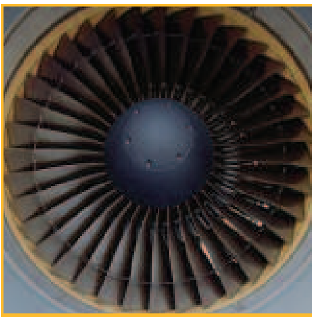

Endurance THE EDGE

Spring/Summer 2006

News and Views from Endurance

Tighten Your Seatbelts

By John Kelly
VP, Aerospace
Endurance Specialty Insurance Ltd.

Not since the Lear Jet, which made its debut more than 40 years ago, has there been this much excitement over an airplane. This airplane is known as a Very Light Jet (VLJ). VLJs are defined as jet aircraft weighing 10,000 lbs. or less and configured for single-pilot operation. VLJs can hold four to five passengers in addition to the pilot.

The VLJ phenomenon started in the late 1990's when Eclipse Aviation[1] announced it could build a jet for $850,000. Since then, there have been several start-ups including the HondaJet, manufactured by the Honda Motor Company. Even though no VLJ has yet been certified for flight, the Federal Aviation Administration (FAA) believes 4,500 VLJs will be produced by 2016.

The Concept

The National Aeronautics and Space Administration (NASA), in partnership with the FAA and state and local aviation and airport authorities, has led a research program for developing and demonstrating technologies needed for a Small Aircraft Transportation System (SATS). The project's mission is to work with the private sector to improve aircraft-based technologies that will increase safety for single-piloted aircraft and allow more dependable use of small airports.

Anyone who must use the airlines to travel has experienced delays or cancellations. Our nation's major airports are overwhelmed with air traffic and it is increasing. With over 5,000 small airports in the U.S., a small aircraft transportation system could vastly improve air travel by freeing up larger airports that are working at close to maximum capacity. The manufacturers of these small aircraft and other aviation experts believe there is a huge untapped market for these low-cost jet aircraft.[2] The first VLJ aircraft are expected to be delivered by mid-2006.

The Market

Customers for VLJs include individuals who want to pilot their own jet and on-demand charter service providers who believe they can provide convenient air travel that is also reasonably priced.

The on-demand charter service is led by DayJet Corporation, which was founded in 2002 by Ed Iacobucci, an entrepreneur who spent most of his career in the computer software industry. DayJet's plan is to use the

Eclipse airplane, which is a VLJ in its fleet, but will also consider other VLJ aircraft as they come to the market.

DayJet's mission is to make on-demand regional travel widely accessible and affordable to the

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Tighten Your Seatbelts

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public. Their service will offer more flexibility and convenience when traveling to and from hard to reach regional markets, allowing its customers to have better control of travel logistics. DayJet plans to price its product at 25% to 75% more than commercial airline fares.

Underwriting Implications

Most jet aircraft are flown by two pilots. However, VLJs will be certified for single-pilot operation. It is expected that there will be a large number of part-time non-professional pilots transitioning from low performance aircraft (i.e. piston or turbo-prop powered aircraft) to the VLJ.

A professional pilot, as defined by aviation underwriters, is one whose full-time occupation is piloting aircraft. A non-professional pilot would be considered a higher risk, because he/she may have less flying experience and thus may be more susceptible to making riskier decisions in flying the airplane. For example, a non-professional pilot in New York who needs to be in Atlanta to meet with a customer may decide to fly the aircraft in unsuitable weather because of the urgency to close a business deal.

The challenges for pilots transitioning from low performance aircraft to VLJs include:

- **High altitude operations.** Jets operate at higher altitudes and these aircraft are pressurized in order to maintain an adequate amount of oxygen in the aircraft cabin. Pilots need to be aware of hypoxia, a condition caused by an inadequate level of oxygen in the blood, which can cause unconsciousness and eventually death. Hypoxia is difficult to detect early if you're not trained to identify the symptoms.

- **High operating speeds.** Pilots must react more quickly to situations to keep up with the faster airplane. Takeoffs and landings must be accomplished at higher speeds and longer runways are required.

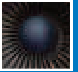
- **Engine/propulsion systems.** A jet engine is more susceptible to foreign object damage than a piston-powered engine. For example, it's not uncommon for a jet's engine to ingest a bird causing severe damage and engine shutdown. Pilots need to know how to handle these and other similar situations and be able to operate a VLJ safely on one engine should the other fail.

- **Automated Flight Management Systems.** Pilots transitioning to higher performance aircraft have many more systems to understand and manage and system automation is required to reduce the pilot's work load. Transitioning pilots need to clearly understand how these systems work and be able to respond quickly and effectively to information provided by these flight management systems.

The National Business Aviation Association (NBAA) has jumped into the fold. The NBAA is a well-respected not-for-profit organization that represents the aviation interests of over 7,000 companies that own or operate general aviation aircraft. The NBAA believes the VLJ will have a considerable impact on personal and business air travel in the near future and will use their influence to promote safety. They have developed recommended training guidelines for VLJs in consultation with VLJ manufacturers, the FAA, training providers and insurance underwriters.

The traditional approach to pilot training focused on practical test standards without much regard to proficiency. There will likely be many relatively inexperienced non-professional pilots who want to purchase a VLJ. Therefore, it is imperative that pilot candidates successfully complete initial training and, more importantly, are able to demonstrate a satisfactory level of operational proficiency for flying VLJs. As such, the concept of a mentor pilot has become an integral part of the training guidelines for VLJs.

After initial training, candidates will be required to fly with a mentor, an experienced professional pilot, until the mentor determines that the pilot is able to fly solo. Afterwards, pilots will be required to obtain recurrent training at least every six months.



Compared to other jet aircraft on the market, VLJs are relatively easy to fly. They will be fitted with the latest avionics technology to reduce pilot work load. In addition, the jet engine is much more reliable than a piston-powered engine and because of its higher performance, the VLJ operates much better on one engine if the other engine were to fail. VLJs can operate at relatively low speeds for takeoff and landing compared to other jet aircraft and thus VLJs can utilize short field airports.

There certainly is a well recognized need to improve our air transportation system and many in the aviation community believe that the VLJ will help to fulfill this need. The insurance market to date has done a good job of assessing the risks associated with the operation of VLJs. In view of the inevitable popularity that will occur when VLJs become available, underwriters should begin to prepare now to effectively underwrite and manage this risk. ❖

The NBAA believes the VLJ will have a considerable impact on personal and business air travel in the near future and will use their influence to promote safety.

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[1] *Founded by Vern Raburn, a former executive at Microsoft*

[2] *VLJ manufacturers include: Eclipse Aviation, Honda Motor Company, Embraer, Adam Aircraft Industries, Diamond Aircraft Industries, Excel Jet, Ltd., Safire Aircraft Company, Cessna Aircraft Company, Israeli Aircraft Industries*

Effect of Medicare Set Aside Regulations on Workers' Compensation Claims

By Brenda Bell
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Medicare recently recognized that it was paying billions of dollars for services that were owed by WC (workers' compensation) carriers. Federal regulations provide that medical expenses for a work related injury should not be shifted to Medicare from the responsible party. In 1981, the Medicare Secondary Payer statute established that Medicare is always a secondary benefit payer behind responsible parties for workers' compensation and other insurance claims, such as no-fault and liability insurance. However, the federal regulations were not being enforced and many claimants collected WC settlements and still filed Medicare claims.

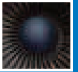
As a result, in July 2001 the federal government enforced the Workers' Compensation Medicare Set Aside (WCMSA) agreement, which prevents shifting the burden for work related injuries from the insurer to Medicare. Use of the WCMSA is limited to services that are related to a WC claim or settlement and would be covered by Medicare if the individual were a recipient. Under federal regulation[1], the Center for Medicare Services (CMS) is not to pay for any expenses related to WC illness or injury until a full accounting of all monies is reviewed prior to any Medicare entitlement. Even if there is no CMS approved WCMSA, any funds from a WC settlement must first be used for Medicare-covered services related to the WC claim until such funds are exhausted. Only then will CMS pay for Medicare-covered services related to a WC claim or settlement that have not been paid.

CMS will assess fines against carriers and other parties who fail to protect Medicare's future interests.[2] In most cases, Medicare will go after the insurers, since they are the deep pocket and should be the most knowledgeable party regarding the federal regulations. The claimant could also be at risk if the WCMSA is funded for less than the amount CMS determines is adequate to protect Medicare's interests: CMS could refuse coverage for all future work related medical treatments. In most cases, however, the court will not penalize the injured claimant and will hold the insurer responsible for payment of the deficit amount.

The workers' compensation insurer has a vested interest in obtaining Medicare approval prior to settling a claim since it could be held responsible if the funds are not properly allocated. However, the steps required to obtain Medicare approval prior to final settlement have made it more difficult to resolve WC claims. Initially, the federal government did not anticipate the enormous number of claims that would be submitted and did not have adequate staff to handle them. As a result, the turnaround time to obtain final approval was taking nine months to a year. This situation has improved since Medicare contracted with outside vendors to assist with reviewing

Medicare has enacted the following guidelines for workers compensation carriers to follow when settling a claim:

- The individual is a Medicare recipient and the total settlement value exceeds $10,000.
- The individual is not a Medicare recipient, but the total settlement is over $250,000 and the claimant will become Medicare eligible within 30 months from the settlement date.
- Worker is receiving Social Security Disability at the time of settlement.
- Worker has end stage renal disease but is not currently Medicare eligible.



The increased waiting time for settlement approval created by the federal bureaucracy of Medicare could adversely impact the ability of workers' compensation insurers to resolve these cases.

claims. Approval time can still take at least three to six months if the proposal is properly submitted – and substantially longer if the proper procedures are not followed. During this waiting time, the insurer still has exposure for the open claim and runs the risk that the claimant's condition could worsen. The projected value of the settlement could increase during this time too, since the insurer is still responsible for providing the claimant's benefits until the final settlement is approved.

Usually, there is only a small window of opportunity to settle a workers' compensation claim, which occurs when the claimant's condition has stabilized. The increased waiting time for settlement approval created by the federal bureaucracy of Medicare could adversely impact the ability of workers' compensation insurers to resolve these cases. If carriers are unable to promptly and efficiently resolve these cases they could be left with substantial exposure to an aging population of individuals, who require more expensive treatments due to the rising cost of medical inflation.

In most cases, the claimant's condition worsens with age and secondary injuries develop that are related to the original work injury. While improvements in medical technology have helped physicians keep more people alive, these advances have increased costs. It is unlikely that a workers' compensation judge would deny a claimant's petition for treatment or rule against life support regardless of the cost or the chances for survival. Therefore, it is vital for workers' compensation insurers to take steps to ensure that they receive timely approval from Medicare so that claims may be settled before claimants develop related injuries that increase the overall exposure of the case. ❖

"Boy, I'm sure glad I got up here before Medicare started running low."

[1] *Federal regulation 42 C.F.R. 411.46*

[2] *Title 42 Part 411.26, allows Medicare to recover damages against the following parties: claimants, attorneys, TPAs, self-insured employers, or insurers. Also, CMS could be entitled to twice the amount specified plus interest.*

Deceptive Trade Practices –

A Multi-Billion Dollar Threat

BY JEFF KASER
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When you think of mass tort class action litigation in cases involving pharmaceutical or tobacco products, plaintiffs must demonstrate that they were physically injured by the defendants' products in order to secure damages, right? Not necessarily. Most states have enacted deceptive trade practice ("DTP") statutes which permit recovery for economic damage claims alone. It appears that now the plaintiffs' bar has discovered the legal value of these statutory rights and has begun to regularly file class actions seeking millions and often billions of dollars in economic damages in cases which until recently had been limited to damages for bodily injury arising out of negligence or products liability.

This article will discuss the emerging threat that DTP claims are playing in several high stakes class actions.

Questionable Class Certification

The most recent significant DTP ruling, in the decades long tobacco litigation, fell hard against plaintiffs. On December 15, 2005, the Illinois Supreme Court reversed a $10.1 billion verdict against Philip Morris, in *Price v. Philip Morris*, ---N.E.2d---, 2005 WL 3434368 (Ill.) and ordered a lower court to dismiss the case. In *Price*, the plaintiffs weren't claiming they got cancer from smoking; rather they accused Philip Morris of defrauding customers in its marketing of "light" and "low tar" cigarettes.

The 4-2 ruling overturned a 2003 decision by a Madison County, Illinois judge who found Philip Morris liable for defrauding 1.14 million people into believing their "light" cigarettes were safer to smoke than regular cigarettes. The record-setting award, reached in a jurisdiction consistently listed as a "Judicial Hellhole" by the American Tort Reform Association, was meant to reimburse class members for decades of cigarette purchases.

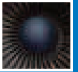
In overturning the verdict, the Illinois Supreme Court ruled that the Federal Trade Commission (FTC) consent orders authorizing tobacco companies to use words like "low," in conjunction with specified disclosures, triggered an exemption in the states' DTP statute, barring the smokers' claims.

The court also questioned class certification by asking whether the words "light" and "lowered tar and nicotine" actually deceived over a million people for decades and expressed serious reservations about the novel approach to the calculation of damages. Whether class certification is appropriate and damages ascertainable will likely figure prominently in most other pending DTP class actions.

Misrepresentation of Product

Compare, however, the Philip Morris ruling with the July 29, 2005 decision in *Intl. Union of Operating Engineers Local No. 28 Welfare Fund v. Merck & Co.*, No. ATL-L-3015-03, 2005 WL 2205341 (N.J. Super. L.) (Not Reported in A.2d). A judge of the New Jersey Superior Court, Law Division, certified a nationwide class consisting of all third-party payors in the U.S.[1] who have paid any person or entity for the purchase of Vioxx since May 1, 1999. Here, Merck is being threatened with billions of dollars in damages, not because plaintiffs claim they were injured by Vioxx, but rather because had they known of the heart attack risks allegedly associated with Vioxx, they would have paid less money for the drug. Merck's alleged misrepresentation was due to their marketing, advertising and promotion of Vioxx.

Due to these risks, the plaintiffs allege that they paid approximately 800% more than they should and/or would have for Vioxx and that health plans allegedly would not have covered these prescriptions had Merck not withheld data concerning the increased risk of heart related problems. Prior to its withdrawal of Vioxx on September 30, 2004, Vioxx was one of Merck's best selling drugs, generating billions of dollars in revenue each year.



Notably, this case is just one of the thousands of personal injury and third-party payor Vioxx-related actions pending against Merck. Merck's withdrawal of Vioxx also spawned an immediate and persistent drop in its share price, which in turn has led to dozens of securities and ERISA-based class actions. Analysts have projected Merck's Vioxx losses could range between four and thirty billion dollars.

In Compliance with the FDA Labeling

Contrary to the good fortunes of the Merck third-party payors, those accusing AstraZeneca of deceptive trade practices in the U.S. District Court for the District of Delaware found their class action dismissed on November 8, 2005. In *Pennsylvania Employee Benefit Trust Fund v. Zeneca Inc et al.*, No. 05-075, 2005 WL 2993937 (D. Del.) (Slip Copy), plaintiffs accused AstraZeneca of deceptively marketing its new reflux drug, Nexium, as being more effective than Prilosec, a predecessor drug which had gone off patent and had become available generically at a greatly reduced cost.

Plaintiffs argued that various ads represented that Nexium was superior to Prilosec in speed of relief versus dosage size. These actions, according to plaintiffs, resulted in "billions of dollars of unnecessary drug expenditures by third-party payors."

Using a rationale similar to that employed by the Illinois Supreme Court in dismissing the *Price v. Philip Morris* class action, the court granted AstraZeneca's motion to dismiss, holding that since the ads were based on Nexium's FDA-approved label, the DTP state claims were preempted by federal law: "By approving information to be included in the drug labeling, the FDA has determined that the information complies with its rules and regulations. Therefore, if the FDA labeling supports the statements made in the advertising for an FDA-approved drug, the statements are not actionable under the [DTP] statute."

Plaintiffs filed their notice of appeal on December 7, 2005 and are still waiting the courts ruling.

Conclusion

Legal and novel coverage issues are intertwined in these early high profile DTP cases. Issues related to federal preemption, class certification and damages quantification predominate. Key coverage issues include whether underlying DTP claims involve "bodily injury" and intentional acts exclusions. "Advertising injury" coverage, which can cover a variety of offenses, including inflated demand, false benefits and unsubstantiated comparisons, occurring in the course of the policy holders advertising activities, may also come into play. Subsequent securities or ERISA claims may develop.

An outcome of these claims is the potential passage of more stringent legislation to give the FDA greater authority over drug matters. In a recent legislative summary of the 109th Congress, the Vioxx "scandal" was highlighted among others in connection with the reauthorization in 2007 of the Prescription Drug User Fee Act and the Medical Devise User Fee and Modernization Act. It appears likely that previous proposals to give the FDA enhanced authority to require post-market studies, remove drugs from the market, impose advertising restrictions and harsher civil and criminal penalties may now have a chance.[2] ❖

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[1] *The class includes a variety of entities, including insurers, HMOs, managed care organizations, large employers, and union-employer groups.*

[2] *News Source: 1/17/06 MONDAQ*

How Katrina Rocked the Surety Market

By Laura Shanahan
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From 2000 through 2004, the surety industry lost over $3.8 billion. The negative publicity about surety stemming from some highly publicized losses — Enron, Kmart, and that "Big Dig" contractor — drove many surety underwriters to peruse the Wall Street Journal every morning to see if there were any new bankruptcies to which they had exposure. The volatility of the contract class of surety coupled with the lack of synergy with other lines of insurance, led several primary and reinsurance markets at the end of 2004 to discontinue supporting the surety product line.

But after those years of horrendous results, the surety industry became cautiously optimistic in 2005. The surety market introduced improvements to the underwriting process, including obtaining stronger indemnity and correcting pricing assumptions. Portfolio management was widely implemented and the Surety Association of America had developed a PML (probable maximum loss) model that could be utilized to evaluate risk. Given these positive actions, it was expected that the surety industry would soon return to profitability.

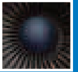
But then Hurricane Katrina blew into Louisiana and Mississippi. It certainly impacted the insurance and reinsurance markets. But did it impact the surety line of business? Generally, when a hurricane or a tornado occurs, surety is one of the few lines of business that is not impacted. While property underwriters tally their loss estimates, review their aggregates, and determine coverage under their reinsurance treaties, surety underwriters salivate about the potential remediation and new construction opportunities that lead to premium increases. Given the terribly poor results of the past few years, surety underwriters began to breathe a sigh of relief after Katrina assuming that they would be out of the spotlight.

But as the extent of the damage became known, insurers and reinsurers began asking more questions. It was no longer acceptable to think that a hurricane never caused a surety loss. Surety underwriters were facing a challenge that they had never experienced before in connection with hurricanes. It became possible that the devastation wreaked by this hurricane could present surety underwriters with many problems. Did the owners and contractors have enough insurance? Was the damage caused by wind or flood? Did they have the appropriate coverages? If projects were delayed and owners did not pay, what ramifications would the contractor face? Would cash flow problems escalate? What would the impact be to the surety market?

Portfolio management helped to answer many of these questions. Some sureties had minimal exposure to the devastated areas; others had large exposures in the affected states with significant projects in progress. For contractors with jobs underway, sureties were able to readily determine whether it was a private or public project. Quick reviews of the contracts were done to confirm the existence of appropriate "force majeure" clauses. Contractors' financials, billings, receivables, etc. were reviewed quickly to determine whether there could be problems with collections.

Katrina highlighted the need for surety underwriters to become more vigilant in their review of contractors' insurance coverages. No longer would an insurance certificate suffice. A thorough examination of the policy, exclusions, and limits was becoming the new norm, especially if the insurance was not handled by a knowledgeable construction insurance agent.

Generally, when sureties reviewed business continuity plans, the focus was on identifying successors who could operate the company upon the contractor's retirement, death, or disability. Katrina now highlighted the need to review the contractor's business disaster recovery plans. Now more than ever, contractors and their sureties must consider risk management strategies and ensure that such plans have



Katrina highlighted the need for surety underwriters to become more vigilant in their review of contractors' insurance coverages.

been developed and are ready to be implemented, instead of scrambling to put a plan in place after the fact. Contractors and their sureties also must reexamine banking relationships because receivables may be slower to collect than was customary and the establishment of credit facilities may be necessary.

The use by surety underwriters of sophisticated models to help them evaluate the likelihood and extent of potential exposures now had to be reevaluated. We all learned from Katrina that models did not go far enough – flood and business interruption had been overlooked or underestimated. Surety underwriters must also consider the total insured value. And while the surety industry is proud of their new surety PEL (probable estimated loss) and PML models – we must learn not to place total reliance on the models and their outputs. Surety underwriters must scrutinize the total amount and type of bonded inforce liability. Models simply can never take the place of underwriting.

Opportunities will be abundant for the construction sector – recent estimates for reconstruction exceed $200 billion. This can translate into significant dollars for the construction and surety industries. But we must be cognizant that we still face many challenges. Construction material costs have skyrocketed, labor shortages are real, and contractors may still face exposure to pollution suits despite the passage of the Gulf Recovery Act. Sureties must go the extra yard to validate that the applicable insurance coverages are in place. Above all, the three C's of surety underwriting must consistently be practiced – capital, capacity and character. ❖

P.S. The surety industry still expects an underwriting profit in 2005 and, so far, no report of a Katrina surety loss.

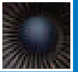
Did You Know?

News from the UK – Contract Certainty

- The FSA requires by year end 2006 that all terms and conditions for insurance and reinsurance contracts must be finalized before inception and delivered to the client, no later than 30 days from the inception date of the contract,
- By implementing the market agreed Code of Practice and by applying the contract certainty checklist, each carrier can measure its progress,
- The target is that a minimum of 85% of the contracts issued by all London carriers will be contract certain by the end of December 2006.

Personal Lines Observations from Florida after the 2005 hurricanes

- A large percentage of the total home owners claims involved damage to pool screens, also known as "cages,"
- Many homes lost their pool cages in two out of three hurricanes (Katrina and Wilma), with the average cost of replacement reaching as high as $35,000/$40,000 in many cases,
- Roofs, whether asphalt shingles or tiles, represented the majority of the dollars paid on personal lines hurricane claims in 2005,
- In addition, the tile roofs that did not have the recommended double nail installation, became projectiles in high winds, causing additional property damage (windows, pool cages, cars…),
- Older homes, pre 70's, stood up well during the hurricanes due to solid concrete and masonry construction, as opposed to wood framing, prevalent in 80's and 90's construction,
- In spite of the uncertainty of hurricane volatility and the difficulty in buying home owners insurance, over 1,000 people continue to move to Florida on a daily basis.



Pandemic Exposures

- "The US Department of Health considers the impact of a severe avian influenza would make 90 million Americans ill." *Business Insurance, January 17, 2006*
- "Projected workers' compensation costs for Avian flu are $27 million." *RMS study, Catastrophe, Injury and Insurance (2005)*
- "Insurer[s]…need to consider how it will function when…50% of its employees are ill or absent providing care for family members." *Jim Toole, fellow of the Society of Actuaries (2005)*
- "The World Bank has…announced that a pandemic could easily cost the global economy up to $800 billion." *Aon, Global Risk Alert, November, 2005*

"That's the gist of what I want to say. Now get me some statistics to base it on."

Endurance

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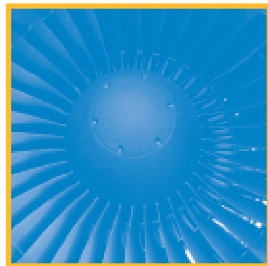

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