplace injury and illness data. While OSHA is not required to interview workers, the GAO report said taking that step could assist evaluating the accuracy of employer records.

Accurate injury and illness records by employers help OSHA identify safety issues. A lack of data hampers OSHA's efforts to encourage and regulate workplace safety, observers say.

"OSHA has to be able to trust the data it is receiving," said Mr. Pasek. "They want to be able to identify problems before they occur."

Mark Maser, Princeton, N.J.-based environmental practice associate and counsel for employers on OSHA enforcement for Drinker Bid-

See **OSHA** page 24

HEALTH CARE BENEFITS

Plan credits healthy habits

Employer cuts costs by allowing workers to 'earn' lower rates

By JOANNE WOJCIK

PHOENIX—Safeway Inc. has reduced its health care cost increases by more than $150 million since 2005 using an approach that closely resembles how auto insurers rate drivers.

Under Safeway's Healthy Measures program, employees "earn" the lower rates for health care coverage—up to 20% off the cost of single coverage—by meeting certain criteria: healthy weight, no tobacco use, controlled blood pressure and controlled cholesterol.

20%

Under Safeway's program, employees "earn" up to 20% off the cost of single coverage by meeting certain criteria.

Employees who fail to meet the criteria at open enrollment for the consumer-driven health plan are eligible for refunds on their higher premiums if they pass the tests at the next year's open enrollment.

Ken Shachmut, executive vp of the Pleasanton, Calif.-based grocery store chain, described the program during a keynote address at the National Business Coalition on Health's annual meeting Nov. 8-10 in Phoenix.

"If you and I were both 35 years old and lived in Pleasanton, Calif., and we both drove a Camry sedan, and you've been a great driver ever since you turned 16, you can get a full suite of insurance for $750" a year, he said. But if "I, on the other hand, am a lousy driver, I can buy that same suite of insurance, but it will cost me over $1,500."

"No one in this room, I will wager, thinks that's unfair," he said. "We believe the same philosophy holds true for health care. If you buy the argument that behavior is important, it's a travesty that most insurance plans don't provide incentives to motivate changes in behavior, and few of them have cost and quality transparency."

To explain to Safeway's employees why those four health conditions were targeted under the Healthy Measures program, Mr. Shachmut compared them to excess costs incurred in the firm's core business.

"In the grocery industry, we have this phenomenon called 'shrink.' It represents anything we buy that we can't sell. It might be a bunch of bananas that rots and we can't sell it. It might be a can of soup that is dented. Or it might be a pack of razor blades that was stolen from one of our stores and resold at a flea market. All that is 'shrink,'" he explained.

"If I told you three-quarters of the 'shrink' was resident in four items, then you would understand pretty readily that I could afford to put one person on a supply chain for each of those four, from the grower's field to my shelves, and I would figure out a way to avoid 'shrink,'" he said.

"That's the situation we think we have in health care because so

See **SAFEWAY** page 24

Errors & Omissions

Due to an editing error, a Nov. 16 chart on the Pension Benefit Guaranty Corp.'s deficit for its single-employer insurance program contained an incorrect figure. The PBGC's 2004 deficit in that program was $23.3 billion.

P/C INSURERS

WASHINGTON TIMES/LANDOV

Special Inspector General Neil Barofsky listens during a House committee hearing in October concerning bonuses at American International Group Inc.

TARP report on AIG bailout sparks calls for Fed audit

By MARK A. HOFMANN

WASHINGTON—A government report critical of the Federal Reserve Bank of New York's handling of American International Group Inc.'s near-collapse has led a group of congressmen to call for an audit of the entire Federal Reserve System.

The report, "Factors Affecting Efforts to Limit Payments to AIG Counterparties," criticized the New York Federal Reserve Bank for making "several policy decisions that severely limited its ability to obtain concessions from the counterparties."

According to the report, which was prepared by Neil Barofsky, special inspector general for the Troubled Asset Relief Program, the bank decided against treating domestic banks that held AIG credit default swaps differently from foreign banks. That led France's bank regulator to refuse to allow two French banks involved to make concessions when negotiating the amount of payment for credit default swap obligations, according to the report.

The bank did not use what the report termed its "considerable leverage" over counterparties that it and the Federal Reserve regulated to force counterparties to accept reduced payments for the instruments, according to the report.

The report also criticized the Federal Reserve for not revealing the identities of AIG's counterparties, which the Federal Reserve argued would undermine AIG and the stability of financial markets.

"After public and congressional pressure, AIG disclosed the identities," the report noted. "Notwithstanding the Federal Reserve's warnings, the sky did not fall." Under most circumstances, "whenever government funds are deployed in crisis to support markets or institutions…the public is entitled to know what is being done with government funds."

In a letter sent last week to the chairmen of the House Financial Services and the Senate Banking, Housing and Urban Affairs commit-

See **TARP** page 22

Time to honor outstanding risk managers

Business Insurance invites its readers to nominate candidates for the magazine's annual Risk Manager of the Year award and Risk Management Honor Roll by the deadline of Dec. 4.

BI and the Risk & Insurance Management Society Inc. will collaborate on the annual honors.

Anyone involved in risk management for a corporation, financial institution, nonprofit organization or government entity can be nominated. Candidates need not practice risk management full time but must be a full-time employee of the organization for which he or she manages risk.

A simplified, two-part process for nominating candidates has been implemented for the awards.

Part I of the process requires a summary, not more than 600 words in length, of a candidate's most recent accomplishments and factors that make him or her worthy of the award.

An independent panel of former award winners and risk management professionals will screen the Part I nominations.

If selected as a finalist, the more detailed Part II Risk Manager of the Year nomination form will be required and reviewed by a panel of independent judges, including executives from leading industry companies, the president of RIMS and the immediate past winners of the awards.

Winners will be profiled in the April 26, 2010, issue of *Business Insurance*, and the 2010 Risk Manager of the Year will be the 33rd person so honored.

To download nomination forms and instructions for completing the forms, please visit *www.BusinessInsurance.com/RMOY*.

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Captive parents advised to be educated

World Captive Forum panelists give tips on setting up captives

By RODD ZOLKOS

BONITA SPRINGS, Fla.—The extent of outside services required to support a captive insurance company vary with the nature of the captive, though current and prospective captive owners should know what services they need and what they should expect from service providers, according to a group of captive experts.

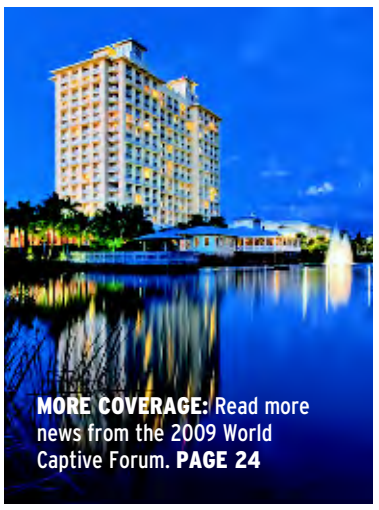
Speaking as part of a panel discussion called "Making Your Captive More Effective" at the 19th annual World Captive Forum last week in Bonita Springs, Fla., D. Hugh Rosenbaum, retired principal at Towers Perrin in London, said, "You have to have the basics, because this keeps the captive running. You might need some enhanced services, but they get more expensive."

Mr. Rosenbaum advised current and potential captive owners to know "what you have to have" vs. "what you might like to have."

For companies looking to form a captive, Nicholas Dove, president of Quest Management Services Ltd. in Hamilton, Bermuda, said, "There's going to be different structures, depending on your needs."

Depending on the type of captive, the timeline of a formation "could be a matter of weeks or it could be a matter of years," Mr. Dove said, with a single-parent captive going from concept to incorporation in a matter of weeks, while a group captive could take years to form.

Regardless of the type of captive, "what you're looking for is a transaction that's treated as insurance for tax purposes," said F. Roy Sedore, partner at Baker & McKenzie L.L.P. in New York. "We always talk about deductibility of premiums. The real tax benefit is the deductibility of loss reserves."



MORE COVERAGE: Read more news from the 2009 World Captive Forum. **PAGE 24**

"That's why—at least from a tax perspective—it's more attractive to have long-tail business in a captive," Mr. Sedore said.

In dealing with consultants studying captive feasibility, prospective captive parents should know that when it gets to the feasibility study, "Within 30 minutes, we'll have a pretty good idea whether this thing has a chance," said Joel S. Chansky, consultant with Milliman Inc. in Wakefield, Mass.

"It normally becomes very apparent very quickly what the captive can insure and what layers of insurance" it can offer, Mr. Chansky said.

Prospective captive parents should be wary of consultants' claims that their programs present unique challenges.

"There are no new things in the insurance business. Just variations on the same theme," said Michael Maglaras, president of Michael Maglaras & Co. in Stamford, Conn. If "someone (is) telling you (that) you have a unique program, man, show that guy the door." Insurance programs may have "unique facets," but there are no truly unique programs, he said.

Mr. Maglaras said hot topics in the captive arena are management liability and employer practices liability coverage.

"The next big captive opportunity—you heard it here first—are cyber risk and cyber liability." Using a captive for $1 million of a $2 million working cyber liability retention with excess insurance or reinsurance above that layer "is the next big opportunity for captives, in my opinion," Mr. Maglaras said.

Mr. Maglaras advised potential captive parents that "a captive is a little bit of extra work. Make sure you budget the time and investment." But, he said, much can be gained from understanding an organization's exposures that comes from forming a captive. "One of the best reasons to form a captive is to get your arms around the data," he said.

Commentary

Wellness rewards will lower health care costs

JOANNE WOJCIK

Senior Editor Joanne Wojcik can be reached at: jwojcik@businessinsurance.com

With Botox, wrinkle creams and plastic surgery readily available, people these days are looking a lot younger as they enter their golden years. But regardless of the how smooth their faces may be, their bodies are getting pretty rickety.

In fact, U.S. residents in their 60s are experiencing more disabilities than did their parents or their grandparents, according to a new study by researchers at the University of California, Los Angeles.

The study, sponsored by the National Institute on Aging and published in the American Journal of Public Health, is the first to chronicle the end of two decades of improving function among the elderly.

Significant increases in disability were noted among individuals between ages 60 and 69, regardless of their sociological or demographic characteristics, health status and health behaviors. However, disability rates were highest among non-whites and people who were obese or overweight, researchers found.

By contrast, there was a lower prevalence of disability among individuals over age 80, suggesting that the oldest people in the study group had better nutrition and better medical care than did the generations that preceded or came after them, resulting in less disability later in life.

U.S. residents in their 60s are experiencing more disabilities than did their parents or their grandparents.

But it's not only the bodies of baby boomers that are breaking down sooner than those of their ancestors. Research recently reported by the Integrated Benefits Institute found that nine out of 10 active employees have one or more chronic health problems. Many suffer from multiple conditions such as depression, diabetes, asthma and heart disease.

This certainly explains the urgency for national health care reform. In fiscal 2008, according to the U.S. Census Bureau, we spent more than $1 trillion—nearly half of the federal budget—on Medicare, Medicaid and Social Security, which provides benefits to disabled individuals under age 65.

In 1962, before Medicare was enacted, defense spending made up half of the federal budget and Social Security was about 15%. By 2007, defense spending was only 20% of the budget while Social Security made up 21% and Medicare was 16% and rising.

As the UCLA researchers concluded, "Our results have significant and sobering implications: Older Americans face increased disability, and society faces increased costs to meet the health care needs of these disabled Americans."

Fortunately, enlightened employers have begun trying to tackle this problem through health promotion programs and value-based benefit design, which improve patients' adherence to medications and prevent chronic conditions from worsening and costing more later.

Despite the recession, which is forcing many U.S. companies to do more with less, most are keeping these programs in place, recognizing that they will save more than they cost in the long run. Some employers even are cracking down on employees' poor health habits that could lead to disability later in life, charging employees who use tobacco, are inactive or overweight more for their health benefits than their counterparts with healthy lifestyles.

A component of one of the health reform bills being considered by Congress would increase the limit on the dollar value of incentives that employers are allowed to offer employees to participate in wellness programs. Hopefully, this provision will be enacted.

In addition to paying employees to take better care of their health, employers also should be rewarded for sponsoring and investing in these health-promotion efforts. If fewer people become disabled when they retire, it could slow the growth in federal spending on entitlement programs, such as Social Security and Medicare, and hopefully eliminate the need for onerous future tax increases to support them.

MAKE PROGRESS.

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Business Insurance OPINIONS

We want transparency with public's money

TRANSPARENCY OUGHT to be the rule, not the exception, when public money is spent to support private entities or markets.

That's why we believe Neil Barofsky, the special inspector general for the Troubled Asset Relief Program, struck just the right tone in his recent report about how the Federal Reserve Bank of New York handled its dealings with American International Group Inc.'s counterparties in the wake of its near-collapse last year.

As we report on page 4, the New York bank and the Federal Reserve System disclosed almost nothing about what was going on. In fact, as the report noted, the Fed resisted even identifying the counterparties.

It's easy to see conspiracies and favored treatment when the facts aren't readily available.

The Fed's argument was that disclosing the names of the counterparties and how much they received would undermine AIG, violate the privacy and business interests of the counterparties, and roil the markets. That argument "simply does not withstand scrutiny," the report noted dryly. "Notwithstanding the Federal Reserve's warnings, the sky did not fall," it said.

There is no evidence that the sky would have fallen had the Fed been more forthcoming. In fact, the emphasis on secrecy, particularly when billions of taxpayer dollars were involved, further poisoned the already toxic atmosphere surrounding the bailout of AIG and other financial institutions. It's easy to see conspiracies and favored treatment of highly placed people and institutions when the facts aren't readily available.

Mr. Barofsky said "there might be circumstances" in which the public's right to know should be restricted, but "those circumstances should be very few and very far between." This was not one of those circumstances.

Health care reform is better, still needs work

HEALTH CARE REFORM legislation that Senate Majority Leader Harry Reid, D-Nev., unveiled last week is a significant improvement from that passed by the House of Representatives.

As we report on page 1, the Senate bill omits a provision in the House bill that would bar employers from cutting retiree benefits unless they do the same for active employees. The only result of such an illogical mandate would be a rush by employers to jettison retiree health care plans.

Also omitted from the Senate bill is a House provision that would require employers to extend COBRA coverage for years beyond the current requirements, which would be a burden on employers.

Still, there is much that can be improved in the Senate bill.

Perhaps the government can't afford the loss of revenue from the lack of a cap on pretax contributions to flexible spending accounts. If there is to be an FSA cap, as the House has done, it should be linked to increases in the Consumer Price Index, otherwise the tax-effective way for employees to pay uncovered health care expenses will seriously erode.

Taxing health care premiums that exceed a certain amount, as Senate would do, strikes us as inequitable. Two companies could offer the same benefits, but an employer with an older workforce and higher health care premiums could be subject to the tax, while an employer with a younger workforce and lower premiums would not.

Both bills are huge at roughly 2,000 pages. House members, who passed their bill after just a few hours of debate, clearly did not give its reform measure the scrutiny it deserved. We hope Senate members carefully analyze that chamber's plan and do not feel compelled to rush to a vote. Health care reform should be enacted only after careful consideration.

WRITE

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

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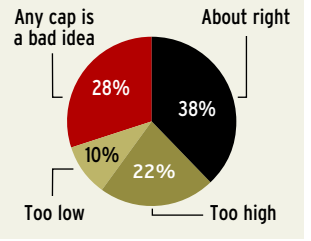
REUTERS/L.ANDOV

AIG CEO Robert H. Benmosche reportedly threatened to quit over government-imposed pay caps.

THIS WEEK'S RESULTS

Q The government's $500,000 cap on executive pay at bailed-out companies is ...



NEXT WEEK'S QUESTION

Q: Is the proposed $2,500 cap on FSA contributions in health care reform bills a good idea?

LETTERS

Let policyholders join the 'par'-ty

TO THE EDITOR: While a government audit found that the Federal Reserve Bank of New York "used a weak negotiating strategy that failed to wring concessions from American International Group Inc. trading partners last year" (*BusinessInsurance.com*, Nov. 17), as an attorney for policyholders I'm delighted to read that AIG's new bosses forced the company to honor its contracts, albeit with taxpayer money.

Hats off to Goldman Sachs, Bank of America et al. for wringing a par buyback of assets underlying their credit default swaps out of the newly generous wounded giant.

A modest proposal for Treasury Secretary Timothy Geithner: Let policyholders join the "par" party. Instruct AIG's insurance subsidiaries to pay all legitimate claims to the full policy limits, without the overbroad coverage defenses and years of delay that customers have long been conditioned to anticipate.

Let policyholders around the world discover that when it's time to file a claim, you get the coverage you paid for. Let the kinder, gentler AIG that the world's largest banks have learned to love show its new smiling face to its hundreds of thousands of policyholders worldwide.

And while we dream, Mr. Geithner, how about creating a federal insurance regulator that keeps a watchful and effective eye on all insurance companies' claims-handling behavior?

William G. Passannante
Co-chair, insurance recovery group
Anderson Kill & Olick P.C.
New York

Insurance
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Market Moves

Prevention, wellness service earns health accreditation

SAN DIEGO—Healthyroads Inc., the prevention and wellness services unit of American Specialty Health Inc., has been accredited under the Wellness and Health Promotion Accreditation of the National Committee for Quality Assurance, with a Performance Reporting rating.

The accreditation process evaluates key aspects of health promotion and implementation in the workplace; privacy of an individual's health information; and how the development of services, such as health coaching, helps individuals make healthier choices.

Healthyroads also earned a Performance Rating from NCQA by submitting 10 actions centered on staying healthy, participation by individuals who have a core risk factor and reducing risk.

XL Insurance takes on team from Unicorn

LONDON—XL Insurance, the global insurance unit of XL Capital Ltd., has acquired an underwriting and claims team from London-based Unicorn Underwriting Ltd., a unit of THB Group P.L.C.

Guy Morrison, who has more than 20 years of equine insurance underwriting experience, has been named chief underwriting officer of equine of XL Insurance's global equine operations. He leads the team of five with underwriting centers in London and Lexington, Ky.

As part of the deal for which terms were not disclosed, XL Insurance also agreed to service the book of equine business formerly underwritten by Unicorn.

XL said the acquisition is intended to strengthen its capabilities and commitment to the bloodstock insurance business, offering coverage that includes mortality, theft, specialized perils, barrenness/prospective foal, stallion availability, infertility and loss of income, the insurer said in a statement.

Hartford, Lord Abbett & Co. form strategic partnership

SIMSBURY, Conn.—The retirement services unit of Hartford Financial Services Group Ltd. has formed a strategic partnership with money management firm Lord Abbett & Co. L.L.C.

Lord Abbett manages approximately 8,000 bundled 401(k) plans comprising more than 59,000 participants in the United States and more than $1.2 million in assets.

The alliance is intended to offer flexibility to Lord Abbett's 401(k) clients, the companies said. That includes allowing clients to transfer their 401(k) plans to Hartford's platform while waiving certain charges for specific kinds of plans that submit paperwork by April 1, 2010, the companies said.

Additionally, broader investment options will become available through its 401(k) products, Hartford said.

Allianz partners with French health insurer

DUBLIN—Allianz Worldwide Care said it has formed a partnership with Caisse des Francais de l'Etranger, a French state insurer that offers basic health coverage to foreign nationals residing outside France.

According to a statement, Allianz said the alliance offers French expatriates medical coverage beyond that of French state-provided health care.

C.F.E. reimburses medical costs for French expatriates only up to the maximum limit applied in France. The partnership allows more comprehensive cover through supplemental insurance.

Allianz will seek reimbursement of medical costs directly from C.F.E. on behalf of clients buying the supplemental coverage, simplifying claims filing, the company said.

Allianz Worldwide Care, based in Dublin, is the international health insurance unit of Allianz S.E.

OneBeacon forms new energy unit

CANTON, Mass.—Specialty insurer OneBeacon Insurance Group Ltd., based in Canton, Mass., has formed OneBeacon Energy Group, the company said in a statement.

The energy unit, which targets middle-market energy risks and alternative and renewable energy sources, will be available to exploration and production, transportation and storage segments of the oil and gas industry, and alternative fuel manufacturers and energy producers.

Coverage will include monoline property, monoline general liability, lead umbrella and general liability combined with auto liability.

OneBeacon Energy Group's office is at 77 Water St., New York, N.Y. 10005. The unit plans to underwrite business with an effective date of July 1, 2010.

TO SUBMIT ITEMS

MARKET MOVES
BI's Market Moves column reports on activities by insurance industry companies and related entities.

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BI's Products & Services column reports on new product offerings.

Please send Product & Services and Market Moves news to Mike Tsikoudakis, 360 N. Michigan Ave., Chicago, Ill. 60601 or e-mail *mtsikoudakis@businessinsurance.com.*

Workers check a wave-powered electrical generating system off the coast of Povoa de Varzim, Portugal, in September 2008, several weeks after the system that uses bobbing tubes to pump hydraulic fluid to drive generators went live.

AFP PHOTO

Capacity to change

Renewables energize market appetite

By STUART COLLINS

Capacity for renewable energy risks has grown and rates have fallen as insurers have become comfortable with established technologies employed by the sector, but new technologies remain a challenge, insurers say.

"The renewable energy sector represents a tremendous growth opportunity for the insurance sector," said David Croom-Johnson, chief underwriter at AEGIS London, the U.K.-based subsidiary of Associated Electric & Gas Insurance Services Ltd.

Annual premiums for the global renewable energy sector could grow 250% within the next decade, up from an estimated $600 million, he said.

Insurers have far more appetite for renewable energy risks and several carriers recently entered the market, said Martina Baugh, renewable energy leader for Europe, the Middle East and Africa at Marsh Ltd. in London.

250%

Annual premiums for the global renewable energy sector could grow 250% within the next decade, up from an estimated $600 million, said David Croom-Johnson of AEGIS London.

"There is still a buzz about renewable energy in the insurance market, with a number of insurers looking to enter," said Ms. Baugh. "Clients should be excited by the growth of insurance capacity for renewable energy."

The market is likely to gain more capacity in the next six to 12 months as more insurers recognize growth opportunities in renewable energy, said Michael Buckle, London-based head of the renewable team at Willis Group Holdings Ltd. Some underwriters are seeking write the renewable risks their existing clients have and others have set up specialist teams to tap a new source of revenue.

But it is not yet clear how the new capacity would be allocated, he said.

"There is sufficient capacity for renewable energy risks like onshore wind," said Mr. Buckle. But there is "limited capacity for renewable energies like wave and tidal power, where the technology is new and unfamiliar to underwriters."

Wind power remains the dominant source of energy in the renewable sector, and also premium for insurers, said Alex Lumby, chief executive of Ascot Renewco in Lon-

See **RENEWABLE** next page

Energy, Climate Change & Environmental Risks

SPOTLIGHT

Renewable: Insurers focus on reliability

CONTINUED FROM PREVIOUS PAGE

don. "Onshore wind is now a well-established sector, the technology is well-known and the resulting exposures are well-understood by insurers," he said.

As a result, rates for onshore wind farms have come down and insurers recently have become more willing to write this business 100%, said Ms. Baugh. Prices also have come down for offshore wind, but there are significantly fewer lead underwriters for the sector and they are unable to take on 100% of the risks, she added.

The offshore wind market is less established and values for offshore projects easily can surpass £1.5 billion ($2.49 billion), Mr. Lumby said. As a result, underwriters are less comfortable with the risk and offer less insurance capacity, he said.

There is "sufficient insurance capacity" for offshore wind projects, said Ms. Baugh. But with insurance premiums accounting for a significant proportion of construction expenditures, some clients say the cost of insurance is unacceptably high, she said. "Currently, underwriters are having to price the offshore product with only limited historical trends," she said.

Few offshore renewable energy projects have been completed without incident, Ms. Baugh said. Claims have been filed in relation to cables damaged during transit or installation but also as a result of minor incidents such as lightning strikes or other bad weather, she added.

New renewable energy technology is an ongoing issue for underwriters. For example, the size of wind turbine blades have grown and boosted loss costs dramatically, Mr. Croom-Johnson said.

While onshore wind is a proven technology, larger wind turbines have led insurers to renew their focus on maintenance and reliability, said Paul Dowling, who heads the European renewable energy and construction practice at CNA Insurance Co. Ltd.

Insurers are mindful of the reliability of new wind turbine technology and manufacturers, said Camilo Posada, Chicago-based energy resources group underwriter at Chubb Corp.

After high levels of claims from onshore wind turbines in the 1980s, some insurers quit the sector and many that remained introduced wordings to limit their exposures to serial defects, said Mr. Posada. A serial defect is where one turbine has a fault, and then this fault materializes in other turbines over time.

'Currently, underwriters are having to price the offshore product with only limited historical trends.'

Martina Baugh, Marsh Ltd.

The renewable sector is evolving fast with monthly developments in tidal, wave, solar and biofuel technologies, said Mr. Dowling. But insurers like CNA are working with manufacturers on insurability studies and getting involved in product development at an early stage, he added.

Insurers also have some concerns with the fire risks and high values associated with waste-to-energy plants, said Ian Harris, senior underwriter of technical lines for the United Kingdom and Ireland at ACE European Group Ltd. in London. This is a key issue for ACE, he said.

Waste-to-energy plants represent a greater fire, machinery breakdown and explosion risk to property and construction insurers than most other power-generation risks, Mr. Harris said.

Mr. Harris said he fears that waste-to-energy projects could become uninsurable. "I fear that some insurers writing renewable energy are not fully aware of the risks. If the construction of facilities is not up to international standards, there will be fire losses and the capacity will disappear."

"A number of property underwriters and new entrants see this as the next great growth area, but they risk writing it too cheaply, and I am concerned that insurers are not pooling enough premium to cover a really big loss or a series of losses," said Mr. Harris.

Questions & Answers

Robert M. Horkovich is a shareholder and insurance recovery attorney at Anderson Kill & Olick P.C. in New York. He spoke recently with Business Insurance Senior Editor Roberto Ceniceros about anti-concurrent causation clauses in property policies and their relationship to claims alleging damage due to climate change.

Clause reflects Katrina

Q: I understand anti-concurrent causation clauses might have relevance for climate change and environmental pollution cases. What is an anti-concurrent causation clause?

They are clauses the insurance industry is putting into first-party property policies that may make property coverage and business interruption coverage illusory. It is a clause put in the preamble of a group of exclusions. It basically says, "I am listing a whole bunch of exclusions, and if there is a covered loss, a loss that you would imagine would be covered by this policy, but any of these other exclusions apply, you don't have coverage." So, it's the sale of a policy in the Gulf Coast for hurricanes, for example, telling people, "We're going to insure you for hurricanes," but then there is a clause for excluding flood damage. It says, "If there is any part of this loss that may be caused by flood, even though your house got blown down by wind before the floods arrived, we're not going to give you coverage."

Q: How widely are these clauses used?

Very widely used. (Insurers) are attempting to put the clauses into all first-party property policies.

Q: Are these in commercial or other types of policies other than property?

They are in commercial policies. Generally, I would imagine they could try to put them into liability policies, but right now they are predominantly used in the first-party property policies and business interruption policies.

Q: Is this relatively new?

Yes. Since Hurricane Katrina, this has been a big deal. Hurricane Katrina had a devastating impact on the Gulf Coast. Hundreds of thousands of homes were knocked down by wind. Later, floods devastated almost any structure present. Many of the policies had flood damage exclusions. Anti-concurrent causation clauses were introduced because some courts were saying, "We've got to separate how much of the damage was caused by wind, which is a covered loss, and flood, which is not a covered loss."

Q: So there have been some recent court decisions about these clauses?

Yes, some courts have refused to enforce them. A federal court in Mississippi in the wake of Katrina said, "These clauses are hidden in the policies; they make the coverage illusory because hurricanes, by their nature, would have wind and flood." If some carrier is out there selling hurricane insurance, people expect to be insured for hurricanes. They don't expect the insurance company to come in at the end of the day and say, "Oh by the way, there was flood and rain and we don't cover water damage, and therefore we're not going to pay you anything." So some courts have stricken the clause, saying they're ambiguous and inherently anti-consumer and anti-public policy.

Q: Is there still a need for policyholders to be concerned then?

Sure, because lots of other courts may not do that. Other courts may say, "Well, this clause is plain on its face."…Then you don't have any coverage. It can go well beyond the circumstance of a hurricane.

Q: Is there a concern that climate change could cause situations where these clauses are triggered?

Sure, there are lawsuits that have been filed against companies for advancing climate change. Those companies may be involved in the extraordinary production of greenhouse gases. The lawsuits against them say, "You are emitting greenhouse gases that are causing the environment to warm up and, because of that, there is extra flooding."

So policyholders may say, "I'm going to make claims to my carriers for those lawsuits against me." The insurance companies. because of anti-concurrent causations, whether flood or some other exclusion, can try to eliminate the coverage they've sold.

This is a burning issue and policyholders—corporate or individuals—should look at their policies to see if they have a preamble to their exclusion section that tries to set out anti-concurrent causation clauses, and if they have any clout whatsoever in managing the language of their policy, try to get that language taken out.

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NEWSCOM

"Cancer Alley" is an area along the Mississippi River in Louisiana which contains hundreds of hazardous waste sites and pollution.

More environmental lawsuits may target firms' directors, officers

Suits may claim company contributed to global warming

By ZACK PHILLIPS

Increased public attention to environmental issues, new regulatory changes, and two recent court rulings combine to raise the risk of lawsuits against directors and officers related to a company's alleged contribution to global warming, attorneys and others warn.

"This is an emerging issue and an issue of increasing focus for directors and officers," said Lindene Patton, Washington-based climate product officer at Zurich Financial Services Group.

On Oct. 19, the 5th U.S. Circuit Court of Appeals reversed a district court in *Ned Comer et al. vs. Murphy Oil USA Inc. et al.*, ruling that Mississippi residents and landowners had standing to sue energy and chemical manufacturing companies for their alleged contributions to global warming, which the plaintiffs argue intensified Hurricane Katrina and property damage they suffered from the storm.

On Sept. 21, the 2nd U.S. Circuit Court of Appeals reversed a district court in *State of Connecticut et al. vs. American Electric Power Co. Inc. et al.* and ruled that lawsuits by state attorneys general and other plaintiffs could proceed against the operators of coal power plants that emitted greenhouse gases and allegedly contributed to global warming.

However, a federal judge in California threw out a similar lawsuit by an Alaskan Eskimo village against oil and gas companies in October.

Still, the two cases in which judges sided with plaintiffs—including in the typically conservative 5th Circuit—worry D&O liability underwriters, attorneys and others.

"If the two cases, *American Electric* and *Comer,* really do signal a way in which courts are going to treat global warming cases, then by all means there is an increased risk of D&O claims," said William G. Passanante, a New York-based attorney and shareholder in Anderson Kill & Olick P.C.

'Pandora's box has been thrown wide open. It will likely take the muscle of either Congress or five U.S. Supreme Court justices to force it shut.'

William Stewart, Cozen O'Connor P.C.

Attorneys say such suits must overcome large legal hurdles to prevail. Regardless of the final outcome, the cost of defending against such a suit is substantial and the recent decisions could invite more plaintiffs to file similar litigation, some say.

"Pandora's box has been thrown wide open," said William Stewart, a New York-based attorney and co-chair of the climate change and global warming practice at Cozen O'Connor P.C., in a recent white paper about the cases. "It will likely take the muscle of either Congress or five U.S. Supreme Court justices to force it shut," wrote Mr. Stewart and co-author Danielle Willard, a law clerk at the firm.

At the same time, disclosure requirements related to greenhouse gas emissions are increasing, legal observers say. An Oct. 27 bulletin from the Securities and Exchange Commission reversed a previous agency rule and allows shareholders to request information about financial risks from social and environmental issues, including climate change. In addition, the SEC reportedly is considering a rule that would

See **D&O** page 16

What’s behind Navigators?

Just turn the page and find out.

NEWSCOM

Steam rises from the Aurora Energy plant in Fairbanks, Alaska, in 2005. The plant supplies Fairbanks with power.

D&O: Suits may target directors, officers

CONTINUED FROM PAGE 14

require public companies to disclose climate change risks in their annual financial filings.

"The bottom line is the SEC has put requirements out there that the companies need to pay greater heed to disclosure around environmental issues," said Michael Speer, who leads the Chicago-based business interruption and fidelity claims investigations unit at SMART Business Advisory & Consulting L.L.C.

The Financial Accounting Standards Board has proposed an accounting standard that would require increased disclosure of a company's contingent liabilities. That rule change is worrisome, Steven L. White, a vp at Arch Insurance Co., said at the conference of the Professional Liability Underwriting Society in Chicago this month.

"If that (passes), much like the mark-to-market changes that occurred a couple years ago, you could have some severe changes in some companies' financials, to the point that they may actually be insolvent by way of greenhouse gases," Mr. White said.

Meanwhile, the National Assn. of Insurance Commissioners in March adopted a long-debated requirement that insurance companies with $500 million in premiums disclose to state regulators the financial risks they foresee from global warming.

When disclosure requirements increase, the number of lawsuits against companies and their executives for inadequately disclosing emerging or potential risks also increases, attorneys and D&O observers say.

"The risk from the (polluting) acts themselves doesn't necessarily go away; it's always been there," Mr. Speer said. "But now we're talking about a greater level of risk from disclosure of these risks."

Shareholders in recent years have filed hundreds of requests for information on companies' responses to such risks, according to CERES, a Boston-based coalition of investors, environmental groups and public interest groups that directs the Investor Network on Climate Risk, an alliance of 80 institutional investors focused on how climate change affects business.

No exclusions in D&O liability policies specifically bar coverage for global warming-related lawsuits, Mr. Passannante said. But he and John G. Nevius, a New York-based attorney and shareholder at Anderson Kill, said they expect insurers to use the pollution exclusion in a D&O liability policy to exclude coverage.

In a case in Virginia state court, Steadfast Insurance Co. maintains the pollution exclusion in its general liability policy—among other reasons—eliminates its duty to defend one of the defendants in the Alaskan Eskimo case, which Mr. Nevius said could have implications for D&O liability pollution exclusions.

Both men say a D&O liability policy's pollution exclusion should not bar coverage for climate change-related lawsuits, because those suits are triggered by the business decision to improperly disclose the risk, not by the actual pollution.

However, Steve Shappell, managing director of Aon Financial Services Group in New York and Denver, said many pollution exclusions are written so broadly that they likely would bar coverage for climate change-related suits.

Still, Mr. Shappell said the soft D&O liability market in recent years has allowed some policyholders to negotiate carve-backs to the pollution exclusion at relatively affordable prices. Those carve-backs would allow coverage for Side A suits against individual directors and officers and, in some cases, shareholder litigation against the company, Mr. Shappell said. But he said they would not cover cleanup costs—for example, where regulators look to tap a bankrupt company's D&O liability policy proceeds to pay for cleanup costs.

Some insurers have begun offering D&O policies that affirmatively cover global warming-related lawsuits. Underwriters are doing a good job of forcing policyholders and brokers to prove why they deserve a carve-back on the pollution exclusion and providing one when merited, Mr. Shappell said.

"There's definitely a bunch of arm wrestling going on with the carriers on how much exposure they're willing to take," he said.

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More public nuisance suits could arise from recent court decisions

By SALLY ROBERTS

In recent months, panels of the 2nd and 5th U.S. Circuit Courts of Appeals have ruled that various oil, chemical and utility companies can be sued under the federal common law of "nuisance" for their alleged contributions to global warming via their greenhouse gas emissions.

Two recent federal appeals court decisions allowing global warming-related suits to proceed likely will result in more litigation against emitters of greenhouse gases accusing them of creating a public nuisance, legal experts say.

To the extent that policyholders tap their commercial general liability underwriters to bear the cost of defending and indemnifying them in these suits, a second wave of coverage litigation is inevitable, they say.

At least one global warming-related public nuisance case already has resulted in litigation over the scope of a CGL insurer's duty to defend.

Experts caution, however, that even though the underlying suits recently passed some legal challenges, significant hurdles remain that ultimately could curtail the suits.

In recent months, panels of the 2nd and 5th U.S. Circuit Courts of Appeals have ruled that various oil, chemical and utility companies can be sued under the federal common law of "nuisance" for their alleged contributions to global warming via their greenhouse gas emissions.

In *State of Connecticut et al. vs. American Electric Power Co. Inc.* and *Ned Comer et al. v. Murphy Oil USA et al.*, the 2nd and 5th Circuits, respectively, overturned lower court decisions that the global warming nuisance suits raised political questions that were not appropriate for judicial review.

Defendants in the *AEP* case since have filed a petition seeking a rehearing before the entire 2nd Circuit Court of Appeals.

Attorneys say that while the rulings may embolden more plaintiffs to bring similar suits against more emitters, enormous challenges remain.

"It's likely that if the (full) 5th Circuit and 2nd Circuit do not overturn *Comer* and *AEP*, respectively, there is going to be a significant influx of climate change-related litigation," said Bill Stewart, co-chair of the climate change and renewable energy practice of Cozen O'Connor P.C. in West Conshohocken, Pa.

But there "are a number of things that could happen that could put a halt to that," he said. If Congress passes climate change legislation, for instance, that could have a "significant impact" on the viability of the public nuisance litigation, he said.

One issue associated with the political question doctrine defense is the degree to which the government has weighed in on the subject. The 2nd and 5th Circuits looked to the lack of governmental action on global warming in their analysis, he said. As such, "if Congress passed legislation that specifically directed how much levels of greenhouse gases can and can't be emitted, that vacuum no longer exists and the political question doctrine argument becomes a much stronger argument," he said.

The American Clean Energy and Security Act of 2009, which would cap greenhouse gas emissions among other things, is pending in Congress.

"There are lots of problems in putting together these types of cases even if certain claims pass the political question doctrine," agreed Laura A. Foggan, a partner at Wiley Rein L.L.P. in Washington. "There are so many causation and damage issues that are very, very difficult" to prove.

For example, in *Comer*, can plaintiffs prove "that Hurricane Katrina was caused by global warming as opposed to natural forces, even if they can show in general that global warming has increased the intensity, severity and frequency of adverse weather events?" Ms. Foggan asked.

Attorneys note that if the public nuisance litigation continues to survive and further litigation is filed, coverage disputes are likely to ensue.

At least one insurer, Steadfast Insurance Co., a Schaumburg, Ill.-based unit of Zurich Financial Services Group, already has filed a motion for summary judgment in Virginia state court seeking a declaration of no coverage for global power company AES Corp.

Arlington, Va.-based AES is among 24 oil, energy and utility companies named in a public nuisance suit brought by the Native Village of Kivalina, a governing body of an Inupiat Eskimo village in Alaska, over alleged damage to the village caused by global warming.

Steadfast argued in its March motion that it has no duty to defend or indemnify AES because the global warming damage alleged in the underlying suit was not caused by an accident, which is required to trigger the liability coverage. It also argues that coverage is barred under the CGL policy's pollution and loss-in-progress exclusions.

Although the U.S. District Court for the Northern District of California dismissed the underlying Kivalina suit Sept. 30 on political question doctrine grounds, the case has been appealed to the 9th U.S. Circuit Court of Appeals.

"A lot of people are watching to see what happens with Steadfast," said John G. Nevius, a shareholder in the New York office of Anderson Kill & Olick P.C. "It's a bellwether case."

One of the big questions that will have to be addressed in the case is whether greenhouse gases are "pollutants" as it relates to Steadfast's broad pollution exclusion, attorneys say.

Among its arguments, Steadfast relies on the 2007 U.S. Supreme Court ruling in *Massachusetts v. Environmental Protection Agency*, in which the high court ruled that greenhouse gases are pollutants under the Clear Air Act. It has asked the Virginia court to adopt the same holding.

But as policyholder attorney Marc S. Mayerson of Hollingsworth L.L.P. in Washington noted, "It's hard for me to think that the content of any individual emitter's emission would be considered itself an irritant or a contaminant because if it was the only (company), there would be no global warming problem. It's only because everybody else is also emitting carbon dioxide that we have the problem."

UP CLOSE Comings & Goings

STEVE PIERCE

NEW JOB TITLE: Dallas-based vp and producer for Lockton Dallas, an office of Lockton Cos. L.L.C.

PREVIOUS POSITION: Dallas-based executive vp of Guaranty California Insurance Services Inc.

GOALS FOR NEW POSITION: Within Lockton as a producer, my primary goal is to be a client advocate and to work on business development. Specifically in my area of expertise, I will continue to focus on real estate and construction, helping bring new relationships to the company and helping to expand our service offerings to real estate owners and developers....I see a lot of opportunity in the correction of real estate and most of the opportunity there is going to be with the FDIC, the large banks, real estate investment trusts and other types of organizations that are buying distressed assets...this is going to be a growth market. I also want to help expand Lockton's risk management platform overall in the Dallas market and expand the middle-market.

INDUSTRY CHALLENGES: Soft market conditions in insurance and also the nature of the economy. A lot of businesses are shrinking; the marketplace is shrinking in general. It's one of the reasons I joined Lockton. Lockton is growing organically in a shrinking market, which tells me that they are doing a lot of things right.

INDUSTRY OUTLOOK: On the insurance side, you're probably going to see a little bit more shrinking as commercial real estate sees more challenges. Overall, most of what you will find is the industry will stay flat.

FIRST MARKET EXPERIENCE: My first job was working with a managing general agency out of Dallas, which designed products for the airline and cruise line industry. I helped set up offshore captives predominantly in Bermuda for airlines and cruise lines. That was back in 1992.

ADVICE: I would say to focus on experiences in claims and experiences in true statistical underwriting. That gives you a tremendous technical foundation. Absorb as (many) experiences as you can as quickly as you can to ultimately move into a revenue-generating role.

Comings & Goings ONLINE

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

TO SUBMIT ITEMS

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

Mike Tsikoudakis
Business Insurance
360 N. Michigan Ave.
Chicago, Ill. 60601-3806
mtsikoudakis@businessinsurance.com

POSTING THIS WEEK

BROKERS:
- Aon Ltd
- Integro Insurance Brokers
- Lockton Cos. L.L.C.

INSURERS:
- Canal Insurance Co.
- Harleysville Insurance Group Inc.
- Liberty Mutual Agency Markets

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LEGAL NOTICE

NOTICE OF BAR DATE FOR CLAIMS AGAINST FRONTIER INSURANCE COMPANY AND TERMINATION OF FUTURE LIABILITY ON BONDS ("NOTICE")

On October 10, 2001, the Supreme Court of the State of New York, County of New York, placed Frontier Insurance Company ("Frontier") into rehabilitation and appointed as rehabilitator of Frontier ("Rehabilitator") the then-Superintendent of Insurance of the State of New York, Gregory V. Serio (and his successors in office) ("Rehabilitation Order"). Pursuant to the New York Insurance Law ("Insurance Law") and the Rehabilitation Order, the Rehabilitator was given the responsibility of, among other things, marshalling Frontier's assets and adjudicating claims consistent with Article 74 of the Insurance Law.

PLEASE TAKE NOTICE that the Supreme Court of the State of New York, County of Albany, has issued an order, dated October 29, 2009, establishing March 12, 2010 ("Bond Bar Date") as the last date on which a notice ("Bond Notice") regarding any bond issued by Frontier, including any surety bond or other bond or guaranty identified in New York Insurance Law Sections 1113(16) or 6801 ("Bond"), may be filed with the Rehabilitator so as to preserve any obligation of Frontier pursuant to such Bond. The Order further provides as follows:

1. The Bond Notice shall identify (a) the Bond pursuant to which it is alleged that Frontier has an obligation, (b) the default, event, accident, or occurrence allegedly giving rise to a claim pursuant to such Bond ("Triggering Event"), (c) the date of the Triggering Event, (d) the alleged injury, loss or damage caused by the Triggering Event, (e) the dollar amount of the claim alleged as a result of the Triggering Event, and (f) the obligee or principal under such Bond who, by submitting a Bond Notice, seeks to preserve such person's rights under the Bond ("Submitting Bond Interest Holder");

2. Any claim against Frontier pursuant to any Bond shall be barred unless a timely Bond Notice has been submitted that accurately and sufficiently identifies the Bond, the claim alleged pursuant to such Bond, and all other information required in Paragraph 1 of this Notice;

3. Any claim under any Bond in which the Triggering Event occurs after January 11, 2010 ("Bond Cutoff Date") shall be barred;

4. All persons will be barred from asserting claims against Frontier pursuant to any Bond other than Submitting Bond Interest Holders who submit a timely, accurate and sufficient Bond Notice in connection with such Bond by the Bond Bar Date; and

5. All Bond Notices must be made in writing and sent to the Rehabilitator by first class mail, postage paid and postmarked on or before the Bond Bar Date, or by overnight courier, fees paid and written acknowledgement of receipt by such courier on or before the Bond Bar Date, to the following address:

Frontier Insurance Company in Rehabilitation
Attn: Legal Department
195 Lake Louise Marie Road
Rock Hill, N.Y. 12775-8000

Copies of Bond Notice forms and instructions have been posted on the internet site maintained by the New York Liquidation Bureau at http://www.nylb.org or may be requested by calling 845-807-5045.

JAMES J. WRYNN
Superintendent of Insurance
of the State of New York as Rehabilitator
of Frontier Insurance Company

LEGAL NOTICE

NOTICE OF CLAIM DATE FOR CLAIMS AGAINST FRONTIER INSURANCE COMPANY ON DIRECT POLICIES ISSUED THROUGH TERRAMAR AGENCIES ("NOTICE")

By order dated October 10, 2001, the Supreme Court of the State of New York, County of New York, placed Frontier Insurance Company ("Frontier") into rehabilitation and appointed as rehabilitator of Frontier ("Rehabilitator") the then-Superintendent of Insurance of the State of New York, Gregory V. Serio (and his successors in office) ("Rehabilitation Order"). Pursuant to the New York Insurance Law ("Insurance Law") and the Rehabilitation Order, the Rehabilitator was given the responsibility of, among other things, marshalling Frontier's assets and adjudicating claims consistent with Article 74 of the Insurance Law.

PLEASE TAKE NOTICE that the Supreme Court of the State of New York, County of Albany, has issued an order, dated October 29, 2009, establishing March 12, 2010 ("Terramar Notice Date") as the last date on which a person may submit a notice ("Terramar Notice") with respect to any insurance policy or insurance or reinsurance contract issued by Terramar Insurance Company, Terramar Insurance Agency, Advanced Risk International, Ltd. or Terramar General Agency ("Terramar Policy") so as to preserve any obligation of Frontier pursuant to such Terramar Policy. The Order further provides as follows:

1. The Terramar Notice shall accurately and sufficiently set forth the required information identifying (a) the Terramar Policy pursuant to which Frontier has or may have an obligation ("Identified Terramar Policy"), (b) the policyholder(s) of such Identified Terramar Policy, (c) the person(s) with an interest in the Terramar Policy who, by submitting a Terramar Notice, seeks to preserve such person's interest in the Identified Terramar Policy ("Submitting Terramar Policy Interest Holder"), and (d) any claim under such Identified Terramar Policy where the Submitting Terramar Policy Interest Holder has knowledge of the event, accident or occurrence giving rise to the claim, the person or property allegedly injured or damaged, and the nature of the alleged injury or damage, prior to the Terramar Notice Date;

2. All claims against Frontier pursuant to any Terramar Policy will be barred unless the Terramar Policy, the policyholder(s) of such Terramar Policy and all other information required in Paragraph 1 of this Notice have been accurately and sufficiently identified in a Terramar Notice submitted by the Terramar Notice Date;

3. Any claim against Frontier pursuant to any Terramar Policy will be barred where the Submitting Terramar Policy Interest Holder had knowledge of the event, accident or occurrence giving rise to the claim, the person or property allegedly injured or damaged, and the nature of the alleged injury or damage, prior to the Terramar Notice Date and did not submit a timely Terramar Notice setting forth such information concerning the claim;

4. All persons will be barred from asserting claims against Frontier pursuant to any Terramar Policy other than Submitting Terramar Policy Interest Holders who submit a timely, accurate and sufficient Terramar Notice in connection with such Terramar Policy by the Terramar Notice Date; and

5. All Terramar Notices must be made in writing and sent to the Rehabilitator by first class mail, postage paid and postmarked on or before the Terramar Notice Date, or by overnight courier, fees paid and written acknowledgement of receipt by such courier on or before the Terramar Notice Date, to the following address:

Frontier Insurance Company in Rehabilitation
Attn: Legal Department
195 Lake Louise Marie Road
Rock Hill, N.Y. 12775-8000

Copies of Terramar Notice forms and instructions have been posted on the internet site maintained by the New York Liquidation Bureau at http://www.nylb.org or may be requested by calling 845-807-5047.

JAMES J. WRYNN
Superintendent of Insurance
of the State of New York as Rehabilitator
of Frontier Insurance Company

LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE
CHANCERY DIVISION
COMPANIES COURT
Claim No. 1652 of 2009
IN THE MATTERS OF

MINSTER INSURANCE COMPANY LIMITED
MALVERN INSURANCE COMPANY LIMITED
THE CONTINGENCY INSURANCE COMPANY LIMITED
PROGRESS INSURANCE COMPANY LIMITED
GAN ASSURANCES IARD
QBE INSURANCE (EUROPE) LIMITED
THE RELIANCE FIRE AND ACCIDENT INSURANCE CORPORATION LIMITED
and IN THE MATTER OF THE COMPANIES ACT 2006

NOTICE IS HEREBY GIVEN [illegible]

LEGAL NOTICE

IN THE MATTER OF THE BERMUDA COMPANIES ACT 1981 AND IN THE MATTER OF COMMERCIAL RISK REINSURANCE COMPANY LIMITED

NOTICE IS HEREBY GIVEN that the above named company intends to discontinue in Bermuda pursuant to Section 132(G) of the Bermuda Companies Act 1981 and to continue in the state of Vermont of the United States of America as if the Company had been incorporated under the laws of the state of Vermont of the United States of America.

Dated this 23rd day of
November 2009
By Order of the Board
Pierre Charles
President

Business Resources

INSURANCE & REINSURANCE MANAGEMENT

EDUCATION & TRAINING

Marsh: Prosecutors throw in the towel in latest bid-rigging case

CONTINUED FROM PAGE 1

adverse outcomes of the first two trials, they really didn't have much of a choice."

In requesting the dismissals, prosecutors cited the high cost of pursuing another lengthy trial and the likely outcome after the recent acquittals.

"Initially, I was surprised they folded so easily, but I think it was the judiciously prudent thing to do," said Fran Semaya, chair of the insurance regulatory practice of Nelson Levine de Luca & Horst L.L.C. in New York, who was not involved in the case.

The former defendants and their attorneys hailed the dismissals as a vindication.

"I've maintained my innocence from the very beginning," Mr. McBurnie said. "In the end I think it's a just result." He said the "long ordeal" has been "particularly difficult" on his family and said he hopes to return to the insurance industry.

"Tom Green has been steadfast in his innocence," said Matthew W. Brissenden, Mr. Green's attorney and a partner at Garden City, N.Y.-based Scaring & Brissenden P.L.L.C. "It's been four long years, but we are obviously very pleased with the attorney general's decision."

Ms. Mandel "never committed a crime, and there was never any scheme to defraud," said Mark Schamel, her attorney and a partner with Washington-based Schertler & Onorato L.L.P.

Assistant Attorney General Gail Heatherly declined to comment.

Mr. Spitzer did not respond to a request for comment.

The original indictments accused the executives of colluding with employees at various insurers including American International Group Inc., ACE USA, Zurich American Insurance Co. and others to rig the market for excess casualty insurance. Investigators accused the executives of steering business to insurers that paid Marsh lucrative contingent commission fees, preventing a competitive bidding process. The defendants were charged with scheme to defraud, restraint of trade and various counts of larceny.

Last month, Judge Yates found three former Marsh executives not guilty of scheme to defraud and restraint of trade charges. They are Joseph Peiser, former managing director and head of Marsh's global broking excess casualty unit; Greg J. Doherty, former Marsh senior vp and ACE USA local broking coordinator team leader; and Kathleen M. Drake, former Marsh managing director and local broking coordinator team leader.

In February 2008, former Marsh Managing Directors William Gilman and Edward J. McNenney were found guilty of an antitrust charge but acquitted of other charges and were sentenced to 16 weekends in jail. They are appealing their convictions and observers say it's too soon to say what impact, if any, the recent developments might have on their appeal.

Some observers say the results show Mr. Spitzer went too deep into the firms in leveling charges but do not diminish the significance of the criminal conduct that was exposed.

"The convictions speak for themselves," but the dismissals are "a tacit admission that the investigation went too far to begin with," said Mr. Carbin. "I think the results suggest the misconduct was isolated and not endemic to the industry," he said.

"I do think (Mr. Spitzer) cast his net too wide," said Ms. Semaya. "In the end, they just didn't have the evidence to support the allegations," she said. But, the investigation "did shed light on the larger issue of alleged misuse of contingent commissions in the industry."

"My sense is that the (attorney general) still considers its investigation both appropriate and successful," said James M. Burns, a partner and chair of the antitrust group of Williams Mullen in Washington. The case "has changed the way the insurance industry looks at the antitrust laws, and demonstrated that the state will vigorously enforce them" if it believes a violation has occurred, he said.

"To that extent, at the very least" the attorney general "did have success, particularly given the settlements and guilty pleas they obtained against other individuals," Mr. Burns said.

Nineteen people, including 10 former Marsh employees, have pleaded guilty to charges stemming from the investigation.

Marsh itself did not face any criminal charges in the case but paid $850 million in January 2005 to end officials' bid-rigging and fraud probes.

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Mercer: Health care plan costs rise 5.5% in '09: Study

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with between 10 and 499 employees in this year's survey offered a CDHP linked to either a health savings account or health reimbursement arrangement, up from 9% last year. Of those offering a CDHP, it is the only medical care plan that 55% provide to employees.

The difference in costs between CDHPs and other plan designs is striking. CDHPs linked to HSAs cost an average of $6,393 per employee in 2009, nearly $2,000 less per employee than preferred-provider organization or point-of-service plans, according to the survey.

Eighteen percent of smaller employers said it is "very likely" they will offer a CDHP next year, while 24% of larger employers—those with at least 500 employees—said it is very likely they will offer a CDHP in 2010. This year, 20% of larger employers offer a CDHP.

Along with increased employer adoption of CDHPs, employee enrollment, while still small, also is rising. In 2009, 9% of employees were enrolled in CDHPs linked to HSAs or HRAs. As recently as 2006, just 3% of employees were enrolled in CDHPs.

Another important factor helping keep costs more controlled is increased employer adoption of health management programs, such as health risk assessment programs that seek to identify employees' health conditions so action can be taken to prevent those problems from worsening.

For example, 73% of employers with at least 500 employees said they offered a health risk assessment program this year, up from 65% last year; 71% offered a disease management program this year, up from 66% last year.

Ms. Havlin says there is much more that can be done to better manage care for employees who generate a majority of health care costs.

Slowing rises in group health care plan costs also resulted from a long-time employer strategy: shifting more costs to plan participants. For example, among PPOs in which a deductible is imposed for in-network coverage, the average individual deductible climbed to $1,096 this year, up from $1,001 last year. As recently as 2004, the average PPO deductible for individual coverage was $686.

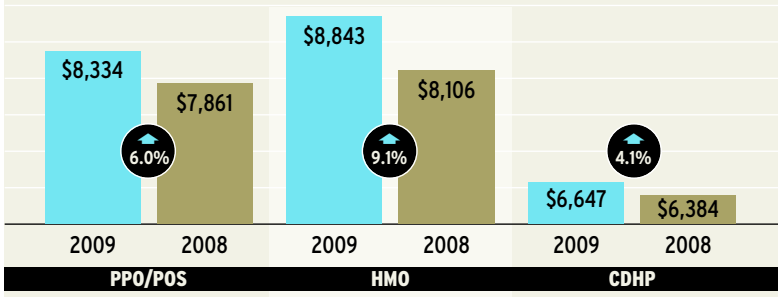
Other survey findings include:

- The percentage of employers offering health care coverage remained steady at 65% in 2009, unchanged from the prior year but down from 70% in 2001.
- Forty-seven percent of employers either have or will have to revamp mental health care benefits to comply with federal requirements that generally go into effect on Jan. 1. Those requirements, embedded in a broader bill Congress passed last year, require group health care plans to provide the same coverage for mental disorders as they do for other medical conditions.
- Employees on average contribute $1,424 a year to their health care flexible spending accounts. That is well below a $2,500 cap included in a health care reform bill passed by the House of Representatives and another measure now awaiting action by the full Senate.
- Twenty-three percent of employers with at least 20,000 employees discount health insurance premiums for nonsmokers, up from 17% in 2008.

The report, "National Survey of Employer-Sponsored Health Plans," will be published in March. The report costs $600 and the report and tables cost $1,200. More information is available at *www.Mercer.com/ushealthplansurvey* or from Tara Lewis at 212-345-2451.

COSTS VARY FOR LARGE EMPLOYERS*

Health care plan costs per worker are highest for health maintenance organizations, followed by preferred-provider organizations/point-of-service plans and consumer-driven health plans.



Source: Mercer L.L.C. **For employers with at least 500 employees*

Spain: Big insurers see big fines

CONTINUED FROM PAGE 3

The CNC has produced its own documentation citing numerous meetings of the insurers and reinsurers and the steps they allegedly took to set coverage prices.

A CNC statement said meetings between the companies resulted in "complete uniformity in the premiums proposed by the different underwriters present in the Spanish decennial market and the elimination of competition."

The insurers and reinsurers tried to set up a cartel that included all insurers offering decennial coverage in Spain, the CNC alleged. "Toward this end, the reinsurers undertook to work the minimum price agreement into the pricing guidelines they annex to the reinsurance contracts. These guidelines are compulsory for insurers," the agency said.

Most of the companies accused of participating in the alleged cartel denied the allegations. By late last week, all of the companies except Munich Reinsurance Co. said they would appeal the fines to the Audiencia Nacional, one of Spain's high courts.

In statements, Madrid-based Asefa S.A. called the commission's charges 'completely unfounded,' and Zurich-based Swiss Reinsurance Co. branded them 'unjustified.'

In statements, Madrid-based Asefa S.A. called the commission's charges "completely unfounded," and Zurich-based Swiss Reinsurance Co. branded them "unjustified."

In a statement, Caja de Seguros Reunidos denied there was any price-fixing agreement and said the CNC had damaged the insurer's reputation by filing the charges.

Asefa said the CNC move "very seriously injures the company's image."

However, one large insurance buyer in Spain said the CNC is on the right track.

Prices throughout the market for decennial coverage were "not exactly the same, but similar," said the head of insurance at a large Spanish construction company, who asked not to be named. "This gives the impression that there was some agreement."

The investigation into the alleged price-fixing was initiated by the directorate of investigation at the CNC, said Miguel Ángel Martín de Pablos, a member of Ms. Naranjo's staff. There were no complaints from policyholders, he said.

TARP: Some calling for fed audit

CONTINUED FROM PAGE 4

tees, the Democratic congressmen, led by Rep. Elijah Cummings, D-Md., cited the report in calling for a congressional investigation of the Federal Reserve System.

Rep. Cummings specifically noted the report's criticism of regulators' unwillingness to negotiate counterparty concessions because the New York Federal Reserve Bank argued that it was acting as an AIG creditor rather than a regulator in the negotiations.

"I believe it is intellectually disingenuous to separate these roles in this case and, frankly, how effective a regulator can the Federal Reserve be if it is unwilling to strive for good public policy through its regulatory powers?" Rep. Cummings wrote.

In addition, two high-ranking Republican congressmen sent a letter last week to Financial Services Committee Chairman Barney Frank, D-Mass., seeking a hearing on the report.

"Without a hearing to fully explore the decisions that led to the bailout of AIG and its counterparties, we are concerned that efforts to extend and expand TARP, as well as legislation currently being considered by (the committee) to codify a permanent bailout authority, will only lead to many of the same mistakes that have cost taxpayers hundreds of billions of dollars," wrote Reps. Spencer Bachus, R-Ala., and Roy Blunt, R-Mo.

Swab: University's policy raises red flags

CONTINUED FROM PAGE 3

collect DNA from applicants for employment."

Mr. Mallo said in the letter he is recommending the revision "in order to both clarify the intent and the language of the current university rule and avoid any real or perceived conflict with 'GINA.'" A university spokesman did not return calls seeking comment.

Title II of GINA, which took effect Nov. 21, states that, with some narrow exceptions, "it shall be unlawful employment practice for an employer to request, require or purchase genetic information with respect to an employee or a family member of the employee."

The university's rule is "a terrible idea," said Jonathan T. Hyman, a partner with Kohrman Jackson & Krantz P.L.L. in Cleveland. If someone submits genetic information, and then is not hired, in light of GINA, "it's going to raise a colossal red flag."

Paul E. Starkman, a partner with law firm Arnstein & Lehr L.L.P. in Chicago, said, "I always tell people, be careful what you ask for, because it can later come back to bite you."

Employers that acquire genetic information that reveals disabilities or a potential genetic disposition run the risk of tainting their hiring process, he said.

"You can try and minimize those risks by segregating the information and keeping it confidential, but usually there's somebody who's going to have to take a look at this information that (will) determine whether you go ahead with the hiring process or not, and that's where it can cause potential problems," he said.

"It may be more trouble than it's worth," said Mr. Starkman.

Anthony J. Oncidi, a partner with law firm Proskauer Rose L.L.P. in Los Angeles, said, "It seems to me the cost of the potential liability outweighs any prospective benefits," he said.

Brian T. Ashe, a partner with Seyfarth Shaw L.L.P. in San Francisco, said the rule also raises concerns about privacy rights violations because "it amounts to snooping around that genetic blueprint."

Even if only initially used for a criminal background check, "you're still going to have this information on hand that is incredibly private and incredibly detailed...that could be used at some future point" for purposes that it was not intended to be used for today, said Mr. Ashe.

"I think it would be very difficult for employers to take on the responsibility of keeping that information safe in the long run," he said.

Rich Stover, a principal with Buck Consultants L.L.C. in Secaucus, N.J., said the rule also raises concerns about violating the ADA, which prohibits non-job-related exams. "You can certainly view collecting DNA" as falling into this category, he said.

The rule "would seem to be fraught with problems in complying with federal law, and I'm not sure, at least right now, what value collecting data would have in identifying…people with a criminal background," Mr. Stover said.

The regulation as it now reads also would hurt faculty recruitment, said William D. Rich, an associate professor in Akron University's law school, who submitted a resolution —which was unanimously approved—to the faculty senate condemning the rule.

The policy is "poorly thought out and ill-advised," said Mr. Rich, who is the senate's vice chairman.

Observers say employers generally have not considered implementing similar approaches. They say one of the rare exceptions concerning DNA and employers involved the Fort Worth, Texas-based Burlington Northern Santa Fe Corp., which agreed in 2002 to pay $2.2 million to 36 workers who claimed the company had conducted genetic tests without their permission. The EEOC, which sued Burlington in 2001, had claimed the genetic testing program, which purportedly was intended to explore a possible genetic link to carpal tunnel syndrome, violated the ADA.

Dr. Harlan Levine, a principal with Towers Perrin in Los Angeles, said, at this point, "the whole field of how to manage genetic information is emerging, and so little is known even on the technical side about what to do with most of the genetic information, I think it's unlikely employers will jump in early and start requiring DNA testing."

"I'm sitting here struggling with why employers would want to do this," said Michael Aitken, director-government affairs at the Alexandria, Va.-based Society for Human Resources, whose organization has had a policy opposing genetic testing for several years.

"It strikes me as probably more invasive in terms of the kinds of inquiries an employer needs to do than would otherwise be necessary," Mr. Oncidi said.

Exams: Coverage not expected to change

CONTINUED FROM PAGE 1

But if more evidence is published and consensus builds in support of the new recommendations, health plans and self-funded employers might reconsider their coverage provisions, they say.

Most fully insured plans provide mammography coverage for women in their 40s as a result of state mandates, so unless state legislatures take up the issue, coverage will remain in place.

After advising women in 2002 to have breast cancer screenings every one to two years beginning at age 40, the U.S. Preventive Services Task Force last week said it now recommends biennial mammograms for women starting at age 50.

The independent panel of doctors and scientists concluded that because any additional benefit gained by starting screening at age 40 rather than age 50 is "small" and potential harm from the screenings—including false positives, unnecessary procedures and radiation exposure—remains, decisions to start regular biennial mammograms after age 40 should depend on individuals rather than be routine.

Health care experts say that while the recommendations have generated controversy, women in their 40s will continue to receive coverage for mammograms, at least in the near term.

"I think a lot of people have been looking at the part of the guideline that relates to women 40-49 and there are two pieces to that," said a spokeswoman for the Washington-based America's Health Insurance Plans.

"The first piece says that the task force is recommending against routine screening for all women 40-49 and in that context 'routine' basically means 'automatic.' But the second part says the decision to start screening earlier than age 50 should be an individual patient decision. So if you're following the guideline, what that means is, if a physician and a patient have a discussion about mammography and decide to go ahead with it and the physician writes the order, than it typically is going to be covered," she said.

In terms of coverage provisions, Randall Abbott, a senior consultant for Watson Wyatt Worldwide in Boston, said, "We don't see anyone rushing to make changes."

As more guidance comes out, there is a possibility that health plans and employers will revisit this, he said. But from an employee-relations point of view, any employer contemplating a reduction in benefits likely will be met with a very adverse reaction from workers. It's not a costly benefit and there are many testimonials from women in their 40s who have survived breast cancer because of early detection from a mammogram, he said.

Coverage changes are not likely to happen immediately, agreed Susan Margolis, a New York-based director in the health care practice of PricewaterhouseCoopers Human Resource Services.

Other professional organizations, such as the American Cancer Society, continue to recommend annual mammography screening for women in their 40s. Until there is more uniform advice, "I don't see any immediate (policy) changes," Ms. Margolis said.

Until health plans issue new coverage provisions, "I don't see employers making changes particularly for something like this that is so controversial," she added.

Rather than denying benefits, Helen Darling, president of the National Business Group on Health in Washington, said she thinks health plans and employers will begin to put more emphasis on individual patients' decisions with their doctors.

"A woman shouldn't decide to get a mammogram because it's covered or not," she said. Rather, she should discuss with her physician her individual risk factors, her comfort level, and all the scientific evidence and then make a decision about whether to have a mammogram.

Health insurers said last week that, while they are reviewing the USPSTF recommendations, they are not taking immediate steps to change coverage provisions.

WellPoint Inc.'s position "will remain unchanged for the immediate future and continues to consider annual screening mammography medically necessary for women aged 40-49 years," the Indianapolis-based health insurer said in a statement. "We will continue to review and analyze the research surrounding breast cancer and other preventive screening procedures and, if appropriate, will evaluate medical policy revisions."

"The decision about when to have a mammography screening is an individual decision between a woman and her doctor, based on an individual's specific circumstances and medical history," CIGNA Corp. said in a statement. "Our current coverage policy provides for coverage of screening mammography beginning at age 40—or as young as 25 if a woman is in a high-risk category—and continues to remain in effect."

Hartford, Conn.-based Aetna Inc. also covers annual screening mammograms for women beginning at age 40 and for women younger than 40 who are at high risk.

"This policy will remain in place while Aetna reviews the USPSTF's recommendations, and conducts a thorough review of the current medical literature and evidence-based guidelines on this topic," the company said in a statement.

In a statement, Minnetonka, Minn.-based UnitedHealthcare said, "A decision about mammography requires a detailed discussion between the patient and her physician and it should consider the medical evidence, patient preferences, and unique clinical issues for each patient."

Safeway: Healthy habits earn premium discount

CONTINUED FROM PAGE 4

much of it is about behavior and so much of it is concentrated in such few areas that we developed incentives to…improve behavior in those four disease states," Mr. Shachmut said.

Using its claims data, Safeway quantified the additional health care costs associated with those four health measures: An employee who smokes costs $1,405 annually more than one who does not; $1,400 for obesity; $645 for lack of exercise; and $600 for uncontrolled hypertension.

Safeway also did some comparison shopping for certain common medical procedures and discovered that the fees charged by facilities where the procedures were performed varied significantly more than the fees charged by physicians and other providers.

Based on this information, the company adopted what it called a "reference price," and then told its employees that was all the company would pay for those particular procedures. If the facility they used charged more than that, they would have to pay the difference, and that out-of-pocket expense would not be applied toward their annual deductibles.

"It should not surprise you that…we've had no colonoscopies in the greater San Francisco area over $1,500," Mr. Shachmut said.

Moreover, because of the Healthy Measures and transparency initiatives, Safeway's 2009 health care costs are projected to be just 2% higher than 2005, and next year will be just 1% more than 2005. This translates into $150 million in cumulative savings since the program began in 2006 and is expected to hit $230 million next year.

"So, technically, we flat-lined our costs without cost-shifting," Mr. Shachmut said.

The company also has shared about 60% of the money saved to reduce employee premiums.

He suggested that if Safeway's program were used nationwide, the percentage of the gross domestic product spent on health care would return to 1980 levels by 2020.

"We don't have to look at taxes on hospitals. We don't have to look at taxes on pharma. We don't have to take money away from Medicare. There are plenty of opportunities (for cost cutting) in the current system," he said.

425 attend NBCH annual gathering

PHOENIX—Some 425 health care coalition representatives, including employers, health plans, coalition directors and health care providers, attended the National Business Coalition on Health's 14th Annual Conference.

The Nov. 8-10 meeting featured panel discussions on health reform and performance measurement, updates on pay-for-performance and transparency initiatives, and innovations in management and value-based design.

The next meeting is Nov. 14-16, 2010, in Washington.

Information is online at *www.nbch.org*.

—By Joanne Wojcik

'Stick' more effective than 'carrot'

NBCH speakers focus on effective tactics to boost generic drugs

By JOANNE WOJCIK

PHOENIX—Employees trying to make a health care purchasing decision are more likely to respond to messages that are framed negatively than those that are presented in a positive tone, behavioral economists are finding.

That's why employers should choose the "stick" approach over the "carrot" when designing financial incentives to encourage greater use of generics, Bob Nease, chief scientist at St. Louis-based pharmacy benefit manager Express Scripts Inc., told attendees at the annual meeting of the National Business Coalition on Health.

"Although financial incentives are incredibly important in motivating behavior change, they're really not sufficient in and of themselves," he said during a consumerology session at Nov. 8-10 gathering in Phoenix.

What's more important is the way those financial incentives are communicated, he said.

"Framing the message negatively has greater impact than framing it positively," Mr. Nease said.

For example, for every 10% decrease in copayments for generic prescription drugs, there is only a 1% increase in the use of generics, he said. However, "if you increase the price, demand drops pretty substantially," Mr. Nease said.

"Tiered copayments are a perfect example. The theory is that people will realize they could substitute down for a lower-priced option that will get the job done and, therefore, you will see behavior shift," Mr. Nease said. But "you can't crank up the copayment difference enough to get people to fully use generics when they are a clinically appropriate alternative."

Two banners on Express Scripts' member portal also provide evidence that people are more sensitive to cost increases than cost reductions, Mr. Nease suggested.

One banner said, "Save precious time and money," while the other said, "Stop wasting your money." While 18% of visitors clicked on the first banner with a positive message, 84% chose the second banner with a more negative message, he said.

Mooresville, N.C.-based home improvement retailer Lowe's Cos. Inc. applied these principles to get its employees to make greater use of its mail-order prescription drug program for maintenance medications, Bob Ihrie, senior vp of employee rewards and services, said during the session.

He said employees who refilled their prescriptions at a retail drug store were told they could get only two more refills at their regular copayment after Jan. 1, 2009, and would pay the full price for subsequent refills—unless they switched to mail order, which would provide three refills for the price of two.

To make the switch easier, Express Scripts, the company's pharmacy benefits manager, called plan members' doctors to change their prescriptions to 90 days, eliminating the need for them to make a doctor's appointment to obtain a new prescription, Mr. Ihrie said.

In addition, Lowe's told its 225,000 employees how much the company would save if everyone switched to home delivery of prescriptions, and sent personalized savings letters to each employee taking a maintenance medication filled at a retail drug store, he said.

This not-so-gentle nudge increased the use of mail order from 15% to 52% in less than three months, saving the company approximately $2.7 million annually. In addition, savings to employees is estimated at nearly $2 million this year, Mr. Ihrie said.

Because of the success of the switch to a mail-order program, Lowe's decided to apply the same behavioral economics principles to other areas, he said.

To encourage employees to open communications they receive from the Lowe's benefits department, it dropped all dependent coverage until employees respond to a dependent audit.

"We're trying to convince our people when they get something in the mail from the benefits department, they need to open it," Mr. Ihrie said. "We had over 4,500 people discover that they better open the envelope next time. They had their dependents dropped in July, and they can't get them back on until Jan. 1."

Lowe's gave employees several opportunities to respond before taking such drastic action. In addition to three rounds of communications, there were two appeals periods during which employees could ask that their dependents be reinstated, he said.

"Behavioral economics is really sort of 'street economics,'" Mr. Nease said. It "shines a light on nonfinancial incentives and assumes that you can motivate people to change in other ways than just manipulating copayments and giving them skin in the game."

Weak economy teaches some tough lessons

World Captive Forum speakers advise taking a longer-term view

By RODD ZOLKOS

BONITA SPRINGS, Fla.—Investment market turmoil during the past year has offered several lessons for captive insurance company investors, not the least of which is not counting on investment market liquidity, one expert says.

Speaking about captive investment strategies in troubled times at the 19th Annual World Captive Forum this month in Bonita Springs, Fla., Clifford Axelson, managing director at Prudential Financial Inc. in Newark, N.J., said, "You have to assume that liquidity will not be there when you need it."

In today's environment, Mr. Axelson said captives should look to cash for their liquidity needs, and suggested they rely on sources such as dividends and income from their captive operations for needed liquidity, rather than expecting to be able to sell securities.

Other lessons offered by the investment climate include viewing investment diversification from a long-term perspective.

"My advice to you would be not to give up on diversification. It works, but it's a longer-term phenomenon," Mr. Axelson said.

Recent events also have shown that bond investments have risks beyond interest rates, Mr. Axelson said, and that "securities lending is not a riskless investment."

The current market also has offered lessons about the role of risk assessment tools that measure value at risk, he said. "Risk tools in the marketplace like value at risk are just that: They're tools," Mr. Axelson said. Those tools are based on economic fundamentals, he said, "and do not work in predicting shocks to the economy."

"Frankly, tools should never dictate anything," Mr. Axelson said. "They should be a guide. They should help you make decisions."

In dealing with a captive's investments, "There is no substitute for a sound fiduciary process," he said.

Among the most important considerations in captives' investment programs are the captive's liability stream and the company's appetite for risk, Mr. Axelson said. "For cyclical companies that go through a cash squeeze when the economy takes a downturn…(they) probably need to set cash aside, be a little more averse to risk," he said.

At the same time, however, Mr. Axelson challenged captive owners to "consider the opportunity cost" of focusing exclusively on extremely short-duration investments.

"While the investments will not make a captive be successful, they can certainly hurt the chance for success," Mr. Axelson said.

Another speaker on the investment panel, Chris DeMeo, division practice leader-East at Watson Wyatt Worldwide in New York, noted investment risk appetite of captives often changes over time. Unfortunately, however, "Those risk appetites often change at the wrong time," he said. "The last thing that a successful captive wants is to trade a risk that they have that they don't want for a new risk that they don't know about."

Noting that he has some clients whose investment policies are "just paper," Mr. DeMeo said it's important that a captive have an investment policy it actually follows.

He advised captives to "be true to thyself" and their governance structures. "Where we've seen investors get in trouble is where they have low governance and a highly complex portfolio," Mr. DeMeo said. It's important that captives align their level of governance with their investment approaches.

In discussing investment strategies, Mr. DeMeo said he looks to engage clients in discussions of, "What's the worst that could happen?"

If captives have set long-term investment plans, market turns alone don't suggest that those strategies are inappropriate, Mr. Axelson said."If you put an asset allocation in place for the long-term, the fact that the markets correct or move up or back abruptly doesn't negate its validity," he said.

Wendy Liu, senior consultant at Towers Perrin in New York, moderated the panel.

OSHA: Data inadequate

CONTINUED FROM PAGE 4

dle & Reath L.L.P., said more frequent audits and interviews of workers would ensure employers properly record injuries and illnesses. In addition, OSHA should increase communication and training to help employers better understand record-keeping requirements.

While the GAO cited peer pressure, loss of safety bonus rewards or company safety ratings as reasons injuries or illnesses go unrecorded, Mr. Maser said the problem could be reduced if OSHA offered incentives for employees and employers to report injuries or an unsafe working condition.

Jordan Barab, acting assistant secretary, said OSHA is developing rewards, adding that OSHA on Oct. 1 installed a national emphasis program on record-keeping in response to several studies of underreporting and congressional interest.

News In Brief

rating agencies, alleging they offered inflated and misleading ratings of mortgage-backed securities and damaged five public employee pension funds that invested in the securities. The suit alleges that Standard & Poor's Corp., Moody's Investors Service and Fitch Ratings made misleading evaluations of mortgage-backed securities, in part, because of the fees they received from the issuers of the securities. Mr. Cordray filed the suit on behalf of the Ohio Public Employees Retirement System, the State Teachers Retirement System of Ohio, the Ohio Police & Fire Pension Fund, the School Employees Retirement System of Ohio and the Ohio Public Employees Deferred Compensation Program. Preliminary estimates indicate the funds lost more than $457 million, Mr. Cordray said.

Ironshore, Starr deal adds aviation capacity

Ironshore Specialty Co. is entering the aviation insurance market through an arrangement with Starr Aviation Agency Inc., which will underwrite aviation risks for the unit of Bermuda-based Ironshore Inc. Ironshore will offer coverage to airlines, aviation manufacturers, airports, aviation refuelers, fixed base operations, corporate aircraft and other general aviation risks worldwide. Gerald E. Frick, who was global leader of the aviation practice at broker Marsh Inc. before his recent retirement, will lead the unit.

Microsoft gets OK for LTD in captive

The Labor Department has given Microsoft Corp. final authorization to fund benefit risks through the Vermont branch of its Bermuda-based captive insurance company. Microsoft will use the Vermont branch of Orcas Ltd., its 11-year-old property and liability captive, to reinsure long-term disability policies covering about 55,000 U.S. employees. The coverage will be written by Prudential Insurance Co. of America, according to Microsoft's application filed by the Somerset, N.J., office of Aon Consulting.

MMC director Olsen dies

David A. Olsen, former chairman and chief executive officer of Johnson & Higgins and later director of Marsh & McLennan Cos. Inc., has died after a brief illness. He was 71. Mr. Olsen joined MMC in 1997 after its acquisition of J&H, where he had served as chairman and CEO since 1990 and 1991, respectively. He served as MMC vice chairman from June through December 1997 and was elected to MMC's board the same year. Mr. Olsen joined J&H in 1966 and helped it become the world's sixth-largest broker before it merged with MMC in a $1.8 billion cash-and-stock transaction.

Willis deal defers Gras Savoye buy

Willis Group Holdings Ltd. has signed a definitive agreement with French private equity firm Astorg Partners to sell part of Willis' stake in Gras Savoye & Cie for $160 million, though the brokerage will retain an option to buy outright its French partner. Willis announced in June that it was seeking to sell some of its 48% stake—valued at $343 million—in Paris-based Gras Savoye, which it has steadily increased since its original investment in 1997. Under a put agreement, however, Willis could have been obligated to buy the remaining shares of the brokerage between now and 2011, if Gras Savoye's shareholders had "put" their shares to Willis. The agreement would end the put option, leave Willis with a 31.8% stake in the Gras Savoye holding company and give Willis the option to purchase 100% of the capital in Gras Savoye in 2015.

Aetna plans to cut more than 1,200 jobs

Aetna Inc. said it will shed 625 jobs due to economic conditions. Aetna, which has approximately 35,000 employees, also said it expects to make a similar number of layoffs by the end of the first quarter of 2010, though it does not plan to exit any markets. Aetna said it expects to incur a restructuring charge of about $40 million after taxes.

XL Insurance to write inland marine cover

XL Insurance is starting an inland marine operation in New York led by Frank Oleskiewicz, who will be vp and senior underwriter. Previously, he was director of inland marine for Catlin U.S.

Noted

The **National Assn. of Insurance Commissioners** has chosen Pacific Investment Management Co. as a third-party financial modeler to help state regulators determine the risk-based capital requirements for residential mortgage-backed securities.

ROAD TO REFORM

How the House and Senate health care reform plans would affect employers

PROVISION	HOUSE	SENATE [AS PROPOSED]
TAX ON EXPENSIVE PLANS	No provision	40% excise tax on premiums exceeding $8,500 for single coverage and $23,000 for family coverage. Higher for certain high-risk professions and early retirees.
COVERAGE MANDATE	Require all but very small employers to offer coverage. Penalty of 8% of pay for each employee not covered.	Penalty of $750 per employee on employers not offering coverage. If premiums exceed 9.8% of family income, other penalties apply. Small employers exempted.
FLEXIBLE SPENDING ACCOUNTS	Starting in 2011, annual FSA contributions capped at $2,500 with future increases linked to the Consumer Price Index.	Similar, except $2,500 cap would be frozen.
RETIREE HEALTH	Bar employers from reducing retiree health care benefits unless they make comparable cuts for active employees.	No provision
COBRA CONTINUATION	Require employers to continue COBRA until beneficiaries find new group coverage or until state health insurance exchanges are set up.	No provision
DEPENDENT COVERAGE	Require plans to extend coverage to dependents through age 26.	Require plans to extend coverage to dependents through age 25.
MEDICARE PRESCRIPTION SUBSIDY	Strip tax break from employers offering retiree prescription drug coverage that is equal to Medicare Part D	Same

Reform: Senate plan differs

CONTINUED FROM PAGE 1

health care plans from cutting benefits and another that would require employers to extend COBRA continuation coverage years longer than under current law.

"This is definitely an improvement over the House bill," said Gretchen Young, vp-health policy at the ERISA Industry Committee in Washington.

"In general, employers felt the House bill was unacceptable," Mr. McArdle said. "The Senate (bill) may be preferable, but where an individual employer will stand will depend heavily on its facts and circumstances."

In fact, the National Assn. of Manufacturers last week said it opposes the Senate bill. The Senate bill "would do real damage to employer-provided health care," John Engler, NAM's president and chief executive officer, said in a statement.

For example, the Senate bill would hammer employers with high health care costs by imposing a 40% excise tax on the portion of health insurance premiums that exceed $8,500 for single coverage and $23,000 for family coverage. The tax—to be paid by insurers and third-party administrators but likely passed on to employers—would start in 2013. The cost thresholds would be somewhat higher for plans covering employees in high-risk industries such as construction and mining or early retirees. From 2014 on, the maximum nontaxed premiums would be linked to the Consumer Price Index, plus one percentage point.

Such a tax would be inequitable, said Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington. The tax could be triggered, not because of the richness of an employer's health care benefits, but because of demographics, such as a company that has a high proportion of older employees with significant health care needs, Ms. Sheaks said.

To avoid the tax, employers might scale back coverage, hurting employees. "You are between a rock and a hard place," she said.

Employers in high-turnover industries, such as retail and fast-food, that typically impose significant waiting periods for employees to enroll in their health care plans, also would face a new tax under the Senate bill.

Under the measure, employers with waiting periods between 31 and 60 days would pay a penalty of $400 per year for each full-time employee affected by the waiting period. For waiting periods between 61 and 90 days, the penalty would be $600. Waiting periods longer than 90 days would be prohibited.

In addition, employers with low-wage workforces and that require employees to pay a significant portion of the premium would face another new penalty. It would affect employers whose workers pay more than 9.8% of their income for employer-provided coverage and those who receive premium subsidies through new state health insurance exchanges.

The annual penalty would be $3,000 for each employee receiving subsidized coverage, or $750 for every employee in the company, whichever is less.

To avoid that penalty, one strategy employers could use would be to reduce premiums for lower-paid employees, Mr. McArdle said.

Like the House bill, the Senate plan would place a $2,500 cap on the maximum pretax contributions employees could make to health care flexible spending accounts starting in 2011.

In a significant departure from the House, though, the Senate plan would freeze the cap; the House bill would link the $2,500 cap to future index increases. Washington observers say, though, attempts will be made on the Senate floor to liberalize the FSA cap.

The heart of the House and Senate bills is identical: providing health insurance premiums to the lower-income uninsured and moving the nation closer to universal coverage.

That could benefit employers because of an expected reduction in the volume of uncompensated care, a cost that providers, where possible, now shift to insured patients.

Business Insurance END PAGE

All I want for Christmas is flu...vaccine

Santa Claus knows 'tis better to give than to receive, but one thing the nation's Santas really want this upcoming holiday season is the vaccine against the H1N1 virus.

In fact, according to the Associated Press, the president of a group of Santa's seasonal helpers called Santa-America Inc. recently asked Rep. Jo Bonner, R-Ala., to designate Santas as a priority group for receiving the H1N1 flu vaccine.

That would put them in the same category as health care workers.

Another group, the Amalgamated Order of Real Bearded Santas Inc., held a seminar on H1N1 in Philadelphia.

AP reported that the group urged its members to use hand sanitizer and take immune system-boosting vitamins.

But Nicholas Trolli, president of the Amalgamated Order of Real Bearded Santas, said that Santa's helpers can't do it alone—parents need to keep sick children away from the jolly old men.

"We don't want any child to go without seeing Santa, but it's not worth bringing your child to the mall, infecting the Santa and infecting the other children," Mr. Trolli told AP.

Christmas may be a time for giving, but the Santas say "regifting" is something they'd rather avoid when it comes to H1N1.


Mr. Claus

Contributing: Jeff Casale, Roberto Ceniceros, Mike Tsikoudakis


REUTERS

Manchester United forward Gabriel Obertan is participating in an unusual rehab plan in recovering from a back injury.

Recovery is goal of light-duty plan

Gabriel Obertan is a multimillion-dollar gardener.

He prunes rosebushes, waters hanging baskets of plants and manicures lawns.

He also happens to play forward for British soccer powerhouse Manchester United, which American International Group Inc. has sponsored and will be succeeded by Aon Corp. effective with the 2010-2011 season.

According to reports, Manchester United coaches wanted to make sure that the 20-year-old native of France didn't think too much of himself because he is playing for one of the world's most popular teams.

So they reportedly gave him a variety of light gardening duties while he was recovering from a back injury.

With a salary of about £20,000 ($33,390) a week, Mr. Obertan didn't feel he was above the yardwork, coaches told reporters. In fact, he proved he could mow a mean lawn.

"He could give the groundsmen a run for their money with his trimming and lawn skills," a Manchester United spokesman told reporters.

Lawsuit puts hair growth firm on the spot

A Chicago-based company is facing a hairy situation based on allegations that its treatments fell flat.

Illinois Attorney General Lisa Madigan filed a lawsuit last week in Cook County Circuit Court against the Natural Hair Growth Institute based on complaints by nine consumers that the business allegedly made false promises and refused to refund their money.

The institute asserted that its science-based laser and scalp therapy treatments, along with its topical hair products, can regrow hair naturally within six months.

Costs for the services average $8,000 to $12,000.

According to the suit, which also names owner Steve Bennis, the company failed to produce results as promised by marketing materials that guarantee natural hair growth or a complete refund.

"The defendants in this case use highly sensational marketing slogans to convince consumers to pay thousands of dollars for a service that simply isn't proven to be effective by modern science," Ms. Madigan said in a statement.

The suit aims to ban the defendants from doing business in Illinois, where they also have clinics in Deerfield and Oakbrook Terrace.

It also seeks full restitution for affected individuals as well as civil penalties of $50,000 for each violation of the Illinois Consumer Fraud Act.

While the institute said laser equipment it used had been approved by the U.S. Food and Drug Administration, "the FDA-approved laser device is not the same device used by the defendants," according to the attorney general.

Study says some Wii games help winners become losers

Not so long ago, playing video games could turn you into a couch potato.

But according to a study by the American Heart Assn., playing the active games of the Nintendo Wii, including Wii Fit, may actually help prevent or reduce obesity and lifestyle-related diseases, based on the intensity of the exercise.

In Wii Sports games, for example, players use motion-sensitive controllers to simulate golf swings, baseball pitches and boxing punches, among other activities.

In the study, which was funded by Nintendo of America Inc., the AHA found that one-third of the virtual physical activities played on the Wii require an energy expenditure of 3 metabolic equivalent values—or METs—or more, which is considered a moderate-intensity exercise.

By comparison, an adult walking 3 mph on a flat surface is expending about 3.3 METs, while a more moderate intensity would use between 3 and 6.

According to the AHA, adults gain the most health benefits when they do the equivalent of at least 2.5 hours of moderate-intensity aerobic physical activity each week.

Researchers found that 23 activities in Wii games involved MET levels between 2 and 3, while nine activities had 3 to 4 METs and five activities had more than 4 METs.

The Wii's boxing game was found to expend the most energy at about 4.5 METs, according to the study, while golf expended about 2 METs.

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