CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 12 2005-2006 NUMBER 2

CONTENTS

FOREWORD *Adam Scales* i

ARTICLES

ASBESTOS LITIGATION IN THE UNITED STATES: TRIUMPH AND FAILURE OF THE CIVIL JUSTICE SYSTEM *Deborah R. Hensler* 255

COMMENTS FOR THE UNIVERSITY OF CONNECTICUT ASBESTOS LITIGATION SYMPOSIUM *James L. Stengel* 281

ON THE APPLICABILITY OF THE SILICA MDL PROCEEDING TO ASBESTOS LITIGATION *Lester Brickman* 289

A FUTURE FOR ASBESTOS APPORTIONMENT? *Michael Green* 315

ASSESSING THE COVERAGE CARNAGE: ASBESTOS LIABILITY AND INSURANCE AFTER THREE DECADES OF DISPUTE *Jeffrey W. Stempel* 349

THE ASBESTOS LITIGATION CRISIS: THE TIDE APPEARS TO BE TURNING *Mark A. Behrens & Phil Goldberg* 477

SOME REFLECTIONS ON THE FUTURE OF MASS TORTS *Peter H. Schuck* 505

AN ELEGY FOR THE FAIR ACT *Patrick M. Hanlon* 517

HeinOnline -- 12 Conn. Ins. L.J. iii 2005-2006

NOTES AND COMMENTARIES

ANOREXIA KILLED HER, BUT THE SYSTEM FAILED HER: DOES THE AMERICAN INSURANCE SYSTEM SUFFER FROM ANOREXIA? *Beth A. Brunalli* 583

THE FUTURE OF THE NATIONAL FLOOD INSURANCE PROGRAM IN THE AFTERMATH OF HURRICANE KATRINA *Quynh T. Pham* 629

REASONABLE EXPECTATIONS IN THE SPHERE OF LIBERTY: A THEORY OF ACCIDENTAL DEATH INSURANCE COVERAGE *Catherine Spain* 657

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS *Emmanuelle Regine Francois* 683

HeinOnline -- 12 Conn. Ins. L.J. iv 2005-2006

FOREWORD

A short lifetime ago, I was a lawyer interviewing law students for my firm. I met one who had been an engineer for a major defense contractor. I like learning about people and how things work, so our conversation wandered. At some point, he talked about fighter jets and his small role in their design. He said that these machines were so complicated that no one actually understood how they worked.

Certainly, someone might understand part of the electrical system, or the hydraulics. Another might be an authority on radar or guidance systems. But there was no one who truly grasped the myriad effects these systems had upon one another—no single designer could possibly comprehend the entirety of what, together, all had wrought. It is amazing, he concluded, that they flew at all.

Tort law has its own engineers, architects and technicians. The legal academy is suffused with theoreticians who design elaborate models involving rational actors, deterrence, risk-spreading and efficiency. Judges and lawyers contribute as well, implementing on the ground suggestions from scholars while improvising patches where theory is undone by experience. In this issue, we present a collection of images of their machine at work, building on the foundation laid at the University of Connecticut School of Law Insurance Center Symposium, held in November, 2005, and entitled *Asbestos: Anatomy of a Mass Tort.*

The machine is called asbestos litigation. It is the most complicated device the tort system has ever built. It may be the most complicated system *anyone* has ever built. Its foundations were laid in the early decades of the twentieth century when manufacturers of asbestos products calculatingly declined to disclose the risks attendant to their use. Major construction could not begin until the 1970s when the modern era of tort law and responsibility for product defects had dawned.

There were no definite blueprints, for such a machine had never been conceived. But there was wrongdoing aplenty and the tort system was feeling particularly optimistic about its capabilities, having recently redefined large swaths of human relationships. Thus armed, the designers and engineers went to work.

Asbestos litigation is largely a piecemeal creation, the evolved product of several decades of common law stretching across every jurisdiction in the United States. To an extent often-underappreciated among its students, the tort system is a marketplace. Claims are defined in response to dynamic legal rules before they are tested, warehoused, showcased, and ultimately exchanged for money. Markets are astonishing aggregators of

HeinOnline -- 12 Conn. Ins. L.J. i 2005-2006

information, and the market for asbestos claims is no exception. Patterns of asbestos claiming have waxed and waned not according to the innate characteristics of asbestos injuries, but rather with the supply of dollars available to meet them.

Our legal system has periodically taken the measure of asbestos litigation, and blanched. It has felt growing unease that wars have been fought and lost, empires risen and crumbled, and an entire generation born and brought to maturity with little sign that asbestos liability is ready to leave the stage. First with confidence, then with increasing desperation, juridical engineers have labored hard to fix the machine. They have drawn widely from the worlds of bankruptcy, procedure, insurance, and occasionally tort law—an ancient doctrine once grounded in the rule of reason—to resolve the problem of asbestos.

The extent of their failure can be expressed in various ways: the five percent of liquidated value that Manville Trust claimants each receive; the nearly $70 billion in asbestos payments made to date, of which fewer than half find their way to the sick and dying; the hundreds of thousands of jobs directly and indirectly crushed under the weight of long-tail asbestos liabilities; the sad joke of forum shopping (and the implicit sale of such fora). Atop this edifice rests the machine that has outwitted, and if unchecked, may indeed outlast us all. Perceptive students of the asbestos phenomenon know only too well that it is now the tort system that should properly claim from economics the mantle of "the dismal science."

To a large extent, the civil justice system itself is on trial. Having loosed an asbestos marketplace upon an unsuspecting world, the tort system has apparently forgotten that while markets are amazing things, they simply do not know when to stop.

I do not know if the workings of the asbestos machine lie beyond the comprehension of any one person, but the contributors to this Symposium certainly come close. Asbestos liability is a subject that rewards repeated study, and several of the pieces that follow recapitulate one or more of the many histories of asbestos.

Ample is the evidence that evolution, rather than intelligent design, supplies the motive power of this machine. Asbestos liability has changed shape, texture, size and meaning in response to tort law's efforts to bring it to heel. I urge readers to reflect on exactly what asbestos liability *is* as they read these pieces. In what way do the features thought to be prominent in our tort system—individualized justice, punishment of wrongdoing, even the jury trial—emerge in the following portraits? I submit that they do not. Asbestos Law ought to be recognized within legal scholarship as a

HeinOnline -- 12 Conn. Ins. L.J. ii 2005-2006

jurisprudence every bit as distinct as Indian Law, Admiralty Law—or even Torts.

To borrow from Kai Erikson's elegant, unforgettable phrase, asbestos epitomizes "a new species of trouble".[1] Neither the confident, industrialized society that gave rise to its widespread use, nor the newly-confident legal institutions that arose to contain it, could have anticipated how much they would fail their societies, and at what cost. After a quarter-century of massive claiming, the horizon continues to recede before us. For asbestos victims, the process seems drawn from Kafka's *The Imperial Message*; for defendants, Dickens' *Jarndyce v. Jarndyce* (or perhaps, *Groundhog Day*). Thirty years after its initial accounting in *Borel v. Fibreboard*, the true costs of the asbestos debt are only now coming due.

Adam F. Scales
Lexington, Virginia
April 2006

1. KAI ERIKSON, A NEW SPECIES OF TROUBLE (1995).

HeinOnline -- 12 Conn. Ins. L.J. iii 2005-2006

HeinOnline -- 12 Conn. Ins. L.J. iv 2005-2006

ASBESTOS LITIGATION IN THE UNITED STATES: TRIUMPH AND FAILURE OF THE CIVIL JUSTICE SYSTEM

Deborah R. Hensler

INTRODUCTION

Over the past several years, asbestos litigation has become the "poster child" for the tort reform movement in the United States. Asbestos litigation is frequently described as an entirely non-meritorious litigation, driven by greedy plaintiff attorneys who seek only to line their own pockets and by greedy plaintiffs who have crowded onto the gravy train to easy money. This view is expressed with varying degrees of hyperbole by prominent editorialists, legal scholars, and judges, and has fuelled calls for congressional action to remove asbestos litigation from the courts.[1]

The portrayal of asbestos litigation as a symbol of the failures of the civil justice system has crowded out an earlier view of asbestos litigation as the culmination of a long, hard battle to remove asbestos from the workplace and compensate workers who had been injured by asbestos, in some instances as a result of deliberate decisions by manufacturers to withhold information about the potential harmful effects of working with asbestos products. To those who celebrated asbestos litigation, the plaintiff lawyers who nurtured it through hard-fought adversarial battles were heroic

---

* Judge John W. Ford Professor of Dispute Resolution, Stanford Law School. This paper draws heavily on research that I have conducted previously in collaboration with my former colleagues at the Rand Institute for Civil Justice, especially STEPHEN CARROLL ET AL., ASBESTOS LITIGATION (2005) and DEBORAH HENSLER ET AL., ASBESTOS IN THE COURTS: THE CHALLENGE OF MASS TOXIC TORTS (1985). Those monographs, in turn, drew on a rich literature of asbestos litigation and disease, which is detailed in the monographs' bibliographies. In this article, I cite the leading non-Rand research on asbestos, but for brevity, I rely heavily on the Rand monographs, rather than the underlying works that those monographs cite. Unless otherwise indicated, my Rand collaborators and I collected and analyzed the numerical data on asbestos filings, costs and outcomes that are reported here and the descriptions of litigation strategies and procedures are based on our qualitative data collection and analyses. In assessing those findings, readers may find it useful to know that all Rand monographs are peer reviewed. Although I draw on Rand publications in this article, the interpretations of the data and perspectives on asbestos litigation are my own and not those of Rand or its supporters.

1. *See, e.g.*, Editorial, *Asbestos of All Possible Worlds?*, WALL ST. J., July 2, 1999, at A1; Editorial, *Screening for Corruption,* WALL ST. J., Dec. 2, 2005, at A1.

figures who made good on the tort system's promises to deter corporate wrongdoing, compensate those who are harmed by such wrongdoing and—in the process—provide a just resolution to the story of asbestos exposure and injury in the workplace.

The true story of asbestos litigation contains ingredients from both these narratives. Asbestos litigation in its early years provided an example of how private litigation can achieve important social policy goals when market forces and other forms of governance fail to achieve these goals. Asbestos litigation in middle-age illustrated the flexibility and resilience of the civil justice system in the face of unexpected caseload pressure. But asbestos litigation in the late 1990s showed the uglier face of the civil justice system, as plaintiff lawyers responded to profound destabilization of the litigation by flooding the system with claims of uncertain value, potentially harming the ability of seriously injured people to receive compensation for their losses in the future. Today, Congress is poised to radically change the system of compensating asbestos-related injuries. Whether the new system designed by the legislature will appropriately balance the needs of those who are injured against the needs of the private sector to confidently predict their future costs to resolve asbestos claims—indeed whether Congress will be able to pass *any* legislation—is uncertain at this time.

In this article, I briefly describe the dynamics of asbestos litigation over the past 25 years. My description is informed by conversations with plaintiff and defense counsel, public interest lawyers, general counsel of major asbestos defendants, insurance company and labor union representatives, and judges and special masters that I was fortunate to have met in the course of my research on asbestos litigation over this time period. All of these participants in the litigation told me different stories of how asbestos litigation came to be, how it evolved, and why it has reached its current state. This story is my own.

I. WHY THE LITIGATION BEGAN

Asbestos is a wonderful but harmful natural substance. It is plentiful, it has amazing fire-retardant qualities, and it can be formed into a variety of products that perform useful functions in ships, factories, and office buildings, other commercial and public facilities, and homes. Unfortunately, exposure to asbestos-containing products can also kill people. Asbestos exposure causes mesothelioma, a dreadful cancer that is always fatal. Asbestos is the only known cause of this cancer; only a few cases have occurred where victims were not known to have been exposed

HeinOnline -- 12 Conn. Ins. L.J. 256 2005-2006

to asbestos and it is possible that those people were exposed without being aware of it. It is seemingly possible for people to get mesothelioma without prolonged intense exposure to asbestos; fortunately, however, only a small fraction of all those who have been exposed to asbestos, even those with heavy exposure, ever get mesothelioma.[2]

Asbestos exposure also causes a variety of other cancers, including lung cancer. The link between some of these cancers and asbestos is subject to scientific debate. Asbestos exposure can cause lung cancer but unlike mesothelioma lung cancer has a plethora of causes, so somebody exposed to asbestos and diagnosed with lung cancer may have the cancer for some other reason. Many people who have been exposed to asbestos are smokers or have smoked in the past, which increases their risk of lung cancer above their risk from asbestos exposure alone.

Asbestos exposure also causes non-malignant respiratory disease, termed asbestosis. Victims of asbestosis have difficulty breathing, and severe asbestosis is fatal. But unlike mesothelioma, asbestosis displays a clear "dose-response" effect meaning that the severity of the disease is linked to the severity or amount of exposure. People at the greatest risk of severe asbestosis are those who had prolonged or intensive (i.e. close) exposure to asbestos. Because asbestos materials remain in place in some residential and work settings today, it is still possible for people to be exposed to asbestos; however, intense exposure to asbestos is much less likely today than it was a couple of decades ago.

Asbestos exposure also causes changes in the body, chiefly in the lining of the lungs or on the lungs (scarring or "plaques") that are visible on x-rays but may not be accompanied by any significant respiratory impairment or any diminishment in a person's ability to work or carry out other normal activities. In most states in the U.S., such changes in the body qualify as "injuries" for legal purposes, meaning that a person with evidence of these changes can file a legal claim for compensation. Because such changes provide clear evidence that an individual who has been exposed to asbestos has been affected by such exposure, knowing that one has scarring or plaques might reasonably make one anxious about the possibility that in the future one would suffer impairment.

Why would a product that causes so many injuries be so prevalent in the workplace and other settings? Asbestos diseases are distinguished from many other common diseases by the fact that they often appear only many

2. For a summary of information and leading scientific references about worker exposure to asbestos in the U.S. and the epidemiology of asbestos disease, see CARROLL ET AL., *supra* note *, at 11-19.

HeinOnline -- 12 Conn. Ins. L.J. 257 2005-2006

years after initial exposure. People diagnosed with asbestos disease in 2000 may have been exposed to asbestos in 1960 or 1970. Many of the claims for compensation for asbestos disease that flooded the courts in the 1980s and 1990s were filed by people who had worked with asbestos in the 1940s and 1950s.

But the dangers of asbestos exposure were known to the asbestos industry at least as far back as the 1930s. Documents from the files of some leading asbestos product manufacturers, such as Johns-Manville (later the Manville Corporation) indicate that corporate officials decided not to tell their workers that they were being injured by exposure to asbestos. The asbestos industry tried to keep scientific reports on the link between asbestos exposure and injury out of circulation in the United States and vigorously opposed proposals to reduce exposure to asbestos in the workplace during the 1950s and 1960s.[3] Asbestos was not regulated in the United States until the passage of the Occupational Safety and Health Act in 1970, which many industry groups also opposed.[4] It seems likely that if manufacturers had voluntarily adopted methods to protect their workers from asbestos, supported epidemiological research on asbestos exposure, and endorsed government regulation of the amount of asbestos in the workplace, the amount of asbestos disease in the U.S.—and the attendant litigation—would have been curtailed.

The federal government also bears significant responsibility for the surge in asbestos disease that began in the 1960s. During World War II, the government conducted a "crash program" to build ships to defend the United States. Shipyard workers laboring in the close quarter of ships under construction received particularly heavy doses of exposure to asbestos. Although manufacturers have been held responsible for asbestos disease over the past several decades, the U.S. government has never

---

3. For details of industry suppression of information about the links between asbestos exposure and injury and opposition to regulation, see BARRY I. CASTLEMAN, ASBESTOS: MEDICAL AND LEGAL ASPECTS (4th ed. 1996) and PAUL BRODEUR, OUTRAGEOUS MISCONDUCT: THE ASBESTOS INDUSTRY ON TRIAL (1985).

4. Testimony of Margaret Seminario, Director, AFL-CIO Department of Occupational Safety and Health, Before H. Comm. On Employment and Education, Subcomm. on Workforce Protection on OSHA's Standard Setting Process, 107th Cong., June 14, 2001, *available at* http://www.house.gov/ed_workforce/hearings/107th/wp/osha61401/seminario.htm. The first asbestos standard was issued by OSHA in 1971. CASTLEMAN, *supra* note 3, at 331. In 1989, the Environmental Protection Agency promulgated a rule banning most uses of asbestos, but the rule was overturned in *Corrosion Proof Fittings v. EPA*, 947 F.2d 1201, 1212 (5th Cir 1991).

HeinOnline -- 12 Conn. Ins. L.J. 258 2005-2006

acknowledged its responsibility by offering to provide compensation to asbestos workers.[5]

II. THE HEROIC ERA

With industry hostile to asbestos regulation and the government apparently disinterested in controlling asbestos disease, it was the industrial union that represented insulation workers that encouraged and funded the major post World War II epidemiological research on asbestos. The key to subsequent successful litigation was the ground-breaking epidemiological research by Dr. Irving Selikoff and his associates that demonstrated the links between asbestos exposure in the workplace and malignant diseases and asbestosis.[6]

With epidemiological evidence in hand, insulation workers and others in industries where there was heavy use of asbestos began filing claims for the costs of medical care and work loss in their states' workers' compensation systems. But many of these claims were turned away by workers compensation administrators who held that the workers could not link their often long-ago exposure to asbestos to their current diseases and employers. Some of these workers found their way to lawyers who were not satisfied by the response of the state workers' compensation systems. Seeking an alternative means of redress for their clients, these lawyers turned to the tort liability system. Since they were precluded by workers' compensation statutes from suing the workers' employers, they instead filed product liability suits against asbestos manufacturers.

Although Selikoff's findings were widely publicized in the 1960s, it was not until the 1970s that plaintiff lawyers scored their first significant victories against asbestos product manufacturers. In *Borel v. Fibreboard*,[7] the Fifth Circuit Court of Appeals upheld the application of strict liability to latent injury torts and found asbestos product manufacturers jointly and severally liable for injury to an asbestos insulation worker.

---

5. Bill Burke, *Shipyards, a Crucible for Tragedy*, VIRGINIAN-PILOT, May 6, 2001, at A1; Shailagh Murray, *U.S. Stands Aside on Asbestos: Government Won't Pay Into Proposed Fund, Despite Navy Cases*, WALL ST. J., Nov. 11, 2003, at A4. Murray cites industry data as showing that "claims from individuals exposed in military and shipyard construction accounted for 26% of cases of mesothelioma, a deadly asbestos-related lung cancer, 16% of other lung-cancer cases and 13% of disabling lung-disease cases."

6. *See, e.g.*, Irving J. Selikoff et al., *Asbestos Exposure and Neoplasia*, 188 JAMA 22 (1964); Irving J. Selikoff et al., *The Occurrence of Asbestosis Among Insulation Workers in the United States*, 132 ANNALS N.Y. ACAD. SCIS. 139 (1965); I. SELIKOFF & D. LEE, ASBESTOS AND DISEASE (1978).

7. 493 F.2d 1076, 1093-96 (5th Cir. 1973).

HeinOnline -- 12 Conn. Ins. L.J. 259 2005-2006

The decision in *Borel* opened the doors to the courthouse for workers who had been injured by exposure to asbestos. But obtaining compensation for asbestos victims from manufacturers remained a challenge for plaintiff attorneys. Plaintiffs needed to prove over and over again, in courts across the country, that asbestos causes disease ("general causation").[8] Each worker had to prove also that asbestos-exposure had caused *his* disease ("specific causation").[9] Each worker needed to prove that he had been exposed to *specific* products manufactured or distributed by the defendants, often a tall order for workers who had handled myriad products over the years, sometimes in multiple worksites. Moreover, in many jurisdictions, the statute of limitations presented a barrier to suit, as defendants argued that the injury that started the statutory clock running had occurred many years before, when the worker first was exposed to asbestos, or at the time of the last exposure (which might well have preceded the date of filing by some years) or at some other time that would bar litigation now. After losing in *Borel*, the lead defendants—armed with resources to purchase top-flight legal representation—re-positioned themselves and successfully fended off later lawsuits.

The necessity for extensive factual investigation of product characteristics and distribution and medical science expertise combined with the clear legal barriers to prevailing and the knowledge that they would be up against aggressive and well-funded defendants gave pause to most plaintiff law firms that might have considered representing asbestos victims. To succeed a firm would have to invest a considerable sum of money upfront, and would recover—if at all—only some years later and then only a fraction (typically one-third) of whatever it managed to win for its successful clients. In an era when powerhouse plaintiff law firms dominate headlines about tobacco lawsuits and securities litigation some may not recall that plaintiff law firms historically were small and under-subsidized. In the period when asbestos claims arose, the typical plaintiff law firm was ill-positioned to take on major corporations in a lengthy and expensive legal battle with a highly uncertain outcome. Few such firms proved willing to represent asbestos victims; indeed in at least a few instances, firms pressed their partners who wanted to represent these victims to either abandon the litigation or leave their firm. Those few lawyers who took up the battle on behalf of asbestos workers were appropriately viewed as the heroes of asbestos litigation: they laid the

8. On the requirement to prove general causation in every case and one judge's efforts to overcome the requirement, see HENSLER ET AL., *supra* note *, at 60-63.

9. Most asbestos workers are male.

HeinOnline -- 12 Conn. Ins. L.J. 260 2005-2006

groundwork for the plaintiff successes that followed.[10] They also built the litigation structure that persists today and that became the structure for mass tort litigation in the United States generally.[11]

III. FLOUNDERING[12]

Although plaintiffs suffered numerous defeats, by the early 1980s the tide was turning in their favor. The first punitive damages were awarded by an Illinois jury in 1981,[13] and by mid-1982 juries had awarded $6 million in punitive damages against the Manville Corporation (formerly Johns-Manville). In 1982, Manville petitioned for Chapter 11 reorganization, claiming that its future liability exposure outweighed its assets.

By the early 1980s, filings were increasing rapidly in areas of the country where there was or had been heavy use of asbestos in workplaces (e.g. in shipyards and petrochemical plants); in some courts, asbestos caseloads grew at the rate of 50 to 60 filings per month, far outstripping the rate of filings in other areas of civil litigation. The litigation was concentrated in some 10 to 20 jurisdictions, divided more or less equally between federal and state courts. In each jurisdiction, a small number of plaintiff law firms (usually no more than three) represented hundreds or even thousands of workers at a time. On the defense side, there were 20 or more corporations, all of whose products were allegedly present in the plaintiffs' worksites and were therefore named on each suit, and many of whom worked hard to shift as much as possible of the responsibility and compensation cost to other defendants. Whatever organization there had been on the defense side unraveled when Manville and UNR, another large asbestos manufacturer, entered bankruptcy proceedings, thereby staying the litigation against them and leaving other defendants facing the possibility that they would have to shoulder Manville and UNR's shares of the compensation burden.

---

10. For a description of these lawyers and their activities, see generally BRODEUR, *supra* note 3.

11. On the evolution and structure of mass litigation in the U.S., see generally Deborah Hensler, *Revisiting the Monster: New Myths and Realities of Class Action and Other Large Scale Litigation,* 11 DUKE J. COMP. & INT'L LAW 179 (2001).

12. This section draws heavily on HENSLER ET AL., *supra* note *, at 20-29.

13. Hammond v. North American Asbestos Co., Ill. Circ. Court, McClean County/ Civil Case No. 80-L-52. The punitive damages award was overturned on appellate review. *See* HENSLER ET AL., *supra* note *, at 20 n.10.

HeinOnline -- 12 Conn. Ins. L.J. 261 2005-2006

Most of the heavily affected courts assigned asbestos cases to a single judge and gave that judge free rein—but often not much assistance—to deal with the new caseload. Some judges focused on streamlining the pretrial process, reasoning that they could speed case disposition by eliminating duplicative motions and rulings for cases that were alike in many respects. But once their cases were prepared for trial, these judges had to confront the fact that there were nowhere near enough judges to try all the cases that they had helped to prepare so efficiently; nor were there enough plaintiff or defense lawyers available to try so many cases simultaneously (a problem exacerbated by the fact that multiple defendants remained on the cases as trials approached). Often, the fully-prepared cases were set aside for some future trial date—when, because of changes that had occurred over time, they would need further pretrial preparation perhaps negating earlier efficiencies.

Other judges focused on settlement, rather than pretrial discovery and motion practice. They ordered plaintiff attorneys (who by this time were representing large numbers of workers who worked at the same factories or other worksites) to meet with defendants to discuss settling *all* of the cases that they had filed by a specified date. From a judicial perspective, aggregate settlements had the virtue of clearing hundreds or thousands of cases from the court calendar in one fell swoop. But group settlements—although often proffered and accepted—also had their limitations as a disposition mechanism. Defendants and their insurers faced cash flow problems if they agreed to pay too many claims at a time. Soon also, plaintiff attorneys representing large groups of workers realized that it was financially attractive to their firms to stretch fee revenues from settlements over time.

While some judges picked their way through the morass of asbestos cases, others simply threw up their hands. The cases were too numerous, they argued, to be managed effectively in any reasonable amount of time. Congress would have to adopt a non-judicial mechanism for resolving asbestos claims. Until then, they would simply file asbestos cases away and attend to other more tractable civil lawsuits.

Regardless of what approach courts took to the resolution of asbestos cases, there was little opportunity for individual asbestos claimants to be heard and little attempt to craft individualized dispositions of their cases. But despite this, transaction costs were high: on average, 39 percent of all dollars paid went to plaintiffs, with the remainder divided more or less

HeinOnline -- 12 Conn. Ins. L.J. 262 2005-2006

evenly between plaintiff and defense counsel fees and expenses.[14] And many cases took years to resolve.

Although few judges in the heavily affected courts thought they were dealing efficiently with asbestos cases and some worried that efforts to achieve efficient resolution were impairing procedural fairness, outside the most affected courts there was less certainty about whether anything special needed to be done by Congress or the judiciary to address the asbestos caseload. In 1980, the Judicial Panel on Multidistrict Litigation, which had been established a decade before[15] to provide for the consolidation of large-scale federal litigation in a single court so as to streamline pretrial preparation, declined to consolidate asbestos lawsuits. After increasing dramatically for several years, by the mid-1980s, annual asbestos filings appeared to have stabilized. Case management approaches adopted by some judges seemed to hold out the promise of containing the litigation.[16] No one knew how many more claims the future would hold. Radical restructuring of court procedures or tort law to respond to asbestos litigation was deemed inappropriate for a litigation that might soon drift to conclusion.

IV. ADAPTATION[17]

As the years passed, asbestos litigation did not abate. But over time, it did acquire predictable ways. By the early 1990s, the plaintiff attorneys, defense counsel and judges who were most actively engaged in the litigation had developed strategies for dealing with asbestos claims that were mutually understood and arguably mutually beneficial. The key to case management for all concerned was aggregation.

For plaintiff attorneys, representing large numbers of asbestos victims with similar work histories and injuries allowed risk-spreading and economies of scale that made asbestos plaintiff representation financially attractive. Because so few plaintiff attorneys had been willing to gamble on asbestos litigation, those who did (what economists term "first movers") had a competitive advantage. In 1985, the ten law firms in the U.S. that represented the largest number of asbestos claimants accounted for about one-quarter of all asbestos cases filed that year; by 1988, the top ten firms

---

14. *See generally* JAMES KAKALIK ET AL., VARIATION IN ASBESTOS LITIGATION COMPENSATION AND EXPENSES (1984).

15. Multidistrict Litigation, 28 U.S.C. §1407 (2000).

16. *See generally* TOM WILLGING, ASBESTOS CASE MANAGEMENT: PRETRIAL AND TRIAL PROCEDURES (1985).

17. This section draws heavily on CARROLL ET AL., *supra* note * at 28-65.

(mostly the same firms) accounted for 40 percent of all asbestos cases filed that year; by 1992, the top ten firms accounted for more than 50 percent of all cases filed.[18] These firms assembled databases of product usage in worksites in the jurisdictions where most of their cases were concentrated, adopted case development procedures that relied on paralegals and bureaucratic processes rather than more expensive interaction with lawyers, and negotiated standing agreements with defendants to settle categories of cases for specified amounts, akin to a workers compensation schedule of damages. Most of these firms represented workers with a variety of injuries, ranging from pleural plaques to mesothelioma, and were able to offer defendants "discounts" on more serious cases in return for settling weaker claims for more. As a result of such strategies they could offer all their clients a kind of rough group justice, although some individual clients might have been better off represented separately.

On the defense side, lawyers also turned to strategies for coordinating activities and presenting a solid front to the plaintiffs. An early attempt to establish a cooperative defense facility—the Asbestos Claims Facility (ACF), frequently termed the "Wellington Group" after Dean Harry Wellington, who facilitated its establishment—failed but a second attempt—the Center for Claims Resolution (CCR)—was more successful, lasting into the early 2000s. The concept underlying both cooperatives was the same: defendants agreed to litigate against plaintiffs as a single entity and to allocate expenses and damages, if any, according to a negotiated formula. The formula was intended to roughly reflect asbestos manufacturers' market shares.[19] Although only a small fraction of all asbestos defendants were members of one or both groups, in the 1990s, CCR allegedly accounted for about three-quarters of all payments to asbestos plaintiffs.

With plaintiffs and defendants both adopting aggregative techniques, it is not surprising that judges did likewise. In 1991, the Judicial Panel on Multi-District Litigation consolidated all federal asbestos lawsuits and transferred them for pretrial preparation to Judge Charles Weiner, of the Eastern District of Pennsylvania.[20] Some state courts with large asbestos caseloads consolidated asbestos cases in a single court within the state.

---

18. CARROLL ET AL., *supra* note *, Table 3.1, at 24.

19. Interestingly, plaintiff attorneys' attempt to apply market share liability formally to asbestos cases failed. *See e.g.*, Prelick v. Johns-Manville Corp., 531 F. Supp. 96, 98 (D. Pa. 1982); Bateman v. Johns-Manville Sales Corp., 781 F.2d 1132 (5th Cir. 1986); Marshall v. Celotex Corp., 651 F. Supp. 389 (D. Mich. 1987).

20. *In re* Asbestos Prods. Liab. Litig. (No. VI), 771 F. Supp. 415 (J.P.M.L. 1991). The JPML had twice previously declined to consolidate federal asbestos lawsuits.

HeinOnline -- 12 Conn. Ins. L.J. 264 2005-2006

Deploying case management techniques that judges at that time were being urged to apply to civil litigation generally, judges with large asbestos caseloads scheduled cases so as to maximize settlement pressure on plaintiffs and defendants alike. Some judges consolidated cases for trial, and adopted innovative procedures, trying common issues such as general causation or liability for punitive damages to a single jury with a few representative plaintiffs, and following these "common issue" trials with individual liability and damages trials for "panels" of four to six plaintiffs. At first judges consolidated just a few dozen cases, but as the litigation proceeded, judges in some jurisdictions consolidated hundreds or even thousands of cases together.[21] Because all of the claimants in these consolidated litigations had filed individual lawsuits, in principle, all would require trial, at least on individual issues. But judges hoped that decisions on common issues and on individual issues in a small sample of cases would establish benchmarks for and encourage group settlements, and generally they were proved right, either because consolidation facilitated efficient decision-making or because defendants were unwilling to take the risk of trying cases whose verdicts might be applied to hundreds of thousands of other cases.

Although aggregation characterized asbestos litigation generally, the most powerful aggregative tool in federal and state judges' arsenal, the class action, was only rarely deployed in asbestos litigation.[22] In part, this reflected appellate opinion on the requirements for class certification; since 1966, when the contemporary version of Federal Rule of Civil Procedure 23 ("the class action rule") was adopted, the weight of judicial opinion has been against certifying mass torts as class actions, on the grounds that in mass personal injury cases, individual issues, such as individual causation and injury severity, outweigh common issues.[23] But the rarity of class actions also reflected asbestos plaintiff attorney disinterest or opposition to the use of class actions, which typically assign control of large-scale litigation to one or a few law firms (to the possible detriment of other firms

---

21. For a description of trial consolidation in asbestos cases, and citations to noteworthy cases, see CARROLL ET AL., *supra* note *, at 30-45.

22. Prior to the two class action settlements that were reversed by the U.S. Supreme Court in *Amchem Products v. Windsor*, 521 U.S. 591 (1997) and *Ortiz v. Fibreboard Corp.* 527 U.S. 815 (1999), only two asbestos class actions were certified: *Jenkins v. Raymark Industries*, 109 F.R.D. 269 (E.D. Tex. 1985), *aff'd* 782 F.2d 468 (5th Cir. 1986) and *Cimino v. Raymark Industries*, 751 F. Supp. 649 (E.D. Tex. 1990) *aff'd in part, rev'd in part* 151 F. 3d 297 (5th Cir. 1998).

23. For a discussion of the evolution of class action doctrine as it applies to mass torts, see DEBORAH HENSLER ET AL., CLASS ACTION DILEMMAS: PURSUING PUBLIC GOALS FOR PRIVATE GAIN (2000), chapter 3.

HeinOnline -- 12 Conn. Ins. L.J. 265 2005-2006

that represent claimants in the litigation) and may require lawyers who have been individually retained by class members to share their fees with class counsel.[24]

By 1993, asbestos litigation seemed to have become a "mature" mass tort.[25] Filing trends appeared predictable, and claims values were agreed upon. With more cooperation among defendants, transaction costs diminished. Individualized process was still lacking, but no one seemed to find that especially remarkable. Asbestos litigation drifted off the civil justice reform agenda, although not off the civil litigation landscape.

V. THE SEARCH FOR "GLOBAL SETTLEMENT"

With the magnitude and shape of asbestos litigation seemingly well understood by all of the key players, the stage was set for a "global" settlement: a comprehensive agreement that would establish standardized procedures and values for resolving the tens of thousands of claims that were pending, as well as the thousands of claims that might appear in the future. Such settlements had been reached in Vietnam veterans' litigation alleging injuries due to exposure to "Agent Orange," in Dalkon Shield litigation alleging injuries due to use of an intrauterine contraceptive device, and in other lesser-known product defect litigations involving smaller numbers of plaintiffs. In a few instances, the vehicle for settlement was a Rule 23 class action; in others, it was Chapter 11 reorganization; in still others the vehicle was multi-district litigation under 28 U.S.C. §1407.[26] From one perspective, achieving a comprehensive settlement of asbestos litigation might appear easier than in other mass tort contexts: by this time, most asbestos claims were already being settled by applying standardized procedures and standardized claims valuations. But from another perspective, achieving a comprehensive settlement of asbestos litigation appeared to be a daunting task, for asbestos litigation, unlike any other mass tort, involved scores of defendants.

---

24. For an example of restrictions placed on individually retained attorneys in mass tort class actions, see HENSLER ET AL, *supra* note *, chapter 11 (describing class action against blood product manufacturers on behalf of HIV-infected hemophiliac victims).

25. The notion of "maturity" in the concept of mass tort litigation was proposed by Francis McGovern who has served as special master in many mass torts, including asbestos litigation. *See* Francis McGovern, *Resolving Mature Mass Tort Litigation,* 69 B.U. L. REV. 659 (1989).

26. For a discussion of aggregation and resolution of mass personal injury litigation, see Deborah Hensler & Mark Peterson, *Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis,* 59 BROOK. L. REV. 961 (1993), and Howard Erichson, *A Typology of Aggregate Settlements,* 80 NOTRE DAME L. REV. 1769 (2005).

HeinOnline -- 12 Conn. Ins. L.J. 266 2005-2006

The 1991 transfer by the Judicial Panel on Multidistrict Litigation (JPML) of all pending federal asbestos cases to Judge Charles Weiner of the Eastern District of Pennsylvania provided the agreed-upon vehicle for global settlement.[27] Judge Weiner was celebrated in the Eastern District for efficiently settling the large asbestos caseload that had accumulated in that court during the 1980s. Under the terms of the multi-district litigation statute,[28] once asbestos cases were "multi-districted," *every* asbestos case filed in federal court thereafter would be sent to Judge Weiner's court, meaning that he would preside over all asbestos litigation in the federal courts: the perfect condition for settlement.

Initially, expectations were high that a global settlement would be achieved in federal court.[29] But it soon became clear that settling all federal cases against all defendants was too tall an order even for a master settler like Judge Weiner. The judge and parties turned instead to devising a settlement of claims against the Center for Claims Resolution (CCR), a consortium of 20 or so defendants that accounted for the large majority of payments to asbestos plaintiffs during this era. Ultimately, a Rule 23(b)(3) class action—an "opt-out" class—was certified for the purpose of settling all claims that would be brought in the future arising out of occupational exposure to the CCR members' asbestos products through 1993; concurrently lawyers for the class agreed to settle all of their claims that were then pending against CCR members.[30] Under the terms of the settlement, claimants would have to meet specified medical criteria to collect compensation for asbestos-related injuries. The statute of limitations would be tolled for those who had been exposed to asbestos but were not yet impaired at the time of the settlement; they would become eligible to collect compensation only when they met the agreed-upon medical criteria. While settlement of claims against CCR was in play in the Eastern District of Pennsylvania, the same plaintiff attorneys who were negotiating that settlement were negotiating a similar settlement in the

---

27. For further discussion of the failed attempt at global settlement in the Eastern District of Pennsylvania, see CARROLL ET AL., *supra* note *, at 45-48 and Deborah Hensler, *As Time Goes By: Asbestos Litigation After Amchem and Ortiz,* 80 TEX. L. REV. 1899 (2002).

28. 28 U.S.C. § 1407 (2000).

29. The federal multidistrict litigation statute does not extend jurisdiction to cases filed in state courts. But if Judge Weiner were to certify a nationwide class of people exposed to or injured by asbestos—as Judge Weinstein had certified a nationwide class of Vietnam veterans exposed to Agent Orange—that class would sweep in state claims. The prospect of such a comprehensive settlement was not, of course, attractive to all participants in the litigation, as the discussion of *Amchem infra* makes clear.

30. Georgine v. Amchem Prod., Inc., 157 F.R.D. 246 (E.D. Pa. 1994).

HeinOnline -- 12 Conn. Ins. L.J. 267 2005-2006

Eastern District of Texas against another major defendant, the Fibreboard Corporation, in this instance under Rule 23(b)(1)(b)—a "non-opt-out" class.[31]

The two class action settlements stirred a storm of controversy. Lawyers whose clients would not collect any time soon (if ever) from CCR or Fibreboard under the terms of the two settlements—and who would not share in class counsel's fees—advised their clients to opt out of the Pennsylvania settlement,[32] and inveighed against the terms of both deals. Academic proceduralists and ethicists joined in the chorus of protest.[33] Critics argued that the settlements improperly barred currently unimpaired claimants who could prove exposure to asbestos from collecting compensation, as they were permitted to do in most jurisdictions. They queried whether claimants who had not previously filed asbestos lawsuits and were not yet impaired as a result of asbestos exposure would read or hear notices that a class action was pending in Pennsylvania and understand that they needed to opt out of that action if they did not want to be bound by its terms some years hence.[34] The fact that the lawyers who had negotiated the class action settlements had simultaneously settled their pending lawsuits on arguably more favorable grounds lent credence to charges of collusion with defendants. Both settlements were appealed, ultimately to the U.S. Supreme Court.

As they awaited the Court's decisions, the lawyers who negotiated the settlements pinned their hopes on the Court remanding the cases for further negotiation and review by the district courts.[35] But the outcomes were more drastic: In *Amchem v. Windsor,* the U.S. Supreme Court conclusively rejected the *Georgine* settlement on due process grounds, holding that conflicts of interests among differently positioned class members violated the adequacy of representation requirement of Rule 23(a)(4); the Court also opined that it might be impossible for *any* class action comprising future claimants to meet due process adequacy of representation and notice

---

31. Ahearn v. Fibreboard Corp., 162 F.R.D. 505 (E.D. Tex. 1995). As in *Georgine,* the defendant agreed concurrently to settle all of the plaintiff attorneys' pending asbestos claims against it. *See* Ortiz v. Fibreboard Corp., 527 U.S. 815, 850 (1999).

32. Ultimately 236,000 asbestos claimants opted out of the *Georgine* settlement. *See* CASTLEMAN, *supra* note 3, at 807-08.

33. For a discussion of the ethical debate and citations to leading commentary, see HENSLER, *supra* note 27.

34. Brian Wolfman & Alan Morrison, *Representing the Unrepresented in Class Actions Seeking Monetary Relief,* 71 NYU L. REV. 439, 452 (1996).

35. The *Fibreboard* lawyers negotiated a separate but related agreement that would only come into play if the Court rejected the Rule 23(b)(1)(b) class certification and settlement.

HeinOnline -- 12 Conn. Ins. L.J. 268 2005-2006

requirements. In *Ortiz v. Fibreboard,* the Court rejected the similarly structured *Ahearn* settlement on the grounds that the defendant did not meet the factual requirements of a limited fund under Rule 23(b)(1)(b), but it noted also that the *Ahearn* class did not meet adequacy of representation requirements as outlined in *Amchem.* Although the Court's sweeping rejection of the "futures class action" in *Amchem* may have surprised some of those who had negotiated that deal, by the time the second shoe dropped in *Ortiz,* the leading participants in the litigation had long abandoned the search for a global settlement.

VI. EXPANSION

The long effort to achieve a class action settlement in the multidistrict litigation stayed litigation against CCR in the federal courts. Federal cases against other defendants also remained at a stand-still as Judge Weiner declined motions to remand cases for trial to the district courts in which they had been filed. With action in federal courts slowing or stayed, plaintiff attorneys increasingly focused their efforts on state courts. Whereas forty percent of asbestos cases were filed in federal courts prior to 1988, by the mid-1990s the fraction was creeping down towards 10 percent. With cases mainly in state courts, some jurisdictions stepped up their efforts to resolve claims in large numbers in informal settlements or consolidations that sidestepped the strictures of the U.S. Supreme Court's decisions on class actions. Easy aggregation, combined with other judicial rulings that arguably favored plaintiffs drew increasing numbers of asbestos plaintiff attorneys and clients to courts in Mississippi, Texas, West Virginia and Ohio where historically juries have been perceived as "plaintiff friendly."[36]

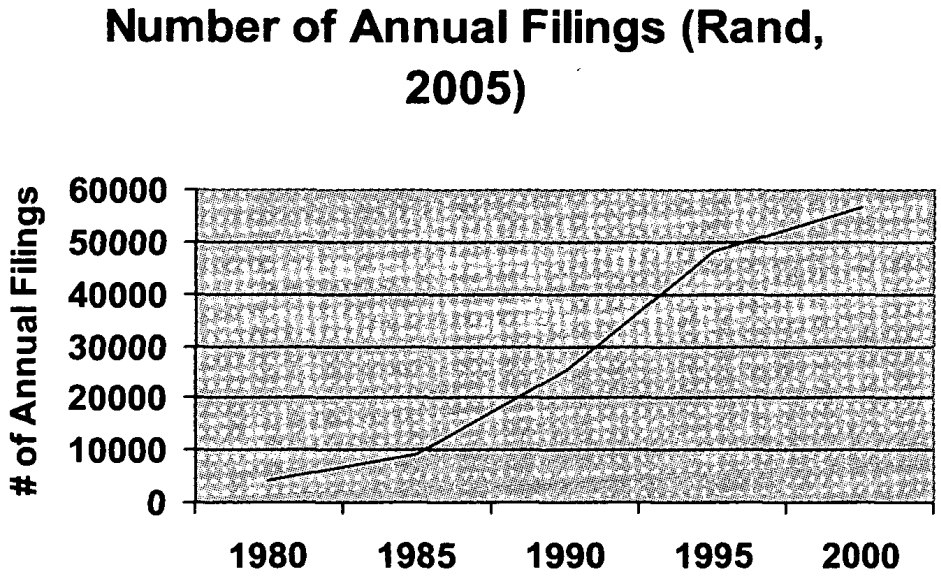
Perhaps in response to the availability of more inviting litigation environments, or as a result of the publicity created by notices and media coverage of the failed asbestos class action settlements in Eastern Pennsylvania and Eastern Texas, asbestos litigation began to surge again. Annual filings rose from approximately 25,000—30,000 in the early 1990s to 40,000—50,000 in the late 1990s (see FIGURE 1). Most of the growth in filings was associated with plaintiffs claiming compensation for asbestosis and pleural plaques (see FIGURE 2). The once small asbestos plaintiff bar began to expand as well: the number of law firms joining the litigation with as many as 100 new claims filed per year rose from 13 in

36. For further details on forum selection in asbestos litigation, see CARROLL ET AL., supra note *, at 59-63.

HeinOnline -- 12 Conn. Ins. L.J. 269 2005-2006

1990 to 23 in 2000.[37] But still, ten firms represented half or more of the claimants who filed annually.[38]

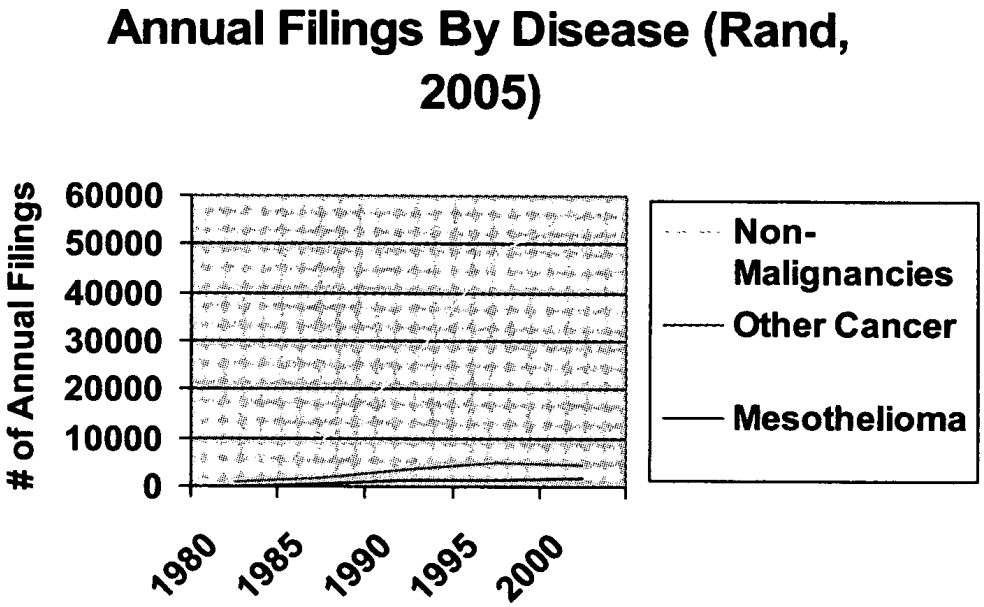
FIGURE 1



37. *Id.*
38. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 270 2005-2006

FIGURE 2



VII. UNRAVELING

As asbestos litigation surged, the leading defendants struggled to respond. With global resolution off the table in federal courts and high-risk (for defendants) mega-consolidations seemingly more popular in state courts, defendants looked for another forum in which to wrest back control of the litigation. Owens-Corning Fiberglass (OCF), which had purchased the remaining assets of Fibreboard after the Supreme Court rejected the Fibreboard settlement, announced a nationwide settlement program, offering quick resolution of claims to asbestos plaintiff lawyers with whom it negotiated long-term deals, based on these lawyers' previous success in the courts. For a brief time, Wall Street bought the notion that OCF and perhaps other major asbestos defendants might be able to cabin their asbestos costs by means of such aggressive settlement strategies. But within 18 months, OCF's program was dead— a victim of an unanticipated tide of new claims.[39] The consortium of defendants that had attempted to resolve their asbestos claims in the *Georgine* settlement suspended

39. Hensler, *supra* note 27, at 1907-08.

HeinOnline -- 12 Conn. Ins. L.J. 271 2005-2006

operations. With their attempts to achieve comprehensive settlements of asbestos claims in the courts blocked, and facing increasing costs in the capital market and decreasing share values, all but one of the asbestos product manufacturers that had been the primary targets of litigation over the previous decades sought the protection of bankruptcy.[40] Between 1997 (when *Amchem* was decided) and 2004, more than 40 major corporations petitioned for bankruptcy reorganization, citing asbestos liability exposure as the primary reason for filing.[41]

The surge of bankruptcy filings signaled the unraveling of the informal understandings and contractual agreements that underpinned asbestos litigation in the 1990s. With the litigation stayed against a large number of defendants, assets that potentially had been available to pay asbestos claims were at least temporarily off the table. But asbestos plaintiff attorneys had built up huge asbestos worker client lists to whom they had promised settlements in the near future—and from whom they had anticipated sizeable fee revenue. To make up the difference between the total amount of money that had been available from asbestos defendants to compensate asbestos claimants and the smaller amount of money that was now available, asbestos plaintiff attorneys turned to "peripheral" defendants: corporations that had not previously been central to the litigation but against whom there were colorable claims of negligence or strict liability. For many years, many of these corporations had settled claims for modest amounts of money, essentially "nuisance value," in order to avoid greater litigation expense. Now asbestos plaintiff attorneys told these defendants that they would have to put more money on the table to avoid litigation—perhaps several times the amount paid previously by these defendants—explaining that they needed to make up for what was no longer available from target defendants. Within a very short time, some peripheral defendants became central to the litigation, and their asbestos liability exposure ballooned. The result might have been anticipated: the once peripheral defendant corporations followed the target defendants into bankruptcy.

As asbestos claims filings and bankruptcy filings mounted, it seemed as if major U.S. corporations that had not previously been perceived as having significant asbestos liability exposure might soon find themselves in the cross-hairs of the asbestos plaintiff attorneys' big guns. What had once seemed a story of interest to only a small slice of American industry and a

40. The one historic target defendant who did not file for Chapter 11 reorganization was Owens-Illinois, which had withdrawn its asbestos products from the market in the 1950s, and as a consequence limited its asbestos liability exposure.

41. CARROLL ET AL., *supra* note *, at 110.

HeinOnline -- 12 Conn. Ins. L.J. 272 2005-2006

small subset of American workers moved onto the front pages of the country's newspapers.

VIII. STUMBLING TOWARDS REFORM

By the late 1990s, congressional representatives were beginning to hear from their business constituents that something needed to be done to resolve "the asbestos crisis." American businesses were far from united in support of government intervention, but enough corporations and business interest groups were lobbying for congressional action that reform proposals, many of which had been introduced in Congress over the years only to languish, began to gain traction.

In the last years of the Clinton administration, some Republicans and Democrats crafted a proposal for an administrative fund that would be an exclusive remedy for asbestos occupational injury compensation claims. Sponsored by Rep. Henry Hyde with the strong support of GAF, a major asbestos defendant, H.R.1283 would have established an Office of Asbestos Compensation (OAC) in the Department of Justice with exclusive jurisdiction over claims for compensation arising out of asbestos exposure. The bill set strict medical criteria for compensation that excluded claims for non-impairing non-malignant disease. Compensation was to be provided by an Asbestos Compensation Fund, which would be subsidized by asbestos defendants, as directed by the OAC director. Introduced in the House and Senate in 1998 and again in 1999, the asbestos reform legislation failed to gain significant support from asbestos defendants, who were wary of initiatives that might substitute requirements to compensate asbestos claimants for the more uncertain (and possibly avoidable) costs of asbestos litigation. Although claim filings were increasing, many major asbestos defendants still believed they could manage asbestos litigation and its attendant costs.[42] Labor unions, still smarting from the attacks they had sustained from members as a result of their support of the *Georgine* settlement, were united with plaintiff trial lawyers in opposition to the Hyde bill.[43]

By 2001, the corporate perspective on asbestos reform legislation had shifted significantly. With many more corporations in bankruptcy reorganization proceedings and asbestos litigation pressing an ever-

---

42. *See, e.g., Fairness in Asbestos Compensation Act of 1999: Hearing Before the H. Comm. On the Judiciary*, 106th Cong. 26-77 (1999) (statement of Maura J. Abeln, General Counsel, Senior Vice President and Secretary of Owens Corning).

43. Jim Vandehei, *Asbestos-Claims Bill Battle Heats Up With Attack on GOP Legislative Backers*, WALL ST. J., Feb. 22, 2000, at B32.

HeinOnline -- 12 Conn. Ins. L.J. 273 2005-2006

widening population of corporations, the peril attendant on not stopping the asbestos litigation engine seemed starker. Moreover, with a Republican president in the White House and the approach of Republican control of both houses of Congress, the prospect for reform legislation that might satisfy corporate objectives looked better than it had for many years previous.[44]

The earlier strategy for asbestos reform legislation had focused on the House of Representatives, by 2002 in the firm control of Republican supporters of corporate interests. But asbestos reform proponents understood that legislative success required Senate support as well, and in the Senate, the Democratic minority, which maintained strong ties with labor interests and the plaintiff trial bar, had the potential to filibuster an asbestos bill. As the lobbying effort gained momentum, reform proponents decided to focus on the Senate.

A new seriousness about the pursuit of asbestos reform legislation yielded a new more consensual strategy: rather than pitting corporate interests against asbestos plaintiff and plaintiff lawyer interests, reform advocates reached across the litigation "V" to asbestos plaintiff attorneys who represent the most serious asbestos victims. Although among the most aggressive of asbestos plaintiff attorneys—and historically the most willing to go to trial—some of these attorneys had become antagonists of the attorneys who specialized in representing large numbers of unimpaired asbestos-exposed workers. In negotiations with business interests groups, some attorneys who represented mesothelioma and other asbestos-related cancer victims agreed to support legislation that would preempt state tort law and establish medical criteria for bringing asbestos personal injury claims.[45] The medical criteria approach to asbestos reform, set forth in S. 413, the Asbestos Claims Criteria and Compensation Act of 2003, was supported by some sectors of the business community and also by the American Bar Association.[46] Under the terms of S. 413, only those whose asbestos disease met the medical criteria specified in the legislation would have viable tort claims: unimpaired asbestos-exposed workers would not be able to bring claims for compensation. However, whenever the currently

---

44. Jim Vandehei & Tom Hamburger, *Business Donors Prepare Another Wish List for Bush—Lobbyists Seek More Tax Breaks, Looser Rules on Workplace and Environment*, WALL ST. J., Jan. 8, 2002, at A20.

45. Gregg Hitt, *Asbestos Makers, Litigants: Uneasy Allies—Partial Alliance Prioritizes Seriously Ill Victims, Eases Firms' Financial Burden*, WALL ST. J., May 28, 2002, at A4.

46. *ABA Votes to Adopt Medical Standards, Set to Lobby for Legislation*, 18:2 MEALEY'S LITIG. REP. ASBESTOS 2 (2003).

HeinOnline -- 12 Conn. Ins. L.J. 274 2005-2006

unimpaired asbestos-posed workers did meet the specified criteria they would be able to file in tort and recover damages without fear of being barred by the statute of limitations.

But as the Senate Judiciary Committee considered the Asbestos Claims Criteria and Compensation Act, support for the legislation in the business community – never universal -- began to wane. The factors leading to the loss of support are not entirely clear. In their lobbying campaign in favor of the medical criteria legislation, business representatives had claimed that they were ready to pay the meritorious claims of asbestos-exposed workers with malignant disease and serious asbestosis; their purpose, they said, was only to rid the tort system of the "not sick." But as the medical criteria approach began to gain support in the Senate, asbestos defendants and insurers seemingly became worried that with unimpaired claims out of the courts, malignancy and asbestosis claims might surge and find a quicker route to trial. Jury verdict data indicated that the value of mesothelioma claims was rising significantly.[47] Suddenly, the prospect of an asbestos litigation comprising solely serious claims seemed unattractive, and there were rumors that corporate and insurance experts had calculated that the costs of the medical criteria approach would be *greater* rather than less than the costs of the litigation status quo. Some potential business supporters also came to believe that a bill that included tough medical criteria would never garner sufficient Democratic support to withstand a filibuster. As time passed, the business coalition supporting asbestos legislation split, and a new proposal for an asbestos trust fund, supported by a group of Fortune 500 corporations emerged.[48]

The new trust fund legislation, introduced by Sen. Orrin Hatch in 2003, bore a strong resemblance to the earlier Hyde bill.[49] But whereas the earlier bill had postponed for the implementation period the question of how much money would need to be put aside to compensate all future asbestos injury claims and how that total would be allocated among asbestos defendants and others, the new legislation confronted those issues squarely. S. 1125, the Fair Act of 2003, which called for a $108 billion trust fund, subsidized by asbestos defendants and insurers, as the exclusive

47. CARROLL ET AL., *supra* note *, at 54.

48. Tom Hamburger, *Law and Business Groups Face Infighting on Asbestos Litigation*, WALL ST. J., Feb. 6, 2003, at A4.

49. *Hatch Introduces $108 Billion Asbestos Trust Fund Legislation*, 18:9 MEALEY'S LITIG. REP. ASBESTOS 4 (2003).

HeinOnline -- 12 Conn. Ins. L.J. 275 2005-2006

source of compensation for asbestos injury claims, cleared the Judiciary Committee in mid-2003.[50]

But the 2003 legislation was only able to secure one Democratic vote in the Judiciary Committee, which signaled its likely failure when it moved on to the Senate floor.[51] Abandoning the medical criteria approach had lost reform proponents the support of plaintiff attorneys who represent mesothelioma and other asbestos-related malignancy victims, as a result re-uniting the asbestos plaintiff attorney bar in opposition to legislative reform. Labor unions, too, were adamantly opposed. With corporations and insurers squabbling over the terms of the trust fund legislation, reform proponents struggled to keep their initiative on track through the close of the 2003 congressional session.[52] By the end of 2003, many reform advocates had given up whatever hope they had held for legislative reform of asbestos litigation. But the key supporters of the trust fund approach refused to give up. As negotiations ground on in the Senate, the dollar value of the fund increased to $118 billion, compensation levels were increased, and other provisions were added in an effort to secure bi-partisan support.[53] But a year later, the trust fund's supporters seemed no closer to their goal.[54]

A new congressional session in 2005 brought a new chairman, Sen. Arlen Spector, to the Judiciary Committee, and new energy to the reform drive. Senator Spector devoted himself to building bi-partisan support for the asbestos litigation reform initiative,[55] and when a revised trust fund bill cleared the Judiciary Committee in May 2005,[56] success appeared tantalizingly close to reform proponents.

But passage had come at a stiff price: the trust fund was now capped at $140 billion, almost half again as large as the fund envisaged in Sen. Hatch's earlier proposal. The bill established strict medical criteria for eligibility for asbestos injury compensation, but it also provided for

---

50. Kathryn Kranhold, *Asbestos Measure Gains In Senate in a Tight Vote*, WALL ST. J., July 11, 2003, at A3.

51. *Id.*

52. Shailagh Murray, *Asbestos Deal Eludes Congress But Settlement Remains Priority*, WALL ST. J., Nov. 24, 2003, at A4.

53. Shailagh Murray, *Frist to Introduce A Revised Bill In Asbestos Saga*, WALL ST. J., Apr. 7, 2004, at B7.

54. Sheryl Stolberg, *Fund for Asbestos Victims Seems Headed for Setback Today*, N.Y. TIMES, Apr. 22, 2004, at A18.

55. David Rogers, *Specter Calls for Bipartisan Action; Judiciary Panel Chairman Urges Cooperation to Settle Asbestos Bill, Judgeships*, WALL ST. J., Feb. 25, 2005, at A5.

56. John Godfrey, *Asbestos Fund Narrowly Approved By Senate Panel*, Wall St. J., May 27, 2005, at B3.

HeinOnline -- 12 Conn. Ins. L.J. 276 2005-2006

medical monitoring of unimpaired claimants.[57] It called for contributions from asbestos defendants ($90 billion), insurers ($46 billion) and the bankruptcy trust funds that had been approved in earlier bankruptcy reorganization proposals ($4 billion). The bill's allocation of shares among asbestos defendants was sharply disputed, and opponents promised constitutional challenges, on "takings" grounds,[58] to the provisions pertaining to insurance coverage assets and the trust funds. Senator Spector's efforts yielded three Democratic votes on the Judiciary Committee, and the support of the United Auto Workers Union, but three of the bill's Republican supporters announced that they had voted in favor only to get the bill to the Senate floor, where they intended to oppose it.[59]

Notwithstanding the squabbling about the bill's provisions, it seemed possible that the committee vote had given the reform initiative the momentum it needed to get through the Senate. But in short order, other events overcame asbestos reform: first, the announcement of Justice Sandra Day O'Connor's retirement from the U.S. Supreme Court and the nomination of Justice John Roberts to replace her, then the events surrounding Hurricane Katrina and its aftermath, and then the death of Chief Justice William Rehnquist, the subsequent nomination of Mr. Roberts to replace him and the ill-starred nomination of Harriet Meirs to replace Justice O'Connor. By the time that the air around the Judiciary Committee had cleared in late 2005, whatever momentum might have been produced by the May committee vote had long dissipated. The intervening events created political space for opponents of the proposed asbestos trust fund, which they were quick to fill. As time passed, opposition to S. 852 mounted among corporations and insurers.[60] Labor union representatives, who had never been enthusiastic about the proposed legislation, and asbestos trial lawyers, who would lose most of their revenue from asbestos injury claims under the provisions of the bill, could simply sit back and wait for the corporate interests that had long lobbied for asbestos litigation reform to undermine its slim remaining chances for success. By the time S. 852 reached the floor of the Senate in February 2006, it was "dead on arrival," opposed variously as too generous and too stingy to asbestos injury claimants, too large and too small to cover all future asbestos injury

57. FAIR Act of 2005, S. 852, 190th Cong. § 132 (2005).

58. Postings of Ashby Jones, *Ted Olson's Asbestos Problem,* WALL ST. J., Feb. 6, 2006, LawBlog, Wall St. Journal Online.

59. Stephen Labaton, *Bill to Create Asbestos Disease Fund Goes to Senate for Vote,* N.Y. TIMES, May 27, 2005, at C7.

60. Brody Mullins, *Insurance Firms Withdraw Support for Asbestos Fund,* WALL ST. J., Apr. 5, 2005, at A3; *Asbestos Showdown,* WALL ST. J., Feb. 14, 2006, at A22.

HeinOnline -- 12 Conn. Ins. L.J. 277 2005-2006

claims.[61] As this article goes to press, Senators Spector and Leahy have introduced a revised version of S. 852, said to include amendments in response to critics on both sides of the aisle.[62]

IX. FAILURE

The long history of asbestos litigation in the United States illustrates the strengths and weaknesses of the American civil justice system. When Congress and regulatory agencies, hamstrung by powerful corporate interests, failed to act to protect workers from asbestos-related diseases, and when workers compensation systems failed to respond to injured workers' need for compensation to cover medical costs and work loss, private civil litigation system filled the gap. Plaintiff attorneys invested in asbestos litigation when the prospects for success appeared bleak, and succeeded in obtaining compensation for their clients in the face of vigorous efforts by well-heeled defendants to deny their liability. By creating a threat of enormous exposure to liability, entrepreneurial plaintiff attorneys sent a powerful deterrence message to corporate America.

But the blunt instrument of tort litigation wreaked havoc as well. Plaintiff attorneys' assiduous pursuit of corporations that might be made to compensate asbestos injury claims swept into court small companies as well as large corporations, and corporations with peripheral connections to asbestos harm as well as those that knowingly placed asbestos workers at great risk. The litigation diverted funds from arguably more productive enterprise. In their pursuit of corporate wrongdoers, plaintiff attorneys unwittingly drew the spotlight away from the federal government's responsibility for the asbestos public health crisis. In their pursuit of asbestos clients, some brought disrepute to the use of tort litigation to obtain compensation for harms, deter future wrongdoers, and achieve some modicum of corrective justice for those who have been harmed by the actions of others.

By creating strategies for efficiently pursuing asbestos injury claims, plaintiff attorneys opened up the courts to workers with modest injuries but meritorious claims who in normal product liability litigation are unable to find legal representation. In the process, asbestos plaintiff attorneys designed the mass tort litigation engine that continues to power product defect litigation today. But plaintiff attorneys kept all or most of the fruits

---

61. Brody Mullins, *Politics & Economics: Bill to Overhaul Asbestos Litigation Seems Headed for Senate Rejection*, WALL ST. J., Feb. 7, 2006, at A4.

62. Ralph Lindeman, *Specter Introduces New Asbestos Measure to Address concerns that Killed Earlier Bill,* BNA DAILY REPORT FOR EXECUTIVES, May 30, 2006.

HeinOnline -- 12 Conn. Ins. L.J. 278 2005-2006

of economies of scale to themselves. Having created an administrative compensation system within the walls of the litigation system, asbestos plaintiff attorneys maintained a fee structure more appropriate for hard fought high risk litigation long after most asbestos litigation fit that characterization. Defendants and their insurers continue to invest in costly insurance coverage litigation over policies purchased decades ago, litigation that enriches defense attorneys. No one—plaintiff attorneys, defense attorneys, defendants, or insurers—should be proud of a bureaucratized claims resolution process that expends more than fifty cents of every dollar spent to resolve asbestos claims on legal fees and expenses and that shortchanges seriously injured asbestos victims in order to provide payments to those with little or no current impairment.

After long advocating congressional action to abate what they perceived as an asbestos litigation crisis, corporations and their insurers have proved not up to the task of agreeing on a legislative scheme that will adequately compensate current and future asbestos injury victims. In their pursuit of a system that will best serve each corporation's and insurer's own needs, they have squandered the opportunities presented over the last half dozen years for creating an administrative claims resolution system that will staunch the flow of funds to pay legal fees and expenses and cabin their long-term costs of compensating asbestos injury claims.

The future of asbestos litigation is highly uncertain. In the past several years, the number of new cases filed annually has dropped dramatically, perhaps because the run-up in claims in the several years prior brought new claims into the courts prematurely, perhaps because attorneys suspended their pursuit of new clients as they awaited legislative developments and the negotiation of new bankruptcy reorganization plans. Charges of fraudulent claims associated with mass screenings are said to have disrupted those practices, perhaps for a long time to come. Some observers believe that if Congress does not adopt asbestos litigation reform legislation, litigation patterns will return to the relatively stable pattern of the early 1990s. But the historical landscape of asbestos litigation is littered with prognostications that the litigation would stabilize or diminish or become otherwise more predictable, all of which were subsequently proved wrong. More importantly, asbestos litigation in the 1990s, although it may have accommodated corporate defendants' and insurers' needs, was not a process to celebrate: it produced little in the way of individualized process or outcomes, shortchanged the very ill in favor of the worried exposed, had little left to achieve in the way of deterrence, and delivered these highly imperfect outcomes at a high transaction cost. To accept

HeinOnline -- 12 Conn. Ins. L.J. 279 2005-2006

asbestos litigation circa 1993 as our goal is to confess to the failure of the American civil justice system.

HeinOnline -- 12 Conn. Ins. L.J. 280 2005-2006

COMMENTS FOR THE UNIVERSITY OF CONNECTICUT ASBESTOS LITIGATION SYMPOSIUM

James L. Stengel[*]

I have been asked to provide descriptive comments regarding asbestos litigation today from the defendants' perspective. At the outset, let me issue a disclaimer. While I represent a number of entities and organizations in the context of both litigation and legislative activities, the views, comments and observations I provide here are mine alone. My essential position is that in an effort to accommodate ever increasing and eventually self-perpetuating claims flows the system of asbestos litigation has, in many respects, surrendered the ability to adjudicate in any meaningful way so that it manages to impose huge and wasteful transaction costs while simultaneously insuring that the wrong people—the unimpaired or fraudulent claims—are being paid while forcing the wrong people—the solvent bystanders—to pay. In an unfortunate parallel with asbestos-related disease, it has taken decades for the system to achieve its current, malign form. The "fixes" or solutions are limited.

We are, as the old proverb says, cursed to "live in interesting times." The broad contours of asbestos litigation today are well known and have been a topic of intense public scrutiny and periodic academic attention. There are hundreds of thousands of claims pending in courts across the United States. The historical cost through 2004 has been calculated by the RAND Corporation to be in excess of $70 billion.[1] Asbestos litigation has claimed more than seventy victims in the context of defendants who have sought refuge in bankruptcy, and had a substantial and detrimental impact on those defendant companies that have avoided bankruptcy. The pace of the litigation changes from time to time but rarely seems to slow. The transaction costs associated with the litigation are staggering. RAND calculates that less than forty cents of each dollar spent on litigation reaches a claimant. Claimants unfortunate enough to have claims against only a single bankrupt defendant may see their claims paid as little as five cents on the dollar. While by any objective measure of performance, it would be hard to defend the current system, none of the alternative solutions, which are primarily legislative, have been adopted. As a result, the current system may be the only system. But again, my task is to

---

* B.A. University of Illinois, J.D. University of Michigan Law School. Partner, Orrick, Herrington & Sutcliffe, LLP.

1. Steven J. Carroll, et al., *Asbestos Litigation* (RAND 2005).

HeinOnline -- 12 Conn. Ins. L.J. 281 2005-2006

provide a description of the litigation environment today. To do so in a meaningful way requires some history because history explains the sorry state of today's asbestos litigation system.

What history has shown is that legal rules have been mutable in the context of asbestos litigation. They have been altered, changed, stretched, or in some cases, ignored to accommodate asbestos litigation as it has metamorphosed over time. In contrast, one set of rules or laws which have been immutable are those of economics. They have not changed and they have performed exactly as expected. Where compensation is made available, claims will be filed. To the extent there are inadequate claims to absorb the available funding, more claims will be found, recruited or manufactured. The economic rules have been consistent throughout. Compensation has provoked, and will provoke, claiming.

Most litigants, courts and scholars date the beginning of the modern era of asbestos litigation with the *Borel* decision of the Fifth Circuit.[2] That case, which imposed strict liability for the first time on an asbestos insulation manufacturer, was the trigger for asbestos litigation. The litigation has taken a variety of forms and those forms explain, in part, its persistence. The first round or generation of asbestos litigation involved claims by individuals who were, for the most part, truly ill, having serious diseases like disabling asbestosis or asbestos-related malignancies like lung cancer and mesothelioma. Those claims were asserted against a relative handful of defendants, primarily in the business of manufacturing thermal insulation products containing asbestos. In most cases, the link between the asbestos-containing product and the illness was clear. What was also clear among this small cadre of asbestos insulation manufacturers was that they had knowledge of asbestos health risks in the '30s, '40s and '50s which was superior to that available to the general public; and, further, that successfully or not, they had taken affirmative steps to obscure the scientific and medical facts of asbestos disease causation. For these reasons, the litigation was born in an era of valid claims and growing suspicion about the conduct of the defendant companies. At this point, asbestos litigation appeared to be and was, in fact, largely conventional tort litigation, although quickly growing to what was considered a mass tort by the late '70s or early 1980s. Of course, if you compare the claim volumes of that early period with those of today, the label of "mass" in that context appears quaint in comparison.

What happened then to turn these core claims into the litigation scheme of today? What happened, in part, was that the Johns-Manville

2. Borel v. Fibreboard Paper Prods. Corp., 493 F.2d 1076 (5th Cir. 1975).

HeinOnline -- 12 Conn. Ins. L.J. 282 2005-2006

Corporation declared bankruptcy. By doing so, Johns-Manville, the largest by a substantial margin manufacturer of thermal insulation products containing asbestos, took itself out of the asbestos litigation. A less fluid or dynamic litigation system might have come to an abrupt end or at least a slackened pace at that point. What happened, though, explains much of what is prevalent today. The litigation continued. The missing market share of Johns-Manville was replaced almost overnight. That replacement occurred because of loose standards of joint and several liability and the active assistance of defendants who entered the fray to name other defendants to reduce their proportionate responsibility for the incoming claims.

At this point, courts also made a substantial contribution, applying very loose standards for joint and several liability, and engaging in no doubt well-intentioned experimentation with mass resolution devices such as class actions, consolidations and other species of mass actions. They did so, again, with best intentions but apparently without an understanding of the consequences of accelerating the flow of asbestos cases through the system. What happened has been described as the "Field of Dreams" phenomenon—"If you build it they will come." And come they did, at an asymptotic rate. This increase was driven, in addition, by some subsidiary aspects of the emphasis on mass claims handling. The numbers of claims largely precluded the courts or defendants from engaging in meaningful, case-by-case assessments, which, in turn, created a seemingly irresistible tendency to settle large volumes of cases at low per case value. In addition, in the late 1980s, the asbestos compensation trusts had begun to come on line, increasing the availability of "sure money" for claims, regardless of their quality.

As it was discovered or made clear that the liability share of Johns-Manville could be easily shifted among target defendants, the litigation began to take on a different coloration. For this reason the funding available in the world of asbestos litigation became virtually limitless. With virtually limitless funding available, there were new incentives to find as many putative asbestos claims as was possible. Thus was born screening. Screening, as you have heard elsewhere, does not involve the typical course of an individual becoming ill, seeking medical assistance and being told that their illness has something to do with occupational exposure to asbestos. It is an inversion of that process where otherwise currently healthy individuals are screened for the *de minimis* X-ray and other indicia of sufficient evidence to claim. This is a critical point—not evidence of illness or impairment, but evidence sufficient to claim. The screening process, coupled with what became eventually via the bankruptcy

HeinOnline -- 12 Conn. Ins. L.J. 283 2005-2006

processes found or easy money from the bankruptcy trusts, fueled an exponential growth of claims by the unimpaired. The claims of the unimpaired had another effect on the litigation scheme beyond creating vast numbers of individuals with little or no current illness.

One of the prime drivers of the current state of asbestos litigation is the fact that the system has been overwhelmed by the sheer number of claims. Courts complained early on that 3,000 or 4,000 claims were beyond their ability to adjudicate, and, as the number of claims has grown beyond those small beginnings, the problem has only been exacerbated. The legal responses have been experimentations with mass consolidations, with class actions, with bellwether trials. All in all, however, what has been produced is a scheme which is not designed to adjudicate claims on the merits. These waves, this tsunami of unimpaired claims, had the effect, not only of paying those who did not deserve to be paid, but aided, or perhaps made possible, the second deficiency of the asbestos litigation system today, which is, not only are the wrong people, the unimpaired, being paid, but the wrong people are paying. Those defendants active in the litigation system today were, in all likelihood, not defendants fifteen, ten or five years ago. RAND reports that some 8400 companies have been named as defendants in asbestos litigation. That bulge in defendants is of relatively recent origin, and it reflects the ongoing process of expanding the payment sources. I have heard plaintiffs' lawyers refer to this process as the search for less and less low-hanging fruit. A more accurate description from the defense side is the "search for the solvent bystander."

As courts have abandoned the ability or willingness to adjudicate, more and more defendants have been forced to step forward and compensate claims. The process has in some ways been insidious and brings to mind the adage about the frog and boiling water. Defendants here, the peripheral defendants who are front and center today, often started down the path of asbestos litigation by settling large numbers of claims for very low dollar values. That made complete rational sense, albeit only in the short term. In many cases they could settle an individual claim for less than it would cost that defendant to open the file and hire lawyers. Economically efficient from the defendants' perspective perhaps, but what that process created was a momentum; and, as other sources of funding disappeared, the peripheral players who had paid small amounts historically were moved to the center. And they were moved to the center in a context of where courts were generally aware that they had paid asbestos claims for years, therefore creating the presumption that "where there is smoke, there is fire."

The current wave of asbestos bankruptcies are in some ways illustrative of this. Courts have, even in the context of bankruptcies, with their natural

HeinOnline -- 12 Conn. Ins. L.J. 284 2005-2006

consolidative structures, been reluctant to adjudicate issues of causation or responsibility. What courts have attempted to do, for the most part, is to tread water until the parties settle with the presumption that the settlements will, by and large, if not entirely, resemble the results which would be obtained in the tort system. Of course, as noted, the tort system has little to recommend it in today's context, as the wrong people are being paid by the wrong defendants. This is not meant as a criticism of bankruptcy courts. Bankruptcy is designed to force consensus, is presided over by courts with no experience in personal injury litigation and is constrained by a statutory requirement of supermajority approval by claimants. Thus, it is hardly surprising that the bankruptcy process has tended to perpetuate the evils of the asbestos tort system.

What evidence is there of this process? Referring back to the Manville Trust is perhaps instructive in many important ways. As noted, Johns-Manville Corporation was far and away the predominant manufacturer of thermal asbestos-containing insulation products, and I think there is broad consensus that these products were the primary cause of at least the first wave of asbestos-related illness. Johns-Manville declared bankruptcy in 1982 and its liability obligations were undertaken by the Manville Trust. At the time the Manville Trust was being created during the Manville bankruptcy, there were various estimates of the "liability share" of Johns-Manville. Those typically ranged from 30% to 65+ %. While not mathematically precise, an interesting confirmation of Manville's proportionate responsibility is provided by looking to the liquidated value of claims Manville has resolved versus the RAND calculation of total asbestos liability paid. What if, counterfactually, Manville were still in the system paying claims? How much of the current burden would it have borne?

We have available the historical payment records of Manville and the Trust. Manville paid, in gross, around $71 million prior to its bankruptcy filing. In its initial operational period, the Trust paid out almost $1.2 billion before the intercession of Judge Weinstein. Both of these numbers are at full value and the pre-filing number requires an adjustment to remove defense costs. The Trust quite helpfully includes in its annual accountings a statement of not only what it has paid out, but also the full liquidated value of those claims. Given that those full values were negotiated in an environment where all of the participants understood that the actual *pro rata* payments would be a small fraction of those values, there is a risk of distortion. The assumption was that they approximated about one-third of full claim values in the tort system, which is, I think, too low, but which makes the actual strength of the calculation presented here potentially

HeinOnline -- 12 Conn. Ins. L.J. 285 2005-2006

understated. In any event, through the end of 2002 (chosen to correspond with RAND data), the full liquidated value of the claims paid by the Trust, post-Weinstein intervention, is reported as being a little over $22 billion. Summing these numbers gets you to a total Manville liquidated claim value of $23,472,653,318 as compared to RAND's reported gross compensation to plaintiffs through the end of 2002 of $49 billion. By my calculation, that means that the full liquidated value of the Manville claims represents about 48% of the gross compensation through 2002. This compares fairly well with anecdotal references to the fact that pre-filing, Manville had a 50% or greater "liability share."

What does this mean in terms of the litigation today? The litigation today is characterized by less and less successful efforts to assert claims on behalf of the unimpaired. Numerous jurisdictions have adopted deferral registries or green card systems which suspend prosecution of the claims of those claimants without impairment to allow arguably more serious claimants to litigate their claims. In addition, the attention given to the screening "problem," i.e., fraud) via the Congressional process of consideration of legislation and hearings in that context, the publication of scientific literature with respect to the deficiencies of screening and, perhaps most importantly, the opinion of Judge Jack in the Silica MDL and the appurtenant grand jury proceedings, there is, at present, a pall cast over screened claims. That is not to say that they are not capable of returning with full force once the "coast is clear." There are mechanisms to deal with the population of unimpaired claims, but they are not uniformly or consistently in place at this time. This is a work in progress; and while the signs are hopeful that there will be fewer such claims, they are far from a non-issue in the system. This is in many ways surprising, as from a medical perspective, there is general consensus that asbestos-related disease of the non-malignant sort is a rapidly disappearing, if not already disappeared, disease process. The ability of these claims to return is enhanced by the mobility of asbestos claims. What reform has taken place to date has been jurisdictionally piecemeal. The historical experience is that these claims will migrate to the most plaintiff-friendly jurisdictions. As a result, absent comprehensive reform, there will always be a risk that these claims will return.

Beyond the unimpaired claimants there is a growing population of asbestos claimants whose diseases, even if malignant, are of contested etiology. Lung cancer cases, for example, are predominantly among individuals who are current or former smokers. The defense perspective, as well as the mainstream scientific medical view, is that these claims arise

HeinOnline -- 12 Conn. Ins. L.J. 286 2005-2006

because of smoking. The Courts are not consistent in assisting presentation of relevant evidence in this regard, and, as non173/2

-malignant unimpaired claims become more and more difficult to prosecute because of deferral registries or unavailability of screening doctors, it can be anticipated that the battleground will shift to lung and other cancers, as well as mesothelioma claims, without obvious asbestos exposure.

The other deficiency of the system, one which shows much less evidence of any solution short of legislation, is the dimension of who pays the current asbestos claims. The claims are being asserted against companies whose relationship is more and more attenuated or against industries or products which historically have not been associated with substantial causal relationships with asbestos disease. A good example of the last are friction products manufacturers. While there have always been brake worker claims, the idea that the shade-tree mechanic could release substantial enough amounts of fiber to become ill is a relatively new theory, born as a direct result of the lack of other more viable defendants in the litigation.

The historical development of asbestos litigation, the notion that Courts believe asbestos claimants, particularly those with malignant disease processes, have asbestos-related illness and should be compensated, constitutes a substantial disadvantage for defendants. The predominant *de facto* if not *de jure* summary judgment standard is that if a plaintiff can show any exposure to the product or premise of a defendant, that will be sufficient to defeat summary judgment. That standard, of course, bears no resemblance to the actual scientific or medical causation issue, which would require a substantial exposure with proximity and continuity over time. Courts, because of the burdens imposed by the litigation, including the sheer number of claims, have not been enthusiastic supporters of detailed adjudication of the merits of individual asbestos claims. Unless and until Courts grasp that particular nettle, there will be an ever-expanding collection of defendants paying larger and larger amounts of money to claimants with less and less obvious connection to asbestos exposure as the cause of their disease.

Can this situation be resolved absent legislation? Given the ability of plaintiffs to move cases from jurisdiction to jurisdiction, to find new courts, pejoratively labeled "swamp jurisdictions," indicates that there will always be a retreat from substantive adjudication. As long as that retreat is accommodated by the system, litigation solutions are unlikely, and the cost will continue, and we will likely be in a system where the wrong people are being paid by the wrong defendants.

HeinOnline -- 12 Conn. Ins. L.J. 287 2005-2006

HeinOnline -- 12 Conn. Ins. L.J. 288 2005-2006

ON THE APPLICABILITY OF THE SILICA MDL PROCEEDING TO ASBESTOS LITIGATION

Lester Brickman[*]

INTRODUCTION

In a series of articles published over the past fourteen years, I have presented the results of an extended study of asbestos litigation.[1] In recounting the history of the litigation, I noted that in the mid 1980s, court decisions dramatically enlarged insurance companies' liability for asbestos-related injury.[2] At the same time, in the face of mounting numbers of claims and judicial aggregations that imposed substantial costs on defendants and in some cases threatened their economic viability, defendants and their insurers began to pay asbestos claims without demanding much in the way of proof of injury or liability.[3] Plaintiffs' lawyers responded opportunistically. As a consequence, asbestos litigation, which had previously focused on malignancies and other debilitating injuries caused by asbestos exposure, underwent a radical shift in the mid

---

* Professor of Law, Benjamin N. Cardozo School of Law of Yeshiva University. I have been ably assisted by my research assistant, Ben Fliegel, in the preparation of this article.

1. *See generally* Lester Brickman, *The Asbestos Litigation Crisis: Is There A Need For An Administrative Alternative?,* 13 CARDOZO L. REV. 1819 (1992) [hereinafter Brickman, *Asbestos Litigation Crisis*]; Lester Brickman, *The Asbestos Claims Management Act of 1991: A Proposal To The United States Congress,* 13 CARDOZO L. REV. 1891 (1992); Lester Brickman, *Lawyers' Ethics And Fiduciary Obligation In The Brave New World Of Aggregative Litigation,* 26 WM. & MARY ENVTL. L. & POL'Y REV. 243, 272-98 (2001) [hereinafter Brickman, *Aggregative Litigation*]; Lester Brickman, *On The Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality,* 31 PEPP. L. REV. 33 (2004) [hereinafter Brickman, *Theories of Asbestos Litigation*]; Lester Brickman, *Ethical Issues In Asbestos Litigation,* 33 HOFSTRA L. REV 31 (2005) [hereinafter Brickman, *Ethical Issues*]; and Lester Brickman, *An Analysis of the Financial Impact of S.852: The Fairness In Asbestos Injury Resolution Act of 2005,* 27 CARDOZO L. REV. 991 (2005) [hereinafter Brickman, *Analysis of S.852*].

2. *See* Brickman, *Asbestos Litigation Crisis, supra* note 1, at 1831-32; *see also* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 55-57.

3. *See* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 57-59; *see also* GRIFFIN B. BELL, ASBESTOS LITIGATION AND JUDICIAL LEADERSHIP: THE COURT'S DUTY TO HELP SOLVE THE ASBESTOS LITIGATION CRISIS 16 (2002) (indicating that many asbestos defendants "often conclude . . . [that] it is cheaper to treat the claims as administrative costs, regardless of merit, than to litigate").

to late 1980s from the traditional model of an injured person seeking a lawyer to an entrepreneurial model under which plaintiff lawyers and their agents actively recruited hundreds of thousands of potential litigants who could claim workplace exposure to asbestos containing products.[4]

I concluded that a substantial percentage of these nonmalignant claimants had no disease caused by asbestos exposure as recognized by medical science and no loss of lung function. Moreover, their claims were often supported by specious medical evidence and entrepreneurially generated witness testimony to mask the fact that there was often insufficient exposure to a defendant's products to denominate that exposure as a substantial factor in causing disease.

While a number of journalists have recognized the significance of this scholarship,[5] it has been widely if not studiously ignored by torts scholars.[6] Recently, in a multi-district litigation involving approximately 10,000 silicosis claims, U.S. District Court Judge Janis Jack has issued findings[7] with regard to silica litigation that largely track those that I had published with respect to asbestos litigation. Because silicosis litigation involves the same modus operandi as entrepreneurially generated nonmalignant asbestos litigation, the same screening enterprises, B Readers, diagnosing doctors, and law firms, it is reasonable to conclude that Judge Jack's findings apply with equal force to asbestos litigation.

In this article, I sketch out the elements of the entrepreneurial model of nonmalignant asbestos litigation and consider the role of a comparative handful of specially certified doctors who are largely responsible for the production of specious medical evidence. I then briefly review Judge Jack's findings and conclude that her findings apply with full force to nonmalignant asbestos litigation and corroborate my own published conclusions.

---

4. *See generally* Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 62-103.

5. A leading legal affairs journalist, Stuart Taylor, has said of Brickman, *Theories of Asbestos Litigation*, *supra* note 1, that "Brickman's empirical research is so massive, his scholarship so meticulous and his 526 footnotes so crammed with compelling evidence, that his article should shift the burden of proof in public debate to those who defend the legitimacy of the asbestos-claims industry." Stuart Taylor, Jr., *Asbestos Litigation: Evidence of Massive Corruption?*, NAT'L L.J., Jan. 3, 2004, at 8. Another leading journalist writing on asbestos litigation, Roger Parloff, commenting on the same article, stated that "[Brickman's] prodigiously researched article made his views more difficult to ignore and the evidence surfacing in . . . [the silica MDL] now takes him a giant step closer to vindication." Roger Parloff, *Diagnosing For Dollars*, FORTUNE, June 13, 2005 at 97, 98.

6. See Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 166-70, for possible explanations of why this is so.

7. *See generally In re* Silica Prods. Liab. Litig., No. MDL 1553, 398 F. Supp. 2d 563 (S.D. Tex. 2005).

HeinOnline -- 12 Conn. Ins. L.J. 290 2005-2006

I. THE ENTREPRENEURIAL MODEL OF NONMALIGNANT ASBESTOS LITIGATION

The elements of the entrepreneurial model include:[8]

(1) a massive client recruitment effort undertaken by "screening" enterprises formed for that purpose which have been paid millions of dollars by lawyers to screen hundreds of thousands of former shipyard, construction and industrial workers in the past fifteen years;

(2) generating virtually all of the nonmalignant claims of injury that have been brought—historically these have made up ninety percent of asbestos claims[9]—though most of these "litigants" have no medically cognizable asbestos–related injury and cannot demonstrate any statistically significant increased likelihood of contracting an asbestos-related disease in the future;

(3) the claims of injury are often supported by entrepreneurially generated medical evidence, including: (a) evidence generated by the entrepreneurial screening enterprises, doctors, and approximately 15-25 B Readers—pulmonologists and radiologists who have been certified by NIOSH as having competence in reading and classifying chest X-rays on the ILO scale.[10] Plaintiff lawyers repeatedly select this small group of B Readers from among the 380-500 certified Readers because they produce X-ray readings and "diagnoses" which are not a product of good faith medical judgment but rather a function of the millions of dollars a year in income that they receive for these services. The claims of injury are additionally supported by pulmonary functions tests (PFTs) which are often administered in violation of standards established by the American Thoracic Society and which maladministration often results in findings of impairment which would not be found but for the improper administration of these tests;

---

8. The entrepreneurial model description that follows is an amalgam of the content of several of the articles cited in *supra* note 1.

9. For example, more than 90% of the 91,000 new claims presented to the Manville Trust in 2001 were 1/0 asbestosis claims mostly generated by attorney sponsored asbestos screenings and read by the same comparative handful of B Readers. *See* THE FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT OF 2003, S. REP. NO. 108-118 (2003) (citing *Hearing on Asbestos Litigation, Before the Senate Comm. On the Judiciary*, 107th Cong. (2002) (statement of David Austern)); *id.* at 84 (citing Letter from Steven Kazan to the Honorable Jack B. Weinstein which states that "90% of the [Manville] Trust's last 200,000 claims have come from attorney-sponsored X-ray screening programs").

10. For an explanation of the ILO classification system, see Brickman, *Theories of Asbestos Litigation, supra* note 1, at 47-48.

HeinOnline -- 12 Conn. Ins. L.J. 291 2005-2006

(4) the claims of injury are further supported by "litigants'" testimony that is often the product of entrepreneurial witness preparation techniques including the use of scripts prepared by their lawyers, which are replete with misstatements with regard to: (a) identification and relative quantities of asbestos-containing products that they came in contact with at work sites (in order to shift the focus of testimony from certain manufacturers that have declared bankruptcy to others that are solvent), (b) the information printed on the containers in which the products were sold, and (c) their own physical impairments;

(5) being asserted mostly in a small number of jurisdictions which were selected, in part, because judges in those jurisdictions readily accommodated the interests of these "litigants" and their lawyers by dispensing with certain evidentiary requirements and proof of proximate cause, under a legal regime which I have termed "special asbestos law;"

(6) being filed *en masse* in selected courts with the intention of overwhelming these courts' dockets and impelling the courts to aggregate the claims in order to move them through the judicial system;

(7) but which aggregations operated perversely to effectively preclude defendants from defending against most of the claims and to instead adopt settlement strategies that included payment of compensation irrespective of whether the litigants had suffered any actual asbestos-related injury or whether any injury was substantially caused by exposure to that defendant's products, thus creating substantial incentives for plaintiffs' lawyers to increase recruitment efforts.

The core of the entrepreneurial model of nonmalignant asbestos litigation that I describe is the mass screening. Individuals who generally lack any healthcare knowledge or experience have set up approximately fifteen enterprises to "screen" hundreds of thousands of workers who could claim exposure to asbestos in their workplaces. Of the 850,000 asbestos claimants that have brought suit through 2004 against over 8,400 different defendants,[11] perhaps 600,000 have been recruited by these mass screenings. Many of the screening entities administer X-rays and several also administer PFTs for the sole purpose of generating evidence for litigation purposes. Mobile X-ray vans are brought to motels, strip malls and other locales to take X-rays at an assembly line rate of one every five to ten minutes and to administer the PFTs.

11. *See* Brickman, *Ethical Issues*, *supra* note 1, at 834.

HeinOnline -- 12 Conn. Ins. L.J. 292 2005-2006

A. THE ROLE OF B READERS IN ENTREPRENEURIAL ASBESTOS LITIGATION

To read the hundreds of thousands of pulmonary X-rays generated by screening enterprises, the enterprises and plaintiff lawyers hire NIOSH-certified B Readers. A comparative handful of B Readers, ranging from 4-6% of all certified B Readers,[12] are consistently chosen by plaintiff lawyers to read most of the hundreds of thousands of X-ray films generated by screenings. This small number of B Readers have accounted for a dramatically disproportionate number of the total number of X-ray readings that are submitted as medical evidence in support of nonmalignant asbestos personal injury claims.[13]

The reliance on a comparative handful of B Readers and diagnosing doctors is a defining characteristic of the entrepreneurial model.[14] For example, The Manville Personal Injury Settlement Trust ("Trust"), the entity created as a consequence of the bankruptcy of the Johns-Manville Corp. in 1982 to which all claims against Johns-Manville relating to asbestos exposure were channeled,[15] recently reported that as of August 30, 2005, it had received 691,910 claims, of which 499,766 included the name of a physician. The fifteen physicians whom the Trust has most frequently identified as the "primary physician" providing medical reports in support of claims, accounted for 200,107 or 40% of the 499,766 claims.[16] These

---

12. As of December 15, 2005, NIOSH listed 387 B Readers on its website; on July 22, 2003, it listed 431; on April 25, 2002, it listed 535; and on February 20, 1998, NIOSH listed 627 B Readers.

13. *See infra* notes 14-18.

14. In the Silica MDL, Judge Jack noted that "the over 9,000 plaintiffs who submitted fact sheets were diagnosed with silicosis by only 12 doctors . . . affiliated with a handful of law firms and mobile X-ray screening companies." *In re* Silica Prods. Liab. Litig., No. MDL 1553, 398 F. Supp. 2d 563, 580 (S.D. Tex. 2005).

A study of a stratified sample of claims submitted to Owens Corning before its bankruptcy filing indicated that just five B Readers (Drs. Raymond Harron, Jay Segarra, Richard Keubler, Philip H. Lucas and James W. Ballard) had read over eighty percent of the X-rays, with Dr. Harron alone accounting for forty-six percent of the X-ray readings. Report of Dr. Gary K. Friedman at 11, 18, 21, Owens Corning Impaired Nonmalignant Claim Submissions 1994-1999 (approx.), (circa 2002). The Manville Trust reported that in a recent period, 49.6% of the tens of thousands of non-malignancy claims it received that identified a doctor were based on the B-reads of just ten doctors.

15. *See* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 128.

16. *See* Report prepared by David Austern, President, Claims Resolution Management Corp., for a Mealey's teleconference on November 30, 2005. The Manville Trust had previously reported that, of 199,533 claims it processed in the period January 1, 2002 to June 30, 2004, just twenty B Readers accounted for sixty-two percent of the total B

HeinOnline -- 12 Conn. Ins. L.J. 293 2005-2006

fifteen physicians are listed below; those with asterisks are now or have previously been certified as B Readers:[17]

Physicians	Claims as Primary Physicians
Ray A Harron*	53,724
Alvin J. Schonfeld*	28,645
Jay T. Segarra*	23,325
Richard B. Levine*	13,896
Dominc J. Gaziano*	13,190
Larry M. Mitchell	11,606
James W. Ballard*	11,111
Roy P. Johnson	9,610
Paul C. Venizelos*	7,840
William H. Goldiner	5,461
Laxminarayana C. Rao*	5,277
Robert J. Mezey*	4,713
Robert A. Cohen*	4,038
Joseph Buono	3,846
Robert B. Altmeyer*	3,825
Subtotal – top 15	200,107
Trust Claims with Doctor Information	499,766
All Manville Trust Claims	691,910

The comparative handful of B Readers and diagnosing doctors, including those listed above, who are regularly selected by plaintiff lawyers, consistently grade a substantial portion of the X-rays they read as 1/0 on the International Labor Office ("ILO") scale and "consistent with asbestosis" and mostly "diagnose" litigants as having mild asbestosis.[18]

Readings. *See also* Power Point Presentation at 8, David T. Austern, President, Claims Resolution Management Corporation, "2004 Asbestos Claim Filing Trends."

17. The above table lists only the claims for which the listed doctors were deemed to be the "primary" physician. The table thus understates the actual concentration of physicians providing most of the medical reports in support of claimants. For example, though Dr. Ray A. Harron, a former B Reader, is listed as primary physician in 53,724 claims, he had actually provided medical reports in support of 76,274 individual Manville Trust claimants. *Id.*

18. As reported in a recently published Johns Hopkins study, "[a] small number of B Readers have made reputations with attorneys by consistently interpreting chest radiographs of asbestos claimants as positive [i.e., 1/0 on the ILO scale] in 90-100% of cases." *See*

HeinOnline -- 12 Conn. Ins. L.J. 294 2005-2006

B. THE PERCENT OF "POSITIVE" READINGS BY ENTREPRENEURIAL B READERS

Unlike B readings that are done outside of the asbestos litigation context, B Readers hired by plaintiffs' lawyers and screening enterprises are not blinded as to the purpose of the X-ray to be read—a process intended to shield them from bias. To the contrary. B Readers hired to generate medical support for an asbestos claim are told that they are reading the X-ray for the purpose of supporting an asbestos related claim and that the outcome of their reading will determine the eligibility of the litigant for compensation.[19] Since B readings for asbestos litigation purposes have no relationship to the health of the litigant, it is not surprising that most of these B Readers find that the substantial majority of the X-rays they are sent to examine are "positive," that is, "consistent with asbestosis."

The percent of the total number of X-rays that B Readers retained by plaintiffs' lawyers read as positive for asbestosis is the key to the legitimacy of their work product. This is so because medical studies consistently show that the actual prevalence of asbestos related disease in most exposed populations is in the one to four percent range.[20] Thus, if B Readers consistently read forty to sixty or even ninety percent of the thousands of X-rays they review for litigation purposes as "consistent with asbestosis," that would not only subject their findings to challenge but also expose these B Readers to more serious risks. That is why B Readers and screening company representatives, when asked about their percent "positives," uniformly refuse to provide access to data they maintain that would allow computation of their percent "positives" and mostly testify that they do not know what percent of screened litigants they found

---

Joseph N. Gitlin et al., *Comparison of "B" Readers' Interpretations of Chest Radiographs for Asbestos Related Changes*, 11 ACAD. RADIOLOGY 843, 844 (2004).

19. *See, e.g.*, Letter from Law Offices of Alwyn H. Luckey to Dr. James Ballard, May 11, 2000 (on file with the author) (stating: "We have recently made a settlement agreement which requires a medical evaluation based upon either an ILO reading of 1/0 or greater, bilateral pleural plaques, bilateral pleural thickening, interstitial Fibrosis or other asbestos related abnormalities. Under separate cover, you will find the chest x-rays of these claimants for your review. Upon your evaluation, please provide a report immediately."); Letter from Dr. James W. Ballard to the law firm of Wallace & Graham (Oct. 10, 2002) (on file with the author) (acknowledging receipt of X-rays sent to him to be "read for asbestosis only" and further stating that "[i]f your office needs b-readings for silicosis, then I will be happy to accommodate you").

20. I have summarized the medical evidence in Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 46-62.

HeinOnline -- 12 Conn. Ins. L.J. 295 2005-2006

positive for asbestosis (and therefore qualified to receive compensation) of the total number of X-rays they reviewed.[21] On the relatively few occasions when they do respond to questions about their "positive" rate, they assert that they find that twenty to thirty-five percent of the X-rays generated by their screenings are 1/0 (or higher) on the ILO scale.[22]

On the basis of my own research, I have concluded that the actual percentage of X-rays generated by attorney sponsored asbestos screenings which are read as 1/0 or higher by plaintiff-lawyer-selected B Readers is mostly in the sixty to eighty percent range.[23] For some B Readers and diagnosing doctors, the positive rates are even higher—over ninety percent.[24]

The very high percentage of X-rays read by plaintiff-lawyer-selected B Readers as 1/0 "consistent with asbestos," as well as the "diagnoses" of mild asbestosis made in reliance on those readings, are inconsistent with the findings of medical experts who have called asbestosis a "disappearing disease,"[25] and a condition that is "exceedingly rare."[26]

According to a number of medical studies, moreover, the actual prevalence of lung conditions consistent with asbestos in a population of workers with work-related exposure to asbestosis is four percent or less.[27] These medical studies and my own empirical research on the rates of "positive" B reads and "diagnoses" lead to the conclusions that (1) the comparative handful of B Readers and other doctors regularly hired by plaintiff lawyers routinely and systematically "over-diagnose" the presence

---

21. *See infra* note 53; *see also* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 86.

22. Brickman, *Theories of Asbestos Litigation, supra* note 1, at 86.

23. *See id.* (the empirical data on which this conclusion is based).

24. For example, "[a]fter December 31, 2000 (when [the screening enterprise] N&M changed its focus from asbestos to silica litigation), Dr. [Ray] Harron [then a B Reader] found . . . [lung] opacities (consistent with silicosis) in 99.6% of the 6,350 B-reads he performed for MDL Plaintiffs. But prior to December 31, 2000 (when N&M focused on asbestos litigation), Dr. Harron performed B-reads on 1,807 of the same MDL Plaintiffs for asbestos litigation and he found . . . opacities (consistent with asbestosis but not silicosis) . . . 99.11% of the time." *In re* Silica Prods. Liab. Litig., No. MDL 1553, 398 F. Supp. 2d 563, 607-08 (S.D. Tex. 2005) (footnote omitted).

25. Kevin Browne, *Asbestos-Related Disorders*, *in* OCCUPATIONAL LUNG DISORDERS 410 (3d ed. 1994).

26. Letter from Dr. James Crapo, FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT OF 2003, Report at 18. Other medical researchers have stated "we have not seen a single case of significant asbestosis with first exposure during the past 30 years." Jederlinic & Churg, *Idiopathic Pulmonary Fibrosis In Asbestos-Exposed Workers,* 144 AM. REV. RESP. DIS. 695, 695-96 (1991).

27. *See* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 46-62.

HeinOnline -- 12 Conn. Ins. L.J. 296 2005-2006

of lung conditions "consistent with asbestosis" and of nonmalignant asbestos-related disease to support entrepreneurially generated claims; and (2) that these B-readings and "diagnoses" are not the product of good faith medical practice but rather a function of the millions of dollars in fees available to be paid to B Readers and other doctors who consistently grade X-rays as 1/0 on the ILO scale and "diagnose" mild asbestosis.[28]

C. ISSUES OF INTER-READER AND INTRA-READER VARIABILITY

According to NIOSH, which has established the B Reader certification program, "[i]t is well known that variation exists not only from [B] Reader to [B] Reader (inter-reader variation), but also between readings by the same reader (intra-reader variation)."[29] The evidence I reviewed, however, indicates that the existence of intra- and inter-reader variability is being used by the comparative handful of B Readers regularly selected by plaintiffs' lawyers to mask their participation in a scheme that U.S. District Court Judge Janis Jack concluded had been devised by lawyers, screening companies and doctors to "manufacture . . . [diagnoses] for money"[30] — that is, to perpetrate fraud.

To be sure, in any given instance or even a set of hundreds of cases involving the X-ray detection of pleural plaques or very mild asbestosis, medical experts can and do differ in their interpretations of the X-rays. In the case of nonmalignant asbestos litigation, however, we are dealing with thousands and tens of thousands of X-ray readings by a comparative handful of B Readers. There are huge and consistent discrepancies between the interpretations of neutral X-ray readers not concerned about a future flow of revenue and the B Readers who realize, in the aggregate, tens of millions of dollars in repeat business for consistently grading the X-rays used for litigation purposes as "consistent with asbestosis" or as indicating the presence of pleural plaques. The discrepancies involved are not simply different profusion readings but also include other variables in a single read such as shape and size of any profusions, lung zone and the

---

28. *See id.* at 90-97.

29. NIOSH's Draft for Public Comment on *Recommendations for Applying the International Labour Office (ILO) International Classification of Radiographs of Pneumoconioses in Medical Diagnosis, Research and Population Surveillance, Worker Health Monitoring, Government Program Eligibility, and Compensation Settings* at 5 (undated), *available at* http://www.cdc.gov/niosh/topics/chestradiography/pdfs/recommendations.pdf (last visited June 30, 2006).

30. *In re* Silica Prods. Liab. Litig., No. MDL 1553, 398 F. Supp. 2d 563, 635 (S.D. Tex. 2005).

HeinOnline -- 12 Conn. Ins. L.J. 297 2005-2006

presence of pleural plaques. Accordingly, the possibility that these consistent discrepancies can be explained as "inter- or intra-reader variability" recedes to near zero.[31]

D. THE GITLIN/LINTON STUDY

This conclusion is buttressed by the results of a study undertaken by Dr. Joseph Gitlin and Mr. Otha Linton of the Johns Hopkins Medical Institutions.[32]

Dr. Gitlin and Mr. Linton selected a panel of six distinguished B Readers to re-read 492 X-rays that had been previously read for litigation purposes by several of the B Readers regularly selected by plaintiffs' lawyers as showing parenchymal abnormalities of 1/0 or higher in ninety-six percent of the X-rays. The panel selected by Gitlin/Linton were not informed that the X-rays had previously been read for litigation purposes. Moreover, the X-rays were masked as to patient and source information.

The panel classified the films as 1/0 or higher in 4.5% of the 2952 readings. Moreover, the degree of inter-reader variability was narrow: three readers found irregularities in 1.6-1.8% of the X-rays; two other

---

31. When, as occurs in asbestos and silicosis litigation, a B Reader reads an X-ray as "1/0, consistent with asbestosis" and with profusions in all six zones and with an *en face* pleural plaque and several years later reads the same X-ray as "1/0 consistent with silicosis" and does not mention asbestosis or the *en face* plaque, that is not a case of intra-reader variability. Rather it is an essential piece of evidence manufactured by a medical professional certified by NIOSH which "accurate or not is money in the bank." *Id.* at 628, 638-39. Furthermore, as observed by Judge Jack, it is an indictment of the B Reader who does so:

> Moreover, as recounted above, the sheer volume of Dr. Harron's asbestosis/silicosis reversals (i.e., reading an x-ray as consistent with asbestosis for asbestos litigation and then reading the same individual's x-ray as consistent with silicosis for silica litigation), simply cannot be explained as intra-reader variability. (Feb. 17, 2005 Trans. at 15.) Instead, it can only be explained as a product of bias—that is, of Dr. Harron finding evidence of the disease he was currently being paid to find.

Id. at 638.

32. Joseph N. Giltin et al., *Comparison of "B" Readers' Interpretations of Chest Radiographs for Asbestos Related Changes*," ACAD. RADIOLOGY 843 (2004). Dr. Gitlin, who has a PhD, is on the faculty of the department of radiology of the Johns-Hopkins Medical Institutions and has been a participant in designing studies of B Readers. Mr. Linton was principal staff to the American College of Radiology Task Force on Pneumoconiosis for twenty-five years, and a consultant to NIOSH, as well as a member of the ILO task force on its chest X-ray classification system.

HeinOnline -- 12 Conn. Ins. L.J. 298 2005-2006

readers found irregularities in 2.4-3.5% and two readers found irregularities in 10.7-12.8% of the X-rays.

Based on a statistical analysis, the Gitlin/Linton study determined that there was a probability of less than 1 in 10,000 "that the differences noted between initial and consultant readers are due to chance alone."[33]

II. THE SILICA MDL

A. SUBSTANTIATION OF SPECIOUS CLAIMING UNDER THE ENTREPRENEURIAL MODEL

My conclusions that, (1) by development of an entrepreneurial model of nonmalignant asbestos litigation, plaintiffs' lawyers and their agents have generated massive numbers of specious claims and (2) that the comparative handful of doctors regularly hired by plaintiffs' lawyers are not engaged in good faith medical practice but rather have entered into business transactions in which they are paid millions of dollars in exchange for a product they are licensed to sell, namely, medical evidence to be used to support litigation claims, have been significantly substantiated by the findings of U.S. District Court Judge Janis Jack, appointed to preside over 10,000 silica claims that were centralized into a multi-district litigation.[34]

While Judge Jack's findings were based on claims of silicosis, she was examining the operation of the same screening enterprises and the same B Readers and diagnosing doctors who had engaged in the identical practices with regard to the generation of claims of asbestosis and the production of medical "evidence" in support of those claims. Judge Jack found that the silicosis diagnoses "were manufactured for money" as part of a "scheme" in which "the lawyers, doctors and screening companies were all willing participants."[35] This is the equivalent of a finding of fraud. She further found that evidence demonstrated, as well, the "unreliability of B-reads in asbestos litigation."[36] Referring specifically to Dr. Ray Harron, who has done tens of thousands of B-reads for asbestos litigation, Judge Jack found that with regard to his silicosis diagnoses, "Dr. Harron [found] evidence of the disease he was *currently* being paid to find."[37]

---

33. *Id.* at 850.
34. *See generally In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 567.
35. *Id.* at 650.
36. *Id.* at 636.
37. *Id.* at 557 (emphasis added).

HeinOnline -- 12 Conn. Ins. L.J. 299 2005-2006

B. THE SILICOSIS "EPIDEMIC"

Silica, principally in the form of sand or quartz, is one of the most common minerals found in nature.[38] Silicosis, like asbestosis, is a scarring of the lungs but is caused by the inhalation of large quantities of silica usually as fine sand dust.[39] Like asbestosis, silicosis, once a scourge, is a disappearing disease because of strict government regulations and employer practices. As a consequence the number of workers exposed to silica dust has steadily declined since 1970.[40] Deaths attributable to silicosis have dropped from 1,157 deaths in 1968 to 448 in 1980, 308 in 1990, 187 in 1999 and to 148 in 2002.[41]

Despite the decline, an "epidemic" of silicosis filings arose in 2002, mostly in state courts in Mississippi and Texas.[42] The reasons for this

---

38. *See* Susan Warren, *Silicosis Suits Rise Like Dust: Lawyers in Asbestos Cases Target Many of the Same Companies,* WALL ST. J., Sept. 4, 2003, at B5.

39. *See In re Silica Prods. Liab. Litig.,* 398 F. Supp. 2d at 569. ("Inhaled silica particles may be trapped in the lungs, causing areas of swelling and scarring. Over time, these swollen areas can grow larger, breathing can become increasingly difficult, and eventually, the lungs may fail completely, resulting in death. This disease is called 'silicosis.'"). For a more detailed explanation of silicosis, see Victor E. Schwartz & Lora Lorber, *A Letter to the Trial Judges of America: Help the True Victims of Silica Injuries and Avoid Another Litigation Crisis,* 28 AM. J. TRIAL ADV. 279, 298-300 (2004).

40. *In re* Silica Prods. Liab. Litig., 398 F. Supp. 2d at 570.

41. *See* NAT'L INST. FOR OCCUPATIONAL SAFETY & HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUBL'N NO. 2004-146, WORKER HEALTH CHARTBOOK, 2004 169 (2004), *available at* http://www.cdc.gov/niosh/docs/chartbook/pdfs/Chartbook_2004_NIOSH.pdf; Cts. for Disease Control & Prevention, *Silicosis Mortality, Prevention, and Control—United States, 1968-2002,* MORBID AND MORTALITY WKLY. REPORT, Apr. 29, 2005, at 1, *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5416a2.htm.

To put these numbers in perspective, in 1999, 721 workers died from "falls" and 585 died from being "struck by object." *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, CENSUS OF FATAL OCCUPATIONAL INJURIES 5 (2005), *available at* http://www.bls.gov/iif/oshwc/cfoi/cfch0003.pdf. In 2001, 300 deaths were caused by "extreme heat exposure." *See* CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., EXTREME HEAT: A PREVENTION GUIDE TO PROMOTE YOUR PERSONAL HEALTH AND SAFETY, *available at* http://www.bt.cdc.gov/disasters/extremeheat/pdf/heat_guide.pdf (last visited May 16, 2006). Between the two periods of 1969 to 1981 and 1982 to 2001, the death rate for silicosis had dropped seventy percent. *See* Brickman, *Analysis of S.852, supra* note 1, at 1024 n.135. From 1980-87, the Mayo Clinic found only ten to twenty-five cases of silicosis per year from the approximately 250,000 patients it sees annually. *Id.*

42. *See Hearings on Asbestos: Mixed Dust and FELA Issues Before the S. Comm. on the Judiciary,* 109th Cong. 6-9 (2005) (written Statement of Lester Brickman, Professor of Law, Benjamin N. Cardozo School of Law) [hereinafter *Statement*].

HeinOnline -- 12 Conn. Ins. L.J. 300 2005-2006

"phantom epidemic"[43] are twofold. First, the U.S. Senate began consideration of legislation to provide an administrative alternative to asbestos litigation, which would, *inter alia*, eliminate recovery for non-malignant unimpaired asbestosis claims.[44] Second, key states, most importantly Mississippi and Texas, enacted comprehensive asbestos litigation reform.[45] Worried about the future of claim generation and concerned that the end game had begun for asbestos litigation,[46] plaintiffs' lawyers began directing some screening enterprises to screen for silicosis;[47] in response, some screening companies abruptly shifted gears from ginning up asbestosis claims to silicosis claims.

All this became more visible when 10,000 of the 35,000 silica claims pending mostly in state courts in Mississippi and to a lesser extent, in Texas, were centralized into a federal multi-district litigation (MDL), presided over by U.S. District Court Judge Janis Jack.[48] After allowing the most extensive discovery ever permitted in asbestos/silica litigation, Judge

---

43. Judge Jack refers to the rise of silicosis claims without a corroborating rise in reliable silicosis diagnoses as a "phantom epidemic." *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 572.

44. *See* Brickman, *Analysis of S.852*, *supra* note 1, at 994-95.

45. *See In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 620; *Statement*, *supra* note 42, at 8-9 (quoting Heath Mason, co-owner of N&M, Inc., who testified that the reason his company changed from asbestos to silica screening is because of the "Hatch Bill").

46. *See In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 620 ("One might also focus on the decline in measures in asbestos lawsuits, leaving a network of plaintiffs' lawyers and screening companies scouting for a new means of support.")

47. *See id.* at 597 ("Sometime around 2001, law firms began asking the companies to screen people for silicosis.") (citing Feb. 17, 2005 Trans. at 287). After N&M had begun screening for silica, Dr. Ray Harron diagnosed 99.69% of 6,350 screenings with abnormalities consistent with silicosis; however, prior to silicosis screening, Dr. Harron diagnosed 1,087 of the same MDL plaintiffs with abnormalities consistent with asbestosis *not* silicosis. *Id.* at 607-08. "In short, when Dr. Harron first examined 1,807 Plaintiffs' x-rays for asbestos litigation (virtually all done prior to 2000, when mass silica litigation was just a gleam in a lawyer's eye), he found them all to be consistent only with asbestosis and not with silicosis. But upon re-examining these 1,807 MDL Plaintiffs' x-rays for silica litigation, Dr. Harron found evidence of silicosis in every case." *Id.* at 608.

48. Most of the Plaintiffs were at one point sandblasters, foundry workers or in another trade that required working with silica dust. *Id.* at 573. Defendants had made products that contained silica, were made for working with silica, or protected workers from silica exposure. *Id.* A majority of these claims were filed in Mississippi and Texas state courts, but were ultimately removed to federal court. *Id.* at 573-74. On September 4, 2003, the Judicial Panel on Multidistrict Litigation (MDL) centralized twenty-two actions for coordinated pretrial hearings. *Id* at 573. By the time Judge Jack issued her report, 85 additional claims were added to the MDL, creating one consolidated suit involving 10,000 plaintiffs seeking compensatory and punitive damages from over 250 corporate producers of silica products. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 301 2005-2006

Jack would report that the phantom silicosis epidemic "is largely a result of misdiagnosis."[49]

C. THE UNRAVELLING OF THE SCHEME TO MANUFACTURE DIAGNOSES FOR MONEY

In an asbestos trial of a nonmalignant claim, a plaintiff's medical evidence typically includes the report of the B Reader who read the X-ray and classified it as 1/0 (or higher) on the ILO scale and "consistent with asbestosis," and the diagnosis and possibly the testimony of the doctor who could be the same B Reader, who based on the X-ray reading, an occupational history and a brief physical examination, concluded to a degree of medical certainty that the plaintiff has asbestosis.[50] As noted, the secret to unmasking the entrepreneurial scheme to generate specious claims is to determine the doctors' "positives" rates, that is, of the total number of X-rays that the B Reader examined for asbestos litigation purposes, how many that B Reader read as positive for asbestosis and, likewise, what percent of those thus found positive were then diagnosed by that same doctor or another doctor as having asbestosis.

B Readers and doctors regularly selected by plaintiffs' lawyers do not provide access to data that they have that would allow calculation of their percent "positives." It is reasonably clear that they do so because that data could constitute "smoking gun" evidence of fraud. B Readers who are deposed and subpoenaed to produce their records, which include data that would enable a determination of their total percent "positives," either refuse to provide the data, move to quash subpoenas in the rare circumstances where defendants seek enforcement,[51] plead the Fifth Amendment to the U.S. Constitution,[52] or simply fail to do so.[53] Prior to

---

49. *Id.* at 632.

50. *See* Gitlin, *supra* note 18, at 843-44.

51. *See infra* note 55.

52. *See, e.g.,* Letter from law firm of Leitman, Siegal & Payne, P.C. to Daniel J. Mulholland (November 11, 2005) (on file with the author) (indicating that Dr. James Ballard "will not be producing . . . [subpoenaed] documents in accordance with his rights under the Fifth Amendment to the United States Constitution"); Defendants' Brief In Support of Their Motion For An Evidentiary Hearing And Their Motion to Dismiss at 3, *In re* All Asbestos Cases, Special Docket No. 073958 (OH Ct. Com. Pl. 2006) (indicating in addition to Dr. Ballard, Dr. Ray Harron was refusing to answer questions about the medical evidence he had provided on 5th Amendment grounds).

53. *See, e.g.,* Letter from Daniel J. Mulholland of the firm of Forman Perry Watkins Krutz & Tardy LLP to X.M. Frascogna, Jr., Special Master, referencing Daniel Fairley, Jr. v. Pulmosan Safety Equip. Co., (Feb. 8, 2006) (detailing Dr. Jay Segarra's repeated and adamant refusals in one matter to produce subpoenaed data that he acknowledged that he

HeinOnline -- 12 Conn. Ins. L.J. 302 2005-2006

the silica MDL, efforts to enforce the subpoena or compel answers to questions seeking such information have generally been denied because a B Reader or diagnosing doctor's readings or diagnoses for other claims not before the court are deemed not relevant. In theory, such medical records would be relevant in a mass consolidation but the fact that the consolidation was approved by a court is strongly indicative of the unwillingness of that court to permit any such inquiry.[54] Currently, however, defendants are devoting significant resources to enforcing subpoenas for B Readers' and diagnosing doctors' records.[55] If these efforts succeed, it is likely that entrepreneurial nonmalignant claim generation will be substantially curtailed. Obtaining these records will also increase the likelihood of indictments being issued in the ongoing investigation of entrepreneurial claim generation.[56]

1. The Progeny of Dr. Martindale's Deposition: A Daubert Challenge

A principal consequence of the absence of data on a B Reader's percent "positives"[57] is that defendants are unable to mount *Daubert*[58] challenges to

---

kept that would allow calculation of his percent "positives"). Dr. Segarra ranks third on the list of fifteen physicians most listed in the claims filed with the Manville Trust. *See* table, *supra* note 17. Mr. Mulholland was the lead lawyer for defendants in the silica MDL. The ongoing but so far unsuccessful attempt to compel Dr. Segarra to produce his records is likely the most vigorous one ever mounted in the annals of asbestos litigation. Defendants' Brief In Response To Dr. Schonfeld's Opposition To Motion For Evidentiary Hearing, *In re* All Asbestos Cases, Special Docket No. 073958 (OH Ct. Com. Pl. 2006) (detailing Dr. Schonfeld's opposition to the defendants' motion for an evidentiary hearing concerning the sufficiency of the medical evidentiary support offered by the plaintiffs pursuant to the court's prior case management order dealing with 35,000 pending asbestos cases. Dr. Schonfeld argues, *inter alia,* that his production of certain requested documents would violate the Health Insurance Portability and Accountability Act ("HIPAA"). Dr. Schonfeld has previously testified that the persons he examines, however, are not his "patients," that he provides no treatment or follow-up care and that he is not their doctor.). *See also* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 84-85.

54. For discussion of such mass consolidation in West Virginia, see Brickman, *Theories of Asbestos Litigation, supra* note 1, at 39-40 n.17.

55. *See, e.g.,* Additional Brief In Opposition To Dr. Ballard's Motion To Quash The W.R. Grace Subpoena, Feb. 26, 2006, *In re*: Deposition Subpoena Served Upon James W. Ballard, M.D., *In re:* W.R. Grace & Co., 315 B.R. 353 (Bankr. D. Del. 2004).

56. *See infra* text at note 98.

57. My research indicates, albeit not robustly (because of a paucity of data and not contradictory information), that the comparative handful of B Readers regularly selected by plaintiffs' lawyers have a predetermined "positive" rate that they generally adhere to. These predetermined percentages range from about 40% to 90% and higher.

58. *See* Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 597 (1993).

HeinOnline -- 12 Conn. Ins. L.J. 303 2005-2006

the admissibility of their medical evidence on the basis of lack of reliability. Without the "positives" rate, plaintiffs' medical experts, who are, of course, licensed as doctors, and in the case of B Readers, certified by NIOSH, are unassailable with regard to the admissibility of their medical evidence (though their conclusions can, of course, be controverted by opposing experts).

The convening of the silica MDL created an opportunity for defendants to mount a *Daubert* challenge by cross examining plaintiffs' medical experts about not just a handful of B reads and diagnoses but here a critical mass—the 10,000 claims that had been centralized into the MDL. To be able to do so and do it effectively, however, they would need both luck and diligence. They had both.

U.S. District Court Judge Janis Jack, sitting in Corpus Christi, Texas and appointed to the bench by President William J. Clinton, was designated to preside over the MDL. As luck would have it, Judge Jack was intimately familiar with medical practice and proper medical procedure: she had been a nurse and was married to a doctor.

Determined to draw a line in the sand, lead defendants' lawyers devoted substantial preparatory efforts to the proceeding. These efforts included undertaking to obtain and compare the social security numbers of those in the MDL with the Manville Personal Injury Settlement Trust data base,[59] which includes a list of all claimants that have filed claims with the Manville Trust. If they could show a substantial overlap, that would indicate that nonmalignant asbestos claims were being retreaded as silica claims and, that, as explained *infra*, they were almost certainly bogus.

The projected consequences of demonstrating substantial overlap would be greatly magnified by the fact that, as indicated above, a defining characteristic of entrepreneurially generated nonmalignant asbestos litigation is the reliance on a comparative handful of B Readers and diagnosing doctors to provide the medical evidence to support claims. This defining characteristic is also true of entrepreneurial silica litigation. Thus, of the 10,000 claims in the silica MDL, only twelve doctors accounted for over 9,000 of the diagnoses.[60] This gave defendants' lawyers the

---

59. *See Statement*, *supra* note 42.

60. *See In re* Silica Prods. Liab. Litig., 398 F. Supp. 2d 563, 580 (S.D. Tex. 2005); *see also* Brickman, *Analysis of S.852*, *supra* note 1, at 1025. Furthermore, of the approximately 10,000 claims in the MDL, only nine physicians accounted for ninety-nine percent of the diagnoses. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 620. Judge Jack opened up the investigation to determine why a "small cadre of non-treating physicians, financially beholden to lawyers and screening companies rather than to patients, managed to notice a

HeinOnline -- 12 Conn. Ins. L.J. 304 2005-2006

opportunity they were seeking: to challenge the admissibility of these medical experts' testimony.

Early in the MDL proceeding, while defendants' lawyers were attempting to bring *Daubert* challenges against the plaintiffs' medical experts, their extensive preparation precipitated a shocking development.[61] Defendants' lawyers first deposed Dr. George Martindale, who had diagnosed 3,617 of the 10,000 plaintiffs in the MDL as having silicosis. Once under oath, however, Dr. Martindale recanted all of his diagnoses, testifying that he "did not intend to make a diagnosis of silicosis . . . ."[62] Indeed, he acknowledged that he did not even know how to diagnose silicosis.[63] In reaction, Judge Jack observed that "it's clear this . . . [diagnosing] business is fraudulent."[64] This bizarre event led Judge Jack to issue an unprecedented order that allowed defendants to cross examine every doctor who had provided a silicosis diagnosis as well as the owners of the screening companies as part of a *Daubert* proceeding in which defendants could challenge the reliability of the expert testimony and do so with Judge Jack presiding.[65]

2. The "Dual Disease" Phenomenon

The results of the comparison of the silica MDL plaintiffs with the Manville Trust data bank were also instrumental in leading Judge Jack to a conclusion that most of the silica claims were bogus. The comparison revealed that sixty percent of the silica claimants had previously filed asbestos claims with the Manville Trust. Thus, these silica claimants were alleging that they had dual diseases: asbestosis and silicosis. Although it is theoretically possible for a person to have both diseases, it is a "clinical

---

disease missed by approximately 8,000 other physicians—most of whom had the significant advantage of speaking to, examining, and treating the Plaintiffs." *Id.* at 633.

61. While shocking to most observers and to the plaintiffs' lawyers, it may not have been unanticipated by the defendants' lawyers.

62. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 581 (citing Martindale Dep. at 101-03).

63. *Id.* at 581.

64. *See* Transcript of Status Conference, Dec. 17, 2004 at 36, *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 580.

65. *See id.* at 17, where Judge Jack states, "I'm very distressed about this Martindale business . . . . I'm thinking about that's such a fraudulent problem. . . . [Y]ou can't label it too many different ways . . . . [B]ecause all of the plaintiffs have been identified in that same type of behavior, what I'm thinking about doing, . . . is just doing all of those . . . diagnosing doctors, a deposition in court . . . [a]nd call it a Daubert deposition . . . . But there's no use pussyfooting around this issue."

HeinOnline -- 12 Conn. Ins. L.J. 305 2005-2006

rarity."[66] At the Senate hearing on the FAIR Act at which I testified, three pulmonary experts testified that, in their combined extensive practices, none of them had seen such a "dual disease" case—that is, one where the patient had both asbestosis and silicosis.[67]

The significance of the evidence of the "dual disease" phenomenon was magnified by evidence that was introduced about the specific practices of some of the B Readers and diagnosing doctors. These practices included a B Reader reading an X-ray as "consistent with asbestosis," and then several years later, in response to a request from a lawyer seeking a "consistent with silicosis" reading, the same Reader then reading the same X-rays as "consistent with silicosis" and making no mention of the prior reading or of the existence of evidence of asbestosis.[68] In another more efficient variation, a doctor reads a single X-ray and simultaneously issues two separate diagnoses, one for each disease.[69]

In the face of the overwhelming evidence that the dual disease claims were at least specious, Richard Laminack, an attorney with the law firm of O'Quinn, Laminack & Pirtie, who represented approximately 100 mostly dual disease claimants in the silica MDL that were, according to Judge Jack, not improperly removed to federal court, sought to defend the

---

66. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 594-96 (collecting different doctors testimony that, although it is theoretically possible, in their extensive pulmonary practice, none of them had ever seen a case of dual disease).

67. One of the medical experts, Dr. David Weill, who practiced for a while in China where diseases of the lung are frequent because of heavily polluted air, testified that "[e]ven in China, where I saw workers with jobs involving high exposure to asbestos and silica (such as sandblasting off asbestos insulation), I did not see anyone or review chest radiographs of anyone who had both silicosis and asbestosis." *Id.* at 595 (quoting Dr. David Weill's Testimony before the Judiciary Committee).

68. *See* Letter from law firm of Frazer Davidson to Dr. James Ballard (June 29, 2004) (on file with the author) (indicating that the firm is enclosing the X-rays of eighty-seven plaintiffs that Dr. Ballard had previously read as "consistent with asbestosis" and requesting him to reread the X-rays for silicosis; and enclosing a suggested letter to be used for indicating that to "a reasonable degree of medical certainty . . . Mr.[X] has silicosis,"); Letter from Dr. James Ballard to the law firm of Frazer Davidson (Aug. 13, 2004) (on file with the author) (following the requested form letter without change). *See also In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 606-08. Judge Jack cites to "two reports from Dr. Harron, wherein Dr. Harron diagnosed the same individual . . . on one date with silicosis and on another date with asbestosis (and neither report references the other)." *Id* at 603. She noted that the two diagnoses are from the same chest X-ray "meaning the diagnoses and the inconsistent work histories originated from the same mass screening." *Id. See also Statement, supra* note 42, at 11-12. Heath Mason of N&M testified that Dr. Harron was paid an additional $50 to write a second diagnosis of silicosis at the time he diagnosed a person with asbestosis. *Id.*

69. *See Statement, supra* note 42; *see also In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 603.

HeinOnline -- 12 Conn. Ins. L.J. 306 2005-2006

integrity of his silicosis claims. In a remarkable courtroom exchange between Judge Jack and Laminack that took place on Aug. 22, 2005, Mr. Laminack justified the *bona fides* of his clients' silica claims by arguing that though his clients had previously filed asbestosis claims, "the explanation on a lot of the cases is the asbestosis diagnosis is wrong." When pressed about the asbestosis claims, Mr. Laminack responded "I doubt the numbers, and I doubt the diagnosis."[70] Thus, his clients were not dual disease claimants because their prior filings of asbestosis claims (presumably represented by other attorneys) were based on bogus diagnoses.

D. THE *DAUBERT* HEARING: THE DOCUMENTATION OF FRAUD

The *Daubert* hearing presided over by Judge Jack was an extraordinary event in the annals of asbestos litigation.[71] Testimony by doctors and screening companies led Judge Jack to conclude that "it is apparent that truth and justice had very little to do with these diagnoses . . . [Indeed] it is clear that the lawyers, doctors and screening companies were all willing participants" in a scheme to manufacture diagnoses for financial gain.[72] "[E]ach lawyer had to know that he or she was filing at least some claims that falsely alleged silicosis."[73]

1. The Silica B Readers' "Positives" Rates

The data with regard to rates of "positives" that was extracted from the B Readers and screening companies under threat of contempt citations went beyond corroboration of my own empirical observations. As summarized by Judge Jack, over 92% of the initial 6,510 B Reads were positive.[74] Dr. Ray Harron's rates were simply off the chart with a 99.69% positive rate.[75] Commenting on the "positives" rate achieved by one of the screening enterprises, Judge Jack observed:

> Overall, N&M–a small Mississippi [screening] company operated without medical oversight–managed to generate

---

70. *Jack The Ripper*, WALL ST. J., Aug. 31, 2005, at A8.

71. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 635; Transcripts of *Daubert* hearings, February 16-18, 2005.

72. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 635.

73. *Id.* at 636.

74. *Id.* at 629.

75. *Id.* at 607-08; *see also supra* note 47 and accompanying text.

> the diagnoses for approximately 6,757 MDL Plaintiffs. To place this accomplishment in perspective, in just over two years, N&M found 400 times more silicosis cases than the Mayo Clinic (which sees 250,000 patients a year) treated during the same period. (Feb. 18, 2005 Trans. at 230.)[76]

A number of Judge Jack's other conclusions affords additional corroboration of the core elements of the entrepreneurial model that I identified.

2. Mass Filings

Another element of the entrepreneurial model which was substantiated by Judge Jack is the mass filing of asbestos claims in a comparatively few jurisdictions, often impelling courts in those jurisdictions to aggregate the claims. These aggregations effectively forced defendants to adopt mass settlement strategies even though many of the claimants had suffered no actual asbestos-related injury or could not show that any asbestos related disease was substantially caused by exposure to a defendant's products.[77] It is the practice of plaintiffs' lawyers in asbestos litigation to name 60-80 or more defendants each time they file a claim of injury and to list the same defendants irrespective of any evidence of actual and substantial exposure to a company's products.[78]

A named defendant in such an action may have to spend thousands of dollars to prove that the plaintiff never had any exposure to its products even though the plaintiff's attorney had no knowledge at the time of bringing the suit that the plaintiff had come in contact with defendant's

---

76. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 603.

77. *See generally* Brickman, *Aggregative Litigation*, *supra* note 1 (discussion of the effects of aggregation of claims on defendants and courts' dockets); *see also* Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 56-59.

78. *See In re Silica Prods. Liab. Litig.* 398 F. Supp. 2d at 574 n.15 ("In many cases, the number of Defendants [named by Plaintiffs represented by one law firm] bear no apparent relationship to the number of Plaintiffs [represented by that firm]. Instead, the number of Defendants (and the identity of the Defendants) seem to be contingent on the identify of the Plaintiffs' law firms rather than the identify of the Plaintiffs. For instance, O'Quinn, Laminack & Pirtie is Plaintiffs' counsel in 18 MDL cases, 16 of which are brought against the same 73 Defendants, despite the fact that the Plaintiffs in those 16 cases range in number from 9 to 410. Likewise, Campbell, Cherry, Harrison, Davis & Dove is Plaintiffs' counsel in two MDL cases, one with 247 Plaintiffs and one with 4,280 Plaintiffs, but both against the same 134 Defendants.").

HeinOnline -- 12 Conn. Ins. L.J. 308 2005-2006

products.[79] Companies thus named in tens and even hundreds of thousands of lawsuits are compelled by litigation costs to settle thousands of such claims even though they are meritless. The "clear motivation" for this scheme to mass manufacture diagnoses is, as noted by Judge Jack:

> [T]o inflate the number of Plaintiffs and claims in order to overwhelm the Defendants and the judicial system. This is apparently done in hopes of extracting mass nuisance-value settlements because the Defendants and the judicial system are financially incapable of examining the merits of each individual claim in the usual manner.[80]

3. TAKING THE OCCUPATIONAL HISTORY

An additional element of the entrepreneurial model that I identified is the taking of the occupational history. The diagnosis of mild asbestosis is not done on the basis of a biopsy but rather on the basis of the X-ray read by a B Reader, the exposure level to asbestos as gleaned from the occupational history and the elimination of other possible causes of the lung opacities observed by the B Reader as gleaned from a review of the medical history and a physical examination.[81] The elimination of other

---

79. A lawyer representing a construction-related firm in a silica litigation ongoing in Florida in 2005-06 stated at a hearing that while his company had been named in 17,000 claims, its products had only been positively identified by plaintiffs in 23. The lawyer stated that where the company has to go through a deposition and then a motion for summary judgment in order to get the claim dismissed, the average cost is $17,000. Transcript of Hearing, Jan. 20, 2006 at 55-56, *In re* Silica Prods. Liab. Litig., 398 F. Supp. 2d 563 (S.D. Tex. 2005); *see also* David Krathen, Editorial, *Trial Bar Cleanup*, WALL ST. J., Feb. 11, 2006, at A8.

80. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 676. These meritless claims require the defendant companies to pay significant litigation costs, injuring current employees and shareholders. *See id.* at 636. Furthermore, every settled meritless claim detracts from the potential recovery by a Plaintiff who is actually suffering from the disease. *See id.; see also supra* note 3 and accompanying text.

81. *See* Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 67. According to doctors interviewed by the American Bar Association Commission on Asbestos Litigation, an accurate diagnosis of an asbestos related condition:

> [R]equires assessment of a number of factors including the review of chest X-rays, pulmonary function tests, latency, and the taking of a complete occupational, exposure, medical and smoking history. Because many symptoms and findings are not specific to asbestos-related disease, this approach is necessary to enable a physician to exclude other more probable causes for various findings. This then enables the physician to

HeinOnline -- 12 Conn. Ins. L.J. 309 2005-2006

possible causes for observed lung opacities or lung impairment is a problematic part of the diagnosis because there are over 100 different causes of lung fibrosis other than asbestos or silica exposure including smoking, obesity and old age.[82]

Because of the importance of occupational and medical history in the diagnostic process,[83] proper medical procedure[84] requires that this task and the information elicited then be reviewed by the diagnosing doctor with the litigant.[85]

My review of the evidence indicates that occupational and medical history in nonmalignant asbestos litigation is taken by untrained personnel and done as part of a process in which the financial incentives to generate claims are dominant.[86] Judge Jack's conclusions mirrored my own. As stated by Judge Jack:

> The "exposure histories" (or "work histories") were virtually always taken by people with no medical training, who had significant financial incentives to find someone positive for exposure to silica . . . . These "histories" were devoid of meaningful details, such as the duration and intensity of exposure, which are critical to determining

---

support a conclusion that the patient's medical condition is the result of asbestos exposure.

A.B.A. COMMISSION ON ASBESTOS LITIGATION, ABA REPORT TO THE HOUSE OF DELEGATES, RECOMMENDATION & RESOLUTION 14 (2003).

82. *See* D. Dail & S. Hammer, eds., PULMONARY PATHOLOGY 647, 648-49 (2d ed. 1994); *see also* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 61-62 nn.81-83.

83. *In re Silica Prods. Liab. Litig.* 398 F. Supp. 2d at 622-25.

84. Judge Jack cites the testimony of Dr. Gary Friedman, who has had substantial involvement in asbestos litigation and who has testified on behalf of both plaintiffs and defendants, saying "a 'detailed' occupational history is necessary for diagnosing silicosis and it should 'come from somebody trained medically to take that kind of history.'" *Id.* at 623 (citations omitted).

85. Dr. Friedman stated that he devotes between an hour and an hour and a half reviewing this information with the litigant. *See* A.B.A. COMMISSION ON ASBESTOS LITIGATION, *supra* note 81, at 50. Compare this with the silicosis diagnosis process of the plaintiffs' doctors. For example, Dr. Barry Levy, a plaintiffs' doctor in the silica MDL, diagnosed approximately 1,389 plaintiffs and relied in part on cursorily issued diagnoses by other physicians whom he had never met. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d. at 633.

86. *See* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 67 n.101 (describing how work histories and a medical form are filled out by part time personnel who were mostly high school graduates without any training).

HeinOnline -- 12 Conn. Ins. L.J. 310 2005-2006

> whether someone has sufficient exposure, dosage and latency to support a reliable diagnosis.[87]

Indeed, in the eyes of the screening company, the occupational history was not important at all.[88] None of the experts challenged in Judge Jack's courtroom took any occupational history, often never even reading the histories, and if they did, then relying on histories that Judge Jack called "so deficient as to not even merit the label."[89] Indeed, not only were these medical histories wholly deficient from a medical practice point of view, they were actually taken under the direction and control not of the doctors rendering the diagnoses but the lawyers sponsoring the screenings who had specific objectives in mind: generating asbestos claims to be added to their inventories.[90]

III. THE SIGNIFICANCE OF THE SILICA MDL FOR ASBESTOS LITIGATION

Though the volume of inculpatory material that Judge Jack permitted to be discovered is simply overwhelming, at least two cautionary notes need to be sounded. First, though the defendants' counsels had precipitated and carefully prepared for the MDL proceeding, they could not confidently expect that Judge Jack would do what no other judge had ever before done with regard to the claims generated by mass screenings, that is, permit

---

87. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 622.

88. Mr. Mason, founder of N&M, one of the largest screening enterprise in the MDL, testified that, in his eyes "to ask the doctor to take a work history in our field would be like asking Mr. Setter [the defense attorney questioning him] to wash my car. I mean it's...very beneath him." *Id.* at 622-23.

89. *See id.* at 622-24; Brickman, *Theories of Asbestos Litigation*, *supra* note 1, at 80-81.

90. Judge Jack observes:

> In almost all of these cases, one vital requirement for the diagnosis of silicosis—the taking of occupational histories—was performed absent medical oversight by the lawyers or their agents or contractors. More generally, the lawyers determined first what disease they would search for and then what criteria would be used for diagnosing that disease. The lawyers controlled what information reached the diagnosing physicians, stymieing the physician's normal ability to ask targeted follow-up questions and perform follow-up exams.

Id. at 634-35.

HeinOnline -- 12 Conn. Ins. L.J. 311 2005-2006

extensive, "no holds barred" discovery of the B Readers and the screening companies. Other judges, when given the opportunity to lay bare this festering sore in the civil justice system, have declined the honor.[91] But for Judge Jack's near heroic act, the extensive evidence that diagnoses were being mass manufactured for money would not have come to light.

Second, Judge Jack concluded that she lacked jurisdiction over the vast majority of the plaintiffs in the MDL because their cases had been improperly removed to federal court.[92] Accordingly, the findings in her report were, for the most part, *dicta* and not binding on state courts to which the cases have been remanded. However, because of significant political changes in Mississippi, which have been manifested in tort reforms enacted by the state legislature[93] and decisions by the Mississippi Supreme Court,[94] it is likely that the silica claims that were part of the MDL will fail. This provides no assurance, however, that judges will permit the same level of discovery as allowed by Judge Jack where equally bogus silica and asbestos litigation is brought in other venues.[95] Judge Jack's legacy remains a work-in-progress.

---

91. *See, e.g.,* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 164 n.503 (describing the decisions of U.S. District Court Judge Robert Sweet in the course of the G-I Holdings bankruptcy proceedings). Another example of judicial reluctance to put the civil justice system on trial is the decision of the U.S. Supreme Court to deny granting certiorari with regard to the decision of the West Virginia Supreme Court to uphold a mass consolidation of asbestos cases that have little to do with truth and justice and everything to do with coercing defendants to settle the more than 8000 claims. *See* Mobil Corp. v. Gaughan, 563 S.E.2d 419 (W. Va. 2002), *cert denied*, 2002 US LEXIS 7389 (2002). *See also* Brickman, *Theories of Asbestos Litigation, supra* note 1, at 39 n.17, 164 n.503. Another example is the decision of a bankruptcy court to ignore a motion to appoint a Chapter 11 Examiner to investigate allegations of breaches of fiduciary duty, inappropriate behavior, and irregular conduct by a U.S. District Court Judge, advisors appointed by the U.S. District Court Judge, a mediator/advisor, several plaintiffs' lawyers and a debtor in the course of several asbestos related bankruptcies. *See* Motion of Credit Suisse First Boston, As Agent, Kensington International, Limited, Springfield Associates, LLC and Angelo Gordon Pursuant To 11 U.S.C. § 1104 For Appointment of Chapter 11 Examiner, May 24, 2004, *In re* Owens Corning, No. 00-03837 (Bankr. D. Del. 2001). *See also* Brickman, *Ethical Issues, supra* note 1, at 838 n.19, 889 n. 216.

92. *See In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d at 574-76.

93. *See* David Hechler, *Mississippi Is No Longer A Mass Tort Haven*, NAT'L L.J., Jan. 10, 2005, at P4.

94. *See e.g.,* Gorman-Rupp Co. v. Hall, 908 So. 2d 749 (Miss. 2005); Harold's Auto Parts, Inc., v. Flower Mangialardi, 889 So. 2d 493 (Miss. 2004).

95. Plaintiffs' lawyers filed 111 silicosis claims in state court in Broward County, Florida that have many of the same attributes as the claims in the silica MDL before Judge Jack. Krathen, *supra* note 79, at A8. In one of those matters, the trial judge, undoubtedly reacting to the disclosures in the silica MDL, allowed defendants to conduct some of the same kind of discovery as Judge Jack permitted. *See generally In re Silica Prods. Liab.*

HeinOnline -- 12 Conn. Ins. L.J. 312 2005-2006

There have been, however, a number of developments indicating that the significance of the silica MDL for asbestos litigation is potentially powerful. One is the announcement by the Manville Trust that it is suspending acceptance of medical reports from certain doctors and screening enterprises:

> The reliability of reports prepared by the doctors and screening facilities listed below has been challenged and is the subject of federal grand jury and congressional investigations into alleged fraud. Based upon evidence presented in the silica Multidistrict Litigation (MDL), the challenge is credible and compels suspension of acceptance of these reports. . . . Pending completion of the grand jury and congressional investigations and the litigation in which the reports were challenged, CRMC will no longer accept reports prepared by these doctors and facilities.
>
> In addition, CRMC has determined that medical reports prepared by Healthscreen, Inc., a pulmonary function testing (PFT) facility formerly located in Jackson, Mississippi (now closed), are not reliable and will no longer be accepted.
>
> Effective immediately, CRMC will not accept reports from the following doctors and screening facilities. . . .
> Dr. James Ballard*, N&M, Inc.
> Dr. Kevin Cooper*, RTS, Inc. (Mobile, Alabama)
> Dr. Todd Coulter, Healthscreen, Inc. (Jackson Mississippi)
> Dr. Andrew Harron*
> Dr. Ray Harron*
> Dr. Glynn Hilbun
> Dr. Barry Levy
> Dr. George Martindale

Litig., 398 F. Supp. 2d at 567. Preliminary results indicate that 72% of the plaintiffs were "dual disease" retreads, that is, that they had previously filed asbestos suits. Transcript of Hearing, Jan. 20, 2006 at 40-41, *In re* Silica Prods. Liab. Litig., 398 F. Supp. 2d 563 (S.D. Tex. 2005). Juxtaposed against that ruling is one by a three judge court in Ohio in cases involving thousands of claims generated by mass screenings, which vacated its prior ruling that required plaintiffs' medical experts to appear and testify about the methodology they used to generate the medical evidence upon which these cases are based. *See* Defendants' Brief in Support of Their Motion For an Evidentiary Hearing And Their Motion To Dismiss, Feb. 3, 2006, at 7, *In re* All Asbestos Cases, Special Docket No. 073958 (OH Ct. of Comm. Pleas 2006). It was precisely this discovery that Judge Jack allowed which led to her findings of the mass manufacture of diagnoses for money.

HeinOnline -- 12 Conn. Ins. L.J. 313 2005-2006

Dr. W. Allen Oaks*[96]

Another is the call for comments by NIOSH on a proposed Code of Ethics for B Readers, published in response to the revelations in the silica MDL.[97]

Undoubtedly, the greatest threat to the continuation of the entrepreneurial model of asbestos claim generation is the ongoing investigation by the U.S. Attorney for the Southern District of New York. That office undertook an investigation in 2004, and convened a federal grand jury to consider possible criminal charges arising from claims of injury due to exposure to silica and asbestos and the use of entrepreneurial witness coaching techniques to implant false memories about product exposure.[98] It remains to be seen whether indictments will be issued, and, if so, which participants in the scheme to manufacture diagnoses for money are named.

Perhaps most of the impact of the silica MDL, however, will not have the prominence or visibility of the events described above. That impact, more subtle but no less significant, will be on judges' reactions to potential mass toxic tort proceedings and related litigations. The specter of facilitating the emergence of another entrepreneurial claim generation process will undoubtedly affect many judges' discretionary decisions that will determine the scope of mass tort litigations.[99]

---

96. Announcement by David Austern, President, Claims Resolution Management Corp., Sept. 12, 2005 (asterisks added to denote B Readers); *see also* Jonathan D. Glater, *Asbestos Fund Bars 9 Doctors,* N.Y. TIMES, Sept. 15, 2005, at C6.

97. Reacting to Judge Jack's findings, NIOSH has published a proposed Code of Ethics for B Readers. Ethical Considerations for B Readers, 70 Fed. Reg. 69,765 (Ctrs. for Disease Control and Prevention Nov. 17, 2005). For my commentary on the insufficiency of the NIOSH proposal, see generally Lester Brickman, *Comments on Proposed B Reader Code of Ethics*, submitted on December 22, 2005, and accessible at www.ssrn.com/abstract= 871965.

98. *See* Brickman, *Analysis of S. 852*, *supra* note 1, at 120; *see also* Mark Behrens, *Silicosis Inc.,* WALL ST. J., Oct. 27, 2005, at A20; Glater, *supra* note 96, at C6; Jonathan D. Glater, *Lawyers Challenged On Asbestos*, N.Y. TIMES, July 20, 2005, at C1.

99. The impact of the silica MDL may have affected the New York Court of Appeals, which ruled that an employer owes no duty of care to a woman who contracted mesothelioma, a deadly cancer mostly caused by asbestos exposure, after thirty years of laundering her husband's work clothes. *In re* New York City Asbestos Litig., 840 N.E.2d 115 (N.Y. 2005). In a unanimous decision, the Court of Appeals reversed a unanimous intermediate court ruling and said courts must weigh "the precedential, consequential, future effects of their rulings, and limit the legal consequences of wrongs to a controllable degree." *Id.* at 119.

HeinOnline -- 12 Conn. Ins. L.J. 314 2005-2006

A FUTURE FOR ASBESTOS APPORTIONMENT?

Michael Green[*]

INTRODUCTION

When Adam contacted me about participating in the Future of Asbestos Symposium, he requested that I think about apportionment of liability. With the extensive litigation that has taken place in this country for decades, involving hundreds of defendants and hundreds of thousands of claimants whose conduct may be implicated in apportionment issues, I would have thought that all of the interesting apportionment issues have been resolved. Or at least that they would have been resolved based on the current state of scientific knowledge about the initiation, progression, mechanisms, and outcomes of the various asbestotic diseases. Hence the dubiety reflected in the interrogatory appended to the title of this article.

Shortly after Adam's invitation to this Symposium, I received an email from an LLM student, Katsuo Yamaura, I had been advising. Katsuo is from Japan, works for a Japanese machinery manufacturer, Kubota, and is studying American law because he is being groomed to oversee his employer's products liability litigation, a substantial amount of which he anticipates will occur in the United States as his employer ramps up its exports here.

I had been struggling with how best to serve his particular purpose when he sent me an email saying he wanted to learn about asbestos litigation.

I was confused—why would a lawyer for a durable goods manufacturer want to know about asbestos? When I read the attachment that he included with his email, I understood. That email explained that his company was caught up in imminent asbestos claims by its employees, several dozen of whom had died in recent years due to asbestotic disease,[1] several hundred (and perhaps more) other employees of a couple of dozen firms who died,[2]

---

* Williams Professor of Law, Wake Forest University School of Law. My thanks to Katuso Yamaura for providing a focus for this paper and assisting me in understanding the emerging asbestos environment in Japan and to Genevieve Markey for her research assistance.

1. *Asbestos Victims? Kubota To Be Quizzed Over Worker Deaths*, THE JAPAN TIMES, July 1, 2005, *available at* http://search.japan times.co.jp/print/nn20050701a3.html.

2. *Probe's Tardiness Rued as METI's Asbestos-death Tally Hits 374*, THE JAPAN TIMES, July 16, 2005, *available at* http://search.japantimes.co.jp/print/nn20050716a6.html.

HeinOnline -- 12 Conn. Ins. L.J. 315 2005-2006

and a number of non-employee residents who lived near factories who were suffering from asbestos-induced disease.[3]

Japan's potential litigation is substantial and lags the United States' because asbestos did not come into widespread usage in Japan until the 1950s and remained in use well after the United States largely eliminated its use.[4] A recent study estimates that 100,000 Japanese will suffer from mesothelioma over the next four decades.[5] With employees who change employers[6] during their careers and non-occupational asbestos victims who may have been exposed to multiple sources of asbestos, apportionment issues will necessarily be confronted in Japan's future litigation. In addition to apportionment among defendants, there is the question of apportionment to plaintiffs based on their conduct.[7]

With the future of asbestos litigation ahead of it for Japan, I thought that I could address how, in light of the experience in the United States, Japan might apportion liability in its asbestos litigation. In order to do that, I will first survey how apportionment has operated in asbestos litigation in this country over its three-decade lifetime. Then, I will suggest first principles for apportionment from our asbestos experience and from my prior work. With those two preliminary matters considered, I propose to think about how a legal system—coming new to asbestos litigation—might structure its apportionment rules on the most difficult issue it confronts: causation. Other apportionment issues based on comparative wrongdoing

---

3. *31 Deaths Tied to Hyogo Asbestos Plant*, THE JAPAN TIMES, July 18, 2005, available at http://search.japantimes.co.jp/print.nn20050718a3.html.

4. In 1989, the U.S. Environmental Protection Agency banned the use of asbestos. That ban was largely struck down in Corrosion Proof Fittings v. EPA, 947 F.2d 1201 (5th Cir. 1991). Nevertheless, domestic consumption of asbestos has declined from 71,000 metric tons in 1973 to 9,000 tons in 2002. *See* http://www.cancer.gov/cancertopics/factsheet/Risk/asbestos (last visited June 16, 2006).

5. *See* T. Murayama et al., *Estimation of Future Mortality from Pleural Malignant Mesothelioma in Japan Based on an Age-Cohort Model*, 49 AM. J. INDUS. MED. 1 (2006).

6. Japanese workers change employment at about half the rate of American employees. *See* Masanori Hashimoto & John Raisian, *Employment Tenure and Earning Profiles in Japan and the United States*, 75 AM. ECON. REV. 721, 724 tbl. 2, 725 (1985) (noting that the typical worker holds 5 jobs during lifetime in Japan compared to 11 jobs in the United States).

7. Researching Japanese law by someone like myself, who does not speak or read Japanese, is exceedingly difficult. I have been assisted considerably by Katsuo Yamaura who has kindly obtained Japanese legal materials and translated them for me. The Japanese Civil Code MINPŌ art. 722, § 2, provides for a "setoff" in the event of wrongful conduct by a plaintiff that serves to reduce, but not bar, plaintiff's recovery. Thus, like most American jurisdictions today, although not at the outset of asbestos litigation here, Japan employs comparative fault. The Japanese Civil Code is based to a large extent on the German Civil Code, which provides for comparative fault in BGB § 254(1).

HeinOnline -- 12 Conn. Ins. L.J. 316 2005-2006

are, to a large extent, a reflection of the legal system in which they operate. We can identify the movement to comparative responsibility for apportioning liability both among defendants (contribution) and between plaintiff and defendants (contributory negligence), but I do not attempt to identify first principles for this form of apportionment and explain how they would apply to Japanese asbestos litigation. Causation, by contrast, is universal.[8]

Before I proceed down the apportionment trail, let me say something that everyone knowledgeable about asbestos litigation in the United States has known for twenty years: the best tort apportionment scheme is none; asbestos is a poster child for a legislatively-enacted compensation scheme. The Japanese appear to be more astute than we were or maybe they can learn from others' mistakes. As I began this paper, there were proposals being floated to create a compensation scheme to address Japan's incipient asbestos situation.[9]

That is not how asbestos litigation proceeded here; it emerged fitfully and took some time to grow and mature. It went through adolescence while apportionment principles were undergoing reform, as explained below. Scientific knowledge about asbestos, the diseases it causes, and the biological mechanisms have evolved considerably, and courts today are more comfortable with those matters than they were in the early days of asbestos litigation.[10] Finally, legal principles on proof of causation when a toxic substance causes disease have evolved considerably since the dawning and development of asbestos litigation. Thus, in the United States, we did not have the benefit of sitting back and reflecting on appropriate apportionment principles when asbestos litigation began in the mid-1970s. With the traditional dispersal of tort cases to the states, we also lacked a single governmental entity to provide uniform rules for resolving the onslaught of cases that developed.

---

8. *See* Fairchild v. Glenhaven Funeral Serv. Ltd., [2002] W.L.R. 1052 (addressing liability of multiple employers of plaintiff, exposed to asbestos at employers' worksites and surveying approaches of other countries to the problem of causal attribution).

9. Toshio Aritake, *Japan Plans to Establish Compensation Fund For Workers With Asbestos-Related Illnesses*, 20 TOXICS L. REP. 910 (Oct. 13, 2005).

10. The first appellate opinion in an asbestos case, *Borel* reveals several errors in understanding asbestos and the diseases it causes. *See infra* note.13

HeinOnline -- 12 Conn. Ins. L.J. 317 2005-2006

I. THE FOUNDATIONS OF APPORTIONMENT: *BOREL V. FIBREBOARD PAPER PRODUCTS CORP.*[11]

Asbestos litigation (and law) began effectively with Judge Wisdom's seminal and wide-ranging opinion in *Borel v. Fibreboard Paper Products Corp.*[12] *Borel*, you may recall, affirmed the first asbestos plaintiff's jury verdict. The plaintiff suffered from both the non-malignant progressive respiratory disease of asbestosis as well as mesothelioma, a cancer of the lining of the stomach.[13] *Borel*, as we shall see, presented a wealth of apportionment issues that required attention and resolution.

The first apportionment issue arose in *Borel* because over the plaintiff's thirty-three years in the workforce, he had been exposed to a number of different manufacturers' asbestos products in different quantities and at different times.

The principle that parties are not liable for what they do not tortiously cause was raised by defendants in *Borel*. They claimed that the dangers of asbestos exposure were not foreseeable until 1968 after Irving Selikoff published his work on the risks of asbestos to secondary workers, i.e., those who worked with products containing asbestos, such as insulation, as distinguished from those who worked in mining or processing raw asbestos. The *Borel* court responded by observing that asbestosis is a

---

11. Borel v. Fibreboard Paper Prods. Corp., 493 F.2d 1076 (5th Cir. 1973).

12. There had been one earlier case in which the plaintiff, Claude Tomplait, lost at trial because of his inability to prove his exposure to defendant's asbestos products. *See* PAUL BRODEUR, OUTRAGEOUS MISCONDUCT: THE ASBESTOS INDUSTRY ON TRIAL 6-10, 31-36 (1985).

13. The court stated that mesothelioma is a form of lung cancer, *Borel*, 493 F.2d at 1082, which is incorrect. MOSBY'S MEDICAL & NURSING DICTIONARY 706 (Walter D. Glanze ed. 2d ed. 1986). The court also stated that mesothelioma is caused by asbestosis, *Borel*, 493 F.2d at 1082, a matter of considerable controversy even today. Asbestosis proceeds based on inflammation of lung tissue caused by the deposition of asbestos fibers that continues to fibrosis. Whether inflammation and fibrosis is a part of the mechanism involved in the development of malignancies is unclear. *See* Daniel E. Banks, *Asbestos Exposure, Asbestosis, and Lung Cancer*, 115 CHEST 320 (1999). The strongest argument for the proposition that asbestosis is necessary for lung cancer is found in William Weiss, *Asbestosis: A Marker for the Increased Risk of Lung Cancer Among Workers Exposed to Asbestos*, 115 CHEST 536 (1999). A recent study of Australians from a single town who were exposed to asbestos found lung cancer in the absence of asbestosis, which supports the idea that asbestosis is not causal but a confounder—differentially associated with another causal factor, asbestos exposure. *See* A. Reid et al., *The Effect of Asbestosis on Lung Cancer Risk Beyond the Dose Related Effect of Asbestos Alone*, 62 OCCUP. ENVIRON. MED. 885 (2005). For a recent review of the evidence bearing on this controversy, see Victor L. Roggli, *Carcinoma of the Lung*, *in* PATHOLOGY OF ASBESTSOS-ASSOCIATED DISEASE 193, 194-97 (Victor L. Roggli et al. eds., 2d ed. 2003).

HeinOnline -- 12 Conn. Ins. L.J. 318 2005-2006

"cumulative" disease and that even exposure after 1968 "could have contributed to his overall condition."[14]

Yet another causal apportionment issue arose in *Borel*. A number of defendants argued that the plaintiff had failed to show which defendants' products had caused his disease. And two defendants argued that they could not have been found to cause his disease because he was not exposed to their products until twenty-six and thirty years, respectively, after his initial exposure—not until 1962 and 1966. Once again, the cumulative effect of exposure to asbestos meant the jury could find each defendant caused some injury to plaintiff; the court suggested that each exposure might cause an "additional and separate injury."[15] And given the variability in latency periods from initial exposure to disease manifestation, even the late exposures to the two defendants' products could have exacerbated or accelerated the plaintiff's disease.[16]

The court then addressed the problem that no one knew how much of each asbestos product from the defendants contributed to the severity of plaintiff's diseases. Invoking a leading Texas case that shifted the burden of proof to defendants in the circumstance in which each defendant caused some harm,[17]—but an indeterminate amount—to plaintiff, the court concluded all defendants were jointly and severally liable for the entirety of plaintiff's harm.

Two more apportionment issues remained, however. Four defendants had settled with the plaintiff, and the question of the credit to which the non-settling defendants were entitled for those settlements required resolution. The trial court provided a dollar-for-dollar (or pro tanto) credit, and the defendants claimed that they should receive a pro rata credit of 4/10 (reflecting the proportion of settling defendants to the total number of defendants) of the plaintiff's damages. The pro tanto credit resulted in a judgment of $58,534.04, approximately $12,000 more than a pro rata credit would have provided.[18]

Finally, on petition for rehearing and rehearing *en banc*, the court was confronted with a fact it had neglected. Three defendants had provided

---

14. *Borel*, 493 F.2d at 1092. The court went on to base its affirmance on an alternative ground: the jury could have found the dangers of asbestos exposure even before 1968 were foreseeable.

15. *Id.* at 1094.

16. *Id.*

17. Landers v. East Texas Salt Water Disposal Co., 248 S.W.2d 731 (Tex. 1952).

18. The trade-offs between a pro tanto credit and one based on the settling defendants' proportionate share of liability is rehearsed in RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY§ 16 cmt. d & rptrs. note (2000).

HeinOnline -- 12 Conn. Ins. L.J. 319 2005-2006

warnings beginning in 1964, five years before Borel ceased working and being exposed to asbestos. For apportionment purposes, the court observed that by 1964 his terminal illness was irreversible; any warnings provided then could not have served their purpose.[19]

One might have thought that if his illness was irreversible by 1964, exposure after that time could not have subjected defendants responsible for those exposures to liability on the ground that they made no difference to the harm suffered.[20] Recall that the court had previously held that defendants whose products had not been present at plaintiff's job site until 1962 and 1966 could be found to have contributed to plaintiff's condition. However, even though his condition was irreversible, if those later exposures accelerated the course of his diseases, either in severity for progressive diseases or in occurrence for non-progressive diseases such as cancer, then the later exposures could have caused *some* harm.

The *Borel* court made assumptions and engaged in hypothesizing about the course of asbestotic disease that resulted in affirming the jury verdict against all defendants found liable. Thus, the court found that the jury could have decided that the late exposures to some defendants' asbestos either accelerated the onset of the disease or increased its severity. But there was no scientific evidence available to support that assessment. Perhaps the court was only concerned with the sympathetic situation of a widow who obtained a $60,000 judgment after litigating for several years and concluding the case without the need for further proceedings. Perhaps the court appreciated that its decision would be an important determinant of whether future asbestos victims were able to obtain compensation in tort. But the *Borel* court's apportionment approach set asbestos litigation in the United States on a course that brought more defendants,[21] even ones with marginal involvement at best, into cases.

The basic apportionment approach of *Borel*, subject to refinements and adaptations to reflect subsequent legal changes has continued for the past thirty years. All defendants to whose defective asbestos products a plaintiff

---

19. Even if they were adequate, another reason the court provided for rejecting the rehearing petitions. *See* Borel v. Fibreboard Paper Products Corp. 493 F.2d 1076, 1104 (5th Cir. 1973).

20. *See infra* text accompanying note 60.

21. Rand found that, in the early years of asbestos litigation, the number of defendants per case averaged twenty. *See* CHARLES SILVER, DOES CIVIL JUSTICE COST TOO MUCH 25n.110, http://www.utexas.edu/law/academics/centers/clcjm/civiljustice/Silver.pdf (last visited May 16, 2006), quoting DEBORAH R. HENSLER, ASBESTOS IN THE COURTS: THE CHALLENGE OF MASS TOXIC TORTS 15 (1985).

HeinOnline -- 12 Conn. Ins. L.J. 320 2005-2006

has been exposed are jointly and severally liable for the plaintiff's harm[22] unless, pursuant to section 433B(2) of the Second Restatement,[23] a defendant can establish that it caused something less than the entirety of plaintiff's harm.[24] Of course, they rarely can.

II. POST-*BOREL* APPORTIONMENT DEVELOPMENTS

Two subsequent legal changes that have affected contemporary asbestos apportionment include the adoption of comparative fault and the concomitant modification of joint and several liability. In *Borel*, the plaintiff recovered damages only because of the strict liability claims. The jury found Borel contributorily negligent. However, because contributory negligence was not a defense to a strict liability claim at that time, the plaintiff recovered full damages. But comparative *responsibility* has been extended to strict liability and today apportionment based on the plaintiff's negligence, if it exists, would occur.[25]

The second change in apportionment law is the modification of joint and several liability. There are as many jurisdictions today with several liability as with joint and several liability, and the plurality rule is some form of hybrid that employs aspects of both.[26] Unlike the dominant role of joint and several liability at the time of *Borel* when all defendants were held jointly and severally liable, that result is no longer the predominant one.[27]

---

22. England, apparently in reaction to the problematic course of asbestos litigation in the United States, adopted a different scheme for apportionment, at least in mesothelioma cases. The House of Lords held that while asbestos defendants are liable to plaintiff, they are only severally liable for the proportional enhanced risk for which each defendant is responsible. Barker v. Corus UK Ltd, [2006] 2 W.L.R. 1027.

23. RESTATEMENT (SECOND) OF TORTS (1965).

24. Subsequently, courts imposed a threshold exposure rule that did limit the defendants who could be held liable. *See infra* text accompanying notes 41-42.

25. *See* RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY §§ 1, 7 (2000); RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 17 (1998); *see also* Zimko v. American Cyanamid, 905 So. 2d 465 (La. Ct. App. 2005).

26. RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § 10 (2000).

27. *See, e.g.*, Rutherford v. Owens-Illinois, Inc., 941 P.2d 1203 (Cal. 1997) (plaintiff's non-economic damages reduced to reflect 1.2 per cent of comparative fault assigned to defendant). The actual outcome of apportionment in jurisdictions that no longer employ joint and several liability is complicated. First, a number of jurisdictions that have rejected joint and several liability have exceptions that retain it for toxic substances or environmental claims. *See generally* RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § 17 cmt. a (2000). Second, a number of the non-joint-and several jurisdictions do not permit assignment of comparative responsibility to non-parties. Bankrupt manufacturers cannot be parties and they cannot be assigned comparative responsibility, moderating the effect of

HeinOnline -- 12 Conn. Ins. L.J. 321 2005-2006

In the aftermath of adopting comparative responsibility and modifying joint and several liability, there are two further changes to asbestos apportionment that are raised, but not yet resolved. In jurisdictions that permit apportionment of comparative responsibility to non-parties,[28] employers, despite their workers' compensation-exclusive remedy immunity, may be assigned comparative responsibility where appropriate.[29] That assignment could have an impact on an apportionment process that occurs outside the suit. Employers retain a subrogation right that entitles them to recover their worker's compensation payments to an employee if the employee prevails in a suit against a third party. The case for an employer, whose negligence is determined in a case and whose negligence reduces the plaintiff's recovery because of the effect of joint and several liability,[30] to recover subrogation is exceedingly weak. If the worker's compensation payment is analogized to settlement—the payment to the employee represents a settlement, albeit legally imposed, of the employers' tort liability to the employee, then the employer should not be entitled to any subrogation from the plaintiff-employee's recovery, in a several jurisdiction, of the third-party asbestos manufacturer's several share. While that outcome has not yet been adopted in any jurisdictions—although it has been endorsed in the Third Restatement[31]—a number of states are working through how to accommodate the employer's subrogation rights in a non-joint-and-several world in light of worker's compensation statutes that provide subrogation rights.[32]

A second potential change that comparative responsibility might produce is with respect to the burden-shifting employed in *Borel* and reflected in section 433B(2) of the RESTATEMENT (SECOND) OF TORTS. The idea that once a plaintiff who shows that each of multiple defendants

---

several liability, which otherwise leaves the responsibility of insolvent defendants on the plaintiff.

28. If a jurisdiction has adopted several liability, thereby limiting a defendant's liability to its "share" of plaintiff's harm, determination of that share should, logically, require determining the share of others who were also a cause of the plaintiff's harm. *See* RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § B19 cmt. c (2000).

29. *See, e.g.*, *Rutherford*, 941 P.2d at 1225 (employer assigned 25 percent comparative fault for plaintiff's decedent's death).

30. I make the assumption that, had the employer not been assigned any comparative responsibility, at least some portion of employer's share would be assigned to the defendants in the case rather than all of it being assigned to the plaintiff.

31. RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § B19 cmt. i (2000); *see also* Andrew R. Klein, *Apportionment of Liability in Workplace Injury Cases*, 26 BERKELEY J. EMP. & LAB. L. 65 (2005).

32. RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § B19 cmt. l (2000).

HeinOnline -- 12 Conn. Ins. L.J. 322 2005-2006

has engaged in tortious conduct and that that conduct has caused some, but an uncertain amount, of the plaintiff's harm, should be permitted to recover is quite easy to accept in a contributory negligence world. Plaintiff is innocent; defendants are not. The plaintiff was harmed by the defendants, so leave it to them to sort out how much each one caused if it is less than the entirety of the plaintiff's harm. But that compelling case is weakened in a day when the plaintiff is not blameless and, indeed, in pure comparative responsibility systems may be apportioned more fault than the defendants, individually or collectively.[33]

This is, to be sure, an unhappy circumstance. The plaintiff has been harmed in some indeterminate amount by the tortious conduct of the defendants. Assignment of the burden of proof (specifically, the burden of producing sufficient evidence) on causal apportionment will be dispositive given the lack of available evidence to permit apportionment. Either the plaintiff will be sent away without any recovery or at least some defendants will be required to pay for harm that they did not cause. For the most part, courts continue with the pre-comparative fault approach of placing the burden on showing the magnitude of harm on the defendant who claims it caused less than all of the plaintiff's harm. I return to this question later in considering how apportionment might be structured from the ground up.[34]

Cigarette smoking and its role did not arise in *Borel* because the decedent did not suffer from lung cancer. However, in lung cancer cases, the role of cigarette smoking raises an apportionment issue that requires consideration. It's well known that there is a synergistic interaction between smoking and asbestos in causing lung cancer. That means that the risk of contracting lung cancer when exposed to both is not simply additive but multiplicative.[35]

Three different approaches to apportionment involving smoking and asbestos have been employed in asbestos litigation in the United States. The first relies on causal apportionment and is revealed in *Dafler v. Raymark Industries, Inc.*[36] The court relied on § 433A, Comment *a* of the RESTATEMENT (SECOND) OF TORTS, which extends causal apportionment to instances "where one of the causes in question is the conduct of the plaintiff himself, whether it be negligent or innocent," and affirmed a jury

33. *See, e.g.*, *Rutherford*, 941 P.2d at 1209 (plaintiff apportioned 2.5% comparative fault while lone remaining non-settling defendant apportioned 1.2% comparative fault).

34. *See infra* text accompanying note 82.

35. *See, e.g.*, Roggli, *supra* note 13, at 197; Piero Mustacchi, *Lung Cancer Latency and Asbestos Liability*, 17 J. LEGAL MED. 277 (1996).

36. Dafler v. Raymark Indus., Inc., 611 A.2d 136 (N.J. Super. Ct. App. Div. 1992), *aff'd*, 622 A.2d 1305 (N.J. 1993).

HeinOnline -- 12 Conn. Ins. L.J. 323 2005-2006

verdict that attributed 70% of the plaintiff's lung cancer to his smoking and 30% to his asbestos exposure. The causal apportionment was based roughly on the comparative relative risks of lung cancer due to smoking and asbestos exposure. Thus, to be precise, apportionment was based not on the harm caused by each of smoking and asbestos but based on their respective contribution to the *risk* of cancer.[37]

A second approach refuses to permit causal apportionment between smoking and lung cancer based on comparative risk contribution.[38] Of course, the effect of refusing to permit causal apportionment to smoking results in asbestos defendants' being subject to liability for the entirety of plaintiff's damages, unless a non-causal method of apportionment is available.

The final apportionment method is revealed in courts that permit apportionment on a very different basis: the comparative responsibility of the plaintiff in smoking.[39] Thus, the factfinder must find that plaintiff was contributorily negligent in smoking, that the plaintiff's negligence was a cause of the harm, and then assign a percentage of comparative responsibility to the plaintiff as well as the defendant.[40]

---

37. It may be worth noting a paradox about toxic substances causal epistemology. We have long appreciated the difficulties of determining causation in this class of cases, largely because of competing causes that are unknown or cannot be ruled out. Yet information about risk enhancement—the extent to which exposure increases the risk—may readily be available for toxic substances that have been the subject of epidemiologic inquiry. By contrast, we rarely have very good evidence of risk enhancement of, say, negligent driving or other species of behavioral negligence. When evidence of causation is meager, risk enhancement becomes an attractive surrogate. *See, e.g.,* Rutherford v. Owens-Illinois, 941 P.2d 1203 (Cal. 1997); Barker v. Corus UK Ltd, [2006] 2 W.L.R. 1027.

38. *See* Borman v. Raymark Indus., Inc., 960 F.2d 327, 334-35 (3d Cir. 1992) (denying apportionment based on § 433A of the RESTATEMENT (SECOND) OF TORTS despite relative risk evidence similar to that presented in *Dafler*); *see also* Martin v. Owens-Corning Fiberglas Corp., 528 A.2d 947, 949 (Pa. 1987).

39. A fourth possibility is revealed in the defendant's strategy in *Martin*, 528 A.2d at 949, although that case involved disability due to asbestosis and emphysema. Defendant's expert took the position that plaintiff's disability was due solely to smoking. Thus, apportionment might occur on an all-or-nothing causal basis: one or the other caused the harm and is therefore responsible, while the other played no causal role. Most asbestos induced lung cancers cannot be distinguished from lung cancers caused by smoking. *See* Roggli, *supra* note 13, at 199, 205.

40. *See* Ingram v. AC and S, Inc., 977 F.2d 1332, 1340-41, 1342 (9th Cir. 1992) (rejecting apportionment based on causation but upholding comparative-responsibility apportionment both among asbestos defendants and between defendants and plaintiff who smoked); Zarow-Smith v. N.J. Transit Rail Operations, 953 F. Supp. 581, 586 (D.N.J. 1997) (upholding comparative-responsibility apportionment to plaintiff based on smoking in FELA case); Fulgium v. Armstrong World Indus., Inc., 645 F. Supp. 761, 763 (W.D. La. 1986) (evidence of plaintiff's smoking admissible for purposes of comparative-

HeinOnline -- 12 Conn. Ins. L.J. 324 2005-2006

One more post-*Borel* apportionment development requires mention. Courts have carved out what might be characterized as a "trivial contribution" doctrine. When an asbestos defendant's products play a sufficiently de minimis role—determined by the extent of the plaintiff's exposure—the defendant is not held liable for the plaintiff's harm.[41] That principle might be thought inconsistent with the *Borel* court's reasoning that each exposure might cause an incremental amount of harm, but *Borel* did not confront the phenomenon that it wrought: ever widening circles of identifying defendants whose asbestos products were anywhere on any job site for any amount of time that plaintiff was there.[42]

---

responsibility apportionment); Rutherford v. Owens-Illinois, Inc., 941 P.2d 1203 (Cal. 1997) (affirming verdict in which plaintiff was assigned 2.5% comparative fault in smoking); Champagne v. Raybestos-Manhattan, Inc., 562 A.2d 1100, 1118 (Conn. 1989) (permitting plaintiff's smoking to be the basis for comparative-responsibility apportionment, citing *Brisboy v. Fibreboard Corp.*); Asbestos Litig. Pusey Trial Group v. Owens-Corning Fiberglass Corp., 669 A.2d 108, 111 (Del. 1995) (trial court erred in permitting apportionment without instructing on and requiring jury to find that plaintiff's smoking constituted comparative fault); Hao v. Owens-Ill., Inc., 738 P.2d 416, 418-19 (Haw. 1987) (adopting a pure comparative negligence standard allowing for apportionment); Owens Corning Fiberglas Corp. v. Parrish, 58 S.W.3d 467, 470 (Ky. 2001) (upholding comparative-responsibility assignment to plaintiffs based on their smoking); Brisboy v. Fibreboard Corp., 418 N.W.2d 650, 655 (Mich. 1988) (allowing plaintiff's smoking to be considered in determining comparative fault); *cf.* Jones v. Owens-Corning Fiberglas Corp., 69 F.3d 712, 720-21 (4th Cir. 1995) (applying North Carolina law; contributory fault by plaintiff in smoking cigarettes can be asserted by asbestos defendants); Gideon v. Johns-Manville Sales Corp., 761 F.2d 1129, 1138-39 (5th Cir. 1985) (applying Texas law; evidence of asbestosis victim's smoking admissible for purposes of defendant's claim of mitigation of damages and for jury to decide if future risk of cancer was caused by smoking, asbestos exposure or both); Richards v. Owens-Illinois, Inc., 928 P.2d 1181, 1191 (Cal. 1997) (statutory immunity of tobacco suppliers prevented apportionment of comparative responsibility to them).

41. *See, e.g.*, Laney v. Celotex Corp., 901 F.2d 1319, 1320 (6th Cir. 1990) (applying Michigan law); Gideon v. Johns-Manville Sales Corp., 761 F.2d 1129, 1144-45 (5th Cir. 1985) (applying Texas law; deciding that asbestos product that released only very modest amount of fibers was not defective). A number of courts express this limitation by requiring that plaintiff demonstrate "frequency, regularity, and proximity" to defendant's asbestos products in order to satisfy the threshold exposure requirement. *See, e.g.*, Lohrmann v. Pittsburgh Corning Corp., 782 F.2d 1156, 1162-63 (4th Cir. 1986); Hoffman v. Allied Corp., 912 F.2d 1379 (11th Cir. 1990) (applying Florida law); Blackston v. Shook & Fletcher Insulation Co., 764 F.2d 1480 (11th Cir. 1985) (applying Georgia law); Menne v. Celotex Corp., 861 F.2d 1453 (10th Cir. 1988) (applying Nebraska law); O'Connor v. Raymark Indus., Inc., 518 N.E.2d 510, 512-13 (Mass. 1988).

42. Two other aspects of asbestos apportionment that may be different from the foregoing discussion occur to me. One is the apportionment employed in collective settlements when a plaintiff's lawyer settles a block of asbestos cases with a defendant. *See* HENSLER, *supra* note 21, at 95 (describing block settlements). I don't know whether the lawyers involved in those settlements invoke the same principles employed by courts in

III. FIRST PRINCIPLES FOR ASBESTOS APPORTIONMENT

My beginning point is that apportionment begins with factual causation. This initial principle is based on the premise that, under tort law, parties do not pay for what they do not cause.[43] A subsidiary principle is that causal apportionment is not comparative. Causes, at least when understood as consisting of the factual causal notion of a necessary condition, cannot be compared; they are a factual cause or they are not and there is no question of degree about them.[44] As J.L. Mackie has put the

---

litigated cases, which I infer, are also employed in more traditional single plaintiff settlements. I also don't know about deviations from these principles that occur in bankruptcy proceedings, which typically employ some form of a compensation scheme for asbestos victims whose claims are resolved in the bankruptcy. The criteria used in the bankruptcy proceeding likely entail a simplified version of those employed in the courts and described above. *See* Deborah R. Hensler, *Alternative Courts? Litigation-Induced Claims Resolution Facilities,* 57 STAN. L. REV. 1429, 1429 (2005) ("The substantive and procedural rules applied by these facilities for resolving claims are usually known only to the small number of lawyers who participated in negotiating the agreements that established the facilities, the administrators of the facilities, and the facilities' overseers, and they have so far largely escaped the scrutiny of legal scholars.").

43. This is a tenet held more tightly by corrective-justice scholars than by those from the economics school, many of whom are content with holding defendants liable who increase the risk of harm, regardless of whether that increased risk came to fruition. Judge Posner's largely unsuccessful efforts to engraft that view into a proportional liability rule, reveals that the law has not accepted the law-and-economics view. *See* MARC FRANKLIN ET AL., TORT LAW AND ALTERNATIVES 366-67 (8th ed. 2006), discussing *Doll v. Brown*, 75 F.3d 1200 (7th Cir.1996), in which Judge Posner advocated a proportional liability scheme for employment discrimination cases. The authors (of whom I am one) observe: "Despite a few cases like *Doll* and significant academic support for proportional liability, most courts have not adopted this reform, i.e., extending proportional liability to cases where a greater than 50% likelihood of loss occurred."

44. *See* McDowell v. Davis, 448 P.2d 869, 871-72 (Ariz. 1968) ("it is not how little or how large a cause is that makes it a legal cause, for a proximate cause is any cause which in a natural and continuous sequence produces the injury and without which the result would not have occurred"); Culver v. Bennett, 588 A.2d 1094, 1099 (Del. 1991) (same, quoting *McDowell*); Lacy v. District of Columbia, 408 A.2d 985, 991 (D.C. 1979), *aff'd on rehearing*, 424 A.2d 317 (1980) (same, quoting *McDowell)*; Waste Mgmt., Inc v. S. Cent. Bell Tel. Co., 15 S.W.3d 425, 433 (Tenn. Ct. App. 1997) ("Causation in fact is an all-or-nothing proposition. . . . While there may be different degrees of liability or fault, specific conduct is either a cause in fact, or it is not."); ARNO C. BECHT & FRANK W. MILLER, THE TEST OF FACTUAL CAUSATION IN NEGLIGENCE AND STRICT LIABILITY CASES 132 (1961) ("we cannot see that there is any justification for distinguishing among causes on the strength of quantity"). *See also* Robert N. Strassfeld, *Causal Comparisons*, 60 FORDHAM L. REV. 913, 918-20 & n.21 (1992) (citing other sources). In the case of a trivial dose that contributes to an over-determined causal outcome, courts employ scope-of-liability (proximate cause) grounds to avoid liability for the actor responsible for such. See *supra text* accompanying note 41.

HeinOnline -- 12 Conn. Ins. L.J. 326 2005-2006

point, "if two factors are each necessary in the circumstances, they are equally necessary."[45]

Another subsidiary principle is that, if a defendant has caused only some of the plaintiff's harm, that defendant is not liable for the entirety of the harm because the law only requires that the defendant be responsible for the portion of the harm that it caused. The final apportionment principle is that, after causal apportionment is completed, further apportionment may occur based on comparative "negligence," "fault," or "responsibility," the term I will employ because its generality fits more disparate circumstances. Finally, we need some "clean-up" principles that deal with the burden of proof, especially in the face of uncertainty about the extent of harm caused by a party.

The core causal apportionment principle is a screen that determines who may be liable for a plaintiff's harm and who is not liable. Beyond determining those who are liable and those who are not, it determines the portion of plaintiff's harm caused and thereby the damages for which a defendants is liable. Thus, some defendants may not have caused any of the plaintiff's harm; others may have caused only a portion of the harm from which the plaintiff suffers; some defendants may have been a cause of

---

One implication of this non-comparative quality to factual causation is that factual cause cannot be employed as an alternative to fault when courts adopt a comparative scheme for apportionment in cases not based on fault. A number of courts have failed to appreciate this limitation. *See* Mauch v. Mfr. Sales & Service, Inc., 345 N.W.2d 338, 348 (N.D. 1984) (adopting a rule that "concurring causes" be compared to determine the respective percentages each contributed in a strict products liability case); Duncan v. Cessna Aircraft Co., 665 S.W.2d 414, 429 (Tex. 1984) (damages to be reduced by percentage of causation attributed to the plaintiff); Webb v. Navistar Int'l Trans. Corp., 692 A.2d 343 (Vt. 1996).

The most persuasive contrary argument is made by Robert N. Strassfeld in *Causal Comparisons*, 60 FORDHAM L. REV. 913 (1992). The strongest case he makes for causal comparisons is to consider how likely there is an available substitute for a cause and when there is a readily-available replacement for one cause but not for another, the latter becomes a more "important" cause. Strassfeld recognizes that this type of comparison will not always permit differentiating among causes, as for example when a product manufacturer sells an uncrashworthy product and the plaintiff's negligence results in an accident in which the harm is enhanced by the lack of crashworthiness. There is no self-evident answer to whether a substitute for the plaintiff's negligence or the defendant's defective design is more readily replaced by an alternative cause. Strassfeld also relies on several continuous outcomes, such as happiness, to suggest that one cause—a new love interest—may be a more important cause of one's current happiness than another—obtaining an A on a school quiz. Each would have provided some happiness, but for most, the former would cause a greater increment of happiness than the latter. This reveals the importance of distinguishing between dichotomous and continuous outcomes, the latter of which may be apportioned causally by the amount of the continuous outcome caused. *See infra* text accompanying notes 47-59.

45. J.L. MACKIE, THE CEMENT OF THE UNIVERSE: A STUDY OF CAUSATION 128 (1980).

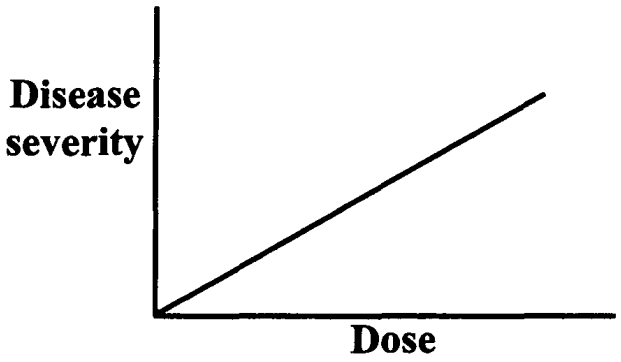
HeinOnline -- 12 Conn. Ins. L.J. 327 2005-2006

the entirety of the plaintiff's harm. Those parties whose tortious conduct was a cause of the plaintiff's harm are subject to liability. Those defendants whose conduct was not a cause of harm are not subject to liability. It is difficult to imagine a tort system that would operate without requiring causation or, to put it slightly differently, a system that would hold persons liable for harm that they had not caused.[46]

With a survey of apportionment issues confronted by courts deciding asbestos cases and first principles for an apportionment scheme, I would like to consider how apportionment of asbestos liability might have been structured. In doing so, I will identify some the causal evidence we would like to have to if we were implementing the principles I propose.

Recall that Judge Wisdom, in *Borel*, relied on the fact that exposure to each defendant's asbestos product might have caused some incremental harm to the plaintiff.[47] What must be appreciated is that, in doing so, Judge Wisdom made an unarticulated assumption about the biology of the plaintiff's disease—he assumed a dose-response curve like that reflected in Figure 1:

FIGURE 1



46. An exception would be a system that ignored actual causation and relied on enhanced risk of harm. The scheme fashioned by Judge Calabresi thirty-six years ago in *The Costs of Accidents* would have operated on the basis of risk enhancement, rather than actual causation. Elegant as Calabresi's scheme is, I'm not sure we would identify it as tort law if it were adopted. The endurance of the actual causation requirement, which has come under a variety of academic and doctrinal challenges in recent years, is explained in Donald G. Gifford, *The Challenge to the Individual Causation Requirement in Mass Products Torts*, 62 WASH. & LEE L. REV. 873 (2005).

47. Borel v. Fibreboard Paper Prod. Corp., 493 F.2d 1076, 1092 (5th Cir. 1973).

HeinOnline -- 12 Conn. Ins. L.J. 328 2005-2006

In this model of asbestotic disease, each dose, from the first to the last, contributes incrementally and proportionately to the plaintiff's harm.[48] If that were the case, then pursuant to the causal apportionment principle, we should determine the incremental harm caused by each defendant and hold each one liable for that incremental harm.[49] However, a more plausible model of the pathology of asbestosis is revealed in Figure 2:

FIGURE 2

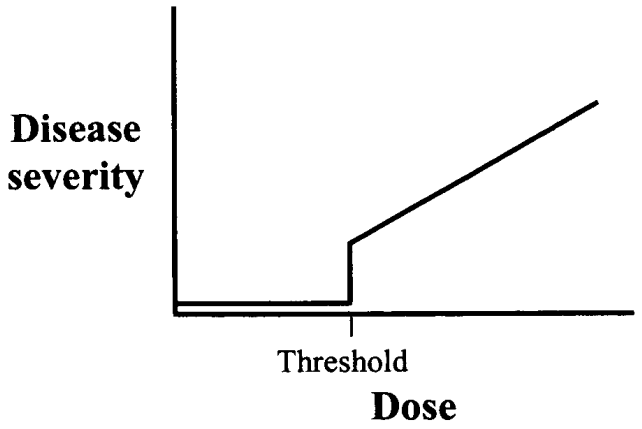


Figure 2 reflects a disease for which there is a threshold level of exposure required before there is any response—consider how many persons are exposed to low doses of asbestos and never suffer any disease. After reaching that threshold, progression of the severity of the disease is continuous (and not necessarily linear as shown in Figure 2). Note how this would affect apportionment in *Borel*; the pre-threshold dose-defendants would be liable for the initial level of the plaintiff's harm, as they were all required for that initial harm, but each of the harms after the

48. So long as these conditions obtain, the defendant responsible for some incremental harm would not be liable for any of the additional harm resulting from later exposures. That harm is unaffected by the earlier exposure to defendant's asbestos, just as the increment of some future exposure is no different than it would have been without the earlier exposures. If the dose-response curve is supralinear, then earlier defendants would also be liable for the portion of any enhanced harm that exceeds a linear dose-response curve.

49. I recognize that we may not have evidence permitting this causal apportionment. That requires attention when we reach the "clean-up" principles to which I adverted earlier. For now, I want to consider how we might construct an apportionment scheme without the inconvenient impediment of uncertainty.

HeinOnline -- 12 Conn. Ins. L.J. 329 2005-2006

threshold would only be liable for the incremental harm for which it is responsible.[50]

Figure 3 contains a more nuanced version of the enhancement rationale of *Borel*.

FIGURE 3

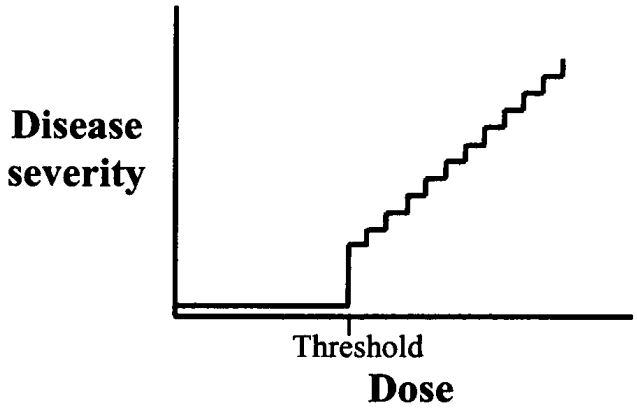
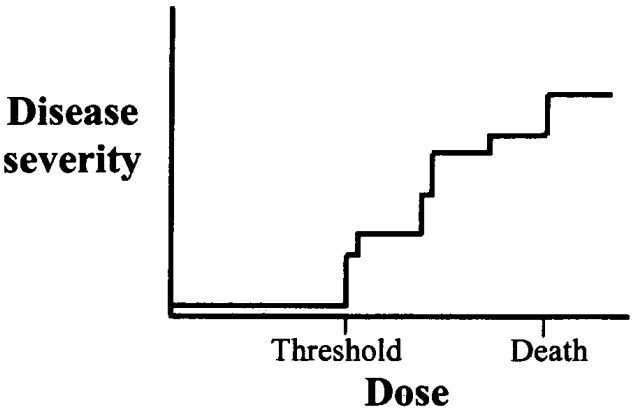


Figure 3 reveals that each increment of harm has a threshold before it occurs. To take the model contained in Figure 3 one step further, consider Figure 4:

FIGURE 4

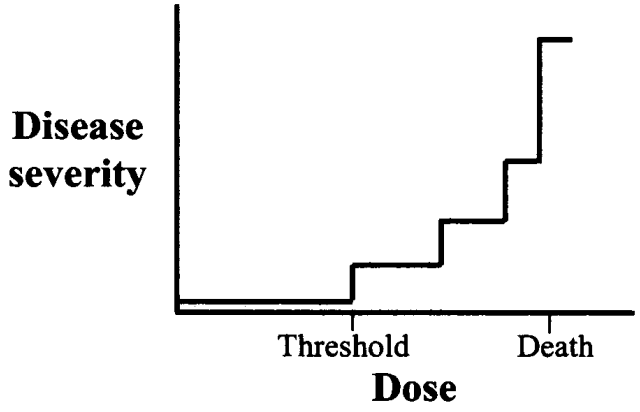


50. If the slope of the response line increases, i.e., prior exposures contribute to increasing marginal harm by later doses, as suggested by Figure 5, then defendants responsible for earlier doses would be liable as well for a portion of the marginal harm. But-for the earlier doses, the later doses would have caused less harm.

HeinOnline -- 12 Conn. Ins. L.J. 330 2005-2006

The increments of harm may not be proportional or symmetrical, as was shown in Figure 3.[51] An additional dose may have a large impact, as it takes the plaintiff over the line of, for example, being sufficiently disabled as not to be able to continue working. Equivalent doses at other points may play little or no role in enhancing the severity of the disease. Harm, in other words, may not be proportional to dose.[52] However, my intuition is that, rather than the rate of progression implied in Figure 4, a more realistic one is that contained in Figure 5

FIGURE 5



51. Figure 4 reveals the difficulty with some interpretations of section 433A(1)(b) of the second Restatement, which permits apportionment to multiple causes when "there is a reasonable basis for determining the contribution of each cause to a single harm." In Griffith v. Kerrigan, 241 P.2d 296 (Cal. 1952), rising water caused damage to the plaintiff's orchard. The court awarded the plaintiff damages for 1/3 of the loss against the defendant who was responsible for 1/3 of the water. That might have meant that there was a reasonable basis for determining that the defendant's contribution damaged 1/3 of the trees in the plaintiff's orchard. However, there is no necessary correlation between the proportion of water supplied and the extent of the damage to the orchard. And, if all of the water was required in order for there to have been any damage to the orchard, then each of the contributions of water was a cause of the entire harm, just as occurs in Figure 6 with the exposures constituting the threshold dose, and apportionment, if it occurs, should be on the basis of comparative responsibility. *See supra* text accompanying notes 44-45. Of course, comparative responsibility was not available at the time of the second Restatement. *See generally* Michael D. Green, *The Unanticipated Ripples of Comparative Negligence: Superseding Cause in Products Liability and Beyond*, 53 S.C. L. REV. 1103 (2002).

52. *See, e.g.,* London v. Lederle Laboratories, 675 A.2d 1133 (N.J. Super. Ct. App. Div. 1996) (suggesting that early doses of tetracycline may have had a greater impact on plaintiff's tooth staining than later doses because of the biology involved).

HeinOnline -- 12 Conn. Ins. L.J. 331 2005-2006

The reason for this intuition is that incremental harms combine to cause harm (or at least damages) that is greater than the sum of the parts. Thus, for example, two separate harms like a broken leg and a broken arm will each cause some harm independent of the other. But the two together may result in a person being unable to work temporarily, which would not have been the case with either injury separately. Thus, across the spectrum of exposures we may find that equal exposures at different times cause different magnitudes of incremental harm.

While *Borel*'s incremental-harm rationale is at least plausible for asbestosis, it will not work for cancer. Clarence Borel suffered not only from asbestosis, a progressive disease,[53] but from mesothelioma, a form of cancer.[54] There is no degree to a cancer, once an individual contracts it, the cancer will run its course, but so far as I have been able to determine there

---

53. *See* Occupational Exposure to Asbestos, Tremolite, Anthophyllite, and Actinolite, 51 Fed. Reg. 22,612, 22,645-66 (Jun. 20, 1986) (to be codified at 29 C.F.R. pt. 1910) (asbestosis is a slowly progressive disorder that may continue to progress after exposure to asbestos has ceased).

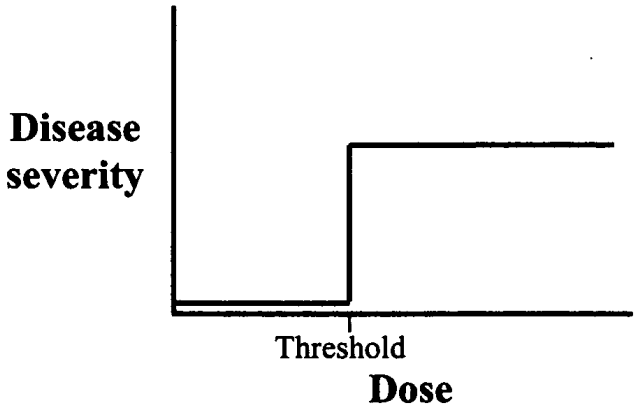
54. The current knowledge and uncertainties about the pathology of mesothelioma are succinctly summarized by Lord Bingham in Fairchild v. Glenhaven Funeral Servs. Ltd., [2003] 1 A.C. 32 (H.L. 2002):

> It is a condition which may be latent for many years, usually for 30-40 years or more; development of the condition may take as short a period as ten years, but it is thought that that is the period which elapses between the mutation of the first cell and the manifestation of symptoms of the condition. It is invariably fatal, and death usually occurs within one to two years of the condition being diagnosed. The mechanism by which a normal mesothelial cell is transformed into a mesothelioma cell is not known. It is believed by the best medical opinion to involve a multi-stage process, in which six or seven genetic changes occur in a normal cell to render it malignant. Asbestos acts in at least one of those stages and may (but this is uncertain) act in more than one. It is not known what level of exposure to asbestos dust and fibre can be tolerated without significant risk of developing a mesothelioma, but it is known that those living in urban environments (although without occupational exposure) inhale large numbers of asbestos fibres without developing a mesothelioma. It is accepted that the risk of developing a mesothelioma increases in proportion to the quantity of asbestos dust and fibres inhaled: the greater the quantity of dust and fibre inhaled, the greater the risk. But the condition may be caused by a single fibre, or a few fibres, or many fibres: medical opinion holds none of these possibilities to be more probable than any other, and the condition once caused is not aggravated by further exposure.

HeinOnline -- 12 Conn. Ins. L.J. 332 2005-2006

is no dose-related cancer severity.[55] Figure 6 illustrates the relationship between disease and dose when the disease is discontinuous and non-progressive.[56]

FIGURE 6



The difference between asbestosis, a progressive disease, and malignant diseases reveals the importance of the biology of disease for causal apportionment. To put the point slightly differently, we need to know the dose-response curve for the plaintiff[57] in order to determine which exposures caused what harm.[58]

---

55. Different individuals may be diagnosed at different stages of the disease, and that has some implications for how successful treatment will be. *See* Nikolay Dimitrov & Samuel McMahon, *Presentation, Diagnostic Methods, Staging, and Natural History of Malignant Mesothelioma*, in ASBESTOS-RELATED MALIGNANCY 225 (Karen Antman & Joseph Aisner eds., 1987).

56. A disease like cancer may progress, once the disease process is initiated, I have no evidence (indeed, not even a hint) that its progression is a function of the dosage. It is clear that unknown factors particular to the victim affect the course of the disease, as well as treatment. Thus, the progress of cancer and other diseases whose severity is unaffected by dosage do not fit the model set forth by the court in *Borel*.

57. I should emphasize that these are dose-response graphs for an individual. Such graphs also exist for groups that are exposed to an agent—one of the factors for inferring causation from a statistical association between exposure and disease is that there is a positive dose-response curve among groups exposed to different doses. An increasing risk of harm in a group exposed to higher doses reflects that different individuals have different resistance or that interactions with other agents or factors that are not consistent for the exposed group may be at work. *See* KENNETH J. ROTHMAN & SANDER GREENLAND, MODERN EPIDEMIOLOGY 16 (2d ed. 1998).

58. Different types of asbestos have differing potentials for causing mesothelioma. *See, e.g.*, Thomas A. Sporn & Victor L. Roggli, *Mesothelioma, in* PATHOLOGY OF ASBESTOS-ASSOCIATED DISEASES 104, 112, *supra* note.13. Unless, however, risk enhancement is

HeinOnline -- 12 Conn. Ins. L.J. 333 2005-2006

Even though additional exposures do not increase the severity of malignant disease, they may still play a causal role if they accelerate the onset of the disease. Contracting a disease earlier rather than later is a real harm, so we cannot exonerate those exposures after the plaintiff's disease is determined.[59] To be sure, the harm and measure of damages for accelerating the onset of disease is different from the harm and damages for causing the disease initially; this requires separating out the accelerators from the initiators in determining damages.

FIGURE 7

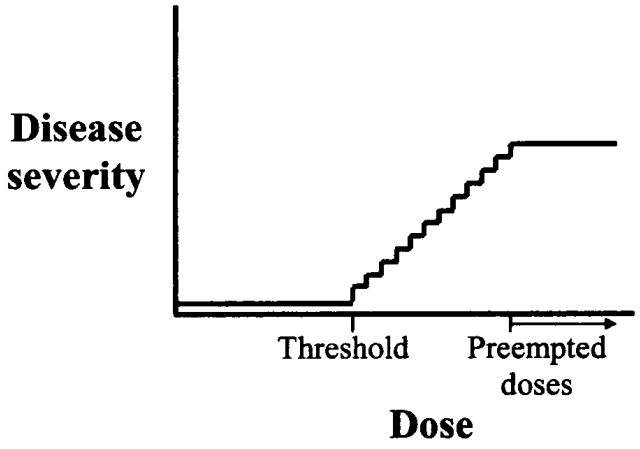


Figure 7 reflects the idea of causal preemption, a matter two of the defendants in *Borel* argued to no avail. By preemption, I mean that once an event has occurred, subsequent events cannot be its cause.[60]

---

employed rather than causation, this has no implication for causal apportionment. *See infra* text accompanying Figure 8.

59. *See, e.g.*, Abernathy v. Superior Hardwoods, Inc., 704 F.2d 963 (7th Cir. 1983) (pre-existing back condition could be considered by jury in awarding pain and suffering damages for subsequent injury to back because subsequent injury may just have accelerated pain that plaintiff would otherwise suffer from pre-existing condition); Henderson v. United States, 328 F.2d 502 (5th Cir. 1964); Kegel v. United States, 289 F. Supp. 790 (D. Mont. 1968) (plaintiff's damages for pain and suffering due to herniated disk reduced based on pre-existing condition and time when pre-existing condition would have produced same harm).

60. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 26 cmt. k (Prop. Final Draft No. 1, 2005).

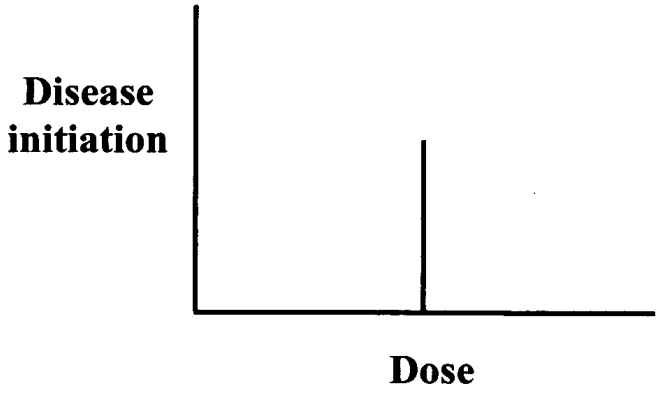
HeinOnline -- 12 Conn. Ins. L.J. 334 2005-2006

Recall the famous *Summers v. Tice*[61] case, in which two hunters fired simultaneously, only one hunter's bullet hit the plaintiff in the eye. If we modify *Summers*, so that after the first bullet goes through the plaintiff's eye, blinding him, the second hunter's bullet, five seconds later, goes through the same hole as the prior bullet, we see that any harm the second bullet might have caused is preempted by the first bullet. What that means is that the second shooter is not liable for the plaintiff's blindness.[62]

Similarly, the defendants whose products to whom plaintiff is exposed after the threshold has been reached should not be held liable for non-incremental diseases like mesothelioma. That threshold exists at the point at which there has been sufficient asbestos exposure to determine plaintiff's disease and, therefore, any later exposures will not have any consequences for the plaintiff's disease.

Yet another model for cancer pathology reflects the one-hit theory about the initiation of the disease and is depicted in Figure 8. This theory posits that it takes only one dose of a carcinogen to cause cancer—the one that hits a vulnerable cell, which thereby begins the disease process. Thus, while an individual may be exposed to multiple doses, only one is responsible for beginning the mutagenesis process that, at the end of the causal chain, results in cancer.

FIGURE 8



61. 199 P.2d 1 (Cal. 1948).

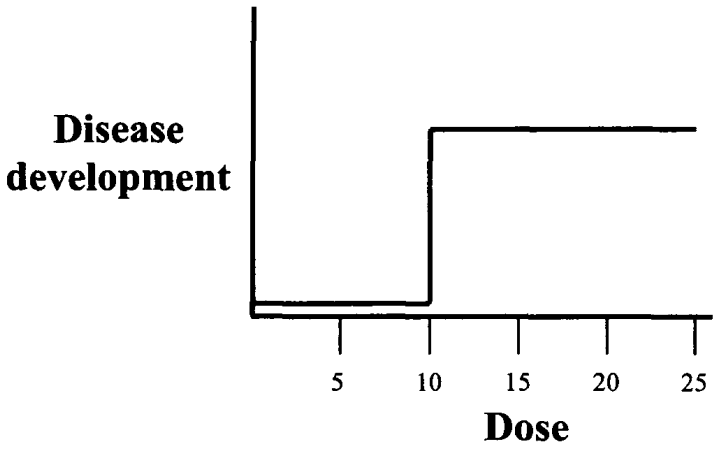
62. *See, e.g.,* London v. Lederle Laboratories, 675 A.2d 1133, 1136 n.2 (N.J. Super. Ct. App. Div. 1996).

HeinOnline -- 12 Conn. Ins. L.J. 335 2005-2006

If this model is correct and it has some currency among many cancer researchers,[63] then it resembles multiple hunters shooting in the same direction, one of whose bullets hits the plaintiff, with all of the others missing.

Asbestos poses an additional and different causal-apportionment problem. This one requires careful consideration of what we mean by causation. Figure 9 indicates a threshold dose, arbitrarily chosen at 10 units, for disease initiation.

FIGURE 9



Yet suppose that before the disease is determined, the plaintiff is exposed to twelve units of asbestos, each from a different defendant. Consider the problem of twelve doses being provided, all simultaneously, with the threshold requirement of only ten.

This resembles the classic case of two fires, each sufficient to cause what is an overdetermined outcome, in the sense that either one of the fires would produce the outcome of the house burning down.[64] The concern that neither is a but-for cause was the genesis for the substantial factor test,

63. *See* COMM. ON RISK ASSESSMENT OF HAZARDOUS AIR POLLUTANTS, NAT'L RESEARCH COUNCIL, SCIENCE AND JUDGMENT IN RISK ASSESSMENT 123-24 (1994); COMM. ON THE INSTITUTIONAL MEANS FOR ASSESSMENT OF RISKS TO PUBLIC HEALTH, NAT'L RESEARCH COUNCIL, RISK ASSESSMENT IN THE FEDERAL GOVERNMENT: MANAGING THE PROCESS 19-20 (1983); Joseph V. Rodricks & Susan H. Rieth, *Toxicological Risk Assessment in the Courtroom: Are Available Methodologies Suitable for Evaluating Toxic Tort and Product Liability Claims?*, 27 REG. TOXICOLOGY & PHARMACOLOGY 21, 23-24 (1997).

64. *See* Anderson v. Minneapolis, St. P. & S. S. M. Ry. Co., 179 N.W. 45 (Minn. 1920).

HeinOnline -- 12 Conn. Ins. L.J. 336 2005-2006

which provides a supplement to the but-for test when there are multiple sufficient causes. But this dosage situation is a bit different from the two fires, each sufficient by itself. Here, no dose by itself is sufficient and requires combining with nine remaining doses before any harm is caused.[65]

Hence the emergence of the idea that, to be a cause, an agent must be a necessary element of a sufficient set of causal factors. Henry Hart and Tony Honoré discussed this idea in their classic treatment of causation,[66] and Richard Wright has developed and advocated the idea in more recent work.[67] This NESS test inquires whether a putative cause is a necessary element of a sufficient set of factors that existed and are sufficient to cause the outcome. Under this standard for causation, all twelve doses would be a cause of the harm.[68] While asbestos courts today rarely acknowledge—perhaps because they fail to recognize it—the existence of multiple sufficient causal sets, it seems evident that this phenomenon must be quite common.

---

65. To my knowledge, Carpenter was the first to raise this problem. *See* Charles E. Carpenter, *Concurrent Causation,* 83 U. PA. L. REV. 941, 948 (1935) (employing a hypothetical in which three people negligently lean against a car, resulting in it being pushed off a ledge; the force from any two of them would have been sufficient for the car to go over the ledge). Professor Wright has been the most vigorous modern proponent for recognizing multiple insufficient incremental tortious acts as factual causes. *See* Richard W. Wright, *Causation in Tort Law,* 73 CALIF. L. REV. 1735, 1791-94 (1985); Richard W. Wright, *Once More into the Bramble Bush: Duty, Causal Contribution, and the Extent of Legal Responsibility,* 54 VAND. L. REV. 1071, 1106-07 (2001); *see also* Michael S. Moore, *Causation and Responsibility,* SOC. PHIL. & POL'Y, 1999, at 1, 9-10 n.40 (1999). Asbestos cases represent the most significant mass of cases accepting the principle that multiple sufficient incremental causes are a cause of the resulting harm. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 27 cmt. g (Prop. Final Draft No. 1, 2005).

66. H.L.A. HART & A.M. HONORÉ, CAUSATION IN THE LAW (2d ed. 1985)

67. *See* Richard W. Wright, *Causation in Tort Law,* 73 CALIF. L. REV. 1735 (1985).

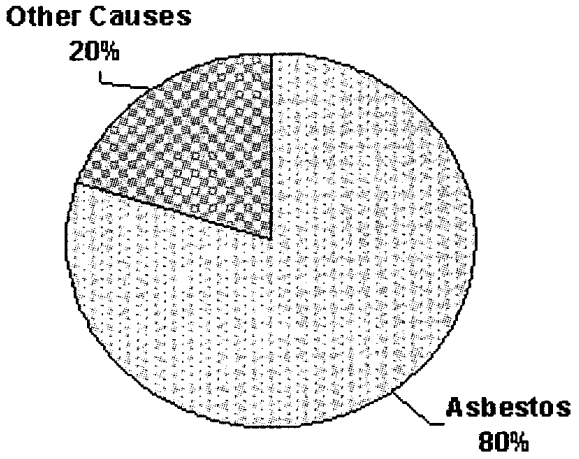
68. The principle was well put by the Maryland Court of Appeals: "In products liability involving asbestos, where the plaintiff has sufficiently demonstrated both lung disease resulting from exposure to asbestos and that the exposure was to the asbestos products of many different, but identified, suppliers, no supplier enjoys a causation defense solely on the ground that the plaintiff would probably have suffered the same disease from the inhaling fibers originating from the products of other suppliers." Eagle-Picher Indus. Inc. v. Balbos, 604 A.2d 445, 459 (Md. 1992); *see also* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 27 cmt. g, rptrs. note (Prop. Final Draft No. 1, 2005). Beyond the United States, many western European countries similarly permit a plaintiff who cannot prove which defendant's product caused the harm to recover from all such defendants. *See* WALTER VAN GERVEN, ET AL., CASES, MATERIALS AND TEXT ON NATIONAL, SUPRANATIONAL AND INTERNATIONAL TORT LAW 441 (2000) (addressing law of Germany, France, and Britain).

HeinOnline -- 12 Conn. Ins. L.J. 337 2005-2006

Having addressed two of the three predominant asbestotic diseases,[69] I want to move to lung cancer and consider two distinct apportionment problems that it creates and that any tort system adjudicating asbestos cases must confront. Since these apportionment issues do not implicate inter-defendant apportionment, we can assume that a single defendant is responsible for all of the plaintiff's asbestos exposure. First, lung cancer, unlike mesothelioma, is not a signature disease for asbestos exposure. Put another way, there are causes of lung cancer unrelated to asbestos exposure. How should we respond to a defendant who says, "Yes, the plaintiff was exposed to my asbestos, but there are causes of lung cancer other than asbestos exposure, and the plaintiff must prove that it was asbestos exposure rather than those other causes."?

The response of the plaintiff is likely to begin with something like what is reflected in Figure 10, putting aside some qualifications that need not detain us here.[70]

FIGURE 10



69. The National Academies of Science recently studied the causal connection between asbestos and five other cancers. The Committee conducting the research concluded that there was sufficient evidence of a causal connection between asbestos and laryngeal cancer. For the other four cancers studied, the evidence was deemed no stronger than suggestive of a causal relationship. INSTITUTE OF MEDICINE, NATIONAL ACADEMIES OF SCIENCE, ASBESTOS: SELECTED CANCERS (2006).

70. For elaboration on why the probability derived from a group study (epidemiology) may vary for any individual, such as an asbestos plaintiff, see RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 28, cmt. c(4) & rptrs. note (Prop. Final Draft No. 1, 2005).

HeinOnline -- 12 Conn. Ins. L.J. 338 2005-2006

Thus, the plaintiff would claim that the probability that asbestos exposure caused her lung cancer is eighty percent, well in excess of the preponderance of the evidence standard. At least at an earlier time,[71] the judicial response might have been something like that of the court in *Smith v. Rapid Transit, Inc.*,[72] which rejected the plaintiff's proof based on statistical non-particularistic evidence. That response was characterized by an attitude expressed by a dissenting judge in 1986 after the tide had turned:

> Liability is not based on a balancing of probabilities, but on a finding of fact. While the majority contends that the measure of what is considered sufficient evidence to draw a reasonable inference resolves itself into a question of probability, a review of case law involving non-identifiable defendant suppliers or manufacturers reveals that a theoretical probability alone cannot be the basis for a reasonable inference. There must be some evidence in addition to the abstraction which will enable a jury to choose between the competing probabilities.[73]

The tide did turn and courts began accepting evidence based on group studies that provide only probabilistic evidence; Judge Weinstein's opinion approving the class settlement in *In re "Agent Orange" Product Liability* Litigation[74] was influential in this movement.

Perhaps the tide would have moved more quickly if plaintiffs had responded to defendants' objections by pointing to the doctrine of res ipsa loquitur. This is a well-accepted device employed to provide an inference sufficient to satisfy a plaintiff's burden of production that entails just the

---

71. Professor Rosenberg's article, David Rosenberg, *The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System*, 97 HARV. L. REV. 849 (1984), was published as toxic substances litigation was growing and courts were discovering the importance of epidemiology (the source of probabilistic evidence of causation). Around that time marks the transformation in courts' treatment of "naked statistical evidence" as reflected in Smith v. Rapid Transit, 58 N.E.2d 754 (Mass. 1945), discussed above, to a willingness to accept this form of evidence as sufficient to satisfy plaintiff's burden of production. It remains an open question whether Rosenberg's work was causal or coincidental with the changed treatment of overtly probabilistic evidence.

72. 58 N.E.2d 754, 754-55 (Mass. 1945).

73. Kramer v. Weedhopper of Utah, Inc., 490 N.E.2d 104, 108-09 (Ill. Ct. App. 1986) (Stamos, J., dissenting); *see also* Guenther v. Armstrong Rubber Co., 406 F.2d 1315, 1318 (3d Cir. 1969).

74. 597 F. Supp. 740 (E.D.N.Y 1984), *aff'd*, 818 F.2d 145 (2d Cir. 1987).

HeinOnline -- 12 Conn. Ins. L.J. 339 2005-2006

same sort of inferential reasoning from general, if not rigorously determined, probabilities. Res ipsa loquitur may be employed when the accident that occurred is one that ordinarily is the result of negligence by someone in the defendant's position:

> [R]es ipsa loquitur is circumstantial evidence of a quite distinctive form. The doctrine implies that the court does not know, and cannot find out, what actually happened in the individual case. Instead, the finding of likely negligence is derived from knowledge of the causes of the type or category of accidents involved.[75]

Thus, res judicata relies on a probability derived from a class of like events to make an inference about what happened in the specific case at hand.

Of course, res ipsa loquitur is about proof of negligence (although it also suffices for causation purposes) not proof of causation. Yet, when we move to proof of causation through circumstantial evidence, we find an identical analytical process at work. Consider a person who falls down an unlit staircase to her death. The stairway is unlit due to the negligence of the defendant. People fall down stairways because of a lack of light, but they also fall down them for a variety of other reasons, including clumsiness or fainting. For courts that permit a jury to infer causation in this situation,[76] the process of recognizing that darkness is capable of causing stairway falls and then determining whether it was, given competing causal possibilities, more likely the cause of the fall is, (once again, save for the impressionistic nature of the evidence) very much what is entailed in the case in which an asbestos plaintiff relied on epidemiology that identifies a relative risk of five for those exposed to asbestos who contract lung cancer. If we really were to prohibit reasoning from the general case to the specific, we would have to abolish circumstantial

---

75. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 17 cmt. a (Prop. Final Draft No. 1, 2005).

76. *Compare* Wolf v. Kaufman, 237 N.Y.S. 550, 551 (N.Y. App. Div. 1929) (Finch, J.) (holding jury question on causation was not created by evidence that decedent fell on unlit stairs because "it would be solely a conjecture for a jury to draw the conclusion that the deceased fell down the stairs because of the absence of light" due to defendant's negligence) *with* Ingersoll v. Liberty Bank of Buffalo, 14 N.E.2d 828, 830 (N.Y. 1938) (Finch, J.) (holding that it was for the jury to decide whether, on the one hand, decedent fell down stairs due to a heart attack or dizziness while carrying 32-pound box or whether, on the other, decedent fell on second-to-last step, which was found broken and had been negligently maintained by defendant, and injuries from fall caused his death).

HeinOnline -- 12 Conn. Ins. L.J. 340 2005-2006

evidence. Naked it may not be, but an assessment of likelihood based on the general, it is.

The second distinct apportionment issue for lung cancer involves the question discussed previously of apportioning between the contribution of asbestos and smoking among victims who are both exposed to asbestos and smoke. One possibility, of course, is that the only apportionment required is to determine whether the plaintiff's disease is a result of smoking or asbestos because there is evidence that permits distinguishing whether one or the other was the cause of a specific plaintiff's disease.[77]

However, if lung cancer is the result of both cigarette and asbestos exposure or we do not have any evidence that enables us to attribute to one or the other as opposed to both, more complicated causal apportionment issues arise. For reasons explained below, I start with the proposition that, unless smoking constitutes negligence or entails tortious conduct by others (such as the manufacturer), then it has no apportionment role to play. The reason is that no agent is sufficient, alone, to cause disease—other factors are always at work to complete the causal set required. When groups are exposed to the same dose of a carcinogen and some, but not all, develop cancer, this reveals that other causes are required for cancer to occur. Whether it is genetic or metabolic or some other environmental factors does not matter. We do not apportion liability to those other factors unless they are associated with tortious or, in the case of plaintiffs, negligent conduct.

We know that smoking (at approximately the dose of one pack a day) is a more powerful carcinogen than asbestos as revealed in Figure 11—recall that Figure 10, based on a relative risk of five, resulted in an attributable proportion of risk of 80 percent.[78] More than twice as powerful, with a RR of twelve and an attributable risk of approximately 92 percent.

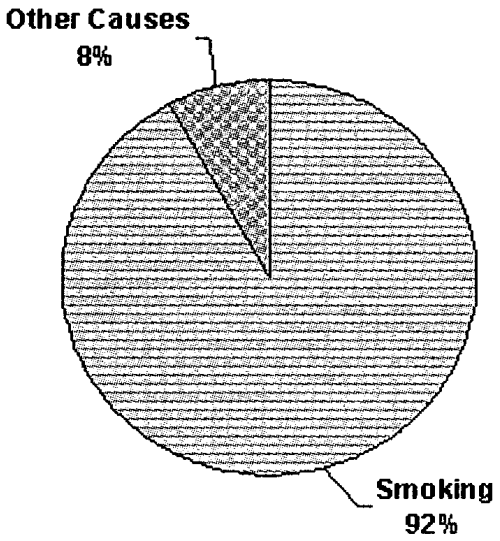
---

77. *But see* Roggli, *supra* note 13, at 193, 199, 205 (reporting "there are no discernible differences between the macroscopic appearance of carcinomas of the lung among asbestos workers and those in individuals not exposed to asbestos" and citing data "consistent with the proposition that most carcinomas of the lung occurring in asbestos workers are histologically similar to those occurring in nonexposed cigarette smokers")

78. The attributable proportion of risk is determined by the equation $(RR-1)\div RR$ (where RR is the relative risk) and reflects the percentage of disease in an exposed group that is due to the exposure being studied. It can be employed, subject to assumptions referred to in note 70, *supra*, to represent the probability of causation for an individual. *See* FEDERAL JUDICIAL CENTER, REFERENCE MANUAL ON SCIENTIFIC EVIDENCE (2d ed. 2000).

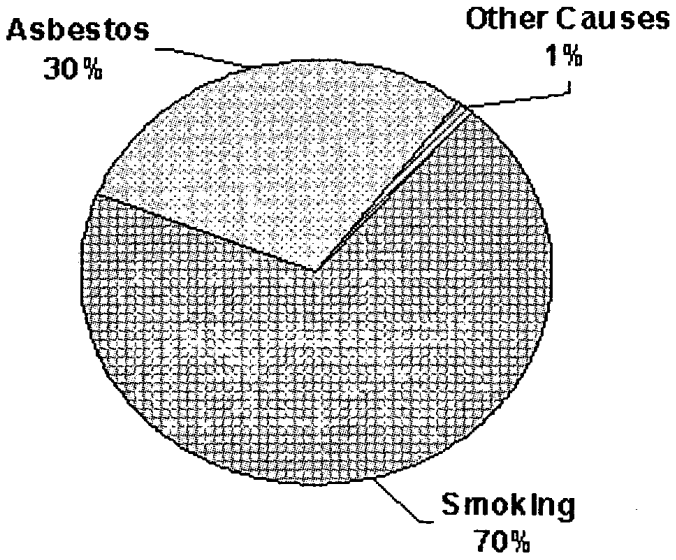
HeinOnline -- 12 Conn. Ins. L.J. 341 2005-2006

FIGURE 11



We might combine those two relative risks for a group exposed both to asbestos and smoking and expect that the resulting attributable risks would look something like that contained in Figure 12.

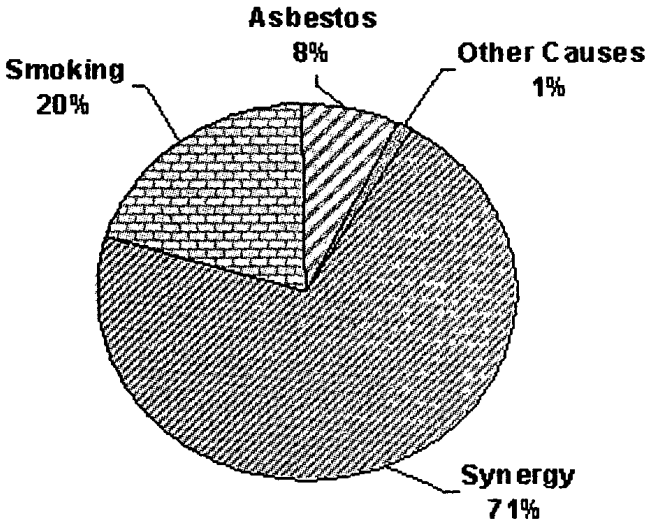
FIGURE 12



HeinOnline -- 12 Conn. Ins. L.J. 342 2005-2006

We might then reason from the probabilities displayed in Figure 12 that smoking is the most likely cause of any plaintiff's cancer. Before, however, we become concerned by the possibilities of over-deterrence (if liability for all with lung cancer is imposed on cigarette defendants) or under-deterrence (because asbestos manufacturers will not be liable for any of this harm) and decide to examine the possibility of proportional liability,[79] we need to recognize the interaction between asbestos and smoking. Figure 13 reveals the synergistic effect of asbestos and smoking.

FIGURE 13



Rather than there being an additive effect from exposure to both (assumed in Figure 12), which would suggest that each operates independently in causing lung cancer, there is a multiplicative effect on the incidence of lung cancer, revealing that the two substances work together to form a more powerful carcinogen than the sum of the parts. As Figure 13 reveals, the interactive effect of asbestos and smoking is responsible for a majority of the lung cancer among those exposed to both agents. That means that each is a cause of the lung cancer in that group, and, if we rely on probabilities as suggested above, whichever parties are responsible for the cigarette and asbestos exposures would be a cause of the harm. Liability, then, as

79. There is an extensive academic literature supporting proportional liability. For discussion of the proposals and a critique, see Michael D. Green, *The Future of Proportional Liability: The Lessons of Toxic Substances Causation, in* EXPLORING TORT LAW 352 (Stuart Madden ed. 2005).

HeinOnline -- 12 Conn. Ins. L.J. 343 2005-2006

discussed above,[80] would be apportioned according to comparative responsibility.

Before concluding this discussion of causal apportionment, I should address the matter of the burden of proof. Specifically, how should the burden of proof be allocated with regard to the amount of harm caused by multiple defendants in two distinct situations? The first occurs when multiple defendants have caused some harm to the plaintiff, but there is uncertainty about how much each of them caused. The second arises when one or more of the defendants has caused the plaintiff's harm but there is uncertainty about which ones.

I addressed the first one previously in explaining asbestos apportionment in the United States, concluding with the observation that the situation provides a more difficult issue once comparative fault replaces contributory negligence and fault may exists on both sides of the case. As with so many other tort rules, placing the burden of apportioning the amount of harm on the defendants depended on the effect of contributory negligence, which ensured that only innocent plaintiffs would be recovering from culpable defendants. We do know that Japan employs comparative fault,[81] but I do not know on whom it places the burden of proof in this situation. Indeed, it is too early in the comparative fault era to know how American courts will rule. But I do have an idea, borne of my earlier work on the Restatement on Apportionment of Liability that I would like to share.[82]

With uncertainty about the amount of harm caused by each defendant—as is ubiquitously the case in asbestosis cases—placement of the burden of proof is dispositive, as no one, given current scientific understanding, can obtain the requisite evidence. Placing the burden of proof on the plaintiff will result in no recovery. Placing the burden of proof on defendant will result in them being found to be a cause of the entirety of the harm. A better solution than either of these is to lower the threshold imposed by the burden of production and permit the factfinder to apportion the harm based on whatever scraps of evidence exist or reasonable suggestions for surrogates for causation that might exist. While dose intensity integrated over time of exposure to a given defendant's

---

80. *See supra* note 45 accompanying text.

81. *See supra* note 7 and accompanying text.

82. The idea comes from a pre-comparative fault case that posed a difficult question about apportioning harm to a plaintiff that occurred in several discrete automobile accidents. The court suggested that the jury make a rough apportionment based on what evidence was available that might permit causal apportionment. Loui v. Oakley, 438 P.2d 393, 397 (Haw. 1968).

HeinOnline -- 12 Conn. Ins. L.J. 344 2005-2006

asbestos may reflect the enhanced risk it produced, it is not the same as the harm caused. Yet using the former as a surrogate for the latter provides a more attractive solution to this problem than allowing the placement of the burden of proof to produce a default all-or-nothing answer.

In cancer cases, the second burden of proof issue identified above is critical. If the one-hit theory of cancer initiation is correct for asbestos-induced cancers, then only one of the defendants to whose asbestos products the plaintiff was exposed caused the cancer. On the other hand, if cancer requires some threshold dose, then an indeterminate subset of defendants was the cause of the plaintiff's harm. Once again, the adoption of comparative fault eliminates at least one significant rationale for the *Summers v. Tice* rule that the burden of proof is shifted to defendants. Moreover, another rationale relied on in *Summers* is only tenuously applicable—defendants do not have any better access to available evidence than plaintiffs, although they may be in a better position to develop such evidence by sponsoring research than plaintiffs. Yet to require the plaintiff to provide proof that is utterly lacking in light of current scientific understanding would result in systemic error exonerating defendants. A modification of market share liability, which has not been employed in asbestos litigation in the United States because of the lack of fungibility of various asbestos products, may nevertheless be a more attractive basis for imposing liability on those responsible for exposing victims to asbestos. The modification would involve employing enhanced risk rather than market share to determine a defendant's proportional liability.[83] As mentioned previously, despite our substantial ignorance about so much of asbestotic disease, there is relatively good evidence about risk enhancement. One private consulting firm has developed an algorithm for calculating risk enhancement of mesothelioma that relies on a variety of parameters demonstrated to have a role in the risk of disease.[84]

Based on asbestos litigation to date and what is currently known or surmised about the biology of asbestotic disease, the foregoing covers the causal apportionment issues arising in asbestos litigation. I have engaged in some modestly-informed speculation in addressing some of the apportionment issues surveyed. What is remarkable is that so many questions still remain, almost half a century after disease was convincingly linked to asbestos product exposure in the seminal work of Irving Selikoff. Asbestos research continues because of its prominence as a public health

83. That is the apportionment regime adopted recently by the House of Lords for mesothelioma victims in England. *See* Baker v. Corus UK Ltd, [2006] 2 W.L.R. 1027.

84. *See* Bertram Price & Adam Ware, *Mesothelioma: Risk Apportionment Among Asbestos Exposure Sources*, 25 RISK ANALYSIS 937 (2005).

HeinOnline -- 12 Conn. Ins. L.J. 345 2005-2006

issue.[85] Future developments that provide new understanding of the mechanisms by which asbestos causes disease could well affect causal apportionment—as I observed at the outset, causal apportionment depends crucially on the biology of how an agent causes what harm it does. My best guess is that more information will mean yet even more complex and contested causal apportionment issues.

Non-causal apportionment issues exist as well, but those are dependent on local law. Whether comparative fault is employed, joint and several liability or some alternative, contribution and crediting provided to non-settling defendants when a co-tortfeasor settles, the effect of an immune employer's fault on a plaintiff's recovery (here I assume workers' compensation—along with its exclusive remedy bar—which does not exist in many other countries, including Japan) and apportionment required because of the bankruptcy of one or more defendants all play a role in asbestos apportionment. But those questions are neither unique to asbestos litigation nor affected by the unique nature of asbestos claims. Finally, when asbestos litigation becomes large enough that collective settlements occur, the apportionment used by plaintiff's attorneys to distribute those settlement funds to each of the individual claimants whose case was settled provides an informal, unreported apportionment mechanism that I can only assume operates to some extent in the shadow of the law, but likely with considerably less attention to detail.

CONCLUSION

After the survey of causal apportionment in asbestos above, my concluding comments to Katsuo, my Japanese student, about asbestos apportionment might go something like this:

> I hope that your eyes are glazed over by the technicalities, scientific uncertainty, and causal mumbo jumbo I have employed. If I've been successful in impressing you with how complicated this matter is and you appreciate that with asbestos litigation, these inquiries will be repeated in case after mind-numbing case, you will understand why Japan should avoid apportionment at all costs—and, as the United States' experience reveals, it is considerable—and go

85. Pubmed Central Homepage, http://www.pubmedcentral.nih.gov/ (last visited Mar. 29, 2006). I found 51 research articles with "asbestos" in the title that have been published in the past year in a PubMed search on March 29, 2006.

HeinOnline -- 12 Conn. Ins. L.J. 346 2005-2006

> directly, without passing Go or collecting $200, to a legislative compensation scheme.

The Japanese appear to be more astute than we were or maybe they have learned from our mistakes. Legislation was approved in February, 2006 for a compensation scheme that took effect in March, 2006 and will provide compensation to those exposed to asbestos (both occupationally and non-occupationally) who suffer lung cancer and mesothelioma.[86] The benefits appear quite modest; non-pecuniary damages in wrongful death cases are less than $25,000,[87] and benefits for occupationally-exposed victims who do not qualify for workers' compensation are less than the benefits provided by workers' compensation. If this legislation is not exclusive, thereby barring victims from making tort claims, Japan may be faced with developing law to deal with the apportionment issues we have been confronting since first presented in Clarence Borel's lawsuit.

86. THE JAPAN TIMES ONLINE, March 21, 2006, at http://search.japantimes.co.jp/cgi-bin/nn20060321a2.htm; THE JAPAN TIMES ONLINE, March 21, 2006, at http://search.japantimes.co.jp/cgi-bin/ed20060315a1.html.

87. *Japan Diet Passes Legislation to Establish Compensation Fund for Asbestos Victims*, Toxics L. Rep. (BNA) Vol. 21, No.7, at 187 (Feb. 16, 2006).

HeinOnline -- 12 Conn. Ins. L.J. 347 2005-2006

HeinOnline -- 12 Conn. Ins. L.J. 348 2005-2006

ASSESSING THE COVERAGE CARNAGE: ASBESTOS LIABILITY AND INSURANCE AFTER THREE DECADES OF DISPUTE©

*Jeffrey W. Stempel**

INTRODUCTION, OVERVIEW, AND SUMMARY

Asbestos is perhaps the penultimate mass tort. It involves millions of victims and purported victims, thousands of defendants, hundreds of insurers, years of litigation, countless hours and transaction costs. As one commentator observed, the asbestos mass tort invites inevitable comparisons to the Ever-Ready Battery television commercials featuring the "Energizer Bunny," a toy that, at least when powered by the advertised battery, keeps going and going and going in seeming perpetuity.[1]

Although such scenes make for memorable product advertisements, there is nothing amusing about the asbestos mass tort. Almost everyone agrees that the asbestos situation has been too prolonged, too costly, too wasteful, and a not-so-great monument to the failures of the American political and legal systems. One commentator labeled asbestos the "tort that ate the Constitution" because of the pressure asbestos cases put on courts to relax traditional adjudication procedure.[2] Just as it seems the asbestos mass tort had appeared to run its course, a new wave of mass litigation against previously peripheral asbestos defendants took root, placing new pressures on asbestos handlers and distributors as well as on liability insurers that wrote liability coverage for these peripheral asbestos defendants as well as major manufacturers. As Deborah Hensler puts it

---

© Copyright 2005; Jeffrey W. Stempel.

* Doris S. & Theodore B. Lee Professor of Law, William S. Boyd School of Law, University of Nevada Las Vegas. Special thanks to Symposium organizers Tom Baker, Deborah Hensler, and Adam Scales as well as to other Symposium participants and thanks also to Ann McGinley. This project was supported by a grant from the James E. Rogers Research and Scholarship Fund. Some of my views on insurance coverage issues relating to asbestos claims were formed in the course of examining these issues as an expert witness or consultant, primarily for policyholders who manufactured, sold or used asbestos in some form.

1. *See* Michael E. Angelina, *The "Energizer Bunny" of Toxic Torts*, EMPHASIS, Vol. 2001, Issue No. 1, at p. 18.

2. *See* Roger Parloff, *The Tort That Ate the Constitution*, AM. LAW., July-Aug. 1994, at 74.

HeinOnline -- 12 Conn. Ins. L.J. 349 2005-2006

well: "People in the 1980s used to wonder what mass tort would be the 'next asbestos'; it turns out that asbestos was the 'next asbestos.'"[3]

What the participants in this long-running asbestos drama cannot seem to agree upon, of course, is the assignment of blame. Asbestos victims, plaintiffs, their counsel, and consumer groups tend to blame the asbestos industry, government, defense lawyers and insurers. Asbestos defendants tend to blame the plaintiff's bar, government, and insurers. Insurers tend to blame policyholders, plaintiffs, and their respective counsel.

These issues of tort liability and civil dispute resolution have tended to dominate discussion of the asbestos mass tort. Often overlooked are the insurance issues related to asbestos and the degree to which the asbestos mass tort has changed the face of liability insurance and liability insurance law. The asbestos mass tort brought insurance coverage litigation into the big leagues of litigation, adjudication, and scholarly examination (although even the most rabid insurance coverage junkie would concede this is not much silver lining to the asbestos cloud). But after 30 years of big-time liability insurance coverage litigation involving asbestos or influenced by asbestos, what is the outcome? My assessment is

> 1. Despite their protestations, insurers have not been unfairly treated by the judiciary's adjudication of asbestos-related insurance matters, although their success in public relations has left many with the impression that the insurance industry was handed too stiff a tab due to the legal system's desire to maximize available compensation for the asbestos mass tort;
>
> 2. Insurers themselves, in designing the comprehensive or commercial general liability ("CGL") policy that has been the focus of so much insurance coverage disputation, willingly took on the asbestos coverage risk, even if they did not specifically anticipate or fully appreciate the exposure they had embraced;
>
> 3. Insurers have survived the asbestos mass tort to date and will, when the final tally is finally tallied, have weathered the financial aspect of the asbestos storm quite well;

---

3. *See* Deborah Hensler, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005). *See also* Deborah Hensler, *Asbestos Litigation in the United States: Triumph and Failure of the Civil Justice System*, 12:2 CONN. INS. L.J. 1 (2006).

HeinOnline -- 12 Conn. Ins. L.J. 350 2005-2006

> 4. With all its faults, the asbestos mass tort has significant traits tending to advantage insurers. Adjudication and payment of the claims has extended over decades, postponing payment. This allows insurers to garner years of investment income and to pay claims in dollars whose real value has been substantially reduced by inflation. By contrast, other catastrophes such as Hurricane Katrina and September 11 require insurers to pay covered claims within a relatively short time frame in which the insurer gets far less benefit from either investment income or the effects of inflation;
>
> 5. In spite of the limited adverse impact of asbestos upon insurers, the insurance industry has successfully portrayed itself as a victim not only of the asbestos mass tort but also of judicial decisions favorable to policyholders. This in turn has made the judiciary more receptive to insurer arguments against coverage, in both asbestos and non-asbestos matters;[4] and
>
> 6. The asbestos mass tort provided insurers with something of a baptism of fire for modern liability exposures and has enabled the insurance industry to structure its products and behavior in a manner reducing its future exposure. Although there may someday be a "next asbestos" for tort law, there will not likely be a next asbestos for the insurance industry.

Insurers, having already paid billions of dollars in asbestos claims and defense costs, are understandably upset about continuing to face ongoing asbestos coverage liability, as they have been from the earliest days of the asbestos coverage litigation, which began in earnest with the *Insurance Company of North America v. Forty-Eight Insulations, Inc.*[5] and *Keene Corporation v. Insurance Company of North America*[6] litigation. Although

4. *See infra* text and accompanying notes 180-245.

5. 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law).

6. 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied,* 455 U.S. 1007 (1982). *Forty-Eight Insulations* and *Keene* are generally viewed as the lead cases that ushered in the modern era of high-stakes insurance coverage litigation. They were the first major federal appeals court cases focusing on the issue of the "trigger" or inception of insurer obligation for so-called "long-tail" tort claims that do not result in tangible injury or claims until years after the

HeinOnline -- 12 Conn. Ins. L.J. 351 2005-2006

I am not suggesting that asbestos has been "good" for insurers, I am suggesting that much insurer bemoaning of the ravages of asbestos claims has a quality of crocodile tears.[7]

In addressing the history and implications of the asbestos mass tort, one must inevitably address insurance coverage questions surrounding asbestos and the question of whether insurers asked to respond to asbestos claims have paid more or less than their cosmically and contractually "fair share" of this oppressive social burden. Professor Adam Scales has observed that the asbestos situation is "almost perfectly-suited for disrupting liability insurance markets and the expectations of insurers."[8] His view, at least as I interpret it, is that insurers have been required to pay too much for the asbestos problem and that during the course of three decades of insurance coverage litigation, insurers have found themselves faced with a body of law that is different than anticipated at the time they wrote the general liability policies implicated by the asbestos mass tort and that this factor—and insurer expectations generally—should have been given more consideration by courts adjudicating asbestos-related coverage disputes than has been the case.

The magnitude and longevity of the asbestos problem undoubtedly caught the insurance industry by surprise. To that extent, I agree with Professor Scales. But I am in disagreement to the extent that he may be

---

initial exposure to the allegedly dangerous substance and years of undetected injury. *See* JEFFREY W. STEMPEL, LAW OF INSURANCE COVERAGE DISPUTES § 14.09[b] (2d ed. 1999 & Supp. 2005)(discussing trigger of liability insurance in "long latency claims" and role of asbestos coverage cases in making law in this area); Eugene Anderson, *A "Keene" Story,* 2 NEV. L.J. 489 (2002) (policyholder counsel who prosecuted *Keene v. INA* coverage case discusses its significance, which included making him one of the nation's best-known insurance coverage lawyers).

7. One can even make quite a persuasive case that the asbestos mass tort has indeed been "good" for insurers because it prompted insurers to redesign the CGL to their advantage and to be more alert to potential mass tort liability exposures. Friedrich Nietze's observation, "that which does not kill me makes me stronger," resurrected by Professor Tom Baker, makes this point well. *See* Tom Baker, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005). In addition, as Professor Baker and insurers have noted, the happening of a large loss tends to make policyholders more conscious of risk and more willing to buy more insurance at higher premiums. *See id.*; Jeffrey W. Stempel, *The Insurance Impact of September 11*, 37 TORT & INS. L.J. 817, 878-79 (2002) (noting comments of insurance executives and analysis that disaster tends to be good for spurring insurance sales and attracting capital, with longer term benefits even if short term effect is to increase indemnity payments and reduce profits).

8. E-mail from Adam Scales, Professor, University of Connecticut School of Law, to other participants in connection with the 2005 Program of the Insurance Section of the Association of American Law Schools (AALS) (Dec. 8, 2004) (on file with author).

HeinOnline -- 12 Conn. Ins. L.J. 352 2005-2006

suggesting that asbestos coverage outcomes have exceeded the scope of the insurance industry's contractual commitments made in the CGL and other liability policies—or that insurers have been treated "unfairly" by courts or the American judicial system. Insurer coverage burdens in this area result not from any disregard of principles of contract or equity but instead stem from the peculiar factual and legal properties of the underlying asbestos mass tort. The asbestos-related financial obligations of insurers result from what has largely been correct judicial application of basic legal principles and not from any result-oriented radical changes in tort law or insurance coverage jurisprudence.

Regarding asbestos and insurer expectations, examination of liability insurance background materials and the development of the occurrence-based CGL policy suggests that insurers were fully cognizant of the possibility that a given third-party claim could trigger multiple consecutive policy periods. Insurers writing comprehensive or CGL coverage certainly understood that they were agreeing to insure injuries that took place gradually over time. In addition, insurers understood when providing general liability coverage that they were obligating themselves to provide both (a) general premises-operations liability coverage and (b) products/completed operations coverage in cases where there was product-related injury to third parties stemming from either ongoing policyholder operations, products sales and distribution, finished construction products, or any combination of these factors.

Unfortunately for the insurance industry, it did not foresee that a particular harmful substance such as asbestos might be able to both cause immediate actual injury upon exposure and to continue to cause new injury during subsequent years after inhalation or ingestion, and to do so on a large scale. As a result, many insurers were probably genuinely surprised to see courts so widely adopt a continuous trigger of coverage in so many cases. But insurers were generally cognizant of the possibility of long-tail, continuous trigger claims and accepted this risk in return for being able to market a broad comprehensive liability cover and capture additional premium dollars that could be profitably invested.

In addition, insurers may have been genuinely surprised that the same substance could lend itself so readily to (a) inflicting new injury during so many policy periods and triggering so many policies; (b) that the asbestos mass tort would have so many individualized injury scenarios, thus making for more "occurrences" under liability policies with per-occurrence limits; and (c) triggering general premises liability claims (e.g., from asbestos released during construction and related operations or building cleanup) as well as products/completed operations hazard claims (e.g., when third

HeinOnline -- 12 Conn. Ins. L.J. 353 2005-2006

parties sued asbestos insulation makers or builders that had improperly installed asbestos-containing products). Insurers were probably also genuinely surprised when so many of their policyholders sought bankruptcy protection, which potentially accelerates the when payment under policies is due.

When the magnitude of the asbestos problem exceeded expectations and investment income fell below expectations, insurers were left with an expensive piper to pay—but this was a risk insurers took on decades ago in what seemed to them a profitable move at the time. Although the reasonable expectations of insurers deserve consideration approaching that of policyholders, asbestos insurance coverage rulings by most courts do not violate the objectively reasonable expectations of insurers in light of the history and background of the comprehensive general liability policy and the broad insuring language selected by the industry.

Despite being required to provide considerable asbestos coverage, general liability insurance as a whole has been a profitable venture from 1943 to the present (the time of the reign of the CGL policy) at the very time that asbestos use and asbestos litigation and coverage litigation flourished. Asbestos appears not to have been an insurmountable problem for insurers, despite the failures of Congress to enact a legislative solution to the asbestos mass tort.

Section I of this article describes the background of the CGL policy. Section II addresses the question of the burden of persuasion when exclusions to the policy's coverage are at issue. Section III focuses on the trigger of coverage and the insurance industry's understanding that multiple CGL policies could apply to tort claims involving hazardous material and other sources of injury. Section IV explains how a standard approach to determining the number of occurrences also worked against insurer efforts to limit CGL coverage for asbestos claims. Section V focuses on the distinction between general operations liability and completed operations liability, and the lack of an aggregate policy limit for the latter during many of the years when asbestos exposure was at its height, a drafting error that in hindsight prevented insurers from obtaining maximum premiums and increased asbestos coverage to at least a significant degree. Section VI addresses the issue of policyholder identity and its potential impact on asbestos coverage. Section VII describes an additional threat to insurers, the risk that policyholder bankruptcy may accelerate the time of payment. Section VIII describes some substantial countervailing judicial victories obtained by insurers, which were arguably if not clearly undeserved and in my view resulted in part from unconscious judicial sympathy for insurers. Section IX describes the degree to which

HeinOnline -- 12 Conn. Ins. L.J. 354 2005-2006

the asbestos coverage experience has made the insurance industry better insulated from similar future coverage obligations. Section X considers whether in the balance of these events, insurers have been unfairly required to provide substantial coverage to asbestos defendant policyholders.

I. THE BACKGROUND AND DEVELOPMENT OF THE CGL POLICY

The Comprehensive General Liability policy (since renamed a "Commercial" General Liability Insurance Policy by the insurance industry in 1986 in order to avoid the broad coverage connotation of the word "comprehensive") has its roots in the 1930s and was established during the 1940s.[9] The first standardized CGL form, crafted by the National Bureau of Casualty and Surety Underwriters and the Mutual Casualty Insurance Rating Bureau, was issued in 1941.[10] Liability insurance itself is "a relatively new line" which began in the late 19th Century in both the United States and England.[11]

A revised standard form CGL issued in 1943 became widely used. The CGL policy was again revised in 1947 and significantly revised in 1955, 1966, 1973, and 1986.[12] The two rating bureaus that crafted the CGL policy eventually merged into the Insurance Services Office ("ISO"). ISO of course continues in its role as drafter of subsequent revisions to the standard form CGL.[13] During the first part of the 20th Century, various types of more sophisticated liability insurance products arose: Public Liability Insurance; Owners', Landlords' and Tenants' Public Liability Insurance; Manufacturers' Public Liability Insurance; Contractors' Public Liability Insurance; Contractual Liability Insurance; Owners' Protective Liability Insurance; Contractors' Protective Liability Insurance; Premises and Operations Insurance; and other separate liability insurance

9. *See* E.W. SAWYER, COMPREHENSIVE LIABILITY INSURANCE Chs. 2, 3 (1943) (Sawyer was an attorney for the National Bureau of Casualty and Surety Underwriters, which eventually merged with the Mutual Insurance Rating Bureau to form the Insurance Services Office ("ISO"); Statement of Richard A. Schmalz on Behalf of the American Insurance Ass'n Before the U.S. Senate Committee on Environment and Public Works 3 (April 3, 1985) (Schmalz was an official of the American Insurance Association).

10. *See* SAWYER, *supra* note 9, at Ch. 2.

11. *See* ALBERT H. MOWBRAY, RALPH H. BLANCHARD & C. ARTHUR WILLIAMS, JR., INSURANCE: ITS THEORY AND PRACTICE IN THE UNITED STATES 233 (3d ed. 1969).

12. *See* EUGENE ANDERSON ET AL., INSURANCE COVERAGE LITIGATION § 1.02 (2d ed. 1999) (also noting less significant revisions in 1988, 1990, and 1993).

13. *See* KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 34 (4th ed. 2005).

HeinOnline -- 12 Conn. Ins. L.J. 355 2005-2006

coverages.[14] The CGL policy is derived in significant part from Public Liability insurance and Premises and Operations insurance, but with additional, more inclusive coverages as implied by the name "comprehensive." At roughly the same time, insurers also began to offer defense of liability claims as part of the insuring agreement.

Prior to the advent of the CGL policy, these types of liability insurance were each sold separately. This presented difficulties for both insurers and policyholders. Insurers disliked the increased potential for adverse selection by policyholders, who might purchase only a coverage more likely to be needed while refusing to buy other coverages, thereby depriving insurers of potential premium dollars. It also raised pricing problems and issues of fairness in that some customers subsidized the coverages of others. It was also thought that presenting this much choice to some policyholders would encourage unduly risky behavior as policyholders gambled on the types of coverages they would need. Rating the multiple coverages was also difficult because of the narrow focus of risk assumed and the smaller pools of premiums for collection and investment.[15]

In response to the problems of splintered policies and coverages, the liability insurance industry developed the CGL policy.[16] The CGL policy, in addition to creating something closer to "one stop shopping" for businesses, risk managers, and brokers, also was designed to help insurers manage their liability exposure and to accept risk transfer profitably. Sale of the more expansive and bundled CGL policy required business policyholders in many cases to buy more insurance and pay more premiums than would otherwise have been the case.[17] These greater

---

14. *See* SAWYER, *supra* note 9, at 11-17.

15. *See* SAWYER, *supra* note 9, at 12-18.

16. *See id.* at 11.

> Whereas, in the past we have offered multiple separate liability covers, each excluding hazards within other covers and each being optional with the insured, and have insured only against hazards within the covers chosen by the insured, we now insure against all of the hazards within the scope of the insuring clause which are not specifically mentioned as excluded. Stated differently, instead of insuring against only enumerated hazards we now insure against all hazards not excluded . . . Liability insurance is now in the process of transition from the multiple separate covers to one comprehensive cover.

17. *See* SAWYER, *supra* note 9, at 135 (CGL insurance "offers opportunities for the producer to increase his own income through the placing of additional insurance") and at 145 ("the producer should do his utmost to place comprehensive liability insurance with every risk that has a need for it. Few businesses are too small to need it or to make it unprofitable for the producer to sell it."); Thomas M. Reiter, David J. Strasser & William J. Pohlman, *The Pollution Exclusion Under Ohio Law: Staying the Course*, 59 U. CIN. L. REV.

HeinOnline -- 12 Conn. Ins. L.J. 356 2005-2006

premium receipts could be used by insurers to earn more money on investment of premium dollars. In the 1940s, as today, insurers made much of their profit on the "float" of holding premium dollars as investments for many years before they were typically required to pay claims.[18] Without doubt, the object of the insurance industry in crafting the

---

1165, 1223 (1991) (CGL policy was sold as comprehensive policy providing "peace of mind" for policyholders for which insurers in turn demanded and received larger premiums); John H. Eglof, *Liability Insurance, The Outside*, *in* BEST'S INSURANCE NEWS (FIRE & CAS. ED.), Vol. 42, No. 1 (1941) (arguing that bundling of liability coverage into a comprehensive policy would enable insurers to obtain greater premium volume by encouraging sale of broad coverage product rather than more selective insurance purchases by policyholders; citing example of initial liability insurance premium of $10/year that could be "built up" to annual premium of $700 for comprehensive policy) (Eglof was Supervisor of the Agency Field Service of The Travelers Insurance Company.)

It appears that Sawyer and Eglof were not only aware of the potentially greater profits to be had from CGL sales, but also genuinely saw the broad coverage product as better for policyholders and even society. In a bit of hyperbolic boosterism that now seems part of a bygone era, Sawyer stated that "[i]f every producer would make a real effort to sell [CGL coverage] to every business on his books, he would be making a contribution toward the solution of war and postwar problems of far-reaching importance." *See* SAWYER, *supra* note 9, at 145-46. Although Sawyer's appeal seems more than a little overwrought, his sincerity appears genuine. He consistently argued for the mutual advantage (for insurer and policyholder) of the comprehensive approach and sought to have insurance move toward a supremely comprehensive all-risk model.

> There seems to be little doubt that the ultimate goal is an "all risk" liability policy. Such a policy would cover all liability hazards of the insured. It would not be limited in any way except to tort liability . . . . [It] is still far in the future [and requires] a long series of intermediate steps [but is] the general direction in which we are traveling.

See SAWYER, *supra* note 9, at 115-16.

18. Insurers make substantial profits because of the time value of funds they hold due to premium payments. Insurers profit from this "float" and investment income for years prior to paying claims. Even where the amount of claim costs exceeds premium collections, insurers typically make money because of earnings on these collected premiums prior to payment of related claims costs. Warren Buffett, who has described his company Berkshire-Hathaway as primarily an insurance company, notes that the insurers owned by Berkshire-Hathaway earn most of their profits not from underwriting but from the float of premiums collected well before claims are paid under the policies for which those premiums were charged. *See* Letter from Warren Buffet to shareholders (2000), at 8-1, *available at* http://www.berkshirehathaway.com. *See also* Richard E. Stewart & Barbara D. Stewart, *The Loss of Certainty Effect*, 4 RISK MGMT. & INS. REV. 29, 32 (2003) (insurers have explicitly recognized that "the earnings on funds reserved for claims [are] the most significant component of earnings for a property liability insurance company" and "[i]nsurance managements are more than sufficiently intelligent to see that delaying the payment of claims increases the float period and denying claims decreases the cost"). *See generally* SCOTT E. HARRINGTON & GREGORY R. NIEHAUS, RISK MANAGEMENT AND

HeinOnline -- 12 Conn. Ins. L.J. 357 2005-2006

CGL was to offer for sale an attractive product providing comprehensive insurance protection in order to both reduce adverse selection and to encourage greater premium payments by policyholders.[19]

The CGL policy at its inception made a broad commitment to the policyholder to pay "all sums" resulting from third-party claims for bodily injury or property damage caused by an accident. The CGL policy form in use today continues to make a broad commitment to providing a wide scope of liability policy coverage to policyholders. The CGL policy is structured with a broad insuring agreement but then utilizes exclusions as necessary to protect insurers from certain risks. The exclusions of the CGL policy are provisions narrowing the scope of coverage. For example, intentionally caused injury was excluded, as was liability assumed by contract, automobile, aircraft, or watercraft liability, employee injuries, and damage to the policyholder's own property or own products.

II. STRUCTURE AND PRESUMPTION IN THE CGL: THE QUESTION OF BURDEN

Because exclusions attempt to take away coverage provided to the policyholder, an axiom of insurance is that the insurer relying on an

---

INSURANCE Ch. 6, *Insurance Pricing* 123-135 (1999) (insurers profit on investment income and delayed payment of claims; underwriting cycles can vary according to changes in investment return and in reaction to previous pricing strategies as well as "capital shocks" from large losses); MARK R. GREENE, RISK AND INSURANCE 147 (4th ed. 1977) ("In property and liability insurance, investment income has accounted for a very substantial portion of total profits and has served to offset frequent underwriting losses.").

19. An insurance company executive writing at the time of the promulgation of the CGL policy emphasized its breadth of coverage:

> [With the CGL policy form, the] burden of determining what to insure and what not to insure is removed from the shoulders of the insured and placed squarely on the producer and the carrier. How much better it is to say – "We cover *everything* except this and this and this" instead of "We cover *only* this and this and this." No longer will an insured with Owners', Landlords' and Tenants' coverage in one company and Elevator coverage in another company take them both to court to prove where the claimant fell down...Since a risk cannot choose the kind of accident that will give rise to the need for liability insurance, it is wise to be protected against all losses under one policy – *One policy – one premium and worry regarding liability insurance is off his mind.*

See Eglof, *supra* note 17, at 19 (emphasis in original) (Eglof was a Supervisor in the Agency Field Services of the Travelers Insurance Company).

HeinOnline -- 12 Conn. Ins. L.J. 358 2005-2006

exclusion is required to shoulder the burden of persuasion as to the applicability of that exclusion if the exclusion is to defeat coverage.[20]

Insurance custom and practice as well as hornbook statements of insurance law provide that ambiguous language is construed against the drafter of the insurance policy and that the insurer shoulders the burden of persuasion to establish the applicability of an exclusion or another provision of the policy that reduces or restricts coverage. The insurance industry has long accepted this axiom of construction of ambiguous language against the drafter as a pivotal principle of resolving insurance coverage disputes.[21] The insurance industry, scholars, and courts have also long accepted the axiom that ambiguous language is construed against the drafter of the insurance policy.[22] Even if a coverage-limiting provision in a

---

20. *See* STEMPEL, *supra* note 6, § 2.06(c); BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 1.03[b] (11th ed 2002).

21. *See* Memorandum to Insurance Industry Officials attached to Letter of July 23, 1957 from Andrew G. Meyer, Esq. of Liberty Mutual Insurance to Messrs. Earle et al., at 39 (where coverage question is "shadowy", then "insurers must either clearly exclude or clearly cover. If insurers fail to eliminate ambiguous language from policies, there is no doubt against whom the ambiguities will be resolved."). This axiom is reflected in numerous insurance and insurance law treatises. *See, e.g.*, MARK S. DORFMAN, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 184 (7th ed. 2001) ("If an insurer denies a claim based on an exclusion and the insured then contests the denial, the insurer has the legal burden of proving the exclusion was applied correctly."); C.A. KULP & JOHN W. HALL, CASUALTY INSURANCE 322 (4th ed. 1968) (describing exclusions as limitations on otherwise existing coverage); ROBERT I. MEHR & EMERSON CAMMACK, PRINCIPLES OF INSURANCE 136 (4th ed. 1966) ("the insuring agreement is the cloth from which the final coverage is cut. The exclusions are the cuttings from the coverage."); Harrington & Niehaus, *supra* note 18, at 176 (describing exclusions as removing coverage for specific losses that would otherwise be covered under the insuring agreement); A.S. ARNOLD, GENERAL INSURANCE PRINCIPLES, REVISED EDITION 96 (1983) ("any ambiguities in the language of the contract are construed against the insurer in favor of the insured. Reasonable doubt as to the meaning of the language of an insurance policy is thus resolved in favor of the insured."); HERBERT S. DENENBERG ET AL., RISK AND INSURANCE 219 (2d ed. 1974) ("Because the insurance contract is one of adhesion, and because it is drafted by the insurer, the contract is usually construed in favor of the insured and against the insurer, when there is any ambiguity."). *See also* OSTRAGER & NEWMAN, *supra* note 20, § 1.03[b][1] and § 10.02[a] ("It is well-settled that the burden of proving the applicability of the pollution exclusion is on the insurer."). *Accord*, STEMPEL, *supra* note 6, § 2.06[c] ("An important legal aspect of exclusions is that demonstrating the applicability of an exclusion places the burden of proof on the insurer."). Even if a coverage-limiting provision in a policy is not denominated as an "exclusion", if an insurer is relying on language in a definition, condition, or other portion of a policy to defeat or reduce coverage, the provision is treated as an exclusion, it is narrowly construed against the insurer in favor of coverage, and the insurer must successfully shoulder the burden of persuasion on the issue.

22. *See, e.g.*, JAMES S. TRIESCHMANN & SANDRA G. GUSTAVSON, RISK MANAGEMENT & INSURANCE 272 (9th ed. 1995) (describing uncertainty as to application of care, custody,

policy is not denominated as an "exclusion", if an insurer is relying on language in a definition, condition, or other portion of a policy to defeat or reduce coverage, the provision is treated as an exclusion, it is narrowly construed against the insurer in favor of coverage, and the insurer must successfully shoulder the burden of persuasion on the issue.[23]

This basic structural and doctrinal framework is important in close insurance coverage questions for a reason seemingly obvious but often overlooked: in close cases turning on exclusionary provisions of a policy, the presumptive default resolution of lack of clarity is that the insurer provides coverage. Further, where the coverage turns on the meaning of non-exclusionary language such as the insuring agreements or conditions of the policy, unclear language will be resolved against the insurer as drafter of the policy, provided that other indicia of meaning (e.g., extrinsic evidence of specific intent, overall purpose of the policy, drafting history of the policy, representations, conduct, and reliance) do not resolve the ambiguity.[24]

Although this framework for assessing coverage disputes does not routinely result in findings of coverage, it is a methodology favoring policyholders in the close cases, one commentators have justified due to the structural advantages held by insurers in the design, marketing, sale,

---

and control exclusion in that "[t]here seems to be no general rule applicable to such cases, except the general rule that always applies – ambiguities in contractual language will be construed against the insurer."); A.S. ARNOLD, GENERAL INSURANCE PRINCIPLES, REVISED EDITION 96 (1983) ("any ambiguities in the language of the contract are construed against the insurer in favor of the insured. Reasonable doubt as to the meaning of the language of an insurance policy is thus resolved in favor of the insured."); DENENBERG ET AL., *supra* note 21, at 219 ("Because the insurance contract is one of adhesion, and because it is drafted by the insurer, the contract is usually construed in favor of the insured and against the insurer, when there is any ambiguity.").

23. *See* OSTRAGER & NEWMAN, *supra* note 20, § 1.03[b]; STEMPEL, *supra* note 6, § 2.06.

24. *See* STEMPEL, *supra* note 6, Ch. 4; OSTRAGER & NEWMAN, *supra* note 20, § 1.01-1.03; ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 25A (2d ed. 2002). Where the policyholder or its agents (e.g., an insurance broker) is in fact the designer or drafter of the policy, this rule does not obtain and the principle of contra proferentem (construing ambiguity against the drafter) can be applied against the policyholder rather than the insurer. *See* STEMPEL, *supra* note 6, § 4.08; Metpath, Inc. v. Birmingham Fire Ins. Co., 86 A.D. 2d 407, 449 N.Y.S.2d 986 (1982). In addition, contextual factors such as the course of dealing of the parties and the particularly knowledge of the policyholder may change the application of these ground rules, perhaps stripping the policyholder of these advantages altogether. *See* Hazel Glenn Beh, *Reassessing the Sophisticated Insured Exception*, 39 TORT & INS. L.J. 85 (2003); Jeffrey W. Stempel, *Reassessing the "Sophisticated" Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 801 (1994).

HeinOnline -- 12 Conn. Ins. L.J. 360 2005-2006

and adjustment of insurance policies.[25] Although insurers are quick to point out that they are at significant risk from information asymmetry, adverse selection, and moral hazard in underwriting liability risks, insurers are able to control these risks through effective design of liability policies in order to limit their exposure.[26] Except in the softest of insurance markets, insurers generally can draft policies to their liking and of course refuse to issue policies absent sufficient comfort with the risk and receipt of an adequate premium.[27]

Most important, insurers are the classic "repeat players" of the dispute resolution game.[28] If an insurer loses on a particular coverage point, it normally remains free to continue to litigate in other forums. Because insurers are in essence, to borrow Professor Baker's phrase, "huge accumulations of money,"[29] insurers are in a favorable position to win wars

---

25. *See, e.g.*, Lawrence Solan, *Pernicious Ambiguity in Contracts and Statuts*, 79 Chi.-Kent. L. Rev. 859 (2004); Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992); Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1 (1991).

26. For a discussion of these basic insurance concepts, see STEMPEL, *supra* note 6, Ch. 1; EMERIC FISCHER, PETER NASH SWISHER & JEFFREY W. STEMPEL, PRINCIPLES OF INSURANCE LAW Ch. 1 (3d ed. 2004).

27. A "soft" insurance market is one in which coverage is widely available at low prices as insurers compete aggressively to capture business and premium dollars. Conversely, a "hard" market is one in which conditions are not favorable for policyholders and coverage is restricted or available only at relatively high premium prices. *See* MARK S. DORTMAN, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 332 (8th ed. 2004).

28. A repeat player is one that frequently participates in the dispute resolution system while a "one shot" player is one that only occasionally is involved in litigation or alternative dispute resolution. The repeat play has significant advantages in battling one shot players, including economies of scale, acquired expertise, institutional memory, familiarity with adjudicators, knowledge of forums, and the ability to spread losses and take the long view of a dispute. *See* Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC. REV. 95 (1974). Individual losses normally tend to be of relatively little consequence to the repeat player while they are often devastating to the one shot player.

In the insurance context, individual policyholders (e.g., homeowners, automobile owners) are classic one shot players. With commercial policyholders, the distinction is muted but still obtains for coverage matters. For example, Acme Widget Company may have substantial experience prosecuting collection actions and fending off customer complaints (particularly if it self-insures or has a liability policy with a large retention making it responsible for small claims). But such companies are seldom frequently embroiled in insurance coverage litigation while insurers are regularly engaged in such disputes.

29. *See* Baker, *supra* note 7; Tom Baker, Remarks at Insurance Law Section Program, Association of American Law Schools (January 6, 2005) (San Francisco, CA).

HeinOnline -- 12 Conn. Ins. L.J. 361 2005-2006

of attrition with both third-party claimants and policyholders simply by wearing them down to accept sub-optimal settlements (all the while continuing to earn investment income).[30]

But because of the pro-policyholder framework for assessing insurance coverage erected to counteract the inherent advantages held by insurers, insurers may find themselves with massive coverage obligations under certain circumstances. To take an obvious example, after a destructive hurricane, a windstorm insurer such as Citizens (Florida's hurricane insurer of last resort) will be paying a lot of claims (and probably losing money in at least the short term) no matter how well it may have priced coverage or constructed the policy to avoid being required to also provide coverage for flooding or other destructive forces.[31] But after large losses come large premium increases,[32] and for many working class and middle class Americans, forgoing hurricane insurance is now not likely to be seen as an option after the disastrous hurricane seasons of 2004 and 2005.

---

30. *See* Baker, *supra* note 7 (noting degree to which insurers earn substantial investment income on premiums with premium receipts predating payment requirements by years or even decades); V.J. Dowling, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005).

31. *See* Liam Pleven, *Who Should Pay? As the Number of Customers Rises For Insurers of Last Resort, Rates May Be Headed Up, Too*, WALL ST. J., Feb. 1, 2006 at B1, col. 2 (noting Citizens' losses after bad hurricane years of 2004 and 2005 but also noting that many Florida homeowners are "in no position to shop around" because the "only company offering a policy is Citizens Property Insurance Corp., Florida's insurer-of-last-resort."). Also, the typical Citizens policy is quite explicit in stating that it covers only wind storm damage and does not cover flood damage or even losses stemming from a "storm surge" of water (even if the water was of course propelled by a hurricane). However, even the most restrictive of draftspersons can miss things. The typical Citizens policy does not establish an aggregate limit on coverage (at least this is to me the clear wording of the policy although it is disputed by the insurer in coverage litigation in which I am an expert witness), which means that the insurer is obligated to pay covered losses stemming from multiple occurrences during an annual policy period. Although comparatively rare, separate hurricanes can ravage the same property twice in a season. For example, in 2004 some parts of Florida were hit by both Hurricane Frances and Hurricane Jean and in 2005, some parts of the Gulf Coast were hit by both Hurricane Katrina and Hurricane Rita.

32. *See* Susanne Sclafane, *Florida Homeowners Rates Could Triple, Citizens Warns*, NATIONAL UNDERWRITER, Dec. 5, 2005, at 21 ("We're looking at a statewide average increase . . . of 60 percent, with many coastal areas receiving triple digit increases," according to Robert Riker, "president and executive director of Citizens Property Insurance Corp. In Florida, the state's largest insurer of last resort."). Although general liability insurance rate increases have been more gradual in response to the more gradual onset of asbestos mass tort insurance coverage, the same economic and marketing factors are at work. *See Sorry America, Your Insurance Has Been Cancelled*, TIME, Mar. 24, 1986 at 20 (describing abrupt rises in select liability insurance premiums).

HeinOnline -- 12 Conn. Ins. L.J. 362 2005-2006

Consequently, insurers are in a relatively good position to recoup past losses through future price increases.

Even if this were not the case, there is nothing unfair about a legal regime structured to give policyholders the benefit of the doubt in close cases after the policyholder has established that a claim comes within coverage (or is potentially within coverage if the question centers on the duty to defend). As discussed in Section X, *infra*, insurance is a aleatory contract, one in which the value of the exchange may be lopsided depending on the contingencies involved.[33] In similar fashion, liability insurers underwriting asbestos policyholders prior to the advent of the asbestos mass tort may have been in a favorable business position. From the time of the CGL policy's introduction in the 1940s until the arrival of asbestos and pollution claims in the 1970s, the CGL appears to have been a business success and large moneymaker for the insurance industry. But when the asbestos mass tort arrived, the basic contractual and legal framework of coverage determination combined with the peculiarities of asbestos to require coverage beyond that anticipated by insurers when they first accepted the risk. This may have made the CGL less profitable, but it hardly brought the liability insurance industry to ruin.[34]

III. THE TRIGGERING SHIFT FROM "ACCIDENT" TO "OCCURRENCE": INSURERS EMBRACE A POTENTIAL CONTINUOUS TRIGGER

The original CGL policy provided coverage where injury giving rise to a liability claim was "caused by accident." The term "accident" was not

---

33. *See infra* text and accompanying notes 247-54.

34. *See infra* text and accompanying notes 247-54 (attributing demise of Providence Washington Insurance Companies, a Rhode Island insurer established in 1800, to its exposure on asbestos claims). *See Special Report, Asbestos: Impact on U.S. Insurance Industry*, FITCH RATINGS, July 25, 2002 at 9 ("ultimately, the development of asbestos claims will have a moderately negative impact on insurer ratings during the next few years.") and at 1 (although asbestos liabilities will produce a "'slow bleed' that will depress future earnings for many years" the "historic asbestos earnings drag has average 1.7 combined ratio points for the commercial lines/reinsurance sectors over the past few years" although near-term future losses may be more significant because of surge in second generation claims in late 1990s and early 21st Century); *Thinking About Asbestos*, LEHMAN BROTHERS GLOBAL EQUITY RESEARCH, March 20, 2002 at 27 (insurer earnings drag from asbestos can reasonably be estimated at 1.5 percent); *Fitch Affirms Rating for St. Paul Travelers Ratings After Asbestos Charge; Outlook is Stable*, INSURANCE JOURNAL, Jan. 31, 2005, http://www.insurancejournal.com/news/national/2005/01/31/50493.htm. *But see, Asbestos Liability Takes an Insurer Out*, RISKPROF, Nov. 1, 2005, *available at* http://riskprof.typepad.com/tort/2004-06/asbestos_liabil.html.

HeinOnline -- 12 Conn. Ins. L.J. 363 2005-2006

defined in the original CGL policy, the 1943 CGL form, the 1947 form, or the 1955 form. Courts divided significantly on the question of whether an injury-producing event must be discrete and isolated in order to constitute an "accident". An emerging, but not overwhelming, majority of courts concluded that an "accident" need not be confined in time and space and could be an injury-producing event taking place over a longer time span.[35] Many insurers were opposed to this perceived judicial trend, arguing that an "accident" needed to be an event confined in time and space.

During the 1955-1966 period, these insurers either came to change their views or accept that this elongated judicial interpretation of the "accident" trigger of coverage was inevitable.[36] In addition, some insurers were offering occurrence-basis coverage that was an attractive competing product because it clearly provided coverage for liability that resulted from ongoing conditions. In response, as part of the insurance industry's 1966 revision to the standard CGL policy, the term "occurrence" was substituted for the term "accident," with an "occurrence" being defined as "an accident, including injurious exposure to conditions, that results during the policy period in bodily injury or property damage neither expected nor intended from the standpoint of the insured."[37]

The language of the 1966 Form's definition of "occurrence" also clarified what had long been the understanding of the insurance industry and the courts; the bodily injury or property damage caused by an accident/occurrence must produce injury or damage "during the policy

---

35. *See* ROWLAND H. LONG, THE LAW OF LIABILITY INSURANCE §1.08[1], 1-58 (2005); JOHN A. APPLEMAN & JEAN APPLEMAN, APPLEMAN ON INSURANCE, § 117.3 (2d ed. 1981). *Compare* Jackson v. Employers Liab. Assurance Co., 139 Misc. 686, 248 N.Y.S. 207 (N.Y. Sup. Ct. 1931), *aff'd*, 259 N.Y. 559, 182 N.E. 180 (1932)) ("accident" must be confined in time and space), *with* Hauenstein v. St. Paul Mercury Indem. Co., 65 N.W.2d 122, 126 (Minn 1954); Shipman v. Employers Mut. Liab. Ins. Co., 125 S.E.2d 72, 75-76 (Ga. Ct. App. 1962) ("accident" may take place over time). *Hauenstein*, a "property damage" case under the CGL, would come out differently today because the 1966 form changed the definition of the term to require "physical" injury (not economic injury alone), but the *Hauenstein* analysis regarding the term "accident" remains reflective of the emerging majority view of the time.

36. *See, e.g.*, John J. Tarpey, *The New Comprehensive Policy: Some of the Changes*, 33 INS. COUNS. J. 223, 223 (1966) (stating that "[t]he principal reason given for revision of the policies [from the 1955 form to the 1966 form] was adverse court decisions"). Mr. Tarpey was a partner in the New York-based law firm LeBoeuf, Lamb & Leiby (now LeBoeuf, Lamb, Leiby & McCrae), which then, as now, represented insurers in coverage matters, and was a member of the Federation of Insurance Counsel.

37. *Compare* the 1955 CGL Form, *reprinted in* ANDERSON ET AL., *supra* note 12, at A-3 to A-8, *with* the 1966 CGL Form, *reprinted in* ANDERSON ET AL., *supra* note 12, at A-9 to A-15.

HeinOnline -- 12 Conn. Ins. L.J. 364 2005-2006

period" in order to trigger coverage. If a policyholder was negligent (either episodically or chronically) but the negligence did not harm any third party during the policy period, there was no insured event and no trigger of coverage. If, however, this negligence produced injury in a later year, the occurrence basis CGL insurance applicable to the year of injury would be triggered and would respond to the claim. Regarding the 1966 Form, one attorney representing insurers commented:

> Probably the most significant portion of the definition [of "occurrence"] is the phrase "during the policy period." It will now be required, to bring the policy provisions into play, that the bodily injury or property damage resulted during the policy period and not that the accident [meaning the antecedent negligence] resulted during the policy period. This should remove problems of interpretation where causative factors operate over a long period of time before any harm results and also where the negligent act or the operative legal fact is far removed in time from the happening of the injury (e.g., a defect in manufacture, the sale of the product).[38]

With the change from an "accident" policy to an "occurrence" policy, the focus of the trigger inquiry shifted from some uncertainty as to timing to a focus on the time at which the third party allegedly suffers injury due to actions for which the policyholder is legally liable.[39] In the 1973

---

38. Tarpey, *supra* note 36, at 224.

39. *See* Gilbert L. Bean, Assistant Sec'y, Liberty Mut. Co., Address at the Mutual Insurance Technical Conference on New Comprehensive General and Automobile Program: The Effect on Manufacturing Risks 6 (Nov. 15-16,1965) ("[C]overage no longer attaches when the accident occurs but rather when the injury or damage takes place. This means that the policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place.") Bean was one of the drafters of the 1966 CGL (on file with the author); *see also id.* at 7 (noting the possibility that events taking place long ago can trigger coverage in subsequent policy years if the injury from those events takes place during later policy years); Richard H. Elliott, *The New Comprehensive General Liability Policy*, *in* LIABILITY INSURANCE DISPUTES, 12-3, 12-5 (Sol Schreiber & Stuart J. Motelson eds., PLI 1968) (containing the statement of Mr. Elliott, who was an industry official, that "for the purpose of applying coverage – the *injury* must take place during the policy period.") (emphasis added); Letter from E.W. Sawyer, Attorney, to Robert L. Mannon, Fireman's Fund Indemnity Company (June 3, 1939).

Under the majority of judicial decisions and what appears to be the majority view of the application of the "accident" trigger, the result would be the same: it was the injury, not the antecedent negligence or other liability-creating conduct that triggered the CGL policy.

HeinOnline -- 12 Conn. Ins. L.J. 365 2005-2006

revisions to the CGL form, there was also a technical modification to the "occurrence" and "bodily injury" terms of the policy.[40]

Accidents "in the air," so to speak, did not trigger coverage. However, because in most instances, negligence and injury were nearly simultaneous (consider, for example, poor driving, a careless workman, an exploding appliance), insurers were undoubtedly taken aback when the asbestos tort arrived. Because inhaled asbestos continues to inflict new damage, it had greater than ordinary potential to trigger multiple policies.

40. As noted above, the 1966 CGL form stated that coverage was triggered by an "occurrence" causing bodily injury or property damage "during the policy period". *See supra* note 37 and accompanying text. In 1973, this "during the policy period" language was relocated from the "occurrence" definition to the bodily injury definition. *See* the 1966 CGL Form, *reprinted in* ANDERSON ET AL., *supra* note 12, at A-17. Beginning with the 1973 Form, "bodily injury" was defined as injury, sickness, or disease "sustained by any person which occurs during the policy period," including resulting death. *See id.* The relocation of this language was not intended to effect a substantive change in the meaning of the CGL. *See* Enclosure to letter from R.H. Elliott, Vice President Commercial Cas. Dep't, Ins. Servs. Office, to Dwight V. Strong, Chairman, WAIB-IBAC Comm. on Revised Liab.Forms 1 (Sept. 22, 1972) (on file with author).

> The revised wording represents no change in underwriting intent. The additional words "which occurs during the policy period" have been included in the definition [of "bodily injury"] and also in the definition of "property damage" because of the elimination of the phrase "during the policy period" from the definition of "occurrence". It is suggested that this emphasizes that [for purposes of triggering coverage] "the time of occurrence [meaning the antecedent negligence] does not matter [for purposes of triggering liability], only the time of its result". Such emphasis is desirable. In many cases, the injurious result takes place at the same time as the cause of such result. The damages that are sought by the claimant and that are to be paid by the insurer on behalf of the insured are related to the adverse effect on the claimant of the occurrence. Until this adverse effect has taken place, there would be no grounds for the claimant to recover from the insured.

Id. As this commentator also observed:

> This point can be demonstrated by consideration of the typical product liability claim. A manufacturer produces a defective product. The claim does not arise then; it arises when the product caused injury to the claimant, after the manufacturer has sold the product to the claimant and [after] the latter puts it to use.
>
> . . . .
>
> [T]he revised definition of "bodily injury" will not result in any less coverage than is currently afforded under the 1966 policy form nor does it impose any different obligation . . . .

Id. (Mr. Elliott was the vice president of the ISO Commercial Casualty Department and a Secretary of the National Bureau of Casualty Underwriters); *see also* R.H. Elliott, Remarks to the Kansas State Agents Association on the January 1, 1973 Changes in the

HeinOnline -- 12 Conn. Ins. L.J. 366 2005-2006

Under the CGL policy's 1966 Form and 1973 Form, some damage or injury during the policy period was clearly required to trigger coverage. Mere negligence standing alone would not trigger the CGL policy unless there was also actual injury. Damage and injury were considered concepts distinct from the "accident" or "occurrence" that brought about the damage or injury.[41] Under the 1955 Form, the situation was less certain because of perceived ambiguity in the word "accident." The insurance industry moved to correct this perceived problem in the 1960s and to focus on the time of injury to a third party. In making this change generally favorable to its interests through limiting the breadth of trigger in most instances,[42] insurers were well aware that more than one policy could be triggered by injury to a single individual.[43]

Because there had been cases treating antecedent negligence as the "accident" under the 1955 CGL form, the insurance industry moved from "accident" to "occurrence" language to make it clearer that injury rather than negligence alone (or "negligence in the air") triggers coverage.[44] But although the time of injury to the third-party claimant is critical to the question of trigger, the time of injury does not have any bearing on the

---

Comprehensive General Liability Policy and in the General Liability Manual 3 (Jan. 3, 1973) ("[This change is] simply editorial in nature and [does] not represent any broadening or restriction in coverage.") (on file with author).

41. *See* Ins. Servs. Office Inter-Office Correspondence from T.V. Bayer to B.J. Shelley 1 (July 28, 1982) ("The first point to make is that the current form says that the injury or damage, and not the occurrence [meaning the antecedent negligence], must take place during the policy term for there to be coverage.").

42. In the typical tort matter, policyholder error and injury to a third party are simultaneous or at least take place within the time frame of the policy period. Where policyholder error and injury are separated, this can as easily work against the policyholder and for the insurer as vice versa. Consider Singsaas v. Diederich, 238 N.W. 878 (Minn. 1976), in which the policyholder performed negligent welding in Year 1 but the poor welds did not give way and cause injury to a third party until Year 2. *Id.* at 879-80. There was no coverage under Policy 1. *Id.* at 880. Because the policyholder had ceased operations and failed to keep insurance in force, there was no insurance coverage at all. *Id.*

Insurers will undoubtedly take issue with my example, finding it small potatoes as compared to the asbestos mass tort. True enough. But my point is simply that insurers in 1966 not only had something to gain from move to an occurrence trigger (resolution of conflicting judicial rulings on the accident trigger) but probably thought that the focus on injury rather than antecedent negligence made it less likely that multiple insurers would be triggered in connection with a tort claim, even though the drafting history of the CGL policy reflects an understanding that gradual injury spanning multiple policies would be covered under multiple policies.

43. *See* GREEN, *supra* note 18, at 318 ("exposure to conditions over a period of time is covered" under the CGL policy).

44. *See* Norman Nachman, *The New Policy Provisions for General Liability Insurance*, 10 CPCU ANNALS 196, 223-25 (1965).

HeinOnline -- 12 Conn. Ins. L.J. 367 2005-2006

classification of the coverage. The source of the injury determines whether the loss is within coverage, is appropriately regarded as a general premise-operations liability matter or a products/completed operations hazard matter, or is subject to an exclusion.

Discussion of the move to an occurrence trigger reflects insurer understanding that an "occurrence" under the 1966 form need not be an episodic "boom" event but could well involve gradual, ongoing or continuous injury. According to a leading insurance company representative,

> The definition [of "occurrence"] embraces an injurious exposure to conditions which results in injury. Thus, it is no longer necessary that the event causing the injury be sudden in character. In most cases, the injury will be simultaneous with the exposure. *However, in some other cases, injuries will take place over a long period of time before they become manifest. The slow ingestion of foreign matters and inhalation of noxious fumes are examples of injuries of this kind. The definition serves to identify the time of loss for application of coverage in these cases, viz, the injury must take place during the policy period. This means that in exposure-type cases, cases involving cumulative injuries, more than one policy contract may come into play in determining coverage and its extent under each policy.*[45]

Insurance industry materials make reference to the ability of the occurrence-basis trigger to implicate two or more liability insurance policies in connection with claims of recurring injury from exposure to harmful conditions or circumstances. Using the examples of waste disposal and pollution, one commentator illustrated the operation of the occurrence basis trigger and its potential to result in triggering of multiple policies.

> Perhaps it is in the waste disposal area that a manufacturer's basic premises-operations coverage is liberalized most

45. *See id.* at 199-200 (emphasis added) (Nachman was at the time manager for non-automobile casualty insurance and multiple lines insurance at the National Bureau of Casualty Underwriters). *See also* Bean, *supra* note 39, at 1 (emphasizing that 1966 form is "considerably broader" in providing coverage for gradual injuries but emphasizing that "coverage, however, is still a casualty coverage") (Bean was Assistant Secretary, Liberty Mutual Insurance Co.).

HeinOnline -- 12 Conn. Ins. L.J. 368 2005-2006

substantially. Smoke, fumes, or other air or streams polution [sic] have caused an endless chain of severe claims for gradual property damage. These wastes disposal cases have been difficult ones, because when the injury or damage first starts to emerge, no corrective action is taken in many cases, because the manufacturers are reticent to admit his waste disposal is causing it. This is probably an honest doubt. When the cause is pinpointed, it may or may not be easy to make a quick elimination of the cause. The cost of an alternative method of waste disposal may be terrifically expensive or might even force the manufacturer out of business, and even if it can be made, it may take months to convert. Our new policy requires the insured to promptly take reasonable steps to correct conditions causing gradual injury or damage, once discovered. Opinions as to what is reasonable may vary widely. Meanwhile losses continue.

This brings into focus one important change in our policy – the fact that coverage no longer attaches when the accident occurs but rather when the injury or damage takes place. This means that the policy in force when a particular injury or damage takes place is the one which applies, regardless of when the causing accident took place. *So if the injury or damage from waste disposal should continue after the waste disposal ceased, as it usually does, it could produce losses on each side of a renewal date, and in fact over a period of years, with a separate policy applying each year.*

The policy limits are renewed every year, so the underwriter of a manufacturing risk may have his limits pyramid under this new contract.

. . . .

So, even for new business, the underwriter must be more alert than ever. More potential losses may be inherited from the past. A harmful waste disposal practice unknown to the underwriter because it has since been corrected, or which the applicant promises to correct, may still produce serious losses during your period of coverage. This has always been

HeinOnline -- 12 Conn. Ins. L.J. 369 2005-2006

> true for products, but with gradual injury or damage being covered, the potential is a lot worse.[46]

As this commentator noted, insurers still retained significant protection in that "the new policy still gives the carrier the right to cancel a policy on 10 days notice." But although this "may free the carrier from liability for future injury or damage from an occurrence which has already taken place while he was on the risk," this type of "cancellation would be no escape from consequences of mishaps which have already happened."[47] "I doubt very much whether the courts would permit a cancelling company to escape the inevitable consequences of what had already happened during their period of insurance."[48]

Other insurance insiders took a similar view of the likely consequences of the move from an accident trigger to an occurrence trigger.

> The new policy will afford coverage on an "occurrence" basis. "Occurrence is defined as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury and property damage neither expected nor intended from the standpoint of the insured." Note that this definition includes the work "accident." This has been done in order to clarify the intent with respect to time of coverage and application of policy limits, particularly, in situations involving a related series of events attributable to the same factor. Under such circumstances only one accident or occurrence is intended as far as the application of policy limits is concerned. For example, the liability of a contractor arising out of the derailment of ten or twelve freight cars as a result of a collision with a piece of his equipment is intended to be subject to one application of the occurrence limit of the policy. Retention of the word "accident" is limiting in this sense and in no other.
>
> Note also the reference to injurious exposure to conditions which results in injury. This eliminates any requirement that

46. *See* Bean, *supra* note 39, at 6 (underlining in original; italics added). Bean was Assistant Secretary, Liberty Mutual Insurance Company, and was one of the principal authors of the 1966 CGL form and the occurrence trigger.

47 *See id.* at 7.

48. *See id.*

HeinOnline -- 12 Conn. Ins. L.J. 370 2005-2006

> the injury result from a sudden event. Although, it is most common that the injury takes place simultaneously with the exposure, *there are many instances of injuries taking place over an extended period of time before they become evident. For example, slow ingestion of foreign substances or inhalation of noxious fumes.* In cases such as these, the definition of occurrence serves to identify the time of loss for the purpose of applying coverage – the injury must take place during the policy period.
>
> In some exposure types of cases involving cumulative injuries, it is possible that more than one policy will afford coverage. Under these circumstances, each policy will afford coverage to the bodily injury or property damage which occurs during the policy period.[49]

The CGL workbook used by a major property/casualty insurer (and one that would later have one of the largest books of asbestos liability business took a similar view.

> Many people consider an occurrence as a one time event with a very short, sometimes split-second duration – such as an accident. However, an occurrence may also mean exposure to conditions which may continue for a period of time.[50]
>
> Because an accident [as contrasted to an occurrence] originates at a particular point in time, it's easily identified as having, or as not having, transpired during the policy period.
>
> . . . .
>
> An accident occurring during the policy period is easily enough identified. But what exactly constitutes "continuous or repeated exposure to conditions"? A related series of events attributable to the same factors may cause a loss. This related series of events may be interpreted as being an accident or an occurrence. This interpretation aids in

49. *See* Elliott, *supra* note 39, at 12-5 (emphasis added). Elliott was Secretary of the National Bureau of Casualty Underwriters.

50. *See* [ANONYMOUS INSURER] THE COMPREHENSIVE GENERAL LIABILITY POLICY WORKBOOK 11 (1973).

HeinOnline -- 12 Conn. Ins. L.J. 371 2005-2006

> determining two things: 1) When the loss occurred; and 2) How the policy limits apply. [Illustration No. 5 (all caps eliminated)] Wilson Chemical Company, the Named Insured, Occupies the Second Floor of a Commercial Building Owned by West End Cleaners. The West End Operation Occupies the Entire First Floor. Wilson Chemical used Acid as a raw material. The acid is stored in 100 gallon drums on the second floor. One storage drum developed a leak allowing acid to drip onto the floor. This eventually caused extensive damage to several structural supports of the building and caused a partial collapse which destroyed much of West End's equipment. West End Cleaners Brought a suit against Wilson Chemical for the replacement of their equipment. Would Wilson's CGL Policy Pay?
>
> Yes. This situation would meet the second part of the definition of occurrence, as the slow leak of acid constitutes a continuous or repeated exposure to conditions." As such, an occurrence of this type is a related series of events attributable to the same factors which caused the damage. Since the damage occurred during the policy period, it would be covered by the CGL Policy – the Company would assume the insured's liability. However, if the "continuous or repeated exposure to conditions" occurred during the policy period, but the actual property damage did not occur until after the policy had expired, the insurance company would not be obligated to assume the insured's liability.[51]

Without doubt, liability insurers understood that the shift from an accident trigger to an occurrence trigger constituted a "broadening of coverage"[52]

> The new definition of "occurrence" does not represent any change in underwriting intent. It is merely a clarification that this term encompasses not only the usual "accident" but

---

51. *See id.* at 11-12.

52. *See* Memorandum from R.H. Elliott, Secretary of the National Casualty Standards Bureau, to "Regional Vice Presidents," Jan. 4, 1937, attaching Richard H. Elliott, The January 1, 1973 Changes in the Comprehensive General Liability Policy and in the General Liability Manuals, Address to Kansas State Association of Insurance Agents, Jan. 3, 1973, at 2.

HeinOnline -- 12 Conn. Ins. L.J. 372 2005-2006

> also exposure to conditions which may continue over a period of time.[53]

Even when the CGL policy employed an "accident" trigger rather than the more encompassing occurrence trigger,[54] insurers realized that because of the breadth of the CGL coverage commitment, they would need control their exposure through other means such as the exclusion of specific risks[55] (today referred to as "lasering out" particular risks) and the use of policy sub-limits for certain types of problematic liability.[56] Regular review of policies and according adjustment of premiums or cancellation were also seen as important to controlling risk under the more comprehensive cover of the CGL form.[57]

In addition, insurers were well aware that expanding the trigger of the industry's basic liability policy could expose insurers to more uncertain risk than that presented by other lines of insurance. Writing shortly before the 1966 revisions to the standard form CGL policy, insurance authorities noted:

---

53. *See id.* at 3.

54. *But see* SAWYER, *supra* note 9, at 120-21 (appearing to interpret accident trigger in a manner similar to interpretation of occurrence trigger in that policy would provide coverage for "continued existence of a cause of injury which results in property damage without a definite accident.")

55. *See id*, at 70 ("[T]here are situations in which it is necessary to exclude from the application of the policy certain business locations in their entirety or certain hazards at specific locations.")

56. *See id*, at 71 ("If higher limits of liability are required for one hazard, such as elevators, the comprehensive policy may be written for the limits common to all hazards and the higher limits may be afforded by endorsement for elevators. If lower limits are required for one hazard than for the other hazards, the limits must be reduced for the single hazard. In either case, the hazard which is to have different limits must be described in the endorsement in the same manner as it would be described in a schedule or single cover policy. If the limits for the hazard are to be reduced below the policy limits it is not necessary to bother with the exclusions, because all of the coverage for the hazard is comprehensive insurance."). *See also* C.A. KULP, CASUALTY INSURANCE: ANALYSIS OF HAZARDS, POLICIES, COMPANIES AND RATES 38 (rev. ed. 1942). Liability forms have policy limits which are based essentially not on the amount of insurance required for full protection (which is incalculable) but on what the insured wishes to pay. Soundly selected, the limits will cover all but the most unusual losses. These limits, however, apply per person and per accident, not per year.

57. *See* SAWYER, *supra* note 9, at 97 ("In considering surveys and audits one cannot keep too closely in mind this feature of the comprehensive liability plan. . . . The success or failure of comprehensive liability insurance rests almost entirely upon the thoroughness with which the survey and audit are made.") and at 110 (providing example of discovery of additional hazards and risks after audit).

HeinOnline -- 12 Conn. Ins. L.J. 373 2005-2006

> The possible liability loss tends to be much more fluid and difficult to estimate than some other types of losses, such as property losses. Changing law and social outlook continually alter the size of judgments, mutations being obvious in the recent trend of verdicts in personal injury accidents. At the same time, it is virtually impossible to put a precise ceiling on a liability loss. Property may be insured for its value, but many forms of liability know no such easy limitations. The risk manager of a large pharmaceutical house admitted that its potential liability arising from products is virtually a matter of guesswork.
>
> Finally, the liability peril not only involves a loss but may imply or seem to imply moral shortcoming of the party who is liable. Consider, for example, the doctor charged with malpractice, or the careless driver charged with liability for the death of a pedestrian, or the defendant charged with libel or slander or assault and battery. This aspect, too, may have important implications for any device to treat the liability risk.[58]

In essence, liability insurers "knew" that by expanding to an occurrence trigger, they were increasing their own risk that liability losses would span more than one policy period and correspondingly increase their responsibility for losses such as toxic torts or pollution.[59]

Certainly, insurers knew that by adopting an occurrence basis trigger, they could potentially be covering latent injury cases long after the initial exposure to the harmful substance. In retrospect,

> [t]he problems resulting form occurrence-type coverage are thus quite obvious in latent injury cases. The rate that the insurer charges for the coverage, and the loss reserves that the insurer sets aside to pay future claims may prove to be

---

58. *See* DENENBERG ET AL., *supra* note 21, at 350-51. *Accord*, Greene, *supra* note 18, at 289 ("[o]ne of the most serious financial risks covered by insurance is that of loss through legal liability for harm caused others."); KULP & HALL, *supra* note 21, at 78 (liability insurance and legal regime closely linked).

59. *See* Nachman, *supra* note 44; MEHR & CAMMACK, *supra* note 21, at 340-41 (noting that term "accident" was sometimes not held to apply to injuries such as those "brought on by repeated exposures to dust from cement" but that term "occurrence" clearly applied to this type of injury and triggered coverage under a liability policy) (note, too, the similarity between an injury from cement dust and one resulting from asbestos dust).

HeinOnline -- 12 Conn. Ins. L.J. 374 2005-2006

> grossly inadequate, depending in part on unpredictable factors such as the following:
> 1. Whether a substance considered to be relatively safe at the time the insurance was issued proves many years later to be hazardous.
> 2. The extent of economic inflation and "social" inflation (for example, the tendency of juries to award greater damages than in the past) between the time of exposure and when a claim is made; and
> 3. Liberalizations in the law, such as the exposure and triple-trigger theories.[60]

The drafters may not have anticipated the avalanche of asbestos claims, but they clearly anticipated multiple policies being triggered by a liability hazard and knew that this risk was less predictable than many of the other risks they undertook. Insurers also knew that the design of the liability insurance product could affect the tort liability regime, in particular prompting larger jury awards as the public became increasingly aware of the likely presence of at least some insurance for the defendant.[61] Although insurers in hindsight may feel they have been subjected to "unacceptable risk," it appears that insurers willingly embraced this risk in the pursuit of broader, more saleable coverage and corresponding profit.[62]

This injury-from-an-occurrence trigger of coverage took on particular significance with the emergence of the asbestos mass tort. Substantial medical evidence has been proffered by plaintiffs and policyholders to suggest that injury from asbestos continues for years after the initial inhalation of asbestos because of the peculiar properties of asbestos.[63] Because injury continues to be inflicted anew by asbestos fibers in the lungs, consecutive liability policies are triggered. This is not the result of judicial fiat or undue sympathy for plaintiffs and policyholders but stems instead from the insurance industry's intentional decision to write broad coverage coupled with an unusually dangerous material with properties that trigger more than one liability policy because it inflicts injury across time.

---

60. *See* DONALD MALECKI AND ARTHUR FLITNER, COMMERCIAL GENERAL LIABILITY COVERAGE GUIDE 114-15 (8th ed. 2005).

61. *See* DENENBERG ET AL., *supra* note 21, at 358-59.

62. *See* MALECKI & FLITNER, *supra* note 60, at 115.

63. *See generally* BARRY CASTLEMAN, ASBESTOS, MEDICAL AND LEGAL ASPECTS (4th ed. 1996); PAUL BRODEUR, OUTRAGEOUS MISCONDUCT 127, 227-28, 274-75 (1985).

HeinOnline -- 12 Conn. Ins. L.J. 375 2005-2006

IV. COUNTING "OCCURRENCES" IN THE CONTEXT OF ASBESTOS-RELATED BODILY INJURY CLAIMS

As discussed above, the trigger of coverage for CGL insurance has been injury caused by an "occurrence." But the trigger or inception of insurance coverage is a different issue than the scope of the coverage or the amount available to pay a covered claim. Liability insurance policies, like all insurance policies (at least those sold by carriers hoping to remain solvent) are not limitless but specify a maximum benefit available for each covered occurrence. Modern liability policies also have an "aggregate limit" establishing the insurer's maximum liability no matter how many occurrences, claims, or injuries may arise from a policyholder's activity during the policy period.

However, aggregate limits were not the norm for general liability claims until the 1986 ISO revision of the standard CGL policy form. Prior to this point, many if not most insurers included an aggregate limit for claims arising from a "products" or "completed operations" hazard (discussed in more detail in Section V, *infra*) but had no aggregate limit for general liability claims that arose out of a policyholder's ongoing operations rather than from sale or distribution of a product or the failings of a completed project causing injury at a later date.

Without an aggregate limit, it is more than possible that an insurer may be required to pay the maximum per-occurrence limit several times as a result of multiple injury-causing occurrences during the policy period. As a result, the manner in which one defines an occurrence and the number of occurrences can become very important in determining an insurer's total liability under a particular policy. Because insurance policies have varying levels of deductibles or retentions for which the policyholder is responsible for payment, a finding of multiple occurrences by either an economic benefit maximizing coverage or an economic detriment requiring the policyholder to pay more out of pocket than it receives from insurance coverage. Consequently, common torts and mass torts may engender a good deal of litigation over the apt counting of occurrences.

Further, the practices of insurers and the jurisprudence of occurrence-counting has not been a model of consistency or coherence. Insurers have a tendency to characterize the number of occurrences in a manner that minimizes their own financial burden while courts have a tendency to do the opposite in a manner that maximizes insurance coverage. Where a policy has a low deductible or no deductible, courts tend to more readily find multiple occurrences, requiring multiple insurer payments. Where deductibles are high, the tendency is to find that even many injuries stem

HeinOnline -- 12 Conn. Ins. L.J. 376 2005-2006

from only one or a few causes, requiring fewer payments of deductibles and more net insurance to the policyholder.

Disputes over occurrence-counting have taken place with a vengeance concerning the asbestos mass tort not only because of the many asbestos claims but also because so many of the policies implicated are older policies lacking an aggregate limit or containing an aggregate limit only for asbestos claims characterized as stemming from a products/completed operations hazard. In addition, many of the older policies had low/no deductibles or policyholder retentions. Perhaps unsurprisingly, courts have tended to find that each asbestos-related injury to a distinct person is a separate occurrence entitling the policyholder to the protection of a full "per-occurrence" policy limit.[64] Equally unsurprising is that insurers tend to complain about this body of precedent, viewing it as excessively result-oriented and pro-policyholder.

As with its complaints about the continuous trigger, the insurance industry is not particularly sympathetic on this point. An objective legal analysis strongly supports the judicial consensus that each asbestos victim's injury is a separate occurrence for insurance purposes. In addition, because older liability policies often have very low per-occurrence policy limits, the absence of an aggregate limit is not nearly the financial burden to insurers that it would be in today's world where million or multi-million dollar per-occurrence limits are common.

The CGL policy was designed to provide protection for businesses from typical general liability risks. For a manufacturer or installer of what proved to be a dangerous material (asbestos), each prospective plaintiff and each lawsuit poses a significant risk of tort liability. Many individual asbestos claims have resulted in seven-figure judgments or settlements for the claimant. Many, many more have produced six-figure settlements and judgments. An extraordinary number of asbestos-related claims have at least nontrivial value and impose nontrivial burdens and exposures upon

64. *See, e.g.*, Prudential Lines Inc. v. American Steamship Owners Mut. Prot. & Indem. Ass'n, Inc., 158 F.3d 65 (2d Cir. 1998) (applying New York law) (each individual injurious exposure of sailors to asbestos on ship is a separate occurrence; presence of asbestos on ship is not itself the cause of injury to individuals and is not the sole occurrence under the policy); Flintkote Co. v. General Accident Assur. Co., 2005 U.S. Dist. LEXIS 11 (N.D. Cal. Jan. 3, 2006); *Parent Company Covered: `Occurrence" Is Each Exposure to Asbestos*, 20-9 MEALEY'S LITIG. REP. INS. 6 (2006). *Accord*, American Red Cross v. Travelers Indem. Co., 816 F. Supp. 755 (D.D.C. 1993) (each distribution of HIV tainted blood causing injury to different individual is an occurrence under the CGL policy; negligence of policyholder does not comprise one overarching occurrence). Mason v. Home Ins. Co., 532 N.E.2d 526 (Ill. App. Ct. 1988) (each sale of contaminated food to different restaurant patron is separate cause of injury comprising distinct occurrence).

HeinOnline -- 12 Conn. Ins. L.J. 377 2005-2006

policyholders. In order for the CGL policy to work properly, policyholders must receive the coverage they purchased for each "occurrence" that presents significant risk. In the case of asbestos claims, this augers in favor of not batching claims in a manner that so consolidates the concept of an occurrence that it effectively deprives policyholders of promised coverage.

Although the CGL policy defines an occurrence as an "accident, including injurious exposure to conditions" resulting in "bodily injury" (the 1966 CGL Form) or an "accident, including continuous or repeated exposure to conditions," which results in "bodily injury" (the 1973 CGL Form), the "continuous . . . exposure to conditions" language was not intended to bundle claims together unless they could reasonably be said to stem from the same cause.

Since the inception of the CGL, insurers and courts both have applied a "cause" test to determine the number of occurrences under a CGL policy.[65] Adopting a cause test does not resolve the occurrence-counting task in self-executing fashion. One must still determine how broadly or narrowly to define "cause." As a concept, the cause of an injury and a tort liability claim cannot be "negligence in the air" or a general corporate policy. Rather, to cause injury, the negligence of a policyholder must actually impact a particular claimant. Without this, no injury takes place, no claim is made, and no policy is triggered. Not surprisingly, most courts facing the issue have therefore concluded that each plaintiff with an asbestos-related injury constitutes an occurrence for purposes of liability coverage,[66] a result that squares with hard-headed logic at least as much as with any judicial sympathy for commercial policyholders facing a multitude of asbestos claims.

As a matter of policy text alone, there appear to be many claims under the CGL policy involving workers or bystanders who have inhaled asbestos that was released by asbestos products that were distributed or used during construction and insulation activities. Although the philosophical inquiry "if a tree falls in the forest and no one hears it, does it make a sound" has become the stuff of TV sitcom parody, the conundrum-cum-cliché makes a

---

65. *See* STEMPEL, *supra* note 6, § 14.02; JERRY, *supra* note 24, § 65[c]; ANDERSON ET AL., *supra* note 12, Ch. 9.

66. *See generally* Exxon Corp. v. St. Paul Fire & Marine Co., 1996 U.S. Dist. LEXIS 17278 (E.D. La. Nov. 15, 1996) (separate encounters with hazardous material by five different men working around oil field constitutes five separate occurrences for insurance policy purposes); *see generally* CSX Transp., Inc. v. Continental Ins. Co., 680 A.2d 1082 (Md. 1996) (each claimant's allegation of noise induced hearing loss is a separate occurrence; insurers argue for multiple occurrences); *see also* Worcester Ins. Co. v. Fells Acres Day Sch., Inc., 58 N.E. 2d 958, 973-74 (Ohio 1990) (discrete acts of child abuse at different locations in school are separate occurrences).

HeinOnline -- 12 Conn. Ins. L.J. 378 2005-2006

valuable point. Events tend to be defined not in the abstract, but by their perception and impact. For asbestos and insurance, where injury is the trigger, an individual claimant must be exposed to harmful asbestos and suffer some kind of injury before there can be an insured event. Furthermore, each person's asbestos exposure and injury is a separate and distinct event that is caused by a different asbestos intake and impact occurrence. Hence, each is better viewed as a separate "occurrence" for liability insurance purposes rather than as the "effects" of a single release of asbestos by the policyholder.

This analysis seems to be the correct one, even where asbestos claims stem from the sale of a single asbestos-containing product or the use by patrons of a single asbestos-containing building. However, it is important to note that there are cases that take a contrary approach and tend to find one or only a few causes based on particular bulk shipments of a product or the manufacture of a uniform injury-causing product.[67] Where injuries

---

67. *See generally* Michigan Chemical Corp v. Midland Ins. Co., 728 F.2d 374 (6th Cir. 1984) (applying Illinois law); *see generally* Maurice Pincoffs Co. v. St. Paul Fire & Marine Ins. Co., 447 F.2d 204 (5th Cir. 1971) (applying Texas law). *Pincoffs* and *Michigan Chemical* are two particularly well-known cases taking what might be termed the "compromise" position that found each shipment of injury-causing contaminated product (bird feed and cattle feed, respectively) to constitute an occurrence. These cases rejected both the view that the contamination was but a single occurrence and the view that each injury to a bird or cow was an occurrence. Applying the rationale of *Pincoffs* and *Michigan Chemical* to asbestos claims, one could take the position that each wholesale shipment of asbestos product or each insulation job site was an occurrence for purposes of CGL coverage.

Although this would not be an absurd analysis, neither is it persuasive. *Pincoffs* and *Michigan Chemical* can be distinguished from asbestos claims brought by workers exposed to asbestos from working with asbestos-containing materials not only because humans are different than animals but because the nature of the injury is different. In *Michigan Chemical*, the distributor of the contaminated feed faced claims from farmers whose herds had been decimated by the poisonous feed. Each cow (or the cow's estate or spouse) was not suing in its own right for bodily injury. The commercial nature of the claim made some degree of aggregation logical in light of the loss claimed. Outside of Charlotte's Web, farmers tend not to worry about a single livestock animal but instead see the herd as a single economic asset. By contrast, each human injured by asbestos make his or her own distinct claim. If a company were suing for lost productivity due to asbestos-related injury to its workforce, the case might be apt for a Michigan Chemical approach finding some interim degree of aggregation based on something other than each individual worker's injurious exposure.

Pincoffs fits the model less well since it involved claims by individual pet owners from the deaths caused by contaminated feed. However, the policyholder was a pet store that needed to resolve the claims as a whole to maintain its business. The perhaps result-oriented view that treating each dead parakeet as a separate occurrence and imposing more deductible payments on the policyholder, a small business, makes analytic sense in that it is

HeinOnline -- 12 Conn. Ins. L.J. 379 2005-2006

arise from exposure to asbestos during construction, insulation, or other general ongoing operations of a policyholder, the "one victim-one occurrence" analysis seems particularly powerful. The nature of asbestos installation activities makes the policyholder's asbestos installation liability the result of many occurrences. A policyholder installing asbestos engages in this activity over many years, in many different locations, over different time periods at each location. During different times and locations, numerous people were exposed in a variety of ways to different amounts and types of asbestos and suffered immediate injuries that continued for years as a result of that exposure. The only reasonable conclusion is that each of these injuries results from a different cause and constitutes a different occurrence under the CGL policy.

Although it is not an asbestos case, *Koikos v. Travelers Insurance Co.*[68] provides a good illustration of the prevailing judicial approach to occurrence counting and the view that each claimant's injury is a separate occurrence under the CGL policy. In *Koikos*, the policyholder was the owner of a restaurant in Tallahassee, Florida. He rented the premises to a Florida A & M University fraternity for a party. When two undesirables attempted to crash the party, an altercation ensued. One of the party crashers fired "two separate – but nearly concurrent – rounds," hitting two different partygoers and causing serious injury to each. Each victim filed a separate lawsuit against Koikos as owner of the restaurant alleging inadequate security. Koikos sought coverage for two separate occurrences. Travelers disagreed, arguing that only a single occurrence—inadequate restaurant security—caused the shootings. The Florida Supreme Court, interpreting a policy that defined an occurrence as including "continuous or repeated exposure to substantially the same general harmful conditions," rejected Travelers' position on number of occurrences and embraced Koikos's view that each shooting was a separate occurrence to which full policy limits applied. The *Koikos* Court said:

> We conclude that the inclusion of the "continuous or repeated *exposure*" language does not restrict the definition of "occurrence" but rather expands it by including ongoing and slowly developing injuries, such as those in the field of toxic torts. Therefore, we reject Travelers' reliance on the "continuous or repeated exposure" language as a basis for

---

more consistent with the purposes of the CGL than a definition of occurrence that leaves the policyholder essentially without coverage when it needs it most.

68. *See generally* Koikos v. Traveler's Ins. C., 849 So.2d 263 (Fla. 2003).

HeinOnline -- 12 Conn. Ins. L.J. 380 2005-2006

> concluding that Koikos's negligent failure to provide security constitutes a single occurrence under the terms of the policy. The victims were not "exposed" to the negligent failure to provide security. If the victims were "exposed" to anything, it was the bullets fired from the intruder's gun.[69]

V. THE ABSENCE OF AN AGGREGATE LIMIT FOR GENERAL OPERATIONS COVERAGE UNDER THE CGL: ANOTHER FACTOR EXPANDING INSURANCE COVERAGE FOR ASBESTOS CLAIMS

A. THE DISTINCTION BETWEEN GENERAL OPERATIONS HAZARDS AND THE PRODUCTS/COMPLETED OPERATIONS HAZARD

The trigger of coverage issue is conceptually distinct from the issues of the scope of coverage and amount of coverage afforded. Resolving the issue of trigger, therefore, does not determine the characterization of a liability claim. Rather, the claim must be based on the event or hazard that produced the injury, irrespective of the time that injury takes place. Trigger involves merely the question of when actual injury takes place. Actual injury may take place in one or more policy years. Actual injury may be *sui generis*, or may be continuous and indivisible. In contrast to trigger, which depends on the date of injury, the question of the appropriate classification of a CGL claim as covered, uncovered, general liability, products, or completed operations depends upon the nature of the event or activity giving rise to the triggering injury.

As its name implies, the CGL policy was designed and intended to afford general liability coverage for business entities. Business policyholders who purchased CGL coverage sought protection from the common types of claims that arose from the business's regular operations. This was the type of liability coverage policyholders formerly acquired (before 1941 and the introduction of the CGL policy) through the purchase of separate polices providing premises and operations coverage, owner, landlord, and tenant coverage, public liability insurance, contractor's insurance, and the like.

---

69. *Id.* at 268 (emphasis in original; citations omitted); *accord* New Hampshire Ins. Co. v. RLI Ins. Co., 807 So.2d 171, 171 (Fla. App. 2002) (three shots fired over course of several minutes from three different locations within apartment complex constitutes three separate occurrences; "[t]he act which causes the damage constitutes the occurrence") (internal citations omitted).

HeinOnline -- 12 Conn. Ins. L.J. 381 2005-2006

At the time of the original CGL, the primary concern of both insurers and policyholders was general premises-operations liability from ongoing operations. This type of liability was the most significant threat to most policyholders. However, insurers were also aware of the risks posed by product liability claims, even for non-manufacturers, in light of *MacPherson v. Buick Motor Co.*,[70] which was decided more than 20 years before the standard CGL policy came into existence. Insurers knew that privity of contract was unlikely to be a successful defense to product liability claims, even those against policyholders with no "fault" other than the misfortune of selling a defective product at retail. As a result, insurers were aware of the need for product liability coverage and were willing to provide it to policyholders.

Insurers were also aware that products claims posed different, troublesome risks as compared to general premises-operations liability claims. The sources of liability for claims that fall within the products/completed operations hazard of CGL policies—the "hazards" for which the products/completed operations hazard was designed—may give rise to liability that may be beyond the control of policyholder and insurer by the time the claims are made. The policyholder's ability to manage the product or construction risk after the fact is quite limited or very expensive (e.g., product recall, retrofitting of a building). By contrast, a policyholder may often correct a general liability exposure quite efficiently after a single injury, removing the risk or reducing it drastically, even if the general premises-operations liability exposure involves use of hazardous material (e.g., adopting new procedures for safer handling of toxic substances). But with products/completed operations hazard claims, the "genie" has escaped the bottle and policyholder and insurer have comparatively less control over the matter. Insurers historically have been more worried about accepting products/completed operations hazard risks than general premises-operations liability risks due to fears that "problems with defective products and construction cannot be reined in once claims arise."[71]

As a result, insurers historically protected themselves with aggregate limits for products/completed operations hazard claims. Insurers knew that when a products/completed operations hazard did materialize and produce injury, the resulting cascade of claims could elude both prediction and control. As one commentator noted:

---

70. *See generally* MacPherson v. Buick Motor Co., 217 N.Y. 382, 111 N.E. 1050 (1916).

71. *See* STEMPEL, *supra* note 6, at 14-32.

HeinOnline -- 12 Conn. Ins. L.J. 382 2005-2006

> [T]he per accident limit is a toothless tiger when it comes to controlling the cumulative impact of several hundred claims from the products of one manufacturer in one year. Therefore, the reinsurer and the insurer have fallen back on some of their old friends – the maximum dollar amount of liability and the specified period of time. This time, though, these concepts are used directly in policies issued by the primary insurer to cover products liability. In addition to the usual "per person" and "per occurrence" bodily injury limits stated in such policies, the manufacturer will find that its general liability policy which covers its products will contain another limit of liability called "aggregate." This limit is normally written as a very low multiple of the per occurrence limit. For example, if the company is carrying $500,000 per person and a million dollars per occurrence or accident, its aggregate limit will probably be one million, or perhaps two million dollars at the most, for all claims in certain categories, and one of the particular categories is products.[72]

Tort law and liability insurance are of course related and overlap to a degree. CGL insurance and its liability insurance predecessors were designed as a business response to the tort system. However the tort law concept of "product liability," in which the term is loosely used to refer to nearly any claim involving the presence of a purportedly dangerous product, is quite distinct from the more targeted CGL insurance terms "products hazard" and "completed operations hazard." The products/completed operations hazard category of liability insurance is considerably narrower. Although a third party's lawsuit against a policyholder may be a "product liability" action for purposes of its tort law description, for insurance purposes it is not a "products hazard" claim unless it arises from use of a product for which the policyholder has previously relinquished control. Similarly, for insurance purposes, a lawsuit is not a "completed operations hazard" claim if the injury to the

---

72. *Products Liability Forum*, 20 FED'N. INS. COUNS. QTRLY 73, 82-83 (Fall 1969); *see also* Nachman, *supra* note 44, at 204; Roger C. Henderson, *Insurance Protection for Products Liability and Completed Operations – What Every Lawyer Should Know*, 50 NEB. L. REV. 415, 426 (1971) (noting 1966 changes separated products and completed operations coverage in order to make it clear that service business not involving goods or products could nonetheless be subject to completed operations provisions of 1966 CGL Form).

HeinOnline -- 12 Conn. Ins. L.J. 383 2005-2006

third party arises prior to the completion of the construction project or insulation contracting activity.

The natural reading of the words of the CGL policy suggests that tort claims arising from a policyholder's regular, ongoing operations are general premises-operations liability claims and do not evolve or transform into "completed operations" hazard claims merely because the construction activity comes to a conclusion sometime after the events that give rise to tort liability irrespective of the claimants' relation to those later activities. Statements by persons associated with the insurance industry also suggest that insurers did not intend to transform general premises-operations liability claims into products/completed operations hazard claims merely because products eventually are no longer in the possession of the policyholder and construction projects eventually are finished. Thus, the text of the CGL policies and the drafting history concerning products/completed operations hazard coverage establish that claims arising out of insulation contracting are general premises-operations liability claims under the CGL policy.

ISO personnel recognize that the correct analysis to determine whether a claim is a products/completed operations hazard claim or a general liability premises/operations claim examines the source of the exposure:

> Products are made to be used in the premises or operations of others . . . Thus, for every *product or completed operations exposure* of the supplier, there is a corresponding *premises or operations exposure* for the user.[73]

This view is consistent with the typical general descriptions of products/completed operations coverage in the scholarly literature.

> Bodily injury and property damage liability insurance is provided under the products-completed operations division of the scheduled policies, to cover the liability imposed upon the insured by law for damages sustained by any person caused by accident during the policy period arising out of the handling or use of or the existence of any condition in goods

73. *See* Howard J. Walker, Jr., Memorandum of Law Addressing the Issue of Limiting the Availability of ISO's "Claims-Made" Policy to Specific Classes of Insureds, Insurance Services Office, Inc. at 5; *see also* Testimony of M. Walters at 46:10-12 ("But I would suggest to you for every product liability exposure you have a corresponding premises operation exposure . . . .") (Ms. Walters, a Senior Vice President of ISO, was representing ISO at a hearing regarding approval of a new claims-made general liability policy).

HeinOnline -- 12 Conn. Ins. L.J. 384 2005-2006

> or products manufactured, sold, handled, or distributed by the insured, if the accident occurs away from premises owned, rented, or controlled by the insured and after the insured has relinquished possessions to others. Coverage is also provided for injury caused by accident arising out of operations if the accident occurs after such operations have been completed or abandoned at the place of occurrence away from premises owned, rented, or controlled by the insured. (Liability resulting from accidents involving pickup, delivery, and the existence of tools, uninstalled equipment, and abandoned or unused materials is not a part of the completed operations hazard and is covered under the premises and operations insurance [provided by the CGL policy].)[74]

B. INSURANCE INDUSTRY INTENT AND THE POLICYHOLDER UNDERSTANDING OF COMPLETED OPERATIONS COVERAGE

The natural reading of the words of the CGL policy suggests that tort claims arising from a policyholder's installation and construction activity are general liability claims and do not become "completed operations" claims merely because the construction activity comes to a conclusion sometime after the events that give rise to tort liability. Statements by persons associated with the insurance industry also suggest that insurers did not intend to transform general liability claims into products or completed operations claims merely because product manufacture and construction projects eventually are finished. Thus, the text of the CGL policies and the drafting history concerning products/completed operations coverage establish that installation-related liability claims are general liability claims under the CGL.

The CGL form has deployed a number of slightly different formulations of the term "completed operations" during various iterations of the CGL. As noted above, the original CGL form provided coverage for "products hazard," which as defined in the policy not only covered product-caused injury but also injury caused by what we now term completed operations. In this very first definition of the type of liability claims that would be classified as a products/completed operations claim, the 1943 CGL Form made it clear that a claim was a "products hazard" claim as opposed to a general liability claim only if "*the accident* occurs

74. *See, e.g.*, MEHR & CAMMACK, *supra* note 21, at 353.

HeinOnline -- 12 Conn. Ins. L.J. 385 2005-2006

after such operations have been completed" (emphasis added). Thus, where the accident takes place prior to the cessation of construction or other operations, any claim resulting from this accident (or "occurrence" in today's parlance) is classified as a general liability claim.

The 1947 CGL Form contained the same "products hazard" definition that classified completed operations as a products hazard. The 1955 Form retained this basic definition but excepted vehicles used by the insured from the definition. The 1955 Form continued to treat the time of the accident causing injury and the time of the cessation of project construction as the key junctures of classification. If an accident took place before completion of the operation, it was a general liability matter. If the accident took place after completion, it was a products hazard matter. The 1966 Form separated the products hazard and completed operations coverages, defining the "completed operations hazard" as:

> [including] bodily injury and property damage arising out of operations or reliance upon a representation or warrant made at any time with respect thereto, but only if the bodily injury or property damage occurs after such operations have been completed or abandoned and occurs away from the premises owned by or rented to the named insured. "Operations" includes materials, parts, or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:
> (1) when all operations to be performed by or on behalf of the named insured under the contract have been completed.
> (2) when all operations to be performed by or on behalf of the named insured at the site of the operations have been completed, or
> (3) when the portion of the work out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.
> Operations which may require further service or maintenance work or correction, repair or replacement because of any defect or deficiency, but which are otherwise complete, shall be deemed completed.

The 1966 Form continued the longstanding exception to this classification for abandoned materials (the "abandoned materials"

HeinOnline -- 12 Conn. Ins. L.J. 386 2005-2006

exception to the definition of products/completed operations is discussed *infra*).

The 1966 Form was not intended to alter the long-standing notion that injury arising from construction activity was general liability injury while injury arising from the finished construction itself was loss from a completed operations hazard. The significance of the 1966 changes was in: (a) clarifying that the applicability of the products/completed operations hazard turned on when the bodily injury first occurred rather than when the antecedent negligence took place; (b) separating "products" coverage from "completed operations" coverage; and (c) clarifying that pure services could be the subject of completed operations liability, with warranty or misrepresentation claims included as well. These changes were carried through in the 1973 CGL Form. As previously discussed, there were also editorial changes to the 1973 Form concerning the placement of the "during the policy period" language. These changes did not alter the basic understanding of this language.[75]

The concept of what constitutes a "completed operation" and the verbiage used to describe and define it has been generally consistent throughout the history of the CGL policy. The CGL policy language itself states the perhaps self-evident proposition that when a policyholder has finished a building or project and moved on to other activities, the building or project then becomes a "completed operation" much like a product that has been placed in the stream of commerce. For injuries that begin after that time, the aggregate limits of the CGL policy applicable to products or completed operations claims set forth the insurer's maximum liability for third-party claims that arise because of failings of the building or project that cause injury. By contrast, injuries that begin during operations are properly classified as general liability injuries. Case law concerning the products/completed operations characterization reflects this common sense approach to the language of the CGL policy.[76]

---

75. *See supra* text and accompanying notes 39-56 (noting insurance industry comments to this effect).

76. *See, e.g.*, Southern Guaranty Ins. Co. v. Zantop International Airlines, Inc., 767 F.2d 795 (11th Cir. 1985) (applying Florida law) (where airplane hanger is built during 1979-80, finished in 1980, then collapses causing property damage during 1982; claims against builder-policyholder considered completed operations claims); Frontier Insulation Contractors, Inc. v. Merchants Mut. Ins. Co., 690 N.E.2d 866 (N.Y. 1997) (liability claims arising out of installation of asbestos are not completed operations claims; insurers must defend claims); Aetna Ins. Co. v. Lythgoe, 618 P.2d 1057 (Wyo. 1980) (where operations incomplete at time injury began, claim one of general liability rather than completed operations); Commercial Union Ins. Co. v. Porter Hayden Co., 698 A.2d 1167, 1209 (Md. Ct. Spec. App. 1997) (liability claims "concern[ing] exposure and injury occurring during

HeinOnline -- 12 Conn. Ins. L.J. 387 2005-2006

Authoritative insurance texts used for decades in teaching insurance principles and operations also suggest that the "completed operations" hazard (or exclusion) was intended to apply only where the injury at issue resulted from the thing constructed rather than from ongoing construction.

> **Completed operations insurance**. This type of policy covers claims from *injuries arising after a service is rendered* and the property's control is returned to the owner. This coverage would help Leaky Louis, the plumber, whose negligence caused a water heater to explode.[77]
>
> The completed operations exposure is similar to the products exposure and consists of the possibility of liability **arising out of work that has been performed**. Such work is, in a sense, the product of the firm, and any damage arising out of it may result in liability if it is defective. The legal liability arising out of products or out of work performed is covered under a form of insurance called *products and completed operations* coverage.[78]
>
> [Under completed operations coverage] the damage must occur after the contractor has completed the work and the work has been accepted by the owner or abandoned by the contractor. Examples of completed operations liability include the following cases. A contractor was held liable for extensive property damage when a rubber hose connection broke in an air-conditioning system several months after the installation and admitted many gallons of water into the attic of a building. In another case, a contractor was involved in litigation 17 years after he repaired an iron railing; it was alleged that faulty repair work caused injury to a person leaning on the railing. An electrical contractor paid $12,000

---

the [construction] operation, such as the emission of asbestos dust during the installation process", are general liability claims rather than completed operations claims); Rhinebeck Bicycle Shop, Inc. v. Sterling Ins. Co., 546 N.Y.S.2d 499 (N.Y. App. Div. 1989) (where policyholder's customer claimed injury from negligent bike assembly but injury took place after purchase and away from shop, the claim was one arising from completed operations rather than general liability).

77. *See* DORFMAN, *supra* note 21, at 397 (boldface in original; italics added).

78. EMMETT J. VAUGHAN & THERESE VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 613 (8th ed. 1999) (italics in original; boldface added). *See also id.* at 674 (defining "completed operations" in glossary as "a commercial liability insurance coverage applicable to liability arising out of work performed by the insured after such work has been finished.").

HeinOnline -- 12 Conn. Ins. L.J. 388 2005-2006

> for the death of a three-year-old child electrocuted by an improperly installed outlet on which the work had been completed 15 months prior to the accident.[79]

These insurance textbooks reflect the clear general understanding of the term "completed operations" held by policyholders, risk managers, brokers, agents, and insurers over the decades. Insurance law treatises reflect a similar understanding. As described by one authority,

> The "completed operations hazard" provision limits an insurer's liability for bodily injury or property damage to losses that occur away from the insured's premises ***and that arise*** from the insured's operations ***after*** those operations have been completed.[80]

Regarding the temporal determination of when ordinary operations (potentially leading to general liability claims) become "completed," Professor Roger Henderson's 1971 article, which is perhaps *the* authoritative assessment regarding the classification of claims as general liability or products/completed operations matters, observed that "[w]here an insured begins an operation and the evidence shows that it is still in progress . . . the answer is self-evident"—liability arising from such a scenario was general operations liability and not completed operations liability.[81] In a more recent assessment making specific reference to Professor Henderson's important article, a prominent attorney representing insurers echoed this analysis.

> Given these seemingly clear [CGL] provisions [regarding competed operations] it should not be surprising that despite efforts by some parties (mostly insurers) to argue for a very broad interpretation of the completed operations hazard, "commentators are in complete agreement that this

---

79. *See* TRIESCHMANN & GUSTAVSON, *supra* note 22, at 156-57 (footnotes omitted). *Accord*, JAMES L. ATHEARN, S. TRAVIS PRITCHETT & JOAN T. SCHMIT, RISK AND INSURANCE 510 (6th ed. 1989) (with completed operations, "the liability arises from the unsatisfactory outcome of the work, not from the actual performance of the work, as with operations liability").

80. *See* OSTRAGER & NEWMAN, *supra* note 20, § 7.02[b][1] at 331 (emphasis added) (citing Southern Guaranty Ins. Co. v. Zantop Int'l Airlines, Inc., 767 F.2d 795, 799 (11th Cir. 1985) (applying Florida law) and Frontier Insulation Contractors, Inc., 690 N.E.2d 866, 869-70 (N.Y. 1997).

81. *See* Henderson, *supra*, note 73, at 434-37

HeinOnline -- 12 Conn. Ins. L.J. 389 2005-2006

> [coverage] refers to ***accidents*** caused by defective workmanship which ***arise after*** completion of work by the insured on construction or services contracts."[82]

This view of the appropriate dividing line separating products/completed operations claims from general liability claims according to the source of the liability-causing event appears to have been shared by ISO personnel as well.

> Products are made to be used in the premises or operations of others . . . . Thus, for every *product or completed operations exposure* of the supplier, there is a corresponding *premises or operations exposure* for the user.[83]

This comports with an example of a general premise-operations liability claim used in an ISO general liability policy training manual:

> Would the following situation be included in the definition [of products-completed operations hazard]?
> The Shadrock Vaccum Cleaning Company sells its vacuum cleaners by door-to-door sales. While a Shadrock salesperson is demonstrating a vacuum in the home of a prospective customer, the vacuum shreds the carpet. Evidence shows the vacuum was incorrectly assembled when manufactured. (Yes/No)

---

82. *See* Theodore A. Howard, *Products/Completed Operations Coverage 1997: Still Learning Professor Henderson's Lessons 25 Years Later*, COVERAGE, Vol. 7, at 33, 38, n. 17 (Dec. 1997) (quoting CPS Chemical Co. v. Continental Ins. Co., 199 N.J. Super 558, 489 A.2d 1265, 1270 (Law Div. 1984) (reversed on other grounds, 495 A.2d 886 (N.J. Super. App. Div. 1985) (emphasis added) and citing other cases rejecting insurer efforts to classify liability claims arising from disposal of hazardous wastes as completed operations matters). *Accord*, Mitchell F. Dolin & Eric G. Lasker, *The New Frontier: Non-Products Coverage For Asbestos Claims*, MEALEY'S LAW REPORTS: INSURANCE, Vol. 12, Issue 16 (1998) (insurers read CGL policy incorrectly when erroneously arguing that "products hazard is coextensive with the common law doctrine of products liability.").

83. *See* Howard J. Walker, Jr., Memorandum of Law Addressing the Issue of Limiting the Availability of ISO's "Claims-Made" Policy to Specific Classes of Insureds, Insurance Services Office, Inc. at 5. *Accord,* Testimony of M. Walters at 46:10-12 ("But I would suggest to you for every product liability exposure you have a corresponding premises operation exposure . . . .") (Ms. Walters, a Senior Vice President of ISO, was representing ISO at a hearing regarding approval of a new claims-made general liability policy).

HeinOnline -- 12 Conn. Ins. L.J. 390 2005-2006

> [Answer] No. Because the product was still in the insured's physical possession.[84]

These ISO training and explanatory materials also point to the initial exposure to the injury-causing conditions as the basis on which to decide whether a claim is a general premises-operations liability claim or a completed operations hazard claim. An ISO general liability policy workbook explains that the completed operations hazard "definition clarifies when an exposure changes from operations in progress to completed operations." The training manual defines "Completed Operations Insurance" as being for "accidents" that happen after a contractor finishes a project.

> **Completed Operations Insurance.** A form of insurance issued particularly to various types of contractors. It covers a contractor's liability for accidents arising out of jobs or operations that he has completed.[85]

C. THE ABANDONED MATERIALS EXCEPTION TO THE COMPLETED OPERATIONS DEFINITION FURTHER EXPANDS INSURER COVERAGE RESPONSIBILITY FOR ASBESTOS CLAIMS

Even if insurers attempting to classify construction and installation-related asbestos liability as products/completed operations coverage in order to obtain the protection of the aggregate sublimit for such claims were correct in their view that the ability of asbestos to generate continuing triggering injury converts on-the-job asbestos exposure to completed

---

84. *See* INSURANCE SERVICES OFFICE, GENERAL LIABILITY COVERAGE '86 27 (1985). This assessment is also reflected in the internal proprietary claims materials of individual insurers. For example, one manual subject to a confidentiality order reviewed in connection with litigation states that a liability claim should be classed as a products hazard claim if it is caused "as a result of 'the claimant's exposure to the insured's product' (not as a result of exposure to a product handled by the policyholder)." Further, according to the insurer, a claim should be classified as a completed operations hazard claim where the claimant's alleged injurious "exposure [was] received as a result of some work that the insured performed, but *only if the exposure occurs after the project is completed.*" *See* [insurer identity withheld], Products/Non-Products Definitions and Examples, Nov. 17, 2000 (emphasis added). This document further provided an example in which "[t]he insured, PQR Corporation, improperly repairs a chemical tank on the premises of STU Corporation. *A few days after PQR finishes their work*, an employee of STU suffers chemical burns when the tank leaks. He sues PQR. This is a completed operations claim." *See id.* (emphasis added).

85. *See* INSURANCE SERVICES OFFICE, *supra* note 84, at 106 (boldface in original).

HeinOnline -- 12 Conn. Ins. L.J. 391 2005-2006

operations asbestos exposure, there is an exception to the CGL policy definition of completed operations hazard which provides that liability stemming from abandoned materials will not be considered a completed operations risk. Specifically, the standard CGL policy language states that the completed operations hazard "(b) [d]oes not include 'bodily injury' or 'property damage' arising out of . . . (1) the existence of tools, uninstalled equipment or **abandoned or unused materials** . . . ."[86]

Many the third-party claims in the asbestos mass tort allege that these third parties inhaled asbestos fibers as a result of insulation contracting or other construction activities conducted by policyholders. In fact, these types of claims formed the genesis of the asbestos mass tort in the late 1960s and 1970s.[87] These policyholder activities caused the creation of asbestos dust at these sites due to cutting and fitting of asbestos. This material is "abandoned material" within the meaning of the CGL policy since it was not intended for use by the policyholder, its customers, or others. Thus, liability from insulation contracting debris or collaterally released asbestos logically must be classified as general premises-operations liability rather than products/completed operations hazard liability.[88]

ISO training materials also suggest that materials that were not used in the final construction product, but are the source of injury to a claimant, are not within the scope of the completed operations hazard. An ISO general liability workbook states that, based on "what is excluded from the definition of 'products/completed operations hazards,'" the following hypothetical presents a situation that would not be subject to the completed operations hazard: "During construction of the hotels for National Inns,

---

86. INSURANCE SERVICES OFFICE, INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 07 98 (1997) (emphasis added).

87. *See* Borel v. Fibreboard Products Corp., 493 F.2d 1076 (5th Cir. 1974) (applying Texas law) (permitting strict products liability cause of action against asbestos maker and rejecting assumption of risk defense); BRODEUR, *supra* note 63, at 6-12, 39-70 (discussing *Borel v. Fibreboard* trial).

88. *See also* Bean, *supra* note 39, at 5. Liberty Mutual's Bean, one of the drafters of the 1966 CGL Form, appeared to regard the debris or waste created by policyholder operations as a general premises-operations liability matter and not a completed operations matter even though these consequences of operations "may create a substantial gradual injury"; collateral creation of dust as byproduct of manufacturing used as example); Gilbert L. Bean, Summary of Broadened Coverage Under New GL Policies, With Necessary Limitations to Make This Broadening Possible at p. 1, attached to Memorandum from E.W. Getschell to Underwriting Managers re New Liability Policies (July 18, 1966) (CGL policy covers gradual bodily injury resulting from dust created by construction operations).

HeinOnline -- 12 Conn. Ins. L.J. 392 2005-2006

Caleb Construction Company piles a supply of lumber at one of the sites. A guest is injured on a rusty nail while rummaging through the pile."[89]

D. Differing Views of the General Operations/Completed Operations Divide

As the foregoing analysis demonstrates, the background, structure, language, and historical understanding of the dividing line between general operations and products/completed operations coverage matters suggests that many asbestos claims are best classified as tort claims stemming from ongoing operations for which there were no aggregate limits in most liability policies issued to asbestos defendants. This is another factor tending to increase insurer coverage responsibilities for the asbestos mass tort and has had, at the margin, an expansive effect on the insurance industry's coverage obligations related to asbestos.

But the flip side of this coin is that insurers have had some significant success in convincing some courts or arbitrators that continuous asbestos injury that began during regular ongoing operations by the policyholder (and therefore was not subject to an aggregate limit) converts into completed operations or product hazard liability where there is some triggering injury that post-dates the initial operations that begat the claim, thereby bringing the products/completed operations aggregate into play and limiting the insurer's asbestos coverage responsibility.

The judicial and arbitral track record in this area remains mixed and continues to be hotly disputed because of the ongoing presence of asbestos coverage disputes related to insulation, installation, and construction activities by asbestos policyholders who continue to face claims from third parties. Although this part of the asbestos mass tort has moved into the recesses of public consciousness, it remains an area with hundreds of millions or even billions of dollars yet at stake as such coverage disputes continue to move through the judicial system or alternative forums such as arbitration.[90]

---

89. *See* INSURANCE SERVICES OFFICE, *supra* note 84, at 28.

90. A fair number of such disputes are subject to the 1984 "Wellington Agreement" (so named for former Yale Law School Dean Harry Wellington, who helped broker it), in which major asbestos producers and their liability insurers agreed to certain ground rules for resolving their coverage disputes, including and arbitration mechanism subject to limited judicial review for purposes of resolving particular controversies.

HeinOnline -- 12 Conn. Ins. L.J. 393 2005-2006

A significant victory for insurers was *In Re Wallace & Gale Co.*[91] In *Wallace & Gale*, the court adopted the view that general liability claims change into completed operations claims where there is continuing injury post-dating completion of the installation.[92] *Wallace & Gale* was an important victory for insurers, a precedent issued by a federal appeals court after heavy litigation. But *Wallace & Gale*, and the entire notion that what clearly begin as general operations claims transform into completed operations claims merely because there is continuing injury, seems clearly incorrect in light of the history, intent, structure, and operation of the CGL.[93]

In addition, the *Wallace & Gale* decision did not consider the "abandoned materials" exception to the definition of the completed operations hazard on the ground that the issue had not been raised at trial and was therefore waived on appeal.[94] Although this may be correct as a matter of the court's procedural law, it casts a considerable shadow on the persuasiveness of the *Wallace & Gale* decision. Wallace & Gale was a contractor that installed asbestos-containing insulation.[95] As part of the process, asbestos fibers were undoubtedly released due to the cutting, sawing, fitting, handling, and discarding of unused insulation. In short, Wallace & Gale, the defendant policyholder, was subject to suit and liability in large part because of the abandoned materials it left at its job sites, a common practice in the days before the dangers of asbestos were fully appreciated. To the extent that asbestos plaintiffs were exposed to asbestos from this type of source, it would seem to fall squarely within the abandoned materials exception to any completed operations limits on coverage and hence be regarded as a general operations claim to which the policies of the day usually contained no aggregate limit.[96] Consequently, the precedential value of the *Wallace & Gale* decision is significantly limited as applied to asbestos contractor defendants and policyholders.

---

91. *See* 385 F.3d 820 (4th Cir. 2004) (applying Maryland law). *See also* 275 B.R. 223 (D. Md. 2002), *vacated in part*, 284 B.R. 557 (D. Md. 2002).

92. *See* 385 F.3d at 833-34.

93. *Wallace & Gale* also is arguably inconsistent with Maryland law. *See* Commercial Union Ins. Co. v. Porter Hayden Co., 698 A.2d 1167 (Md. Ct. Spec. App. 1997).

94. *See* 385 F.3d at 835.

95. *See* 385 F.3d at 823-24. Although Wallace & Gale stopped using asbestos in the 1970s, it nonetheless became a sufficient target of asbestos claims that it filed for bankruptcy in 1984.

96. *See supra* text and accompanying notes at 87-89 (analyzing the abandoned materials exception to the completed operations definition).

HeinOnline -- 12 Conn. Ins. L.J. 394 2005-2006

In counterbalance to *Wallace & Gale*, policyholders can point to *Frontier Insulations Contractors, Inc. v. Merchants Mutual Ins. Co.*[97] as substantial support for the policyholders' view that asbestos injuries resulting from the general business operations of the policyholder remain general operations claims for purposes of determining insurer coverage responsibilities, thus avoiding exclusions or aggregate limits for products or completed operations liability. In *Frontier Insulation Contractors*, the New York Court of Appeals unanimously reversed an Appellate Division decision in which the majority had erroneously regarded the claims against the policyholder as products/completed operations hazard claims merely because the underlying tort claim involved a dangerous product (asbestos). The Appellate Division majority had failed to appreciate that the category of "products hazard" claims under a CGL policy is only a "subset of product liability claims" found in the tort system.[98] The Appellate Division majority had also failed to appreciate that the classification of a claim as a general premises-operations liability matter or a products/completed operations hazard matter "depends on the location of the accident and possession of the product" rather than whether the underlying tort claim is based on strict liability or involves a dangerous product."[99] Observed the *Frontier Insulations* Court:

> Defendants have failed to establish that all of the underlying bodily injury claims satisfy the time and place prerequisites of the product-hazards exclusion. The exclusions, **by definition, cannot apply to accidents or occurrences that allegedly took place while Frontier's installation work was in progress because the offending product – the asbestos insulation – was not relinquished from Frontier's control until installation was complete.** In fact, a number of the plaintiffs in the underlying lawsuits expressly allege that Frontier's "negligent installation" of the asbestos insulation caused their personal injuries. More importantly, none of the underlying complaints specify that the plaintiffs' personal injuries occurred **only** *after* Frontier had completed installation and departed from the covered premises. **Since asbestos fibers may be readily released into the air and inhaled while a contractor is cutting and**

97. 690 N.E.2d 866 (N.Y. 1997).
98. *See Frontier Insulations Contractors*, 690 N.E.2d at 869.
99. *See* Henderson, *supra* note 72, at 420.

> **sawing the product during installation, there is a reasonable possibility that any liability attributed to Frontier would stem from injuries that occurred during ongoing operations** – covered events [under its general liability coverage]. Accordingly, [the insurers] have failed to establish as a matter of law that the product-hazards exclusions provide shelter from their duty to defend Frontier.[100]

Although *Frontier Insulations* was a "duty to defend" case rather than an indemnity payment case, its rationale provides a persuasive assessment regarding the divide between a policyholder's general operations hazard and the product/completed operations hazard. *Frontier Insulations* reflects a sounder analysis and better reflects the longstanding judicial and insurance industry approach to the products/completed operations hazard than does *Wallace & Gale.*

Where a third party's claimed injury results from ongoing operations and begins prior to completion of construction, the claim should be treated as one of general liability rather than completed operations liability.

It appears that arbitration results regarding the issue are similarly mixed (although many arbitration awards remain confidential, which makes it difficult to assemble a policyholder-insurer scorecard). For example, in *ACandS, Inc. v. Travelers Casualty & Surety Co.*,[101] a split panel of three distinguished arbitrators sided with the insurer's effort to classify ongoing claims arising out of the policyholder's asbestos insulation activity as subject to the aggregate limit for completed operations. The arbitration, conducted between parties to the 1985 Wellington Agreement between major asbestos defendants and insurers, provides a startling example of how even distinguished jurists can completely misjudge an insurance coverage question.

In addition to the Wellington Agreement, ACandS and Aetna Casualty and Surety Co (subsequently acquired by Travelers) had agreed in August 1988 to a presumptive allocation of claims and payments in which fifty-five percent of the amounts would be treated as products/completed operations coverage (which was subject to aggregate limits in the relevant policies) and forty-five percent as general operations coverage, which was not subject to an aggregate limit. As time went by, ACandS questioned this

---

100. *See Frontier Insulations Contractors*, 690 N.E.2d at 870 (citations omitted) (italics emphasis in original; boldface emphasis added).

101. *See* In the Matter of the Arbitration Between ACandS, Inc. v. Travelers Casualty and Surety Company (CPR Institute for Dispute Resolution, July 29, 2003).

HeinOnline -- 12 Conn. Ins. L.J. 396 2005-2006

apportionment contending that much more of its asbestos liability stemmed from general operations such as construction and insulation installation.[102] ACandS was also undoubtedly hoping to maximize its insurance coverage by having more of its liability outside the aggregate limits restricting products/completed operations coverage. Travelers was just as eager to have more of the policyholder's liability classified as subject to the aggregate limits. In particular, the parties disputed classification of claims for the 1976-1979 policy years.

In addition to the dispute over claims classification, the parties had major differences over the scope of the arbitration, commenced by ACandS, and the relief the arbitrators could provide. ACandS took the position that since it had brought the arbitration and Travelers had not petitioned for relief from the 1988 Agreement, the arbitrators could either grant the ACandS request or leave the 1988 percentages intact. Travelers argued that the panel could make a downward adjustment in the general operations allocation as well. In addition, ACandS filed for bankruptcy in September 2002 while the arbitration was proceeding but nearly a year prior to the panel's award. ACandS argued that the automatic stay of claims against the debtor provided by the Bankruptcy Code prevented any adjustment of the 1988 percentages in favor of Travelers on the ground that this would be unauthorized relief against the debtor. Both the panel majority and a federal district court disagreed.[103] However, the Third Circuit found the bankruptcy stay to bar an alteration of the apportionment in favor of Travelers.[104] Thus, the dispute remains unresolved in spite of the arbitration panel's ruling.

Although ACandS may have been granted a reprieve on procedural grounds, the arbitration itself was a complete victory for Travelers on the question of claim classification, one the District Court was unwilling to overturn under any of the grounds provided by the Federal Arbitration Act.[105] The "all-star" arbitration panel was comprised of former Eighth

---

102. ACandS stands for Asbestos Construction and Supply, a name that itself strongly suggests that at least some significant amount of its asbestos liability stemmed from ongoing construction/insulation activities and not manufacture, sale, or distribution. Nonetheless, the panel majority did not bother to use even this common sense check on its ruling that not a single dollar of 1976-79 claims could be classified as general operations liability.

103. *See* Arbitration; AcandS, Inc v. Travelers Casualty & Surety Co., 2004 U.S. Dist. LEXIS 27714 (E.D.Pa. Sept. 16, 2004).

104. *See* AcandS, Inv. v. Travelers Casualty & Surety Co., 435 F.3d 252 (3d Cir. 2006).

105. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, originally enacted in 1926, provides only limited grounds for vacating or modifying an arbitration award. *See* 9 U.S.C. § 11. In essence, an award can be changed only in cases of clear clerical error or set aside

HeinOnline -- 12 Conn. Ins. L.J. 397 2005-2006

Circuit Judge and FBI Director William Webster (appointed by Travelers), University of Pennsylvania Law Professor Stephen Burbank (appointed by ACandS), and former Third Circuit Judge John Gibbons (selected by Webster and Burbank as the "umpire" of the arbitration panel). In a 2-1 decision, Judges Gibbons and Webster ruled for Travelers, holding that the percent of general operations liability for the 1976-79 period was zero.

Although Judges Gibbons and Webster are highly regarded, the majority opinion in the AcandS arbitration is riddled with error and misconceptions about the nature of liability insurance. After quoting the standard CGL language, the panel majority states that the "insuring agreement unambiguously requires an occurrence within the policy period" if there is to be coverage.[106] This statement, of course, is dead wrong—the type of error that would result in a low or even failing grade for a student in an insurance or insurance law course. As discussed at length above, the triggering event for purposes of CGL coverage is injury or damage—not the occurrence ultimately leading to the injury or damage.[107]

This misconception of the panel majority created a chain reaction of incorrect analysis of the classification issue. Because the majority thought that there was general premises/operations coverage only if there was a covered occurrence taking place during the policy period, it incorrectly reasoned that there could be no general operations liability in the 1976-79 period because ACandS had "ceased using asbestos in its operations prior to those years."[108] With the certainty of a comic opera character, the majority further stated that the "unambiguous language of the policy requires an occurrence in the policy year"[109] and that "[i]f ACandS were using asbestos in its operations in those years there would be operations coverage without aggregation. But it is undisputed that there were no

---

only where the arbitrators are biased, exceed their authority or demonstrate manifest disregard for controlling law. In practice, reviewing courts are unlikely to find any of these grounds met except in egregious situations. As discussed *supra* text and accompanying notes at 90-98, the ACandS arbitration panel majority's misconceptions about the operation of insurance was clearly at odds with Pennsylvania law (and insurance law and principles everywhere). Normally, however, the "manifest disregard of law" basis for vacating an award is invoked only when the tribunal is made award of controlling precedent "on all fours" with the case and nonetheless refuses to follow the controlling precedent. Deficient legal reasoning alone is not grounds for vacating an award. *See* Jeffrey W. Stempel, *A Better Approach to Arbitrability*, 65 TULANE L. REV. 1377, 1382 (1991).

106. *See* Arbitration Award at 7.

107. *See supra* Part III.

108. Arbitration Award at 7.

109. Arbitration Award at 8.

HeinOnline -- 12 Conn. Ins. L.J. 398 2005-2006

ACandS asbestos operations in those years. Thus, there could not be an asbestos operations occurrence during those years."[110]

With this misstep and its insistence that there be active policyholder negligence or other liability-creating behavior during the policy period, the panel majority avoided undertaking any analysis of the history and purpose of CGL general operations coverage and the insurance industry's understanding that the source of an injury—"the hazard"—was generally the key to determining whether the injury and resulting claim should be classified as a part of a general operations hazard or a products or completed operations hazard.

The panel majority's assessment is particularly odd because it took the view that there must be an "occurrence" in order for coverage only with regard to general operations coverage. But the panel found that after general operations were finished, an injury taking place "qualif[ied] as an **occurrence** if there is physical manifestation in the policy year"[111] making this sort of covered matter a completed operations hazard subject to the policy's aggregate limit. At this point in the opinion, the majority's thought process crossed from the merely erroneous to the truly bizarre. There is simply no basis—in the CGL policy language; in its history; in its purpose; in custom and practice; in logic; or in equity—for suggesting that general operations coverage requires a liability-creating activity during the policy period but that products/completed operations liability requires only an injury.

In effect, the majority is creating from thin air two different triggers for operations and completed operations: a negligence trigger for operations and an injury trigger for products and completed operations. This dichotomy has no basis in law, fact, history, or insurance theory and in fact is squarely contradicted by these factors. In addition, when the majority was willing to use an injury trigger (for at least the completed operations claims), it chose an operational definition of the injury trigger that has been rejected by nearly all courts, most importantly, perhaps, the courts of Pennsylvania, the state of controlling law for the dispute.

Recall that the panel majority found injury only if there "is physical manifestation" of the injury during the policy year.[112] This, in essence, is an adoption by the panel of the "manifestation" trigger of coverage, which competed with the "exposure" trigger, the injury-in-fact or actual injury

110. Arbitration Award at 8.
111. Arbitration Award at 9 (boldface in original).
112. Arbitration Award at 9.

HeinOnline -- 12 Conn. Ins. L.J. 399 2005-2006

trigger, and the continuous trigger.[113] As discussed above, the continuous trigger has been the clear winner in this marketplace of adjudicatory ideas, having been embraced by the majority of states.[114] As also noted above, the nature of asbestos-related injury makes the actual injury trigger in essence function as a continuous trigger because of the continuing ability of asbestos fibers in the lungs to inflict new injury over the years.[115] Even under the exposure trigger, most famously embraced in *Insurance Co. of North America v. Forty-Eight Insulations*,[116] a close analysis of the case reveals that the court in that case was really requiring that there be "injurious exposure" to trigger coverage.[117] When the layers of the case law onion are peeled sufficiently, the history of asbestos trigger litigation reveals only a few cases embracing a "manifestation" trigger, with some of those in essence overruled by subsequent cases rejecting manifestation as a trigger. Relatedly, it is important to emphasize that courts adopting an actual injury trigger have not required the injury to be palpable, visible, apparent, or otherwise manifest. For example, in one famous trigger case (albeit one involving prescription drugs rather than asbestos), the Second Circuit modified an otherwise well-reasoned district court opinion that required that the injury in question be medically diagnosable in order to be

---

113. *See* STEMPEL, *supra* note 6, at 14-42 to 14-44. The continuous trigger is also referred to as the "triple-trigger" in that for courts adopting this trigger, either exposure or injury or manifestation of injury acts to activate an occurrence CGL policy on the risk at the time of any of these events. Some courts have also used a "double trigger" in which either exposure or manifestation are regarded as activating the policy. *See, e.g.*, Zurich Ins. Co. v. Raymark Indus., 514 N.E. 150, 160-61 (Ill. 1987).

114. *See supra* Part III.

115. *See supra* Part III.

116. 633 F.2d 1212 (6th Cir. 1980) (applying Illinois and New Jersey law), *cert. denied,* 454 U.S. 1109 (1981).

117. *See* STEMPEL, *supra* note 6, § 14.09[b], at 14-48:

> Despite the different verbiage, all of the approaches to bodily injury trigger when viewed in the light of the facts of the cases themselves can be seen as application of an actual injury trigger. But for many, probably most, of the claims, there was injury alleged or taking place from the initial exposure on to the time of manifestation. Consequently, the various triggers can be harmonized on their facts. For the most part, the trigger standard in the United States is an actual injury trigger, which is consistent with policy language, the purpose of the insurance, and the expectations of the policyholder.

This observation is particularly true for asbestos, because of the peculiarly perpetual injurious traits of the material.

HeinOnline -- 12 Conn. Ins. L.J. 400 2005-2006

a sufficient triggering "injury."[118] Like the Second Circuit, most courts applying an injury trigger have found it sufficient that asbestos was causing injury even though the ability to detect that injury was years away. This was also the understanding of those involved in the development of the 1966 CGL Form. As a result, of course, the actual injury trigger tends to become a continuous trigger for asbestos matters.

This portion of the *ACandS-Travelers* panel majority opinion is a bit like the 13th chime of the clock, calling into question the soundness of the clock and the accuracy of any of its time readings. First, the majority adopts two different triggers for different types of claims and then it uses an injury trigger that has essentially been relegated to the dustbin of litigation history. It is as if an astronomy department at a university evaluated a tenure candidacy on the basis of Tyco Brach (who thought the sun revolved around the earth) rather than Copernicus. More important, perhaps, Pennsylvania, the state of applicable law, is clearly on record as embracing an actual injury/continuous trigger in asbestos coverage cases—and not a manifestation trigger.[119]

The majority opinion contains other substantial errors of assumption and analysis as well. First, it finds that the "insured has the burden of putting itself within the [general operations] coverage."[120] Although it is true that the policyholder generally has a burden to show that it has suffered a covered loss, this burden was already satisfied almost as a matter of stipulation by the parties or concession by Travelers. Recall that ACandS and Travelers had an agreement as to presumptive coverage and even as to presumptive allocation, building in an ADR agreement to permit changes to the allocation percentages if a dispute as to those percentages should arise. Travelers had in effect agreed, as any reasonable insurer in the late 20th Century must, that asbestos claims against the policyholder are torts covered under the CGL policy. It was conceded that ACandS, which has been the target of asbestos litigation for more than a quarter-century, clearly had been sued for asbestos liability and that the Aetna/Travelers policies provided coverage for that liability. Without doubt, then, ACandS had established a prima facie case of coverage and satisfied the basic "burden" of the policyholder to bring a liability claim within presumptive coverage.

In response to this prima facie case of coverage, Travelers was essentially arguing that the coverage was restricted or capped because of

118. *See* American Home Prods. v. Liberty Mut. Ins. Co., 748 F.2d 760 (2d Cir. 1984) (applying New York law), *modifying* 565 F. Supp. 1485 (S.D.N.Y. 1983).

119. *See* J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502 (Pa. 1993).

120. *See* Arbitration Award at 8.

HeinOnline -- 12 Conn. Ins. L.J. 401 2005-2006

the policies' aggregate limit for products/completed operations claims. In essence, Travelers was arguing that although ACandS had established coverage, the nature of the liability claim should result in a reduction in coverage because the type of claim for which there was admitted coverage was subject to a particular limitation for such claims. This argument is in the nature of invoking an exclusion in the policy to avoid coverage. As such, it is actually the burden of Travelers to demonstrate that any limitation on coverage applies, just as it would be the burden of Travelers to establish the applicability of an exclusion.[121]

The panel majority relied substantially on the district court's opinion in *Wallace & Gale*, finding that it was "[t]he only judicial opinion that has considered the question whether occurrences 'after such operations have been completed or abandoned' are treated as Products or Non-Products [general operations] claims . . ."[122] Throwing aside the majority's continued error in focusing on the time of occurrence rather than the time of bodily injury, the statement suggests further problems with the majority opinion. As discussed above, the *Frontier Insulations* decision of the New York Court of Appeals is at least as relevant to the question as is *Wallace & Gale*.[123] Yet the panel majority recognizes and defers to *Wallace & Gale* while ignoring *Frontier Insulations*.

The majority also appeared to have turned the venerable ambiguity doctrine on its head. ACandS expert witness Richard Stewart, a former New York Superintendent of Insurance and widely recognized authority, was regarded by the majority as "conced[ing] that the construction of the policy we adopt is certainly plausible."[124] Therefore, reasoned the

---

121. *See supra* text and accompanying notes 20-34, (describing respective burdens of persuasion of policyholder and insurer in coverage litigation).

122. *See* Arbitration Award at 9.

123. *See supra* text and accompanying notes 90-99, (discussing *Wallace & Gale* and *Frontier Insulations* opinions).

124. *See* Arbitration Award at 13. Although Stewart's willingness to consider the insurer's linguistic argument about the meaning of the completed operations definition in the CGL is admirable in its non-partisanship, I find it too charitable to Travelers and other insurers attempting to classify any post-completion injury as completed operations injury. Although the insurer argument is not quite frivolous if one focuses only on the definitional language in isolation, it is a stained textual argument based on hyperliteralism. More important, the argument is clearly incorrect when one considers the background and purpose of the CGL policy, historical insurer understanding and practice, and the context and source of the asbestos liability claims. Consequently, my view is that the Travelers argument is not even "plausible." Much of the asbestos liability of ACandS, Wallace & Gale, and other insulation contractors, arose out of its ongoing general operations. Such claims are properly classified as premises/operations claims no matter how long the asbestos for which the defendant/policyholder is responsible continues to cause injury.

HeinOnline -- 12 Conn. Ins. L.J. 402 2005-2006

majority, ACandS had failed to carry its burden to show coverage because it had failed to demonstrate that its interpretation of the policy was the only reasonable understanding of the policy. Of course, the majority stacked the deck some more with its bizarre conclusion that the language of the completed operations definition clearly made any matter of injury after completion a completed operation regardless of the source of the injury or its onset. But in essence, the majority was reversing the traditional doctrine of contra proferentem. Normally, the ambiguity doctrine requires that the drafter of the policy, normally the insurer, exclude all other reasonable interpretations of the contested policy provision. In the hands of the panel majority, however, it appeared that the nondrafter policyholder was now charged with negating all other reasonable interpretations in order to prevail.

The majority dismissed concerns about double coverage raised by Stewart (going so far as to label his argument a "straw man") by stating that the CGL dealt with the issue through its "other insurance" clause.[125] Again, the majority betrays a misunderstanding of insurance in that the other insurance clause is generally regarded as coordinating concurrent overlapping insurance coverage but not speaking to the issue of coordination of coverage responsibilities among consecutively or successively triggered liability policies.[126]

Further, the panel majority does not address the issue of whether the abandoned materials exception to the definition of completed operations might apply, even if the majority were correct in its view that any injury taking place after completion was a completed operations injury even if the source of the injury were regular, general, ongoing construction and insulation operations.[127] Unlike the Fourth Circuit's *Wallace & Gale* opinion, there is no discussion of waiver or policyholder failure to raise the

---

125. *See* Arbitration Award at 14.

126. *See* STEMPEL, *supra* note 6, § 14.10; William R. Hickman and Mary R. DeYoung, *Allocation of Environmental Clean-Up Liability Between Successive Insurers*, 17 N. KY. L. REV. 291, 305 (1990). *See also* Susan Randall, *Coordinating Liability Insurance*, 1995 WIS. L. REV. 1339 (1995) (focusing on other insurance clauses as means of coordinating overlapping concurrent coverage). To be fair to the majority, the same error was made by an even more distinguished judge, David Bazelon, who authored the famous opinion in Keene Corp. v. Ins. Co. of No. Am., 667 F.2d 1034 (D.C. Cir. 1981) (applying general legal principles), *cert. denied*, 455 U.S. 1007 (1982). But Judge Bazelon wrote more than 20 years before the ACandS panel majority, at a time when asbestos coverage litigation was in relative infancy, with the issues of consecutively triggered coverage and allocation of insurer (and perhaps policyholder) coverage responsibility was not even fully articulated. By the 21st Century, two similarly well-regarded judges should have known better.

127. *See* Arbitration Award.

issue, although it appears that ACandS did argue the applicability of general operations coverage via the abandoned materials exception. Perhaps the panel majority found it unnecessary to address the issue since the initial injuries caused by abandoned materials began prior to the policy years in question. In effect, the abandoned materials exception became another casualty of the majority's error in thinking that there could be no general operations coverage unless operations and liability-creating conduct took place in the policy period.

By contrast to the majority's error-ridden analysis, the Dissenting Statement of Professor Burbank is well-reasoned and persuasive, appreciating the background, function, and operation of the CGL policy. Professor Burbank also concluded that the panel could not change the percentage of claims classified as general operations claims in Travelers' favor,[128] a procedural point on which he was vindicated by the Third Circuit's ruling.[129] As the dissent observed:

> Travelers' interpretation requires us to lash a "hazard" under the 1976-79 policies to the concept of "bodily injury" temporally, even though – contrary to the view taken by my colleagues – there is no such temporal link required of an "occurrence," and even though a "hazard" ("a source of danger or risk") is logically prior to an "occurrence." An asbestos bodily injury claim brought against ACandS by someone who was exposed during and as a result of one of its installation contracts is an operations claim. The source of the risk is not a completed operation, and the persistence and/or progression of injury across policy years, triggering coverage in those years, does not change the source of the risk. On this view, in such a case, the relevant "bodily injury," even though occurring during the policy period, is inseparable from the "bodily injury" during the period of first exposure and thus cannot be said to occur, at least entirely, "after such operations have been completed or abandoned." ACandS's expert medical testimony, the only such testimony offered, supports this view of the asbestos disease process.
>
> . . . .

128. Arbitration Award Dissent at 1.

129. *See* ACandS, Inc. v. Travelers Cas. & Sur. Co., 435 F.3d 252, 257-58 (3d Cir. 2006) (applying federal bankruptcy law).

HeinOnline -- 12 Conn. Ins. L.J. 404 2005-2006

> [T]he analyses of the changes made in the 1966 form CGL policy by Gilbert Bean of Liberty Mutual (in documents accompanying Mr. Stewart's expert report)[Bean was one of the drafters of the 1966 CGL Form] quite clearly recognize that the change from focus on the time of the accident or occurrence to the time of the bodily injury would lead successor insurers to inherit unknown risks under premises/operations coverage. Moreover, those discussions assume that the hazard does not change.
>
> In sum, I believe that the policy language can sustain more than one reasonable interpretation, which under Pennsylvania law requires that the interpretation favoring the insured be adopted.[130]

At the risk of being accused of occupational jingoism, it seems unmistakable that in the *ACandS* arbitration, the law professor got it right, while two noted judges completely misconstrued basic matters of insurance as well as the specific issue before the tribunal.

Although the *ACandS* arbitration panel decision provides some significant comfort to insurers attempting to limit asbestos coverage, the analytical defects of the majority opinion and Professor Burbank's far more persuasive analysis in dissent may limit its precedential utility for insurers.

A different Wellington Group proceeding provided a much sounder assessment of the issue, relying significantly on expert testimony from insurance industry experts, and should prove more persuasive to future tribunals. *Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co.*[131] was a Wellington Agreement arbitration in which the Trial Judge (essentially an arbitrator despite the litigation nomenclature) expressly found that asbestos installation claims are general liability matters and are not subject to characterization as completed operations merely because injury from asbestos released during installation continues beyond the date installation ceases.

In particular, the arbitrator heard testimony regarding the derivation of the CGL and concluded that the historical view of the insurance industry was that claims are to be categorized according to the source of the injury and did not change character over time even if the injury was continuing. Of course, this did not stop the insurer in the arbitration from asserting that

---

130. Arbitration Award Dissent at 4.

131. Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co. (CPR Inst. Dispute Res.) (Phase I) (Feb. 26, 1999) (Bua, Trial Judge) at pp. 40-46.

HeinOnline -- 12 Conn. Ins. L.J. 405 2005-2006

there was such metamorphosis in asbestos claims, particularly with millions of dollars hinging on the potential application of aggregate limits. This arbitrator, also a distinguished former judge, rejected the insurer's attempt to convert general operations claims into completed operations claims in order to reduce its coverage responsibilities.

> [T]o adopt [the insurer's] construction would result in the unprecedented holding that a hazard under one policy could be reclassified to a different hazard category in subsequent policies. This would be contrary to industry practice and indeed, the entire "hazard" concept. Liberty Mutual's William Upham, for example, was *not aware of any cumulative injury claim that Liberty Mutual had ever classified as a nonproducts [general premises/operations] claim under one policy, but as a products/completed operations claim under later policies*. Testimony from other witnesses was in accord. The insurers' expert and the claims managers for Century, Reliance, the London Market Insurers, and Travelers were unaware of any claims that the insurers had ever classified as one hazard under one policy, but as another hazard under other policies. . . . According to [an insurance company claims supervisor, if a claim] "started out as an operations claim, it stayed an operations claim; if it started as products, it stayed as products. I don't have a recollection having one changing in midstream." . . .
>
> [T]he record in this cases makes it clear that in practice the insurers do not reclassify claims over time. Indeed, such reclassification runs contrary to the very concept of hazards in the insurance industry [and is] contrary to industry practice.[132]

VI. THE CGL AND CHANGES IN POLICYHOLDER IDENTITY AND OPERATIONS

A. ASSIGNMENT AND TRANSFER OF POLICY RIGHTS

The general rule of contract law is that contract rights may be freely transferrable and may be assigned. As one leading authority notes, "[i]f the

132. *See id.* ¶¶ 107, 108, at 44-45 (emphasis added; citations omitted).

HeinOnline -- 12 Conn. Ins. L.J. 406 2005-2006

rule were otherwise, our modern credit economy could not exist."[133] Delegation of contract duties is somewhat more restricted in that the duty to perform a contract cannot be delegated if this will materially increase the other contracting parties' risk of non-performance or inferior performance. Although this can be a significant restriction on personal service contracts (e.g., the multimillionaire who hires U-2 to play at her 50th birthday party will be more than a little annoyed if a tribute band should show up in lieu of Bono and the rest of the real group) or where there are pronounced differences between delegator and delegatee (e.g., company that hires Cisco Systems for its internet wiring will not be pleased to find the task delegated to an untested start-up company), it is not a significant restriction on alienability of contract rights and responsibilities. Most transfer of contract rights and obligations takes place between commercial entities that have equivalent capability to perform contractual obligations.

Insurance policies, of course, are contracts, and are subject to this general rule or free alienability—as well as the general rule that the ordinary "default" rules of contract can be specifically modified by contracting parties. Although insurers might successfully argue that the assignment of policies intrinsically increases risks in an unacceptable manner and unduly undermines the underwriting process, insurers have made such debates largely academic by routinely including in their policies provisions prohibiting assignment in the absence of the insurer's consent.[134] Policyholder assignment of the policy's protections are generally ineffective without the insurer's consent.[135]

At least this is the case where a policyholder assigns the policy and the assignee expects coverage for future property loss or liability claims that stem from the assignee's activities. In such cases, insurers can persuasively argue that they issued the original general liability policy to a particular policyholder that presented a particular risk profile and not to the second purported policyholder that presented a significantly different risk profile. An obvious example might be issuing a CGL policy to a bookstore and then finding the policy assigned to the nightclub that purchased the

133. E. ALLAN FARNSWORTH, CONTRACTS 682 (4th ed. 2004).

134. *See* STEMPEL, *supra* note 6, § 3.15.

135. *See id. See, e.g.*, National Union Fire Ins. Co. v. Care Flight Ambulance Serv., Inc., 18 F.3d 323 (5th Cir. 1994) (applying Texas law) (assignment not valid without insurer's consent where assignee seeks coverage for injury or events that took place after assignment); Christ Gospel Temple v. Liberty Mut. Ins. Co., 417 A.2d 660 (Pa. Super Ct. 1979), *cert. denied*, 449 U.S. 955 (1980) (assignment invalid and no fire coverage for church that purchased property and received insurance policy assignment from predecessor church).

HeinOnline -- 12 Conn. Ins. L.J. 407 2005-2006

property from the bookstore (even the wildest Barnes & Noble is unlikely to generate claims on a par with the volatile mixture of alcohol, violent patrons, bouncers, and youthful hormonal activity found in the average nightclub).

But where the liability-creating events predate the assignment of a liability policy and where the identity of the new policyholder played no role in the risk involved or the third party claim, courts have long permitted such assignments notwithstanding clear anti-assignment or consent-to-assignment language.[136] After a loss or injury has occurred, there is by definition no increase in the insurer's risk if the policyholder simply assigns its rights under the policy to a successor entity or another third party.

This common sense exception to the enforceability of policy language restricting assignment has significant potential impact for asbestos coverage or other long-tail torts such as pollution, prescription drugs, or insidious disease caused by toxins. If Company A manufactured, distributed, or used asbestos in its operations, there is of course more than a little chance that Company A will be sued. If Company A is sold to or acquired by Company B and Company B receives an assignment of the CGL policies of Company A, Company B will understandably want to use those rights should it be sued over asbestos as successor to Company A.[137]

Historically, this type of hypothetical would present no significant difficulty for insurers or courts—the CGL insurer would be required to

---

136. *See, e.g.*, Travelers Indem. Co. v. Israel, 354 F.2d 488 (2d Cir. 1965) (applying New York law); Northern Ins. Co. v. Allied Mut. Ins. Co., 955 F.2d 1353 (9th Cir. 1992) (applying California and Washington law); B.S.B. Diversified Co. v. Am. Motorists Ins. Co., 947 F. Supp. 1476 (W.D. Wash. 1996); Texaco A/S, S.A. v. Commercial Ins. Co. of Newark, 1995 U.S. Dist. LEXIS 15818 at *16-*18 (S.D.N.Y. Oct. 25, 1996); Gopher Oil Co. v. Am. Hardware Mut. Ins. Co., 588 N.W.2d 756 (Minn. Ct. App. 1999). *But see* Quemetco Inc. v. Pacific Auto. Ins. Co., 29 Cal. Rptr. 2d 627 (Cal. Ct. App. 1994) (rejecting general rule where liability claim founded on CERCLA statute that did not exist at time of transfer of policy); Red Arrow Products Co. v. Employers Ins. Co., 607 N.W.2d 294 (Wis. Ct. App. 2000) (refusing to allow transfer of policy rights after asset purchase). Cases like *Quemetco* and *Red Arrow* are arguably distinguishable from the general rule in that there appeared to be no specific assignment of the insurance policies, with the successor asserting rights based on asset purchase or changes in corporate form alone. *See also* Globecon Group, LLC v. Hartford Fire Ins. Co., 2004 U.S. Dist. LEXIS 13130 (S.D.N.Y. July 13, 2004) (recognizing general rule of assignment permitted after loss even in the face of restrictive policy language but refusing transfer of policy rights in particular case where assertion of policy rights by successor would impose substantial burden on insurer). *But see* Globecon Group, LLC v. Hartford Fire Ins. Co., 2006 U.S. App. LEXIS 452 (2d Cir. Jan. 9, 2006) (reversing trial court on question of transferability of insurance policy rights and remanding for further proceedings).

137. *See generally* STEMPEL, *supra* note 6, § 3.15.

HeinOnline -- 12 Conn. Ins. L.J. 408 2005-2006

defend and indemnify Company B as it would Company A, even if the insurer had not consented to the assignment. Although there may be a technical violation of any anti-assignment language in the CGL policy, it brought no harm to the insurer where the events giving rise to the asbestos claims took place when Company A was conducting business. In this type of case, the assignment of the insurance policy is like an assignment of any other asset. There was no risk to the insurer that Company B would engage in riskier behavior with asbestos than did Company A. The wisdom of this traditional approach is particularly apt in many asbestos situations where such assignments may well post-date the mid-1970s halt to the use of asbestos in the United States. Under such circumstances, the asbestos claims almost certainly are all centered on the activities of assigner Company A rather than assignee Company B. The same analysis should ordinarily govern not only asbestos but other long-tail claims such as pollution liability or pharmaceutical drug liability.

For the most part, these types of post-loss assignments have been freely permitted by courts (and are as a practical matter probably only challenged by insurers when the losses are large). Consequently, even though the asbestos mass tort has its roots in victim exposure that often took place many years and company changes ago, this has generally not reduced the insurance coverage otherwise available for asbestos claims. However, as discussed below, the California Supreme Court in its 2003 *Henkel Corp. v. Hartford Accident & Indemnity Co.*[138] decision refused to enforce a transfer of policy rights with an analysis cutting against the grain of the traditional rule. Although the case was one involving a toxic tort from exposure to metallic chemicals, the implications for asbestos coverage are potentially significant both because of California's size and its importance as a precedent-setting jurisdiction. By now, one would have expected asbestos claims to have so run their course that policy assignment should not matter. But in view of the seeming perpetuity of the asbestos mass tort, one expects there are at least some significant cases posing the issue, although they may be out of the public eye due to arbitration or negotiation. As discussed below, *Henkel* is an extremely poorly reasoned decision providing a windfall to insurers,[139] one I regard as part of the judiciary's unconscious result-oriented balancing of the scales of insurance coverage litigation in response to the view that courts were too generous to policyholders in adopting the continuous trigger.[140] But whether *Henkel* is wise or foolish,

138. 62 P.3d 69 (Cal. 2003).
139. *See infra* text accompanying notes 149-178.
140. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 409 2005-2006

if it continues to be followed in California or gathers support in other jurisdictions, it will have a significant coverage-restricting effect not only for insurance but for other long-tail liabilities.[141]

B. COVERAGE FOR POLICYHOLDER ACQUISITIONS

Situations like *Henkel* and standard assignment of policies present the issue of whether there is insurance coverage when the initially applicable policy is transferred from the policyholder after the events giving rise to a third party claim. There is also a flip side to the transfer question: what happens when an insurance policy is issued to a policyholder that subsequently acquires other companies that had activity during the policy period that later gives rise to liability claims against the original policyholder, who still holds rights under the liability policy originally issued? This is a more difficult issue with less established precedent than exists on the question of assignment of policy rights after a loss or liability-creating injury has taken place.

Insurers argue that they should be relieved of the consequences of the liability claims against the original policyholder if the liability arises from activities performed by an entity acquired by the policyholder after the policy period—even though the claims themselves allege triggering injury during the policy periods and even though the policies as written apply to any business of the policyholder, including businesses that were acquired by the policyholder after the policy period. Although the insurers' objections may seem initially compelling on the ground that the insurer should not be responsible for later changes that expand the policyholder's potential liability exposure, closer examination suggests that insurers are incorrect in refusing to provide coverage in such situations.

First, the policies themselves—drafted by the insurers—frequently contain no such limitation. In the absence of any limiting language, the insuring agreement itself is of course the primary touchstone for determining coverage. The CGL insuring agreement simply states that the CGL insurer will pay "all sums" for which the policyholder may become liable. There is no exclusion or exception for policyholder liability that arises due to subsequent acquisition of a company with legal liabilities. To

---

141. *See* Century Indem. Co. v. Aero-Motive Co., 318 F. Supp. 2d 530 (W.D. Mich. 2003) (following *Henkel*); Gregory J. May, *Successors' Rights to Insurance Coverage for Predecessors' Preacquisition Activities: Recent Developments*, 40 TORT & INS. L.J. 911, (2005) (observing "trend" in favor of "limiting of a successor's ability to claim coverage under its predecessor's policies."). *But see* Glidden Co. v. Lumbermen's Mut. Cas. Co., 2004 Ohio LEXIS 6922 (Ohio Ct. App. 2004) (rejecting *Henkel*).

HeinOnline -- 12 Conn. Ins. L.J. 410 2005-2006

the extent there is any uncertainty as to the application of the insuring agreement, doubts are required to be resolved in favor of the policyholder according to the ground rules governing insurance.

Second, the most natural reading of the type of policy language often found in older liability policies is that the insurer intended to provide coverage to all operations of the policyholder, regardless of when acquired. For example, the named insured endorsement in many policies issued during the 1945-1970 time period is particularly broad, naming as policyholder not only the named insured as currently comprised but also all related entities as currently or "hereafter constituted." With regard to the primary policies, it was not until the 1980s that ISO issued an endorsement for use by insurers in issuing policies where the insurer wished to exclude coverage for any acquisitions carrying liability that predated the policy period in question.[142] This suggests that the insurance industry historically understood that coverage would be provided for all acquisitions of the policyholder without regard to the timing of such acquisitions.

Third, background information concerning the CGL policy suggests that insurers consciously assumed the risk posed by coverage for liability that accompanied changes in the policyholder's operations through either growth or acquisitions. Persons associated with the insurance industry have long stated the general rule that the expansion of policyholder assets and operations does not negate the insurer's coverage obligations. For example, one insurance company executive described the benefit of the CGL policy as follows:

> Take each policy needed . . . weld them together in a Comprehensive coverage, limiting exclusions to a minimum and adding *automatic coverage* for *any new venture* an insured may care to undertake, and you have one of the most potent weapons for protection ever afforded a risk.[143]

Elmer Sawyer, one of the architects of the CGL policy, stated that insurers expected the CGL policy to cover liabilities befalling a policyholder because of expansion of the policyholder's business, including expansion by the acquisition of other companies. Sawyer observed that the

---

142. *See New Commercial General Liability Endorsements Filed*, ISO CIRCULAR, July 30, 1984, at 5 (setting forth list summarizing CGL Endorsement GL 21 10 and describing it as "a new endorsement" that "[e]liminates any coverage for newly acquired corporations under the policy").

143. *See* Eglof, *supra* note 17, at 19 (emphasis added).

HeinOnline -- 12 Conn. Ins. L.J. 411 2005-2006

CGL was designed to provide "Automatic Coverage" for new activities of the policyholder business.

> Under the multiple cover plan it has been customary to afford no automatic coverage or little automatic coverage with respect to additional locations, changes in the business operations of the insured or new hazards at the locations covered. Automatic coverage has more often been the subject matter of special, individual negotiation. To accomplish the objective of comprehensive general liability insurance, which is to cover all hazards of liability not excluded, it is necessary to provide a very broad automatic coverage.
>
> The coverage can no longer be limited to the type of business in which the insured is engaged at the time the policy is written, but must follow his activities even though the nature of this business operations change completely. Consequently the coverage must apply automatically to all operations not specifically excluded. . . .
>
> Neither can the coverage be limited to locations used by the insured at the time the insurance is written. The insured may acquire new locations by purchase, by lease, by the creation or acquisition of affiliates or in other ways. His business may expand to other States. Comprehensive general liability insurance must automatically apply to hazards of liability thus created.[144]

Insurers appear to have regarded this view as a natural corollary to the comprehensive nature of the CGL policy, which was marketed as broad coverage designed to allay policyholder concerns regarding the need to purchase other, particularlized liability policies. Instead, the broad CGL policy was designed not only to cover the risks not specifically excluded by the policy language but also to provided adequate liability protection for the the expanding business of the policyholder. Commenting on the term "Comprehensive" in the CGL policy, one major insurer stated:

> This word means exactly what is says. For insurance purposes, it means that all operations, all commercial businesses, and all hazards of the commercial insured are

144. *See* SAWYER, *supra* note 9, at 26-27 (emphasis added).

HeinOnline -- 12 Conn. Ins. L.J. 412 2005-2006

> covered. It means all-encompassing and all-inclusive. It indicates the broadest possible coverage for insureds with a variety of business exposures. By providing coverage on a comprehensive basis *not only are all existing hazards covered, but newly arising hazards are covered without any further extension of the policy.*[145]

An insurance industry insider described the breadth of CGL coverage for new products of the policyholder, an situation analogous to a policyholder's acquisition of new operations or companies, in similar fashion:

> New Products. It is not unusual for insureds to market new products during a policy's lifetime without the knowledge of the insurer, and, therefore, *without the insurer having an opportunity to evaluate the exposure.*
> The query: Should some control on the automatic coverage afforded basically by the policy be introduced in the policy?
> The answer: This is not a general problem; it is encountered chiefly in the larger risk. It is possible, when desired, for companies to react to it in limited or broad fashion by *restricting coverage to products existing at policy inception.*[146]

In addition, insurers have traditionally used retroactive premium adjustment as a means of managing the risk of expanded policyholder liability due to expanded policyholder operations. The presence of retroactive premium provisions in the policies suggests that insurers were aware that a policyholder's business operations could expand and increase the relative liability risk faced by the policyholder and subsequently its insurers.

Adding and deleting subsidiary companies and operations is part and parcel to modern commercial activity. This can occur either through outright purchases of other companies or changes in the operations of a commercial policyholder. For example, a policyholder may begin operating an installation subsidiary that deals with asbestos simply by expanding its own operations rather than purchasing an installation

145. *See* [ANONYMOUS INSURER], *supra* note 53, at 4 (italics added; underlining in original).

146. *See* NORMAN NACHMAN, PRODUCT LIABILITY INSURANCE: A STUDY 17-18 (ISO Paper Dec. 1972) (emphasis added).

HeinOnline -- 12 Conn. Ins. L.J. 413 2005-2006

company. The risk posed by either expansion of asbestos installation activities from within or by acquisition of a new subsidiary that installs asbestos insulation is the same. The insurer is at no greater risk merely because the liability-creating activity was the product of a subsequently purchased subsidiary business rather than additional activities by the parent company.

Case law is divided on the issue of insurance coverage for liability-generating occurrences that predate the policyholder's ownership of the entity whose actions are the source of the claim. Some cases support the insurer position against coverage for entities acquired by the policyholder while others support the policyholder position.[147] The cases permitting coverage under policies held by policyholders acquiring other businesses (and their attendant liabilities) are better reasoned and more persuasive. *K F Dairies*[148] is particularly trenchant on this point. Referring to cases supportive of the insurer position, the Ninth Circuit found that such cases "are in conflict with generally established principles of insurance contract construction as articulated by the California Supreme Court. . . ."[149] Continued the Ninth Circuit:

> KF Dairies's insurance policy states that the insurer "shall have the right and duty to defend any suit seeking damages on account of . . . bodily injury or property damage" where the injury or damage is "caused by an occurrence." The policy defines an "occurrence" as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured." This language is unambiguous. Moreover, there is no

147. *Compare* Total Waste Management Corp. v. Commercial Union Ins. Co., 857 F. Supp. 140 (D.N.H. 1994); Textron, Inc. v. Aetna Cas. & Sur. Co., 638 A.2d 537 (R.I. 1994); Caterpillar, Inc. v. Aetna Cas. & Sur. Co., 282 Ill. App.3d 1065, 668 N.E.2d 1152 (Ill. App. 1996); Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co., 52 Cal. Rptr. 2d 690, 725 (1996) (supporting insurers) *with* K F Dairies, Inc. v. Fireman's Fund Ins. Co., 224 F.3d 922 (9th Cir. 2000) (applying California law); Weyerhaeuser Co. v. Commercial Union Ins. Co., 142 Wn.2d 654, 15 P.3d 115 (Wash. 2000); Aetna Cas. & Sur. Co. v. Gulf Resources & Chem. Corp., Civil No. 87-3043 (D. Idaho Mar. 18, 1993); The Boeing Co. v. Aetna Cas. & Sur. Co., No. C86-352WD, 1991 WL 575712 (W.D. Wash. Oct. 14, 1991); Garriott Crop Dusting Co. v. Superior Court, 270 Cal. Rptr. 678 (Ct App. 1990) (supporting policyholders).

148. *See* K F Dairies, Inc. v. Firemany's Fund Ins. Co., 224 F.3d 922 (9th Cir. 2000) (applying California law).

149. 224 F. 3d at 925.

HeinOnline -- 12 Conn. Ins. L.J. 414 2005-2006

> language in the policy stating that the insured's liability, as opposed to the damage that serves as the basis for that liability, must arise within the policy period. An exclusion or limitation on policy coverage cannot be read into the insurance contract; rather, such provision must be "conspicuous, plain, and clear."[150]

In a slightly different context involving the question of whether the third party claimant must have owned the injured property at the time of injury, another court observed:

> [U]nder the terms of the insurance policies . . . the event triggering coverage is one that cause[d] "physical injury to or destruction of tangible property" during the policy period. Nowhere do the policies say to whom that property must belong, save that it must not belong to the insured. In other words, the policies themselves do not expressly require that the eventual claimant own the property at the time the property is damaged for coverage to ensue; they merely require that the damage . . . take place during the policy period.[151]

Both this analysis and that of *KF Dairies* are correct. The language, structure and purpose of the CGL policy do not require either that claimants have had a property interest at the time of injury or that the policyholder have owned the liability-creating entity at the time of injury. The CGL is instead focused simply on injury as trigger. It is sufficient if there is ownership at the time of the claim. If an insurer wishes not to assume this broad risk, it can simply exclude the coverage rather than use retroactive premiums as its vehicle for recouping any increased costs from additional coverage responsibility.

Courts permitting insurers to avoid coverage merely because the company responsible for the liability was not acquired during the policy period in effect convert an occurrence-basis CGL policy into a product more like the less valuable claims-made policy. A claims-made policy by its express terms requires that claims against the policyholder be made and reported prior to the expiration of the policy period. Coverage is lost not because of the nature of the injury or ultimate liability but merely because

150. *See* 224 F.3d at 927-28 (bracket in original; internal citation omitted).

151. *See Garriott Crop Dusting Co.*, 270 Cal. Rptr. at 682.

HeinOnline -- 12 Conn. Ins. L.J. 415 2005-2006

of accidents of the timing of litigation. There is no such timing requirement in an occurrence-basis CGL policy such as those sold to asbestos defendants prior to the 1980s. However, cases barring coverage for the liabilities that came along with the policyholder's acquisition of a company (despite the liability resulting from injury beginning during the policy period) are essentially engrafting an unwritten exclusion onto the CGL policy by requiring that the source of the injury be owned by the policyholder both at the time of injury and at the time when the claim is made. In effect, courts adopting the insurer viewpoint have rewritten the CGL policy to make it less favorable to policyholders and more favorable to the insurers that drafted the instrument. This is at odds with the drafting history of the CGL policy.

VII. ASBESTOS BANKRUPTCIES AND INSURANCE

Asbestos defendant bankruptcies provide both a contentious legal battleground and an illustration of the degree to which insurers have largely fared better than their policyholders. Although society and the legal system should not mistake the real victims of the asbestos mass tort (the persons who lost health and life due to asbestos exposure), asbestos defendants can make a good case of victimhood by pointing to many bankruptcies of asbestos defendants resulting from the weight of the mass tort's claims.[152] Although the asbestos mass tort has resulted in the apparent demise of a few insurers and has certainly forced some painful reorganizations (the Lloyd's-Equitas situation being the most prominent example), it seems clear that policyholders have suffered more than insurers. While there are a handful of insurer insolvencies linked to asbestos coverage, there are more

152. Although commentators may differ as to who is most "at fault" for the asbestos problem and whether some have profited exorbitantly as a result of the problem, there is no disagreement that asbestos liability litigation has been the major civil litigation phenomenon of the late 20th Century and early 21st Century. *See generally* CASTLEMAN, *supra* note 63; BRODEUR, *supra* note 63 (reviewing history of asbestos, discovery of its dangerous properties, and early asbestos litigation; casting primary blame on manufacturers; describing bankruptcy of Johns-Manville in Chapter 10). *See also* WALTER K. OLSON, THE RULE OF LAWYERS CH. 6 (2003) (finding economic incentives for lawyers largely to blame as well; finding that (at 205) "chaotic" asbestos litigation [in the tort system] "makes no sense whatsoever as a means of providing surrogate social insurance" and that "[t]he litigation, like the mineral . . . proved inextinguishable"; "Past estimates of the scope of asbestos liability have all had one thing in common: They have been far too low. Most mass torts peak and then subside, but asbestos litigation just grows and grows . . ." (at 206); "Companies that made a point of settling cases generously and early, so as to avoid wasting money on lawyers' fees, went broke. And so did those who followed the opposite strategy" (at 207)).

HeinOnline -- 12 Conn. Ins. L.J. 416 2005-2006

than seventy bankruptcies of asbestos defendant policyholders. But for the insurance industry as a whole, the asbestos problem is estimated to be only a 1-3 percent drag on earnings.[153] Even for the so-called "Dirty 30" of insurers with the greatest amount of asbestos coverage responsibility, asbestos is thought to be only a 3-6 percent drag on earnings.[154] Economically, at least, it appears that insurers have done better than many of their policyholders facing asbestos claims. The doctrinal battle over coverage for bankrupt companies attempting to settle asbestos claims remains ongoing, although insurers seem to have the edge.

Bankruptcies have affected not only the major manufacturers of asbestos and those that knew of the material's dangerous properties but failed to warn society and its potential victims, but also what many term "peripheral" asbestos litigation defendants who had no knowledge of the dangers of asbestos and merely used the material in their own products or activities. For example, building material manufacturers may have used asbestos in their products. Further, the asbestos content may have been low and the product one that was not likely to give rise to airborne asbestos fibers that damage the human lung.

During the first wave of asbestos litigation in the 1970s and 1980s, these asbestos defendants were largely left alone by plaintiffs who instead logically pursued the core manufacturer and large installer/insulator defendants that possessed large assets, including substantial insurance coverage. But as these defendants ran out of insurance (perhaps because claims personnel and counsel were too quick to characterize all asbestos liability as subject to the aggregate limit for the products/completed operations hazard discussed in Section V, *supra*), they sought refuge in bankruptcy, further limiting their potential as sources of compensation for plaintiffs even in cases of Chapter 11 reorganization bankruptcy rather than Chapter 7 liquidation bankruptcy.

Anxious to continue to pursue claims, victim compensation, and counsel fees, plaintiffs and their attorneys brought forth the so-called "second wave" of asbestos mass tort claims against "peripheral" defendants not normally regarded as companies responsible for asbestos use and injury. The consequences were a startling rise in the number of asbestos claims during the 1990s and early 21st Century, a time well beyond any 1980 observer's predictions as to the longevity of the asbestos mass tort. Many of these peripheral defendants had fewer resources of their own or limited insurance. They may also have been embroiled in significant

153. *See* V.J. Dowling, *supra* note 30; Baker, *supra* note 7.
154. *See id.*

HeinOnline -- 12 Conn. Ins. L.J. 417 2005-2006

coverage disputes with their insurers, depriving them of a strong defense to the claims, many of which were regarded as strained by some observers—but which nevertheless posed substantial individual risk of tort liability and in the aggregate posed a substantial burden for the peripheral defendants.

The sheer bulk of the asbestos claims created potentially company-ending liability for some asbestos defendant policyholders, even if the individual asbestos claims ultimately prove to reflect only modest injury—or even if the claims prove to be unmeritorious. The experience of asbestos defendants has historically been that their costs of defense in relation to amounts paid in judgments or settlements of asbestos claims is essentially the same, at a ratio of approximately 1:1.[155] Asbestos defendants in the absence of bankruptcy protection, would be required to defend perhaps thousands of asbestos claims, often from their own pockets in the absence of insurance or where insurers were disputing coverage. As a result, a rational asbestos defendant facing thousands of claims will find the notion of global omnibus settlements quite attractive.

For a variety of reasons, this second wave of asbestos defendants sought bankruptcy protection, as had many of the first wave core of asbestos defendants.[156] The economics and practical litigation logistics of

---

155. *See* STEPHEN J. CARROLL ET AL., ASBESTOS LITIGATION COSTS AND COMPENSATION: AN INTERIM REPORT VII, 60 (2002) ("Carroll/RAND Study") ("transaction costs", primarily legal costs, "have consumed more than half of total spending on asbestos") (defense costs exceed claims payments during 1980s litigation and were roughly a quarter of total expenditures during 1990s litigation); J.S. KAKALIK ET AL., VARIATION IN ASBESTOS LITIGATION COMPENSATION AND EXPENSES (1984) ("Kakalik/RAND Study") (of total amounts spent related to asbestos litigation, approximately one-third went to plaintiffs' legal fees, one-third to defendants' legal fees, and one-third to actual compensation of victims); Letter from Jennifer L. Biggs, Chair, Chair, Mass Torts Subcommittee, American Academy of Actuaries, to Sen. Bill Frist, Majority Leader (R-Tenn.), March 24, 2004, at 2 [hereinafter *Biggs Letter*] ("More than half of the costs relate to plaintiff and defense attorney fees."). For some defendants and some claims, asbestos defense costs have exceeded the amounts paid in judgment or settlement.

156. *See* CARROLL, *supra* note 155, at vi-vii, 40, 47 (more than 6,000 companies named as asbestos defendants and "litigation has spread far beyond the asbestos and building products industries"; annual filing of claims "has risen sharply"; claims against nonmanufacturer defendants "are growing most rapidly"); Statement of Jennifer L. Biggs, Chair, Mass Torts Subcommittee, American Society of Actuaries (July 10, 2003), at 1 [hereinafter *Biggs Statement*] (congressional hearing on "Proposed Resolution Regarding the Need for Effective Asbestos Reform") ("As the initial targets in the [asbestos] litigation have become unable to pay their share of damages, plaintiffs['] attorneys have named additional peripheral defendants (who did not manufacture asbestos . . . . Many defendant companies believe they are not getting a fair legal evaluation of their cases in court . . .); Randy J. Maniloff, *Asbestos: Insurance Coverage Issues On a Changing Landscape*, MEALEY'S LITIGATION REPORT: INSURANCE, July 9, 2002, at 4 (noting trend of asbestos litigation in which "The Peripheral Asbestos Defendant Becomes A Target"); Angelina,

HeinOnline -- 12 Conn. Ins. L.J. 418 2005-2006

the asbestos tort litigation phenomenon have pushed more than seventy asbestos defendants into bankruptcy.[157] Many asbestos defendants found bankruptcy a prudent alternative, particularly to the degree it facilitated global settlement. Commentators, although not uniform in assessment, appear to agree.[158] In addition, asbestos defendants discovered that a 1994

---

supra note 1, at 18 (Tillinghast-Towers Perrin consultant notes that, in defiance of predictions, asbestos claims have grown dramatically during late 1990s and 2000 even though use of asbestos has been effectively banned for 25 years); General Cologne Re, *The Reemergence of Asbestos: More Claims, More Defendants, More Dollars*, HAZARDOUS TIMES, Nov. 2001, at 1. *See also Biggs Statement* at 4 (noting that "[r]oughly 50,000 to 70,000 new claimants filed lawsuits per year from 2000 to 2002", a rate "significantly higher than the average of approximately 20,000 per year experienced by several major defendants in the early 1990s.") and at 12 (noting differences between typical tort claim and asbestos mass tort claim).

157. *See* Georgene Vairo, *Mass Torts Bankruptcies: The Who, The Why and The How*, 78 AM. BANKR. L.J. 93, 106-07 (2004) ("Over seventy companies are in bankruptcy court as a result of their asbestos exposure, and most parties familiar with the area expect that most, if not all, "traditional" asbestos defendants will have filed for bankruptcy by the end of 2004."); *Biggs Statement*, *supra* note 156, at 20 (listing asbestos defendants filing for bankruptcy during the period of 1982 to mid-2003, ranging from a "target" defendant like major manufacturer Johns-Manville to "peripheral" defendants such as Kentile Floors and Swan Transportation). *Accord*, Lee L. Bennett, *Defense Community Issues: New Liabilities and How to Respond to the Plaintiffs' Bar*, DEF. COUN. J., July 2002, at 273, 277-78 (describing asbestos litigation as a "Lazarus Phenomenon" that will not die, noting "skyrocketing filing of new asbestos claims" that "is causing numerous asbestos-related bankruptcies" as peripheral defendants become targets); Angelina, *supra* note 1, at 18 (preferring more contemporary, commercial metaphor); Robert P. Hartwig, Testimony before U.S. Senate Judiciary Committee (June 4, 2003) ("Solving the Asbestos Crisis: S. 1125; The Fairness of Asbestos Injury Resolution [Act] of 2003") (Arguing in favor of legislation to resolve asbestos claims because of high costs of addressing such claims through tort system) (Hartwig is Senior Vice President and Chief Economist of the Insurance Information Institute); American Insurance Association, Myths and Facts About Asbestos Litigation (March 2003) (available at 222.http://www.aiadc.org).

158. *See* Alan N. Resnick, *Bankruptcy as a Vehicle for Resolving Enterprise-Threatening Mass Tort Liability*, 148 U. PA. L. REV. 2045, 2092 (2000) (Exhibit C-54) ("The bankruptcy system provides an appropriate framework for resolving enterprise-threatening mass tort liability"). *See also* S. Elizabeth Gibson, *A Response to Professor Resnick: Will This Vehicle Pass Inspection?*, 148 U. PA. L. REV. 2095, 2116 (2000) (Exhibit C-55) (expressing some reservations about efficacy of bankruptcy solution to mass tort problem but noting that "Professor Resnick has stated well the advantages of utilizing bankruptcy as a vehicle for resolving mass torts. Bankruptcy has many procedural and conceptual features that can be applied to permit a resolution of all of the claims facing a beleaguered mass tort defendant."); Vairo, *supra* note 157, at 98 (noting that bankruptcy system, although presenting some problems, "provides an important vehicle to resolve mass tort liabilities" because it "seeks to provide equality of distribution to creditors in a proceeding that encompasses the interests of all parties while mitigating the effect that a huge mass tort liability may have on the worth of a business.") and at 131-52 (Reproducing as Appendices U.S. Judicial Conference Committee on the Administration of the

amendment to the Bankruptcy Code permitted asbestos defendants to seek a "prepackaged" bankruptcy that could potentially reduce both their asbestos liability exposure and the costs and time normally associated with bankruptcy. The 1994 Amendment, codified at 11 U.S.C. § 524(g), was patterned after the Johns-Manville reorganization that had commenced with the company's 1982 bankruptcy petition.

Essentially, a pre-packaged bankruptcy is one in which the asbestos defendant/prospective debtor negotiates with its creditors, particularly counsel representing asbestos claimants, regarding resolution of claims against the policyholder or likely to be made against the policyholder from asbestos claims "in the pipeline." If three-fourths of the creditors approve a negotiated settlement, this can be embodied in a court-approved bankruptcy plan that is in essence ready to be approved upon the filing of the bankruptcy petition (hence the term "prepackaged" bankruptcy). The bankruptcy court then issues a "channeling injunction," which requires all asbestos claims against the debtor to be brought before the bankruptcy court where they are subject to the pre-petition settlement agreement concerning such claims and the agreed schedule of payments to claimants, including eligibility criteria for compensation.[159]

In the Johns-Manville litigation, the victim compensation Trust funded by insurance and company stock and the criteria for compensation were developed during the course of the bankruptcy. In a prepackaged bankruptcy, this is negotiated prior to the petition and the court is presented with a plan for funding the Trust, criteria for determining asbestos claimant eligibility, and a schedule for compensation depending on the degree of asbestos-related injury or impairment.

Passage of the Bankruptcy Reform Act of 1994, which added Section 524(g) to Title 11 of the Bankruptcy Code, can be read as an expression of congressional intent and national public policy in favor of resolving asbestos liability problems for beleaguered companies through the global settlement mechanism. The Act added detailed provisions to section 524 for the purpose of confirming the legality and enforceability of the trust mechanisms set up in the Johns-Manville, UNR, and other asbestos-related Chapter 11 cases in the 1980s to benefit asbestos victims, while protecting debtor manufacturers from future liability. The amendments also confirm the enforceability of channeling injunctions that enjoin asbestos-related

---

Bankruptcy System Report of the Subcommittee on Mass Torts and portions of the 1997 Recommendations of the National Bankruptcy Review Commission for Amendments to the Bankruptcy Code Regarding Mass Torts, both of which are supportive of use of bankruptcy reorganization and global settlement in addressing mass tort claims).

159. See 11 U.S.C. § 524(g) (2004).

HeinOnline -- 12 Conn. Ins. L.J. 420 2005-2006

claimants from pursuing the reorganized debtor, thereby forcing them to seek recourse only against the trust.[160]

In pursuing either a "regular" or a prepackaged bankruptcy, the policyholder facing substantial asbestos liability seeks to use the reorganization process, creation of a Trust for victim compensation, and a channeling injunction as a means of achieving global resolution of its asbestos exposure in one forum in a manner that will provide compensation to past and future claimants while preserving the company. Insurers tend to oppose such a global solution on the ground that it might accelerate the otherwise gradual payments they will inevitably be forced to make. This can create a pointed conflict between insurer and policyholder.

By now, some of the insurer objections to negotiated bankruptcy resolution of asbestos claims are familiar in that they tend to mirror insurer objections to mass or inventory settlements of asbestos claims generally. The argument against such resolution is that it tends to result in the settlement of large blocks of cases in the hands of a few law firms in which compensation is paid after truncated review that is far less searching than the scrutiny such claims would get at trial or even if vetted through the pretrial process normally attending individual claims. A somewhat revised addition to this long-standing criticism notes that certain prominent asbestos plaintiff law firms tend to repeatedly use the same medical diagnosticians who manage to find asbestos injury at astonishingly high rates using suspect methodology.[161] There are also, particularly from

---

160. *See* Resnick, *supra*, note 158, at 2073. *See also* Susan Power Johnston & Katherine Porter, *Extension of Section 524(g) of the Bankruptcy Code to Nondebtor Parents, Affiliates, and Transaction Parties*, 59 BUS. LAWYER 503, 510-11 (2004)

> In 1994, Congress amended the Bankruptcy Code to provide a restructuring model for asbestos-related bankruptcies. Section 524(g) represents a congressional response to the need for an effective mechanism to facilitate reorganization of companies facing massive numbers of asbestos claims. A variety of efforts to achieve such relief outside Chapter 11 has not proven successful. Section 524(g) codifies the approach that [Johns-Manville] used in its bankruptcy in the mid-1980s to deal with the asbestos claims against it. (footnotes omitted).

See also Bennett, *supra* note 157, at 278 (although concerned about risk of accelerated payment obligations for insurers, insurance defense lawyer states that "bankruptcy may be the only alternative for these [asbestos defendant] companies since the U.S. Congress has refused to act, the U.S. Supreme Court essentially has made settlement class actions unworkable, and most trial courts have refused to dismiss claims involving asymtomatic, unimpaired claimants.").

161. *See* Lester Brickman, *On The Applicability of the Silica MDL Proceeding To Asbestos Litigation*, 12:2 CONN. INS. L.J. 35 (2006); Lester Brickman, *Contingent Fees*

Professor Brickman, criticisms of the high fees garnered by claimant counsel.[162]

The core of criticism against such arrangements is that they constitute a settlement "mill" in which resolution is mass produced without relation to the merits of individual claims. Insurers further argue that even if these arrangements are good for policyholders in that they achieve global peace at lower cost than individualized defense of claims, it unfairly deprives insurers of their right to individualized control of covered claims and tends to at least accelerate insurer payments if not to increase overall payments as well. Defenders of the bankruptcy solution and prepackaged negotiations of asbestos claims counter that for many asbestos defendant policyholders, bankruptcy is not only the clearly superior approach but perhaps the only practical approach for acceptably satisfying asbestos claims and permitting the policyholder company to survive. Although insurers may have an expectation that most liability coverage expenses will take place over an extended time period, this is not part of the insuring agreement. Rather, the insurer accepts the policyholder's premiums in return for taking the risk that liability claims payments may be large or small, fast or slow, etc.

The pro-bankruptcy argument has powerful equitable persuasiveness even if it is in tension with concepts such as individual adjudication of claims and particularized insurer control over claims handling and defense. If an asbestos defendant bravely defends and settles claims on an individual basis but then sinks under the weight of asbestos claims, there are severe costs. Although the first asbestos claimants may receive full value for their claims, when the money runs out, asbestos victims remaining in the queue receive only a small percentage of claim value or perhaps receive no compensation at all.

An early global settlement may undercompensate some seriously injured asbestos victims that would have obtained large damage awards at trial (or from settlement on the proverbial courthouse steps) and it may undercompensate future claimants who are not "on the scene" to argue for their rights and who by definition will get less attention from a lawyer representing a block of current claims and anticipating a large "contingency" fee. Thus, individual asbestos claimants may receive less in a global arrangement. However, the group of asbestos victims as a whole

---

Without the Contingency: Hamlet Without the Prince of Denmark, 37 UCLA L. REV. 29 (1989).

162. *See* Brickman, *Contingent Fees, supra* note 161 (noting that fees for some asbestos plaintiffs' counsel appear to be thousands of dollars per hour for quickly settling claims were liability is close to a foregone conclusion because dangerous properties of asbestos are well established).

HeinOnline -- 12 Conn. Ins. L.J. 422 2005-2006

probably does better, provided that there is some reasonable differentiation between seriously injured claimants and those with only minor lung scarring or pleural plaque. Almost by definition, an early global settlement, particularly one coupled with a pre-packaged bankruptcy, should dramatically reduce the dispute resolution costs that ordinarily are equal to what the defendant (or its insurers) pay out in compensation to victims.

In addition, if the global settlement prevents a policyholder company from liquidating itself into the mists of history, this would clearly appear to be a net social gain resulting from bankruptcy-related resolution of asbestos claims. Unless the policyholder company operates in a shoddy manner or engages in only unwanted activity, the company almost certainly hires, pays taxes, and generally contributes to the economic well-being of the community. Although there are perhaps some business entities that deserve to die, that is presumably the exception rather than the rule.[163] Consequently, permitting reasonable policyholder resort to available bankruptcy law would seem to be an important public policy goal.

Certainly, the public policy choice has been made in favor of continued existence be virtue of the Bankruptcy Clause of the Constitution[164] and the Bankruptcy Code,[165] including 524(g), as well as government's frequent efforts to protect many businesses from liability or obligations viewed as threatening the companies' continued existence. Ironically, some of the core asbestos defendants may present among the strongest cases for permitting a company to fall under the weight of liability rather than to survive through reorganization. Companies such as Johns-Manville produced and distributed without warning an inherently dangerous product that injured millions and had at least constructive knowledge of the danger. It would be hard to imagine any business entity (other than perhaps tobacco companies) that so appropriately deserves to die when the liability chickens come home to roost. But the legal system permitted Manville to survive and Congress subsequently approved the Manville model for other asbestos

163. This same principle holds not only for the availability of bankruptcy and insurance for businesses but is also reflected in prevailing Justice Department norms that where there is corporate wrongdoing, the individuals responsible should be pursued criminally but that the entity itself should not be criminally prosecuted (although it may be heavily fined or otherwise punished through devices such as a bar to government contracting). The prosecution of now-defunct accounting firm Arthur Andersen was a notable exception, one reversed by the Supreme Court (*see* United States v. Arthur Andersen, 125 U.S. 2129 (2005)) and viewed by many observers with considerable regret as an example of prosecutory overkill.

164. *See* U.S. Const., Art. I, Sec. 8, Cl. 4.

165. *See* 11 U.S.C. § 363, et. seq.

HeinOnline -- 12 Conn. Ins. L.J. 423 2005-2006

defendants in desperate liability straights. This seems a rather strong indicator that public policy factors favor policyholders rather than insurers on the issue of asbestos bankruptcy and insurance coverage.

Whatever any personal qualms members of the public may have regarding the cosmic justice of the situation, the positive law of the United States appears to hold that the greater good is in preserving business entities where some reasonable amount of liability compensation can be accomplished with the company continuing in some form. Further, this implicit decision to favor continued survival over liquidation is not irrational or intrinsically in derogation of justice. To be sure, some officials at core asbestos defendants such as Manville engaged in reprehensible behavior. But many or most of the company employees did not. And even a business that had asbestos as its primary activity also engaged in socially useful activity. Even if one's concept of a perfect world would include full compensation to asbestos victims, life in an imperfect world requires some compromises. The judicial system has implicitly adopted this view in permitting asbestos defendant bankruptcy reorganization, including prepackaged bankruptcy.

But notwithstanding these advantages, global settlements pursuant to bankruptcy reorganization, especially prepackaged bankruptcy, is often vigorously contested by insurers. Although the ostensible grounds for these objections are insurer contentions that such arrangements unfairly deprive them of the right control defense of claims, it is quite apparent that a major driving force is the insurers' desire to obtain the anticipated economic benefit of the elongated nature of asbestos claims and gradual payment over time with inflation-affected dollars.

Policyholders pursuing bankruptcy as a solution for asbestos liability should not be deprived of insurance purchases years earlier and on which insurers have earned premium income for decades. There remain closer issues of the terms under which insurers must pay and the timing of the payments. Even prior to the 1994 enactment of § 524(g), a potentially important decision held that confirmation of a bankruptcy plan provides for an immediate trigger of liability insurer coverage obligations.[166] In *UNR Industries, Inc. v. Continental Casualty Co.*,[167] the Seventh Circuit concluded that confirmation of the bankruptcy plan and Trust arrangement constituted settlement or adjudication of claims and required insurer payment of policy proceeds to the Trust.[168]

166. *See* UNR Indus., Inc. v. Cont'l Cas. Co., 942 F.2d 1101, 1104-05 (7th Cir. 1991) (applying Illinois law).

167. 942 F.2d 1101 (7th Cir. 1991).

168. *Id.* at 1104-05.

HeinOnline -- 12 Conn. Ins. L.J. 424 2005-2006

For insurers, who essentially profit by holding on to policyholder premiums and related investment income for as long as possible, this aspect of insurance bankruptcy was seen as a significant threat, but one that for several years appeared unlikely to materialize in significant manner. However, with the 1990's second wave of asbestos litigation against peripheral defendants and the surge in bankruptcy filings of asbestos defendants, the picture changed and brought the issue of bankruptcy-related triggering of insurer coverage to the fore. In addition, another decision in the vein of *UNR* suggested that more than one court might reach the same conclusion resulting in accelerated insurer payments due to policyholder bankruptcy. *Fuller-Austin Insulation Co. v. Highlands Insurance Co*,[169] also ruled that the settlement of asbestos liability claims as part of a bankruptcy reorganization is the equivalent of settlement or judgment for purposes of triggering an insurer's obligation to pay policy proceeds.

As expressed by the *UNR* court, the judicial rationale for requiring a debtor-poliyholder benefits under its liability insurance policy at the time of bankruptcy plan approval is that the:

> [B]ankruptcy reorganization was a judgment or settlement and so triggers CNA's insurance obligations. The reorganization required UNR to pay a sum certain (the stock, which had a market value of $150 million) in satisfaction of the asbestos claims. The order confirming that reorganization was final and appealable. And the order is binding. The parties may not re-litigate the matter. Under any definition of judgment or settlement, this qualified. Having suffered an adverse judgment or settlement, UNR has suffered a "loss" within the meaning of the CNA [excess general liability] policy.[170]

The *UNR* Court further noted that under a common excess general liability policy, the insurer has:

> [T]he option not to defend. Instead, it could make [the policyholder] defend itself after the exhaustion of [the policyholder's] primary coverage and later indemnify [the policyholder] for the costs that it insured. . . . [Where the

169. Fuller-Austin Insulation Co. v. Highlands Ins. Co., 38 Cal. Rptr. 3d 716 (Cal. Ct. App. 2006).

170. UNR Indus., Inc. v. Cont'l Cas. Co., 942 F.2d 1101, 1104-05 (7th Cir. 1991).

HeinOnline -- 12 Conn. Ins. L.J. 425 2005-2006

> policyholder settles a claim under these circumstances, the insurer need not pay] "collusive or overly generous or unnecessary settlements by the insured at the expense of the insurance carrier.". . . This case presents no such danger because the [bankruptcy] reorganization could not have taken place with the consent of just UNR and the asbestos victims. UNR's other creditors all had to approve, and they had strong reason to fight for as low a valuation of the asbestos claims as possible. The lower the valuation, the greater the portion of UNR's assets these other creditors could reach. This antagonism of interests removes any significant danger that the $254 million valuation of the asbestos victims' claims might contain any artificial inflation at CNA's expense. In short, CNA is bound by the $254 million valuation of the asbestos victims' claims in the reorganization.[171]

Insurers and their counsel have been critical of the *UNR* and *Fuller-Austin* decisions and have consistently complained that under the *UNR* and *Fuller-Austin* approach they will be required to pay policy proceeds at an earlier date than planned and suggested that asbestos-related bankruptcies be opposed or conditioned on insurer consent. As noted above, *UNR* appears not to have received much attention in the earlier years after the decision. However, *Fuller-Austin* received considerably more adverse attention by insurers, with insurer consternation sometimes bordering on the apoplectic,[172] most likely because insurers had faced an additional

---

171. *Id.* at 1105-1106. *But see* Amatex Corp. v. Aetna Cas. & Sur. Co. (*In re* Amatex Corp.), 97 B.R. 220, 226 (Bankr. E.D. Pa.), *aff'd*, 102 B.R. 411 (E.D. Pa.1989), *aff'd without opinion*, 908 F.2d 961 (3d Cir. 1990) (refusing to require immediate insurer payment to trust fund).

172. *See, e.g.*, Gary A. Saunders & Stefanie J. Birbrower, *Debtors avail themselves of trusts*, NAT'L L.J., Aug. 9, 2004, at 23 ("*Fuller-Austin* set an unsettling precedent for insurance companies and underscored the possibility that asbestos bankruptcy cases can fix and accelerate insurance companies' liabilities – even absent the insurance companies' participation in the bankruptcy process and irrespective of the language in the plan preserving their rights to disputes liability.") (Attorneys Saunders and Birbrower are with King & Spaulding, a firm that regularly represents insurers); Leonard P. Goldberger, *Sorry, We Don't Allow That Here*, 22 AM. BANKR INST. J. 38 (2003) (insurer attorney criticizes *Fuller-Austin* and *UNR*) (Goldberger is a partner in White & Williams, a firm that regularly represents insurers); Leonard P. Goldberger, *Strangers in a Strange Land: A Road Map for Insurer Strategies in Bankruptcy Cases*, CGL REPORTER, 2003 Supplement, at 1 (contending that bankruptcy courts are "inhospitable" and "no friend of insurers"); Laura A. Foggan, *Bankruptcy Perils: Asbestos illustrates the risks insurers can face when policyholders go*

HeinOnline -- 12 Conn. Ins. L.J. 426 2005-2006

decade of bankruptcy-related coverage litigation, where they tend to see the forum as excessively concerned with maximizing policyholder assets, and because of the late 1990's upsurge in asbestos claims and bankruptcies substantially raised the financial stakes of adopting the approach of *UNR* and *Fuller-Austin*.

The *Fuller-Austin* trial court ruling was also particularly vexing to insurers in that the insurers had not been permitted to intervene in the bankruptcy proceeding (although they were able to commence parallel coverage litigation) and because, like the *UNR* court, the trial court found that confirmation of the bankruptcy plan was a final adjudication that bound the insurers to pay immediately and that the amounts and terms of the settlement could not be questioned.[173]

On appeal, the insurers were successful in obtaining reversal and remand, with California's Second District Court of Appeals holding that because the bankruptcy plan confirmation of asbestos claims was based on a negotiated settlement, it lacked the binding power of an adjudication. Consequently, as would be the case whenever a policyholder settles without an insurer's consent, the policyholder must establish the insurer's improper failure to defend or cover the claim. Further, the insurer may challenge the reasonableness of the settlement amount or the collusiveness of the settlement.[174] If the insurer should prevail on these grounds, the settlement is set aside, even where the insurer was guilty of abandoning the policyholder. (However, the policyholder would logically continue to have

---

under, LEGAL TIMES, Feb. 17, 2003, at 25 (insurer attorney criticizes *Fuller-Austin* and *UNR*) (Foggan is a partner in Wiley, Rein & Fielding, a firm that regularly represents insurers); Bennett, *supra* note 157, at 278 ("for insurance companies a problem has been created by [*Fuller-Austin*]. It could require insurers to accelerate payments for an insured's current and future asbestos liabilities into a trust established to pay those claims"); Maniloff, *supra*, note 156, at 13 (insurer attorney notes potential significance of *Fuller-Austin* and notes that *Wall Street Journal* "Heard on the Street" column regards decision as having significant impact) (Mr. Maniloff is a partner in White & Williams, a firm that regularly represents insurers); Gen Re, *California Asbestos Decision Could Accelerate Claims Payouts: Excess and Umbrella Carriers Are Held to Pay Pending and Future Claims*, HAZARDOUS TIMES, March 2002, at 1; Julia Molander & Lillian Stenfeldt, *Like Dorothy in the Land of Oz: Insurers in Bankruptcy Court*, SEDGWICK, DETERT, MORAN & ARNOLD, April 2004, http://sdma.com/sedgwick.updates/articles/insurance-bad-faith (Attorneys Molander and Stenfeldt are partners in Sedgwick, Detert, Moran & Arnold, which regularly represents insurers and contains a self-designated "Insurance Industry Team" within the Firm's practice).

173. *See generally* Fuller-Austin Insulation Co. v. Highlands Ins. Co., 38 Cal. Rptr. 3d 716 (Cal. Ct. App. 2006); *California Panel: Fuller-Austin Plan Confirmation Did Not Establish Indemnity Obligations*, 16 MEALEY'S LITIG. REP. REINSURANCE 9 (2006).

174. *See Fuller-Austin Insulation Co.*, 38 Cal. Rptr. 3d at 741.

a right to negotiate a second, more reasonable arm's length settlement that would subsequently bind the insurer).

Most helpfully for insurers, the appellate court ruled that a finding of the estimated present value of the current and future asbestos payments required by the policyholder's global settlement did not require immediate payment by the insurers.[175] Rather, it appears that under the appellate court's view, insurers would be permitted to pay covered settlements on a rolling basis as the actual costs of the settlement become apparent. (Recall that the nature of a large asbestos inventory settlement is based on an estimate of validity of current claims, the severity of injuries among the group (e.g., proportion of mesothelioma as opposed to pleural plaque), and the number and composition of future claims). Alternatively (and this appears not to be foreclosed on remand), insurers may be required to pay their policy limits to the trust established by an omnibus settlement, with pro-rata refunds owed to insurers if the actual number and severity of claims does not exhaust the trust fund.[176]

Although the trial court decision in *Fuller-Austin* was reversed on appeal, the threat remains for insurers. First, the California Supreme Court, which has shown an oscillating tendency regarding policyholder-insurer coverage battles, could restore the trial court approach (it could also, of course, embrace the insurers' phobia about such decisions).[177] Second and more likely, the trial court on remand may again support accelerated insurer payment if additional findings support this approach. The appellate

---

175. *Id.* at 746.

176. The *Fuller-Austin* appellate opinion is not specific, or even particularly clear on these points regarding administration of any approved settlement.

177. Policyholders wishing to attack the appellate opinion can not only argue that the appellate panel was too solicitous of insurer desire for calculated damages for each asbestos claimant but also point to a part of the opinion that suggests some lack of sophistication on the part of the panel. On a subsidiary point, the panel found that the trial court had erred on a part of the case controlled by Louisiana law because the trial court applied a continuous trigger rather than the exposure trigger endorsed by Louisiana courts. Where asbestos is concerned, the nomenclature is often misleading. *See supra* text accompanying notes 35-63. When courts speak of exposure to asbestos, they usually mean injurious exposure. Because asbestos continues to have "exposure-in-residence" in the victim's lungs, the exposure trigger, the actual injury trigger, and the continuous trigger usually tend to provide the same result regarding asbestos claims and insurance trigger. The *Fuller-Austin* appellate opinion seems oblivious to this and undertakes no analysis of whether the trial courts embrace of a continuous trigger actually brought a different result than would self-conscious use of an exposure trigger. *See Fuller-Austin*, 38 Cal Rptr. 3d at 726. This part of the appellate opinion is disturbingly formalist and superficial and provides something of a 13th chime of the clock to an opinion, that although not a model of clarity, generally reflects an appellate court conscientiously and sensitively trying to come to grips with a difficult problem and resolve it in a fair manner consistent with the contract rights of the affected parties.

HeinOnline -- 12 Conn. Ins. L.J. 428 2005-2006

court in *Fuller-Austin* did not close the door completely to the type of relief and coverage sought by the policyholder/debtor. In fact, the *Fuller-Austin* appellate opinion endorsed the longstanding general rule that if an insurer fails to defend a policyholder or is adverse to the policyholder, the defendant/policyholder is entitled to negotiate a settlement without insurer consent and receive coverage as long as the settlement was reasonable and made in good faith.[178] The appellate court found the trial record insufficient on the question of reasonableness and hence remanded the matter.[179] Third, of course, is the possibility that other courts will be less concerned about these issues than the California Court of Appeals and more concerned about the efficiency and finality benefits of bankruptcy and global settlement and will approve declarations of insurance coverage on trial records similar to that of *Fuller-Austin*.

Even if the *Fuller-Austin* appellate opinion should become the dominant approach to the problem of insurance coverage and asbestos bankruptcy, it is hardly a "Get Out of Jail Free" card for insurers. Much of the Second District's analysis supports policyholder claims of a right to enter into global asbestos settlements as part of bankruptcy (pre-packaged or conventional) without insurer consent or loss of coverage under certain circumstances. As the court observed:

> Summarized, California law provides that a defending insurer must consent to a settlement order for there to be coverage, but if an insurer erroneously denies coverage and/or improperly refuses to defend the insured in violation of its contractual duties, the insured is entitled to make a reasonable settlement of the claim in good faith and may then maintain an action against the insurer to recover the amount of the settlement. [However,] the trial court erred in finding that these principles mandated the conclusion that appellants had surrendered their right to consent solely by reserving their rights and not undertaking the defense of the matter. An insurer does not breach any duty to the insured merely by reserving its rights under the policy.[180]
>
> . . . .

178. *See Fuller-*Austin, 38 Cal. Rptr. 3d at 716-38.

179. *See id.* at 746-51.

180. *See id.* at 736 (internal citations and quotations omitted). Continued the court: "Thus, by reserving their rights to contest coverage, appellants did not wrongfully deny coverage in violation of their policies. Moreover, appellants did not breach any duty to defend Fuller-Austin, as their policies did not contain any defense obligations." *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 429 2005-2006

> [The jury verdict form stated that no insurers breached their policies prior to confirmation of the Fuller-Austin bankruptcy plan.] Accordingly, neither the law nor the facts supports the trial court's conclusion that appellants waived their right to consent to the Plan because they breached their policies by erroneously denying coverage or refusing to defend.[181]

Notwithstanding these findings, the appellate court left open on remand considerable opportunity for the trial court to nonetheless find that the global settlement was enforceable against non-consenting insurers. As the court first noted, the Fuller-Austin excess insurance policies did not contain a duty to defend but did contain language permitting the excess insurer to participate in or even take over defense of claims.

> [B]ecause appellants were neither acknowledging coverage nor providing a defense, and therefore were in no way exercising control over the asbestos claims brought against Fuller-Austin, we find it difficult to permit appellants to rely, without qualification, on a consent provision that is designed to protect defending insurers. . . . Indeed, appellants [insurers] have not directed us to a case holding that a nonbreaching excess insurer with knowledge of an impending settlement may decline to participate in settlement negotiations, yet then rely on the policy's consent provision to avoid responsibility under the settlement.[182]
>
> . . . .
>
> [A]n excess insurer, although not contractually obligated to take an active part in the defense of an insured, still owes its insured a duty of good faith when faced with an offer of settlement that exhausts the underlying policy limits.[183]
>
> . . .
>
> It would impose an unnecessary burden on primary insurers and parties to an underlying action to hold that an excess insurer has an absolute right to withhold its consent to a settlement, while at the sem time decline to participate in the action.[184]

---

181. *Id.*
182. *Id.* at 736-37.
183. *Id.* at 737.
184. *Id.* at 738.

HeinOnline -- 12 Conn. Ins. L.J. 430 2005-2006

> . . .
> Allowing Fuller-Austin to enter into a global settlement in the bankruptcy court without appellants' participation, while permitting appellants to challenge the bankruptcy Plan for fairness, reasonableness and lack of fraud or collusion in the instant action, does no violence to the policy language requiring appellants' consent. We do not believe that the policies can be read to permit an excess insurer to hover in the background of critical settlement negotiations and thereafter resist all responsibility on the base of lack of consent....On remand, appellants will be entitled to litigate the issue of whether, as to them, the bankruptcy Plan is unfair, unreasonable or the product of fraud or collusion.[185]

In short, the recent *Fuller-Austin* appellate opinion has something for both insurers and policyholders. Although insurers clearly won this round of the *Fuller-Austin* "battle," the court's groundrules for further determination on remand suggest that policyholders might well be able to prevail in the continuing "war" over policyholder and insurer prerogatives regarding global asbestos settlements and bankruptcy. Importantly, the appellate court affirmed the long-standing view that where an insurer fails in its obligations to the policyholder, the policyholder is not strictly bound by consent-to-settle or similar language of the policy. In such cases, the policyholder may take prudent steps to protect itself from devastating liability exposure and litigation expense by negotiating reasonable omnibus settlements in good faith, just as a policyholder may do so regarding individual claims where insurers deny coverage or refuse to defend.

The hard part, of course, devolves to the devilish details of particular insurer conduct, asbestos settlements, and bankruptcy arrangements. To a large extent, correct resolution of these insurer-policyholder conflicts will be highly situation specific and contextual. For example, insurers will argue that a reservation of rights letter, no matter how extensive, is only a reservation and (per the *Fuller-Austin* appellate opinion), a "mere" reservation of rights is not the sort of insurer misconduct that free the policyholder to protect itself with the best settlement possible. Alternatively, policyholders will look at these same letters and find that they are in practical effect a denial of coverage or that they establish adversity between insurer and policyholder that further makes it unwise to give literal enforcement to consent or cooperation clauses. In addition,

185. *Id.* at 741.

HeinOnline -- 12 Conn. Ins. L.J. 431 2005-2006

policyholders and insurers will both argue that particular conduct supports their position. If insurers fail to acknowledge coverage, agree to coverage-in-place agreements, or attend briefings, policyholders will find this the equivalent of denial of coverage or the type of "hovering in the background" condemned by the *Fuller-Austin* appellate panel. If policyholders fail to appraise insurers of developments and provide some reasonable opportunity to assume defense or settlement of claims, insurers will argue that it is the policyholder rather than the insurer that is in breach.

Beyond these situation-specific disputes, there is a broader gulf separating insurers and policyholders due to the importance of the time value of money. In my view, these differences auger in favor of permitting policyholders who become asbestos mass tort defendants substantial leeway in negotiating settlements and pursuing bankruptcy – unless its insurers are serving the CGL policy's function of providing protection to the policyholder facing this sort of "bet-the-company" liability.[186]

Insurers argue that *UNR* and *Fuller-Austin* unfairly deprive insurers of their rights under the standard CGL policy and common excess liability policies through essentially bypassing the adjustment, defense and seriatim settlement of claims that would ordinarily occur for tort matters. Similarly, the bankruptcy plan resolution of asbestos liability, by bundling resolution of asbestos matters and establishing an administrative system of compensation with set damage awards prevents insurers from deriving a typical benefit of liability insurance – the elongated path between the initial claim and final payment of the claim.

Where the insurer is required to make payments in a bloc or to fund a trust after only a few months or a couple years of bankruptcy maneuvering, this is quite different economically for the insurer than defending and paying claims seriatim over the course of many years or perhaps even several decades. Insurers make their money less from underwriting profit (i.e., taking in more in premiums dollars than they pay in claims) and more from the "float" of holding policyholder premiums to general investment income for as long as possible before paying claims. In addition to this obvious incentive to pay claims later rather than sooner, insurers also profit from delay because later payments tend to cost less in real dollars due to inflation. As the industrialist John Paul Getty put it well, "a billion dollars doesn't go as far as it used to."[187] A billion dollars in 1955 (when asbestos

186. Although excess or umbrella liability policies are not, strictly speaking, CGL policies, most excess policies "follow-form" to the underlying primary CGL policy. Even stand-alone or modified excess policies largely echo the coverage provided in the CGL.

187. *See* Stephanie Mansfield, *Billionaire behavior*, ST. PETERSBURG TIMES, Nov. 8, 1992, p. 5D, col. 1 (quoting Getty); Bella English, *A little advice for the Donald,* BOSTON

HeinOnline -- 12 Conn. Ins. L.J. 432 2005-2006

was in wide use) would equate to $ 6.874 billion in 2005.[188] In essence, a dollar paid by insurers on a 1950s liability policy is the equivalent of thirteen cents today.

The net effect of these basics of insurance economics is to give insurers a distinct advantage over policyholders in dealing with the financial consequences of unforeseen mass tort liability. When a mass tort such as asbestos produces a rush (perhaps even an avalanche) of claims, this is more than a little frightening—and economically threatening—to even the largest commercial entities. Although such a rush of claims is hardly good news for insurers, neither is it as immediate a concern. The insurer is by definition more diversified and frequently has far more capital than all but the largest manufacturers, contractors, or retailers. Most important, the insurer may have the luxury of time and it attendant effect on money. By contrast, the policyholder must take immediate action to fend of claims, settle them, or through some combination discourage more such claims.

The Federal Rules of Civil Procedure give the tort defendant only 20 days to respond and begin to mount a defense.[189] Although this deadline is routinely extended, the point remains: for policyholder defendants in a mass tort situation, peril is close at hand. For insurers, the day of reckoning is further in the future. In practice, of course, commercial policyholders typically tender mass tort claims to their insurers swiftly after receipt, which places pressure on at least the primary liability insurer to make a reasonable and expeditious decision regarding defense of the claim or risk exposure to a bad faith claim by the policyholder. But even with the potential equalizer of bad faith, the deck is still largely stacked in favor of the commercial liability insurer.

The CGL insurer may agree to defend mass tort claims but due so under a "reservation of rights," essentially refusing to commit to indemnity coverage until further information becomes available and the insurer is able to make a final assessment. The insurer may even commence a simultaneous declaratory judgment action seeking a ruling that it has no duty to indemnify or defend the claim. In the case of long-tail tort claims such as asbestos that extend over many years, several different policy periods and primary insurers may be implicated, leading to insurer

---

GLOBE, June 11, 1990, p. 17 (quoting Getty). Further, this article, in which the author notes the current financial distress of Donald Trump, who 15 years later would again be perceived as mega-wealthy and have television star status, also illustrates that much can happen over time to permit insurers and other businesses to soften financial blows.

188. *See* MORGAN INFLATION CALCULATOR, available at http://www.westegg.com. inflation (visited Mar. 9, 2006).

189. *See* Fed. R. Civ. P. 8(b) and 12(b).

HeinOnline -- 12 Conn. Ins. L.J. 433 2005-2006

hesitancy to commit to defense or coverage while they argue among themselves as to relative responsibility.

Excess and umbrella insurers are in an even better perch for playing a waiting game with policyholders. Excess and umbrella insurance typically does not "attach" until primary insurance is exhausted. Although this is not a particularly problematic requirement or difficult determination in the average case, it can become a ground for dispute and delay in long-tail mass tort situations. Insurers can raise questions and then contend that they need make no coverage decision until these questions are resolved. When is primary insurance exhausted for a particular policy period? What is the effect of insolvency of primary or other excess insurers? How should any deductibles or retentions be applied? How are the underlying claims to be classified, as general operations matters for which there is no aggregate limit or as products/completed operations matters subject to an aggregate limit?

Even if this insurance version of 20 questions is completed, the net effect is to put excess insurers in an advantageous position relative to policyholders. While the policyholder faces an immediate mass tort problem that may even destroy the company, the excess insurer is simply waiting to be judicially required to pay a limited amount of money pursuant to a contract for which the excess insurer was paid years ago, since investing the premiums. In addition, most excess policies provide that any amounts spent on defense reduce the policy limits otherwise available for indemnity payments. The excess insurer thus typically does not face the primary insurer's dilemma of whether to expend more on defense in hopes of avoiding policyholder liability or reducing the amounts spent in settlement or judgment. Absent bad faith liability, the excess insurer's maximum liability is capped at the policy limits (at least per-occurrence limits and perhaps aggregate limits as well) whether it spends its millions or defense or tribute.

In addition, notwithstanding requirements that the insurer make a relatively expeditious decision on providing a defense and the liberality of duty-to-defend doctrine (which requires not that coverage be established but only that the allegations of the third party's complaint create a "potential for coverage"), insurers as a practical matter take considerably longer than 20 days to decide whether the policyholder will receive a defense. In the meantime, a mass tort may mushroom into an even bigger problem for the policyholder as the notoriety of the claim spreads and well-funded plaintiffs' counsel gather more plaintiffs through advertising.

Although a commercial policyholder normally has the resources to fund its own defense, at least for some time, while its liability insurers

HeinOnline -- 12 Conn. Ins. L.J. 434 2005-2006

assess their position, even the best-heeled of policyholders will soon feel the pinch. If the liability insurance for which the policyholder has already paid does not provide a relatively quick, vigorous defense or put a sound dispute resolution strategy in place, the policyholder will soon face a cash-flow emergency and perhaps even true insolvency in which current liabilities exceed current assets. At that point, bankruptcy may evolve from option to practical necessity for the policyholder.

In short, mass torts such as asbestos are no picnic for liability insurers, particularly the primary insurers that must defend claims without defense expenditures reducing the amounts they may owe to pay judgments and settlements (particularly if aggregate limits do not apply). But mass torts are a far worse problem for policyholders, one which suggests that policyholders should be given wide room to pursue protection through bankruptcy, including inventory or prepackaged settlements triggering insurance coverage. If insurers will not provide an adequate defense and coverage commitment to policyholders facing mass tort liability, the bankruptcy alternative seems more than reasonable both as a matter of the insurance contract agreement, the relative equities of the parties, and national public policy.

Congress was aware of the UNR bankruptcy and presumably was at least constructively aware of the role played by insurance coverage in the UNR reorganization and settlement of asbestos claims. Under these circumstances, it is fair to assume that the Congress that enacted current 11 U.S.C. §524(g) had no objection to requiring insurers to fund such trust arrangements as part of a reasonable global settlement of asbestos claims and to requiring earlier payment of policy proceeds than what might be preferred by insurers. Section 524(g) would thus appear to effectively precludes literal application of the cooperation and consent-to-settle provisions typically found in liability policies where the asbestos defendant policyholder is seeking bankruptcy protection.

In "ordinary" tort liability matters, the claim is tendered to the insurer and settled or defended-and-settled, occasionally reaching trial, verdict and appeal (but often with settlement pending appeal). Under these typical circumstances, the liability insurer is of course entitled to insist on its contractual right to control the defense and settlement of the case (assuming that its interests are not adverse to those of the policyholder) and to refuse to pay any settlements negotiated by the policyholder as "lone wolf" without the consent of the insurer. Bankruptcy mass torts, however, suggest that these parts of the insurer-policyholder relationship must be enforced under a rule of reason rather than one of linguistic literalism.

HeinOnline -- 12 Conn. Ins. L.J. 435 2005-2006

Consider a hypothetical bankruptcy scenario not much different from actual cases. The mass tort asbestos defendant is facing thousands of claims. Defending the claims seriatim is not a realistic option because of the cost. The policyholder has decades of primary insurance backed by several layers of excess or umbrella insurance. However, the insurers have been slow to agree to take on the burden of defending and resolving the claims. They argue among themselves (but to the detriment of the policyholder) as to which policies are triggered, which primary carriers should initially defend which claims, when excess coverage attaches, the effect of insolvencies, the apt apportionment of coverage responsibility, and other matters. They may even assert complete defenses to coverage such as the intentional act exclusion or the pollution exclusion. Even though these defenses are unlikely to succeed, they create an additional lawyer of uncertainty and exposure for the policyholder, as insurers deny coverage or reserve rights. Some insurers may even join in a declaratory judgment action seeking a determination of no coverage.

In the meantime, the policyholder needs to try to preserve its ongoing business. It cannot realistically bear the burden of simultaneously running that business, fighting with its insurers, and defending mass tort claims. Bankruptcy reorganization is an attractive solution because it permits the policyholder to reduce a huge looming liability to a large but calculable liability that has parameters as to compensation levels and provides a controlled process of settlement payouts within the financial means of the policyholder (assuming there is as lease significant available insurance). It also dramatically reduces defense and other disputing costs for the company. The policyholder gains an economically sound resolution of a company-threatening liability with insurers generally paying less for asbestos claims under this approach than if they had been allowed to fester for years. Society avoids the complete liquidation of the company and its more severe economic consequences to shareholders, employees, and the community.

The policyholder negotiates a plan with creditors. All it wants now is for insurers to pay their fair share of the compensation amounts. But insurers object, arguing that there can be no enforceable asbestos mass tort settlement without the insurers' express consent and that the policyholder's efforts to resolve the imbroglio are in fact breaches of the policy's cooperation clause. Under these circumstances, are the insurer objections well taken? I think not. Although insurers should certainly be able to object and insist on bankruptcy court scrutiny of the debtor's overall plan

HeinOnline -- 12 Conn. Ins. L.J. 436 2005-2006

and in particular the asbestos settlement system,[190] insurers should not have a right to veto or thwart an otherwise sensible bankruptcy merely because the insurance policies contain control-of-defense, consent-to-settle, and cooperation provisions designed for more ordinary torts and times.

This is particularly true where the insurers are adverse to the policyholder or have denied coverage or otherwise abandoned the policyholder – and where the insurers have failed to attempt in good faith to participate in the bankruptcy resolution. (By the same token, the insurers should be included in the negotiation of the settlement to the extent feasible). In mass tort bankruptcy situations, there is little justification for cleaving to a formalist approach to insurance coverage. Rather, the focus should be on whether the negotiated resolution of asbestos claims is fair and reasonable and the product of good faith conduct on the part of the policyholder. If this standard is met, there is essentially nothing about which the insurer can complain – it is providing the same or less coverage than it would be required to provide had there been no bankruptcy-produced global settlement of asbestos claims. The only "harm" to the insurers is that they will generally pay out their shares of the settlement sooner than would be the case in the absence of bankruptcy. Although this a legitimate business concern of insurers, it is not a legitimate basis for denying policyholder recovery.

The mechanics of the § 524(g) prepackaged bankruptcy change the dynamic somewhat in that the bankruptcy plan can arguably be "crammed down" by a three-fourths vote of the claimants – which as a practical matter means that asbestos tort claimants (most of whom will be in the stable of clients of a few high-powered plaintiffs' firms) can reach a settlement with the policyholder even where other creditors find the terms of the arrangement suboptimal. In this sense, the *UNR* Court's confidence in the policing power of creditor approval appears reduced in the § 524(g) bankruptcy as compared to a regular bankruptcy.[191] But even in the § 524(g) situation, the bankruptcy judge is not required to approve a defective plan. The court still retains equitable control over the bankruptcy process and logically should be providing some supervision and policing of these agreements.

Of equal importance to insurers is that even if the global settlement and overall plan is lopsided in favor of asbestos claimants and in derogation of other interests, the insurers retain the right to challenge the settlement plan,

190. *See* Mark D. Plevin, Robert T. Ebert & Leslie A. Epley, *Pre-Packaged Asbestos Bankruptcies: A Flawed Solution*, 44 S. TEX. L. REV. 883 (2002-2003).

191. *See id.*, *supra* note 190; *Fuller-Austin*, 38 Cal. Rptr. 3d at 738 (noting that UNR preceded enactment of § 524(g)).

HeinOnline -- 12 Conn. Ins. L.J. 437 2005-2006

both as to eligibility criteria and amount of compensation in relation to particular injury. If the insurers can demonstrate that the asbestos global settlement was collusive, otherwise in bad faith, or simply too generous, the insurers should not be required to fund the settlement and should be able to force settlement negotiations back to the metaphorical drawing board.

Although the new world of asbestos, bankruptcy and prepackaged bankruptcy differs from the ordinary liability coverage matter, there is ample precedent for this approach to assessing insurer obligations under bankruptcy-related global settlements. It is the natural corollary of the well-established doctrine that policyholders may settle a claim when insurers fail to shoulder the claim and the insurer must pay so long as the policyholder-generated settlement is reasonable.[192] What insurers should not be able to do is thwart asbestos global settlements in bankruptcy merely because they are asbestos global settlements in bankruptcy. This would reduce 524(g) to a nullity.

Further, it seems undeniable that the reasonableness of asbestos mass tort settlements is more easily and accurately gauged than that of individual tort claims or emerging mass tort claims. In 1989, mass tort expert Francis McGovern labeled asbestos a "mature" tort, introducing the concept that were a type of tort claim is mature, questions of liability, medical evidence, applicable defenses, and the range of verdicts and judgments is well-established[193] while these questions may be quite open (even wide open) for new, emerging, or individuated tort claims. Under these circumstances, it is far easier for mature mass tort litigants and courts to assess whether the criteria for proving up claims and the amounts specified in a settlement agreement are reasonable.

The asbestos mass tort is so sufficiently mature that major congressional legislation has adopted a payment schedule for asbestos claims.[194] Although the asbestos resolution bill will probably falter on the

---

192. *See, e.g.*, Red Giant Oil Co. v. Lawlor, 528 N.W.2d 524 (Iowa 1995); United Services Auto. Ass'n v. Morris, 741 P.2d 246 (Ariz. 1987); Miller v. Shugart, 316 N.W.2d 729 (Minn. 1982); Griggs v. Bertram, 443 A.2d 163, 174-175 (N.J. 1982); Damron v. Sledge, 460 P.2d 997 (Ariz. 1969). *See* STEMPEL, *supra* note 6, §§ 902, 9.05, 9.11. *But see* State Farm Fire & Cas. Co. v. Gandy, 925 S.W.2d 696 (Tex. 1996) (requiring that claim be fully adjudicated to determine value and insurer coverage responsibility).

193. *See* Francis E. McGovern, *Resolving Mature Tort Litigation*, 69 B.U. REV. 659 (1989). *See also* Samuel Issacharoff & John Fabian Witt, *The Inevitability of Aggregate Settlement: An Institutional Account of American Tort Law*, 57 VAND. L. REV. 1571 (2004).

194. *See* Fairness in Asbestos Injury Resolution Act of 2005, S. 852 (or "FAIR" Act) (this is the main asbestos resolution bill under debate and championed by Judiciary

HeinOnline -- 12 Conn. Ins. L.J. 438 2005-2006

shoals of partisan politics[195] or fears that the proposed trust would be inadequately funded,[196] objections to the bill tend not to argue that the payment schedule is too generous. Almost by definition, any settlement that provides for a payment schedule significantly below the amounts of the congressional legislation would appear to be per se reasonable, at least as to amount.

There remains, of course, room for debate as to whether particular settlements have adequate mechanisms for validating claims. Insurers and their counsel have been particular critical of the posited tendency of bankruptcy-related settlements to involve log-rolling between counsel, defendants, and claimants without the true adversity of full-dress litigation.[197] Although the limited funding available because of the magnitude of mass torts, insurance policy limits, and the resources of companies in bankruptcy (or contemplating bankruptcy) undoubtedly encourages cooperation, this hardly makes such settlements collusive. Individual examination is required, with some deference to the financial realities presented by the now-mature asbestos mass tort. Depending on the facts surrounding bankruptcy and global settlement, insurers may well prevail in their arguments that the arrangements are unenforceable.[198]

Committee Chair Arlen Spector). The FAIR Act provides the following compensation schedule:

> $ 25,000 for evidence of asbestos-related injury without impairment;
> $ 100,000 for asbestosis with pleural plaque;
> $200,000 where an asbestosis victim has "other cancer" not specifically earmarked as an asbestos-induced cancer;
> $ 400,000 for severe asbestosis;
> $ 850,000 for disabling asbestosis;
> Amounts ranging from $300,000 to $850,00 for lung cancer depending on whether the victim is a smoker, ex-smoker, or non-smoker;
> $ 1.1 million for mesothelioma.

195. *See* Brody Mullins, *Bill to Overhaul Asbestos Litigation Seems Headed for Senate Rejection*, WALL ST. J., Feb. 7, 2006, at A4, col. 5; Editorial, *Justice for Asbestos Victims*, NEW YORK TIMES, Feb. 7, 2006, at A24.

196. *See Fed Study Raises Doubts About Proposed Asbestos Trust Fund,* INS. J., Dec. 22, 2005, available at http://www.insurancejournal.com/news/national/2005/12/22/63347.htm. *See also Justice for Asbestos Victims*, *supra* note 195 (expressing concern over whether proposed $140 billion trust fund will be adequate).

197. *See* Plevin, *supra* note 190; Brickman, *supra* note 161. *See also* Francis E. McGovern, *The Tragedy of the Asbestos Commons*, 88 VA. L. REV. 1721, 1728-35 (2002) (positing that litigation system's lack of incentives for cooperation are major part of the asbestos mass tort problem).

198. *See, e.g.*, In re Combustion Engineering, 391 F.3d 190, 245-46 n.66 (3d Cir. 2005).

HeinOnline -- 12 Conn. Ins. L.J. 439 2005-2006

But the need for scrutiny over particular settlements should not obscure the overall insurance coverage picture. Insurers arguing that they are entitled to literal enforcement of consent-to-settle clauses, cooperation clauses, or related provisions restricting policyholder authority to settle asbestos claims are simply wrong – unless the insurer is properly defending the policyholder or otherwise firmly committed to coverage (subject to any discrete, targeted, non-frivolous reservation of rights based on the specific nature of a problematic claim. By this point in the asbestos saga, it is too late for insurers to credibly rely on boilerplate objections to coverage regarding the much litigated (cum overlitigated) asbestos mass tort.

VIII. EQUILIBRIUM EFFECTS: OVERLOOKED INSTANCES OF INSURER VICTORIES IN ASBESTOS AND RELATED COVERAGE BATTLES

Insurers and their counsel have done an effective job of highlighting the degree to which the asbestos mass tort has been a bane to the insurance industry. Although insurers as a class have not successfully portrayed themselves as victims relative to those injured by asbestos, their efforts have succeeded to the extent that many observers appear to see insurers as more severely and unfairly impacted by the asbestos mass tort than asbestos defendant policyholders. As discussed above, particularly in Section VII concerning the impact of bankruptcy on insurance coverage,[199] and as further elaborated in Section X, below,[200] insurers appears to have suffered the least damage of any entity touched by the asbestos tragedy and mass tort. By any reasonable objective measure, the asbestos mass tort has been more of a burden to those injured, society in general, and to commercial policyholder asbestos defendants than to insurers.

This pattern would appear not only to continue but to be codified should congressional asbestos legislation be enacted in the form currently discussed. The primary bill most likely to pass in some form (should any bill pass, which is unlikely)[201] provides for a $ 140 billion fund to

199. *See supra* text and accompanying 152-179.

200. *See infra* text and accompanying 248-255.

201. *See* Elihu Inselbuch, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005) (contending that proposed omnibus asbestos legislation has proven such a highly effective lever helping Republicans raise funds from businesses and insurers favoring the bill while helping Democrats raise similarly substantial funds from plaintiffs' trial lawyers that generally oppose the legislation; as a result, neither party really is motivated to actually enact some form of legislation and remove this mutually effective fundraising device).

HeinOnline -- 12 Conn. Ins. L.J. 440 2005-2006

compensate current and future asbestos victims, with two thirds of the fund the fund financed by asbestos defendants and one third from liability insurers.[202] Policyholders are thus expected to pay more than their insurers in this attempt to bring global peace to the asbestos mass tort. But the amount demanded of insurers by Congress appears to be considerably less than the limits of the unexhausted liability policies in force, at least if I am correct regarding the proper classification of general operations claims and completed operations claims (as discussed in Section V, *supra*).[203] An alien landing on Earth with a basic knowledge of insurance would immediately conclude that insurers are walking away from the asbestos negotiating table with money in their pockets while policyholders are turning theirs inside out. Having insurers pay less to the settlement fund than policyholders would make sense if the amount required reached or exceeded the limits of available coverage. It makes no sense to embrace an omnibus asbestos solution in which insurers pay less than what they would presumably pay in the absence of such legislation.

But thus far, everyone in Washington and at this Symposium seems to think this is fair and reasonable, or at least not odd, which is itself a mark of how successful insurers have been in shaping the debate and perceptions of fairness regarding payment for the asbestos mass tort. To recap: Under the main congressional proposal for a global legislative resolution of the asbestos mass tort, the liability insurers will pay less than their policy limits for claims that are clearly within coverage even though the amount of the liability clearly exceeds those policy limits. However, this is not because claimants have agreed to take such a deep discount that policy limits are never reached. Rather, policyholders would be required to pay billions of dollars of their own money for this global resolution even though they have not exhausted their available insurance. Further, even the policyholders appear to be think of such a result as a victory.[204] This can only be

---

202. *See* Patrick Hanlon, *An Elegy for the FAIR Act*, 12:2 CONN. INS. L.J. 263 (2006).

203. *See supra* text and accompanying notes 70-131.

204. And, it appears that the policyholders are correct. Although it appears that insurers benefit vis-a-vis policyholders under the congressional proposals, it also appears that policyholders would ultimately gain from a global resolution either by paying lower aggregate compensation costs, lowering disputing costs, achieving the business benefits of certainty or some combination of these factors. *See* Hanlon, *supra* note 202. *See also* John Bowman, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 4, 2005) (plaintiffs' trial lawyer views proposed legislation as have net effect of reducing victim compensation); Craig Berrington, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 4, 2005) (insurer representative sees legislation lowering overall ultimate cost of asbestos mass tort by lowering disputing costs).

HeinOnline -- 12 Conn. Ins. L.J. 441 2005-2006

characterized as a tremendous public relations coup for insurers as well as a good deal should the proposed legislation be enacted. Congress appears to share the judiciary's sympathy for the purported plight of asbestos liability insurers and appears to accept the insurer argument that the industry has already paid enough and that policyholders must do more.

This is not to say that policyholders have not won some important victories in their coverage battles with insurers. Prominent policyholder lawyers such a Eugene Anderson, Robert Saylor, Jerold Oshinsky and Scott Gilbert have careers launched by or built upon their success in asbestos coverage matters.[205] But, as discussed below, the major policyholder victories were achieved relatively early in the asbestos coverage wars. During the past 15 years, insurers have tended to win the greater share of coverage victories, in both asbestos matters and other coverage disputes.

My thesis posits that many of these insurer victories, discussed below, were undeserved or at least problematic or presenting close questions. Yet insurers—who perennially maintain that they always lose in a rigged game of ambiguity analysis, reasonable expectations, and bad faith claims—have nonetheless assembled a surprisingly good track record in recent years, arguably one good enough to tip the overall balance in favor of insurers as against policyholders. Although not all of these insurer victories are in asbestos cases, they may have indirect impact on asbestos coverage and provide insurers with ample ammunition for future coverage battles. These underappreciated doctrinal victories by insurers form the basis for a world of future coverage disputes in which insurers will probably do better than they deserve, in at least some part because of the judiciary's over-correction to what are perceived as some very pro-policyholder developments arising from the asbestos mass tort.

---

205. Mr. Anderson, name partner in the well-known policyholder firm of Anderson, Kill, was the lead attorney for Keene Corporation in its successful effort to obtain the favorable trigger of coverage rulings discussed. *See supra* text accompanying notes 35-63. Mr. Saylor, a partner in Covington & Burling, was a well-established commercial lawyer who turned to representing asbestos defendant policyholders and achieved significant victories during the 1980s and 1990s, perhaps most prominently in Armstrong World Indus. v. Aetna Cas. & Sur. Co., 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (Cal. Ct.. App. 1996). Mr. Oshinsky is a prominent coverage attorney and partner at Dickstein, etc. who represented policyholders in the early seminal asbestos coverage litigation such as *Forty-Eight Insulations*. *See supra* text and accompanying note 6. Scott Gilbert, a former Covington partner who formed Gilbert, Heintz & Randolph, has long represented asbestos defendant policyholders in coverage litigation and was chief author of the Wellington Agreement. He also appears to be the policyholder attorney most associated with policyholder efforts to prevent insurers from too quickly classifying insulation and construction asbestos liability as products/completed operations liability in order to take advantage of aggregate limits for these types of claims.

HeinOnline -- 12 Conn. Ins. L.J. 442 2005-2006

As a general matter, courts and other social institutions appear to seek equilibrium between competing perspectives and to maintain a basic, stable status quo. After rendering decisions that arguably shift the status quo in favor of certain interests, the judicial system tends to render countervailing decisions that seek to restore the status quo or at least the pre-existing balance of power.[206] In a battle of long-running antagonists such as policyholders and insurers, courts simply get uncomfortable if either side racks up too long a string of victories.

As a general matter, this is a healthy tendency of the judicial system, one that mitigates against abrupt or radical change that may be unwise or unduly disruptive. It also reflects a basic judicial desire for objectivity and neutrality in which courts are not viewed as favoring certain interests over others. Properly functioning equilibrium tendencies can function to prevent doctrine or precedent from being oppressively applied. But this same tendency can also produce a less defensible form of equilibrium in which courts imitate a mediocre referee that alternates imposition of fouls or penalties, or over-corrects for a bad call by making a worse call for the other side.

Have the insurance coverage battles of the past quarter-century reflected a pattern of equilibrium? Has it been a sound equilibrium or mere alternating between one side and another. A summary examination of the coverage scorecard, beginning with the asbestos liability insurance trigger cases of the late 1970s and 1980s tends to show early policyholder victory followed by an increasing pattern of insurer wins in cases they probably should not have won. Legal developments concerning insurance coverage appear to reflect the equilibrium-seeking tendencies of law generally, but with a sub-optimal, unduly pro-insurer balance that may be the result not only of judicial error but also a perception that insurers had suffered enough from the policyholder's early victories and the weight of the asbestos mass tort in general.

Examination of the overall judicial treatment of insurance coverage during the asbestos mass tort era suggests that on the whole, the asbestos mass tort has not been bad for insurers overall or in the long run in terms of legal doctrine. Although insurers may have paid more than preferred over asbestos claims, the insurance industry emerges from 25 years of asbestos coverage litigation with a significant number of doctrinal victories that give

206. *See* Jeffrey W. Stempel, *Arbitation, Unconscionability, and Equilibrium: The Return of Unconscionability Analysis as a Counterweight to Arbitration Formalism*, 19 OHIO ST. J. DISP. RES. 757, 761-66, 859-60 (2004); William N. Eskridge, Jr. & Philip K. Frickey, *The Supreme Court, 1993 Term, Foreword: Law as Equilibrium*, 108 HARV. L. REV. 26 (1994).

HeinOnline -- 12 Conn. Ins. L.J. 443 2005-2006

it a greater comparative advantage in coverage disputes than it had before the asbestos mass tort arrived.

So, what is the rough scorecard in the continuing sage of insurer-policyholder coverage battles of the modern (asbestos mass tort) era? The most significant policyholder victory, of course, is the widespread adoption of the continuous trigger in which a asbestos victim's continuing injury from asbestos in the lungs is deemed to be an injury during each of the successive policy periods going forward from the time of the claimant's initial injurious exposure to asbestos.[207] As discussed above, the continuous trigger is today seen by most as a natural consequence of a correct reading of the standard CGL policy, which establishes trigger based on "bodily injury" from an "occurrence" and does not require that the injury be manifest, detected or even diagnosable at the time the injury takes place.[208] The CGL policy, which was or course drafted by the insurance industry, does not require any particular form or quantity of harm to trigger coverage. When combined with the peculiar properties of asbestos, in which essentially indestructible asbestos fibers continue to inflict harm to the body for many years after inhalation, the continuous trigger results.[209]

Insurers fought hard against the continuous trigger and tended to argue for a trigger jurisprudence that would confine asbestos liability coverage to

---

207. *See supra* text accompanying notes 38-66.

208. *See supra* text accompanying notes 38-66. *See, e.g.*, Stonewall Ins. v. Asbestos Claims Management Facility, 73 F.3d 1178 (2d Cir. 1995) (applying New York and Texas law); ACandS, Inv. v. Aetna Cas. & Sur. Co., 764 F.2d 968 (3d Cir. 1985) (applying Pennsylvania law); Keene Corp. v. Ins. Co. of North America, 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982) (applying general principles of law); Owens-Illinois v. United Ins., 650 A.2d 974 (N.J. 1994). *Accord* Montrose Chem. Corp. v. Admiral Ins. Co., 10 Cal. 4th 645, 913 P.2d 878 (Cal. 1995) (applying continuous trigger in construction defect context).

209. *See supra* text accompanying notes 38-66. Despite the differing terminology, a court's application of an "exposure" trigger or an "actual injury" or "injury-in-fact" trigger becomes a continuous trigger for asbestos claims. *See, e.g.*, Abex v. Maryland Cas. Co., 790 F.2d 119 (D.C. Cir. 1986); Ins. Co. of North America v. Forty-Eight Insulations, Inc., 633 F.2d 1212 (6th Cir. 1980)(applying Illinois and New Jersey law); *See also* Commercial Union Ins. Co. v. Sepco Corp., 765 F.2d 1543 (11th Cir. 1985)(applying Alabama law)(applying exposure trigger in pollution liability context that results in continuous triggering); American Home Products Corp. v. Liberty Mut. Ins. Co., 748 F.2d 760 (2d Cir. 1984)(applying New York law)(applying actual injury trigger that results in continuous triggering for insidious injury allegedly caused by pharmaceutical product). *See* STEMPEL, *supra* note 6, § 14.09[b] at 14-48 (observing that in practice exposure trigger requires injurious exposure, which equates it to actual injury trigger and that properties of asbestos product actual injury in multiple policy periods once ingested, resulting in continuous trigger regardless of court's nomenclature).

HeinOnline -- 12 Conn. Ins. L.J. 444 2005-2006

a single policy.[210] They lost this battle, largely because the CGL policy language pretty clearly establishes trigger based on injury, even slight injury and because asbestos is able to cause injury over the course of many years.[211] But insurers continue to act as though the widespread judicial adoption of the continuous trigger were some type of radical leftist jurisprudence unmoored from insurance policy text or basic principles, which is clearly incorrect. The continuous trigger is the logical result of the insurance industry's own adoption of an actual injury trigger combined with the relentlessly ability of asbestos to inflict injury over many years.

As discussed in Section III, *supra*, when adopting the 1966 version of the occurrence basis CGL policy and more clearly focusing on the date of injury (rather than the date of negligent conduct or activity giving rise to liability) as the trigger of coverage, the insurance industry anticipated that multiple insurance policies could be triggered if injury took place in more than one policy period.[212] The ability of asbestos to cause injury in so many policy periods and the overall magnitude of the asbestos mass tort was undoubtedly not anticipated by insurers, who, as a general rule expected the overwhelming number of claims subject to CGL coverage to take place in one clearly defined space and time. But it cannot credibly be said that judicial rulings establishing the continuous trigger are at odds with CGL policy language, industry understanding, or the physical properties of asbestos. Consequently, insurers with asbestos coverage liability due to the

---

210. However, insurers were not always consistent and sometimes took inconsistent positions on trigger depending on the particular case and the insurer's own place in the chain of potentially implicated liability policies. Thus, perhaps unsurprisingly, insurers on the risk during the early years of a claimant's exposure could be found arguing for a "manifestation" trigger that required asbestos related disease to be more apparent while insurers on the risk in later years argued for a trigger based on mere "exposure" to asbestos so that the early year carriers would be implicated. *See* Eugene R. Anderson & Nadia V. Holober, *Preventing Inconsistencies in Litigation with a Spotlight on Insurance Coverage Litigation: The Doctrines of Judicial Estoppel, Equitable Estoppel, Quasi-Estoppel, Collateral Estoppel, "Mend the Hold," "Fraud on the Court" and Judicial and Evidentiary Admissions*, 4:2 CONN. INS. L.J. 589 (1998).

211. *See* STEMPEL, *supra* note 6, § 14.09[b].

212. *See supra* text accompanying notes 35-63. Although the 1955 CGL form used the term "accident" rather than "occurrence" and the drafting history surrounding the 1966 Form is clearer on this point, the adoption of the occurrence trigger represents a recodification of the injury-based 1955 accident trigger and was not intended to change the operation of the CGL. Trigger was always to be based on injury. Prior to 1966, there may have been some division among insurers as to whether an accident to span multiple policy periods. The 1966 changes resolved the issue by embracing the view that triggering injury could take place in multiple policy periods.

HeinOnline -- 12 Conn. Ins. L.J. 445 2005-2006

continuous trigger should be given no more sympathy than any other contracting party that suffers economic loss through miscalculation.

Although they were correctly decided on the merits, there is no denying that the continuous trigger precedents greatly benefitted policyholders by making more liability policies potentially applicable to a policyholder's asbestos claims, thereby tending to increase the amount of coverage. Of almost equivalent important were judicial decisions, like those discussed in Section IV, *supra*, that tended to regard each injury to a separate asbestos claimant as a separate occurrence,[213] although there were decisions to the contrary.[214] If courts instead had chosen to define an occurrence as the mining of asbestos, manufacture of asbestos, or bulk sales or distributions of asbestos, the amount of available coverage would have been considerably reduced. As with the continuous trigger, however, the occurrence jurisprudence of the courts was not a gift to asbestos defendant policyholders but resulted from objectively correct application of basic insurance principles and the common sense conclusion that each claimant's own exposure to asbestos is the occurrence out of which bodily injury arises for purposes of the CGL. But, as also noted in Section IV, occurrence-counting jurisprudence is not a model of consistency.[215] One can certainly envision courts having veered to a more restrictive view of occurrence-counting, which would have limited insurer responsibility in spite of the absence of aggregate limits.

Other policyholder victories in the asbestos coverage wars were perhaps even more prosaic but nonetheless important in providing coverage. In the early stages of asbestos coverage litigation, insurers routinely asserted the "intentional act" defense, which bars coverage where the injury to the third party claimant is "expected or intended from the standpoint of the insured" (a limitation more often today applying broadly to "an insured" or "any insured"). Courts have for the most part correctly rejected this defense, reasoning that even if a policyholder fully intended to make, sell, distribute or use asbestos, this hardly proves that the

213. *See supra* text accompanying notes 64-69.

214. *See, e.g.*, Appalachian Ins. Co. v. Liberty Mut. Ins. Co., 676 F.2d 56 (3d Cir. 1982) (applying Massachusetts law); Bartholomew v. Appalachian Ins. Co., 655 F.2d 27 (1st Cir. 1981) (applying Rhode Island law); Champion Int'l Corp. v. Continental Cas. Co., 546 F.2d 502 (2d Cir. 1976), *cert. denied*, 434 U.S. 819 (1977) (applying New York law).

215. *See supra* text accompanying notes 64-69.

HeinOnline -- 12 Conn. Ins. L.J. 446 2005-2006

policyholder did so with the subjective expectation of injuring third parties, much less an intent to injure.[216]

The closest cases for applying an "expected or intended" defense are those in which personnel of a core asbestos defendant had knowledge of the harmful properties of the material and wilfully failed to warn of the danger or attempted to conceal it. There is evidence of such misconduct for a few such asbestos defendants but little suggestion that insulation contractors, flooring tile makers, or such other peripheral asbestos defendants ever had any such mens reas in the conduct of their activities giving rise to asbestos-related liability.[217] Further, although a company employee may be "an insured" under a liability policy as well as a creator of vicarious tort liability for the company, a single employee or small group of employees cannot reasonably be regarded as "the insured." The language of the older liability policies applicable to most asbestos claims thus itself tends to preclude successful assertion of the intentional act defense, even in cases of significant corporate culpability.[218]

Insurers have generally failed in attempting to interpose policy exclusions for pollution-related liability as a barrier to asbestos claims. For the most part liability policies tended not to contain any sort of pollution exclusion until the late 1960s and the qualified pollution exclusion did not become standard a 1970 ISO endorsement and the 1973 version of the CGL Form.[219] As is now well-chronicled, the pollution exclusion of that era excepted pollution liability stemming from a "sudden and accidental" release of pollutants into the air, ground or water. As a result, many courts correctly read the exclusion as pertaining only to dispersed outdoor harm rather than toxic torts of bodily injury. In addition, approximately half the courts found the "sudden and accidental" criteria for coverage satisfied where the pollution discharge was unintentional,[220] a helpful factor for

---

216. *See* STEMPEL, *supra* note 6, § 1.05[a][1] (describing the concept of the intentional act exclusion and the application of expected or intended defense to liability insurance coverage).

217. *See* Olson, *supra* note 152, at 181-208; CASTLEMAN, *supra* note 63; BRODEUR, *supra* note 63.

218. See STEMPEL, *supra* note 6, § 1.05[a][1]; Jeffrey W. Stempel, *A Mixed Bag for Chicken Little: Analyzing Year 2000 Claims for Insurance Coverage*,48 EMORY L.J. 169, 226-231(1999) (concluding that the intentional act defense should not bar coverage for Y2K liability claims simply because policyholders eventually came to understand that there was risk in continuing to operate their legacy computer systems).

219. *See* OSTRAGER & NEWMAN, *supra* note 20, § 10.03.

220. *See* STEMPEL, *supra* note 6, § 14.13; Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Exclusion in Context and in Accord with its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1, 5-7 (1998-1999); William P. Shelley & Richard C. Mason, *Application of the Absolute Pollution Exclusion to Toxic Tort Claims:*

HeinOnline -- 12 Conn. Ins. L.J. 447 2005-2006

asbestos defendants facing claims arising out of construction activity, debris, or abandoned materials that were not specifically sold or distributed as a commercial enterprise.[221]

Policyholders also tended to defeat insurer efforts to defeat coverage based on any uncertainties as to the causation of asbestos-related injury. Although some diseases such as mesothelioma are signature asbestos diseases caused by no other material, victims of lung cancer may owe their unfortunate condition not only to asbestos but also to cigarette smoking or proximity to coal or other industrial materials. Consequently, an asbestos maker or its insurer may well successfully defend a plaintiff's tort claims on causation grounds.[222] However, pending the outcome of any such trial, there is obviously at least the potential that a judge or jury will determine that asbestos is at least partially to blame for diseases such as lung cancer or other injury in which the causation may also result from factors other than asbestos. As a result, causation-based defenses are a part of the liability insurer's duty to defend rather than a ground for avoiding the duty.

Will Courts Choose Policy Construction or Deconstruction?, 33 TORT & INS. L.J. 749, 750-51 (1998). The inefficacy of the qualified pollution exclusion led the insurers to adopt the "absolute" pollution exclusion in the 1986 revision to the CGL form. Because the 1986 CGL form also included a broad asbestos exclusion (*see* Section IX, *infra*), there has been little attempt to use the absolute pollution exclusion as a bar to asbestos claims.

221. Outside the asbestos context, insurers have avoided coverage by invoking the "absolute" or "total" pollution exclusion in situations where coverage should probably have been required. *See, e.g.*, Reliance Ins. Co. v. Moessner, 121 F.3d 895 (3d Cir. 1997) (applying Pennsylvania law) (holding that liability stemming from carbon monoxide poisoning due to furnace malfunction was excluded from CGL coverage); United States Liab. Ins. Co. v. Bourbeau, 49 F.3d 786 (1st Cir. 1995) (applying Massachusetts law) (holding that liability stemming from child's ingestion of flaking lead paint chips in apartment was not covered); Deni Assoc.v. State Farm Fire & Cas. Ins. Co., 711 So.2d 1135 (Fla. 1998) (holding that there was no coverage under CGL policy where liability stems from accidental tipping of blueprint machine and spillage of chemicals during office move). *See generally* Stempel, *supra* note 220; Jeffrey Stempel, *Unreason in Action: A Case Study of the Wrong Approach to Construing the Liability Insurance Pollution Exclusion*, 50 FLA. L. REV. 463 (1998) (addressing *Deni Associates* and companion case in detail and criticizing the Florida Supreme Court for permitting absolute pollution exclusion to bar coverage in circumstances far afield from the "pollution" intended to be excused by 1986 CGL revision).

222. *See* Hensler, *supra* note 3; James Early, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005), James Stengel, *Comments for the University of Connecticut Asbestos Litigation Symposium*, 12:2 CONN. INS. L.J. 27 (2006). *See also* Hanlon, *supra* note 202 (discussing degree to which differences in proof of causation have influenced valuation ranger of certain asbestos injuries in discussions over appropriate schedule of benefits under proposed federal legislation).

HeinOnline -- 12 Conn. Ins. L.J. 448 2005-2006

In addition, judicial fealty to established doctrines such as construing ambiguities against the insurer/policy drafter undoubtedly aided policyholders in this emerging coverage controversy. So, to did the rise of the reasonable expectations approach/doctrine, which was named and popularized in Judge Keeton's famous 1970 Harvard Law Review article published on the eve of the new era of asbestos coverage battles.[223] But the ambiguity approach was hardly a newfangled doctrine added in the late 20th Century to benefit policyholders[224] and the reasonable expectations approach, although of course helpful to policyholders at the margin, has not been self-consciously invoked by many asbestos coverage decisions and tended to be applied only when courts found ambiguity, so it did not become the major coverage revolution feared by insurers in the immediate aftermath of Keeton's article.[225] Although policyholders have of course won other coverage victories during the past 30 years, these did not directly involve asbestos and in large part can be viewed as simply reaffirming the traditional approach to insurance policy construction in the face of insurer efforts to curtail coverage.[226]

On the whole, asbestos defendant policyholders were successful in obtaining substantial amounts of insurance coverage—but often were thwarted and arguably received less coverage than they were entitled to under the policies. As the sun finally appears to be beginning to set on the

---

223. *See generally* Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970).

224. The principle of construing ambiguous language against the drafter applies to contract law generally, not only insurance contracts and has been an established axiom or canon of construction for at least 200 years. *See* FARNSWORTH, *supra* note 133, §§ 7.7-7.14; STEMPEL, *supra* note 6, § 4.08.

225. *See* Jeffrey W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5:1 CONN. INS. L.J. 181 (1998); Mark C. Rahdert, *Reasonable Expectations Reconsidered*, 18 CONN. L. REV. 323 (1985).

226. *See* Vandenberg v. Superior Court, 982 P.2d 229, 246 (Cal. 1999) (CGL coverage not barred merely because claim against policyholder styled as "breach of contract" rather than tort where claim alleges physical injury to tangible property due to policyholder's conduct); Hazen Paper Co. v. United States Fidelity & Guaranty Co., 555 N.E.2d 576, 578-79 (Mass. 1990) ("potentially responsible party" letter from EPA regarding policyholder duties to remediate contamination pursuant to CERCLA qualifies as "claim" under CGL policy). *But see* Foster-Gardner, Inc. v. Nat. Union Fire Ins. Co., 959 P.2d 265 (Cal. 1998) (PRP letter not a claim triggering CGL duty to defend) *and* Traveler's Ins. Co. v. Eljer Mfg., Inc., 757 N.E.2d 481 (Ill. 2001) (rejecting under Illinois law trigger based on incorporation of defective plumbing components embraced by Judge Richard Posner in Eljer Mfg., Inc. v. Liberty Mut. Ins. Co., 972 F.2d 805 (7th Cir. 1992) (applying Illinois and New York law), requiring that there be actual leakage of plumbing and damage to homes before builder's CGL coverage is triggered).

HeinOnline -- 12 Conn. Ins. L.J. 449 2005-2006

asbestos coverage wars, policyholders are largely left with only two doctrinal victories of major impact (the continuous trigger and a liberal approach to occurrence counting, which benefits policyholders if the deductible or retention is not large and there are no aggregate limits). By contrast, during the past dozen years, insurers have won significant victories in perhaps a half-dozen major issues bearing directly or indirectly on asbestos coverage as well as having significant potential application in future years. As discussed in Section VI, *supra*, insurers have at least obtained mixed results concerning coverage for liability stemming from acquired operations - an area were the correct analysis suggests insurers should have consistently lost.[227] As discussed in Section V, *supra*, the same is true regarding classification of claims as general operations or products/completed operations claims, enabling insurers to more often obtain the protection of aggregate limits in cases that should have been classified as general operations liability matters not subject to an aggregate limit.[228]

The most significant victory for insurers involves allocation of insurance policy limits to different policy periods.[229] Because of the long-tail nature of the asbestos tort and the trigger of insidious injury from exposure to asbestos, asbestos claims often trigger multiple liability policies. For example, an asbestos plaintiff may have been initially exposed to asbestos dust at a power plant in 1955 and continued to work there until his retirement in 1985, bringing a claim when he developed mesothelioma in 1990. The asbestos defendant policyholder may have had 30 separate one-year CGL policies and 30 different excess insurers.

In determining how to deploy the triggered liability insurance, the policyholder and these 60 insurers might be in quite a bit of tension. The policyholder would like to be able to direct deployment of all triggered policies in a manner most likely to maximize the coverage it has purchased over this 30-year period. For example, if its 1970-1980 policies are exhausted due to payment of other claims or insurer insolvency, the policyholder would like to use an unexhausted policy to defend and pay

---

227. *See supra* text accompanying notes 133-151.

228. *See supra* text accompanying notes 71-132.

229. For background information on the problem of liability insurance allocation, see generally STEMPEL, *supra* note 6, § 14.11, and Jeffrey W. Stempel, *Domtar Baby: Misplaced Notions of Equitable Apportionment Create a Thicket of Potential Unfairness for Insurance Policyholders*, 25 WM. MITCHELL L. REV. 769, 774-76, 807-24 (1999), and Garrett G. Gillespie, *The Allocation of Coverage Responsibility Among Multiple Triggered Commercial General Liability Polices in Environmental Cases: Life After Owens-Illinois*, 15 VA. ENVTL. L.J. 525, 570-71 (1996), and Hickman & DeYoung, *supra* note 126.

HeinOnline -- 12 Conn. Ins. L.J. 450 2005-2006

this claim, including use of the excess insurance from that policy year if necessary. By contrast, both the primary and excess insurers would prefer that the respective insurer liabilities be spread across the 30 years of injurious exposure, which has the effect of limiting any particular insurance year to a maximum of 1/30th of the claim and eliminating the chance that a particular policy year (e.g., 1981) would be required to pay the entire mesothelioma claim. Excess insurers would further prefer that responsibility for the claim be spread across all of the primary insurers and that each responsible primary carrier pay its share before the primary insurance could be considered sufficiently "exhausted" to permit attachment of any excess insurance.

Although the issue is relatively complex, the policyholder position essentially is that it paid for triggered insurance and should get the full benefit of its triggered insurance, without any allocation of multi-year claims that has the effect of reducing coverage and forcing the policyholder to expend its own funds on asbestos matters while their remains untapped, triggered insurance. In addition, policyholders note that the CGL policies of the era state that the insurer will pay "all sums" the policyholder is required to pay on covered liability claims, not merely a portion of the sums for which the policyholder is liable. In contrast, insurers argue that the CGL makes the insurer responsible only for injury that takes place during its policy period, thereby requiring apportionment even if this has the effect of diminishing the policyholder's otherwise available coverage. Excess insurers further argue that they are entitle to full payment by applicable primary insurance before they must pay, because excess insurance should only be available after primary insurance is exhausted and because excess liability premiums are significantly lower than primary CGL premiums based on the assumption that primary insurance will provide front line liability protection for policyholders.[230]

Pro-ration of insurance coverage across years of triggered policies makes perfect sense as a means of intra-insurer allocation of coverage responsibilities and can provide a useful template for determining questions of contribution and indemnity among multiple triggered insurers. But where imposition of pro-rata apportionment by years acts to prevent policyholders from being able to access triggered coverage under policies they purchased long ago, such allocation is indefensible.[231] Notwithstanding my strong objections to such apportionment, many state

230. *See* Stempel, *supra* note 229.

231. *See id.* at 824-906.

high courts have endorsed it, including those in Minnesota,[232] New Jersey,[233] and New York.[234] A common version of the apportionment formula considers not only time on the risk of each triggered insurer but also the respective policy limits of the triggered insurers.[235] A few decisions have even permitted pro-ration of insurer defense obligations,[236] although this seems the minority view[237] and is even less (pardon the pun) defensible because the duty to defend has traditionally been viewed as an indivisible, all-or-nothing matter. Although a substantial number of states have rejected apportionment of insurer responsibility by time on the risk,[238] the net tally in this portion of the insurer-policyholder scorecard reflects a significant doctrinal and financial victory for insurers.

Because the case for prorating insurer coverage and allocating responsibility to the policyholder while trigger policies remain unexhausted is so weak, this appears to be an area in which courts have provided insurers with a counterweight to the continuous trigger. Several of the courts endorsing apportionment see it as an inevitable corollary of the continuous trigger that is necessary if the continuous trigger is not to result in overpayment to the policyholder.[239] Of course, this is incorrect on at least two levels. First, the trigger of coverage (i.e., what makes a policy

---

232. *See* Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997); Northern States Power Co. v. Fidelity & Cas. Co. of New York, 523 N.W.2d 657 (Minn. 1994).

233. *See* Carter-Wallace v. Admiral Ins. Co., 712 A.2d 1116 (N.J. 1998); Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974, 988-90 (N.J. 1994).

234. *See* Consolidated Edison Co. of N.Y. v. Allstate Ins. Co., 774 N.E.2d 687 (2002). *Accord*, Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F.3d 1178 (2d Cir. 1995) (applying New York and Texas law).

235. *See, e.g.*, Carter-Wallace v. Admiral Ins. Co., 712 A.2d 1111 (N.J. 1998).

236. *See, e.g.*, Security Ins. Co. of Hartford v. Lumbermen's Mut. Cas. Co., 826 A.2d 107 (Conn. 2003); Wooddale Builders, Inc. v. Maryland Cas. Co., 695 N.W.2d 399 (Minn. Ct. App. 2005). *See also* Elizabeth Festa, Note, *Pro-Rating Defense Costs to an Insured for Periods of Uninsurance: What Happened to the Duty to Defend*, 11:1 CONN. INS. L.J. 207 (2004).

237. *See* STEMPEL, *supra* note 6, § 14.11; Stempel, *supra* note 229, at 819-23. *See, e.g.*, Ray Indus., Inc. v. Liberty Mut. Ins. Co., 974 F.2d 754, 769-70 (6th Cir. 1992) (applying Michigan law); J.H. France Refractories Co. v. Allstate Ins. Co., 625 A.2d 502 (Pa. 1993).

238. *See* Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 774 N.E.2d 764 (Ohio 2002); Keene Corp. v. Insurance Co. of North Am., 667 F.2d 1034, 1048 (D.C. Cir. 1981) (applying general principles of law); Monsanto Co. v. C.E. Heath Compensation & Liability Ins. Co., 652 A.2d 30 (Del. 1994); Armstrong World Indus. v. Aetna Cas. & Surety Co., 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996).

239. *See, e.g.*, Domtar, Inc. v. Niagara Fire Ins. Co., 563 N.W.2d 724 (Minn. 1997); Northern States Power Co. v. Fidelity & Casualty Co., 523 N.W.2d 657 (Minn. 1994).

HeinOnline -- 12 Conn. Ins. L.J. 452 2005-2006

applicable) is a distinct concept from the scope of coverage (i.e., what the policy must provide if triggered). There is not logical linkage between a continuous trigger and pro-rated apportionment of triggered policies.[240] Second, a pro-policyholder rule of continuous trigger does not equate either to inequity for the insurer or overcompensation for the policyholder. The insurer promised to pay full policy limits if there was coverage and is therefore given a windfall at the expense of the policyholder if coverage is reduced through temporal proration.[241] The policyholder is not overcompensated when it has yet to receive the full amount of its liabilities (up to applicable policy limits) from its insurers. As the many asbestos defendant policyholder bankruptcies (see Section VII above)[242] show, policyholders were not overpaid (through insurance payments or otherwise) by the asbestos mass tort.

Insurers have also prevailed in avoiding coverage for punitive damages even in cases where insurer bad faith arguably led to the punitive damages. And, of course, punitive damages against insurers are limited as a result of the U.S. Supreme Court's decision in *State Farm v. Campbell*,[243] which reduces policyholder leverage (and insurer caution) regarding not only asbestos coverage disputes but all claims matters.[244] Insurers obtained

---

240. *See, e.g.*, Armstrong World Industries v. Aetna Cas. & Surety Co., 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996).

241. *See* Stempel, *supra* note 229.

242. *See supra* text and accompanying notes 152-179.

243. *See* State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003), reversing Campbell v. State Farm Mut. Auto. Ins. Co., 65 P.3d 1134 (Utah 2001) (striking down $145 million punitive damages award in insurance bad faith case. *See also* Campbell v. State Farm, 98 P.3d 409 (Utah 2004) (awarding $9 million in punitive damages on remand.

244. In *Campbell*, the U.S. Supreme Court significantly tilted the constitutional law of punitive damages in favor of defendants, particularly insurers. Reiterating that there were federal constitutional limits on punitive damages awards (a view disputed by Justices Scalie, Thomas, and Ginsburg), the Court continued to emphasize basic guideposts for reviewing the award such as the reprehensibility of the defendant's conduct, the ratio of the punitive award to the compensatory award, and its comparative severity as measured against statutory penalities In addition to arguably sugar-coating the degree of State Farm's wrongdoing (which was, of course, within the jurisdiction of the Utah courts, not the Supreme Court), the Court adopted a more stringent view of permissible punitive:compensatory ratios. In particular, the Court suggested that ordinarily, a 9:1 ratio would be the likely outer limit, at least where the compensatory award was of significant size. Earlier opinions of both the Supreme Court and other courts had been far less confining in terms of acceptable ratios of awards, frequently accepting double-digit multipliers.

Perhaps most important, in Campbell, the Court declared that defendant wealth was not a factor to be considered, even though this would seem a logical evidentiary datum since the purpose of a punitive award is to punish a defendant and to deter future such conduct, by that defendant and others. Put simply, a $100,000 punitive damages award would more than

HeinOnline -- 12 Conn. Ins. L.J. 453 2005-2006

additional leverage with the 1997 California decision of *Buss v. Superior Court*,[245] which permitted liability insurers to reserve the right to seek recoupment of defense costs expected upon uncovered claims even though the standard liability policy obligates the insurer to defend "suits" rather than "claims". Although the criteria for pursuing fee recoupment as set forth in *Buss* are limited,[246] the decision nonetheless increases insurer leverage in negotiating with policyholders as to the parameters of defense, coverage, and reservations of rights. Although some states have rejected *Buss* outright,[247] it has been endorsed by other courts, arguably the majority.[248] In addition to being advantageous for insurers, *Buss* seems

---

get the attention of most people but would be only pocket change to Warren Buffett. Insurers, of course, are tremendously wealthy companies even if insurance stocks are not always the darlings of Wall Street. Removing wealth from the punitive equation is a major victory for insurers. Previously, even a large award like that reversed in Campbell ($145 million) would be only a small micro-percentage of the assets of the insurer, a factor that plaintiffs could use to persuasively argue that even large punitive awards are not excessive. Those days are gone. Today, insurers have a colorable argument that any punitive award exceeding nine times the plaintiff's injury is excessive, no matter how trivial to the insurer's bottom line and no matter how bad the insurer's conduct. It may not completely salve the pain of asbestos coverage, but Campbell is a big benefit to insurers.

245. 939 P.2d 766 (Cal. 1997).

246. *Buss* held that where an insurer defends a lawsuit containing both covered claims and those that are not even potentially covered under the policy, the insurer may, after defending, seek recoupment of defense cost expenditures related to defense of the uncovered claims. The requirements for a *Buss*-style recoupment are stringent in requiring the insurer to demonstrate that particular expenditures were for only uncovered matters rather than a mix of matters in a multi-count complaint. Nonetheless, *Buss* provides a powerful lever to insurers in negotiating defense and coverage in place agreements in that the insurer can maintain the threat of a recoupment action if a policyholder does not accept defense cost sharing proposed by the insurer. *Id.* at 770-75.

247. *See, e.g.*, Shoshone First Bank v. Pacific Employers Ins. Co, 2 P.3d 510 (Wyo. 2000); General Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods, Co., 828 N.E.2d 1092 (Ill. 2005); Matagorda County v. Texas Ass'n of Counties County Gov't Risk Mgmt. Pool, 52 S.W.3d 128 (Tex. 2000). *See also* Riley Stoker Corp. v. Fidelity & Guar. Ins. Underwriters, Inc., 26 F.3d 581, 589-90 (5th Cir. 1994) (applying Louisiana law); Timberline Equip. Co., Inc. v. St. Paul Fire & Marine Ins. Co., 576 P.2d 1244 (Or. 1978) (pre-*Buss* cases rejecting recoupment).

248. *See, e.g.*, Lockwood Int'l, B.V. v. Volm Bag Co., Inc. 273 F.3d 741, 743 (7th Cir. 2001) (applying Wisconsin law); United Nat'l Ins. Co. v. SST-Fitness Corp., 309 F.3d 914, 920 (6th Cir. 2002) (applying Ohio law); Morrow Corp. v. Harleysville Mut. Ins. Co., 101 F. Supp.2d 422, 429-30 (E.D. W.Va. 2000). *See also* Morgan, Lewis & Bockius, L.L.P. v. Hanover Ins. Co., 929 F. Supp. 764 (D.N.J. 1996); Lowenthal v. Security Ins. Co. of Hartford, 436 A.2d 493 (Md. 1981) (pre-*Buss* cases supporting recoupment). *See* Jeanne H. Unger, *Recoupment of Defense and Indemnity Expenses*, in DEFENSE RESEARCH INSTITUTE, INSURANCE COVERAGE AND PRACTICE SEMINAR (New York: December 2004) (recoupment is majority approach). Although many cases endorsing recoupment predate *Buss*, almost none predate the asbestos mass tort. Indeed, one case cited by Unger as approving defense cost

HeinOnline -- 12 Conn. Ins. L.J. 454 2005-2006

simply wrongly decided. The typical liability policy promises that the insurer will defend "suits," which suggests that the insurer must defend the entire action as part of its duty to defend even though its obligation to indemnify is limited to covered actions.[249] In addition, the *Buss* holding needlessly complicates an already complex area of law and runs counter to the comprehensive "peace of mind" promised by insurers through the CGL policy.

Finally, a relatively recent decision from the nation's largest state has cast some shadow on the continued vitality of the traditional rule that insurance policy benefits could be freely transferred after a covered loss or liability-creating event had taken place. *Henkel Corporation v. Hartford Accident & Indemnity*,[250] held that Henkel Corporation was not covered for toxic tort liability stemming from its acquisition of certain operations of Amchem Products and apparently would not have had rights under the policies even had there been a formal assignment of these contracts to Henkel, a ruling that provoked considerable attention and commentary.[251] In doing so, the *Henkel* Court appears to have adopted a more stringent view of assignment than that traditionally established by insurance law precedent. If the *Henkel* approach should "catch on" with other courts, the

---

recoupment is the early and important asbestos coverage case *Insurance Company of North America v. Forty-Eight Insulations, Inc.*, 657 F.2d 814 (6th Cir. 1981) (applying Illinois and New Jersey law).

249. *See Buss*, 939 P.2d at 784 (Kennard, J., dissenting).

250. 62 P.3d 69 (Cal. 2003).

251. In reaching this decision, the Supreme Court reversed *Henkel Corp. v. Hartford Accident and Indemnity*, 106 Cal. Rptr. 2d 341 (Cal. Ct. App. 2001), an opinion written by Judge Walter Croskey, author of the *California Insurance Law & Practice* treatise. *See also* Jason Hoppin, THE RECORDER, Feb. 11, 2003, at 11 (noting irony in Court's reversal of intermediate court judge widely recognized as insurance authority; Judge Croskey unsure of whether Supreme Court's decision is his first full reversal of his estimated 2,500 opinions). The trial court had ruled for the insurers on this issue. *See also* Roberto Ceniceros, *Insurer Consent is Required for Coverage to Transfer in Acquisition: California Court*, BUSINESS INSURANCE, Feb. 10, 2003, at 3; Robert D. Chesler & Michael L. Rodburg, *Environmental Compliance & Litigation Strategy*, Vol. 19, Issue 10, March 2003, at 1; *Buyers Face Threat of Losing Targets' Insurance Policies: California Court Ruling May Jeopardize A Traditoinal Post-Deal Protection*, MERGERS & ACQUISITIONS J., July 1, 2003, at 1; Thomas C. Klein, *Recent California Decision Impedes Assigning Product Liability Insurance Coverage in Asset Acquisitions*, INSIGHTS, Vol. 17, No. 5, May 2003, at 1; John Merrigan, *Permission Slip*, DAILY DEAL, Aug. 4, 2003, at 5; *California Court: Insurance Rights Not Transferred in Corporate Transactions*, MEALEY'S LITIG REP. INS., Vo. 17, Issue 38, Aug. 12, 2003, at 7; Randy J. Maniloff, *The Year's Ten Most Significant Insurance Coverage Decisions – Third Annual Look Back At Future Coverage Disputes*, MEALEY'S LITIG. REP. INS. Vol. 18, Issue 1, Jan. 7, 2004, at 10 (naming *Henkel* one of 2003's "Top Ten" insurance cases and leading off with *Henkel* as perhaps most important insurance case of the year).

HeinOnline -- 12 Conn. Ins. L.J. 455 2005-2006

availability of insurance to corporate successors could be significantly curtailed, reducing available insurance coverage for lurking claims against the company for long-tail torts such as asbestos and pollution.

Sustained analysis of *Henkel*, a potentially import case with highly problematic reasoning, reflects the degree to which courts are on occasion handing insurers some dramatically undeserved victories in the coverage wars. The story of the *Henkel* claim began with Amchem, a Pennsylvania corporation with two product lines: agricultural chemicals and metalic chemicals. Amchem obtained liability insurance from Hartford and other insurers. In 1977, Union Carbide acquired Amchem through a stock purchase and merger. In 1979, Union Carbide created a new subsidiary called Amchem Products, which was a Delaware Corporation (mercifully referred to as "Amchem No. 2" by the California Supreme Court). As part of this process, Amchem (No. 1) transferred all of its metalic chemical business to Amchem No. 2, with the new company also accepting all liabilities of the first Amchem. Thus, after the 1979 transaction, there was Amchem No. 1 (specializing in agricultural products) and Amchem No. 2 (specializing in metallic chemicals). In 1980, Union Carbide sold all of the stock in Amchem No. 2 to Henkel Corporation, with a Henkel-Amchem No. 2 merger resulting. In 1986, Union Carbide sold Amchem No. 1 to Rhone Poulenc (today known as Aventis CropScience USA), with Rhone obtaining the rights and obligations of Amchem No. 1.

As the saying goes, you can't tell the players without a scorecard – and a reasonably detailed scorecard was required to keep track of the two Amchems and their successors. The chain of custody resulting from these events was roughly as follows:

Amchem >>>> Union Carbide (1977) >>>>>

Amchem (1979)(original) (ag products)	Amchem Products (1979)(spin-off) (metallic chemicals)
Rhone Poulenc (1986) (Aventis Crop Service)	Henkel (1980) (Sale and Merger)

Lockheed Employees v. Henkel Corp. (1989) (over 1959-1976 toxic torts) (defended by Henkel Corp. and settled for $7.6 million)

Lockheed Employees v. Aventis (1992) (stipulated dismissal)

HeinOnline -- 12 Conn. Ins. L.J. 456 2005-2006

All of this would probably not be important except for the ensuing litigation and insurance coverage battle. In 1989, current and former employees of Lockheed, the aerospace company, sued Henkel and "Amchem Products" for alleged injuries arising out of the use of the metalic chemicals sold by the "old" Amchem that were used to assist in painting metallic surfaces during the 1959 to 1976 period. Henkel, on the basis of the old Amchem insurance policies it acquired with the purchase of Amchem No. 2 (the metallic chemicals wing of old Amchem) tendered the claim to Hartford and the liability insurers, all of which denied coverage.

In 1992, the Lockheed employees also sued Rhone Poulenc for Amchem-related liability. This litigation was stopped by quashed service. Rhone Poulenc argued that according to the terms of the various transformations of Amchem, it was Henkel that was responsible for any lingering Amchem liability that stemmed from the sale or sue of metallic chemicals. The Lockheed employee plaintiffs apparently agreed, stipulating to dismissal of their claims against Rhone Poulenc. This left the Lockheed plaintiffs' suit against Henkel, which was settled in 1995 for $7.6 million.

Henkel then turned to its insurance carriers for indemnity as well as reimbursement of defense costs. The insurers again refused coverage, arguing that the policies were invalid without the insurers' consent to the transfer of the policies to Henkel. Henkel, in turn, argued that under well-settled principles of insurance law, assignment of an insurance policy prior to a covered occurrence generally requires insurer consent (because the risk may change) while assignment after the loss has occurred is subject to the general rules of contract permitting assignment absent special circumstances such as a personal service contract (because, after loss, the risk to the insurer is unchanged by a change in the identity of the policyholder). As a result, argued, Henkel, the insurance policies should generally be viewed as assets acquired along with other property as part of a corporate sale or acquisition. In a bizarre and disappointing opinion, the California Supreme Court not only departed from the ordinary ground rules of insurance policy succession but also essentially relieved the liability insurers of obligations they would otherwise have had there been no acquisition of Amchem.

As Justice Moreno, the lone Supreme Court dissenter noted, the Court's decision was a windfall for the insurers, who collected years of premiums in connection with Amchem's operations but were not required to provide any coverage notwithstanding that their risk and exposure appear not to have increased at all as a result of the corporate mergers resulting in Amchem becoming a part of Henkel. Also troubling to the

HeinOnline -- 12 Conn. Ins. L.J. 457 2005-2006

dissenting Justice was that the California Supreme Court appears to have changed the rules regarding insurance policy acquisition and assignment in a way that benefits insurers without admitting that it has departed from what I thought was settled law. Even if the *Henkel* Court majority had been a bit more candid about what it was doing, the decision is also troubling because the reasons supporting the Court's newfound protection of insurers are so weak.

Applying the "general rule" to the *Henkel v. Hartford* situation would presumably lead to coverage for Henkel. Although the attorneys working on the various corporate transactions should in hindsight have also included formal assignment of insurance policies, this almost certainly would have provided no ultimate benefit. The Supreme Court majority opinion language states that insurance policy rights do not follow from *either* the acquisition of assets or the formal assignment of specific insurance policies. But surely this was a case for which the traditional general rule counseled transfer of the policy rights. The basis of the Lockheed plaintiffs' claims arose out of alleged injurious exposure to Amchem metallic chemicals during the 1959-1976 time period, a juncture well before the change in Amchem from separate company, to Union Carbide subsidiary, to Amchem No. 1 & Amchem No. 2, or to part of the current Henkel. The alleged "loss" or liability had clearly been triggered well before the assignment of the insurance, even if there were yet to be claims under the policy and not yet a settlement or judicial resolution.[252]

More important, transferring the old Amchem policies to Henkel well after the end of the policy period did nothing to increase the risk to insurers. Either something has happened during the policy period or it has not. Assigning the insurance from Amchem to Henkel will not effect this. Although occurrence basis insurers may feel unfairly imposed upon by "long-tail" latent injury claims from the past, this problem results from the language of the policies (which the insurers wrote) and the nature of toxic tort claims, it is not a problem created by assignment. Put another way, Hartford and the other insurers are no worse off because Henkel (rather than the old Amchem) is the policyholder tendering claims to them. Consequently, after reading the facts of the case recited by the Henkel Court, a reasonable person versed in insurance law would have thought that

252. As noted above, the Amchem-Henkel policies were "occurrence" basis policies that provide coverage if the policyholder is alleged to have caused an injury during the policy period. Under prior California lawas well as the law of most jurisdictions, occurrence policies are deemed triggered if injury is alleged to take place during the policy period even if the injury has not become palpable, manifest, or known until years later. *See* Montrose Chemical Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995).

HeinOnline -- 12 Conn. Ins. L.J. 458 2005-2006

the Court would have voted unanimously to uphold the transfer of the policies. Instead, it voted nearly unanimously against transfer of the policies. How did this happen?

First, the *Henkel* majority appears to have changed the "rules" of assignability (the meaning of precedent) in the middle of the "game" (the dispute between Henkel and its insurers), a point noted by only one dissenting Justice.[253] Instead of following the prevailing precedent that post-loss assignment is normally permitted, the *Henkel* Court implied that "consent-to-assignment" clauses were universally enforceable, specifically citing to prior California law decisions, *Greco. v. Oregon Mut. Fire Ins. Co.*,[254] and *Bergson v. Builders Ins. Co.*[255] However, both these cases involved attempts to assign insurance policies prior to the occurrence of a loss or claim. Thus, these cases are consistent with the general rule of no assignment (without consent) for pre-loss matters but assignment being acceptable after the loss has taken place. More important, these cases are inapposite to the *Henkel* situation and in fact counsel in favor of permitting Henkel to exercise rights under the policies originally sold to Amchem.

The *Henke*l majority acknowledged the general rule and cited cases supporting it, but then distinguished the cases on the basis of the division of Amchem during the course of the corporate mergers.[256] With this rhetorical move, the *Henkel* Court changed the general rule of exceptions to the anti-assignment rule. In California, it is no longer enough for the loss event to have taken place in order for an insurance policy to become assignable (even in the face of anti-assignment or consent requirement language in the policy). Instead, the loss must not only have taken place but must "have been reduced to a sum of money due or to become due under the policy." Instead of merely requiring an occurrence, injury, loss or claim, the *Henkel* Court required that there must have already been a

---

253. *See Henkel*, 62 P.3d at 77. (Moreno, J., dissenting). The dissent also collects case law representative of the pre-*Henkel* general rules of assignability:

> It is unclear from what source the majority's novel conclusion is derived. The majority cites [prior California cases] for the proposition that benefits under an insurance policy *can* be assigned notwithstanding a contractual provision barring the assignment of such benefits. Yet the majority ignores the actual rule articulated in these case, that an insured can assign policy benefits once the loss insured against has occurred.

Id. at 77 (emphasis in original) (also referring to majority's "abandonment of the general rule").

254. 12 Cal. Rptr. 802 (Cal Ct. App. 1961).

255. 38 Cal. 541 (1869).

256. *See Henkel*, 63 P.3d 69 at 75.

HeinOnline -- 12 Conn. Ins. L.J. 459 2005-2006

judgment or settlement. Although the *Henkel* Court does not admit it, it has dramatically changed the law in this regard.[257]

Second, the *Henkel* Court was reluctant to permit transfer of insurance policy rights on the ground that it might be unfair to the liability insurers because it presented the possibility of confusion as to which of the Amchem successor entitities was entitled to a defense.[258] Although the Court's concern is understandable, it is overdone, both as a general matter and in light of the specific facts of the *Henkel* case. As Henkel Corporation noted, the possibility of forcing the liability insurers to fight a two-front war was eliminated by the Lockheed plaintiffs' agreement to leave alone Rhone Poulenc, the other successor to the original, pre-split Amchem. The Supreme Court was unmoved, finding that "if the Lockheed plaintiffs had refused to dismiss their suit against Rhone Poulenc, defendants would have faced the dilemma whether to defend Rhone Poulenc, Henkel, or both."[259]

---

257. For example, in discussing assignability precedent, the Court cites cases and the leading California insurance law treatise. However, none of these sources require that the loss incurred have been reduced to a sum certain. *See, e.g.,* Westoil Terminals Co. v. Harbor Ins. Co., 641, 86 Cal. Rptr. 2d 636, 640 (Cal. Ct. App. 1999); Quemetco, Inc. v. Pac. Auto. Ins. Co., 29 Cal. Rptr. 2d 627, 630 (1994); Greco v. Oregon Mut. Fire Ins. Co., 12 Cal. Rptr. 802 (Cal. Ct. App. 1961); Trubowitch v. Riverbank Canning Co., 182 P.2d 182, 185 (Cal. 1947); WALTER CROSKEY ET AL., CAL. PRAC.GUIDE: INSURANCE LITIGATION ¶ 7.431 (2002).

Although in some of these cases (e.g., assignment of a bad faith claim after an adverse jury verdict in excess of policy limits), the loss was reduced to a set figure, it hardly follows that this is essential. In fact, from a risk management and insurance theory perspective, it matters not at all whether the pre-assignment loss has been liquidated into a certain amount. What is important is that the loss precede the assignment so that assignment not impact the risk faced by the insurer. Consequently, one might consider the Court's differentiation of previous cases upholding assignment to be the lawyer's proverbial "distinction without a difference." When one focuses on the core of the pre-*Henkel* cases in California, one finds that what is key to the inquiry is the time of loss, not the stage of claims proceedings arising out of the loss or occurrence.

258. *Henkel*, 62 P.3d at 76.

> Even assuming enforcement of the no consent clauses requires a showing of additional burden or risk on the insurer, Henkel cannot prevail. An additional burden may arise whenever the predecessor corporation still exists or can be revived, because of the ubiquitous potential for disputes over the existence and scope of the assignment. If both assignor and assignee were to claim the right to defense, the insurer might effectively be forced to undertake the burden of defending both parties. In view of the potential for such increased burdens, it is reasonable to uphold the insurer's contractual right to accept or reject an assignment.

See id.

259. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 460 2005-2006

In the face of this potential (but only potential rather than actual) dilemma, the Court found it appropriate to permit the insurers to insist upon strict compliance with their consent-to-assignment clauses.

Although the Court's concern for the insurers is touching, it tends to ring a little hollow in the real world of insurance coverage litigation. First, of course, the "two-front war" problem was not at issue in the case. Second, the long-standing law of the duty to defend generally requires a liability insurer to defend an action if there is so much as a "potential for coverage" under the applicable policy. In the *Lockheed-Amchem-Henkel* case, there clearly was such potential. At the very least, the law of post-loss assignability was unsettled, if not in favor of Henkel. Third, in the actual case, Henkel Corporation did defend the claims and resolved them. Although a $7.6 million price tag is large, there is no suggestion in the opinion that the amount of the settlement was excessive or that the Lockheed plaintiffs had a weak case as to liability. Unless the settlement was unreasonable, one is hard-pressed to see what theinsures are complaining about – at least as respects the duty to indemnify.

Further, insurers in the real world are hardly the vulnerable confused lambs suggested by the *Henkel* Court. If an insurer is faced with a post-loss assignment that legitimately creates uncertainty as to which of several entities is owed the defense, the insurer may commence a declaratory judgment to resolve the issue, something insurance companies are quick to do when it is in their interests to pursue judicial declaration In addition, the *Henkel* Court's concerns seem overblown in light of the Court's own precedents establishing an liability insurer's rights to obtain recoupment of defense costs spent in connection with uncovered claims. As discussed above, prior to *Henkel*, the Court in *Buss v. Superior Court*,[260] the Court found that insurers may seek reimbursement of defense costs expended in defending uncovered claims. Although, this has not been a right commonly used by insurers in practice (because of the stringent requirements of a *Buss*-style reimbursement action), the problem of defending the correct corporate successor would appear to be one of those rare cases where *Buss* may benefit both policyholders and insurers.

Although the *Henkel* decision can be arguably justified based on considerations of fairness toward insurers and adherence to contract language, the Court seems not to have engaged at all in any serious reflection about the public policy, risk management, and compensation issues presented by the case. In addition, a major rationale for commercial insurance is to facilitate economic activity and growth by providing risk

260. 65 Cal. Rptr. 2d 366 (Cal. Ct. App. 1997).

HeinOnline -- 12 Conn. Ins. L.J. 461 2005-2006

management protection for economic actors. To the extent that insurance protection (for past but possibly unknown losses) may be more freely assigned as part of corporate recombinations, this lowers transaction costs and facilitates economic activity and wealth enhancement. Consequently, the general rule permitting post-loss assignment is a good rule – which is why the courts have crafted it over the years even though it appears to contradict the clear text of many insurance policies and the courts' expressed fidelity to contract language. The post-loss exception to the general rule of restricted insurance assignability is a venerable rule borne of experience and practicality. After *Henkel v. Hartford*, it appears that the law of post-loss assignment has been made much narrower in California which may have substantial negative implications for the law of insurance assignability in general.

In addition to the reasons previously set forth, *Henkel* is a very problematic decision in that it appears to run counter to both basic contract law and basic insurance law and principles. In addition to the problems of assignability noted above, *Henkel* is at odds with the prevailing notion that contract rights are property rights that deserve fulfillment and that Disproportionate Forfeiture and absurd results should be avoided.[261] The *Henkel v. Hartford* opinion may simply be the an unusual result driven in part by the Court's perhaps subconscious effort to provide a legal victory to an insurance industry that has to a large degree successfully portrayed itself as a victim of both the largest mass tort in history and of judicial rulings unduly favorable to policyholders. *Henkel* becomes potentially important to the question of insurance coverage for asbestos liability because, like toxic torts, pharmaceuticals, and pollution, asbestos claims are long-tail and are more likely than most tort claims to involve injuries taking place in distant policy periods. To the extent that the *Henkel* approach takes root in other jurisdictions, insurers will successfully avoid some asbestos coverage liability that rightfully should have been imposed.[262] Although most of the

---

261. *See* RESTATEMENT (SECOND) CONTRACTS § 229 (1981).

262. *Henkel* has influenced at least one other decision outside California. *See* Century Indemnity Co. v. Aero-Motive Co., 318 F. Supp. 2d 530, 540 (W.D. Mich. 2003) (refusing to permit assignee to obtain coverage under assignor's policy). *Henkel* has of course been noticed by treatise writers, which makes it widely available to counsel and courts for reference in subsequent disputes. *See e.g.*, APPLEMAN & APPLEMAN, *supra* note 35, §§ 1215 Supp., n. 64.11; 1293 Supp. n. 95.1; 4269, n. 1926; CALIFORNIA INSURANCE LAW & PRACTICE §§ 8.1147.07[1], 11E.24, 80.01(2001); CALIFORNIA FORMS OF JURY INSTRUCTION 1-3C, MB 300C.05 (2006); CALIFORNIA FORMS OF PLEADING AND PRACTICE 26-308 (2006); STEMPEL, *supra* note 6, § 3.15[d].

Vigorously contested litigation in Ohio may provide further clues regarding judicial reaction to *Henkel* Outside of California and the degree to which *Henkel* is an outlier or part

HeinOnline -- 12 Conn. Ins. L.J. 462 2005-2006

initial commentary in reaction to *Henkel* has been critical,[263] the decision has its defenders[264] and the insurance industry is likely to try to persuade other jurisdictions to take a similarly restrictive view of insurance policy transfer, which has significant implications for insurers for long-tail obligations under occurrence policies. At the very least, *Henkel* would appear to provide insurers with protection in some number of coverage disputes subject to California law.[265]

My hypothesis is that bad decisions like *Henkel* result in significant part because courts on occasion strain to give insurers doctrinal victories out of a conscious or subconscious desire to even the score due to a perception that policyholders have benefitted from very favorable coverage decisions in the past, some arising from the asbestos mass tort. One need not be an extreme legal realist to regard much of the emerging law in this area as the result of compromise. On one hand, most jurisdictions give the

---

of a trend. In *Pilkington No. Am., Inc. v. Travelers Cas. & Surety Co.*, Case No. 3:01CV7617 (N.D.Ohio, W.D. 2005), assignee Pilkington, which acquired policy rights from Libby-Owens-Ford, and now faces claims arising out of injuries arising out of the LOF activities, is seeking coverage for these toxic torts claims. Travelers has interposed a *Henkel* defense. In pretrial motions, the antagonists have brought in prominent insurance experts: Professor Tom Baker (Connecticut) for Pilkington and Professor George Priest (Yale) for Travelers. A district court ruling or subsequent Sixth Circuit decision will undoubtedly help to determine if the *Henkel* decision creates a trend. Certification to the Ohio Supreme Court has been granted regarding three questions:

1. Is Pilkington's demand for a defend to the environmental claims a chose-in-action under Ohio law?

2. Do insurance policy anti-assignment clauses bar acquisition by Pilkington or other successors from acquiring such chose-in-action rights?

3. Are insurance policy rights transferred by operation of law in situations such as the Pilkington transaction with Libby-Owens-Ford?

See Pilkington N. Am. v. Travelers Cas. and Sur., 105 Ohio St. 3d 1514, 826 N.E.2d 313 (N.D. Ohio 2005). Cases like *Pilkington* may accelerate or retard *Henkel*'s influence depending on the outcome.

263. Perhaps most vigorously in STEMPEL, *supra* note 6, at § 3.15[d].

264. *See e.g.*, May, *supra* note 141, at 911; Alan S. Rutkin, *Movable Coverage: Successor Coverage May be Narrower Than Successor Liability*, BEST'S REVIEW, May 1, 2003, at 62.

265. *See e.g.*, Associated Aviation Underwriters, Inc., v. Purex Industries Inc., B149365, 2003 Cal. App. Unpub. LEXIS 7501 (2d Dist. Ct. App., Aug.4, 2003) (applying *Henkel* and finding no coverage for assignee under predecessor's liability policy). *See also* Martin v. Watson/Hopper, F041808, 2004 Cal. App. Unpub. LEXIS 148, at *7 (5th Dist. Ct. App., Jan. 8, 2004) (citing *Henkel* in passing when finding no produce successor liability in case at hand).

HeinOnline -- 12 Conn. Ins. L.J. 463 2005-2006

policyholder the benefit of a very "liberal" rule of triggering occurrence coverage based upon allegation of even sub-cellular damage rather than requiring more concrete and manifest injury to trigger coverage. But on the proverbial other hand, many courts have restricted policyholder recovery by requiring proration of multiple triggered policies, assigning coverage responsibility to the policyholder for some significant time periods. Many courts have also tended to take an arguably overbroad view of the pollution exclusion, which was substantially re-written in 1986 in response to such claims. Courts have also generally been unwilling to look behind policy language to the drafting history of such provisions and have also been reluctant to find insurers estopped by prior representations on the matter.

IX. INNOCULATION EFFECTS: HOW ASBESTOS-RELATED CHANGES IN LIABILITY POLICIES AND INSURER PRACTICES HAVE PROTECTED INSURERS

Although not "unfairly" required to provide substantial coverage for asbestos-related claims, insurers certainly had considerable cause to be displeased with the situation and it impact on their revenues. But, as discussed in Section VII above and addressed more in Section X below, asbestos coverage responsibility has been a manageable burden for insurers and only a contained drag on earnings from which most insurers, even those with the greatest concentration of asbestos policyholders, have recovered. In addition, facing the asbestos coverage problem forced insurers to consider changes in liability insurance product design and industry operations to reduce the risks of similar exposure in the future. These reactions have greatly reduced the risks of "another asbestos" for insurers and further shifted the balance of power toward insurers.

The asbestos mass tort, with some additional help from the environmental liabilities of the 1970s, prompted significant revisions in the standard CGL form. Most obvious is the exclusion for any asbestos-related liability coverage, which began as an endorsement but was not added to the CGL until the 1986 revision. The asbestos exclusion is broadly worded and its purpose and application clear in light of the asbestos mass tort. Insurers wanted no part (at least not at standard premium rates) of asbestos liability claims against policyholders, even if the policyholders used only trace amounts of asbestos in their products or services. The subsequent second wave of asbestos claims against peripheral defendants has underscored the industry's wisdom in adopting a broad asbestos exclusion for the CGL rather than merely directing the exclusion at asbestos manufacturers or large contractors.

HeinOnline -- 12 Conn. Ins. L.J. 464 2005-2006

Of course, to some extent, the methaphorical cow had already escaped the barn even before the asbestos mass tort was apparent due to the occurrence basis format of the CGL and the insidious nature of asbestos disease. Nonetheless, it remains surprising that it took the insurance industry more than a dozen years from the time the asbestos mass tort became apparent with the rendering of the Fifth Circuit's 1973 *Borel v. Fibreboard* decision.[266] *Borel* recognized asbestos injury as a legitimate tort and rejected manufacturer defenses based on contractual privity, assumption of risk, employer negligence, and cost-benefit analysis. After *Borel*, there was no reasonable doubt that asbestos would be a major source of tort litigation and tort liability, even if observers could not then estimate the full magnitude of the mass tort that resulted. But insurers did not move to immediately exclude asbestos.

Perhaps the initial delay resulted not only from insurer underestimation of the size of the asbestos tort but also from underestimating the number of policies that would be triggered and the application of the per occurrence limits with so many individuals claiming bodily injury. However, by the mid or late-1970s, insurers logically should have seen a good deal of this coming because of coverage battles such as *Forty-Eight Insulations v. INA* and *Keene Corporation v. Aetna* being waged at the trial court level. By 1980, these coverage clashes had resulted in prominent appellate court opinions adopting broad trigger rules that were the talk of the industry. Yet the industry did not adopt the broad asbestos exclusion for another six years.

Although the hesitancy of insurers to embrace an asbestos exclusion is difficult to understand and difficult to explain through the archeology of policy drafting, it appears to have ushered in a new era in which insurers are much quicker to adopt blanket exclusions when faced with a looming mass tort or coverage risk. Compare the leisurely pace of the asbestos exclusion with the experiences of mold, silicon, or the Year 2000 problem. In these instances, insurers reacted with the alacrity of an urban SWAT team. The potential computer crashes and collateral damage of the Year 2000 problem was first noted in the early 1990s by a group of technological Cassandras, most notably Peter De Jagr. But by 1997, the Y2K issue was big news worrying governments, business and insurers. Well before New Year's Eve 2000, most insurers had responded with Y2K exclusions, frequently employing one of the exclusions drafted by ISO for use by the insurance industry.

---

266. *See* Borel v. Fibreboard Paper Products Corp., 493 F.2d 1076 (5th Cir. 1973) (applying Texas law).

HeinOnline -- 12 Conn. Ins. L.J. 465 2005-2006

Insurers have shown similar speed and flexibility in making other modifications in liability policies in reaction to particular court decisions or classes of claims. The first significant court decision requiring coverage for mold was rendered in 2001. By 2002, most insurers had revised or added mold exclusions to attempt to eliminate coverage for this type of liability or loss. When California's 1995 *Montrose* decision adopted the continuous trigger for construction defect coverage claims, insurers quickly began including a "*Montrose* endorsement" in their policies, language that seeks to restrict coverage for a loss or injury to a single policy even if multiple policies are triggered. In response to court decisions finding coverage where an excluded cause of loss such as earth movement or flooding acted in combination with a covered cause of loss, insurers moved relatively swiftly to use of a broad "lead-in clause" to the list of excluded perils, providing that coverage was barred whenever an excluded cause was part of the chain of events leading to loss.

The lesson I draw from the comparison of the path of the asbestos exclusion (and the industry's slowness in moving from a qualified to an absolute pollution exclusion during the same 1973-1986 period) as compared to more recent events is that the asbestos mass tort made insurers more cognizant of the potential for large coverage exposure due to a mass tort and prompted the industry to be more alert and to react swiftly. Rather than worry too long about adverse policyholder, regulator, or public reaction to constricting coverage, the new ethos of insurers appears to be one in which they will exclude first and ask questions later rather than risk fiddling while a new mass tort catches flame. Perhaps this is an overreaction to asbestos (and to pollution liability CERCLA clean-up), an example of "fighting the last war". But this seemingly faster reaction time of insurers suggests we will never see insurers take the type of financial hit presented by asbestos coverage obligations.

The asbestos coverage imbroglio also spurred an number of changes to the CGL that are not asbestos-specific. Liability policies now routinely have an aggregate limit for all types of coverage, not just products/completed operations coverage. As a result, insurers are well protected from any future mass torts that might be subject to the continuous trigger or a finding of many occurrences based on many injured third parties. This move alone substantially limits the insurance industry's exposure to any "next asbestos."

The insurers can, of course, choose to take on risks excluded under the standard CGL and appear willing to do so if the price is right. Policyholders can "buy back" certain excluded coverages for an additional premium or may be able to purchase a particular "stand-alone" policy for a

HeinOnline -- 12 Conn. Ins. L.J. 466 2005-2006

particular risk. In what must undoubtedly surprise laypersons and tort reform advocates (who so often argue that tort liability makes insurance practically unavailable), even asbestos coverage can be purchased notwithstanding the broad general exclusion for such coverage in the average liability policy. General Re, a company controlled by Warren Buffett, has offered to reinsure asbestos coverage obligations in a product viewed as profitable by industry observers. Buffett did not become the world's richest person (or second-richest, depending on the performance of the Bill Gates portfolio) by taking unreasonable risks. The General Re product suggests that even asbestos liability remains insurable to a degree and that observers such as Fitch, Dowling, and Baker are correct about asbestos obligations of insurers being manageable.

Perhaps more important, the new operating methodology of excluding problematic risks from the standard CGL form but addressing those risks individually almost certainly results in more advantageous insurance policy design and pricing by insurers. To the extent this business model is more successful than the previous model of aggressively offering comprehensive coverage to garner premium dollars and curb adverse selection, insurers paradoxically will find the asbestos mass tort to have been helpful. To the extent that the asbestos mass tort "burned" insurers, it has also had the potentially salutatory effect of making insurers more careful about underwriting and pricing generally.

Another major product design innovation prompted by asbestos (with an obligatory continuing nod to pollution) is the claims-made liability policy. Although use of a claims-made form is not per se new (it has existed for some time in professional liability, director's and officer's liability and other specialized lines), it was not common for general liability insurance prior to the 1980s. But in reaction to the asbestos mass tort (and pollution and long-tail product liability claims generally), insurers and reinsurers prevailed upon ISO to developed a standardized CGL form with a claims-made trigger. Aggressive insurer efforts to make claims-made general liability policies the norm created a firestorm of litigation that even reached the U.S. Supreme Court among allegations of collusive behavior violative of the antitrust laws. Nonetheless, nearly every state regulator and the courts have approved use of claims-made CGL policies. Although the claims-made form has not supplanted the occurrence form, which is preferred by policyholders and is generally readily available except in very hard markets, the availability of claims-made insurance as an alternative to the occurrence policy gives insurers another powerful means of responding to mass tort coverage threats.

HeinOnline -- 12 Conn. Ins. L.J. 467 2005-2006

Under an occurrence form, coverage is triggered by injury during the policy period, even if the injury is undetected for years or claims are not made for years. The occurrence policy thus provides unlimited prospective coverage to the policyholder. If Acme Corp. causes injury to others through its use of asbestos in 1970, its 1970 CGL policy will provide coverage for claims that are not made until 2000. By contrast, a claims-made CGL form provides no prospective coverage (unless the policyholder purchases an extended reporting endorsement for injuries during the policy period that result in claims during later years). When the claims-made policy expires, so does the coverage. The claims-made policy does provide unlimited retroactive coverage, at least in theory (most insurers sell the policies with a "retroactive date" that prevents coverage for older injuries even if the claim is made during the policy period). But where insurance trigger is based on claims, insurers are in a good position to both reserve for claims payment and to monitor the potential emergence of a mass tort. If the insurer suspects that claims made in policy Year A are the tip mass tort iceberg (or even large tort debris), the insurer can simply refuse to sell liability coverage to the policyholder in Years B, C, D, etc. Alternatively, the insurer can also increase premiums or even cancel the policy.

Because of customer resistance and improving insurance underwriting conditions, the claims-made policy did not supplant the occurrence policy and debate subsided over the relative merits of the forms and the appropriateness of perceived insurer strong-arming of policyholders into the claims-made form. In fact, one might argue that an occurrence form is more profitable for insurers in the long run now that insurers seem to know how to quickly exclude unwanted coverages during the early signs of trouble, as reflected in the examples of mold, silicon, and Y2K. Under an occurrence form, the insurer faces the threat of the emergence of long-tail liability but in return has a longer period of investment income and pays claims in inflation-impacted dollars.

But the industry's new focus on the claims-made form has increased its use not only in traditional areas such as medical malpractice and D&O liability but also has made claims-made underwriting more common in excess insurance, particularly high level excess policies such as those sold by Bermuda-based companies, other offshore entities, and captive insurers. ACE and XL, two large Bermuda insurers, began as the creation of brokers and policyholders attempting to deal with the hard insurance market of the 1980s, and adopted not only a claims-made trigger but also adopted other provisions favorable to insurers such as a New York choice of law clause and an arbitration agreement.

HeinOnline -- 12 Conn. Ins. L.J. 468 2005-2006

A classic complaint of insurers has long been that American courts, particularly lay juries, are unduly sympathetic to policyholders in coverage disputes. One obvious response for liability insurers is the inclusion in the policy of a clause requiring arbitration of disputes, replacing the jury and the judge with an arbitrator or panel of arbitrators. The conventional wisdom holds that arbitrators are not disposed to favor policyholders and are less moved by concerns of sympathy for the policyholder or third party claimant. Arbitration clauses are now commonly used in many commercial insurance forms, although the standard CGL has no arbitration clause, most likely because of perceived resistance from regulators. However, commercial CGL policies frequently provide for arbitration by endorsement. The widely used Bermuda forms not only provide for arbitration but also contain a choice of venue provision specifying that arbitration be in London pursuant to the procedures of the British Arbitration Act. The net effect is to make it considerably more likely that at least a majority of the arbitrators will be British. According to the conventional wisdom, British arbitrators are more favorably disposed to insurers than their American counterparts. Since the mid-1980s, U.S. law has favored the enforceability of arbitration and other alternative dispute resolution clauses, making it considerably more likely that such language in insurance policies will "stick" than was the case prior to the asbestos mass tort.

In addition, again led by the example of Bermuda insurers, liability policies now often contain choice of law clauses, which were comparatively rare prior to the asbestos mass tort. As any American lawyer knows, shopping for the most favorable forum and applicable law is a major part of litigation strategy. Although the choice of law factors focus on a state's contact with the dispute rather than the forum in which the dispute is heard (an Nevada court may find itself applying California law or Florida law), there is a perceived tendency for courts to chose their own law in close cases because of the court's familiarity with its own state's law. A specific choice of law prevents this, and may further be coupled with a choice of venue provision so that policyholders may not site coverage battles in states perceived to have a more pro-policyholder judiciary or jury venire.

Through these provisions, insurers can ensure that disputes are governed by a body of law most acceptable to insurers. As noted above, New York law is particularly popular for Bermuda insurers and others in the industry because New York is viewed as a somewhat pro-insurer jurisdiction that has a few particularly favorable rules aiding insurers. Most importantly, choice of forum and choice of law clauses permit the

HeinOnline -- 12 Conn. Ins. L.J. 469 2005-2006

insurer to avoid the types of pro-plaintiff or pro-policyholder jurisdictions tort reforms have labeled "judicial hellholes". Although this type of rhetoric is of course excessive, overly politicized, and misleading, it well illustrates the basic point: insurers would rather have coverage disputes decided under New York law and heard in Manhattan or London rather than face a jury in Madison County, Illinois presided over by an elected judge with substantial discretion to choose a body of law favorable to a policyholder.

Insurers have also expanded the scope of the intentional act/expected or intended limitation on coverage (sometimes expressed as an exclusion but now more often part of the insuring agreement) by providing that coverage may be defeated by the intent to injure not only of "the insured" but by "an insured" or "any insured." Insurers have largely been successful in arguing that this slight change in language no longer makes it possible for innocent family members or other co-policyholders to obtain coverage where a single person insured under the policy has acted with the requisite disqualifying state of mind.

Although the asbestos mass tort did not create aggregate limits, broad or laser-like exclusion, more favorable policy language, choice of law, choice of forum, or arbitration clauses, it helped prompt the insurance industry to develop these sorts of tools of policy design and to deploy them more frequently and aggressively. The result is that insurers today are in a considerably better position for disputing coverage than was the case 30 years ago.

X. ASSESSING THE EQUITIES OF ASBESTOS AND INSURANCE

Having extensively reviewed the saga of the asbestos insurance coverage wars, it is time for an attempt at ultimate assessment: Have insurers been treated unfairly or suffered unduly as a result of the asbestos mass tort? The answer seems to be a resounding "no." Asbestos may not have been the best thing to ever happen to the insurance industry but appears to be a storm insurers have successfully ridden out and will continue to ride out. Even the best known example of asbestos-based pressure on insurance industry – the troubles at Lloyd's during the 1980s and the formation of Equitas – appears headed toward an acceptable if not classically happy ending.[267] By comparison to the financial pressure

267. *See* Glenn Brace, Remarks at the University of Connecticut School of Law Insurance Law Center Symposium: Asbestos: Anatomy of a Mass Tort (Nov. 3, 2005).

HeinOnline -- 12 Conn. Ins. L.J. 470 2005-2006

imposed on insurers by real storms such as Hurricane Katrina, the Northridge Earthquake, and Winterstorm Jeannette, the asbestos coverage exposure has been manageable.

As important as the question of financial impact is the question of justice. Even if asbestos is only a small drag on earning for liability insurers, this alone hardly justifies erroneous legal treatment of their contract disputes with policyholders. Although insurers complain about judicial decisions mandating coverage, it seems indisputable that these decisions have largely been correct and that insurers have won at least as many coverage disputes they deserved to lose. In addition, when one examines the overall justice of the asbestos coverage experience rather than only the more narrow question of particular litigant rights in a particular context, it also appears that insurers have not been forced to take on any asbestos liabilities for which they did not bargain and receive compensation.

An insurance policy, like any contract, allocates risk. Insurance policies are different from other contracts, however, in that risk allocation is to a large extent the main purpose of the contract, whereas risk allocation, although important, may be secondary in contracts involving sales of goods or real estate, situations in which acquisition of property or money is the core of the transaction. Under the insuring arrangement, the policyholder pays a premium to the insurer in return for the insurer's acceptance of the contingent risk of suffering future third-party claims and adverse settlements or judgments.

Insurance by definition involves a policyholder's incurring a relatively small but certain loss (i.e., payment of premiums) in return for obtaining protection from large but contingent and uncertain risks (coverage under the policy up to the policy limits, either per occurrence or aggregate). The very nature of the insurance undertaking is one in which the policyholder is at risk of needlessly paying for a product he never can use while the insurer bears the risk that it must pay amounts far larger than a particular policyholder's premiums should substantial tort liability be visited upon the policyholder.

Either way, the parties to that insurance policy, an aleatory contract, are involved in an exchange that is certain to be unequal. Insurance scholars define an aleatory contract as one in which the outcome is affected by chance and that the number of dollars given up by the contracting parties will be unequal. The insured pays the required premium, and if no loss occurs, the insurance company pays nothing. If a loss does occur, the insured's premium is small in relation to the amount the insurer will be

HeinOnline -- 12 Conn. Ins. L.J. 471 2005-2006

required to pay. In the sense that it is aleatory, and insurance contract is like a gambling contract.[268]

Because of the emergence of the asbestos mass tort, more of those contingent risks resulted in claims and liability than was originally predicted by either the insurers or policyholder/asbestos defendant. Although this had adverse economic consequences for both the insurers and policyholders, it is no reason for relieving or reducing the insurance coverage responsibility of general liability insurers. On the contrary, there is every reason to hold the insurers to their risk-shifting bargain. Acceptance of this sort of risk is the essence of insurance. It is the reason American businesses pay premiums to insurers. Insurance markets, risk management, and commerce are adversely affected when insurers are allowed to escape their contractual commitments, with correspondingly adverse social and economic consequences.[269]

Because insurers are by definition in the risk-acceptance and risk distribution business, liability insurers typically protect themselves in several ways. In addition to the product design protections detailed in Section IX, above, liability insurers diversify risks of all sorts, not merely asbestos, construction, or manufacturing risks. Insurers insured more than just asbestos-related businesses during the 1950s-1980s period and collected premiums from a variety of business, not merely those using distributing or using asbestos. Before one can accept the insurer proposition that it has unduly suffered because of asbestos coverage obligations under the CGL form (and pollution or other long-tail liablities), one must look at the overall economic impact of the CGL and related policies. It appears that on the whole, the CGL has been a money-maker for insurers and that insurers as a whole have prospered during the time of the asbestos mass tort.[270] Although asbestos stocks have not performed like Google, Microsoft, Intel, or Cisco Systems, neither have they been Enron,

---

268. *See* Vaughan & Vaughan, *supra* note 78, at 168; EDWIN W. PATTERSON, ESSENTIALS OF INSURANCE LAW 62 (1955). *See also* GEORGE E. REJDA, PRINCIPLES OF RISK MANAGEMENT AND INSURANCE 80 (4th ed. 1992) (aleatory contract "*is one in which the values exchanged are not equal.* Depending on chance, one party may receive a value out of proportion to the value that is given"; using example of homeowner paying $400 in premium but collecting $100,000 policy limits if home destroyed by fire) (italics in original).

269. *See* Stewart & Stewart, *supra* note 18. *See also* Kenneth S. Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85 (2001).

270. *See, e.g.*, Testimony of Wade Harrell (June 20, 1986) 144:20-21 ("I'll also put in the record that over 50% of our policies are loss free.") (testimony before Texas State Insurance Regulators seeking approval of new "claims-made" general liability policy) (Mr. Harrell was Vice President of Underwriting for Liberty Mutual).

HeinOnline -- 12 Conn. Ins. L.J. 472 2005-2006

WorldCom, or Global Crossing. On the whole, insurers have done well by selling risk shifting to American businesses on a general liability basis.

Although selling CGL insurance to asbestos companies may prove in retrospect to be bad business for insurers, insurers undoubtedly had many liability policies during this time period that were profitable because of low claim incidence relative to premiums collected. In addition, insurers purchase reinsurance to cover their risks. Reinsurance is insurance purchased by an insurance company, in which a reinsurer essentially indemnifies or otherwise compensates an insurer for some or all claims payments above a certain amount. Thus, the insurer is protected to a large degree from surprisingly large or frequent CGL claims.[271] Further, reinsurers are bound to "follow the fortunes" of the primary and excess insurers they reinsure and are bound by the judgments and settlements covered by the underlying policies.[272] When primary and excess insurers have a bad loss experience, reinsurers must shoulder a good deal of the burden, which considerably softens the blow to front line insurers from the asbestos mass tort.

Where insurers have faced tough times, this has often been a creature of their own making and not the result of large tort awards or judicial decisions unduly favorable to policyholders. Instead, the insurance industry's own cyclical underwriting and pricing behavior—alternatingly accepting problematic risks as bargain basement prices and refusing to write coverage or dramatically increasing premiums when investment conditions change—has produced the seesaw of soft and hard markets that both disrupts insurer income statements and frustrates policyholders and policymakers.[273] At times, insurers appear to dramatically overreact to changes in market conditions or isolated adverse legal rulings.[274]

---

271. *See generally* BARRY R. OSTRAGER & MARY KAY VYSKOCIL, REINSURANCE LAW AND PRACTICE Ch. 1, esp. § 1.02 (2d ed. 2000).

272. *See* North River Ins. Co. v. ACE Am. Reins. Co., 361 F.3d 134, 139-40 (2d Cir. 2004) (applying New York law) (follow-the-fortunes doctrine, sometimes called follow-the-settlements doctrine, "requires a reinsuers to indemnify a cedent [primary or excess insurer purchasing reinsurance] for a settlement as long as that settlement is reasonable and made in good faith" and includes deference to insurer's allocation of payments according to policy period and coverage classification); North River Ins. Co. v. CIGNA Reins. Co., 52 F.3d 1194, 1205 (3d Cir. 1995) (applying Ohio law); Christiana Gen. Ins. Corp. v. Great Am. Ins. Co., 979 F.2d 268, 280 (2d Cir. 1992) (applying New York law).

273. *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH (2005).

274. Sean M. Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10:2 CONN. INS. L.J. 255 (2004) (summarizing and reviewing traditional economic views of insurance and tendency of insurance pricing to be cyclical in response to interest rates and other factors; also contending that psychological factors such as fear and uncertainty by policyholders and insurers plays greater role than commonly acknowledged)

HeinOnline -- 12 Conn. Ins. L.J. 473 2005-2006

In addition, the insurance industry remains well known for paying relatively high sales commissions and maintaining a large separation between the sales, underwriting, and claims aspects of the operation. The result is that part of an insurer's work force has an undue incentive to sell coverage to even shaky risks while another part of the organization has a strong incentive to be overly ungenerous in handling claims and providing defense as part of the company effort to profit and in reaction to inadequate pricing and overly aggressive sales of the initial policies.

Further, insurers tend to have high administrative expenses, which further erodes profit. Even where a carrier's underwriting ratio is not bad, combined ratios are often poor because of the administrative expense of running an insurance company. As in other areas, insurers have improved in this regard since the advent of the asbestos mass tort, with greater use of computers and other technology and improved efforts to reduce disputing and transactions costs (which may of course be in part the unavoidable result of the U.S. judicial system). But these business operations remain primarily the domain of insurers and not the inevitable consequence of policyholder activities or the legal system.

To return briefly to a question raised by Professor Scales at this Symposium and the 2005 AALS Annual Meeting—that asbestos has been a "perfect storm" for disrupting insurance markets. At this juncture, it is not at all clear that the asbestos mega-tort is the cause of any significant, ongoing disruption of liability insurance markets. Instead, one might regard the asbestos problem as a "one-time only" event that despite its magnitude is largely confined to a particular type of product no longer in use. Despite its resemblance to the Energizer Bunny, the asbestos tort and related coverage issues will eventually pass. More long-standing problems for insurers and policyholders arguably include toxic torts generally, cyclical interest rates and investment results, natural disasters, terrorism, litigation inefficiencies and high transaction costs generally in policy administration and dispute resolution.

Further, as noted above, the asbestos situation arguably provided assistance to insurers in the long-run by prompting carriers to make structural changes in the policy form, underwriting, and pricing that perhaps should have been done long ago. The same appears true regarding

---

(Fitzpatrick is an executive with Chubb.); *At Risk: A Survey of International Insurance*, THE ECONOMIST, Sept. 25, 1982, at 4 ("Thus, in America last year, a whopping underwriting loss of $5 billion of property/casualty business was dwarfed by investment income of almost $10 billion"). In many asbestos matters, insurers have been able to profit for decades due to the float on policyholder premiums, a financial gain that surely salves the pain of having to for coverage years later.

HeinOnline -- 12 Conn. Ins. L.J. 474 2005-2006

other coverage pressures faced by insurers from pollution exposure, Hurricane Andrew, the Northridge Earthquake, September 11, and other large loss events that lack the elongated payout pattern of asbestos. One need not be a cynic to note that in the aftermath of large losses, policyholders are willing to pay more for insurance. Insurance executives themselves have made this observation. Distasteful as it may initially sound, disaster may be good for insurer profit margins in the long run.

Asbestos is primarily distinguished from other disasters and mass torts by its enduring (seemingly never-ending) quality. Large losses and capital shocks are always part of the risks presented to a general liability or all-risk property insurer. Asbestos is different in that it combines the "ordinary worst" of large losses with long-running repetition. Although this may make the asbestos coverage problem seem more oppressive than other problems facing insurers, a more sustained analysis suggests that the elongated time frame of the asbestos mass tort has favored insurers and made asbestos much less of a problem for insurers than more compressed losses such as the U.S. Hurricanes of 2004 and 2005. The long-running asbestos saga provided insurers with more breathing space and ability to profit from the float on premiums than was presented by the natural disasters and September 11. Further, as also discussed above, asbestos is a discreet, identifiable source of tort liability and a single substance that can be and has been specifically excluded.

Seen in this light, perhaps asbestos is no worse or even arguably better than other risks that turn out poorly for insurers (again, assuming that it is a "poor" outcome when insurers must pay large claims but then can more than recoup them charging higher premiums on policies with reduced coverage). What may present a greater risk to insurers is their own success in reaching out to new markets. Consider the impact if property insurance had been in abundance in late 2004 Indonesia, Sri Lanka, India, and East Africa or if Pakistan in 2005 were heavily insured. The financial impact to insurers from the 2004 Asian Tsunami or the 2005 Pakistan Earthquake would have made asbestos exposure look tame by comparison. Instead, insurers are largely, like the rest of us, only distant witnesses to these third world tragedies.

As a result of the asbestos experience, insurers are considerably wiser limiting their exposure to the unanticipated mass torts or natural disasters of the future. Paradoxically, the large asbestos liability payments of the past twenty-five years appears to be a bargain for insurers, providing the underwriting and policy drafting savvy to make insurance markets more stable in the future (albeit more expensive for policyholders).

HeinOnline -- 12 Conn. Ins. L.J. 475 2005-2006

CONCLUSION

The asbestos mass tort and attendant insurance coverage wars have inflicted substantial, sometimes grave, casualties on all sides. Although the seemingly perpetual nature of asbestos disputing continues to foreclose a final or definitive assessment, it appears that on balance, insurers have fared at least as well and probably better than other participants in this long-running drama. In terms of both legal doctrine and business economics, insurers appear to have weathered the asbestos storm just fine, perhaps considerably better than they have fared in relation to real storms and the catastrophic losses occasioned by natural disaster.

HeinOnline -- 12 Conn. Ins. L.J. 476 2005-2006

THE ASBESTOS LITIGATION CRISIS: THE TIDE APPEARS TO BE TURNING

Mark A. Behrens[*]
and Phil Goldberg[**]

INTRODUCTION

In 1997, the United States Supreme Court said that this country was experiencing an "asbestos-litigation crisis."[1] Most of the "elephantine mass"[2] of claims being filed resulted from attorney-sponsored mass screenings and involved plaintiffs with little or no asbestos-related impairment.[3] As claims poured in at an extraordinary rate, scores of employers were forced into bankruptcy and payments to the sick became threatened.[4] In addition, some judges bent procedural rules to usher cases

---

* Mark A. Behrens is a partner in the Public Policy Group of Shook, Hardy & Bacon L.L.P. in Washington, D.C. He received his B.A. from the University of Wisconsin-Madison in 1987 and his J.D. from Vanderbilt University Law School in 1990, where he was a member of the *Vanderbilt Law Review.*

** Phil Goldberg is an associate in the Public Policy Group of Shook, Hardy & Bacon L.L.P. in Washington, D.C. He received his B.A. from Tufts University and his J.D. from The George Washington University School of Law, where he was a member of the *Order of the Coif.*

1. Amchem Prods., Inc. v. Windsor, 521 U.S. 591, 597 (1997).

2. Norfolk & Western Ry. Co. v. Ayers, 538 U.S. 135, 166 (2003) (quoting Ortiz v. Fibreboard Corp., 527 U.S. 815, 821 (1999)).

3. *See* Lester Brickman, *Ethical Issues in Asbestos Litigation*, 33 HOFSTRA L. REV. 833 (2005); *see also* Robert J. Samuelson, Editorial, *Asbestos Fraud*, WASH. POST., Nov. 20, 2002, at A25.

4. *See* Griffin B. Bell, *Asbestos Litigation and Judicial Leadership: The Courts' Duty to Help Solve the Asbestos Litigation Crisis*, 6:6 BRIEFLY 1, 29 (June 2002), *available at* http://www.nlcpi.org/books/pdf/Vol6Number6June2002.pdf.; Mark A. Behrens, *Some Proposals for Courts Interested in Helping Sick Claimants and Solving Serious Problems in Asbestos Litigation*, 54 BAYLOR L. REV. 331 (2002); Paul F. Rothstein, *What Courts Can Do in the Face of the Never-Ending Asbestos Crisis*, 71 MISS. L.J. 1 (2001); Richard O. Faulk, *Dispelling the Myths of Asbestos Litigation: Solutions for Common Law Courts*, 44 S. TEX. L. REV. 945 (2003).

HeinOnline -- 12 Conn. Ins. L.J. 477 2005-2006

through their dockets.[5] Filings were concentrated in a small group of jurisdictions.[6]

Recently, courts and legislatures in key states have adopted reforms that have improved the overall asbestos litigation environment.[7] Now, after years of downward spiral, the asbestos litigation tide finally may be turning.[8]

I. TRENDS IN ASBESTOS LITIGATION

A. THE CURRENT ASBESTOS LITIGATION CRISIS: AN OVERVIEW

1. Mass Filings by the Non-Sick Threaten Payments to the Truly Sick

When asbestos litigation was in its infancy, most claims were filed by "workers suffering from grave and crippling maladies. The most common was mesothelioma,"[9] a type of cancer. Today, the vast majority of new asbestos claimants—up to ninety percent—are "people who have been exposed to asbestos, and who (usually) have some marker of exposure such as changes in the pleural membrane covering the lungs, but who are not

---

5. *See* Victor E. Schwartz & Leah Lorber, *A Letter to the Nation's Trial Judges: How the Focus on Efficiency Is Hurting You and Innocent Victims in Asbestos Liability Cases*, 24 AM. J. TRIAL ADVOC. 247, 256-57 (2000).

6. *See* STEPHEN J. CARROLL ET AL., ASBESTOS LITIGATION (RAND Inst. for Civil Justice 2005), *available at* http://www.rand.org/publications/MG/MG162 [hereinafter CARROLL ET AL.].

7. *See* James A. Henderson, Jr., *Asbestos Litigation Madness: Have the States Turned a Corner?*, 3:6 MEALEY'S TORT REFORM UPDATE 12 (Jan. 18, 2006) [hereinafter Henderson]; *see also* Mark A. Behrens & Cary Silverman, *Now Open for Business: The Transformation of Mississippi's Legal Climate*, 24 MISS. C. L. REV. 393 (2005) [hereinafter Behrens & Silverman].

8. *See* TILLINGHAST, U.S. TORT COSTS AND CROSS-BORDER PERSPECTIVES: 2005 UPDATE 5 (2006), *available at* http://www.towersperrin.com/tillinghast/publications/reports/2005_Tort_Cost/ 2005_Tort.pdf ("The impact of asbestos in 2004 was less than in each of the prior three years"); Matt Brady, *Asbestos Reserve Shortfall Down to $10B*, NAT'L UNDERWRITER PROP. & CAS., Apr. 10, 2006, at 8 (according to A.M. Best, insurance industry annual asbestos losses retreated from a high of $8 billion in 2002 to $6 billion in 2003 to less than $4 billion in 2004); Paul Davies, *Plaintiffs' Lawsuits Against Companies Sharply Decline*, WALL ST. J., Aug. 26-27, 2006, at A1, *abstract available at* 2006 WLNR 14914829.

9. Roger Parloff, *The $200 Billion Miscarriage of Justice; Asbestos Lawyers Are Pitting Plaintiffs Who Aren't Sick Against Companies that Never Made the Stuff - and Extracting Billions for Themselves*, FORTUNE, Mar. 4, 2002, at 158, *available at* 2002 WLNR 11958234.

HeinOnline -- 12 Conn. Ins. L.J. 478 2005-2006

impaired by an asbestos-related disease and likely never will be."[10] Cardozo Law School Professor Lester Brickman has said, "the 'asbestos litigation crisis' would never have arisen and would not exist today" if not for the claims filed by the unimpaired.[11]

2. Lawyers in Search of Plaintiffs

"Claimants today are diagnosed largely through plaintiff-lawyer arranged mass screenings programs"[12] that are frequently conducted in areas with high concentrations of workers who may have worked in jobs where they were exposed to asbestos.[13] According to former United States Attorney General Griffin Bell, mass screenings conducted by plaintiffs' lawyers and their agents have "driven the flow of new asbestos claims by healthy plaintiffs."[14] *U.S. News & World Report* has described the recruitment process:

> To unearth new clients for lawyers, screening firms advertise in towns with many aging industrial workers or park X-ray vans near union halls. To get a free X-ray, workers must often sign forms giving law firms 40 percent of any recovery. One solicitation reads: 'Find out if YOU have MILLION DOLLAR LUNGS!'[15]

---

10. *The Fairness in Asbestos Compensation Act of 1999: Hearing on H.R. 1283 Before the House Comm. on the Judiciary*, 106th Cong. 5 (July 1, 1999) (statement of Christopher Edley, Jr., Professor, Harvard Law School); *see also* Roger Parloff, *Welcome to the New Asbestos Scandal*, FORTUNE, Sept. 6, 2004, at 186, *available at* 2004 WLNR 17888598 ("two-thirds to 90% of the nonmalignants are 'unimpaireds'—that is, they have slight or no physical symptoms"); Alex Berenson, *A Surge in Asbestos Suits, Many by Healthy Plaintiffs*, N.Y. TIMES, Apr. 10, 2002, at A15.

11. Lester Brickman, *Lawyers' Ethics and Fiduciary Obligation in the Brave New World of Aggregative Litigation*, 26 WM. & MARY ENVTL. L. & POL'Y REV. 243, 273 (2001).

12. *In re* Joint E. & S. Dists. Asbestos Litig., 237 F. Supp. 2d 297, 309 (E.D.N.Y. & S.D.N.Y. 2002); *see also* Judyth Pendell, *Regulating Attorney-Funded Mass Medical Screenings: A Public Health Imperative?* (AEI-Brookings Joint Center for Regulatory Studies Sept. 2005), *available at* http://www.aei-brookings.org/publications/abstract.php?pid=993.

13. *See* Eagle-Picher Indus., Inc. v. Am. Employers' Ins. Co., 718 F. Supp. 1053, 1057 (D. Mass. 1989) ("[M]any of these cases result from mass X-ray screenings at occupational locations conducted by unions and/or plaintiffs' attorneys, and many claimants are functionally asymptomatic when suit is filed.").

14. Griffin B. Bell, *Asbestos & The Sleeping Constitution*, 31 PEPP. L. REV. 1, 5 (2003) [hereinafter Bell].

15. Pamela Sherrid, *Looking for Some Million Dollar Lungs*, U.S. NEWS & WORLD REP., Dec. 17, 2001, at 36, *available at* 2001 WLNR 7718069; *see also Eagle-Picher*, 718

HeinOnline -- 12 Conn. Ins. L.J. 479 2005-2006

Professor Brickman has estimated that over one million workers have undergone attorney-sponsored screenings.[16]

The practice of mass litigation screenings has come under significant scrutiny.[17] Attorney General Bell has noted, "[t]here often is no medical purpose for these screenings and claimants receive no medical follow-up."[18] Senior U.S. District Judge John Fullam has said that many X-ray interpreters (called B Readers) hired by plaintiffs' lawyers are "so biased that their readings [are] simply unreliable."[19]

The American Bar Association Commission on Asbestos Litigation ("Commission"), with the help of the American Medical Association, consulted prominent occupational medicine and pulmonary disease physicians to craft legal standards for asbestos-related impairment.[20] The Commission confirmed that claims filed by the non-sick generally arise from for-profit screening companies whose sole purpose is to identify large numbers of people with minimal X-ray changes "consistent with" asbestos exposure. "Some X-ray readers spend only minutes to make these findings, but are paid hundreds of thousands of dollars—in some cases, millions—in the aggregate by the litigation screening companies due to the volume of films read."[21] The Commission also reported that litigation screening

---

F. Supp. at 1057 (many asbestos cases result from mass X-ray screenings "conducted by unions and/or plaintiffs' attorneys"); Owens Corning v. Credit Suisse First Boston, 322 B.R. 719, 723 (D. Del. 2005) ("Labor unions, attorneys, and other persons with suspect motives caused large numbers of people to undergo X-ray examinations (at no cost), thus triggering thousands of claims by persons who had never experienced adverse symptoms.").

16. *See* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality?*, 31 PEPP. L. REV. 33, 69 (2003).

17. *See* Eddie Curran, *Asbestosis Diagnoses Have Come Under Fire From Critics*, MOBILE REGISTER, Apr. 4, 2004, at A1, *available at* 2004 WLNR 20359014; Eddie Curran, *Diagnosing for Dollars?*, MOBILE REGISTER, Apr. 4, 2004, at A1, *available at* 2004 WLNR 20406347.

18. Bell, *supra* note 14, at 5; *see also* David Egilman & Susanna Rankin Bohme, *Attorney-Directed Screenings Can Be Hazardous*, 45 AM. J. OF INDUS. MED. 305 (2004) (noting danger of attorney-directed screenings that fail to provide adequate medical counseling or treatment).

19. *Owens Corning*, 322 B.R. at 723.

20. *See* ABA COMM'N ON ASBESTOS LITIG., ABA REPORT TO THE HOUSE OF DELEGATES (2003), *available at* http://www.abanet.org/leadership/full_report.pdf [hereinafter ABA COMM'N REP.]. In February 2003, the ABA's House of Delegates adopted the Commission's proposal for the enactment of federal medical criteria standards for nonmalignant asbestos-related claims. *See Asbestos Litigation: Hearing Before the Sen. Comm. on the Judiciary*, 107th Cong. Appen. A (Mar. 5, 2003) (statement of Hon. Dennis Archer, President-elect, American Bar Ass'n), *available at* 2003 WL 785387.

21. ABA COMM'N REP., *supra* note 20, at 8.

HeinOnline -- 12 Conn. Ins. L.J. 480 2005-2006

companies find X-ray evidence that is "consistent with" asbestos exposure at a "startlingly high" rate, often exceeding fifty percent and sometimes reaching ninety percent.[22]

Most recently, researchers at Johns Hopkins University compared the X-ray interpretations of B Readers employed by plaintiffs' counsel with the subsequent interpretations of six independent B Readers who had no knowledge of the X-rays' origins.[23] The study found that, while B Readers hired by plaintiffs claimed asbestos-related lung abnormalities in 95.9% of the X-rays, the independent B Readers found abnormalities in only 4.5% of the same X-rays—a difference the researchers said was "too great to be attributed to inter-observer variability."[24]

One physician, Dr. Lawrence Martin, explained the reason plaintiffs' B readers seem to see asbestos-related lung abnormalities on chest X-rays in numbers not seen by neutral experts: "the chest X-rays are not read blindly, but always with the knowledge of some asbestos exposure and that the lawyer wants to file litigation on the worker's behalf."[25] Some attorneys reportedly pass an X-ray around to numerous radiologists until they find one who is willing to say that the X-ray shows symptoms of an

---

22. *Id.* One of the earliest detailed reviews of B Reads in litigation arose out of information distributed to tire workers, which said that 94 percent of the workers screened at one location and 64 percent of the workers screened at another location were found to have asbestosis. *See* Raymark Indus., Inc. v. Stemple, 1990 WL 72588, *5, *10 (D. Kan. May 30, 1990). In 1986, the National Institute for Occupational Safety and Health looked into the matter and found that only 0.2% of the workers they evaluated had physical changes consistent with asbestosis. *See* J. JANKOVIC & R. B. REGER, HEALTH HAZARD EVALUATION REPORT, NIOSH Rep. No. HETA 87–017–1949 (Dep't Health & Human Servs., NIOSH 1989). In 1998, an audit by the Manville Settlement Trust determined that 59 percent of X-ray readings relied upon by plaintiffs' counsel to show asbestos-related abnormalities were inaccurate. *See In re* Joint E. & S. Dists. Asbestos Litig., 237 F. Supp. 2d 297, 309 (E.D.N.Y. & S.D.N.Y. 2002). Another review of asbestos cases conducted by medical experts appointed by U.S. District Judge Carl Rubin of the Southern District of Ohio found that 65 percent of the claimants reviewed had no asbestos-related conditions and 20 percent presented only pleural plaques. *See* Carl Rubin & Laura Ringenbach, *The Use of Court Experts in Asbestos Litigation*, 137 F.R.D. 35, 37-39 (1991).

23. *See* Joseph N. Gitlin et al., *Comparison of "B" Readers' Interpretations of Chest Radiographs for Asbestos Related Changes*, 11 ACAD. RADIOLOGY 843 (Aug. 2004).

24. *Id.* at 852.

25. David E. Bernstein, *Keeping Junk Science Out of Asbestos Litigation*, 31 PEPP. L. REV. 11, 13 (2003) (quoting Lawrence Martin, M.D.). Vanderbilt Law School Professor Richard Nagareda has explained, "[t]he game for plaintiffs' attorneys is: Seek out doctors willing to diagnose a problem where the vast majority of doctors would not." Davies, *supra* note 8, at A9.

HeinOnline -- 12 Conn. Ins. L.J. 481 2005-2006

asbestos-related disease—a practice strongly suggesting unreliable scientific evidence.[26]

3. The Impact of "Unimpaired Claimants" on Asbestos Litigation

a. The Truly Sick

Mass filings by unimpaired claimants have created judicial backlogs and are exhausting scarce resources that should go to "the sick and the dying, their widows and survivors."[27] For example, the Manville trustees report that a "disproportionate amount of Trust settlement dollars have gone to the least injured claimants—many with no discernible asbestos-related physical impairment whatsoever."[28] The Trust is now paying out *five cents on the dollar* to asbestos claimants.[29] The Celotex and Eagle-Picher Settlement Trusts also have had to cut payments to claimants.[30]

Cancer victims now have a well-founded fear that they may not receive adequate or timely compensation unless trends in the litigation are

---

26. *See* David Egilman, *Asbestos Screenings*, 42 AM. J. OF INDUS. MED. 163 (2002); *see also* Stephen Hudak & John F. Hagan, *Asbestos Litigation Overwhelms Courts*, CLEVELAND PLAIN DEALER, Nov. 5, 2002, at 1, *available at* 2002 WLNR 269888 (quoting one medical witness for plaintiffs who said he was "amazed to discover that, in some of the screenings, the worker's X-ray had been 'shopped around' to as many as six radiologists until a slightly positive reading was reported by the last one.").

27. *In re* Collins, 233 F.3d 809, 812 (3d Cir. 2000), *cert. denied sub nom.* Collins v. Mac-Millan Bloedel, Inc., 532 U.S. 1066 (2001) (internal citation omitted); *see also* Larson v. Johns-Manville Sales Corp., 399 N.W.2d 1, 9 (Mich. 1986) ("We believe that discouraging suits for relatively minor consequences of asbestos exposure will lead to a fairer allocation of resources to those victims who develop cancers."); *In re* Joint E. & S. Dists. Asbestos Litig., 129 B.R. 710, 751 (E.D.N.Y. & S.D.N.Y. 1991) ("Overhanging this massive failure of the present system is the reality that there is not enough money available from traditional defendants to pay for current and future claims."), *vacated*, 982 F.2d 721 (2d Cir. 1992); *In re* Asbestos Prod. Liab. Litig. (No. VI), MDL 875, Admin. Order No. 8, 2002 WL 32151574 , *1 (E.D. Pa. Jan. 16, 2002) ("Oftentimes these suits are brought on behalf of individuals who are asymptomatic as to an asbestos-related illness and may not suffer any symptoms in the future. Filing fees are paid, service costs incurred, and defense files are opened and processed. Substantial transaction costs are expended and therefore unavailable for compensation to truly ascertained asbestos victims.").

28. Quenna Sook Kim, *Asbestos Trust Says Assets Are Reduced as the Medically Unimpaired File Claims*, WALL ST. J., Dec. 14, 2001, at B6.

29. *See id.*

30. *See* James L. Stengel, *The Asbestos End-Game*, 62 N.Y.U. ANN. SURV. AM. L. 223, 262 (2006); *see also* Mark Goodman et al., Editorial, *Plaintiffs' Bar Now Opposes Unimpaired Asbestos Suits*, NAT'L L.J., Apr. 1, 2002, at B14.

HeinOnline -- 12 Conn. Ins. L.J. 482 2005-2006

addressed.[31] In fact, some lawyers who primarily represent cancer victims have been highly critical of other plaintiffs' lawyers who file claims on behalf of the non-sick.

Matthew Bergman of Seattle: "Victims of mesothelioma, the most deadly form of asbestos-related illness, suffer the most from the current system . . . the genuinely sick and dying are often deprived of adequate compensation as more and more funds are diverted into settlements of the non-impaired claims."[32]

Peter Kraus of Dallas: Plaintiffs' lawyers who file suits on behalf of the non-sick are "sucking the money away from the truly impaired."[33]

Terrence Lavin of Chicago (and former Illinois State Bar President): "Members of the asbestos bar have made a mockery of our civil justice system and have inflicted financial ruin on corporate America by representing people with nothing more than an arguable finding on an X-ray."[34]

Steve Kazan of Oakland: "The current asbestos litigation system is a tragedy for our clients. We see people every day who are very seriously ill. Many have only a few months to live. It used to be that I could tell a man dying of mesothelioma that I could make sure that his family would be taken care of. That statement was worth a lot to my clients, and it was true. Today, I often cannot say that any more. And the reason is that other plaintiffs' attorneys are filing tens of thousands of claims every year for people who have absolutely nothing wrong with them."[35]

---

31. *See, e.g.*, Albert B. Crenshaw, *For Asbestos Victims, Compensation Remains Elusive*, WASH. POST., Sept. 25, 2002, at E1.

32. Matthew Bergman & Jackson Schmidt, Editorial, *Change Rules on Asbestos Lawsuits*, SEATTLE POST-INTELLIGENCER, May 30, 2002, at B7, *available at* 2002 WLNR 2149929.

33. Susan Warren, *Competing Claims: As Asbestos Mess Spreads, Sickest See Payouts Shrink*, WALL ST. J., Apr. 25, 2002, at A1.

34. Editorial, *ABA Backs Asbestos Reform*, WASH. TIMES, Feb. 16, 2003, at B2.

35. *See Asbestos Litigation: Hearing Before the Sen. Comm. on the Judiciary*, 107th Cong. (Sept. 25, 2002) (statement of Steven Kazan), *available at* http://judiciary.senate.gov/testimony.cfm?id=472&wit_id=12069.

HeinOnline -- 12 Conn. Ins. L.J. 483 2005-2006

b. Bankruptcies and the Economic Impact of Asbestos Litigation

Asbestos litigation has forced an estimated eighty-five employers into bankruptcy.[36] Since 2000, the process has accelerated due to the piling on nature of asbestos liabilities.[37] The RAND Institute for Civil Justice ("RAND") found that following 1976, the year of the first bankruptcy attributed to asbestos litigation, there were nineteen bankruptcies in the 1980s, seventeen in the 1990s, and an astounding thirty-six bankruptcy filings from 2000 and mid-2004.[38] Bankruptcies cost employees their jobs, ordinary citizens their retirement savings, and adversely impact affected communities.[39]

c. Peripheral Defendants Are Being Dragged into the Litigation

Experience shows that when "traditional" asbestos defendants file bankruptcy, plaintiffs' lawyers will simply cast their litigation net wider and pull in "peripheral" defendants that may be "far removed from the

36. *See* Martha Neil, *Backing Away from the Abyss*, ABA J., Sept. 2006, at 26, 29.

37. *See In re* Combustion Eng'g, Inc., 391 F.3d 190, 201 (3d Cir. 2005) ("mounting asbestos liabilities have pushed otherwise viable companies into bankruptcy"); *see also* Christopher F. Edley, Jr. & Paul C. Weiler, *Asbestos: A Multi-Billion-Dollar Crisis*, 30 HARV. J. ON LEGIS. 383, 392 (1993) (each time a defendant declares bankruptcy, "mounting and cumulative" financial pressure is placed on "remaining defendants").

38. *See* CARROLL ET AL., *supra* note 6, at xxvii; *see also* Ronald Barliant et al., *From Free-Fall To Free-For-All: The Rise of Pre-Packaged Asbestos Bankruptcies*, 12 AM. BANKR. INST. L. REV. 441 (2004); Mark D. Plevin et al., *Pre-Packaged Asbestos Bankruptcies: A Flawed Solution*, 44 S. TEX. L. REV. 883 (2003); Mark D. Plevin et al., *The Future Claims Representative in Prepackaged Asbestos Bankruptcies: Conflicts of Interest, Strange Alliances, and Unfamiliar Duties for Burdened Bankruptcy Courts*, 62 N.Y.U. ANN. SURV. AM. L. 271 (2006).

39. Bankruptcies resulting from asbestos litigation put up to 60,000 people out of work between 1997 and 2000. Those workers and their families lost up to $200 million in wages, and employee retirement assets declined roughly 25 percent. *See* Joseph E. Stiglitz et al., *The Impact of Asbestos Liabilities on Workers in Bankrupt Firms*, 12 J. BANKR. L. & PRAC. 51, 76, 83 (2003); *see also* Ieropoli v. AC&S Corp., 842 A.2d 919, 932 (Pa. 2004) (noting concern about "the heavy toll that asbestos litigation is visiting upon certain Commonwealth corporations."). Workers, communities, and taxpayers will bear as much as $2 billion in additional costs due to indirect and induced impacts of company closings related to asbestos. *See* JESSE DAVID, THE SECONDARY IMPACTS OF ASBESTOS LIABILITIES (Nat'l Econ. Research Assocs., Jan. 23, 2003).

HeinOnline -- 12 Conn. Ins. L.J. 484 2005-2006

scene of any putative wrongdoing."[40] One well-known plaintiffs' attorney has called the litigation an "endless search for a solvent bystander."[41] Currently, over 8,500 defendants[42] are "ensnarled in the litigation"[43]—up from 300 in 1982.[44]

B. IMPROPER CONSOLIDATIONS

Initially, some courts dealt with the enormous pressure on their dockets by joining dissimilar claims, either in mass consolidations or in clusters. Former Michigan Supreme Court Chief Justice Conrad L. Mallett, Jr. described how trial judges inundated with asbestos claims might feel compelled to adopt such procedural shortcuts:

> Think about a county circuit judge who has dropped on her 5,000 cases all at the same time . . . . [I]f she scheduled all 5,000 cases for one week trials, she would not complete her task until the year 2095. The judge's first thought then is, "How do I handle these cases quickly and efficiently?" The judge does not purposely ignore fairness and truth, but the demands of the system require speed and dictate case consolidation even where the rules may not allow joinder.[45]

The largest single mass consolidation occurred in West Virginia in 2002 when a trial court joined more than 8,000 plaintiffs suing more than 250 defendants:

---

40. Editorial, *Lawyers Torch the Economy*, WALL ST. J., Apr. 6, 2001, at A14; *see also* Susan Warren, *Asbestos Suits Target Makers of Wine, Cars, Soups, Soaps*, WALL ST. J., Apr. 12, 2000, at B1; Richard B. Schmitt, *Burning Issue: How Plaintiffs' Lawyers Have Turned Asbestos Into a Court Perennial*, WALL ST. J., Mar. 5, 2001, at A1; Susan Warren, *Asbestos Quagmire: Plaintiffs Target Companies Whose Premises Contained Any Form of Deadly Material*, WALL ST. J., Jan. 27, 2003, at B1.

41. *'Medical Monitoring and Asbestos Litigation'—A Discussion with Richard Scruggs and Victor Schwartz*, 17:3 MEALEY'S LITIG. REP.: ASBESTOS 5 (Mar. 1, 2002) (quoting Mr. Scruggs).

42. *See* Deborah R. Hensler, *California Asbestos Litigation—The Big Picture*, COLUMNS–RAISING THE BAR IN ASBESTOS LITIG., Aug. 2004, at 5.

43. *In re* Joint E. & S. Dists. Asbestos Litig., 129 B.R. 710, 747-48 (E.D.N.Y. & S.D.N.Y. 1991), *vacated*, 982 F.2d 721 (2d Cir. 1992).

44. *See* JAMES S. KAKALIK ET AL., VARIATION IN ASBESTOS LITIGATION COMPENSATION AND EXPENSES 5 (RAND Inst. for Civil Justice 1984).

45. *The Fairness in Asbestos Compensation Act of 1999: Hearings on H.R. 1283 Before the House Comm. on the Judiciary*, 106th Cong. 6 (1999) (statement of the Hon. Conrad L. Mallett, Jr.).

HeinOnline -- 12 Conn. Ins. L.J. 485 2005-2006

> [T]his litigation involves thousands of plaintiffs; twenty or more defendants; hundreds of different work sites located in a number of different states; dozens of different occupations and circumstances of exposure; dozens of different products with different formulations, applications, and warnings; several different diseases; numerous different claims at different stages of development; and at least nine different law firms, with differing interests, representing the various plaintiffs. Additionally, the challenged conduct spans the better part of six decades.[46]

The court's multi-phased trial plan—where the "fault" of premises owners, employers, and manufacturers and punitive damages multipliers would be determined before basic issues of causation and compensatory damages[47]—"so depart[ed] from [the] accepted norm as to be presumptively violative of due process."[48] The plan was in clear conflict with federal appellate decisions holding that due process does not permit the overbroad aggregation of widely disparate claims without any review for commonality or risk of prejudice to the litigants.[49] The trial court apparently presumed that post-trial review would be precluded by the forced settlement of large numbers of claims. In fact, within days after the United States Supreme Court declined to stay the trial or review the plan, all but one of the original 259 defendants settled.[50]

A smaller, yet no less troubling, consolidation occurred later that year in Virginia when 1,300 asbestos claims against twenty-five defendants were joined, even though the trial court found that "consolidation of all of the cases would adversely affect the rights of the parties to a fair trial."[51] Also, in 1998, a Mississippi trial court joined the claims of 1,738 plaintiffs

---

46. State *ex rel.* Mobil Corp. v. Gaughan, 565 S.E.2d 793, 794 (W. Va. 2002) (Maynard, J., concurring).

47. *See In re* Asbestos Litig., Civ. Action No. 02-C-9004 (Cir. Ct. Kanawha County, W. Va. Aug. 12, 2002) (transcript of hearing before Judges Arthur Recht, Booker Stephens, and Alan Moats).

48. TXO Prod. Corp. v. Alliance Res. Corp., 509 U.S. 443, 457 (1993).

49. *See, e.g., In re* Brooklyn Navy Yard Asbestos Litig., 971 F.2d 831, 853 (2d Cir. 1992); *see also* Malcolm v. Nat'l Gypsum Co., 995 F.2d 346, 350 (2d Cir. 1993); Garber v. Randell, 477 F.2d 711, 716 (2d Cir. 1973); *In re* Chevron U.S.A., Inc., 109 F.3d 1016, 1020 (5th Cir. 1997).

50. *See Mobil Settles, Leaving Carbide as Lone Asbestos Defendant*, ASSOC. PRESS NEWSWIRE, Oct. 10, 2002.

51. *In re* Hopeman Bros., Inc., 569 S.E.2d 409, 409 (Va. 2002).

HeinOnline -- 12 Conn. Ins. L.J. 486 2005-2006

who alleged various asbestos-related conditions.[52] A trial of the first twelve plaintiffs' claims resulted in a jury verdict of $48.5 million, including $2 million for each of five plaintiffs who reported no respiratory problems and had normal pulmonary function test results; all other cases settled.[53]

C. MIGRATION OF FILINGS TO JUDICIAL HELLHOLES

Personal injury lawyers have focused their filings in certain jurisdictions, which has put added pressure on those courts. Rather than file where there is a logical connection to a claim or claimant, plaintiffs' lawyers often strategically flock to "magic jurisdictions" with a reputation for producing large settlements and verdicts.[54] Mississippi plaintiffs' lawyer Richard Scruggs has explained:

> What I call the "magic jurisdiction," . . . [is] where the judiciary is elected with verdict money. The trial lawyers have established relationships with the judges that are elected; they're State Court judges; they're popul[ists]. They've got large populations of voters who are in on the deal, they're getting their [piece] in many cases. And so, it's a political force in their jurisdiction, and it's almost impossible to get a fair trial if you're a defendant.[55]

---

52. *See The Fairness in Asbestos Compensation Act of 1999: Legislative Hearing on H.R. 1283 Before the H. Comm. on the Judiciary*, 106th Cong. 39-40 (1999) (statement of Professor William Eskridge, Yale Law School), *available at* http://judiciary.house.gov/judiciary/eskr 0701.htm; John H. Beisner et al., *One Small Step for a County Court . . . One Giant Calamity for the National Legal System*, 7 CIVIL JUSTICE REP. 16 (Apr. 2003), *available at* http://www.manhattan-institute. org/pdf/cjr_07.pdf.

53. *See Mississippi Jury Awards $48.5 Million in 12 Cases*, 20:12 ANDREWS ASBESTOS LITIG. REP. 1 (July 17, 1998). The judge reportedly told the defendants that if they did not settle, he would try the other claims immediately before the same jury. When defense counsel replied that sounded like "this side of hell," the judge purportedly said, "no counselor, that is hell." Behrens & Silverman, *supra* note 7, at 398.

54. For example, in one case, an Indiana plaintiff with mesothelioma filed a claim against U.S. Steel in Madison County, Illinois, for injuries allegedly sustained from asbestos exposure at a U.S. Steel plant in Indiana. The plaintiff had no significant connection to Illinois, much less to Madison County. Nevertheless, his trial resulted in a $250 million verdict. *See* Brian Brueggemann, *Man Awarded $250 Million in Cancer Case*, BELLEVILLE NEWS-DEMOCRAT, Mar. 29, 2003, at 40.

55. Richard Scruggs, *Asbestos for Lunch,* Panel Discussion at the Prudential Securities Financial Research and Regulatory Conference (May 9, 2002), *in* INDUSTRY COMMENTARY (Prudential Securities, Inc., N.Y., New York), June 11, 2002, at 5; *see also* Richard Scruggs,

HeinOnline -- 12 Conn. Ins. L.J. 487 2005-2006

The American Tort Reform Foundation ("ATRF") calls these places "Judicial Hellholes,"[56] because court procedures and laws are routinely applied in an unfair manner against civil defendants.

RAND found that from 1998 to 2000, eleven states saw the brunt of asbestos filings: Texas (19%), Mississippi (18%), New York (12%), Ohio (12%), Maryland (7%), West Virginia (5%), Florida (4%), Pennsylvania (3%), California (2%), Illinois (1%), and New Jersey (1%).[57] In recent years, ATRF has identified Judicial Hellholes in Texas, Mississippi, West Virginia, Florida, Pennsylvania, California, and Illinois.[58]

II. DEALING WITH NON-SICK CLAIMANTS AND MASS SCREENINGS

Many courts and legislatures in states with a disproportionate number of asbestos filings have decided to give priority to sick claimants by setting aside or dismissing the claims of the unimpaired.[59]

A. PRIORITIZING CLAIMS TO BENEFIT THE SICK

1. State Courts

a. No Injury Cases

Courts in Arizona, Delaware, Maine, Maryland, and Pennsylvania have held that physically unimpaired asbestos claimants do not have legally compensable claims.[60] Federal courts interpreting Hawaii and Massachusetts law have reached the same conclusion.[61]

Tobacco Lawyers' Roundtable: A Report from the Front Lines, 51 DEPAUL L. REV. 543, 545 (2001).

56. AM. TORT REFORM FOUND., BRINGING JUSTICE TO JUDICIAL HELLHOLES (2005), *available at* http://www.atra.org/reports/hellholes/.

57. *See* CARROLL ET AL., *supra* note 6, at 62.

58. *See id.*

59. *See* Mark A. Behrens & Phil Goldberg, *State-Based Medical Criteria For Asbestos Suits Gains Momentum*, 15:13 LEGAL OPINION LETTER (Wash. Legal Found., July 1, 2005), *reprinted in* 27:20 ANDREWS ASBESTOS LITIG. RPTR. 10 (July 29, 2005), *and* 23:13 ANDREWS TOXIC TORTS LITIG. RPTR. 11 (Aug. 5, 2005).

60. *See* Burns v. Jaquays Mining Corp., 752 P.2d 28 (Ariz. Ct. App. 1987); *In re* Asbestos Litig. Leary Trial Group, 1994 WL 721763 (Del. Super. Ct. June 14, 1994), *rev'd*

HeinOnline -- 12 Conn. Ins. L.J. 488 2005-2006

The Supreme Judicial Court of Maine, in *Bernier v. Raymark Industries, Inc.*, was the first state high court to hold that "the subclinical injury resulting from [asbestos] inhalation is *insufficient* to constitute the actual loss or damage to a plaintiff's interest required to sustain a cause of action."[62] The court held that "[t]here is generally no cause of action in tort until a plaintiff has suffered an identifiable, compensable injury."[63] An Arizona appellate court in *Burns v. Jaquays Mining Corp.* stated that it would be impossible to determine appropriate damages without a manifest injury.[64] In *Simmons v. Pacor, Inc.*, the Pennsylvania Supreme Court held that "asymptomatic pleural thickening is not a compensable injury which gives rise to a cause of action."[65] Individuals with pleural conditions, the court said, "lead active, normal lives, with no pain or suffering, no loss of an organ function, and no disfigurement due to scarring."[66]

b. Inactive Dockets

A growing number of courts have implemented inactive asbestos dockets (also called deferred dockets or pleural registries) to give trial priority to the sick.[67] Under these docket management plans, the claims of the non-sick are suspended and preserved;[68] they also are exempt from

---

on other grounds sub nom. Mancari v. A.C. & S.,Inc., 670 A.2d 1339 (Del. 1995); Bernier v. Raymark Indus., Inc., 516 A.2d 534 (Me. 1986); Owens-Illinois v. Armstrong, 591 A.2d 544 (1991), *aff'd in part, rev'd in part on other grounds*, 604 A.2d 47 (Md. Ct. App. 1991); Simmons v. Pacor, Inc., 674 A.2d 232 (1996); *see generally* Victor E. Schwartz et al., *Defining the Edge of Tort Law in Asbestos Bankruptcies: Addressing Claims Filed by the Non-Sick*, 14:1 J. BANKR. L. & PRAC. 61 (2005).

61. *See In re* Hawaii Federal Asbestos Cases, 734 F. Supp. 1563 (D. Haw. 1990); *In re* Massachusetts Asbestos Cases, 639 F. Supp. 1 (D. Mass. 1985).

62. *Bernier*, 516 A.2d at 543 (emphasis added).

63. *Id.* at 542.

64. *Burns*, 752 P.2d at 31.

65. *See Simmons*, 674 A.2d at 237.

66. *Id.* at 236; *see also In* re Asbestos Prods. Liab. Litig. (No. VI), 1996 WL 539589, *3 n.8 (E.D. Pa. Sept. 12, 1996) ("Pleural disease is most often an asymptomatic scarring of the pleura—a tissue thin membrane surrounding the lung. Many states, including Pennsylvania, do not allow for a cause of action based upon this condition alone if it is asymptomatic. It can only be discovered through x-ray and, in and of itself, does not pose a health risk or impairment.").

67. *See* Susan Warren, *Swamped Courts Practice Plaintiff Triage*, WALL ST. J., Jan. 27, 2003, at B1.

68. *See In re* Report of the Advisory Group, 1993 WL 30497, at *51 (D. Me. Feb. 1, 1993) ("plaintiffs need not engage in the expense of trial for what are still minimal damages, but are protected in their right to recover if their symptoms later worsen.").

HeinOnline -- 12 Conn. Ins. L.J. 489 2005-2006

discovery. Claimants may petition for removal to the trial docket when credible medical evidence of impairment is shown.[69]

Inactive asbestos dockets offer important public policy benefits.[70] The sick are moved "to the front of the line" and do not have to wait until earlier-filed claims brought by the unimpaired are resolved. This can be particularly important when the claimant is elderly or has a fatal disease. Unimpaired individuals are protected from having their claims time-barred should an asbestos-related disease later develop.[71] Defendants can conserve scarce financial resources needed to compensate sick claimants, the spread of asbestos litigation to peripheral defendants is slowed, and courts are relieved from having to decide "claims that are premature (because there is not yet any impairment) or actually meritless (because there never will be).".[72]

Inactive dockets were first adopted in the late 1980s and early 1990s in jurisdictions that were experiencing large numbers of filings by the unimpaired—Massachusetts (September 1986), Chicago (March 1991), and Baltimore City (December 1992).[73] Since 2002, the list of jurisdictions with inactive asbestos dockets has grown to include Cleveland, Ohio (March 2006); Minnesota (coordinated litigation) (June 2005); St. Clair County, Illinois (February 2005); Portsmouth, Virginia (August 2004);

---

69. *See generally* Dr. John E. Parker, *Understanding Asbestos-Related Medical Criteria*, 18:10 MEALEY'S LITIG. REP.: ASBESTOS 45 (June 18, 2003).

70. *See In re* USG Corp., 290 B.R. 223, 226 n.3 (Bankr. Del. Feb. 2003) (the "practical benefits of dealing with the sickest claimants . . . have led to the adoption of deferred claims registries in many jurisdictions"); Sopha v. Owens-Corning Fiberglass Corp., 601 N.W.2d 627, 641 (Wis. 1999) (inactive dockets "may be [a] good solution to an admittedly difficult situation.").

71. *See* Mark A. Behrens & Monica G. Parham, *Stewardship for the Sick: Preserving Assets for Asbestos Victims Through Inactive Docket Programs*, 33 TEX. TECH L. REV. 1 (2001); *see also* Mark A. Behrens & Manuel López, *Unimpaired Asbestos Dockets: They Are Constitutional*, 24 REV. LITIG. 253 (2005) [hereinafter Behrens & Lopez].

72. Peter H. Schuck, *The Worst Should Go First: Deferral Registries in Asbestos Litigation*, 15 HARV. J.L. & PUB. POL'Y 541, 555 (1992) [hereinafter Schuck].

73. *See* Mass. State Ct. Asbestos Pers. Injury Litig., Order (Middlesex Super. Ct., Mass. Sept. 1986); *In re* Asbestos Cases (Cook County Cir. Ct., Ill. Mar. 26, 1991) (Order to Establish Registry for Certain Asbestos Matters); *In re* Asbestos Pers. Injury and Wrongful Death Asbestos Cases, 1992 WL 12019620 (Baltimore City Cir. Ct., Md. Dec. 9, 1992). Judge Hiller Zobel in Massachusetts said the inactive docket has been "really a very good system that has worked out." *Unimpaired Asbestos Dockets: Are They Easing the Flow of Litigation?*, COLUMNS–RAISING THE BAR IN ASBESTOS LITIG., Feb. 2002, at 2. Baltimore City Circuit Court Judge Richard Rombro has stated that "the docket is working." *In re* Pers. Injury and Wrongful Death Asbestos Cases, No. 24-X-92-344501, at 5 (Baltimore City Cir. Ct., Md. Aug. 15, 2002) (Memorandum Opinion and Order Denying Modification to Unimpaired Docket Medical Removal Criteria) (on file with the authors).

HeinOnline -- 12 Conn. Ins. L.J. 490 2005-2006

Madison County, Illinois (January 2004); Syracuse, New York (January 2003); New York City (December 2002); and Seattle, Washington (December 2002).[74] In 2005, RAND called the "reemergence" of inactive dockets "one of the "most significant developments" in asbestos litigation.[75]

2. Federal Multi-District Litigation

The same principles have been applied to cases on the federal asbestos multi-district litigation docket from as far back as 1992. Under the stewardship of U.S. District Court Judge Charles Weiner,[76] plaintiffs were grouped into four disease categories (mesothelioma; lung cancer; other malignancies; and asbestosis with disability) and required to have a written medical opinion by a board-certified specialist indicating that exposure to asbestos or an asbestos-containing product was a contributing cause to the alleged condition.[77] Thousands of cases involving unimpaired claimants were dismissed under the court's ordering plan.[78]

In 1996, Judge Weiner dismissed thousands of maritime asbestos cases where the plaintiff could not provide the court with sufficient medical evidence of a personal injury.[79] In January 2002, Judge Weiner went further and dismissed all asbestos cases initiated through mass screenings.[80] Cases may be reinstated only if the claimant shows evidence of asbestos exposure and an asbestos-related disease.[81] Judge Weiner explained:

---

74. *See* Mark A. Behrens & Phil Goldberg, *Asbestos Litigation: Momentum Builds for State-Based Medical Criteria Solutions to Address Filings by the Non-Sick*, 20:6 MEALEY'S LITIG. REP.: ASBESTOS 33, 4 (Apr. 13, 2005) (providing citations); *In re* Cuyahoga County Asbestos Cases, Special Docket 73958 (Ct. Com. Pl. Cuyahoga County, Ohio Mar. 22, 2006) (applying to nonmalignant asbestos cases filed before Ohio's 2004 asbestos medical criteria law, Am. Sub. H.B. 292, became effective).

75. CARROLL ET AL., *supra* note 6, at xx.

76. Judge Weiner managed the docket from 1991 until his death in late 2005. *See* Mark A. Behrens & Phil Goldberg, *In Memoriam: Senior United States District Judge Charles R. Weiner*, 20:22 MEALEY'S LITIG. REP. ASBESTOS 24 (Dec. 21, 2005). The docket is now being managed by Chief Judge James T. Giles of the Eastern District of Pennsylvania.

77. *In re* Asbestos Prod. Liab. Litig. (No. VI), MDL 875, Admin. Order No. 3, at 1 (E.D. Pa. Sept. 8, 1992) (on file with the authors).

78. *See id.; In re* Asbestos Prod. Liab. Litig. (No. VI), MDL 875, Order (E.D. Pa. Oct. 16, 1997) (on file with the authors).

79. *See In re* Asbestos Prods. Liab. Litig. (No. VI), MDL 875, Civ. Action No. 2, 1996 WL 239863, at *5 (E.D. Pa. May 2, 1996).

80. *In re* Asbestos Prod. Liab. Litig. (No. VI), MDL 875, Admin. Order No. 8, 2002 WL 32151574 , *1 (E.D. Pa. Jan. 16, 2002).

81. *See id.*.

HeinOnline -- 12 Conn. Ins. L.J. 491 2005-2006

"[T]he filing of mass screening cases is tantamount to a race to the courthouse and has the effect of depleting funds, some already stretched to the limit, which would otherwise be available for compensation to deserving plaintiffs."[82]

3. Medical Criteria Laws

State legislatures also acting to set aside and preserve the claims of the non-sick so that resources can be focused on the sick. In 2004, Ohio became the first state to require plaintiffs to demonstrate physical impairment under objective medical criteria in order to bring or maintain an asbestos-related action.[83] In 2005, Georgia, Texas, and Florida enacted similar medical criteria laws.[84] In 2006, medical criteria legislation in Kansas enjoyed massive bipartisan support and received the signature of Democratic Governor Kathleen Sebelius, a former executive of the Kansas Trial Lawyers Association. South Carolina also joined the list of asbestos medical criteria states in 2006.

Early indications are that these laws are working to prioritize asbestos claims and suspend the claims of the non-sick. For example, Bryan Blevins of Provost & Umphrey, a national plaintiffs' practice based in Beaumont, Texas, has said that since Texas enacted its asbestos medical criteria law, "[t]he only cases getting filed now are cancer cases, which are 12% to 15% of the cases being filed nationwide. I think we are going to see dramatic, dramatic changes. . . ."[85] Richard Schuster, chairman of the Columbus-based Vorys, Sater, Seymour and Pease's national toxic tort defense litigation practice, has said that Ohio's medical criteria law

---

82. *Id.* (emphasis added).

83. *See* OHIO REV. CODE § 2307.91 *et seq.* (Anderson 2005); *see also* Kurtis A. Tunnell et al., Commentary, *New Ohio Asbestos Reform Law Protects Victims and State Economy*, 26:22 ANDREWS ASBESTOS LITIG. REP. 10 (Aug. 26, 2004). Ohio also enacted medical criteria legislation to help ensure that silica filings would not be exacerbated by plaintiffs' lawyers who might be discouraged from bringing weak or meritless asbestos suits as a result of the asbestos medical criteria law. *See* OHIO REV. CODE § 2307.85 (Anderson 2005).

84. *See* Mark A. Behrens & Phil Goldberg, *State-Based Medical Criteria For Asbestos Suits Gains Momentum*, 15:13 LEGAL OPINION LETTER 1 (Wash. Legal Found. July 1, 2005), *available at* http://www.wlf.org/upload/070105LOLBehrens.pdf.; *see generally* James S. Lloyd, Comment, *Administering a Cure-All or Selling Snake Oil? Implementing an Inactive Docket for Asbestos Litigation in Texas*, 43 HOUS. L. REV. 159 (2006) (arguing that Texas's medical criteria law is constitutional).

85. Peter Geier, *States Taking up Medical Criteria: Move is to Control Asbestos Caseload*, NAT'L L.J., May 22, 2006 (quoting Mr. Blevins) [hereinafter Geier].

HeinOnline -- 12 Conn. Ins. L.J. 492 2005-2006

"dramatically cut the number of new case filings by more than 90%."[86] John Cooney, an asbestos plaintiffs' lawyer based in Chicago, recently said, "I know whole firms that just don't do asbestos anymore."[87]

"A lot of companies that were seeing 40,000 cases in 2002 and 2003 have dropped to the 15,000 level," according to Jennifer Biggs, who chairs the mass torts subcommittee of the American Academy of Actuaries.[88] Frederick Dunbar, a senior vice president of NERA Economic Consulting, recently studied the Securities and Exchange Commission filings of eighteen large asbestos defendants and found that, "for all of them, 2004 asbestos claims had dropped from peak levels of the previous three years. Ten companies saw claims fall by more than half between 2003 and 2004."[89]

C. DECREASING THE USE OF MASS SCREENINGS

The judicial and legislative reforms outlined above have diminished the economic incentive for plaintiffs' lawyers to conduct mass screenings. Another event that should accelerate the demise of mass screenings was a watershed ruling in June 2005 by the manager of the federal silica multi-district litigation docket, U.S. District Judge Janis Graham Jack of the Southern District of Texas. Judge Jack recommended that all but one of the 10,000 claims on the silica docket should be dismissed on remand because the diagnoses were fraudulently prepared. "[T]hese diagnoses were driven by neither health nor justice," Judge Jack said in her opinion, "they were manufactured for money."[90] The U.S. Attorney's Office in Manhattan and the Texas Attorney General have convened grand juries to

---

86. *Id.* (quoting Mr. Schuster).

87. Patti Waldmeir, *Asbestos Litigation Declines in Face of US Legal Reforms*, FIN. TIMES, July 24, 2006, at 2, *available at* 2006 WLNR 12719566 (quoting Mr. Cooney).

88. Alison Frankel, *Asbestos Removal*, AM. LAW., July 2006, at 15.

89. *Id.*; *see also* Mark A. Behrens & Frank Cruz-Alvarez, *State-Based Reforms: Making a Difference in Asbestos and Silica Cases*, 16:21 LEGAL BACKGROUNDER (Wash. Legal Found. Aug. 4, 2006), *reprinted in* 28:22 Andrews Asbestos Litig. Rptr. 12 (Aug. 25, 2006).

90. *See In re* Silica Prods. Liab. Litig. No. MDL 1553, 398 F. Supp. 2d 563, 635 (S.D. Tex. 2005); *see also* Fred Krutz & Jennifer R. Devery, *In the Wake of Silica MDL 1553*, 4:5 MEALEY'S LITIG. REP. SILICA 10 (Jan. 2006); Roger Parloff, *A Court Battle Over Silicosis Shines a Harsh Light on Mass Medical Screeners–The Same People Whose Dignoses Have Cost Asbestos Defendants Billions*, FORTUNE, June 13, 2005, at 96, *available at* 2005 WLNR 8694138.

HeinOnline -- 12 Conn. Ins. L.J. 493 2005-2006

consider criminal charges arising out of Judge Jack's findings.[91] In addition, the U.S. House Energy & Commerce Subcommittee on Oversight & Investigations is probing fraud in silica filings.[92]

The B Readers and mass screening companies referenced in Judge Jack's opinion have helped generate thousands of asbestos claims.[93] For example, at least sixty percent of the claimants with silica claims before Judge Jack had filed asbestos-related claims with the Manville Trust, even though it is extremely rare for someone to have both silica-related and asbestos-related disease.[94] In 2005, the Manville, Eagle-Picher, and Celotex Asbestos Settlement Trusts announced that they will no longer accept reports prepared by the doctors referenced in Judge Jack's opinion.[95] Similarly, the Court of Common Pleas of Cuyahoga County (Cleveland), Ohio recently dismissed approximately 3,755 asbestos cases after the screening doctors, some of whom had been involved in the silicosis litigation, refused to testify, asserting their Fifth Amendment right against self-incrimination.[96] "Another 35,000 asbestos cases, in which plaintiffs had been diagnosed by the same doctors, were put aside until they could

---

91. *See* Jonathan D. Glater, *Lawyers Challenged on Asbestos*, N.Y. TIMES, July 20, 2005, at C1, *available at* 2005 WLNR 11332864; Peter Geier, *Silica Cases Drawing Resistance; Fallout From Key Texas Case Continues with Grand Jury, Legislation*, NAT'L L.J., Dec. 19-26, 2005; Lynn Brezosky, *Texas Probing Potentially Fraudulent Diagnosis of Lung Disease in Thousands of Lawsuits*, AP DATASTREAM 23:40:04 (June 8, 2006).

92. *See* Press Release, Barton, Whitfield Query Physicians Regarding Silicosis, Aug. 2, 2005, *available at* http://energycommerce.house.gov/108/News/08022005_1619.htm; Julie Criswell, *Testing for Silicosis Comes Under Scrutiny in Congress*, N.Y. TIMES, Mar. 8, 2006, at C3, *available at* 2006 WLNR 3870056.

93. *See Asbestos: Mixed Dust and FELA Issues, Hearing Before the Senate Comm. on the Judiciary*, 109th Cong. (Feb. 2, 2005), *available at* http://judiciary.senate.gov/print_testimony.cfm?id=1362&wit_id=3963 (statement of Professor Lester Brickman, Cardozo Law School).

94. *See id.* "One doctor has made roughly 88,000 asbestos diagnoses over the years and diagnosed about 70% of the 10,000 silicosis cases that Judge Jack found fraudulent." Davies, *supra* note 8, at A9.

95. *See* Announcement by David Austern, President, Claims Resolution Management Corporation (September 12, 2005), *available at* http://www.claimsres.com/Home/PDF/9 05 Suspension Memo.pdf; Letter from William B. Nurre, Executive Director, Eagle-Picher Personal Injury Settlement Trust, to Claimants' Counsel (Oct. 19, 2005), *available at* http://www.cpf-inc.com/includes/content/PhysicianNotice.pdf; Notice of Trust Policy Regarding Acceptance of Medical Reports from John L. Mekus, Executive Director of the Celotex Asbestos Settlement Trust (Oct. 20, 2005), *available at* http://www.celotextrust.com/news_details.asp?nid=22.

96. *See In re* Cuyahoga County Asbestos Cases, Special Docket 73958 (Ct. Com. Pl. Cuyahoga County, Ohio Mar. 22, 2006); Geier, *supra* note 85 (quoting Ohio defense lawyer Richard Schuster); Peter Geier, *Thousands of Asbestos Cases Dismissed*, NAT'L L.J., Apr. 10, 2006, at 13; Davies, *supra* note 8, at A9.

HeinOnline -- 12 Conn. Ins. L.J. 494 2005-2006

get diagnoses from other doctors."[97] Plaintiffs' lawyers, however, may have difficulty recruiting new medical experts to fill the shoes of colleagues under investigation.

In addition, the King County Superior Court in Seattle has ruled on motions for summary judgment in cases brought on the basis of findings by Dr. Jay Segarra, an out-of-state physician-screener not licensed in Washington. The court said that Dr. Segarra "improperly performed examinations, rendered diagnoses, and recommended treatment without being licensed in Washington, a criminal offense."[98] The court concluded that allowing the cases to proceed would "contravene public policy" and dismissed them without prejudice.[99]

III. ENDING JOINDER ABUSE

There is now a better understanding that bending procedural rules to put pressure on defendants to settle cases does not make cases go away, it invites new ones.[100] As mass tort expert Francis McGovern of Duke University Law School explained, "[j]udges who move large numbers of highly elastic mass torts through their litigation process at low transaction costs create the opportunity for new filings. . . . If you build a superhighway, there will be a traffic jam."[101] One West Virginia trial judge involved in that state's asbestos litigation acknowledged that, "we thought [a mass trial] was probably going to put an end to asbestos, or at least knock a big hole in it. What I didn't consider was that that was a form of advertising. . . . [I]t drew more cases."[102] Consolidations also raise serious

---

97. Davies, *supra* note 8, at A9.

98. *See* Behrens & Lopez, *supra* note 71, at 274 n.104.

99. *Id.*

100. *See* Victor E. Schwartz et al., *Addressing the "Elephantine Mass" of Asbestos Cases: Consolidation Versus Inactive Dockets (Pleural Registries) and Case Management Plans that Defer Claims Filed by the Non-Sick*, 31 PEPP. L. REV. 271 (2004).

101. Francis E. McGovern, *The Defensive Use of Federal Class Actions in Mass Torts*, 39 ARIZ. L. REV. 595, 606 (1997)); *see also* Glenn W. Bailey, *Litigation Is Destroying American Companies*, USA TODAY (MAG.), Jan. 1, 1994, at 76, *available at* 1994 WLNR 2872064 ("Judges' efforts to resolve cases all too often have resulted in a perverse incentive—causing more cases and more backlog.").

102. *In re* Asbestos Litig., Civ. Action No. 00-Misc.-222 (Cir. Ct. Kanawha County, W. Va. Nov. 8, 2000) (statement of West Virginia Judge A. Andrew MacQueen in hearing before Judge John Hutchinson); *see also* CARROLL ET AL., *supra* note 6, at 26 (steps "to streamline the litigation actually increased the total dollars spent"); Helen E. Freedman, *Product Liability Issues in Mass Torts—View from the Bench*, 15 TOURO L. REV. 685, 688 (1999) (New York City asbestos judge: "Increased efficiency may encourage additional filings and provide an overly hospitable environment for weak cases.").

HeinOnline -- 12 Conn. Ins. L.J. 495 2005-2006

due process issues because defendants lack a meaningful opportunity to defend against individual claims.[103]

Courts are taking a fresh look at this practice. For example, the Mississippi Supreme Court has severed several multi-plaintiff asbestos-related cases.[104] In one of the cases, *Harold's Auto Parts, Inc. v. Mangialardi,*[105] the court called the joinder of 264 plaintiffs who alleged asbestos exposure over a seventy-five year period to products associated with 137 defendants a "perversion of the judicial system. . . ."[106] In July 2005, the Ohio Supreme Court amended the Ohio Rules of Civil Procedure to preclude the joinder of pending asbestos-related actions.[107] Most recently, in August 2006, the Michigan Supreme Court adopted an administrative order that precludes the "bundling" of asbestos-related cases for trial.[108] The order states: "It is the opinion of this Court that each case should be decided on its own merits, and not in conjunction with other cases. Thus, no asbestos-related disease personal injury action shall be joined with any other such case for settlement or for any other purpose, with the exception of discovery."[109]

State legislators also are acting to shut down improper trial consolidations. They are beginning to appreciate that, in addition to fundamental fairness and due process problems, consolidating cases to force defendants to settle is a bit like using a lawn mower to cut down weeds in a garden—the practice may provide a temporary fix to a clogged docket, but ultimately the approach is likely to create more problems than it solves. In 2005 and 2006, Georgia, Kansas, and Texas enacted laws that generally preclude the joinder of asbestos cases at trial.

---

103. *See* Victor E. Schwartz & Rochelle M. Tedesco, *The Law of Unintended Consequences in Asbestos Litigation: How Efforts to Streamline the Litigation Have Fueled More Claims*, 71 MISS. L.J. 531 (2001).

104. *See, e.g.*, Amchem Prods., Inc. v. Rogers, 912 So. 2d 853 (Miss. 2005); Illinois Cent. R.R. Co. v. Gregory, 912 So. 2d 829 (Miss.2005); 3M Co. v. Hinton, 910 So. 2d 526 (Miss. 2005); 3M Co. v. Johnson, 895 So. 2d 151 (Miss. 2005).

105. 889 So. 2d 493 (Miss. 2004).

106. *Id.* at 495.

107. *See* OHIO R. CIV. P. 42(A)(2) ("In tort actions involving an asbestos claim, a silicosis claim, or a mixed dust disease claim, the court may consolidate pending actions for case management purposes. For purposes of trial, the court may consolidate pending actions only with the consent of all parties. Absent the consent of all parties, the court may consolidate, for purposes of trial, only those pending actions relating to the same exposed person and members of the exposed person's household.").

108. *See* Admin. Order No. 2006-6, Prohibition on "Bundling" Cases (Mich. Aug. 9, 2006), *available at* 2006 WLNR 14601437.

109. *Id.*; *see also* Editorial, *Unbundling Asbestos*, WALL ST. J., Aug. 21, 2006, at A10, *available at* 2006 WLNR 14482501.

HeinOnline -- 12 Conn. Ins. L.J. 496 2005-2006

IV. ENDING FORUM SHOPPING ABUSE

Forum shopping refers to the practice of filing claims in "magic jurisdictions" or "Judicial Hellholes." It is the reason why the eleven states referenced earlier have housed roughly eighty-four percent of the asbestos litigation in the country.

State legislatures are taking their courts back from "litigation tourists" by enacting venue and *forum non conveniens* reforms. These laws generally require a claimant to file in a forum with a logical connection to the claimant or claim, such as where the claimant lives or was exposed. Recently, Alabama, Arkansas, Georgia, Missouri, Mississippi, South Carolina, and Texas have enacted venue reforms—all of these states have been home to Judicial Hellholes.[110]

Courts also are beginning to do a better job of enforcing state venue and *forum non conveniens* laws. For example, several high profile cases have put a dent in the magnet that has drawn cases to Madison County, Illinois. In *Dawdy v. Union Pacific Railway Co.*, the Illinois Supreme Court held that a foreign plaintiff's forum choice deserves less deference if it is not the plaintiff's home.[111] In *Gridley v. State Farm Mutual Automobile Insurance Co.*,[112] the court remanded a Louisiana man's case back to Madison County with directions to dismiss the complaint based on *forum non conveniens*. In addition, the judge overseeing asbestos litigation in Madison County has ordered the transfer of an out-of-state mesothelioma case, noting that

> As much as this judge, or any judge with any compassion whatsoever, would like to do anything to assist such a litigant, with expedited schedules and to accommodate him in any way possible, such accommodation must be reasonable in following the law. The court must consider, not only how many jury trials actually occur out of this docket; but, also what would happen if every case or even a

110. *See* ALA. CODE § 6-3-7 (2005); ARK. CODE ANN. § 16-55-213 (2005) (amended by H.B. 1038 (Ark. 2003)); GA. STAT. Ann. §§ 51-14-8, 51-14-9 (2005) (amended by H.B. 416 (Ga. 2005)); MO. REV. STAT. § 508.010 (2005) (amended by H.B. 393 (2005)); MISS. CODE ANN. § 11-11-3(1) (2005) (amended by H.B. 19 (Miss. 2002) and H.B. 13 (Miss. 2004)); S.C. CODE ANN. § 15-7-100(A)(3) (2005) (amended by H.B. 3008 (S.C. 2005)). A similar reform enacted in West Virginia, W. VA. CODE 56-1-1(C) (2005) (amended by S.B. 213 (W. Va. 2003)), was limited in *Morris v. Crown Equip. Corp.*, 633 S.E.2d 292 (W. Va. June 29, 2006).

111. 797 N.E.2d 687, 694 (2003).

112. 840 N.E.2d 269 (Ill. 2005).

> similar percentage of these cases to all other types of civil jury lawsuits were to go to trial. . . . .
>
> If large numbers of these cases did actually go to trial, then this docket would no longer be the "cash cow." Such circumstances would place an astronomical burden upon the citizens of Madison County to serve as jurors; would require more trial judges, courtrooms, clerks, bailiffs and other necessary accommodations than could be handled. It is one thing to make such efforts to accommodate the citizens of Madison County and others whose cases bear some connection or reason to be here.
>
> But when, as in the case being considered, there is no connection with the county or with this state, the trial judge would probably be required to apply Louisiana law (another factor not only of difficulty to the trial judge but a consideration of local problems being decided locally); the treating physicians are all from Louisiana; there is a similar asbestos docket with expedited trial settings for persons similarly situated to the plaintiff herein; the distance from the home forum and the area of exposure is in excess of 700 miles and this county has such an immense docket; the case should be transferred.[113]

In July 2005, the Ohio Supreme Court amended the Ohio Rules of Civil Procedure to limit venue in asbestos actions.[114] The Mississippi Supreme Court also has issued rulings to address the problem of forum shopping.[115]

---

113. Palmer v. Riley Stoker Corp., No. 04-L-167 (Madison County Cir. Ct., Ill. Oct. 4, 2004).

114. *See* OHIO R. CIV. P. 3(B)(11) (asbestos actions may be brought in the county in which all of the exposed plaintiffs reside, a county where all of the exposed plaintiffs were exposed to asbestos, or the county in which the defendant has its principal place of business).

115. *See, e.g.*, Culbert v. Johnson & Johnson, 883 So. 2d 550 (Miss. 2004) (transferring in-state cases to the proper county and dismissing out-of-state plaintiffs).

HeinOnline -- 12 Conn. Ins. L.J. 498 2005-2006

V. ADDITIONAL REFORMS THAT ARE IMPROVING THE ASBESTOS LITIGATION ENVIRONMENT

In addition to the reforms discussed above, courts and legislatures have adopted several other reforms that are helping to improve the asbestos litigation environment.

A. JOINT LIABILITY

Joint liability provides that, when two or more persons engage in conduct that might subject them to individual liability and their conduct produces a single, indivisible injury, each defendant will be liable for the total amount of damages.[116] The proliferation of asbestos-related bankruptcies means that the issue of joint liability may be an important factor in more cases.[117]

Currently, about forty states have abolished or modified their joint liability rules.[118] In just the past few years, joint liability reforms have been enacted in Arkansas, Florida, Georgia, Minnesota, Mississippi, Missouri, Ohio, Oklahoma, South Carolina, Texas, and West Virginia—several of these states have been a focus of asbestos litigation.[119]

These reforms may reduce asbestos litigation costs in several ways. First, solvent defendants may be liable for their "fair share" of any judgment, but may no longer be forced to pay for harms caused by others.[120] Second, the fault of many of the newer peripheral defendants

---

116. *See* Coney v. J.L.G. Indus., Inc., 454 N.E.2d 197 (Ill. 1983) (describing joint and several liability).

117. *See* Richard L. Cupp, Jr., *Asbestos Litigation and Bankruptcy: A Case Study for Ad Hoc Public Policy Limitations on Joint and Several Liability*, 31 PEPP. L. REV. 203 (2004).

118. *See* Steven B. Hantler et al., *Is the "Crisis" in the Civil Justice System Real or Imagined?*, 38 LOY. L.A. L. REV. 1121, 1147-51 (2005); *see also* RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIABILITY § 17 cmt. a (2000) ("The clear trend over the past several decades has been a move away from joint and several liability.").

119. *See* ARK. CODE ANN. § 16-55-201 (2003); FLA. STAT. § 768.81 (2006) (amended by H.B. 145, signed by Gov. Apr. 26. 2006); GA. CODE ANN. § 51-12-33 (amended by S.B. 3, signed by Gov. Perdue on Feb. 17, 2005); MINN. STAT. ANN. § 604.02 Subd. 1 (2003); MISS. CODE ANN. § 85-5-7 (2004) (amended by H.B. 13, 1st Spec. Sess. (2004), signed by Gov. Barbour on June 16, 2004); MO. STAT. § 537.067.3 (amended by B.B. 393, signed by Gov. Blunt on Mar. 28, 2005); OHIO REV. CODE ANN. § 2307.22 (2003); OKLA. STAT. ANN. tit. 23, § 15 (West 2005); S.C. CODE ANN. § 15-38-15; TEX. CIV. PRAC. & REM. CODE ANN. § 33.013 (2003); W. VA. CODE ANN. § 55-7-24 (2005).

120. *See, e.g.*, DaFonte v. Up-Right, Inc., 828 P.2d 140 (Cal. 1992) (law abolishing joint liability for noneconomic damages precluded manufacturer from being held jointly

HeinOnline -- 12 Conn. Ins. L.J. 499 2005-2006

may be below the "trigger point" needed for joint liability to attach in states that have adopted a modified approach to the doctrine. Third, some cases may settle for less—or might not be brought at all—because of the dynamic between joint liability and the contingency fee system. These are likely to be cases involving a bankrupt defendant that was substantially at fault for a harm. As California plaintiffs' lawyer Alan Brayton has observed:

> The litigation environment was . . . changed in California by Proposition 51, which eliminated joint and several liability for non-economic damages. That law changes the dynamic of against whom you go to trial and what kind of cases you can take to trial, because if you do not have large economic damages, and you only have a one percent responsible defendant, it is not economically viable to take that case to trial.[121]

B. PUNITIVE DAMAGES

The asbestos litigation environment also is improving for defendants as a result of the reining in of punitive damages awards, both in general and respect to asbestos cases.

For example, the United States Supreme Court has held that due process places an outer limit beyond which punitive damages may not go.[122] The Court has offered guideposts for lower courts to use in deciding

---

liable for noneconomic harm attributable to plaintiff's employer, who was statutorily immune).

121. Alan Brayton, *Alternatives to Asbestos Impairment Standards*, 31 PEPP. L. REV. 29, 29-30 (2004). Recently, San Francisco Superior Court Judge Stephen Allen Dombrink, in response to a defense motion, gave a simple and straightforward instruction to the jury on the effect of joint and several liability. The jury was told that, under California law, any finding of a proportionate share of liability for economic damages would result in the defendant being responsible for the full amount of economic damages. Judge Dombrink had faith that juries are responsible enough to handle this knowledge. *See* Horr v. Allied Packing, No. RG-03-104401, slip op. at *2 (Cal. Sup. Ct. Feb. 13, 2006); *see also* Kaeo v. Davis, 719 P.2d 387 (Haw. 1986); Luna v. Shockey Sheet Metal & Welding Co., 743 P.2d 61 (Idaho 1987); Decelles v. State, 795 P.2d 419 (Mont. 1990); Reese v. Werts Corp., 397 N.W.2d 1 (Iowa 1985); Coryell v. Town of Pinedale, 745 P.2d 883 (Wyo. 1987).

122. *See* Pac. Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 18 (1991) (acknowledging that excessive punitive damages awards could violate the Due Process Clause of the Fourteenth Amendment); TXO Prod. Corp. v. Alliance Res. Corp., 509 U.S. 443, 455-56 (1993) (stating in a plurality opinion that "grossly excessive" punitive damages awards violate due process).

HeinOnline -- 12 Conn. Ins. L.J. 500 2005-2006

whether a punitive damages award is unconstitutionally excessive.[123] The Court's decisions should have an impact on verdicts and, in turn, settlement values.[124]

In addition, state legislatures have addressed runaway punitive damages by limiting the amount that can be imposed; raising the burden of proof that must be met before punitive damages can be awarded; and by preventing evidence that is highly prejudicial and relevant only to the issue of punishment from being improperly considered when juries determine compensatory damages liability.[125] The key asbestos states of Texas, Mississippi, and Ohio have adopted punitive damage reforms in the past few years.[126] Other states enacting such reforms since 2003 include Arkansas, Colorado, Idaho, Missouri, and Montana.[127]

Finally, some judges and legislators are abolishing punitive damage awards in asbestos cases to help ensure that resources are available to compensate sick claimants. In 2000, the Third Circuit Court of Appeals approved a decision by Judge Weiner to sever all punitive damages claims from federal asbestos cases.[128] State courts that have severed, deferred, or stayed punitive damages claims include Baltimore City; Northampton County (Bethlehem and Easton) and Philadelphia, Pennsylvania; and New

---

123. *See* BMW of N. Am., Inc. v. Gore, 517 U.S. 559, 575, 580, 583 (1996) (stating that punitive damage awards against BMW was grossly excessive); State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 416 (2003) (held punitive damages of $145 million was excessive and violates Due Process Clause of the Fourteenth Amendment).

124. *See, e.g.*, Henley v. Philip Morris, Inc., 9 Cal. Rptr. 3d 29, 72-75 (Cal. App. 1 Dist. 2004) (reducing 33:1 ratio between punitive damages and compensatory damages to 6:1 under *State Farm*); Taylor Woodrow Homes, Inc., v. Acceptance Ins. Co., 2003 WL 21224088 (Cal. Ct. App. May 28, 2003) (remitting a 17:1 ratio to a 3.1:1 ratio); *see also* Laura Clark Fey et al., *The Supreme Court Raised Its Voice: Are The Lower Courts Getting The Message? Punitive Damages Trends After State Farm v. Campbell,* 56 BAYLOR L. REV. 807, 837 (2004) ("Lower courts are generally following the single-digit ratio guideline.").

125. *See* Victor E. Schwartz et al., *Reining In Punitive Damages "Run Wild": Proposals for Reform by Courts and Legislatures*, 65 BROOK. L. REV. 1003 (1999).

126. *See* TEX. CIV. PRAC. & REM. CODE Ann. §§ 41.003, 41.008 (2005) (requiring a unanimous jury verdict to award punitive damages); MISS. CODE ANN. § 11-1-65 (2004) (as modified by H.B. 13 (Miss. 2004), signed by Gov. on June 16, 2004) (lowering the limits for punitive damages according to a sliding scale based on the net worth of a defendant); AM. SUB. S.B. 80 (effective Apr. 7, 2005) (amending OHIO REV. CODE ANN. § 2315.21) (limiting punitive damages to two times compensatory damages, establishing bifurcated proceedings, and largely prohibiting the awarding of multiple punitive damages for the same act or conduct).

127. *See* ARK. CODE ANN. § 16-55-208 (2005); COLO. REV. STAT. § 13-21-102 (2005); IDAHO CODE ANN. § 6-1604 (2005); MO. ANN. STAT. § 510.265.1; MONT. CODE ANN. § 27-1-220(3) (2005).

128. *In re* Collins, 233 F.3d 809, 812 (3d Cir. 2000).

HeinOnline -- 12 Conn. Ins. L.J. 501 2005-2006

York City.[129] In 2004, the Florida legislature banned punitive damages in asbestos actions.[130]

C. ADDITIONAL PROCEDURAL FAIRNESS

Finally, some courts are allowing defendants to better evaluate and defend claims. For example, the Mississippi Supreme Court in *Mangialardi* ordered each plaintiff to submit to the trial court such basic information as the name of the defendant(s) "against whom each plaintiff makes a claim, and the time period and location of exposure."[131]

Other important changes have occurred in Madison County, Illinois. The circuit court had a reputation for routinely refusing to grant defendants' pre-trial motions, giving defendants notice of an upcoming trial shortly before the trial was scheduled to begin, and scheduling multiple trials against the same defendants for the same day.[132] In October 2004, Judge Daniel Stack took control of the asbestos docket. Reports are that he is fairer than his predecessor and that the litigation environment has improved.[133] For example, individual asbestos trials held in Madison County between 2000 and 2003 resulted in verdicts of $16 million, $34 million, and $250 million.[134] In 2005, however, one trial resulted in a defense verdict and another in a $500,000 award against two of three named defendants in a mesothelioma case.[135] In addition, the number of asbestos filings has dropped from over 800 cases each year from 2001 to

---

129. *See* Mark A. Behrens & Barry M. Parsons, *Responsible Public Policy Demands an End to the Hemorrhaging Effect of Punitive Damages in Asbestos Cases*, 6 TEX. REV. L. & POL. 137, 154-55 (2001).

130. *See* FLA. STAT. ANN. § 774.207(1) (2005).

131. *Mangialardi*, 889 So. 2d at 495.

132. *See* Victor E. Schwartz et al., *Asbestos Litigation in Madison County, Illinois: The Challenge Ahead*, 16 WASH. U. J.L. & POL'Y 235, 243-52 (2004); Editorial, *Where Asbestos Rules*, ST. LOUIS POST-DISPATCH, Sept. 26, 2004, at B2, *available at* 2004 WLNR 1313866.

133. *See* Editorial, *Cash Cow Cashed Out*, ST. LOUIS POST-DISPATCH, Oct. 12, 2004, at C6, *available at* 2004 WLNR 1272675; Paul Hampel, *Dismissal of Asbestos Suits is Change for Madison County*, ST. LOUIS POST-DISPATCH, Jan. 29, 2005, at 6, *available at* 2005 WLNR 24288223.

134. *See* Editorial, *Paradise Lost for Plaintiffs*, BELLEVILLE NEWS-DEMOCRAT, June 8, 2005, at 4A, available at 2005 WLNR 22693580.

135. *See* Dee McAree, *'Plaintiffs Mecca' Turns Out Two Big Defense Wins*, NAT'L L.J., June 13, 2005, at 6; Brian Brueggemann, *Jury Rules GE Not Liable in Asbestos Trial*, BELLEVILLE NEWS-DEMOCRAT, June 4, 2005, at 1B, *available at* 2005 WLNR 22693007; Paul Hampel, *Defense Attorneys Revel in $500,000 Asbestos Award*, ST. LOUIS POST-DISPATCH, May 20, 2005, at B1.

HeinOnline -- 12 Conn. Ins. L.J. 502 2005-2006

2003, to 477 cases in 2004, to 389 cases in 2005—"the lowest amount of cases in seven years."[136] Most recently, Circuit Judge Ann Callis, who took over as Madison County's Chief Judge on May 1, 2006 has reportedly instituted several reforms to make the jurisdiction more balanced.[137]

CONCLUSION

Recently, courts and legislatures in states with large numbers of asbestos cases have acted to restore fairness and promote sound public policy in the litigation.[138] These reforms are making a difference. As the CEO of a large mutual insurer recently testified:

> The beneficial impact of these efforts cannot be overstated. Historically Texas, Ohio and Mississippi have been the leading states to generate claims filed against [our] policyholders, collectively accounting for approximately 80% of the asbestos claims filed against [our] insureds. Since the statutory and judicial reforms in those three key states, the decrease in the volume of claims has been truly remarkable. In Mississippi, the decrease has been 90%, in Texas nearly 65% and, in Ohio, approximately 35%. Across all states, from 2004 to 2005 we have seen over a 50% decrease in the number of new claims filed, a trend that continued in 2006. These numbers are the best evidence that state-driven initiatives are working . . . .[139]

If these trends continue, asbestos litigation will once focus on the truly sick, which is where it should be. In addition, the litigation will occur more

---

136. Steve Gonzalez, *Asbestos Cases Continue to Drop in Madison County*, THE RECORD, July 7, 2006, *available at* http://www.madisonrecord.com/printer/article.asp?c=181352; *see also* Brian Brueggemann, *Asbestos Lawsuits Continue to Decline*, BELLEVILLE NEWS DEMOCRAT, June 21, 2005, at 1A, *available at* 2005 WLNR 22695995.

137. *See* Ann Knet, *Stack to Head Madison County's Civil Division*, MADISON RECORD, July 18, 2006 (reporting that measures include limits on cases filed by out-of-state lawyers and substitution of judge motions, as well as restrictions on cases filed under seal), *available at* http://madisonrecord.com/news/newsview.asp?c=181841.

138. *See* Henderson, *supra* note 7; Editorial, *Asbestos Exposure*, WALL ST. J., Apr. 10, 2006, at A18 ("For the first time in 30 years, courts are taking steps toward cleaning up the asbestos mess they helped to create.").

139. *The Fairness in Asbestos Injury Resolution Act of 2006: Legislative Hearing on S. 3274 Before the Sen. Comm. on the Judiciary*, 109th Cong. at 5 (June 7, 2006) (testimony of Edmund F. Kelly, Chairman, President & CEO, Liberty Mutual Group), *available at* 2006 WLNR 9748946.

HeinOnline -- 12 Conn. Ins. L.J. 503 2005-2006

often in jurisdictions that have a logical connection to the claimant or claim, and parties will be more likely to receive individualized justice.[140]

140. *See* Peter Geier, *'Sea Change' in Asbestos Torts is Here*, NAT'L L.J., Oct. 31, 2005, at 1 (quoting Texas plaintiffs' lawyer Bryan Blevins as saying that changes in the law and court rules are making asbestos more like other tort litigation "in which cases are worked up on an individual basis, negotiated on an individual basis and tried on an individual basis.").

HeinOnline -- 12 Conn. Ins. L.J. 504 2005-2006

SOME REFLECTIONS ON THE FUTURE OF MASS TORTS

Peter H. Schuck[*]

INTRODUCTION

This conference, as I understand it, is meant to be an exercise in expert prognostication. Such an exercise is a welcome diversion from the more familiar but daunting tasks of trying to understand the congeries of problems that mass tort adjudication has bequeathed to us, and then figuring out how best to clean up the mess; particularly the need to compensate deserving victims while marshalling the requisite corporate and governmental resources for doing so.

We have had less occasion to think about the *future* of mass torts, and perhaps it is just as well since our prognostication about such things is notoriously fallible. It was a wise Chou en-lai who, when asked in the 1950s what the effect of the French Revolution had been, replied "it's too soon to tell." Imagine being asked in the late 1960s, when the *Borel* case[1] went to trial, what the mass tort system would look like in 2006. Who could have anticipated the course of Hurricane Asbestos—the swath of destruction leaving millions of past victims and future claimants; the scores of bankruptcies and judicially-established trusts; the rejection by the Supreme Court of the only practicable judicial solution, global settlements; the remarkable development of a sophisticated, "teched-up" plaintiffs' bar capable of redressing some if not all of the imbalances that previously favored defendants; the massive insurance coverage litigation annexed to many mass tort cases; novel discovery and claims-splitting rules and other elements of what Lester Brickman has called a special asbestos law; collateral mini-trials to determine market share, *Daubert*[2] challenges to expert testimony, pre-bankruptcy solvency risks, and the like; and, most recently, Judge Janis Jacks' thunderbolt in 2005 debunking the tactics of plaintiffs' lawyers and their hired B-readers in asbestos, silicosis, and perhaps other cases. I think that it is fair to say that much of what has actually transpired in mass torts litigation would have been quite unimaginable at the time. So we should be humble about prognostication.

---

* Yale Law School

1. Borel v. Fibreboard Paper Products Corp., 493 F.2d 1075 (5th Cir.), *cert. denied*, 419 U.S. 869 (1974).

2. Daubert v. Merrill Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993).

HeinOnline -- 12 Conn. Ins. L.J. 505 2005-2006

Hindsight being 20-20, it is considerably easier to identify some of the most salient and distinctive features of mass torts, features that would-be reformers must take very seriously. We can best identify these features by examining asbestos litigation. I certainly do not claim that asbestos is a typical mass tort. Indeed, it is quite distinctive in some respects. But this is also true of other mass torts. For example, Agent Orange involved the U.S. military. DES created multi-generation risks and difficult product identification problems. Silicone gel breast implants and Dalkon Shields were in high demand by millions of women. The scientific, legal, and insurance coverage issues—to name just a few—differed for each of these litigations.

For present purposes, I claim only that anyone seeking to assess the future of mass torts should attend carefully to certain features of asbestos litigation that are illustrative and recurrent in most other litigation of this kind. I shall very briefly mention only four of these features: (1) the nature of the causal evidence, (2) the large number of product distributors and their risk heterogeneity; (3) the immense liability costs borne by the defendants and their insurers; and (4) the fecklessness of the tort system in dealing with the problem.[3]

I. CAUSAL EVIDENCE

Asbestos is not the only mass tort involving strong toxicological evidence against the product–cigarettes, lead paint, and some pharmaceuticals are others–but the evidence in asbestos is especially damning. This evidence secured the claims of a large and steadily growing group of claimants, a high percentage of whom have consequently received some compensation. The unusually long latency periods associated with asbestos-related illnesses both multiplied the number of such claimants and increased the difficulty of product (and hence defendant) identification, necessitating some evidentiary innovations in order to facilitate the claims. For most other completed mass torts–Agent Orange,[4] Bendectin,[5] silicone

3. For a detailed discussion of, and evidence on, each of these features, see Stephen J. Carroll, et al., "*Asbestos Litigation*," RAND Institute for Civil Justice, *available at* http://www.rand.org/pubs/monographs/2005/RAND_MG162.sum.pdf (last visited July 25, 2006).

4. PETER H. SCHUCK, AGENT ORANGE ON TRIAL: MASS TOXIC DISASTERS IN THE COURT (enlarged ed., 1987).

5. *See generally* MICHAEL D. GREEN, BENDECTIN AND BIRTH DEFECTS: THE CHALLENGE OF MASS TOXIC SUBSTANCES LITIGATION (1998).

HeinOnline -- 12 Conn. Ins. L.J. 506 2005-2006

gel breast implants,[6] and even Love Canal and Chernobyl[7]—the scientific basis for the causal claims was weak, and has actually become weaker with the passage of time.

II. NUMBER AND RISK HETEROGENEITY OF DEFENDANTS.

The number of actual and potential asbestos defendants is very large. This reflects not only the many firms involved in its manufacture, distribution, and application, but also the large number of bankruptcies among the larger defendants, which causes plaintiffs' lawyers to engage in an ever more desperate and creative search for companies that had even the most peripheral role in the use of asbestos. This heterogeneity among defendants has led to even higher litigation costs and much unfairness in the distribution of liability burdens.

III. LIABILITIES

The magnitude of established and potential asbestos-related liabilities is staggering, leading to numerous bankruptcies, inadequate compensation of many of the victims, reduced availability of insurance, immense transaction costs, long litigation delays due to the higher stakes, and many other problems. If economic incentives mean anything, one must suppose that these consequences will affect calculations by manufacturers, insurers, research programs, and many other actors about whether to invest in product development that carries such risks. Some of this calculation, of course, should properly be considered as desirable deterrence of unreasonable risk creation, but significant *over*-deterrence is another, not inconsistent possibility.

IV. TORT LAW'S CAPACITY TO REGULATE MASS TORT RISKS EFFECTIVELY.

Here, I mean to invoke a technocratic, means-ends rationality criterion of effective risk regulation and problem-solving. In this context, it implies administering a set of rules and institutions that create optimal deterrence, provide adequate and prompt compensation to deserving victims, affirm (or

---

6. *See generally* MARCIA ANGELL, SCIENCE ON TRIAL: THE CLASH OF MEDICAL EVID. AND THE LAW IN THE BREAST IMPLANT CASE (1996).

7. Elisabeth Rosenthal, *Experts Find Reduced Effects of Chernobyl*, N.Y. TIMES, Sept. 6, 2005, at A10; Anthony DePalma, *Pollution and the Slippery Meaning of 'Clean,'*, N.Y. TIMES, Mar. 28, 2004, at p.3.

HeinOnline -- 12 Conn. Ins. L.J. 507 2005-2006

at least do not undermine) social norms of morality and fairness, and achieve these goals with an acceptable level of competence and efficiency.

I am hardly the first commentator to doubt the tort system's ability to effectively regulate the kinds of risks and claims involved in asbestos and many other mass tort litigations. Numerous judges, lawyers, scholars, members of Congress, and other analysts without a personal stake in the system have joined me in both entertaining and strongly expressing such doubts.[8] Our case is easy to make, at least in absolute terms. The tort system has provided neither timely nor fair compensation to deserving claimants, including some of the most severely harmed. It has failed to devise meaningful screens that can discriminate, long before trial, between strong claims and the much larger number of weak or spurious ones, which has shifted the center of gravity in the litigation toward the latter. It has managed to create inadequate deterrence of unreasonable risk (after all, *Borel* was decided only after many decades during which asbestos was in widespread use), while at the same time likely over-deterring desirable investment in products that are socially beneficial but carry some risks. It has produced so many instances of inaccurate fact-finding and inconsistent verdicts that one cannot accurately predict outcomes and conform one's conduct accordingly.[9] As already noted, the transactions costs in these litigations are very high relative to the returns to victims.

V. ALTERNATIVES TO REGULATING MASS TORT RISKS THROUGH LITIGATION

Tort law is not the only available instrument for regulating these risks. This point, which should be obvious, is often overlooked. Consider the alternatives. The vast majority of risks of injury by far are regulated by private insurance and other commercial contracts governed by traditional or modified contract law rules, often through alternative dispute resolution (ADR) processes. Almost all job-related health risks are covered by workers' compensation schemes. Many environmental, product-related, occupational, and other risks are regulated by administrative agencies

---

8. *E.g.*, MANUAL FOR COMPLEX LITIGATION, FOURTH (2004), *available at* http://www.fjc.gov/library/fjc_catalog.nsf/autoframepage?openform&url=/library/fjc_catalog.nsf/bysubjectfrm?openform&category=Complex+Litigation (last visited July 25, 2006); Hearings on the Asbestos Litigation Crisis, S. No. J-108-4, Mar. 5, 2003 and June 4, 2003, *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_senate_hearings&docid=f:89326.wais.

9. Among the litigations illustrating the tort system's erratic outcomes are the Bendectin, tobacco, breast implant, and the Vioxx litigations.

HeinOnline -- 12 Conn. Ins. L.J. 508 2005-2006

pursuant to statutory delegations of authority. Indeed, most of the risks that mass tort litigation has targeted were already subject to regulatory limitations. I shall mention still other alternatives below.

In the brief time that remains, I want to focus on one of these alternatives, administrative regulation, by comparing it to the tort law system that we have been so carefully dissecting over the last few days. I want to emphasize some distinctive advantages that society would gain by mobilizing the regulatory agencies and techniques that are already in place rather than relying as much as we do on the tort system. I shall do this by calling attention to some of what I take to be the distinctive institutional and operational differences between the two systems. I want to emphasize that I am not making a strong categorical claim that managing risk through regulatory processes is superior to doing so through court litigation, although I do think that this is true in many, many situations. Nor am I suggesting that the two systems cannot live side by side, as indeed they do under existing law in many areas. My point, rather, is that the relationship between the tort and administrative systems of regulation is not as well-designed as it could and should be, particularly with respect to implied pre-emption.

Let us consider, then, a number of differences between them, differences that ought to be a focus of regulatory redesign in the future. In each case, I shall emphasize the comparative advantages of administrative regulation over litigation, while mentioning some of tort law's countervailing advantages.[10] The first difference between the two systems is that regulation through the FDA, EPA, OSHA, and other agencies established to manage health and safety risks is largely *preventive*. Its orientation is to the future, not to the past. It manages risks so that injuries will not occur, rather than seeking, as tort law does, to compensate for injuries that have already happened. It is both more humane and more socially efficient to prevent injuries rather than simply compensating their victims when they occur. The key word here, of course, is "simply." In principle, tort law prevents as well as compensates—by deterring the creation of undue risks. In practice, however, tort-generated deterrence is often unsystematic, distorted, and either too weak or, occasionally, too strong,[11] to be effective.

---

10. For an earlier version of this comparison, see Peter H. Schuck, *The New Judicial Ideology of Tort Law*, *in* NEW DIRECTIONS IN LIABILITY LAW 14-17 (Walter Olson ed., 1988).

11. *See generally* DON DUFF, DAVID DEWEES, & MICHAEL J. TREBILCOCK, EXPLORING THE DOMAIN OF ACCIDENT LAW: TAKING FACTS SERIOUSLY (1996); Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 558 (1989).

HeinOnline -- 12 Conn. Ins. L.J. 509 2005-2006

A second difference that generally favors regulatory agencies relative to tort system juries and generalist judges is the agencies' greater expertise. Health and safety agencies, it should be recalled, were usually established because of the inadequacies of the tort system in regulating those risks. In principle and in fact, agencies study—more or less systematically—the nature and magnitude of risks and the alternative techniques for managing them. They are also more likely to study and take account of the tradeoffs among competing risks. A constitutive feature of tort law is that it focuses evidence and the jury on one risk only—the risk presented by the suspect product or environmental hazard. In the real world, however, we are almost always faced with the much more complex dilemma of risks versus risks, requiring tradeoffs that may not be presented in the evidence and that a jury is singularly ill-equipped to assess.[12] The Vioxx case exemplifies this problem. The lawsuits challenging Vioxx have focused, as they must, on the risk of heart disorders from taking Vioxx. But Vioxx also possesses certain advantages in dealing with a variety of widespread and serious pain conditions. If tort law discourages the use of Vioxx, it magnifies those other pain-related risks. In contrast, the FDA considered those tradeoffs in deciding whether and under what conditions (including labeling) to allow the marketing of Vioxx. FDA may make the wrong decision about those tradeoffs, but at least it is asking the right questions – and more of them.

Regulatory agencies are also more expert with respect to the conflicting social values implicated by a decision about how to manage risk. They employ procedures that are designed to elicit and explicate those values and to provide some information about the intensity with which those values are embraced by different groups in society. Notice-and-comment rulemaking procedures, for example, are calculated to elicit widespread public participation by the affected interests in the form of reason-giving and evidence. Regulatory agencies are also responsive—some would say *too* responsive—to a politically accountable Congress and President and thus are responsive indirectly to the interests that those institutions represent. In contrast, judges and juries are meant to be quite independent of such influences; they wear their institutional independence as an emblem of constitutional integrity and honor. The jury, moreover, is—and is designed to be—a black box from which only an oracular, opaque decision emerges.[13] Although jurors inevitably express their values through their

12. *See generally* JOHN D. GRAHAM & JONATHAN B. WEINER, RISK VERSUS RISK: TRADEOFFS IN PROTECTING HEALTH AND THE ENVIRONMENT (1997).

13. *See generally* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES: THE CONFLICTS SOCIETY CONFRONTS IN THE ALLOCATION OF TRAGICALLY SCARCE RESOURCES (1977).

HeinOnline -- 12 Conn. Ins. L.J. 510 2005-2006

decisions, they neither explain those decisions nor identify their values. Indeed, they provide no materials from which others might be able to deduce their social meanings.[14]

Regulatory agencies also foster more accurate and consistent fact-finding; they do not exclude any evidence that seems relevant to the problem at hand and they draw on a wide variety of sources. They do not base their decisions on individual trials whose shape and outcomes turn on contingencies such as the quality of the lawyering and judging, the kinds of evidence that the lawyers decide to adduce and the judges admit, the tactical choices that both sides make, and so forth. The trial produces a highly stylized factual basis for decision that is much narrower than that used by an agency. Another way of putting this is that the standard deviation from the truth with respect to agency-found facts is likely to be much smaller than in the case of a jury decision. An important virtue of accurate and consistent decisions, moreover, is predictability. Consider again the Vioxx litigation. After a little over a year of jury verdicts, the score is now 5-4 against Merck. Merck's lawyers must ask themselves: What do we advise our client to do now? The answer is not at all clear. To be sure, the plaintiffs in these nine cases were different people who presented different facts. Nevertheless, these nine verdicts are totally inconsistent on the key issue: the adequacy of the warning (approved by the FDA) that Merck used for Vioxx.

Another important difference between regulatory agencies and the tort system concerns the variety of tools that they can deploy to shape the behavior of the groups and individuals subject to their power. Where tort law possesses only one instrument—the incentives created by the prospect that the court and jury will award money damages—regulatory agencies can wield a formidable armamentarium of weapons. They include regulatory standards, research, negotiation, publicity and public education, investigation, injunctive relief, and the application of a variety of sanctions.

Perhaps the most important advantage of agencies over the tort system is what I call the capacity for rapid social learning. Consider Linda Mullenix's charming chronology of how asbestos litigation evolved. It took the tort system *forty years* to learn about the risks of asbestos. The plaintiffs' lawyers did a wonderful job of developing some of the information that has propelled this litigation, and my hat (if I wore one) is off to them for this achievement. In stark contrast to this laborious, incremental process of case-by-case adjudication, regulatory agencies have

14. For an elaboration of this point in the Vioxx context, see Peter H. Schuck, "When Juries Send Messages," LOS ANGLES TIMES, Aug. 29, 2005, at B11.

HeinOnline -- 12 Conn. Ins. L.J. 511 2005-2006

the capacity to conduct research, hold hearings, learn from experience, and quickly incorporate that experience into their risk management apparatus. As their information changes concerning the nature of the problem and the best remedy for it, the agency can adjust accordingly. A court that concludes that it has adopted the wrong legal rule must nevertheless wait for the next case to come before it that presents that legal rule. Even then, of course, the court is to some extent bound by precedent and constrained by the arguments presented by counsel.

By the same token, regulatory rules can be more detailed, more refined, and more contextualized than even the most open-textured rules of tort law, such as the negligence standard. (Juries' decisions can be extraordinarily contextualized, but the opacity of the elements of those decisions means that the rest of us will know only the outcome of this contextualization, not its nature or elements). Although regulatory rules are often criticized as too rigid and one-size-fits-all, they need not be. Consider the FDA's regulation of Accutane, a wonder drug that is used to heal severe acne but can be very dangerous to pregnant women. FDA has designed a monitoring program to identify potential users who are pregnant and inform them of the high risk that they face and prevent them from using the drug while allowing others to use it who do not bear that risk. This system is far from perfect, I hasten to add, but it suggests the degree of differentiation and refinement in regulatory requirements that is possible.

Another difference between tort law and regulation has to do with the magnitude and incidence of transactions costs. This conference has delved deeply into this subject, so I won't say more about it here except that most of the costs of regulation are borne by taxpayers, whereas litigation costs are borne by the parties and their lawyers. One would expect, therefore, that the investment in a tort litigation would be highly targeted on what the lawyers need to win their case rather than on what society needs to solve the larger problem of which the individual case is merely a symptom – and, given the litigation selection bias, probably an atypical one at that.

I readily acknowledge that there are some counter-arguments—that the tort system has some attractive features lacking in administrative regulation. Perhaps the most attractive, even iconic one is the principle that every individual enjoys a constitutional right to a day in court. In a liberal, highly individualistic society that is congenitally suspicious of governmental power, this right is indeed precious. But if there is any clear lesson that comes from our discussion during the last two days, it is that the individualized opportunity to seek a form of justice tailored to one's own circumstances is utterly mythical, at least in the context of asbestos litigation and many other mass torts. In reality, the most that an individual

HeinOnline -- 12 Conn. Ins. L.J. 512 2005-2006

asbestos claimant can hope for is that he will be a member of a larger class that will achieve a generous settlement in which he can share in an amount that roughly reflects the strength of his claim and the nature of his loss. Whatever this hope is—and as noted above, mass tort litigation mocks it at many points—the reality is decidedly *not* an individual day in court.

A second counter-argument is that regulatory agencies are not the neutral expert entities depicted in the Progressive ideal, but rather political entities that are readily captured by special interests. Different people have different views as to who is capturing whom. Most political scientists now consider the capture thesis to be vastly oversimplified—and in many cases, flatly wrong. At the very least, the question of which interests influence agency decisions, in what ways, and with what consequences, is very complex, context-dependent, and usually in the eye of the beholder.

A third counter-argument, and one that I take very seriously, is that the quality of regulatory personnel is not what it should be—or, perhaps, used to be, as the gap between public and private sector compensation has grown. This possibility is especially disturbing with respect to the kind of scientific expertise and competence that FDA, EPA, OSHA, NRC, and other health and safety agencies need in order to do their work effectively. This is certainly a legitimate concern, but it is one that I think can be at least partly addressed by improving regulatory conditions, performance, and the resulting reputation that regulatory agencies enjoy so that they can attract better people.

Again, however, the comparison to the tort system is revealing. There, the crucial decision makers consist of a generalist judge and a jury of twelve people who have been conscripted on the basis of their ordinariness, people who the *voir dire* will assure know nothing about the subjects on which they will be asked to render a decisions. Now, the jury as an institution possesses many great strengths—perhaps Judge Kosinski will want to comment on this—and most judges who deal with juries claim to hold them in very high regard. I do as well.[15] But as a matter of comparative institutional competence, they score low in their ability to comprehend and analyze the kind of complex scientific evidence that underlies most mass tort cases, and to do so consistently and transparently.

Regulatory agencies clearly need more and better epidemiological research if they are to develop sound safety standards directed at risks that the population encounters in occupational, environmental, and other contexts. This is a matter of money and of designing and conducting

15. Peter H. Schuck, *Mapping the Debate over Jury Reform, in* VERDICT: ASSESSING THE CIVIL JURY SYSTEM ch.9 (R. Litan, ed. 1993).

HeinOnline -- 12 Conn. Ins. L.J. 513 2005-2006

reliable studies, which is not easy to do. Nevertheless, the courts often rely on epidemiological research and some judges, like Judge Weinstein in the Agent Orange litigation, hold that in many mass tort situations, epidemiological research is the only kind of proof of general causation (specific causation being even harder to prove) that can be submitted to the trier of fact.[16] In any event, the inadequacy of epidemiological evidence is as much an argument against the accuracy of tort system judgments as it is against leaving risk management decisions to the regulators.

I could go on and on, but my bottom line is that we ought to consider a very specific remedy for the ills of the tort system—reform of the tort law doctrine of implied preemption. This doctrine holds that unless the legislature makes it very clear that it intends to pre-empt the common law action, the jury may second guess the regulators' decision on the risk management issue. It may utterly ignore a standard that the agency may have taken twenty years and two hundred million dollars of research, analysis, and public participation to develop. It may simply arrive at its own determination as to whether a product is safe enough or whether the warning is informative enough, with little or no regard to the agency's considered decision, even one reviewed by Congress and the executive branch before its issuance. This doctrine strikes me as plainly irrational.[17]

CONCLUSION

In closing, I want to insist that we do not have to choose between managing risks through regulatory standards and having a tort system. In some respects, they have different tasks and serve different functions. My point is that there are better ways in which to integrate those two valuable institutions. We should think very carefully about, and law reformers should design, forms of interaction between them with a view to identifying those conditions of administrative regulation that are necessary in order for society to have a high level of confidence in an agency decision, so that it becomes binding in subsequent tort litigation. Once we identify those conditions, we can allow pre-emption in some cases but not in others, rather than leaving it to the courts, absent clear legislative direction, to make it up as they go along. This has usually meant allowing juries to jettison what the regulatory agency has painstakingly wrought and

16. Peter H. Schuck, Commentary, *Judicial Avoidance of Juries in Mass Tort Litigation*, 48 DEPAUL L. REV. 479 (1998).

17. For a contrary view by a leading commentator on both tort law and administrative regulation, see Robert L. Rabin, *Regulatory Compliance As a Defense to Products Liability*, 88 GEO. L.J. 2049 (2000).

HeinOnline -- 12 Conn. Ins. L.J. 514 2005-2006

to substitute their own intuitive and common sense judgments on technical issues as to which intuition and common sense provide little useful guidance for far-reaching social policymaking.

HeinOnline -- 12 Conn. Ins. L.J. 515 2005-2006

HeinOnline -- 12 Conn. Ins. L.J. 516 2005-2006

AN ELEGY FOR THE FAIR ACT

Patrick M. Hanlon[*]

"The argument is sensibly made that a nationwide administrative claims processing regime would provide the most secure, fair, and efficient means of compensating victims of asbestos exposure. Congress, however, has not adopted such a solution." *Amchem, Inc. v. Windsor,* 521 U.S. 591, 628-29 (1997) (Ginsburg, J.).

INTRODUCTION

Since 1997, when the Supreme Court first drew Congress's attention to asbestos litigation as a judicial nightmare that cried out for a legislative solution, the Supreme Court has twice more returned to the same theme. Significant asbestos bills have been introduced in each of the last three Congresses. Three of those bills were reported out of committee. One, S. 852, the Fairness in Asbestos Injury Resolution Act of 2005 (the "FAIR Act" or "S. 852") reached the Senate floor, only to fail by a single vote on a procedural motion.[1] While at this writing the bill's sponsors are making heroic efforts to revive the FAIR Act, the prospects are not bright.[2] Thus,

---

* Patrick M. Hanlon is a partner at Goodwin Procter LLP in Washington DC. He represents the National Association of Manufacturers (NAM), which coordinates one of the two main industry groups supporting a trust fund bill. The views expressed in this article are his own and not necessarily those of his law firm or his clients.

Because the basic theme of this article is that the structure of the asbestos problem makes a legislative solution, however "sensible" extremely difficult, there is not much discussion of personalities. If, however, the FAIR Act came close to solving the asbestos problem, it is due largely to the patience, wisdom, wit, humanity – and courage -- of Judge Edward R. Becker of the U.S. Court of Appeals for the Third Circuit. Judge Becker passed away on May 19, 2006, after a long illness. He will be missed by everyone who knew him.

1. The Senate Budget Resolution, approved in 2005, allows a point of order against any bill that involves more than $5 billion in Federal spending in each 5-year period beginning in 2016. *See* Fairness in Asbestos Injury Resolution Act of 2005, S. 852, 109th Cong. (2005).

2. On May 26, 2005, Senators Specter and Leahy introduced a new version of the FAIR Act (S. 3274) with a number of changes designed to broaden the bill's support. *See* 152 Cong. Rec. S5344 (daily ed. May 26, 2006) (Statement of Senator Specter & text of new bill). The new bill has been placed on the calendar and thus can be called up at any time, without going back to committee. The Judiciary Committee did, however, hold a hearing on the new bill on June 7, 2006, the record of which can be found at http://judiciary.senate.gov/hearing.cfm?id=1931. S. 3274 is not radically different from S.

HeinOnline -- 12 Conn. Ins. L.J. 517 2005-2006

almost 9 years after the Supreme Court's *Amchem* decision, Congress has still not established a nationwide administrative processing scheme to replace litigation as a means of compensating victims of asbestos exposure, and in the absence of a remarkable reversal of course in the Senate, we are not likely to see such a scheme any time soon.

Other contributors to this symposium have described asbestos litigation in great detail. It would be hard to imagine a situation in which the argument for replacing the courts with an administrative compensation system could be stronger. As Professor Brickman has pointed out, the current system is shot through with fraud and abuse, especially, but not exclusively, the use of litigation screening to recruit tens of thousands of claimants who may have a claim under applicable law but who are not actually sick. Even without the abuses that Professor Brickman deplores, asbestos litigation would be dysfunctional. In the first place, the cost of providing compensation through tort litigation is extraordinarily high. According to the Rand Institute on Civil Justice, it has cost defendants and their insurers $2.40 to provide $1.00 of compensation to claimants.[3] This disproportion is indefensible. The high cost of tort litigation is traditionally defended as the price of individualized justice. But, as Professor Hensler points out, there is little individualized justice in asbestos litigation. In practice asbestos trials are exceedingly rare, and the tort system operates, in effect, as a congeries of loosely related administrative compensation schemes worked out between each defendant and the various sets of lawyers who represent asbestos claimants. Moreover, individualized justice is itself of dubious value in asbestos litigation, where the companies who are predominately responsible for the asbestos plague have long since passed from the scene, leaving behind a handful of trusts that usually cannot begin to pay claimants in full for the harm that has been done. In this setting, the tort system's traditional deterrence rationale is weak, and the careful examination of individual responsibility that is supposed to be the centerpiece of the civil justice system seems weirdly out of place.

In asbestos litigation, surely, the emphasis should be placed on compensation. Administrative systems are generally thought to be much more efficient than the tort system in providing compensation to claimants at a reasonable cost.[4] And so, as Justice Ginsburg said, the argument is "sensibly made that a nationwide administrative claims processing regime

852. Since the differences generally do not affect the argument in this paper, I will not address the new bill in detail.

3. *See* STEPHEN CARROLL ET AL., ASBESTOS LITIGATION 92-93 (RAND Inst. for Civil Justice 2005) [hereinafter "RAND Report"].

4. *Id.* at 127.

HeinOnline -- 12 Conn. Ins. L.J. 518 2005-2006

would provide the most secure, fair, and efficient means of compensating victims of asbestos exposure."[5] Why, then, has this sensible solution to the asbestos compensation problem been so hard to achieve?

Well, there are politics, of course. Changing the way we compensate asbestos victims would affect the distribution of billions of dollars. Any scheme will create winners and losers, and the people affected may be expected to enter the lists to assert their interests. In addition, political ideology has an effect. The failure of supporters of the FAIR Act to overcome a budget point of order in February 2006 was due in large part to the opposition of a group of (mostly Western) conservative Republican senators. For most of these senators (and for many other Republicans who did vote with the leadership), a $140 billion entitlement program for asbestos victims went very much against the grain. Indeed, the fact that the bill failed on a budget issue symbolizes a certain deep-seated distrust born of conservative principles, a distrust that was overcome by other considerations for some senators, but not for others.[6] In our system of government, it is always much easier to stop legislation than to pass it, and that is especially true in the U.S. Senate, where as few as 41 senators can block any proposed reform. Nothing is less surprising than the fact that asbestos legislation has been able to proceed only slowly, amid bitter controversy.

The thesis of this paper, however, is that politics is only part of the story. Any effort to develop an administrative compensation system to replace civil litigation involves vexing problems. It is necessary to figure out how the new compensation scheme will fit in with other methods of compensation, to balance efficiency and precision in administration, to determine the criteria for, and the amount of, compensation, to deal with uncertainties in program costs, to figure out how to allocate costs in the absence of any agreed-upon metric of responsibility, and to reconcile the thirst for certainty with the reality of uncertainty. Political controversy

---

5. Amchem, Inc. v. Windsor, 521 U.S. 591, 628-29 (1997).

6. It is interesting to reflect upon the faith that many conservatives repose in the tort system, notwithstanding their general espousal of "tort reform." Some on the left might respond that it is natural for conservatives to support a system that gives so many advantages to insurers and defendants who participate as repeat players. But while left and right may disagree on the right balance between plaintiffs and defendants within the tort system, they share a certain anti-statist (and more or less "democratic") orientation toward compensation for civil wrongs. Compensation through the American judicial system seems less governmental, more popular, and more, well, American, than compensation through large-scale administrative systems. *Cf.* O.G. Chase, *American "Exceptionalism" and Comparative Procedure*, (N.Y. Univ. Sch. of Law Pub. Law & Legal Theory Working Paper Series, Research Paper No. 39, 2002).

HeinOnline -- 12 Conn. Ins. L.J. 519 2005-2006

tends to crystallize around the proposed solutions to these problems. Accordingly, it is helpful to step back from the political battles to examine the way in which projected legislation addresses the inherent difficulties in creating administrative compensation schemes to replace tort litigation. As we will see, these problems do not have any single right answer, and there are so many problems, and so many possible solutions, that any overall scheme will inevitably be complex and controversial. Perfection in this situation is not only unattainable -- it is indefinable.

In the pages that follow I will summarize the proposed FAIR Act as reported out of the Senate Judiciary Committee in May 2005 and then focus in on the way in which the bill has addressed a number of the problems inherent in constructing a new administrative compensation system.[7] I hope to show how those (still tentative) answers underlie many of the political issues that will have to be hammered out if the FAIR Act is ever to become law. The difficulty of legislation in this area underscores the surprising stability and persistence of the tort system as a means of providing compensation to asbestos victims. As unsatisfactory as asbestos litigation is, it has been extraordinarily, but predictably, difficult to design the "sensible" alternative Justice Ginsburg had in mind.

I. THE FAIR ACT: SUMMARY

Senator Arlen Specter (R-PA), chairman of the Senate Judiciary Committee, has described the FAIR Act as the most complex bill that he has encountered in over twenty-five years in the Senate. The bill is almost 400 pages long. In addition to establishing an administrative compensation program, it provides for an asbestos ban, research on naturally occurring asbestos, a medical screening program for people who have been exposed

7. During floor action on S. 852, Senator Specter and Senator Leahy introduced a manager's substitute (Amendment No. 2746) which made a number of changes in the bill, but those changes were never voted on by the Senate because of the intervention of the budget point of order. *See* Amend. 2746, 152 Cong. Rec. S983 (daily ed. Feb. 9, 2005). Several other amendments had been agreed upon and would almost certainly have been accepted had the legislative process gone forward. In addition, approximately 150 amendments were filed, some complete substitutes and others relatively minor tweaks. For the sake of simplicity, I have treated the bill as reported out by the committee as "the FAIR Act" and have generally not attempted to describe the changes that would have been made in the substitute or managers' amendment had either been adopted. From time to time, however, I will refer to proposed amendments that are especially important or help illustrate a point. As noted above, on May 26, 2006, Senators Specter and Leahy introduced S. 3274, which was based on the manager's amendment but which made some additional changes in medical standards and in the allocation formula, among other things.

HeinOnline -- 12 Conn. Ins. L.J. 520 2005-2006

but are not injured, and medical research.[8] We shall focus on the bill's federally administered and privately funded no-fault compensation program.

A. ADMINISTRATION

The FAIR Act's compensation program would be run by an Administrator in the Department of Labor who would have broad authority to contract out financial management and claims processing services.[9] The claims processing system would be non-adversarial. The Administrator would issue a proposed decision within a fixed time, and there would be opportunities for a hearing and, if necessary, an internal appeal.[10] The Administrator's final decision would be subject to judicial review on a "substantial evidence" standard.[11]

While claimants would be free to retain lawyers if they wish, the Administrator would train non-lawyer representatives and maintain a list of lawyers willing to provide pro bono assistance.[12] In order to ensure that the savings arising from the non-adversarial, no-fault program go to claimants rather than lawyers, lawyers' fees would be capped at 5% of the claimant's award.[13]

B. ELIGIBILITY AND AWARDS

1. The Basic Scheme

The bill establishes nine disease "levels" and prescribes exposure criteria, medical criteria, and an award value for each one. The bill generally requires occupational exposure for all disease categories other than mesothelioma,[14] although people with non-occupational exposures can file claims under the exceptional medical claims procedure at least in some instances.

---

8. *See* S. 852 §§ 501, 502, 225, 226 (2005).
9. *Id.* § 101(b)-(c).
10. *Id.* § 114(b), (d).
11. *Id.* § 302(c).
12. *Id.* § 104(a)(4), (d)(2) (pro bono list)
13. *Id.* § 104(e)(1).
14. The occupational exposure requirement is incorporated into the medical criteria of each of the disease levels from I to VIII. *See id.* § 121(d)(1)-(8). Level IX – Mesothelioma does not require exposure to be occupational. *Id.* § 121(d)(9)(B).

HeinOnline -- 12 Conn. Ins. L.J. 521 2005-2006

The statutory disease levels are summarized in Table 1.

Table 1: Disease Levels and Award Amounts Under S. 852			
Level I – Unimpaired Non-Malignant Conditions receive reimbursement for medical monitoring but no monetary compensation			
Level II – Mixed Obstructive – Restrictive Disease	$ 25,000	Level VI – "Other Cancer"	$ 200,000
Level III – Asbestos Disease with impairment	$100,000	Level VII – Lung Cancer without Asbestosis	$ 300,000 [s] $ 725,000 [x] $ 800,000 [n]
Level IV - Asbestos Disease with More Severe Impairment	$400,000	Level VIII – Lung Cancer with Asbestosis	$ 600,000 [s] $ 925,000 [x] $1,100,000 [n]
Level V – Asbestos Disease with Most Severe Impairment	$850,000	Level IX – Mesothelioma	$1,100,000
Note: Smoking status, indicated by [s] = smoker, [x] = former smoker, and [n] = non-smoker.			

Claimants who do not meet the exposure and medical criteria for any disease level may seek compensation on the basis of an individualized review by a panel of doctors (a "Physicians Panel") as an "exceptional medical claim."[15] Several other kinds of claim that present special difficulties of proof are also sent to the Physicians Panels. These include

15. *Id.* § 121(g). The standard for exceptional claims is strict: the claimant must, "through comparably reliable evidence that meets the standards under this section...show that the claimant has an asbestos-related condition that is substantially comparable to that of a medical condition that would satisfy the requirements of a category under this section." *Id.* § 121(g)(4)(B). This standard would require a claimant relying on non-occupational exposure to show exposure levels similar to those that would occur in an occupational setting. Ordinary background exposure would not do.

HeinOnline -- 12 Conn. Ins. L.J. 522 2005-2006

certain claims involving so-called "take-home" exposures and all claims for cancers other than mesothelioma and lung cancer.[16]

Although the bill refers to the various disease categories as "levels," that is accurate only in the sense that award values increase from level to level. The compensation scheme is only apparent if we break the disease levels down into discrete units:

The Impairment Line. At the outset, there is a fundamental distinction between Level I claimants and all the others. Level I claimants are the "unimpaired" who until recently have dominated filing in the tort system.[17] They are the "worried well." Under S. 852 they do not receive monetary compensation, but do receive reimbursement for the expense of medical monitoring.[18]

Non-Cancer (Non-Malignant) Categories. The core of the bill's non-malignant categories are Levels III through V.[19] These levels all involve significantly impairing asbestos-related disease. They are distinguished primarily by degree of impairment,[20] and the award values reflect the severity of the claimant's illness.

Non-Malignant Level II is a compromise. The people who fall into this category have serious respiratory impairment, but doubt exists as to whether that impairment is due to smoking (or other another cause of obstructive pulmonary disease) or an asbestos-related condition. Rather than make an either-or decision, the bill allows people in this category to obtain some compensation, but it is limited in amount compared to the other non-malignant disease categories.[21]

---

16. *Id.* § 121(c)(3), (d)(6)-(7). The typical "take-home" exposure occurs when a worker brings asbestos home on his clothes, and his spouse is exposed while doing the wash. In litigation, most of these "take home" situations involve mesothelioma claims. The bill does not require mesothelioma claims to be referred to a Physicians Panel, but does require an individualized determination of causation when other diseases are involved. For Level VI claims, see *infra* p. 270

17. Level I claimants meet minimum exposure and latency requirements and have a diagnosed asbestos-related condition, but they do not have any functional breathing impairment. S. 852 § 121(d)(1).

18. *Id.* § 131(b)(1), (5).

19. *Id.* § 121(d)(3), (5).

20. The lines between the levels are based on the American Medical Association's Guide to the Evaluation of Permanent Impairment. *See* LINDA COCHIARELLA & GUNNAR ANDERSON, EDS., GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 117 & tbl. 5-12 (5th ed., Am. Med. Ass'n 2002). Generally, Levels III, IV, and V under the bill are equivalent to impairment categories 2, 3, and 4 under the AMA Guides.

21. The medical criteria for Level II – Mixed Disease With Impairment are set forth in S. 852 § 121(d)(2). The scheduled claim value, $25,000, can be found in § 131(b). For

HeinOnline -- 12 Conn. Ins. L.J. 523 2005-2006

Cancer. The four cancer categories include mesothelioma, lung cancer (two levels), and "other" cancers. There is no significant controversy about mesothelioma. Asbestos exposure is the only known cause of this cancer, although some mesothelioma cases cannot plausibly be linked to asbestos exposures and have to be left in the unexplained category. The medical criteria for mesothelioma require some identifiable asbestos exposure, as well as pathological evidence that the cancer is in fact mesothelioma.[22]

Lung cancer is divided into two "levels" (VII and VIII). They are distinguished not by the severity of disease—lung cancer is lung cancer—but by the probability of causation. Level VIII includes lung cancers in which asbestosis is present and where causation is relatively uncontroversial.[23] Level VII claims, in contrast, involve lung cancers where there is a great deal of exposure, and pleural conditions that verify that exposure, but no asbestosis.[24] Causation is controversial in Level VII claims. Both of these lung cancer "levels" involve claims that would have value in the tort system.[25] Level VII claims, however, would be relatively less valuable because causation is relatively less certain.[26]

Level VI, the so-called "other cancer" category, is the most controversial. Everyone accepts that asbestos causes lung cancer and mesothelioma, but there is much disagreement on whether it causes any

---

comparison, a claimant who qualifies for Level III (which involves no more impairment but a greater probability of asbestos causation) would receive $100,000.

22. *Id.* § 121(d)(9).

23. *Id.* § 121(d)(8).

24. *Id.* § 121(d)(7). Level VII does not expressly exclude asbestosis, but no claimant with asbestosis would have a reason to file for Level VII rather than Level VIII with its higher award values.

25. Because of the vigorous disagreement among medical experts on whether lung cancer can be attributed to asbestos exposure in the absence of asbestosis, see *infra* p. 301, courts usually submit the issue of causation in such cases to a jury. The inherent unpredictability of jury verdicts gives substantial value to lung cancers where there is a great deal of exposure (confirmed by pleural changes) even if there is no asbestosis. A remarkable recent decision of the Texas Court of Appeals for Beaumont, however, held that under Texas law there was "no evidence" of causation, notwithstanding the plaintiff's expert's contrary opinion, because only one of the studies relied upon by the expert indicated that asbestos causes lung cancer in the absence of asbestosis, and that study noted that other studies disagreed. Mobil Oil Corp. v. Bailey, No. 09-04-225-CV, 2006 WL 560584, at *5-*8 (Tex. App., Mar. 9, 2006).

26. Both of the lung cancer categories make distinctions in award levels based on the smoking history of the claimant. Non-smokers have the highest awards, smokers the lowest, and former smokers (those who have quit smoking more than 10 years before the onset of disease) are in the middle. Again, these distinctions are not based upon the severity of the cancer, but on probability of causation, and variations in claim value in the tort system. *See* S. 852 § 121(d)(7)-(8).

HeinOnline -- 12 Conn. Ins. L.J. 524 2005-2006

other kind of cancer. Level VI includes the various cancers where an asbestos connection arguably exists—cancers of the colon, rectum, stomach, esophagus, pharynx, and larynx.[27] While these cancers can give rise to valuable claims in the tort system, settlement values would be discounted because of uncertainty of causation.[28]

Under the FAIR Act, Level VI claims are subject to four important limitations. First, the award ($200,000) is discounted compared to mesothelioma and lung cancer to reflect uncertainty.[29] Second, the Institute of Medicine ("IOM") is required to review existing medical literature to determine whether the listed cancers are caused by asbestos.[30] If the IOM concludes that there is no general causation, the relevant cancer would cease to be compensable under the Act.[31] Third, all Level VI cancers are referred to Physicians Panels for an independent determination of causation.[32] Fourth, to qualify for compensation under Level VI, a claimant must meet a heightened exposure requirement.[33]

2. Special Issues and Adjustments

a. Libby, Montana

Libby, Montana is the site of a former W.R. Grace vermiculite mine and processing center.[34] The vermiculite produced at Libby contained

---

27. *Id.* § 121(d)(6).

28. The value of "other cancers" in the tort system is illustrated by two recent verdicts of over $1 million in colon cancer cases. *See California Jury Returns $1.083M Verdict for Asbestosis, Colon Cancer Sufferer*, in 21-3 MEALEY'S LITIG. REP. ASB. 1 (2006); *Colon Cancer Victim Wins $3.4M Verdict Against U.S. Subsidiary of Saint-Gobain*, 3-4 MEALEY'S INTL. ASB. LIAB. REP. 4 (2005).

29. S. 852 § 131(b).

30. *Id.* § 121(e). The IOM study is also discussed *infra* p. 300.

31. S. 582 § 121(e).

32. *Id.* § 121(d)(6)(B). There is, however, a controversial presumption in favor causation for claims that meet the medical criteria for the category.

33. *Id.* § 121(d)(6)(A). The claimant must show 15 weighted years of exposure and the presence of asbestosis or asbestos-related pleural plaques or pleural thickening. *See id.*

34. The Libby "story" was broken in a series of articles in the Seattle Post-Intelligencer in the late 1990s. The authors of those articles subsequently developed and updated their views in A. SCHNEIDER & D. MCCUMBER, AN AIR THAT KILLS (2004). There is a growing, if uneven, literature on the medical effects of exposure to tremolite at Libby. *See, e.g.*, A. Whitehouse, *Asbestos-Related Pleural Disease Due to Tremolite Associated with Progressive Loss of Lung Function: Serial Observations in 123 Miners, Family Members, and Residents of Libby, Montana*, 46 AM. J. INDUS. MED. 219, 219-225 (2004); L. Piepens et al., *Radiographic Abnormalities and Exposure to Asbestos-Contaminated Vermiculite in the Community of Libby, Montana*, 111 ENVTL. HEALTH PERSPECTIVES 1753,

HeinOnline -- 12 Conn. Ins. L.J. 525 2005-2006

tremolite asbestos. Most people who were exposed to tremolite at Libby were exposed on the job, but some were exposed in the community. Libby residents assert that pleural conditions resulting from their exposure to tremolite are more likely to be impairing than exposures to other forms of asbestos.

The FAIR Act gives special treatment to Libby claimants in three key respects. First, the exposure criteria are waived, which means that occupational exposure is not required for any disease category.[35] Second, Libby claimants are subject to special impairment criteria that allow them to recover for purely obstructive disease.[36] Third, the bill bumps up the compensation level so that all Libby claimants (even claimants in Level II, who otherwise would get $25,000), to a minimum of $400,000.[37]

In our democratic system, it is impossible to give such favorable treatment to one community without generating calls for equal treatment for other people similarly situated. Vermiculite from Libby was processed at 28 major processing centers around the country, many in major urban areas such as Chicago, Minneapolis, Trenton-Philadelphia, and Washington DC.[38] The Judiciary Committee narrowly defeated a proposed amendment to extend the special Libby provision to areas surrounding these processing plants.[39]

b. Naturally Occurring Asbestos

In California and other parts of the country asbestos naturally occurs in the soil. As a result of substantial media attention to the possibility that

---

1753-59 (2003); Agency for Toxic Substances & Disease Registry, Chemical-Specific Health Consultation: Tremolite Asbestos and other Related Types of Asbestos (Sept. 2001) at www.atsdr.cdc.gov/asbestos/more_about_asbestos/health_consultation; Agency for Toxic Substances & Disease Registry, U.S. Department of Health and Human Services, *Preliminary Findings of Medical Testing of Individuals Potentially Exposed to Abestiform Minerals Associated with Vermiculite in Libby, Montana: An Interim Report for Community Health Planning* (Feb. 22, 2001).

35. S. 852 § 121(c)(4).

36. *Id.* § 121(g)(8)(C) (eliminating the requirement of an FEV1/FVC ratio of at least 65%, which allows Libby claimants to receive compensation for obstructive diseases such as chronic bronchitis or emphysema).

37. *Id.* § 121(g)(8)(B), (C).

38. *See* AGENCY FOR TOXIC SUBSTANCES & DISEASE REGISTRY, NATIONAL ASBESTOS EXPOSURE REVIEW, http://www.atsdr.cdc.gov/naer/index.html (last v isited Apr. 19, 2006).

39. While not extending Libby treatment to all of the areas surrounding vermiculite processing facilities, the Judiciary Committee did provide for the potential extension of the Libby provisions following a study by the Agency for Toxic Substances and Disease Registry ("ATSDR"). S. 852 § 121(g)(9).

HeinOnline -- 12 Conn. Ins. L.J. 526 2005-2006

residents of areas with high levels of naturally occurring asbestos might get sick from non-occupational exposures, S. 852 was amended in markup to allow people exposed to naturally occurring asbestos in their communities to file exceptional medical claims, even though they may not have an occupational exposure.[40]

C. FUNDING

The FAIR Act would be funded by contributions from defendants (up to $90 billion over 30 years), insurers (up to $46.025 billion over 28 years), and the resources of the bankruptcy trusts for the payment of future (i.e., unliquidated) bodily injury claims.[41] The total funding package is a bit more than $140 billon, assuming $4 billion from the bankruptcy trusts.

1. Defendants

The defendants' basic obligation is to meet their annual funding minimum, after any adjustments for hardship or inequity.[42] For the first 10 years, the defendants' annual funding obligation is $3 billion per year, but it is reduced (stepped down) by 10% in year 11 and every 5th year thereafter.[43] In order to raise the targeted amount, every "defendant participant" is required to make a scheduled payment based on its placement in a complex set of tiers and subtiers.[44] If the scheduled payments are insufficient to meet the defendants' annual funding obligation each year, the Administrator must impose a surcharge on all defendants pro rata (with certain relatively minor exceptions noted below) in order to raise the required annual minimum.[45]

---

40. *Id.* § 121(g)(10).

41. *Id.* §§ 202(a)(2) (defendants' liability), 212(a)(2)(A) (insurers' liability), 402(f) (trusts).

42. *Id.* § 204(h).

43. *Id.* § 205(a). The $3 billion annual funding requirement is net of any adjustments for hardship and inequity.

44. *Id.* § 204(i) The tiers are defined in § 202(b) (Tier I) and 202(d) (Tiers II-VI). The subtiers are defined, and scheduled payments set forth, in § 203. Defendants with less than $1 million in "prior asbestos expenditures" as of the end of 2002 are exempt from funding obligations under the bill.

45. *Id.* § 204(*l*).

HeinOnline -- 12 Conn. Ins. L.J. 527 2005-2006

This system is summarized in Table 2.

Table 2: Defendant Tiers

Tier: Prior Asbestos Expenditures as of Dec. 31, 2002	# Subtiers	Range (millions)	Average (millions)
I: Bankruptcy [1]	3	Up to $80	-
II: $75 million	5	$16.5-27.5	$22.0
III: $50 million	5	$5.5 - $16.5	$11.0
IV: $10 million	4	$0.55 – $3.85	$2.13
V: $ 5 million	3	$0.20 - $ 1.0	$0.57
VI $ 1 million	3	$0.1 - $0.5 2	$0.28 [2]
VII: FELA Tier [3]	3	$.55-11.0	-

1. Tier I includes companies in Chapter 11. The contribution is set at 1.67024% of 2002 revenues.

2. The range and average for Tier VI are based on scheduled contributions and do not take into account the limits on Tier VI contributions adopted during markup. See *infra* p. 275.

3. The FELA tier includes the FELA/Jones Act liabilities of rail carriers and water carriers. To the extent that those carriers have prior asbestos expenditures because of other liabilities, they may be in Tiers II through VI as well. The threshold for contributions in Tier VII is $5 million, rather than the $1 million applicable in the other tiers.

Tier I consists of defendants in bankruptcy.[46] These companies are collectively responsible for approximately 20% on a net present value basis of the defendants' funding commitment, including approximately $1.4 billion in up-front funding from Owens Corning's Fibreboard Trust. The funding obligation of operating companies was 1.67024% of gross revenues in 2002.[47]

The solvent defendants are placed in Tiers II through VI based on their "prior asbestos expenditures" through the end of 2002.[48] "Prior asbestos expenditures" include both defense and indemnity costs, whether covered by insurance or not.[49] Within each tier, companies are placed into subtiers

46. *Id.* § 202(b)-(c).
47. *Id.* § 203(b)(2)(B)(i).
48. *Id.* § 202(d).
49. *Id.* § 201(7)(A)-(B).

HeinOnline -- 12 Conn. Ins. L.J. 528 2005-2006

based on their size (as measured by 2002 gross revenues).[50] The exception to this scheme is Tier VII, which is a special tier for companies who have FELA or Jones Act liabilities.[51]

This structure does not result in larger companies being in higher tiers and smaller companies in lower tiers. A company's tier assignment is based on its past involvement in the tort system and has nothing to do with its size. There are large, and small, companies in every tier. Within a tier, however, the funding obligation is apportioned by size, with larger companies paying more than the smaller ones.

This scheme, as complicated as it is, still vastly oversimplifies the problem of determining a "fair" allocation of burdens among defendants. Recognizing this roughness, S. 852 modifies the strict system of tiers and subtiers in several ways. First, it exempts all small business from paying anything at all.[52] Second, it determines past asbestos liabilities as of December 31, 2002, a pre-dating that has the effect of reducing the costs allocated to "peripheral defendants" that were just being drawn into the litigation as a result of the many bankruptcies of central players that began in 2000.[53] Third, the bill caps the annual liability of Tier I companies at $80 million.[54] Fourth, the bill authorizes the Administrator to grant hardship adjustments to ensure that scheduled funding obligations do not result in unreasonable financial burdens on companies.[55] The bill also authorizes (and in some cases requires) the Administrator to grant inequity adjustments, primarily but not exclusively to address the concerns of defendants who are heavily insured.[56] Inequity and hardship adjustments are generally capped at $300 million per year, although the cap can be

---

50. *Id.* § 203(a)(2)(A), (c)(1), (d)(1), (e)(1), (f)(1), (g)(1). If a tier has five subtiers, the top quintile are in subtier one, the second quintile in subtier two, and so on. *See, e.g., id.* § 203(c)(1)(A)-(E) (describing Tier II subtiers). Since it is impossible to know the entire population of defendant-participants in any tier until the Administrator has gathered the necessary data, companies cannot now predict with assurance the subtier into which they will fall, though obviously this is less a problem for very large and very small companies than those in between.

51. *Id.* § 203(h)(1)(A). A company may be simultaneously in Tier VII and some other tier because of liabilities other than FELA and Jones Act liabilities.

52. *Id.* § 204(b).

53. *Id.* § 201(7)(A)

54. *Id.* § 203(b)(2)(D)(iv).

55. *Id.* § 204(d)(2), (5).

56. *Id.* § 204(d)(1), (3). The provisions relating to inequity adjustments recognize several special situations that appeared inequitable when presented by a constituent to one or another senator. As discussed below, the absence of any agreed upon measure of fairness also makes it hard for companies unhappy with their allocation to rely on administrative relief from the Administrator.

HeinOnline -- 12 Conn. Ins. L.J. 529 2005-2006

breached in the event of a carryover from earlier years and in hardship situations involving a risk of insolvency.[57] Finally, the bill modifies the funding provisions applicable to distributors subject to an overall cap of $50 million per year.[58]

2. Insurers

As is true of defendants, the insurer's aggregate commitment ($46,025 billion) is broken down into annual minimum payments, as shown in Table 3.

Table 3: Insurer Contributions by Year

Year	Annual Amount (in millions)	Cumulative Percentage (End of Period)
1-2	$2,700	11.7%
3-5	$5,075	44.8%
6-27	$1,147	99.6%
28	$ 166	100.0%

Source: § 212(a)(3)(C).

Insurers do not have an allocation system, they have a process. Senate Bill 852 provides for an "Asbestos Insurers Commission" to adopt allocation principles and to apply them to all insurers with $1 million or more in liabilities.[59] The bill also allows insurers to divide the responsibility for contributions among themselves by unanimous agreement.[60] The Asbestos Insurers Commission would be appointed by the President subject to Senate confirmation—an often lengthy procedure.[61] Once in place, the Commission would determine the insurer allocation in two steps—first, by establishing a general methodology, and second, by applying that methodology to individual carriers. Normal rulemaking procedures—and the opportunity for judicial review—would apply at each stage.[62]

This laborious procedure is mitigated a little by the Administrator's authority to require an interim payment within 90 days of enactment equal

57. *Id.* § 204(d)(4).
58. *Id.* § 204(m).
59. *See generally id.* §§ 212, 213.
60. *Id.* § 212(c).
61. *Id.* § 211(b)
62. *Id.* § 212(b).

HeinOnline -- 12 Conn. Ins. L.J. 530 2005-2006

to 50% of the insurers' aggregate obligation for the first year.[63] Although the Administrator's interim allocation decisions are final agency actions subject to review, payment cannot be stayed pending review.[64]

Insurers, unlike defendants, do not fully guarantee that they will make their annual minimum payments. They do guarantee the first five years' payments, subject to a credit during the second five years.[65] Starting in year 6, the Administrator may call for additional contributions from insurers to make up their statutory "minimums" only in restricted circumstances.[66]

3. Trusts

The third source of funding for the program comes from the assets of the existing bankruptcy trusts. Section § 402(f) would amend 11 U.S.C. § 524 to add a new subjection (j). Under that subsection, trusts formed for the payment of asbestos claims would be required to pay over their assets to the national Fund within 90 days after enactment. [67] The trust may, however, retain assets allocable to claims other than asbestos claims (e.g., property value claims) and bodily injury claims that have been approved for payment but not yet fully paid.[68] The bill also absolves trustees of any liability to a third party arising out of their payment of trust assets over to the Fund.[69]

The exact amount expected from the trusts is uncertain, because it is impossible to know what assets the trusts will have left at the date of enactment. As of February 2006, the aggregate assets of the bankruptcy

63. *Id.* § 212(e)(1). The bill's interim payment provision ensures that half of the insurers' first-year contribution will be paid into the system promptly. However, it does not ensure prompt payment of the second half of the first year's funding commitment, and it does not address the possibility that the Commission may not make its final allocations until long after the first year is over.

64. *Id.* § 212(e)(4).

65. *Id.* § 212(a)(1)(B), (a)(3).

66. Sections 212(a)(3)(E)(iii) and (f)(3) together provide that after the first five years, the carriers are only required to make up a shortfall as provided in § 405(e)(1)(C). That section, in turn, requires the Administrator to impose shortfall assessments if the insurer shortfall "is the substantial factor that would cause the Administrator to recommend" sunset, but prohibits him from imposing such assessments "if the additional amounts would not be sufficient to permit the Administrator to avoid recommending" sunset. In addition, the total shortfall assessment imposed on insurers to avoid sunset cannot be more than their aggregate annual payment obligation for the preceding year.

67. *See id.* § 402(f), adding new § 524(j)(2)(A)(i).

68. *See id.* § 402(f), adding new § 524(j)(2)(C), (E).

69. *See id.* § 402(f), adding new § 524(j)(3)(A).

HeinOnline -- 12 Conn. Ins. L.J. 531 2005-2006

trusts are believed to total about $7.3 billion.[70] However, since defendants and insurers are entitled to credits for their contributions to certain of the trusts, the net amount that would be realized by the Fund is closer to $4 billion.

Several of the asbestos trusts have announced that they will challenge the FAIR Act if it is enacted on the grounds that it is an unconstitutional taking and a violation of the separation of powers and the due process rights of the trustees and beneficiaries of the trust.[71] Insurers and defendants collectively guarantee the yield of the bankruptcy trusts in the event of a successful constitutional challenge.[72] The guarantee is split between insurers and defendants based on the ratio of their aggregate payment obligations over the life of the Fund.[73]

D. TRANSITION

The transition from the current system to the tort system raises two distinct issues. One is how to deal with pending claims—that is, claims that are so far along in the tort system that it is arguably unfair to subject them to a new set of rules. This issue is addressed by the bill's provisions

---

70. The lion's share of the assets expected from the asbestos trusts comes from a limited number of trusts: Manville, Celotex, Fuller Austen, National Gypsum, Western MacArthur, and Halliburton.

71. The constitutional debate exceeds the scope of this paper. At the request of the trusts, several noted constitutional scholars and experts in bankruptcy law have presented to members of the Senate Judiciary Committee statements arguing that it is unconstitutional not to allow the trusts to opt out of the FAIR Act. *See* Letter from Theodore B. Olson to Senator John Cornyn (Apr. 18, 2005) (on file with author);. Memorandum from R. Fallon et al. to Walter J. Taggart et al. (Oct. 2, 2003) (on file with author); Memorandum from R. Fallon et al. to Walter J. Taggart et al. (Oct. 31, 2003) (on file with author). Other at least equally notable scholars have provided contrary statements. *See L.* Tribe, *S. 2290 – Analysis of Constitutional Issues Relating to Asbestos Bankruptcy Trusts* (June 8, 2004) (on file with author); Memorandum from L. Tribe to Senate Judiciary Staff, FAIR Act – Constitutional Issues Relating to Bankruptcy Trusts (Oct. 17, 2003) (on file with author); Memorandum from Carter Phillips to Senate Judiciary Staff (2004) (on file with author); Letter from Carter Phillips to Senator Arlen Specter (Feb. 7, 2006) (on file with author); Memorandum from Michael A. Carvin, FAIR Act – Takings Analysis Involving Bankruptcy Trusts (Mar. 1, 2006) (on file with author).

72. *See* S. 852 § 222(c). The guarantee of the bankruptcy trusts is limited to $4 billion. To a considerable extent the issue relating to the proceeds of bankruptcy trusts is a question of timing. To the extent that the trusts pay the same people who would qualify under the FAIR Act, the amount received by the claimant from the trust would be a collateral source that would reduce his FAIR award. The Fund would permanently lose only the amount that the bankruptcy trusts paid to people who would not be entitled to a monetary award from the Fund—for example, the unimpaired.

73. *See id.* § 222(c)(2).

HeinOnline -- 12 Conn. Ins. L.J. 532 2005-2006

regarding pending claims and settlements. The second issue is how to protect some or all claimants against the possibility that the Administrator will take longer than expected to establish the new program. This problem is addressed by the "Feinstein Start-Up" provisions, named after Senator Dianne Feinstein (D-CA) who was instrumental in including those provisions in the bill.

1. Pending Claims and Settlements

Upon enactment, S. 852 will be the exclusive remedy for all pending claims except individual claims that have commenced trial or have reached a final verdict.[74] Similarly, S. 852 will preempt most settlements that have not been completed as of the date of enactment.[75] However, binding and legally enforceable written settlement agreements between a solvent defendant and a specific named plaintiff would generally be preserved if the conditions for settlement are met within 30 days after enactment.[76]

2. "Feinstein Start-Up"

Unlike the FAIR Act's provisions regarding pending cases and settlements, the Feinstein start-up provision, § 106(f) ("the Feinstein Start-Up"), addresses the possibility that delay in setting up the program will lead to unreasonable delay in paying claims that are otherwise appropriately subject to the exclusivity provisions of the bill.

Obviously, the most straightforward way of dealing with delays in start up is to make sure they don't occur. To this end, § 106(a) gives the Administrator ninety days to adopt interim regulations for the processing of claims and management of the Fund, and those interim regulations must provide for the expedited processing of exigent claims (i.e., claims on

74. *Id.* § 403(d)(2). For this purpose, a jury trial "commences" when a jury is impaneled and begins hearing evidence, and a bench trial commences when the presentation of evidence has begun. *Id.*

75. *Id.* § 403(c).

76. Section 403(c)(3) preserves settlements *with solvent defendants* executed before enactment by the specific individual plaintiff; containing an express obligation to make a direct monetary payment, in a fixed amount, to the plaintiff; and within 30 days after the date of enactment, all conditions to payment under the settlement agreement are fulfilled. This provision does not apply to settlements involving defendants in Chapter 11. A plaintiff with an asbestos settlement is an unsecured creditor in a bankruptcy proceeding, and like all other such creditors, his rights are subject to adjustment in the bankruptcy process. The plaintiff's interest in the inviolability of his agreement with the bankrupt defendant is much less in this situation than it is where a solvent defendant is involved..

HeinOnline -- 12 Conn. Ins. L.J. 533 2005-2006

behalf of the terminally ill) and for the use of a claims facility to process claims. The bill also provides an accelerated timetable for payments into the Fund to help ensure that the Administrator will have the necessary resources to pay claims as soon as possible.[77]

The Feinstein Start-Up distinguishes between "exigent claims" and claims generally. For both kinds of claim, judicial proceedings are stayed on enactment but the stay may be lifted if there is excessive delay.[78] The waiting period before the stay is lifted, and the consequences of lifting the stay, differ between exigent and non-exigent claims.

a. "Exigent Claims"

The theory underlying the Feinstein Start-Up is that defendants will back up the Administrator in the event that the Administrator is unable to process or pay exigent claims. The claimant therefore looks first to the Administrator (or the claims facility retained by the Administrator) for a determination of whether the claim satisfies the requirements for an exigent health claim. If so, the Administrator must immediately issue and serve on all parties a certificate of eligibility and determination of the value of the claim and will pay the award.[79] If the Administrator is able to decide and pay the claim, the rest of the Feinstein start-up process is unimportant in practice.

If the Administrator is unable make a determination of eligibility or to pay the claim in a timely way, the defendants must make a good faith settlement offer within 30 days after the Administrator gives up or fails to pay the claim.[80] If all offers together equal the amount that the claimant would have been entitled to receive from the Fund, the claimant is required to accept.[81] As long as the Administrator has been able to certify

77. Defendants in Tiers II-VI are required to make a payment of their estimated liability within 90 days after enactment, subject to adjustment after the defendant's tier allocation is finally determined. *Id.* § 204(i)(1). Defendants in Tier I must pay their contributions within 60 days. *Id.* § 204(i)(2). Insurers must make an interim payment of 50% of their estimated first year contribution within 90 days of enactment, and the bankruptcy trusts have 90 days to transfer their unencumbered assets to the Administrator. *Id.* §§ 212(e)(1), 402(f).

78. *Id.* § 106(f).

79. *Id.* § 106(f)(2)(A)(v).

80. *Id.* § 106(f)(2)(A)(vi)-(viii).

81. *Id.* § 106(f)(2)(A)(x). If the defendants offer more than the amount that the claimant would get from the Fund, all of the offers are deemed reduced *pro rata*; if they offer less, they have a 10 business-day period to cure the shortfall. *Id.* § 106(f)(2)(A)(viii)-(ix).

HeinOnline -- 12 Conn. Ins. L.J. 534 2005-2006

eligibility and the amount of the claim, the defendants know exactly how much they must offer to force a settlement of the case. If, however, the Administrator fails to certify, the defendants must form their own best judgment of the value of the claim, if any.

Defendants may offset the amount that they have paid to settle a claim against their next and subsequent contributions to the Fund unless the Administrator finds that they have settled in bad faith.[82] In effect, the amounts paid in settlement are like advances to the Fund, and as such, they are not covered by insurance.[83]

Exigent claims are stayed for 9 months from the date they are filed with the Administrator (or until the Administrator certifies that valid exigent claims are being processed and paid at a reasonable rate).[84] If an exigent claim falls through the cracks, the defendants may settle it at any time before the stay expires by paying 150% of the amount that the claimant is entitled to receive from the Fund.[85] Once again, the amount paid in settlement may apparently be offset against the defendants' future obligations to the Fund.[86] After the stay is lifted, however, the exigent claim may proceed in court without damage caps or other limitations on recovery and may stay in the tort system even if the Administrator determines the following day that the Fund is operational.[87] Defendants who resolve cases after they have been allowed to proceed in court may offset against future contributions to the Fund the amount the claimant would have been entitled to receive from the Fund, but any additional

---

82. *Id.* § 106(f)(2)(A)(xii)(I). A defendant that would be unable to write-off the amount of its settlement within three years is entitled to reimbursement. *Id.* § 106(f)(2)(A)(xii)(II).

83. *See id.* § 106(f)(2)(A)(xii)(I).

84. *Id.* § 106(f)(2)(B).

85. *Id.* § 106(f)(2)(A)(xiii). Similarly, if the defendants settle and then fail to pay on time, then the claimant is entitled to receive 150% of the amount he would receive from the Fund until the stay lifts. *Id.* § 106(f)(2)(A)(xiv).

86. Section 106(f)(2)(A)(xii) allows cost-recovery to any defendant whose "settlement offer is accepted" and does not make a distinction between settlements accepted during the initial settlement process and 11th hour settlements reached as the 9-month stay is about to expire. Thus, it appears that the 50% penalty for failure to settle on time is ultimately for the account of the Fund. If the defendants allow the stay to expire, however, then their offset against the Fund is limited to the amount that the Fund would have paid to the claimant.

87. The clock for reversion to the tort system begins ticking only when a claim (or notice of intent) is actually filed with the Administrator. Thus, a claimant cannot refuse to file a claim (and thus refuse to participate in the Feinstein start-up procedure), hoping that the 9-month period will expire and that he will be able to continue unimpeded in the tort system.

HeinOnline -- 12 Conn. Ins. L.J. 535 2005-2006

amount is for the defendant's account.[88] Whether such payments are (or should be) covered by insurance is hotly debated.

b. All Claims

While the Feinstein Start-Up scheme gives priority to exigent claims, it also provides a safeguard against undue delay for non-exigent claims entitled to monetary compensation. (The claims of the unimpaired in Level I, who are entitled to medical monitoring but not monetary compensation, are not covered by this safeguard). If the Administrator is unable to certify within 24 months after enactment that the Fund is operational and paying all claims at a reasonable rate, then the stay is lifted with respect to non-exigent claims and they may proceed in any state or federal court where the claimant resides or where his exposure took place.[89] If thereafter the Administrator issues an operational certification, non-exigent cases that have not yet reached trial must be reinstated with the Fund.[90]

E. RELATIONSHIP TO OTHER SOURCES OF COMPENSATION

The tort system is not the only way in which people may receive compensation for asbestos related injuries. An injured person could be entitled to other forms of compensation including workers' compensation benefits and health insurance coverage. The new compensation program established by the FAIR Act has to fit within this overall system. It also has to take into account that some people compensated in part under the tort system will have a claim for additional compensation under the Act.

The key issue has to do with workers' compensation. Under state workers' compensation law, an employer (or the employer's workers' compensation insurance carrier) who provides benefits to an employee normally has a lien on any recovery that the employee may receive from the third-party wrongdoer. The generally accepted principle is that workers' compensation provides no-fault compensation for a subset of the same harms that would be the subject of a judgment for damages in the tort system, and the employee should not be allowed to recover twice for the same injury.[91]

---

88. S. 852 § 106(f)(2)(C)(ii).

89. *Id.* § 106(f)(3)(A).

90. *Id.* § 106(f)(3)(E)(iv).

91. See 6-110 Larson's Workers' Compensation Law §110.02 (2004). The employer's right of subrogation (or right to assert a lien on the proceeds of a settlement) is generally a creature of statute, and the extent of the lien depends upon the wording of the statute.

HeinOnline -- 12 Conn. Ins. L.J. 536 2005-2006

Unlike current practice, the FAIR Act treats awards from the Fund as compensation *in addition to* workers' compensation. Thus, it expressly provides that workers' compensation liens are not enforceable against awards from the Fund.[92] As a result, every claimant who is eligible to file a workers' compensation claim has an incentive to do so. This is in sharp contrast to the asbestos litigation system, in which many workers pass up their workers' compensation benefits because the system as a whole limits them to one recovery.[93]

Although early versions of the FAIR Act broadly offset "collateral source" compensation from awards from the Fund, S. 852 offsets only prior tort awards. While this remaining "collateral source offset" is limited, it is vitally important. Without it, the overhang of pending cases would surely crush the Fund in its early years.

F. SUNSET

The FAIR Act is designed to be a liquidating trust. In theory, once the last claim is paid, forty or fifty years from now, the Administrator will turn out the lights and retire. But, that depends on adequacy of funding. No one can predict with absolute certainty how many claims will be filed with the Fund and what the ultimate cost of the program will be.

If the money runs out—that is, if the Administrator concludes that he cannot pay claims in full as they become due and meet the Fund's other

---

Compare Ryan v. General Electric, 256 N.E. 2d 188 (NY 1970) (workers' compensation lien enforceable against award under Military Claims Act) *with* Atkinson v. City of New York, 751 N.E. 2d 455 (N.Y. 2001) (lien may not be asserted against payments made under National Vaccine Injury Program).

92. S. 852 § 135(a)(2). The provisions regarding "subrogation" in S. 852 were at odds with earlier versions of the bill, which left the question whether state workers' compensation liens applied to Fund awards to state law.

93. Less controversial is a similar rule relating to health coverage. Generally, health insurers (including Medicare and Medicaid) reserve a right of subrogation against third parties who may be responsible for a patient's medical bills. The FAIR Act prevents such health insurers from imposing a lien on awards from the Fund. *See id.* § 135(a). While superficially similar to the FAIR Act's approach to workers compensation liens, the policy considerations are different. The medical costs of treating asbestos related diseases are very small compared to the universe of medical costs covered by insurance. The practical consequences of preempting insurance liens are not at all comparable to the consequences of suddenly imposing a new category of compensation costs on employers and their workers' compensation carriers. Moreover, it is exceedingly unlikely that the FAIR Act's policy on health insurance subrogation would affect claims made on health insurance policies, one way or the other.

HeinOnline -- 12 Conn. Ins. L.J. 537 2005-2006

obligations -- the administrative compensation program sunsets.[94] Future asbestos claims may be brought in the tort system, subject only to rules that prevent abusive forum shopping and apply Federal evidentiary standards to expert testimony on both sides.[95] The Administrator is required to review the performance of the program constantly in order to discern unfavorable trends, identify problems early, and either make administrative changes or recommend new legislation.[96]

II. INTRACTABLE PROBLEMS

Some of the controversies surrounding the FAIR Act are *sui generis*. For example, the Libby problem is essentially political. The media has created a public image of Libby, Montana, as a community uniquely victimized by an especially virulent form of asbestos that damages the health of residents in unique ways. The senators from Montana have a strong interest in seeking special treatment for Libby. Senators from other states have an interest in avoiding discrimination against their own constituents—either by attacking the special provisions for Libby or by extending them to other communities. As fascinating (and important) as this dynamic is, it does not illustrate a general theme.

Other issues, however, will inevitably arise in some form whenever it is proposed to substitute an administrative compensation program for the tort system. A review of some of those issues and the way the FAIR Act deals with them shows both how ingenious the FAIR Act is and how difficult the problems are.

---

94. *Id.* § 405(f)(1).

95. *Id.* § 405(g). There is a special problem with reversion to the tort system at sunset in the case of people who have claims against bankruptcy trusts. Since the assets of the trust will all have been taken by the Fund in the first year, those people would be out of luck if they were unable to proceed against the Fund (either because of limitations on join and several liability or because the company who original established the trust was the only possible defendant). The bill addresses this problem by providing for a refunding of the asbestos trusts in the event of sunset. *Id.* § 405(f)(8).

96. The FAIR Act does require the Administrator to analyze unexpected influxes of claims and to make recommendations for changes in the legislation if he finds that a significant number of unwarranted claims are being paid under the Act. *Id.* § 405(c). But, those recommendations go to Congress, which would have to legislate anew to change the medical or other eligibility criteria. The Administrator does not have the authority to change medical criteria or awards values on his own.

HeinOnline -- 12 Conn. Ins. L.J. 538 2005-2006

A. How Should the New Compensation System Relate to Other Compensation Schemes?

One of the knottiest problems in designing the FAIR Act has been to define its relationship to other potentially available sources of compensation. Here, however, I will focus on two such relationships: (1) between the FAIR Act and the tort system; and (2) between the FAIR Act and the workers' compensation system.[97] These issues are not only important in themselves but shed light on some of fundamental problems that must be faced in designing an administrative compensation program to substitute for tort liability.

1. Exclusivity . . .

Only some of the difficult problems in defining the relationship between the FAIR Act and the tort system are discernable from the structure of the current bill. At the beginning, for example, the bill's framers had to decide whether the bill would be mandatory or voluntary. It would have been possible to set up a compensation system allowing defendants (and possibly insurers) to opt in, perhaps giving them significant incentives for doing so.[98] This approach was in fact considered. It would also have been possible to give plaintiffs a choice on whether to use the new system or to stick with the old.

As we have seen, the framers of the bill generally opted for exclusivity. There were several good reasons for this. In the first place, a program voluntary for *claimants* would have been subject to adverse selection: people with strong claims in the tort system would have stayed there, and people whose tort claims were weak would have resorted to a no-fault fund. The fund would have been devoted to compensating people whose tort cases were so weak that they could not obtain equivalent compensation from any other sources.

---

97. As introduced in 2003, the FAIR Act would have provided back-up compensation after other all other "collateral source" benefits were taken into account. These collateral sources would have included, for example, claimants' health insurance benefits. That approach did not survive markup-up of S. 1125 in July 2003. S. 852 would limit collateral source benefits to prior settlements and judgments in the tort system. *See* S. 852 § 135.

98. The quasi-coerced opt-in pattern was used by the legislation that would have enforced the settlement between tobacco companies and state attorneys' general in 1997. *See generally* The Universal Tobacco Settlement Act (as reported), S. 1415, 105th Cong. § 708 (1998).

HeinOnline -- 12 Conn. Ins. L.J. 539 2005-2006

A program that was voluntary for *defendants* would also have presented serious problems. A voluntary program would arguably have had the advantage of solving the allocation problem, since defendants would not have to sign on if the price were too high. But, "exit" for defendants would also have been (involuntary) exit for insurers, since defendants who opted out of the Fund would have turned to their insurers for coverage. Determining the ground rules of insurer participation in such a scheme would have posed extraordinary difficulties, which the framers of the Act avoided by making participation mandatory for defendants.[99] It is important to observe how the need to address insurance fundamentally affects the design of the funding side of the program. We will see that phenomenon over and over again, especially in connection with controversies over the allocation of the financial burden between insurers and defendants and among defendants.

While the mandatory character of the FAIR Act program is now well established, the existing bankruptcy trusts have made a major push for an amendment that would enable them to opt out of the Act. This argument is rather like a mammoth in the ice—it is the last relic of a controversy that in all other contexts was resolved ages ago.

In part, the trusts' position rests on the constitutional concerns that we have noted above, and in part it rests on policy. The trusts say that they have done a good job at compensating their claimants, that some people to whom they owe a duty would receive less or nothing under the Act, and that they are concerned that their beneficiaries would be unprotected if the Fund ran out of money.[100]

These contentions do not withstand scrutiny. In the first place, no person who meets the medical criteria of the FAIR Act could possibly want to apply to a half-dozen or more existing trusts, proving product

---

99. Theoretically, the program might have been voluntary for insurers, but that would have raised, the other way around, the problems of matching up defendants and insurers that would occur as a result of making the program voluntary for defendants. A more daring suggestion would have been to exclude insurers from the program altogether, so that defendants could pay their contributions into the Fund and look to their insurers for coverage. This would arguably have simplified the problem of determining the allocation of burdens between insurers and defendants, and some insurers did in fact suggest this solution to the allocation problem. But, there would have been practical problems in matching up payments into the Fund with insurance policies of different kinds (general liability, products, etc.), covering different years, with different limits, and so forth. This approach would either have bogged down in the Congress or left it to the courts to work out the inevitable coverage disputes—with huge uncertainty and litigation expense for defendants.

100. *See* The Common Interest Group's website, charmingly named www.dontbetray theirtrust.org (last checked April 13, 2006).

HeinOnline -- 12 Conn. Ins. L.J. 540 2005-2006

identification in each case, when he could obtain a no-fault recovery from the Fund. And that is true even without considering that attorneys' fees under the FAIR Act are limited to 5%. No existing trust limits attorneys' fees to an amount less than 25%, and many have no limitations at all.[101] Allowing the bankruptcy trusts to opt out of the Fund would benefit the trustees and their employees, and it would benefit the trial lawyers, but it would not benefit claimants.

Of course, the trustees argue that some of their claimants would not qualify for compensation under the FAIR Act. That is true. The primary categories of claimants in this situation would be the unimpaired and the people whose medical evidence fell short of FAIR Act standards. But, there is a broad consensus in the Congress that those people generally should *not* be compensated—that resources should instead go to the genuinely sick. No one would claim that an individual defendant should be able to opt out of the FAIR Act just so it could pay such claimants, and there is no good reason why the bankruptcy trusts (who in this respect stand in the shoes of the defendants that established them) should be permitted to opt out either.

Finally, the expressed concern that trust beneficiaries would be out of luck if the Fund were to fail financially simply ignores the provisions of the Act requiring a refunding of the trusts in the event of sunset.

What is really at stake here (apart from the jobs of the trustees and their employees) is the availability of $7.3 billion from the trusts, primarily to pay pending claims in the first year or two of the Fund. The current asbestos trusts are often very close to the trial lawyers, who designed them, who played a major role in the initial selection of trustees, and who continue to play a key role as part of each trust's "Trust Advisory Committee." Like the trial lawyers, they have every reason to be hostile to proposals to substitute for the existing system a nationwide, no-fault, administrative compensation plan. If the trusts are allowed to opt out of the Fund, they would have the means to destroy the FAIR Act in its crucial early period, which is just what they and their allies in the trial bar want.

2. . . . And Its Limits

Having opted for exclusivity, the framers of the FAIR Act were nevertheless forced to consider a number of limitations on that principle.

---

101. Among the major trusts, Western and Manville both limit attorneys' fees to 25%. The other large trusts do not limit attorneys' fees. At least three small ones also have a 25% limit: E.J. Bartells, M. H. Detrick, and Rutland Fire & Clay.

HeinOnline -- 12 Conn. Ins. L.J. 541 2005-2006

These limitations create the potential for what insurers and defendants call "leakage"—i.e., circumstances in which the defendants and insurers who pay into the Fund must nevertheless pay for asbestos injuries outside the Fund. It turns out that some of the most vexing points of controversy regarding the FAIR Act relate to the application of the exclusivity principle.

a. The Problems of Transition

Transition to a new compensation system involves two inherent, and to some degree related, problems. The first is dealing with claimants who have already gone a certain distance in the tort system and who arguably have an interest, if not in any particular outcome, at least to their place in the queue. The second problem is how to protect claimants from delay in starting up a new program.

i. Pending Claims

The pending claims problem has a fairly simple structure. Basically, it is an exercise in line drawing. The first draft of the FAIR Act (S. 1125) preempted all pending claims—it applied, in other words, to all claims that had not reached a final, non-appealable judgment.[102] This meant that claims that had already been tried to verdict, or that were on appeal, could be preempted by the new legislation. Many defendants and insurers—inspired in any event by the conviction that the asbestos litigation system was wholly corrupt and without legitimacy—endorsed that rule. To others, however, it seemed too draconian.

Other lines could be drawn. Some Democrats, for example, argued that claims with a trial date should stay in the tort system. In the absence of "gaming the system," that might have been a sensible rule. But plaintiffs' lawyers choose their forum for a reason, and defendants and their insurers had a reasonable fear that compliant state judges would set wholly fictitious trial dates in order to allow a claimant to circumvent the new system.

At the end of the day, S. 852 took an intermediate position: conceptually, individual claims on trial are grandfathered and claims that have not yet reached trial are not. While this line makes sense in concept,

102. Under Federal constitutional law, no person has a vested interest in a cause of action. Duke Power Co. v. Carolina Envtl. Study Group, Inc., 438 U.S. 59, 82-90 & n.32 (1978). Only a final non-appealable judgment gives a plaintiff a vested property right that is protected against a "taking" by the Fifth Amendment.

HeinOnline -- 12 Conn. Ins. L.J. 542 2005-2006

many insurers and some defendants still fear gaming the system and cite this provision as a potentially major source of leakage.[103]

ii. Delay in Start-Up

Although the pending claims problem is an important concern, it pales in comparison to the more general problem of dealing with delays in start-up.

One approach to the start-up problem is to say that exclusivity doesn't attach until the new program is ready to open its door for business. When the government builds a new bridge, it doesn't close down the old one until the new bridge is ready for service. So, the argument runs, if you want to replace one compensation system with another, you don't shut down the existing system until the new one is in place.

The AFL-CIO, the trial lawyers, and many Democrats hold this view, which has a certain surface plausibility. But take it one step further: suppose the old bridge is unsafe. The proponents of legislation contend that the existing asbestos litigation system is fundamentally broken and continued use of old system in the year or two necessary to establish the new one threatens new bankruptcies and further damage to employers, communities, and many injured people. Moreover—and this is probably the key point—there would be a tremendous rush to commence and pursue lawsuits in the asbestos litigation system before the new system could get under way, if only because the plaintiffs' lawyers who *de facto* control the decision have a strong financial interest in using the current system to the extent possible.

The opposite approach would be to make the principle of exclusivity attach on enactment. If the start-up period is short enough, it is not necessarily inappropriate to ask claimants to wait for the new program to become operational. Preference could be given to claimants with an especially strong interest in a quick award—perhaps claimants with trial dates in the tort system, or claimants with especially serious disease, or claimants in financially pressing circumstances who might lack the money to obtain needed medical care. The idea would be to speed along the most pressing cases, proceed at a more measured pace for other cases, and reach final operability soon enough so that no one is seriously inconvenienced.

Previous versions of the FAIR Act took this approach. For example, S. 2290 (in the 108th Congress) would have made exclusivity attach on

103. *See* L. Brickman, *An Analysis of the Financial Impact of S. 852: The Fairness in Asbestos Injury Resolution Act of 2005*, 27 CARDOZO L. REV. 991, 1020-25 (2005).

HeinOnline -- 12 Conn. Ins. L.J. 543 2005-2006

enactment, expedited establishment of the new compensation system, and prioritized "exigent" claims—defined as mesothelioma claims and other claims where the claimant has less than a year to live.[104]

In the event, neither of the extreme approaches was able to command assent. The Feinstein Start-Up provisions described above are an attempt to chart out a "third way." The basic idea is fairly simple: during the start-up period, defendants should effectively act as the Fund's agent to settle claims, ultimately at the Fund's expense. In order to induce the defendants to take on this responsibility, however, the provision reserves as a hammer the possibility of leaving defendants in the tort system without a right of indemnification from the Fund.

This ingenious provision is simple only in concept. In practice, it is a potential nightmare. First, the Feinstein scheme presupposes that defendants and insurers will be better situated than the Administrator to ensure that exigent claims are settled. That confidence may be misplaced. A huge number of exigent claims could demand compensation in a limited period of time, not from any one defendant, but from dozens. The defendants would have to establish some sort of cooperative settlement mechanism—not a task that has traditionally been up their alley—to deal with all of those claims within the tight statutory time frame. That will not be so difficult if the Administrator is able to certify that the claim qualifies for compensation at a given award level. But if the administrative problems that give rise to the need to use the Feinstein scheme also prevent the Administrator from making the necessary certifications, the defense community could find itself in very serious difficulties. The defendants are in no position to apply the eligibility criteria or even the rules on collateral source compensation on their own.

Second, the Feinstein scheme is based on a much oversimplified understanding of the tort system in asbestos cases. The image that underlies the scheme is that of a one-on-one lawsuit between a plaintiff and a defendant. If the Administrator cannot pay the award, then the defendant is expected to step up within the context of the existing lawsuit. But asbestos cases are almost never one-on-one affairs. Each lawsuit names scores of defendants. Some of these defendants are in nearly every suit;

---

104. S. 2290 did not have a "start up" provision comparable to the Feinstein start up. Section 106(a), however, gave the Administrator 90 days to promulgate regulations for the expedited treatment of exigent health claims. Under § 106(c), moreover, the Administrator was required to adopt interim regulations if necessary to process such claims, which were defined as mesothelioma claims and those where the claimant had less than a year to live. *See* Fairness in Asbestos Injury Resolution Act of 2004, S. 2290, 108th Cong., § 106(a), (c) (2004).

HeinOnline -- 12 Conn. Ins. L.J. 544 2005-2006

others are named in just a portion of them, depending on the claimant's work history, location, and who happens to be on his lawyer's word processor. For purposes of the Feinstein scheme, it is perfectly arbitrary which defendant is involved in which lawsuit—in effect the defendant community will have to step up to resolve claims during the start up period. If, however, the link between an individual defendant and an individual participant is broken, there is no reason not to involve all participants—defendants and insurers alike—in the process. Conceptually, what is going on is not substituting litigation for the FAIR Act claims resolution process, but rather giving participants an incentive to apply the FAIR Act scheme directly, without an Administrator. For this reason, Senators Specter and Leahy proposed in their manager's amendment to involve insurers more in the Feinstein Start-Up process.[105]

Third, the problem that defendants have in applying the requirements of the Act in the absence of the Administrator's certification of eligibly and value translates into a significant financial problem for the Fund. Under the Feinstein scheme, a defendant that fails to settle a questionable claim runs the risk of being pursued in court without any limitations at all on liability. If the same defendant settles the claim, it will be indemnified by the Fund. Any rational defendant will settle under those circumstances, at the Fund's expense.[106]

Fourth, holding the tort system open, even as a last resort, causes very serious problems for defendants and insurers. The obvious difficulty is exposing defendants to the potential hammering that the unpredictable tort system can deliver. The danger here is much worse than it would be in the tort system today, because the plaintiffs' trial bar would have every incentive to swing for the fences in the last few asbestos cases remaining to them.

Beyond that obvious fear, however, is a more subtle, but no less vexing problem—insurance coverage. The language of S. 852 as it stands is less than clear on whether a claim that slips through the cracks and ends up in the tort system would be covered by insurance. Insurers argue that their commitment to the Fund is the price they pay for washing their hands of all

105. *See* Amend. 2746, 152 CONG. REC. S983 (daily ed. Feb. 9, 2006). The amendment in a number of places substitutes the word "participant" for defendant in § 106(f), thereby including insurers. Thus, for example, insurers are entitled to information about the claimant's application, § 106(f)(2)(v), and may make settlement offers under § 106(f)(2)(ix). *See id.* at S988.

106. The FAIR Act would require judicial approval of settlements in this situation (*see* S. 852, § 106(f)(2)(A)(viii)), but it is hardly to be expected that courts will seriously inquire into the *bona fides* of settlements where there is no objecting party to challenge them.

HeinOnline -- 12 Conn. Ins. L.J. 545 2005-2006

asbestos claims, including start-up claims. Defendants, of course, argue that if the Feinstein Start-Up allows some asbestos claims to revert to court, their pre-enactment insurance coverage should be fully available to cover those claims. The only way to avoid blows between insurers and defendants over this coverage question is to keep these claims within the Fund, so that anything paid by defendants or insurers to settle those claims would be offset against contributions to the Fund.

b. Subrogation

The FAIR Act's attempted resolution of the workers' compensation subrogation problem is one of its most controversial provisions. As previously discussed, the bill would allow claimants who are entitled to workers' compensation benefits to receive both those benefits and an award from the Fund. This is in sharp contrast with the tort system, where state law would almost always give an employer or its workers' compensation insurance carrier a lien against a settlement between the worker and a third party. Insurance carriers have been vocal in their opposition to this provision, as have many self insured employers.[107]

The FAIR Act's resolution of the subrogation issue is problematic for two reasons. First, it imposes potentially significant new liabilities on employers and workers' compensation carriers, who not only cannot enforce liens against employees' recoveries from the Fund but also cannot sue third party tortfeasors for indemnity or contribution. Employers are left holding the bag for liabilities that today they can shift to others deemed more responsible. Second, by allowing double recovery, the FAIR Act is likely to cause a wave of new workers' compensation claims. Today, the rule against double recoveries means that many people with asbestos related injuries forgo workers' compensation claims, preferring to bring an action in tort, where the potential recovery is much greater. There is no incentive to file for workers' compensation benefits, since they will be deducted from any tort award or settlement. If workers can keep both their awards from the Fund and their full workers' compensation benefits, they

107. An amendment proposed by Senator Jeff Sessions (R-AL) would have allowed employers subject to the Federal Longshore and Harbor Workers' Compensation Act, which are often self-insured, to recover the cost of benefits from claimants. While the Sessions amendment related only to the LHWCA, the principles involved apply equally to other workers' compensation programs. *See* Amend. 2756, 152 CONG. REC. S1036 (daily ed. Feb. 9, 2006).

HeinOnline -- 12 Conn. Ins. L.J. 546 2005-2006

would be ill-advised not to file for both. That, in turn, would generate a potentially large additional asbestos compensation cost outside the Fund.[108]

B. How Should Administrative Efficiency Be Balanced With Program Integrity?

Any administrative compensation system must strike some balance between administrative efficiency and program integrity.[109] One aspect of this balance relates to how adversarial a program is. A highly adversarial system tends to ensure that only "deserving" cases are compensated, but this increased program integrity has a price in transaction costs and delay. On the other hand, a non-adversarial system tends to have low costs but to be relatively less effective at weeding out non-deserving claims.[110]

The tension between integrity and efficiency underlies other aspects of compensation programs as well. For example, eligibility standards are often a more easily administered surrogate for the condition that provides

---

108. See Nat'l Council on Comp. Ins. Inc., Analysis of S. 852 Fairness in Asbestos Injury Resolution (FAIR) Act of 2005 (on file with the author) (estimating cost of subrogation provision at $39 billion to $88 billion). Professor Brickman, while discussing the NCCCI analysis, prudently refrains from giving an estimate of his own. *See* Brickman, *supra* note 103, at 1018-21. In fact, it is impossible to determine what the cost impact of the subrogation provision would be, since it is impossible to know what percentage of asbestos claimants would be eligible for workers' compensation in the first place. Many asbestos claimants are retirees and could encounter significant difficulties under many states' laws in obtaining recovering benefits. The NCCI estimate does, however, illustrate that this problem is larger than a bread box. Probably much, much larger.

109. I am using the word "integrity" very broadly to refer to the ability of the Fund to avoid paying those who should not be paid. It is analogous to the concept of specificity. A program with a high level of program integrity would be highly effective in weeding out "undeserving" claimants. While integrity is a good thing, all else being equal, other things are usually not equal. There is a trade-off between integrity and administrative cost (since achieving a higher level of integrity can involve higher standards of proof.) There is also a trade-off between integrity and program effectiveness—i.e., making sure that all deserving people are compensated. Where there is a high standard of proof, the risk of uncertainty is placed on the claimant, which inevitably means turning away some deserving claimants in order to avoid paying some who are not deserving.

110. It will not escape notice that the tort system in theory places an extremely high value on what I am calling "integrity" and pays a very high price in terms of transaction cost and delays. In practice, the tort system generally—and certainly the asbestos litigation system—pays much of the price of a system committed to integrity without getting much integrity in return. In part this is due to the fact that the "tort system" in the asbestos context involves a set of private administrative compensation systems that have historically valued efficiency over integrity. Following this analysis further, however, would go far beyond the scope of this paper, and so I shall leave the matter here.

HeinOnline -- 12 Conn. Ins. L.J. 547 2005-2006

the real basis for compensation.[111] Similarly, the amount of compensation may be reduced to reflect a program's preference for efficiency over integrity.

One of the most controversial aspects of the FAIR Act is the way it strikes this balance. Most of the Republican members of the Senate Judiciary Committee stressed that an asbestos compensation program must compensate those, *and only those*, who are sick from an asbestos-related disease.[112] While this comment related in the first instance to eligibility standards, it attested to a strong conservative emphasis on integrity over efficiency.

The administrative provisions of the FAIR Act were for the most part hammered out in discussions between representatives of organized labor, defendants, and insurers. The basic structure of the program is non-adversarial, reflecting the point of view of the AFL-CIO. In many medical categories, awards of compensation should be extremely fast and certain. For example, claimants in mesothelioma cases need only provide a reliable diagnosis of mesothelioma and evidence of some identifiable exposure to asbestos to recover. In other categories, however, claims are subject to more searching scrutiny. For example, certain family (or "take-home") exposure claims must be considered by a panel of doctors for an individualized determination of causation. The underlying concept is to provide relatively light administrative review in situations where the probability of error is small, and more searching scrutiny in situations that are more problematic.

In addition, the FAIR Act emphasizes the importance of ensuring the quality of the data that are used in the administrative process. This is especially critical given the history of medical fraud and abuse that has made asbestos litigation such a scandal. Thus, for example, all medical tests must meet applicable standards regarding equipment, testing methods and procedures;[113] diagnoses must be based on physical examinations performed by a diagnosing physician and x-ray results read by a qualified B-reader (in the case of non-malignant disease categories), and must

---

111. For a discussion of the presumptions involved in the Black Lung program, see PETER S. BARTH, THE TRAGEDY OF BLACK LUNG: FEDERAL COMPENSATION FOR OCCUPATIONAL DISEASE 109-28 (W.E. Upjohn Inst. for Employment Research 1987). That program contained an irrebuttable presumption of disability which was upheld by the Supreme Court in *Usery v. Turner Elkhorn Mining Corp.*, 428 U.S. 1 (1976).

112. *See, e.g.*, Additional Views of Senators Sessions, Cornyn, Grassley, Kyl, Graham, Brownback, and Coburn, S. Rep. 109-97, at 91 (2005)

113. S. 852 § 121(b)(3).

HeinOnline -- 12 Conn. Ins. L.J. 548 2005-2006

consider exposure and smoking history; [114] and the claimant must provide information and supporting documentation of smoking history.[115] All information provided in support of a claim is subject to an audit to the extent the Administrator considers necessary to ensure that the program's interests are protected,[116] and there are specific requirements for the auditing of B-readings and smoking assessments.[117] The Administrator also has the authority to request additional information, including new x-rays or CT scans, if he thinks it is necessary to decide the claim.[118] People who provide (or work with others to provide) false information are subject to criminal prosecution,[119] and the Administrator can refuse to accept data from doctors or laboratories that he finds have failed to meet professional standards or the Act's data requirements.[120]

While not perfect, the FAIR Act appears to have balanced the goals of administrative efficiency and program integrity in a sensible way. This was a significant accomplishment, since a perceived failure to achieve that balance was a major point of controversy earlier in the legislative process.

C. WHO SHOULD GET WHAT?

The relative success of the bill's sponsors in balancing program integrity and efficiency in the administrative process was not repeated with respect to the bill's eligibility criteria. On the contrary, the consensus behind the criteria unanimously accepted by the Judiciary Committee in 2003 unraveled with time, and by the end, the eligibility criteria were among the most controversial parts of the bill. The essence of the controversy was whether the program compensated everyone it should compensate and no one else.[121] This issue was inevitably linked with the

---

114. *Id.* § 121(b)(2)(A)(i)-(iii), (c).

115. *See generally id.* § 115(c) (smoking assessments).

116 *Id.* § 115(a)(1).

117. *See id.* § 115(b)-(c). The auditing of B-reader reports is not just a system function but can affect individual claims.

118. *Id.* § 121(b)(3).

119. *Id.* §§ 115(c)(4), 121(c)(6), 401(a) (willful or intentional false or fraudulent statements punishable under 18 U.S.C. § 1351). *See also id.* §§ 101(c)(2), 221(d)(2).

120. *See id.* § 115(a)(2). It is also worth observing that, because the administration of the FAIR Act would have been lodged in the Department of Labor, it would also have been under the jurisdiction of the Department's Inspector General. The Inspector General, in turn, would have had the duty of ferreting out fraud and abuse.

121. A separate question, discussed below, is whether the compensation criteria and award values are affordable. While that issue is affected by the fit between the eligibility criteria of the bill and its underlying policy, that is only part of the story with regard to costs.

HeinOnline -- 12 Conn. Ins. L.J. 549 2005-2006

bill's award values, and while considerably less attention was paid to that issue, it lurked like a mine in the harbor, ready to blow up at any time.

1. An Overview

Before turning to the specific problems of the FAIR Act, let's pause for a moment to consider what the standard for setting eligibility requirements and award values should be. At the outset, there is a broad distinction between a medical model, where Congress (or the Administrator) would establish eligibility criteria based on what it considered the best medical evidence, and a settlement model, which roots eligibility decisions in the practices followed in the civil justice system except where Congress believes those practices should be overridden for policy reasons.

The FAIR Act was based primarily on a settlement model. In some ways, this model was inevitable, since asbestos litigation was already well established and fairness to claimants had to be judged, at least in the first instance, against what claimants could expect to receive in the tort system. Nevertheless, tort system outcomes are untidy, and the use of the settlement model exposed the program to all of the slings and arrows to which compromise is vulnerable.

At least four difficulties arose from the use of the settlement model to establish eligibility. First, eligibility criteria inevitably reflected compromises between opposing positions on medical issues. The program was therefore always vulnerable to charges that it was paying people who should not be paid (on a defense-oriented view of the evidence) or failing to pay people who should be paid (on a plaintiff-oriented view of the evidence).

Second, under a settlement model, eligibility and awards are necessarily linked. A strong medical case results in a high award, and a weak medical case results in a discounted award. Since the strength of a claimant's case on causation is irrelevant to the amount of harm he has experienced, the use of a settlement model creates a dissonance between award values as the product of compromise and award values as a measurement of actual harm.

Third, the use of a settlement model raises the question of how much claims are currently worth in the tort system. Data to answer this question are unavailable, and because of various policy overrides that make the FAIR Act's compensation scheme different from those applied in the tort system, it would be hard in any event to use actual settlement data from the

HeinOnline -- 12 Conn. Ins. L.J. 550 2005-2006

tort system as a way of determining actual values.[122] Thus, while the *structure* of the system was designed to replicate the settlement patterns for the tort system (with some modifications), the *actual award values* at best have an approximate relationship to settlement values.

Fourth, settlement patterns in the tort system reflect the conditions in which they evolved. Legislation, however, must be drafted to deal with situations that may be rare in the asbestos litigation but are potentially important to members of Congress. This disjunction has led, among other things, to the vexing problem of non-occupational exposures.

Fifth, and similarly, the settlement model reflects practices as of a particular point in time based on a particular state of medical technology. Legislation is for the long term. Thus, technological change can also change the assumptions underlying the practical compromises on which the settlement model was based. The controversy over the use of CT scans is a manifestation of this problem.

With these overarching considerations in mind, let's turn to three discrete problem areas: the FAIR Act's medical categories, the problem of proof of exposure, and the question of award values.

2. The Medical Categories

Surprisingly, the FAIR Act's policy of not paying any monetary compensation to unimpaired non-malignant claimants (in Level I) was uncontroversial, and almost unnoticed. Level I claimants could obtain reimbursement for medical monitoring, but nothing more. This choice was the first and possibly most important policy override of tort system practices.

There was very little controversy regarding the medical and exposure criteria for mesothelioma (Level IX), for lung cancer with asbestosis (Level VIII), and for the core non-malignant asbestos-related diseases (Levels III

122. It is surprising that the "whole-case" value of asbestos claims is impossible to ascertain. There are several reasons for this. First, while every defendant knows what it pays for a certain kind of claim, defendants can only guess what other defendants are paying. (Moreover, since defendants do not all apply the same settlement scheme, settlement values in many categories could not be added up across defendants even if more information about each defendant's settlement practices were available.) Second, while plaintiffs lawyers know the price that they themselves get overall, they do not know how much other plaintiffs' lawyers were settling for in similar cases. And third, insurance companies, who might be expected to have the data that would enable all of this to be sorted out, have not historically kept track of the information necessary to calculate whole claims values. That number is only useful in public policy conversations, and insurer data organization methods have been guided by more mundane concerns.

HeinOnline -- 12 Conn. Ins. L.J. 551 2005-2006

through V). None of those categories involved crucial policy overrides; the FAIR Act more or less replicated tort system settlement standards, with some important but not highly controversial strengthening. The key problems have involved "mixed" obstructive-restrictive disease (Level II), "other cancers" (Level VI), and lung cancer without asbestosis (Level VII).

a. Level II: Mixed Obstructive-Restrictive Disease

As discussed above, the theory behind Level II cases is that some people who are significantly impaired by chronic obstructive pulmonary disease may also be impaired by asbestos-related disease. Standard pulmonary function tests do not detect such dual-cause impairment. In the tort system, these cases are usually paid at a discount compared to cases involving impairment clearly due to asbestos-related disease.

The tort-system compromise was carried over into Level II under the FAIR Act. The key to the compromise was the award value, which was only $25,000, the lowest of any disease level for which monetary compensation is paid. However, while the bill's general approach to Level II had roots in the tort system, its specific criteria were the product of legislative bargaining and could not easily withstand scrutiny. The principle underlying Level II was supposed to be that mixed obstructive-restrictive disease should be inferred when the x-ray evidence of an asbestos contribution is especially strong. For that reason, the minimum ILO score to qualify for compensation was set at 1/1—one step higher than the minimum abnormal reading of 1/0. But, as the conservative Republicans pointed out, it was still possible to qualify for Level II based on pleural plaques, without any asbestosis at all.[123] Moreover, an ILO score of 1/1 was a low hurdle for showing that asbestosis was a contributor to a pattern dominated by obstructive impairment. By contrast, the American Bar Association's recommended medical criteria, adopted in 2003, would have required an ILO score of 2/1 or higher in a similar situation.[124] Had the FAIR Act survived in the Senate, it is highly likely that Level II would have been revisited, and probably revised, in the House.

---

123. S. Rep. 109-97, at 100 (2005).

124. In February 2003, the American Bar Association House of Delegates recommended the adoption of medical criteria legislation that would defer the claims of the unimpaired. *See* ABA STANDARD FOR NON MALIGNANT ASBESTOS RELATED DISEASE CLAIMS FEBRUARY 2003. Such legislation necessarily results in binary, "go" and "no-go" decisions: it is impossible to compromise by discounting awards. An objection to medical criteria is that it rules out the claims of people who are impaired by obstructive disease but who have a strong case that there is some asbestos contribution to their impairment. To

HeinOnline -- 12 Conn. Ins. L.J. 552 2005-2006

b. Level VI "Other Cancer"

As discussed above, there are several cancers other than lung cancer and mesothelioma that are arguably caused by asbestosis. Some of these cancers are very common, others are rare.[125] All of these cancers are compensated in the tort system to some degree, but that degree varies from disease to disease and defendant to defendant.[126] The epidemiological evidence in favor of general causation is relatively weak for all of these cancers, but it is strong enough as a practical matter to allow "other cancer" cases to get to a jury.[127]

Level VI raised a classic problem in reconciling medical and settlement models for eligibility criteria. Because the Level VI cancers were compensable in the tort system, there was a presumption that they should be compensated at some level under the Act. To be sure, as was true of the Level II claims, doubts about causation could and did justify a reduction of the award: Level VI cancer claimants received only $200,000, a fraction of

---

address this situation, the ABA recommended allowing plaintiffs to pursue their cases in court if they had sufficiently strong radiographic evidence of asbestosis (an ILO reading of 2/1). *See* 4(c).

125. By far the most prevalent of the "other cancers" is colorectal cancer. According to the American Cancer Institute, an estimated 148,610 new cases of cancer of the colon or rectum will be diagnosed in 2006. The estimated incidence of the other cancers in Level VI is 8,950 (pharynx), 14,550 (esophagus), 22.800 (stomach), and larynx (9,510). These rates are for both sexes. Since substantial asbestos exposure took place primarily among males, it is also useful to look at incidence among men: colon and rectum (72,800), pharynx (6,820), esophagus (11,260), stomach (13,400), and larynx (7,700). i AMERICAN CANCER SOCIETY, CANCER FACTS & FIGURES 2006, at 4 (2006).

126. The "trust distribution plans" of bankruptcy trusts are a reasonably accurate indicator of settlement practices in the tort system. The main trusts all compensate most or all of the Level VI cancers. Level VI cancers have settlement value in the tort system because, notwithstanding doubts about general causation, they typically get to a jury and present a significant threat of a substantial verdict. For example, in the last year there have been two colon cancer verdicts in excess of $1,000,000. *See California Jury Returns $1.083M Verdict for Asbestosis, Colon Cancer Sufferer, supra* note 28; *Colon Cancer Victim Wins $3.4M Verdict Against U.S. Subsidiary of Saint-Gobain, supra* note 28.

127. The cancers in Level VI were generally identified as asbestos-related by Selikoff in the 1970s. Since then, a reexamination of Selikoff's work and the accumulation of other evidence has raised considerable doubt on the existence of a causal relationship. Some doctors, including Dr. James Crapo, on whom the conservative Republicans on the Judiciary Committee rely, are convinced that there is no conclusive evidence of asbestos causation for any of those cancers. Others are less definite. *See* R. Doll & J. Peto, *Other Asbestos-Related Neoplasms, in* KAREN ANTMAN & JOSEPH AISNER, ASBESTOS-RELATED MALIGNANCY 81-96 (1986) ("no grounds" for causal relationship in the case of gastro-intestinal cancers, strong evidence for causation for laryngeal cancer, suggestive but inconclusive evidence on esophageal cancer).

HeinOnline -- 12 Conn. Ins. L.J. 553 2005-2006

the amount received by lung cancer or mesothelioma claimants. But the causation evidence for Level VI was weak enough to raise the possibility that further study could justify a policy override of tort system settlement practices for at least some of the cancers at issue. Thus, the FAIR Act would have required the Institute of Medicine to study the scientific literature on causation and to determine which if any of the Level VI cancers could be caused by asbestos.[128] If the IOM decided that a particular cancer was not caused by asbestos, that cancer could no longer be compensated under the Act.

For those cancers that survived the mandated IOM review, the eligibility criteria would still be based on rules of thumb ultimately rooted in tort system settlement practices.[129] This involved 15 weighted years of exposure plus the presence of non-malignant asbestos-related disease (which could include either asbestosis or pleural disease). The requirement of non-malignant disease was not, however, based on any causal relationship between the non-malignant disease and the "other cancer" at issue. Rather, the non-malignant disease was a confirmation that the claimant had a great deal of exposure. Given the serious questions as to whether any of the "other" cancers were caused by asbestos at all, it is apparent that the default medical criteria were not based on any scientific understanding of how much exposure is required to attribute any of these cancers to asbestos and what other considerations may be relevant in making such an attribution. Indeed, the very fact that the bill had one set of medical criteria for five diverse cancers betrays the crudeness of these criteria.

The absence of any scientific basis for the Level VI criteria exposed them to the charge that they would allow many people whose sickness was not caused by asbestos to qualify for an award. This is a straightforward

---

128. Through a contract with the National Institutes of Health, the IOM established a committee in April 2005 to determine whether there is a causal relationship between asbestos and colorectal, laryngeal, esophageal, pharyngeal, or stomach cancers. The committee is chaired by Dr. Jonathan Samet of Johns Hopkins University. It is scheduled to issue its report in or around June 2006. For the status of the IOM study, see THE NAT'L ACADS, CURRENT PROJECTS, http://www8.nationalacademies.org/cp/projectview.aspx?key=175 (last visited May 24, 2005).

129. The FAIR Act looked both ways on causation determinations for those cancers that survived IOM scrutiny. On the one hand, all Level VI cases still had to go to Physicians Panels for an individual determination of causation. That could mean that, if the IOM found that asbestos caused cancer A, but at exposure levels much higher than those in the Level VI medical criteria, the Physicians Panel could reject causation in particular cases. On the other hand, the bill established a presumption of eligibility for Level VI cases that met the general eligibility criteria, and it was not at all clear what information the Physicians Panel had to have to override the presumption.

HeinOnline -- 12 Conn. Ins. L.J. 554 2005-2006

criticism that is an unavoidable risk in relying on the settlement model. However, the sheer number of potential other cancer claims and the significant award value for this category greatly heightened the concern.

The Level VI criteria also raised an additional problem that provoked considerable uneasiness: the possibility that changes in diagnostic technology—particularly developments in CT scans and other imaging techniques—could make the practical compromise reflected in the other-cancer criteria unreasonable. This problem affects other medical categories as well, especially Level VII lung cancers, and is discussed in subsection (d) below.[130]

c. Level VII – Lung Cancer Without Asbestosis

There is no doubt that exposure to asbestos can cause lung cancer, and it is generally accepted that lung cancer in a person with asbestosis may reasonably be attributed to asbestos exposure. The FAIR Act addresses this relatively clear case in Level VIII – Lung Cancer With Asbestosis.

The situation is much more murky, however, when lung cancers occur in people with asbestos exposure and no diagnosis of asbestosis. Some experts believe that lung cancer can never be attributed to asbestos exposure without a diagnosis of asbestosis, while others believe that an attribution can be made even in the absence of asbestosis if exposure levels were high enough.[131] The FAIR Act does not resolve this conflict but

---

130. A second problem with Level VI was the possibility that criteria workable in one institutional arrangement (the tort system and bankruptcy trusts) might encourage a flood of new claims in a different arrangement (a no-fault compensation scheme). This possibility, while important for Level VI, is even more important in Level VII (lung cancer claims without asbestosis). The problem here is not necessarily that *undeserving* claims would be compensated, but rather that a reduction in a transaction costs in a no-fault administrative system would greatly increase the rate of claiming (whether the medical criteria are valid or not). This issue lies at the heart of concerns about the financial viability of the program that are discussed in section (D), *infra* p. 315.

131. For the view that a diagnosis of asbestosis is a prerequisite for attributing lung cancer to asbestos exposure, *see* R. Jones, *Asbestos Exposures and Thoracic Neoplasms*, XXVII SEMINARS IN ROENTGENOLOGY 94 (1992); W. Weiss, *Asbestosis: A Marker for the Increased Risk of Lung Cancer Among Workers Exposed to Asbestos*, 115 CHEST 536 (1998); Letter of James R. Crapo to Sen. Jon Kyl (July 22, 2003), appendix E to Additional Views of Sen. Jon Kyl, Sen. Rep. 108-18, at 151-52 (2003). For the contrary view, see D. Egilman & Alexander Reinert, *Lung Cancer and Asbestos Exposure: Asbestosis is Not Necessary*, 20 AM. J. INDUS. MED. 398 (1996); *Consensus Report, Asbestos, Asbestosis, and Cancer: The Helsinki Criteria for Diagnosis and Attribution*, 23 SCAND. J. WORK. ENVIRON. HEALTH 311, 314 (1997) ("Heavy exposure, in the absence of radiologically diagnosed asbestosis, is sufficient to increase the risk of lung cancer.").

HeinOnline -- 12 Conn. Ins. L.J. 555 2005-2006

(typically) compromises around it. Thus, it provides compensation for lung cancers in the absence of asbestos, but only if the claimant can meet a heightened exposure requirement (12 weighted years of exposure) and has pleural changes (which are markers of exposure).[132]

The FAIR Act's treatment of lung cancers without asbestosis is probably the most controversial issue relating to eligibility. The consequences of getting the lung cancer criteria wrong are enormous. The American Cancer Society estimates that 174,470 lung cancers (92,700 in men) will be diagnosed in 2006.[133] If the criteria in the FAIR Act are written too narrowly, many people who in fact have asbestos-related lung cancers could die without receiving compensation. If they are overly generous, however, the consequences to the Fund could be serious enough to raise questions about its long-term viability.

Resorting to a medical model to resolve this problem is exceedingly difficult. As a practical matter, it would have been impossible just to eliminate Level VII, precluding recovery for lung cancer in people who have a great deal of exposure to asbestos but no asbestosis. There is simply too much responsible medical opinion supporting the view that asbestosis should not be a prerequisite for attributing lung cancer to asbestos exposure. Moreover, while there is a general consensus that, at the very least, a great deal of exposure is required to attribute lung cancer to asbestos exposure, there is no agreement on any simple and workable quantitative measure of the necessary level of exposure.

The settlement model did not show the way out of this dark wood either. First, the indicators of exposure in Level VII—12 weighted years plus pleural conditions—were arguably not accurate enough to restrict recovery under that category to a sufficiently highly exposed population. As discussed below, this problem would have grown more severe as CT scans became more widely available for diagnosing pleural changes. Second, the award levels for Level VII ($300,000 for smokers, $725,000 for ex-smokers, and $800,000 for non-smokers) are arguably too high to

---

132. Previous versions of the FAIR Act allowed lung cancer claimants to establish causation on the basis of asbestos exposure alone, even in the absence of pleural changes confirming actual exposure. S. 2290, 108th Cong. § 121(d)(7); S. 1125, 108th Cong. (2003) (as reported) § 121(d)(7). In a major concession to the Republicans on the Judiciary Committee, however, Senators Specter and Leahy agreed in spring of 2005 to delete the relevant medical category (the "old" Level VII) from the current version of the bill. This concession provoked the ire of some Senate Democrats, who, led by Senator Ted Kennedy, who have sought to restore the old Level VII category or at least allow claimants who would have qualified under Level VII to bring asbestos claims in the tort system. *See* 152 CONG. REC. S1265 (daily ed. Feb. 14, 2006).

133. *See* AMERICAN CANCER SOCIETY, *supra* note 123, at 4.

HeinOnline -- 12 Conn. Ins. L.J. 556 2005-2006

offset the risk that the medical criteria will be insufficiently specific to rule out questionable cases.

Interestingly, the British government recently faced the very same problem that confronted the Congress in the FAIR Act. Britain has an occupational disease compensation fund that pays benefits to workers with asbestos-related (as well as other industrial) diseases. As is true with the FAIR Act, the British scheme needs to distinguish between lung cancers that are and are not caused by asbestos. In 2005, the Department of Work and Pensions (DPW) laid before Parliament a report of its Industrial Injuries Advisory Council on the criteria for asbestos-related diseases that recommended a number of changes in the program's lung cancer criteria.[134] The Council reaffirmed that lung cancer can be attributed to asbestos exposure with reasonable certainty where asbestosis is present. It also concluded, however, that a "substantial exposure" to asbestos doubled the risk of lung cancer *even in the absence of clinical evidence of asbestosis.*[135] Thus, the Council had to face the problem of devising criteria for such a "substantial exposure." It rejected the idea of using a quantitative measure of cumulative exposure, in part because that would not be workable in a scheme not "based on an individual proof system."[136] It also rejected the continued use of diffuse pleural thickening as a criterion for a lung cancer award because it thought diffuse pleural thickening was an "unreliable" indicator of asbestos exposure.[137] The Council settled on a measure of exposure based on employment in certain very high exposure jobs for a prescribed period of time.[138]

---

134. DEP'T OF WORK & PENSIONS, ASBESTOS RELATED DISEASES: REPORT OF INDUSTRIAL DISEASES ADVISORY COUNCIL 16-19 (July 2005) [hereinafter "DWP REPORT"]. The Government has endorsed these proposed changes but as of early 2006 had not yet incorporated them into the necessary legislation.

135. *Id.* at 17.

136. *Id.*

137. *Id.* Prior to the adoption of the Council's recommendations, the British industrial compensation scheme would allow a worker without asbestosis to obtain a benefit for lung cancer upon showing "unilateral or bilateral diffuse pleural thickening extending to a thickness of 5 mm or more at any point within the area affected as measured by a plain chest radiograph (not being a computerized tomography scan or other form of imaging), which: (i) in the case of unilateral diffuse pleural thickening, covers 50% or more of the area of the chest wall of the lung affected; or (ii) in the case of bilateral diffuse pleural thickening, covers 25% or more of the combined area of the chest wall of both lungs." *Id.* at app. 1. This formula is less strict than the FAIR Act because it does not require bilateral pleural changes, but it is far stricter in requiring pleural thickening that covers a far more extensive portion of the pleura.

138. The eligible jobs were asbestos textile workers, asbestos sprayers, asbestos insulation workers including those applying and removing asbestos containing-material in

HeinOnline -- 12 Conn. Ins. L.J. 557 2005-2006

Had the FAIR Act gone further in the legislative process, there would have been pressure to improve upon the criteria for Level VII lung cancers. The essential problem would have been to develop an adequate measure of substantial exposure. A number of options would have been available. First, Congress might have given up on self-enforcing criteria and committed determinations of causation to the discretion of Physicians Panels, as it had done for Level VI claims. Second, Congress might have tightened up on the degree of pleural thickening necessary to lay the basis of a lung cancer claim. For example, it could have required pleural changes of at least "B2" under the ILO system. Third, it could have adopted a quantitative threshold for measuring cumulative past exposures. Finally, it could have followed the lead of the British Industrial Injuries Advisory Council in adopting a more restricted list of the occupations and industries where employment would give rise to an inference of occupational exposure.

These options could have been used singly or in combination. All would have presented policy problems, and policy problems would quickly have become political problems. For our purpose, it is principally important to realize that there is no good solution to the problem of lung cancer criteria, and so any proposal to address the issue is bound to become a political lightning rod.

d. The CT Scan Issue

Our discussion of the Level VI and Level VII medical criteria has already touched on the CT scan issue—i.e., the effect of improved imaging techniques on the criteria for asbestos-related diseases. That issue is actually relevant to every medical category except mesothelioma.

On a strict medical model, improvements in imaging technology can only be a good thing. If, for example, the program is designed to compensate impairment caused by asbestosis, and if technology shows us a better way to diagnose asbestosis, the improved technology is not a problem but a blessing.

Under a settlement model, however, the situation is fuzzy. A weakness of the settlement model is that it tends to reify the practical resolution of a controversy at any given point of time. That resolution is not based on medical science, but on practical results: Is it affordable to defendants?

---

shipbuilding. For exposures occurring before 1975, workers must be in the listed occupation for 5 years; for exposure after that time, 10-years' employment in the listed job would be required. DWP REPORT, *supra* note 132, at 19.

HeinOnline -- 12 Conn. Ins. L.J. 558 2005-2006

Does it provide adequate relief to claimants? A characteristic feature of settlement-model eligibility criteria is the use of more or less arbitrary (but ascertainable) standards to provide a reasonable stand-in for a situation that cannot be rigorously measured. The FAIR Act presents a good example of this strategy in basing the qualification for other cancers and lung cancers partly on the presence of pleural changes. No one seriously contends that pleural changes are themselves a risk factor for these diseases; they are at best a practical (though imperfect) indicator of exposure. This rough and ready metric is acceptable on the defense side only because of a more or less clear understanding about how many people in a population will be able to meet the criteria. If suddenly a much more sensitive test, such as CT scans, were introduced, that increased sensitivity could upset the practical compromise on which the criterion is built. In the tort system, this problem would be worked out over time in bargaining among the players, but in a legislated compensation scheme, there is no such self-correcting mechanism.[139]

It is inevitable that over the forty or fifty year life of the program there will be changes in imaging technology that will greatly increase sensitivity in detecting pleural changes. CT scans are merely the technology just over the horizon; they will certainly not be the last word. As techniques for measuring pleural changes become more sensitive, the adequacy of pleural changes as a confirmation of exposure diminishes. At that point, the settlement model must be revised in some way to restore the balance.

While the defect of using pleural changes as a confirmation of exposure is especially apparent in lung and other cancer cases, the same problem also appears in the non-malignant categories. It is practically impossible for pleural plaques by themselves to cause significant breathing impairment. However, pleural changes could be an indication of asbestosis that isn't showing up on a chest x-ray, and that asbestosis might cause impairment. Here again pleural changes are at best a stand in for the real causative factor, and any such stand-in necessarily reflects an implied bargain that takes into account the sensitivity and specificity of the test at

139. A part of the problem with CT scans is the absence of any agreed-upon method for reading them. There is no CT scan equivalent of the ILO scale for reading chest x-rays, although the FAIR Act would have promoted the development of such a method at least for the diagnosis of pleural conditions. S. 852 § 121(h). Subjectivity, however, was not the whole problem—if it were, the statute could easily avoid it by requiring CT scans to be read by independent experts. The fact is that CT scans are more sensitive and show pleural changes that ordinary x-rays miss. Eligibility criteria based on "what works" in a settlement context, rather than on medical science, will seem much less appropriate when changes in imaging technology increase the number of claims that meet the applicable criteria.

HeinOnline -- 12 Conn. Ins. L.J. 559 2005-2006

issue. As sensitivity increases, it becomes more and more important to ask whether the test is an adequate stand in for what it is really supposed to measure.

2. Exposure

All of the medical categories depend on proof of underlying exposure. However, no one really knows exactly how much exposure any individual has. Unlike some radiation workers, who wear badges that purport to measure their cumulative dose of radiation, people exposed to asbestos did not have real-time monitoring. Indeed, prior to the 1970s, effective monitoring of asbestos concentrations in the work environment was uncommon; and even if those concentrations were known, precise information on where a person worked will be absent. In litigation, the parties sometimes hire dose reconstruction experts to try to model the asbestos exposures to which a worker was subject. Leaving to one side questions about how reliable such studies are in principle, it is obvious that an administrative compensation scheme would break down if doses had to be reconstructed by experts in this way.[140]

Thus, the FAIR Act's exposure standards are not based on measured doses, but rather on inferences from information on the industries where the claimant worked and the jobs he held. It is critically important that information on employment history be complete and detailed—if conclusory assertions regarding employment were acceptable, the exposure criteria would cease to be meaningful and the medical criteria for all of the disease categories in the bill (other than mesothelioma) would be undermined. S. 852 as reported was probably deficient in this regard, although the managers' amendment pending on the Senate floor would have made significant improvements.[141]

---

140. Under the Energy Workers' Compensation Program, reconstruction of claimants' radiation dose is a major source of delay. GENERAL ACCOUNTING OFFICE, ENERGY EMPLOYEES COMPENSATION: MANY CLAIMS HAVE BEEN PROCESSED, BUT ACTION IS NEEDED TO EXPEDITE PROCESSING OF CLAIMS REQUIRING RADIATION EXPOSURE ESTIMATES, GAO-04-958, at 17-21 (Sep. 10, 2004). That is true, moreover, even though radiation workers subject to that program wore badges that kept track of their exposure. Just reading the badges has proved to be a time consuming procedure.

141. Amendment No. 2746, § 121(c)(2), while continuing to allow claimants to prove exposure by affidavit, would have required such affidavits to be "detailed and specific." *See* Amend. 2746, 152 CONG. REC. S983. (This amendment was subsequently incorporated into S. 3274, *supa*, note 2, at § 121(c)). This combined with detailed submission requirements relating to employment and exposure would provide the Administrator with a sufficient record to evaluate allegations of exposure, and § 121(c)(1)(C) allows him to require

HeinOnline -- 12 Conn. Ins. L.J. 560 2005-2006

The second major exposure problem arises from the FAIR Act's focus on occupational exposure to asbestos. This is perhaps an inevitable result of thinking in terms of the settlement model. In the tort system, lawsuits based on non-occupational exposure are very rare, and settlements typically do not address such situations.[142] Moreover, the drafters assumed that all of the diseases compensated under the FAIR Act, other than mesothelioma, would require an amount of exposure that could not in practice be satisfied except in an occupational setting.

What works, however, in the rough and ready world of tort settlements does not necessarily work in a legislative scheme. Although the Libby, Montana, experience is controversial and hard to interpret, it seems clear that at least some of the people who claim to have been injured at Libby were exposed to asbestos environmentally. Similarly, while there is not much evidence regarding illnesses other than mesothelioma arising out of exposure to naturally occurring asbestos, the Senate did not feel comfortable excluding the possibility of an award in that setting just because exposure was not occupational.[143]

The solution adopted by the Judiciary Committee in both of these cases was to underscore the authority of Physicians Panels to adjudicate causation through the exceptional medical claims procedure. These situations are, however, just special instances of the general problem of community exposure. In my view, the FAIR Act should be read as allowing claimants to present a case on causation to exceptional medical

---

additional information if necessary. None of this is perfect. Employment records typically show no more than the fact of employment and (sometimes) occupation, and coworker testimony in the asbestos context is not very reliable. The program will inevitably depend on the claimant's sworn testimony to some extent, and hope is that the penalties for fraud combined with the need to provide specific statements that could in principle be verified will keep false statements down to a manageable level. Exactly the same problem exists in the tort system, of course.

142. Take-home exposure is classified for this purpose, as it is under the FAIR Act, as occupational exposure.

143. Several amendments pending on the floor when the bill failed would have proposed relaxing the occupational exposure requirement further in the case of the World Trade Center attack and natural disasters such as Hurricane Katrina. *See* Amend. 2834, 152 Cong. Rec. S1270 (daily ed. Feb. 14, 2006) (amendment of Sen. Landrieu); Amend. 2745, 152 Cong. Rec. S982 (daily ed. Feb. 14, 2006) (amendment of Sen. Clinton). The substance of these amendments were incorporated into S. 3274, § 121(g)(11). It was simply not a satisfactory answer to these amendments that it is practically impossible for relatively small short term non-occupational exposures to asbestos to cause asbestos-related diseases other than mesothelioma (for which there was no occupational exposure requirement in the first place). Nor does it seem to have been important that the underlying exposure, in either the disaster or naturally occurring asbestos categories, cannot easily be attributed to the defendants and insurers paying the bill.

HeinOnline -- 12 Conn. Ins. L.J. 561 2005-2006

claims panels in any non-occupational exposure case. The bill did not, however, provide the panels any clear guidance on how such cases should be decided (except in the case of Libby exposures, where the bill clearly departed from any sensible method for ascertaining causation). If the bill had been more explicit in addressing the duties of these panels in environmental exposure cases—even if that meant directing the Administrator to address the matter in rule-making—it might have been possible to avoid politically driven rules for Libby that could wind up being applied in other settings as well.

3. Values

The FAIR Act's scheme of award values was subjected to two questions: (1) whether the overall *level* of awards was too high or too low; and (2) whether the *structure* of the awards system was equitable. As shown in Table 4 (next page), concern over the adequacy of awards led to a steady increase in claim values in different versions of the bill from 2003 through 2005. In addition, efforts to address Democrats' fears that the bill's award values were too small raised other significant problems with the bill—most notably the problems related to subrogation discussed above.

HeinOnline -- 12 Conn. Ins. L.J. 562 2005-2006

Table 4: Evolution of Claim Values Under the FAIR Act in Selected Diseases Levels 2003-2005

	S. 1125 (2003)			S. 2290 (2004)[2]	S. 852 (2005)
Level	As Introduced	Kennedy – Leahy Proposed	As reported[2]		
Asbestos Related Disease With Impairment (III)	$40,000		$75,000	$ 85,000	$ 100,000
Other Cancer (VI)	$200,000		$ 150,000	$ 150,000	$ 200,000
Lung Cancer – Pleural (VIII/VII)[1]			$ 175,000 s $ 500,000 x $ 804,500 n[3]	$ 200,000 s $ 500,000 x $ 800,000 n	$ 300,000 s $ 725,000 x $ 800,000 n
Lung Cancer – Asbestosis (IX/ VIII)[1]	$100,000 s $400,000 x,n	$ 500,000 s $1,500,000 x,n	$ 350,000 s $ 700,000 x $ 900,000 n	$ 550,000 s $ 800,000 x $ 900,000 n	$ 600,000 s $ 975,000 x $1,100,000 n
Mesothelioma (X/IX)	$750,000	$1,500,000	$1,000,000	$1,000,000	$1,100,000

Notes:

1. S. 1125 as introduced did not distinguish between lung cancer with underlying pleural disease and lung cancer with underlying asbestosis.

2. S. 1125 as reported and S. 2290 provided for ranges of awards in the lung cancer categories, with levels within the range dependent on the amount of exposure and smoking (if any). The values in the table are the mid-points of the ranges.

3. In S 1125 as reported, the lower and of the range for lung cancers-pleural non-smoking was $609,000. This obvious misprint was corrected in S. 2290.

a. Structure

In 2003, Senator Orrin Hatch, then Chairman of the Judiciary Committee, decided that, in general, the FAIR Act would have a fixed payment matrix. Thus, for any given disease level there would be a single award amount (except with respect to lung cancers, where the award varied by smoking status).[144] This meant that there would usually be no

144. As initially introduced in 2003, the FAIR Act provided for fixed lung cancer values depending on smoking status. *See* S. 1125, 108th Cong. § 131(b) (as introduced, May 22, 2003). However, in markup the Committee established ranges for lung cancer awards within each smoking status category, and the Physicians Panels were supposed to determine the award value based on individual information about exposure and smoking

HeinOnline -- 12 Conn. Ins. L.J. 563 2005-2006

individualized inquiry into a claimant's damages. It would not matter whether the claimant was living or dead, old or young, rich or poor, employed or unemployed; nor would it matter if he were the head of a family with many dependants or whether he was beset with high medical bills. This decision made award values predictable and greatly simplified administration. Whether the award values were equitable or not depended on one's perspective. The bill's approach avoided the radical difference in compensation often seen in the tort system, which was surely a plus. Opponents argued, however, that it was not fair to treat everyone alike when their underlying circumstances were different.[145]

The matrix structure chosen by Senator Hatch was not successfully challenged over the next 2 ½ years. It did show some fraying at the edges, however. In particular, S. 852 authorized the Administrator to promulgate regulations to increase awards to younger mesothelioma victims with dependents, as long as that could be done on a cost-neutral basis (within the Level IX – Mesothelioma category) and as long as every mesothelioma claimant received at least $1 million.[146] Moreover, had the bill been considered on the floor, amendments would have been offered to provide for full recovery of medical costs in mesothelioma cases.[147] It was at least possible, given the structure of the FAIR Act, that a full award might be insufficient to cover medical costs, leaving the claimant with nothing left of his award after paying his medical bills.

---

history and the claimant's age at diagnosis. *See id.* §§ 131(b)(1)-(3). That concept was continued in S. 2290 in 2004 but abandoned in S. 852 in 2005, which returned to the original idea of a fixed matrix. *See* S. 2290 § 131(b); S. 852 § 131(b).

145. One reason for the early insistence on an award matrix that would avoid individualized inquiries into damages was dissatisfaction with the level of controversy that beset the 9/11 Victims' Compensation Fund. There was a sense that that Congress had made a mistake in requiring an individualized look at "degrees of victimhood" and that it would be better to avoid such inquiries in the future. *See generally* KENNETH R. FEINBERG, WHAT IS LIFE WORTH? THE UNPRECEDENTED EFFORT TO COMPENSATE THE VICTIMS OF 9/11 (2005) (giving the essential account of the problems encountered by the 9/11 fund).

146. An amendment pending on the floor would have further modified the individualization of mesothelioma awards by authorizing the Administrator to pay the cost by reducing claim values in other categories. *See* 2826 CONG. REC. S1269 (daily ed. Feb. 14, 2006).

147. Amend. 2804, 152 CONG. REC. S1264 (daily ed. Feb. 14, 2006) (amendment of Sen. Reid); Amend. 2817, 152 CONG. REC. S1266 (daily ed. Feb. 14, 2006) (amendment of Sen. Kennedy).

HeinOnline -- 12 Conn. Ins. L.J. 564 2005-2006

b. Level

Much of the controversy over the structure of the compensation provided by the bill was driven by suspicions on the Democrats' side that the bill was providing less compensation than the tort system. It was impossible to verify this suspicion, since data on the tort system whole-claim values were unavailable.[148] Moreover, in the tort system a claimant's legal and other expenses would be much higher than they would be under the FAIR Act (which would have limited attorneys' fees to 5% of the amount of the award). If, for example, a claimant's attorneys' fees and other expenses were 40%, an award of $1.1 million for mesothelioma under the FAIR Act would be equivalent (in terms of the amount actually received by the claimant) to a tort settlement of $1.83 million. In some jurisdictions, such as Madison County or New York City, claimants in the tort system could receive more than that, although that would not be true everywhere. To the extent that award values under the Act would be less than tort system values, proponents of the bill pointed out that recovery under the bill would be much quicker and more certain that tort system recoveries typically are. Moreover, as claims values rose in successive versions of the bill from 2003 through 2005, voices were increasingly heard on the conservative side that claims values under the bill were actually higher, especially in the lung cancer categories, than they were in the tort system.[149]

Concern on the left (especially the AFL-CIO) that award values might be light led to heavy pressure to immunize FAIR Act awards from workers' compensation liens, and that pressure resulted in an agreement between Senators Specter and Leahy in early 2005 to do just that. As discussed above, however, the FAIR Act's rule on workers' compensation

148. *See supra* note 120.

149. *See, e.g.*, C. BATES & C. MULLIN, ANALYSIS OF S. 852 FAIRNESS IN ASBESTOS INJURY RESOLUTION (FAIR) ACT 27 (September 2005), *available at* http://www.bateswhite.com/news/pdf/2005_Bates_FAIR_Act_report.pdf. According to Bates and Mullin, the FAIR Act's value for mesothelioma cases is about 20% high, and its values for "other cancers" is about 75% high. It is impossible to compare the FAIR Act's lung cancer values with those asserted by Bates and Mullin, but the average lung cancer value asserted by Bates and Mullion ($230,000) is only about 77% and 38% of the FAIR Act's award values for smokers in Levels VII and VIII, respectively. If Bates and Mullin are correct (and they provide no explanation of the source of their proprietary data), the FAIR Act would be vastly more generous than the tort system, even without taking into account the reduction in transaction costs brought about by replacing civil litigation with a no-fault system. Needless to say, Democrats who were fond of quoting Bates and Mullen on the floor, did not mention this aspect of their work.

HeinOnline -- 12 Conn. Ins. L.J. 565 2005-2006

"subrogation" was fraught with difficulties of its own. Moreover, the subrogation rule also made necessary a decision to provide additional benefits under the "FELA adjustment" for workers who otherwise would have an asbestos claim against carriers by rail or water. In effect, looking outside the box to find a way of increasing the flow of money to certain workers transformed a claim value issue into a leakage issue.

4. The Overall Problem of Program Cost

Ultimately, the cost of the administrative program set up by the FAIR Act is governed by three factors: the number of valid claims filed over time, the values of those claims, and interest and other administrative costs incurred in managing the program. Republicans on the Judiciary Committee expressed concerns even in the committee report (in July 2005) that the medical and exposure criteria were porous and that the Fund would be receive more claims that it could afford to pay.[150] The Republican senators were afraid that if a flood of claims inundated the Fund, a future congress would feel compelled to bail the Fund out with taxpayer support. Thus, notwithstanding the bill's sunset provision and its clear provisions exempting the Federal government from any liability, these senators were worried that the Fund's insolvency would adversely affect the budget. Ultimately, this was the concern ostensibly behind the budget point of order on which the bill ultimately failed.

The Congressional Budget Office issued a report in August 2005 that put total program costs at $120 billion to $150 billion. Although these estimates implied some risk that the Fund would run out of money eventually, even, in the worst case, the CBO did not predict a short term collapse of the Fund. At the same time, the CBO stressed the uncertainty of its cost estimates, as it was to do over and over in the months ahead.

In September, Charles Bates and Charles Mullin, of the Washington consulting firm Bates White, issued a report arguing that the actual cost of the FAIR Act would be at least $300 billion and that the program would sunset within three years with an accumulated debt of $45 billion.[151] Given that the entire cost of asbestos tort litigation from the very beginning

---

150. CONG. BUDGET OFFICE, COST ESTIMATE: S. 852 FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT (Aug. 25, 2005) (on file with author)

151. *See* BATES & MULLIN, *supra* note 147, at 2. Dr. Bates has never explained just how his report came to be commissioned and who actually paid for it. The report does, however, reflect the point of view of the "Coalition for Asbestos Reform," which, despite its name, is an organization formed by insurance companies and major industrial companies in the oil and other industries to oppose the FAIR Act. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 566 2005-2006

through 2002 is estimated at about $70 billion, and that authoritative estimates of the future cost of the litigation were only $130-195 billion, this was a truly extraordinary claim.[152] Not surprisingly, it came under heavy fire in a special hearing of the Senate Judiciary Committee convened by Senator Specter on November 17, 2005, and was rejected by the CBO in a report issued in December.[153] Bates and Mullin issued a rebuttal to the CBO's December report on February 6, 2006, the first day of floor action on the bill, and their views were cited promiscuously by the bill's opponents, Democrat and Republican, during the debate on the budget point of order that led to the bill's demise on February 14, 2006.[154]

The initial Bates White Report in effect put a number on the concerns expressed by the Republican members of the Judiciary Committee that the eligibility criteria of the bill were insufficiently rigorous—as it was presumably intended to do. The Report's enduring interest, however, was in raising a previously undiscussed issue of great importance: the extent to which claiming behavior in the tort system is predictive of claiming behavior in a no-fault administrative system. Before Bates White, every analysis of the cost of the program had been keyed to claims projections in the tort system. Bates White, however, attempted to determine how many people would meet the eligibility requirements of the bill in the categories of concern to him (Level VI – Other Cancer and Level VII – Lung Cancer Without Asbestosis) and then characterized that as an "entitlement" (implicitly assuming that claiming rates would be at or near 100%, because transaction costs would be very low).[155]

The Bates White analysis thus goes far beyond the question raised by the Republicans on the Judiciary Committee regarding the rigor the medical criteria. Even if the medical criteria were tightened to a level that made them far more stringent than the rules of thumb that guide settlements in the tort system, the Bates White analysis would suggest that the program

---

152. RAND Report 2005, *supra* note 2, at 105-06 .

153. CONG. BUDGET OFFICE, ANALYSIS OF POTENTIAL CLAIMS UNDER S. 852, THE FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT OF 2005 (Dec. 19, 2005), *enclosed in* Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office to Senator Arlen Specter (Dec. 19, 2005).

154. C. BATES & C. MULLIN, BATES WHITE RESPONSE TO CBO LETTER TO CHAIRMAN SPECTER OF DECEMBER 19, 2005 (Feb. 6, 2006) (on file with author).

155. While Bates White's report is sometimes treated as saying that the FAIR Act would cost at least $300 billion, the report actually says that it would create an entitlement valued at $300 billion (assuming, of course, that everyone who may meet the eligibility criteria of the bill will self-identify and file a claim.). *See* BATES & MULLIN, *supra* note 147, at 2. Bates White offer no justification for that assumption.

HeinOnline -- 12 Conn. Ins. L.J. 567 2005-2006

was financially unsound because it would reduce barriers that, today, keep otherwise deserving claimants from asserting their claims.

In its December 2005 response to Bates-Mullin, the CBO found that nothing in the consultants' analysis warranted changing its previous conclusions regarding the cost of S. 852. In doing so, it rejected Bates White's criticism of using claims rates in the tort system—and more specifically the asbestos trusts—as a basis for projecting claims against the Fund. There were certainly a number of good reasons to do so, first among them the total implausibility of the conclusion that the asbestos litigation involves radical *underclaiming* in the other cancer and lung cancer categories, notwithstanding the organization and entrepreneurial effectiveness of the plaintiffs' trial bar, and the incentive that plaintiffs' lawyers have now to leave no stone unturned to find people with valuable claims in the tort system.[156] Nevertheless, Bates White struck a nerve. Beginning at least with the Black Lung program there has been a history of underpredicting the number of claims that would have to be paid under administrative schemes.[157] Claims projections for the asbestos trusts have

---

156. *See* BATES & MULLIN, *supra* note 147, at 14. Bates White suggests that cases involving cancers other than mesothelioma and lung cancers with asbestosis are not compensated in the tort system because of problems of proof. *Id.* at 11. But, that argument does not make sense. To be sure, difficulties of proof make non-asbestotic lung and other cancer cases less valuable than mesothelioma cases would be. But they are very far from being valueless. On the contrary, any lung cancer or other cancer claim that would be compensable under the FAIR Act would have substantial settlement value in the tort system (and would certainly be settled by most if not all of the asbestos trusts). Nor would transaction costs be a barrier to bringing the claim. From the claimant's point of view, the transaction costs for lung and other cancer claims are essentially the same as the costs for other asbestos claims—the usual contingent fee plus expenses. While it might cost more to try a lung cancer or other cancer claim than a mesothelioma claim, only an infinitesimal number of cancer claims of any sort are tried, and the expenses involved in settling such claims in the tort system are relatively small. The key consideration, however, is probably not the transaction costs paid by the claimant but the cost to the lawyer. Here again, there is no reason to think that such costs would discourage the bringing of the claim. Since virtually all cases are settled, the plaintiff's lawyer has a high certainty of recovering his fee, and the cost of processing claims through various settlement systems are essentially administrative. Any lawyer willing to bring a non-malignant claims should be ready to bring an "other cancer" or lung cancer claim as well. It is, of course, possible that the claim acquisition cost is higher in lung cancer and other cancer cases—there is no evidence on that one way or the other—but it is hard to believe that the 6-figure settlements typically reached in these cancer cases would be insufficient to support the costs of advertising.

157. *See* BARTH, *supra* note 111, at 283 (pattern of underestimation of claims volume "had all the earmarks for disingenuousness on the part of the program advocates in Congress"). Underestimation was addressed by the GAO in response to a request for information by certain House members in connection with asbestos legislation. *See generally* GENERAL ACCOUNTING OFFICE,, FEDERAL COMPENSATION PROGRAMS:

HeinOnline -- 12 Conn. Ins. L.J. 568 2005-2006

also been historically short of the mark (although there the problem was not in the cancer claims but in the non-malignant claims). Bates White's suggestion that the FAIR Act would generate so many new claims that its cost would be more than double the cost of the tort system was enough to set off alarms politically. And, finally, it is impossible to disprove the hypothesis that an administrative scheme would have a much higher claim rate than the asbestos litigation system unless Congress enacts the FAIR Act. Thus, the substantive problem—the possibility that reduced transaction costs will generate an unknown number of new claims—goes hand in hand with a political problem—anxiety that the costs of the new program would get out of hand.

D. How Should Costs Be Allocated In the Absence of Any Agreed Metric for Fairness?

Much of the complexity of the FAIR Act comes not from the design of the compensation system, but from the provisions for allocating costs. Title II, which deals with overall funding, is perhaps the most daunting of the entire bill.

Much of this complexity flows from two facts: (1) public funding for the FAIR Act is completely out of the question; and (2) there is no practical and generally accepted metric for the allocation of costs. The unavailability of public funding means that the companies that are responsible for asbestos costs today—as insurers or defendants—must assume the burden of funding the program. Moreover, private funding must be accomplished directly, through some system of contributions, and not indirectly, through an excise tax of some kind.

1. The Heterogeneity of Firms Responsible for Asbestos Costs

The companies responsible for the costs of asbestos compensation in the absence of a trust fund are diverse. Generally, those costs are split in the first instance between insurers and defendants. Insurers include both

---

Perspectives on Four Programs, GAO–06-230 (Nov. 2005). GAO found that Black Lung and the Radiation Exposure Compensation Program had cost considerably more than projected, but that the National Vaccine Program and the Energy Employees Occupational Illness Compensation Program had not. *Id.* at 3-4, 41. The jury is still out on the Energy Employees program, however, because that program has seen an unexpected number of claims but has also denied more than expected and has a considerable backlog. Moreover, sometimes program costs increase because of changes in the program, and while changes of this kind matter, they do not discredit prior estimates based on different rules.

HeinOnline -- 12 Conn. Ins. L.J. 569 2005-2006

direct insurers and reinsurers, and at least some, like Equitas, are run-off entities with limited resources. Insurers also wrote different kinds of policies—for example, some adopted asbestos exclusions earlier than others and participated in the market at different times. They have widely different potential exposures to asbestos costs and liabilities.

The defendants are even more diverse. Generally speaking, defendants may be liable because of either products they made or sold, or premises they owned or operated.[158]

Products defendants include manufacturers and sellers of asbestos or asbestos containing products. The range of products that can give rise to asbestos liabilities is extremely wide. Asbestos was ubiquitous in the twentieth century, used in building insulation, electrical equipment, boilers, refractory bricks, valves, gaskets, brakes and clutches, mechanical equipment generally, grinding wheels, asbestos cement products, joint compound, and even paints. A few companies originally manufactured many of these products, but those central players have long since passed from the scene. What is left is a congeries of defendants in different industries—building products manufacturers such as Owens Illinois and USG, electrical equipment manufacturers like GE and Westinghouse (Viacom), valve and gasket manufacturers like Garlock, automobile parts manufacturers like Dana, and major automobile companies like General Motors or Ford. The list goes on and on. There simply is no "asbestos industry" any more, and defendants comprise a wide sampling of American industry generally.[159]

Moreover, different products differ in toxicity, in the amount of asbestos they contain, and in the ease with which they release breathable fibers or dust. Products defendants also vary a great deal in their insurance situation. Because product liability insurance policies generally have aggregate limits of coverage, products defendants tend to be fully or very nearly fully insured for a long time, and then to lose all or a major part of their insurance as they reach the limits of their various policies.

Premises defendants are also a mixed lot. They differ based on location and applicable state law, whether they have a long history of asbestos litigation or are relatively new to the litigation, their level of

158. There is a third significant category of asbestos defendant-companies that provided services related to asbestos in an allegedly negligent way. This category includes maintenance contractors such as Brown & Root (the Halliburton subsidiary) and installers of asbestos materials, such as ACandS.

159. The roster of potential defendants is even longer because products defendants include not only the manufacturers of asbestos products but also downstream sellers and distributors. *See* STEPHEN J. CARROLL ET AL., ASBESTOS LITIGATION, xxv-xxvi (2005).

HeinOnline -- 12 Conn. Ins. L.J. 570 2005-2006

knowledge historically about the hazards of asbestos, whether they are self insured, whether they are sophisticated, the degree to which they exercised control over asbestos contractors at their sites, and whether they maintained state of the art industrial hygiene (or environmental) standards.

Because of the heterogeneity among responsible parties, traditional ways of shifting costs to private industry, such as an excise tax, are exceedingly difficult, if not impossible, to design.[160] Thus, the FAIR Act had to devise allocation rules that would directly apportion costs. This, however, has led to a Hobbesian struggle over allocation—between insurers and defendants, and within the insurer and defense "communities" —that made the life of the bill nasty and brutish, if not short.

2. The Search for an Allocation Principle

In the abstract, it would be reasonable to think that the burden of financing the FAIR Act should be borne by insurers and defendants in proportion to their responsibility for future costs in the tort system. Even this "future-cost" principle, however, is not universally accepted. For example, insurers and defendants have raised ability to pay or spreading of the loss as potential allocation principles. Insurers often argue that their relatively small share of overall costs ($46.025 billion) is justified because that burden must be borne by a relatively small number of companies (who implicitly could not stand more).[161] Some defendants have similarly argued for loss-spreading. For example, companies with historically heavy asbestos expenditures sometime argue that they have been bearing more than their fair share because they were easier targets for plaintiffs and that a fair allocation system would spread some part of the loss to others. Still other defendants have asserted an ability to pay principle, maintaining that they would go out of business if they had to pay full-freight under the

160. *See* BARTH, *supra* note 111, at 185-90 (discussing funding for the Black Lung trust fund).

161. According to insurance consultants Tillinghast Powers Perin, insurers are expected to pay $122 billion (or 61%) of the estimated $200 billion total cost (past and future) of asbestos litigation. *See The Fairness in Asbestos Injury Resolution Act: Hearing Before the S. Comm. on the Judiciary*, 108th Cong. (2003) (statement of Jennifer L. Biggs, Principal, Tillinghast Towers Perin). Under the FAIR Act, insurers would buy 33% of the dollars in on a nominal basis, and about 45% on a present value basis. To be sure, eventually particular defendants will hit the limit of product liability coverage, so the insurance share should go down with time. But, on the other hand, the plaintiffs' trial bar is expert at finding new defendants with as yet untapped coverage or defendants with general liability insurance, which has no aggregate policy limits. It is by no means certain that the insurer share in the tort system will dramatically shrink any time soon.

HeinOnline -- 12 Conn. Ins. L.J. 571 2005-2006

FAIR Act. Indeed, the fear that the bill would put small companies out of business was a major problem when the bill was considered on the floor.[162]

While the theoretical objections to the future-cost principle are important, far more important is the fact that *it is practically impossible to determine how the future cost of asbestos compensation would be distributed among defendants or insurers.* A fundamental characteristic of asbestos litigation is its dynamism and unpredictability.[163] In the past, new players have been drawn into asbestos litigation as traditional players succumbed to bankruptcy and left a funding gap that the plaintiffs' trial bar attempted to fill. In this sense, asbestos litigation is *not* a mature mass tort, but rather a tort in transition, where defendants are highly uncertain as to whether or not they would be engulfed by the spreading litigation. It has been notoriously difficult to predict the future asbestos costs even of the core defendants; contested bankruptcy estimation procedures have had to reconcile extremely divergent estimates from various experts.[164] To predict how the course of the litigation might affect the less established players would be speculation, pure and simple.[165] The litigation's dynamism also affected the insurance side -- since new claims would come from different insured defendants (which affect insurers differently) and because the plaintiffs' trial bar would make every effort to find defendants with plenty of insurance (including an emphasis on premises defendants and others who would not have aggregate products limits).

---

162. The problem of ability to pay is particularly severe under the FAIR Act, because some smaller defendants have very high past asbestos expenditures which were covered by insurance and which they never had to pay, and could not possibly have paid, themselves. In essence, these companies were being sued as conduits to their insurance policies.

163. See P. Hanlon & A. Smetak, *Asbestos Changes*, 61 NYU ANN. SURVEY OF AMERICAN LAW (forthcoming 2006).

164. *See, e.g.,* In re Federal Mogul Global, Inc., 330 B.R. 133 (Bankr. D. Del. 2005); Owens Corning v. Credit Suisse First Boston Corp., 322 B.R. 719 (Bankr. D. Del. 2005), *reh'g denied*, 2005 Lexis 10752 (Bankr. D. Del. Apr. 13, 2006); In re Eagle Picher Indus, 189 B.R. 681 (Bankr. S.D. Ohio 1995)..

165. As a practical matter, predicting what a company's future expenditures will be is hard to keep separate from an inquiry into what they ought to be. New defendants always have what they consider to be defensible products—often because those products give rise to very little exposure, at least compared to the insulation materials that first fueled the asbestos litigation. On the other hand, other companies that had a low-dose defense—for example, USG, which made joint compound with very small levels of asbestos in it—have found themselves overwhelmed with claims and forced into Chapter 11. The truth is, no one can tell *ex ante* whether a product will be easily defensible or not, or whether a product that gives rise to little liability in 2006 would do so in 2011. Defendants will obviously be inclined to read the tea leaves their own way.

HeinOnline -- 12 Conn. Ins. L.J. 572 2005-2006

A further complication involves insurance coverage. According to the future-cost principle, every defendant would pay into the system an amount equal to its expected responsibility for asbestos costs, net of insurance (the assumption being that the insurers' direct payment would make up the difference). But figuring out a defendant's future insurance situation is exceedingly difficult. In the first place, defendants and insurers often disagree on whether and how much coverage exists. The Administrator of the program could not reasonably be expected to resolve such disputes. Moreover, insurance coverage does not exist in the abstract. Different policies, covering different periods, have different policy limits, and many defendants will have retained some portion of the risk. Unscrambling all this for hundreds of companies is simply impractical.

Realizing the difficulties, proponents of taking insurance into account have suggested looking at a defendant's past liabilities, net of insurance. That, however, turns the future-cost principle on its head. As noted above, since product liability insurance has aggregate caps, a defendant will typically have a high level of coverage right up to the time it rolls off the cliff and has none at all. A company's past asbestos costs net of insurance are simply not an indicator of its future asbestos costs, net of insurance. On the contrary, a low level of net-of-insurance costs in the past could be an indicator that a defendant is fast exhausting its policy limits and will have very high net costs in the future.

Finally, the future-costs principle cannot be limited to direct asbestos compensation costs. Asbestos litigation involves "collateral damage," especially to defendant companies. In particular, at least since 2002 capital markets have often been closed to companies that Wall Street considers "tainted" by asbestos, and this secondary effect is, for many companies, a bigger problem than the cost of the litigation itself. The FAIR Act is designed to provide a much higher level of certainty about each company's asbestos expenditures, and that certainty, in turn, is expected to ease the problem of financing business operations. Insurance companies do not fully share that interest in certainty, and various defendants share it in different degrees. The special value that many defendants place on certainty is one of the reasons why the FAIR Act was funded disproportionately by defendants.

HeinOnline -- 12 Conn. Ins. L.J. 573 2005-2006

3. Muddling Through

In the absence of a metric that would allow Congress to design a rational and practical allocation system, the FAIR Act attempts to muddle through. Its allocation of costs between defendants and insurers is based almost entirely on political considerations. Although a strong argument can be made that the insurer share should be higher, with most of the insurance industry against the bill already, it seems unrealistic to expect added funding from that source.

The allocation system for defendants involves rough justice—but whether the roughness or the justice predominates depends a great deal on one's situation. At the outset, the system allocates 20% of the defendant contributions to the companies who happen to be in Chapter 11, who therefore must pay either much too much or much too little, depending on how one looks at it.[166] It then groups companies into tiers based on "prior asbestos expenditures"—a measure of a defendant's *past* participation in the tort system—and into subtiers, based on ability to pay (measured, again very roughly, by gross revenues).

Those are the rules. By themselves, they were insufficient from both a policy and a political perspective, and so the bill had two major exceptions. From the very beginning it was recognized that the FAIR Act could not be allowed to force any company out of business, and thus the Administrator was authorized from the beginning to provide an individualized hardship adjustment. That adjustment was liberalized in the markup of S. 852, and Senator Jon Kyl (R-AZ) was on the Senate floor proposing a further refinement when the point of order was raised that ultimately derailed the bill.

---

166. This point is illustrated by USG. USG is a moderate sized defendant in Chapter 11, with gross sales of about $3.5 billion in 2002 (the measuring year under the Act). Its annual payment under the FAIR Act would be approximately $57 million per year, making it the third largest contributor on the defendant side, behind Owens Corning and Federal Mogul. By contrast, the highest contribution made by companies not in Chapter 11 would be $27.5 million per year. Companies paying that rate would include some giants of U.S. industry like Exxon Mobil, GE, Dow, and Honeywell. It is hard to explain why a company like USG should pay almost twice as much as these much larger companies, all with extensive prior experience in the tort system. On the other hand, USG has reached an agreement in its Chapter 11 case that would require it to pay $900 million if the FAIR Act passes in 2006 and another $3 billion if it does not. Opponents of the bill have seized on that disparity to suggest that USG would pay too little under the Act (and others would pay too much). *See Group: USG Deal Exposes FAIR's Multibillion-Dollar Windfall* 5 MEALEY'S ASBESTOS BANKRUPTCY REPORT 16 (2006) (the "Group" cited is the "Coalition for Asbestos Reform," an entity largely funded by major insurance companies and the oil industry that purports to speak for small and mid-sized asbestos defendants).

HeinOnline -- 12 Conn. Ins. L.J. 574 2005-2006

The other main issue recognized from the outset was the potential unfairness to some companies of basing their contributions to the Fund on their prior asbestos expenditures even though those expenditures had been covered by insurance and insurance coverage was solid as far as the eye could see. Again, the bill from the beginning had a provision for an "inequity" adjustment from the beginning, which was intended to address just this situation. The amount available under the inequity provision was capped, however, and companies who thought they would qualify for it preferred up-front relief, by rule, without having to compete for a limited fund in an administrative proceeding.[167]

This basic system attempts to balance several different possible principles of allocation while at the same time keeping the structure at least reasonably administrable. As the bill has proceeded through Congress, the allocation scheme has grown more complicated in an effort to balance other interests:

- "Prior asbestos expenditures," which determine a company's tier, are defined to include only expenditures made prior to the end of 2002. This tends to favor the companies that were just beginning to be drawn into the asbestos litigation after the bankruptcies of 2001-2002. Using the 2002 cut-off date effectively recognizes the uncertainty of predicting a company's future involvement in asbestos litigation based on its experience over a short period, and it also indirectly takes into account that fact that new defendants tend to be more richly insured.
- Small businesses are exempt from any contributions at all. This, again, indirectly takes into consideration the allocation of insurance assets, since small businesses are typically sued as a conduit to their insurance policies.

---

167. The Kyl amendment would have capped the amount that smaller and mid-sized companies would have to pay under the Act and would have liberalized and removed the statutory cap from hardship adjustments. Between the per se relief offered by the cap and the liberalized case specific relief offered through the hardship process, the bill would have addressed all reasonable complaints based on ability to pay. *See* Amend. 2754, 152 CONG. REC. S1035 (daily ed. Feb 9, 2006). The Kyl amendment was incorporated into S. 3274 in May 2006. *See* S. 3274, §§ 204(a)(2),(d)(2) & 152 Cong. Rec. S. 5356 (daily ed. May 26, 2006) (statement by Sen. Specter).

S. 3274 also contains a provision that caps the payment of smaller, generally well-insured companies, in Tier II – which is a major step toward providing the clear and predictable inequity relief that some opponents of S. 852 sought. S. 3274, § 204(d)(4). It also prioritized claims for inequity relief in an effort to recognize insurance coverage and to reduce the burden on premises defendants. *Id.* § 204(d)(3)(B).

HeinOnline -- 12 Conn. Ins. L.J. 575 2005-2006

- Companies may seek inequity relief if they have spent millions in defense but not a penny in tribute. Presumably, the rationale is that a defendant in this situation is really innocent, and it would be unfair to require a contribution based just on the amount of defense costs that the company is saving under the bill.
- Companies that are involved in asbestos litigation based solely on their brief ownership of an asbestos manufacturer are entitled to inequity relief.[168]
- A special tier (Tier VI) has been created to provide special treatment for companies whose liabilities are based on FELA and the Jones Act, in both cases based ostensibly on the future costs principle.

The foregoing list of exceptions and special situations, though no doubt exhausting, is not by any means exhaustive. The defendant funding scheme simply bristles with such provisions. And, notwithstanding all of this, many defendants continue to claim that they are paying too much, and that others are paying too little. In the absence of a divine Administrator, this is not a solvable problem. All Congress can do is try to devise an allocation system that is reasonably tolerable, knowing that it will never be wholly coherent and will always be found wanting on the basis of some principle of justice. The FAIR Act was a valiant attempt—at least as to defendants—but it fell short.

With respect to insurers, the FAIR Act was not a valiant attempt, but an abdication. The process for allocation set forth in the bill—a two step system whereby a Commission will determine allocation methodology and then apply it to individual carriers—would take years to complete, and no adequate system for interim payments was provided. Moreover, this delegation to the Commission did not make insurers any more comfortable. On the contrary, the insurers continually reassured Congress that they would work out a voluntary allocation scheme of their own if the bill were ever to pass, since no one would want the commission to have the power that the FAIR Act gave it. At the end of the day, insurance industry opposition to the FAIR Act was motivated at least in part by anxiety over how the allocation process would work out in practice. While less visible,

168. This provision, which recognizes the special situation of Crown Cork, is partly based on a sense of the unfairness of imposing huge liabilities on a company based on such a small connection with the trade in asbestos, and partly based on the future cost principle, since Crown Cork had been successful in securing legislation in several states recognizing its special equity claims. See Mark A. Behrens, *Successor Asbestos-Related Liability Fairness Act*, 7 ALEC POLICY FORUM 18 (Spring 2005).

HeinOnline -- 12 Conn. Ins. L.J. 576 2005-2006

the strain of allocation within the insurance committee was as powerful a force undermining support for the bill as the similar discontent within the defendant community.

E. WHAT SHOULD HAPPEN IF PROGRAM FUNDING IS NOT ENOUGH?

As we have seen, under the FAIR Act the administrative compensation program will sunset if it runs out of money. Although today this solution appears to be the only one available, the initial version of the FAIR Act (S. 1125, introduced by Senator Orrin Hatch in 2003) did not have a sunset provision, and when one was added on the motion of Senator Joseph Biden (D-DE) in the Judiciary Committee markup in July of that year, it was almost immediately greeted as a poison pill.

In fact, the Biden amendment was a poison pill, because it was designed to bring about the dissolution of the program based on criteria that did not necessarily measure the long-term health of the Fund. But the amendment was approved unanimously by the committee for a good reason: it provided the only plausible answer to the question, "What do you do if there just isn't enough money?"

There are only three possible answers to that question. The first is that taxpayers will make good the shortfall. I have had conversations with outstanding economists, both conservative and liberal, who argue that as a matter of public policy, the burden of asbestos compensation should fall on the public generally rather than on an arbitrary selection of companies that happened to be left holding the bag when the music stopped. Whether these economists are right or wrong, not one of them has a seat in the United States Senate. The one thing that is *not* controversial about the FAIR Act is that it must be 100% privately financed. Skeptical Democrats and Republicans vie with each other to raise the specter of a taxpayer bailout of the program, but if there is any sitting senator who would favor such a thing, he or she has yet to speak up.

The second possibility is that the claimants would (as a group) take less. That is what would have happened under the FAIR Act as originally introduced, and it was the preferred solution for defendants and insurers yearning for finality. But that solution, too, is a fantasy. No one thinks that Congress would really deny compensation to people who are sick and dying from asbestos or reduce their awards to keep to a budget. This is the scenario that most worries senators who purport to fear an eventual Federal takeover of the program.

HeinOnline -- 12 Conn. Ins. L.J. 577 2005-2006

The third possibility would be to look to defendants and insurers for increased funding if there is an increased demand for funds. Another non-starter. That would be a complete negation of any certainty, and defendant and insurer support for the FAIR Act has always been premised on a cap in the overall amount of payments into the Fund. Moreover, many defendants and insurers believe that if the Administrator ran out of money, it would be because the eligibility criteria have allowed too many unsupportable claims, and no one is interested in being locked into a runaway system of that kind. Before the adoption of the sunset idea, defendants seriously discussed among themselves and with Senate staff ingenious ways of binding the hands of future Congresses to prevent changes in the funding formula. Sunset, once they got used to the idea, provided the solution to this insoluble problem.

If survival of the program requires imposing additional costs on claimants, defendants and insurers, or the taxpayers, and if it is a political non-starter to require any of those groups to pick up the tab, it follows that the program just can't continue. The question is not whether the program would have to sunset, but how it would be done and what the consequences would be.

Under S. 852, the Administrator must terminate the program if he determines that he cannot pay out all claims at 100 cents on the dollar and still pay the program's debt service and other obligations. This is a mandatory duty.[169] The Administrator is required, however, to do everything possible to see from afar the approach of the fatal day, to figure out why things are going wrong, and to formulate solutions and recommend them to Congress. If the program is fundamentally sound and merely needs a mid-course correction, surely it would be better to fix it than throw it away.

That leaves important questions about the consequences of sunset. The fundamental question is whether plaintiffs and defendants will go back to the same tort system they left when the bill was enacted. The AFL-CIO has consistently maintained that reversion should be to the *status quo ante*—if a trust fund doesn't work, we should all go back to where we started and puzzle things out again. Some insurers and defendants feel that their $140 billion will have been spent in vain if they had to go back to the same broken tort system that led them to seek relief from the Congress in

169. In the Managers' Amendment proposed by Senators Specter and Leahy, the decision whether to terminate the program would be taken away from the Administrator and given to the Chief Financial Office of the Labor Department. *See* Amend. 2746, 152 CONG. REC. S983. This amendment was designed to avoid the possibility that the Administrator might fail to terminate the program in a timely way because of his commitment to it.

HeinOnline -- 12 Conn. Ins. L.J. 578 2005-2006

the first place. Such defendants and insurers, and their allies in the Senate, have proposed the adoption of medical criteria to screen out unimpaired, venue reforms to control abusive forum shopping, and other tort reform members that would make the tort system a friendlier environment for defendants if sunset occurred.[170]

III. RECAPITULATION

When the Supreme Court endorsed a legislated administrative compensation system for asbestos victims as a "sensible solution" to the asbestos litigation morass, it cannot have understood just how hard that would be to achieve. The principle, after all, is simple. In general, an administrative compensation system should be cheaper, faster, and fairer than the tort system. But designing an actual administrative compensation scheme involved a tangle of problems that would put to shame the thicket protecting Sleeping Beauty's castle.

It was, of course, foreseeable that any effort to create an administrative claims processing scheme would be contested. Too many billions of dollars are at stake for legislative reform to be easy. Moreover, while asbestos litigation seems at first sight a dry subject, there is nothing dry about the pain of asbestos victims and their families, or the misery of people who lose their jobs because of asbestos bankruptcies, or the outrage against the evil practices of some asbestos defendants—and the abuses of some asbestos trial lawyers. Asbestos compensation is an emotional issue that stirs up deep passions.

These political concerns coalesced around substantive issues, some of which were unique to asbestos, but many of which would be raised by any attempt to substitute an administrative compensation system for the tort system. Moreover, these substantive issues turned out, on further inspection, to present problems that were not just due to different perceptions about facts but also different ideas about policy goals and even concepts.

In the end, the FAIR Act came to grief because of problems in addressing three overarching issues: cost, funding, and leakage. The cost issue ultimately came down to the problem of providing an appropriate amount of compensation to everyone who deserved it, while not providing

---

170. Senator Jeff Sessions (R-AL) proposed a number of amendments aimed at shaping the post-sunset tort system. *See* Amend. 2758, 152 CONG. REC. S1036 (daily ed. Feb. 9, 2006) (attorneys' fees); Amend. 2765, 152 CONG. REC. S1075 (daily ed. Feb. 10, 2006) (medical criteria), and Amend. 2766, 152 CONG. REC. S1075 (both medical criteria and attorneys' fees).

HeinOnline -- 12 Conn. Ins. L.J. 579 2005-2006

any to people who did not. This problem was a little easier to solve than might have been have been expected, because there was a consensus that no monetary compensation should go to people who were not impaired, and because the eligibility criteria for mesothelioma and the financially significant non-malignant disease categories were relatively uncontroversial. There were still several vexing difficulties. First, the bill had to walk a tightrope between over and under compensation. While every senator was concerned about the plight of the asbestos victim, many were also concerned to prevent the FAIR Act from becoming "a smokers' bill." This meant that there was no leeway in determining eligibility criteria—the bill had to get them just right. Second, it was hard to find an appropriate model for eligibility criteria in key categories such as lung cancer and other cancer. The settlement model provided imperfect guidance, and a medical model would necessarily founder on the sharp disagreement among experts on the criteria for attributing these cancers to asbestos. And third, at the end of the day, it was impossible to allay fears that the claims experience of the Fund would be very different from, and worse than, claiming in the tort system. As a result, even the CBO repeatedly stressed the uncertainty of all cost estimates, and everyone in the Senate must have had at least a residual fear that the cost of this program could get out of hand. With the fell image of Black Lung hovering above, this was an major source of anxiety for conservatives.

At least as important, in my view, was the problem of allocation of the financial burdens. If it had been politically acceptable to fund the FAIR Act through general taxation, it is highly likely that other issues would have been resolved. But Federal funding was and remains absolutely out of the question—it is dangerously heretical even to mention it—and that meant that some way of allocating costs between insurers and defendants and within each group had to be found. The initial allocation between insurers and defendants was political and left defendants, at least, with the sense that insurers were picking up too little of the tab, and defendants too much. That feeling exacerbated the conflicts within the defendant participant community. The defendant allocation scheme was specific, but it could not be justified on any clear principle of fairness, and the list of special amendments to give groups of companies, or sometimes single companies, a financial break, was in effect a long and lengthening indictment of the underlying allocation structure. It is not clear that the FAIR Act could have done better. In some ways it was most remarkable that the bill got as far as it did with such a rickety funding structure. My point is just that the inherent difficulties of allocating costs in the absence of an accepted allocation principle (not to mention basic information about the past or any

HeinOnline -- 12 Conn. Ins. L.J. 580 2005-2006

clear picture of the future) meant that the FAIR Act faced long odds from the beginning.

The same picture emerges even more clearly from a consideration of insurer allocation. The insurers were unable to agree on any allocation method, and so encouraged Congress to create a bill in which the entire insurer funding scheme was to be a placeholder pending an agreement among carriers that gave no signs of actually happening. Moreover, unlike defendants who guaranteed that their contributions would meet the bill's funding requirements, the insurers obtained provisions in the bill that would reduce their overall obligation if a carrier were unable to pay or excused from paying.

The third leg of our triangle of critical issues was "leakage." The leakage problem was not, primarily, a matter of breach of exclusivity during the pendency of the program.[171] The main problem was leakage during the transition from the tort system to the administrative compensation system created by the Fund. It was here that the interest of claimants in prompt compensation (or, sometimes, in keeping their place in the court queue) was most sharply in conflict with the interest of defendants and insurers to rid themselves of the asbestos litigation burden once and for all. This conflict, moreover, was fueled on the defendant-insurer side, at least, by a profound distrust of the plaintiffs' trial lawyers, who, it was feared, would game the system to keep as many cases in court as they could.

The leadership, hard work, creativity, and bargaining that brought the FAIR Act to the brink of success in the Senate was a tremendous accomplishment. Even had the bill succeeded, however, much more work would have lain ahead as it worked its way through the House. Understanding how many and how deep the problems were both makes the controversy about the bill more intelligible and helps one appreciate all of the progress that was made.

But now we are back where the Supreme Court was when it decided *Amchem*. We know, as Justice Ginsburg did, that an administrative compensation program would be a sensible solution to the problems of asbestos litigation. But we also know, as she perhaps did not, just how hard it is to get there from here. While we reflect on the experience of the FAIR Act over the last three years and wonder what next, new asbestos claims are being filed by the tens of thousands, the likelihood of a new

171. A partial exception would be workers' compensation subrogation, which did not allow asbestos claimants out of the system, but did provide, in effect, additional compensation outside the system (compared to the *status quo*) for claimants within the system.

HeinOnline -- 12 Conn. Ins. L.J. 581 2005-2006

wave of bankruptcies is high, claimants with serious disease will inevitably face a future in which it is hard to find a solvent defendant to sue, and the asbestos litigation tragedy will continue. Many defendants and some insurers hope that state tort reform will help control asbestos claims, and perhaps it will. That would be good for them. It is not so clear that it would be good for claimants. And, of course, state tort reform efforts could fail, leaving everyone in the morass that exists today.

HeinOnline -- 12 Conn. Ins. L.J. 582 2005-2006

ANOREXIA KILLED HER, BUT THE SYSTEM FAILED HER: DOES THE AMERICAN INSURANCE SYSTEM SUFFER FROM ANOREXIA?

Beth A. Brunalli[*]

TABLE OF CONTENTS

INTRODUCTION 584

I. ANOREXIA NERVOSA: A PHYSICAL ILLNESS OR A MENTAL ILLNESS? 587
A. SYMPTOMS OF ANOREXIA NERVOSA 588
B. ORIGINS OF ANOREXIA NERVOSA 589
C. TREATMENT OF ANOREXIA NERVOSA 591

II. PRIVATE HEALTH INSURANCE & ANOREXIA NERVOSA 591
A. THE PRIVATE INSURANCE INDUSTRY 592
B. ADVENT OF THE MENTAL ILLNESS LIMITATIONS 594
1. Background 594
2. The Mental Illness Limitations: Anorexia Nervosa 595
3. Effects of the Mental Illness Limitations with Respect to Anorexia Nervosa 597
4. Court Interpretations of Mental Illness Limitations 598
C. PARITY LEGISLATION: IN GENERAL 600
D. FEDERAL PARITY LEGISLATION 602
1. Precursor Legislation 603
2. The Mental Health Parity Act of 1996 605
3. Is the Paul Wellstone Amendment a Solution? 607
E. MENTAL HEALTH PARITY LEGISLATION IN THE FIFTY STATES 610
1. States without Enacted Mental Health Parity Legislation 611
2. States with Enacted Mental Health Parity Legislation 612

---

* Candidate for Juris Doctor, University of Connecticut School of Law, 2007; Bachelor of Arts, University of Notre Dame, 2001.

HeinOnline -- 12 Conn. Ins. L.J. 583 2005-2006

a. States with parity legislation excluding anorexia nervosa 612
b. States with parity legislation that neither clearly includes nor excludes anorexia nervosa 615
c. States with parity legislation including anorexia nervosa 616
3. Effectiveness of State Enacted Mental Health Parity Legislation for Providing Sufficient Treatment 620

III. PUBLIC HEALTH INSURANCE & ANOREXIA NERVOSA 622
A. PUBLIC HEALTH INSURANCE 622
1. Medicaid 623
2. SCHIP Programs 625

IV. THE UNINSURED & ANOREXIA NERVOSA 626

CONCLUSION 627

INTRODUCTION

After years of struggling with anorexia nervosa, twenty-one year old Anna Westin took her own life by overdosing on Tylenol.[1] Anna felt like a burden to her family; she was not only ill, but also responsible for expensive financial costs to her family.[2] These financial costs arose when the Westin's insurance company refused to continue covering the necessary treatments for Anna's anorexia, leaving the Westins to finance approximately $20,000 worth of treatment.[3] After Anna's death, Mrs.

1. Tom Majeski, *Family's Tragedy Turns to Hope: Parents who Lost a Daughter to Anorexia Use a $1 Million Settlement to Finance a Treatment Center for People with Eating Disorders*, ST. PAUL PIONEER PRESS, July 6, 2001, at A1, *available at* http://www.annawestinfoundation.org/pioneerplanetarticle.htm. Anna Westin was sixteen years old when she was first diagnosed with anorexia. *Id.*

2. Alex Tresniowski & Margaret Nelson, *For the Love of Anna: Their Daughter Lost Her Struggle Against Anorexia, but Kitty and Mark Westin Fought a Landmark Battle Against Her Insurer that Could Help Save Thousands Like Her*, PEOPLE, Oct. 8, 2001, at 114, *available at* http://eatingdisorderresources.com/peoplemag/100801fortheloveofanna.htm.

3. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 584 2005-2006

Westin remarked that "[a]norexia killed her . . . [b]ut the system failed her."[4]

The story of the Westins, although unique in its details, is not an isolated incident. Anorexia nervosa has reached epidemic proportions in the United States,[5] and its absolute incidence has increased in recent decades.[6] While affecting approximately 2.5 million Americans,[7] anorexia nervosa afflicts predominately females and adolescents.[8] This potentially fatal illness is the leading cause of death in females between the ages of fifteen and twenty-four, and is the deadliest illness in comparison to all mental illnesses.[9] In addition to having an increased risk of death, individuals suffering from anorexia, like Anna Westin, are seventy-five times more likely to commit suicide.[10]

---

4. Majeski, *supra* note 1.

5. *E.g.*, Peggy Goetz, *Anorexia is Not Normal, but is Epidemic*, IRVINE WORLD NEWS, May 9, 2002, http://216.173.246.226/Bstories/may9/anorexia2.html (stating that anorexia nervosa first reached epidemic proportions in the 1970s); Barbara F. Meltz, *Don't Dismiss Signs of a Possible Eating Disorder*, BOSTON GLOBE, Jan. 18, 2001, at H3 (stating that a Public Broadcasting Service NOVA program, "Dying to be Thin," called anorexia nervosa an "alarming epidemic"); Carol Lawson, *Anorexia: It's Not a New Disease*, N.Y. TIMES, Dec. 8, 1985, at A93.

6. *E.g.*, Martin Fisher et al., *Eating Disorders in Adolescents: A Background Paper*, 16 J. ADOLESCENT HEALTH 420, 420 (1995); A.H. Whitaker, *An Epidemiological Study of Anorectic and Bulimic Symptoms in Adolescent Girls: Implications for Pediatricians*, 21 PEDIATRIC ANNALS 752, 752-59 (1992); A.R. Lucas et al., *50-Year Trends in the Incidence of Anorexia Nervosa in Rochester, Minn.: A Population-Based Study*, 148 AM. J. PSYCHIATRY 917, 917-22 (1991). *But see* Hans Wijbrand Hoek & Daphne van Hoeken, *Review of the Prevalence and Incidence of Eating Disorders*, 34 INT'L J. EATING DISORDERS 383, 383-96 (2003) (concluding that the incidence rate increased over the past century until the 1970s based upon one reported study in the United States and several reported studies in Western Europe).

7. Peg Tyre, *Fighting Anorexia: No One to Blame*, NEWSWEEK, Dec. 5, 2005, at 54, *available at* http://www.msnbc.msn.com/id/10219756/site/newsweek.

8. Rebecca Dresser, *Feeding the Hunger Artists: Legal Issues in Treating Anorexia Nervosa*, 1984 WIS. L. REV. 297, 300-01 (1984). Approximately eighty-five to ninety-five percent of those afflicted with anorexia are females, and about 0.5 to 3.7 percent of females suffer from anorexia nervosa in their lifetime. MELISSA SPEARING, NAT'L INST. OF MENTAL HEALTH, EATING DISORDERS: FACTS ABOUT EATING DISORDERS AND THE SEARCH FOR SOLUTIONS (2001), http://www.nimh.nih.gov/publicat/NIMHeatingdisorder.pdf. The incidence rates are highest for females between the ages of fifteen and nineteen, with this age group experiencing about forty percent of identified cases. Hoek & van Hoeken, *supra* note 6, at 388. However, the age of the youngest anorexia patients has declined to eight years old. Tyre, *supra* note 7, at 52.

9. Lyn Patrick, *Eating Disorders: A Review of the Literature with Emphasis on Medical Complications and Clinical Nutrition*, 7 ALTERNATIVE MED. REV. 184, 184 (2002).

10. *The Promoting Healthy Eating Behaviors in Youth Age of 2002 as part of a Women's Omnibus Health Bill: Hearing on Women's Health Before the Subcomm. on Public*

HeinOnline -- 12 Conn. Ins. L.J. 585 2005-2006

A full course of treatment is essential to a patient achieving recovery, but health insurance rarely provides comprehensive coverage for the treatment of anorexia nervosa. Studies show that proper treatment of anorexia nervosa requires inpatient treatment until the individual is close to his or her ideal body weight.[11] Until patients reach ninety percent of their ideal body weight, psychiatric medications are ineffective and the rate of relapse or readmission doubles.[12]

Due to the severe limitations written into insurance policies for the treatment of anorexia nervosa, it is necessary for the individuals with anorexia, either individually or in conjunction with their families, to finance on average $80,000 worth of treatment, which represents nearly two-thirds of the cost for complete treatment per incident.[13] As a result, patients must make a difficult choice between privately paying for the remainder of the expensive treatment and abandoning necessary treatment.[14] Since the advent of the limited insurance coverage for the treatment of anorexia, the relapse or readmission rate for anorexia nervosa has increased from ten percent to thirty-three percent.[15] This perpetuating cycle of illness not only places more patients in a continued life-threatening situation, but also exerts increased financial burdens upon the patients, their families, employers, and insurers.

Health and the S. Health, Education, Labor and Pension Comm. 107th Cong. (2002) [hereinafter *Hearing on Promoting Healthy Eating*] (prepared statement by the Eating Disorders Coalition for Research, Policy & Action), *available at* http://help.senate.gov/Hearings/2002_04_25_a/EatingDisorders.pdf.

11. William T. Howard et al., *Predictors of Success or Failure of Transition to Day Hospital Treatment for Inpatients with Anorexia Nervosa*, 156 AM. J. PSYCHIATRY 1697, 1701-02 (1999) (presenting the results of a study that the percentage of normal body weight at the time of inpatient discharge is a key predicator of treatment outcome and recommending weight restoration of individuals to, at the minimum, close to ninety percent of their ideal body weight); *see* William N. Davis, Ph.D., FAED, Renfrew Ctr. Found., The Revolving Door in Residential Treatment at the Congressional Briefing on Eating Disorder Treatments: Rarely Covered Health Care (July 15, 2003), http://www.eatingdisorders coalition.org/congbriefings/July2003/July%2015%202003%20William.htm (last visited Jan. 22, 2006).

12. Sam Menaged, Eating Disorders Coal., Removing the Obstacles to Accessing Care at the House Briefing on the Dangers of Eating Disorders and the Need for Health Care Reform (April 2001), http://www.eatingdisorderscoalition.org/congbriefings/042401/house briefing042401.html#menaged (last visited Jan. 22, 2006).

13. *See* Leah Litman, *Starving for Treatment: Insurance Companies Refuse to Cover Eating Disorders*, PERSP., Nov. 2002, http://www.digitas.harvard.edu/~perspy/issues/2002/nov/leah.html (last visited Jan. 22, 2006).

14. OFFICE OF THE N.Y. STATE ATT'Y GEN., FOCUS ON: EATING DISORDERS 3 (2004), *available at* http://www.oag.state.ny.us/press/2004/feb/feb26a_04_attach.pdf.

15. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 586 2005-2006

This Comment will consider the failure of the American insurance system to provide adequate coverage for the treatment of anorexia nervosa. Insurers write coverage limitations into insurance policies for the treatment of anorexia nervosa based upon their classification of anorexia nervosa as a mental illness, and Part I of this Comment will discuss the extent to which anorexia nervosa is actually a mental illness or a physical illness. Part II will examine the private insurance market. This examination will discuss the advent of mental illness limitations on the treatment of anorexia nervosa written into private insurance policies, court interpretations of these mental illness limitations, and the legislative responses in the form of federal and state mental health parity legislation. Following this discussion of the private insurance market, Part III will examine the public insurance market, particularly the coverage provided by Medicaid and the State Children's Health Insurance Program ("SCHIP"). After examining the insurance coverage provided to the insured for anorexia nervosa in Parts II and III, Part IV will address the problem of the uninsured and anorexia nervosa.

I. ANOREXIA NERVOSA: A PHYSICAL ILLNESS OR A MENTAL ILLNESS?

The severe limitations on insurance coverage for the treatment of anorexia nervosa are based upon the insurers' classification of the eating disorder as a mental illness rather than as a physical illness.[16] Although commonly referred to as a mental illness, it is ambiguous whether anorexia nervosa is a mental illness or a physical illness. Illnesses are commonly classified as physical or mental on the basis of the symptoms, the origin, or the treatment of the illness.[17] Regardless of the conceptual approach utilized, anorexia nervosa lies somewhere between an entirely mental illness and an entirely physical illness.

---

16. *See* Emily Sohn, *The Hunger Artists: Are Genes and Brain Chemistry at the Root of Eating Disorders?*, U.S. NEWS & WORLD REP., June 10, 2002, at 45, *available at* http://www.usnews.com/usnews/health/articles/020610/archive_021599.htm.

17. The psychiatric community classifies mental illnesses based upon symptoms, in terms of the patient's description as well as the clinical features. Defining Mental Illness: An Interview with a Mayo Clinic Specialist, http://www.mayoclinic.com/health/mental-health/HQ01078 (last visited on Feb. 19, 2006). In contrast, the legal community classifies mental illnesses based upon either the symptoms, the origins, or the treatment depending upon the jurisdiction. Youndy C. Cook, Comment, *Messing With Our Minds: The Mental Illness Limitation in Health Insurance*, 50 U. MIAMI L. REV. 345, 348-49 (1996) (describing these three approaches to classifying illnesses adopted by the courts).

HeinOnline -- 12 Conn. Ins. L.J. 587 2005-2006

A. SYMPTOMS OF ANOREXIA NERVOSA

The symptoms of anorexia nervosa are neither entirely physical nor entirely mental. Anorexia nervosa is diagnosed based upon physical as well as mental symptoms.[18] There are two physical symptoms used for diagnosis: (1) body weight at or below a minimally normal weight for age and height,[19] and (2) amenorrhea in women, which is the absence of at least three consecutive menstrual cycles.[20] Likewise, there are two mental symptoms for diagnosis: (1) an intense fear of gaining weight or becoming fat,[21] and (2) a distortion of body image.[22]

Beyond the symptoms for the diagnosis of anorexia nervosa, the eating disorder results in both physical and psychological consequences. The physical consequences of anorexia nervosa manifest throughout the entire body system and absent effective treatment can be severe, permanent, and deadly.[23] Potentially irreversible physical consequences include growth retardation, osteoporosis, structural abnormalities to the brain, and infertility.[24]

Anorexia nervosa is not only associated with serious physical consequences, but also psychological morbidity.[25] In addition to causing an intense fear of being fat and body image distortion, anorexia nervosa is

---

18. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 539-45 (4th ed. 2000).

19. *Id.* The typical benchmark is weight loss resulting in a body weight less than eighty-five percent of the expected body weight for height, age, and body type. *Id.*

20. *Id. But see* S.F. Abraham et al., *Usefulness of Amenorrhea in the Disgnoses of Eating Disorder Patients*, 26 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 211, 211-15 (2005) (concluding that there is insufficient evidence to support usage of amenorrhea as a criterion for any eating disorder based upon the finding that menstrual disturbance is not limited to anorexia nervosa and other eating disorders).

21. AM. PSYCHIATRIC ASS'N, *supra* note 18.

22. *Id.*

23. *See* Ellen S. Rome et al., *Children and Adolescents with Eating Disorders: The State of the Art*, 111 PEDIATRICS 98, 102 (2003); Neville H. Golden et al., *Eating Disorders in Adolescents: Position Paper of the Society for Adolescent Medicine*, 33 J. ADOLESCENT HEALTH 496, 496-97 (2003). Among the most common physical consequences are constipation, hair loss, fatigue, muscle loss, growth of lanugos, cardiac and pulmonary irregularities that produce a risk of heart failure, severe dehydration that produces a risk of kidney problems, brain abnormalities, and osteoporosis that produces an increased risk of broken bones and fractures. Fisher et al., *supra* note 6, at 422-25 (1995); Ellen Haller, *Eating Disorders: A Review and Update*, 157 W. J. MED. 658, 659 (1992).

24. Golden et al., *supra* note 23; *Hearing on Promoting Healthy Eating*, *supra* note 10.

25. *See, e.g.*, Golden et al., *supra* note 23, at 497.

HeinOnline -- 12 Conn. Ins. L.J. 588 2005-2006

often comorbid with other psychiatric conditions.[26] For instance, there is a fifty to eighty percent lifetime incidence of affective disorders, especially depression, and a thirty to sixty-five percent lifetime incidence of anxiety disorders, such as obsessive-compulsive disorder,[27] among those treated for anorexia nervosa.

B. ORIGINS OF ANOREXIA NERVOSA

There is no known specific etiology for anorexia nervosa.[28] Current theories view anorexia nervosa as a multifactor disorder of complex biopsychosocial issues with a final common symptom pattern.[29] In other words, anorexia is believed to have both a physical component based upon genetics and a mental component based upon individual psychology and the social environment.[30]

The physical origin of anorexia nervosa lies in the individual's genetic makeup. Researchers have utilized both family studies and twin studies to detect a genetic component of anorexia.[31] Family studies have shown that anorexia nervosa is substantially familial, with the disorder statistically more common among family members than the general population.[32] Given the difficulty in isolating genetics in family studies, the results of twin studies are even more important.[33] Twin studies show that familial aggregation is significantly influenced by additive genetic effects, which are the cumulative effects of many genes, each having a different degree of

---

26. *Id.*; Hans-Christoph Steinhausen, *The Outcome of Anorexia Nervosa in the 20th Century*, 159 AM. J. PSYCHIATRY 1284, 1286 (2002).

27. Golden et al., *supra* note 23, at 497.

28. *E.g.*, Steinhausen, *supra* note 26, at 1284; Rome et al., *supra* note 23, at 98.

29. Rome et al., *supra* note 23, at 98.

30. *Id.*

31. *See* Cynthia M. Bulik, *Exploring the Gene-Environment Nexus in Eating Disorders*, 30 J. PSYCHIATRY NEUROSCIENCE 335, 335-36 (2005).

32. Lisa R. Lilenfeld et al., *A Controlled Family Study of Anorexia Nervosa and Bulimia Nervosa*, 55 ARCHIVES GEN. PSYCHIATRY 603, 605-07 (1998). The manifestation of eating disorders in family members occurs on a spectrum from subthreshold forms, such as eating disorders not otherwise specified, to full blown eating disorders. *Id.*

33. Patrick, *supra* note 9, at 186.

HeinOnline -- 12 Conn. Ins. L.J. 589 2005-2006

an effect.[34] Estimates of heritability are still imprecise, but estimates range from thirty-three to eighty-four percent.[35]

Despite evidence of a biological component to anorexia nervosa, the social environment and individual psychology are still thought to play an important role in the onset of anorexia nervosa. Common personality traits are perfectionism[36] and low self-esteem.[37] Individuals with anorexia nervosa tend to be good students and excellent athletes,[38] yet they have unrealistic expectations of themselves.[39] In spite of their achievements, they feel inadequate and worthless.[40] This psychological disposition makes these individuals particularly sensitive to our nation's obsession with dieting and the ideal of thinness.[41] A primary symptom of anorexia is fear of being overweight, which is largely rooted in the knowledge that society discriminates against overweight people.[42] Dieting and the media are believed to be the primary causes of eating disorders by the majority of Americans.[43] More importantly, there is evidence that dieting can trigger anorexia nervosa in genetically predisposed individuals,[44] and that there is a correlation between increased incidence of anorexia and increased diet-related articles and advertisements in women's magazines.[45]

---

34. E.E. Walters & K.S. Kendler, *Anorexia Nervosa and Anorexic-Like Syndromes in a Population-Based Female Twin Sample*, 152 AM. J. PSYCHIATRY 64, 64-71 (1995); Bulik, *supra* note 31, at 336.

35. Bulik, *supra* note 31, at 336 (arguing that consistent replication across samples and across countries, regardless of different strategies, supports that there is some critical genetic component to anorexia nervosa).

36. Kalam Sutandar-Pinnock et al., *Perfectionism in Anorexia Nervosa: A 6-24-Month Follow-Up Study*, 33 INT'L J. EATING DISORDERS 225, 228 (2003); *Anorexia Nervosa: Study Analyzes Perfectionism among Women with Eating Disorder*, WOMEN'S HEALTH WKLY., Jan. 30, 2003, at 4.

37. Nat'l Alliance on Mental Health, About Mental Illness: Anorexia Nervosa (2003), http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=7409 (last visited Jan. 22, 2006).

38. *Id.*

39. Anorexia Nervosa & Related Eating Disorders, Inc., What Causes Eating Disorders? (Nov. 2005), http://www.anred.com/causes.html (last visited Jan. 22, 2006).

40. *Id.*

41. Tyre, *supra* note 7.

42. Katherine Mayer, Note, *An Unjust War: The Case Against the Government's War on Obesity*, 92 GEO. L.J. 999, 1016 (2004).

43. GLOBAL MARKET INST., INC., AMERICAN PUBLIC OPINION ON EATING DISORDERS 6 (2005), *available at* http://www.gmi-mr.com/gmipoll/docs/NEDA_Briefing.pdf.

44. *Treatment Center Reports Dieting Can Trigger Genetically Based Eating Disorders*, OBESITY FITNESS & WELLNESS WK., Oct. 15, 2005, at 544, *available at* 2005 WLNR 16232738.

45. Cheryl B. Preston, *Significant Bits and Pieces: Learning From Fashion Magazines About Violence Against Women*, 9 UCLA WOMEN'S L.J. 1, 67 (1998).

HeinOnline -- 12 Conn. Ins. L.J. 590 2005-2006

C. TREATMENT OF ANOREXIA NERVOSA

Similar to its symptoms, the treatment of anorexia nervosa is neither entirely a medical treatment for a physical illness nor entirely a psychological treatment for a mental illness. The complex biopsychosocial issues underlying anorexia should be and typically are addressed by an interdisciplinary team consisting of medical, nutritional, and mental health professionals.[46]

Emphasizing the dichotomy in the treatment of anorexia nervosa are the two published treatment guidelines.[47] One guideline, which is published by the American Psychiatric Association, emphasizes the psychiatric perspective.[48] Treatment according to accepted psychiatric practice involves cognitive and behavioral individual therapy related to weight and the underlying psychological issues as well as family counseling.[49] In contrast, the second guideline, which is published by the Society for Adolescent Medicine, focuses on the treatment of the specific medical problems.[50] Medical treatment is necessary for the physical symptoms of anorexia nervosa, such as malnutrition, osteoporosis, and growth retardation.[51]

II. PRIVATE HEALTH INSURANCE & ANOREXIA NERVOSA

Despite the lack of clarity as to whether anorexia nervosa is a mental or physical illness, insurers classify anorexia as a mental illness.[52] Consequently, when insurers started to include greater coverage limitations for the treatment of mental illnesses in the policies they sell to employers, individuals with anorexia nervosa were adversely affected. However, the adverse effects extend beyond the patient and the patient's family, to both insurers and employers.

This part will first explore the private insurance market and then, the advent of the mental illness limitations in private insurance policies as well as their adverse effects. The organizations advocating for greater insurance coverage of anorexia nervosa have pursued and continue to actively pursue

---

46. Golden et al., *supra* note 23, at 497; Fisher et al., *supra* note 6, at 429.

47. Rome et al., *supra* note 23, at 103.

48. *Id.*

49. Katherine A. Halmi, *Complicated Process: Diagnosing and Treating Anorexia Nervosa and Bulimia*, 22 PSYCHIATRIC TIMES 59, 61 (2005).

50. Rome et al., *supra* note 23, at 103.

51. Halmi, *supra* note 49; Fisher et al., *supra* note 6, at 422.

52. *See* Sohn, *supra* note 16.

HeinOnline -- 12 Conn. Ins. L.J. 591 2005-2006

the enactment of mental health parity legislation on both the federal and state levels.[53] This part will also examine the limited achievements of federal and state parity legislation as well as whether these pursuits can accomplish what the advocacy groups seek to achieve.

A. THE PRIVATE INSURANCE INDUSTRY

Private health insurance consists of individual insurance, union sponsored health benefit plans, and employer-sponsored health benefit plans,[54] but employment-based health benefit plans dominate the private health insurance market.[55] Most Americans, including the majority of adolescents, are covered by employment-based health benefit plans.[56] Although the provision of an employment-based health benefit plan is a common expectation of American workers, there is no legal obligation for an employer to provide such a health benefit plan.[57]

The provision of employment-based health benefit plans to employees occurs through either "insured" plans or "self-insured" plans.[58] An employer utilizing an insured plan purchases the health insurance coverage for the employees as a group from a third party,[59] which today is typically a

---

53. *See* Nat'l Mental Health Ass'n, 361 Organizations Supporting Parity, http://www.nmha.org/state/parity/organizations.cfm (last visited Jan. 22, 2006).

54. CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, PUBL'N NO. 60-229, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004 16 (2005), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf.

55. *Id.*

56. *Id.* In 2004, 59.8% of the population was covered by employment-based health insurance whereas 60.4% was covered in 2003. *Id.*

57. *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 402 (2002) (Thomas, J., dissenting) (reminding that "no employer is required to provide any health benefit plan under ERISA"); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) (stating that the ERISA does not mandate employers to provide any particular benefits to employees). Due to several events, health benefits became a common and cost-effective method to increase employee compensation. Anne Maltz, *Health Insurance 101*, *in* INSURANCE LAW 2005: UNDERSTANDING THE ABC'S, at 354, 361 (PLI Litig. & Admin. Practice, Course Handbook Series No. 6011, 2005). Prior to World War II labor unions advocated for employment based health insurance, but not until the provision of employee health benefits became a method to compete for scarce workers during World War II by circumventing wage controls did employers start to provide and to increase employee health benefits. *Id.* Employer sponsored health benefits, as an alternative method of compensating employees, gained support through favorable federal tax treatment. *Id.*

58. *See* Elizabeth S. Boison, Comment, *Mental Health Parity For Children and Adolescents: How Private Insurance Discrimination and ERISA Have Kept American Youth From Getting the Treatment They Need*, 13 AM. U. J. GENDER SOC. POL'Y & L. 187, 196 (2005).

59. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 592 2005-2006

managed care company.[60] In contrast, an employer utilizing a self-insured plan provides the funding for the medical claims.[61] While the employer self-funds the claims under a self-insured plan, the employer will typically purchase stop-loss insurance, which protects the employment-based health benefit plan from catastrophic medical care claims in a given year.[62] In the last decade, more than half of all employees with employment-based health benefits have been covered by self-insured plans.[63]

Whether an insured or self-insured plan, employment-based health benefit plans are employee benefit plans[64] and consequently, are within the scope of the regulatory scheme enacted by the Employment Retirement Income Security Act of 1974 ("ERISA").[65] Although the preemption clause of the ERISA prohibits all state laws that "relate to" employee benefit plans,[66] two other clauses in the ERISA create a two-tiered regulatory scheme for health insurance benefit plans. While one clause, which is the savings clause, exempts from preemption all state laws that "regulate[] insurance,"[67] the deemer clause prevents such state laws regulating insurance from extending to self-insured employment health benefit plans.[68] Under this two-tiered regulatory scheme insured employment health benefit plans, but not self-insured employment health

---

60. Harriette B. Fox et al., *Private Health Insurance for Adolescents: Is It Adequate?*, 32 J. ADOLESCENT HEALTH 12, 12 (2003). In 2000, ninety-two percent of employees covered by an employer-based health benefit plan were enrolled in managed care plans. *Id.*

61. Maltz, *supra* note 57, at 363; Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 110 (2005).

62. Korobkin, *supra* note 61, at 110-11 (2005).

63. *Id.* at 109. A report in 2003 by the Kaiser Family Foundation stated that fifty-two percent of workers with an employment-based health benefit plan are covered by a self-insured plan and an earlier study by KPMG indicated that fifty-six percent of employees with an employment-based health plan are covered by a self-insured plan. *Id.*

64. Any program providing benefits for contingencies, such as illness, accident, disability, or death, is an "employee welfare benefit plan," which is one type of employee benefit plan. 29 U.S.C. § 1002(1), (3) (2000).

65. *See generally id.* §§ 1001-1461; Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90-91 (1983) (discussing the subjection of employee benefit plans to federal regulation under ERISA).

66. *See* 29 U.S.C. § 1144(a) (stating that the ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan . . .").

67. *See id.* § 1144(b)(2)(A) (providing that "nothing . . . shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . .").

68. *See id.* § 1144(b)(2)(B) (stating that employee benefit plans "shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ").

HeinOnline -- 12 Conn. Ins. L.J. 593 2005-2006

benefit plans, must comply with state as well as federal insurance regulations, such as those mandating protections for covered employees like mental health parity legislation.[69] Thus, employers providing a self-insured employment health benefit plan only need their plans to be in compliance with the mental health benefits mandated by federal legislation under the ERISA.[70] Yet, when Congress enacted the ERISA the language was almost void of substantive requirements concerning the content of employee health benefit plans.[71]

B. ADVENT OF THE MENTAL ILLNESS LIMITATIONS

1. Background

In the absence of substantive requirements under the ERISA for mental health parity and the increased costs of health care, most insured became uninsured or underinsured for certain conditions or types of care, such as mental illness.[72] This is due to insurers using health insurance policies with greater restrictions and limitations on mental illnesses to reduce health care costs.[73] In addition to articulating cost containment as a reason for limiting mental health benefits, insurers make arguments for limited mental health coverage that are based upon the relative subjectivity of mental health treatment.[74] By the 1990s, the majority of employer-sponsored health benefit plans that contained coverage for mental health services were written to provide this coverage on a more limited basis than coverage for medical services.[75]

The mental illness limitations written into insurance policies cap mental health benefits at levels far below those for physical or surgical

---

69. Korobkin, *supra* note 61, at 90.

70. *See* Boison, *supra* note 58, at 203.

71. *See* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983). ERISA contains formal requirements in terms of judicial remedies, procedural requirements for internal claims, and administrative requirements. *See* 29 U.S.C. §§ 1021-31, 1104, 1132 (2000). However, these provisions regulate only the form, not the substance, of employee health benefit plans. *See* Edward A. Zelinksy, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443, 446-47 (2003).

72. Rome et al., *supra* note 23, at 105; Cook, *supra* note 17, at 345.

73. C. Geoffrey Weirich & Ashoo K. Sharma, *Tracking the Path to Parity Between Mental and Physical Health Benefits*, 17 LAB. LAW. 469, 469-70 (2002).

74. Cook, *supra* note 17, at 346.

75. Dana L. Kaplan, *Can Legislation Alone Solve America's Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 329 (2005).

HeinOnline -- 12 Conn. Ins. L.J. 594 2005-2006

conditions.[76] These limitations take the form of treatment and fiscal limitations on either an annual or a lifetime basis.[77] Treatment limitations include limitations on the number of days of hospitalization, inpatient treatment, or outpatient visits for mental health care.[78] The plans also impose lower annual or lifetime financial coverage maximums for mental health care,[79] and impose fiscal stipulations such as cost-sharing arrangements, as observed in higher deductibles and higher copayments for mental illnesses.[80]

2. The Mental Illness Limitations: Anorexia Nervosa

Since the advent of the restrictive coverage for mental health services pursuant to the mental health limitations written into policies, the length of covered treatment for anorexia nervosa has changed drastically. This is illustrated by the average length of hospitalization, inpatient treatment, or residential treatment covered by insurers being fifty days prior to the advent of these limitations,[81] but typically only ten to fifteen days after the advent of these limitations.[82]

Mental health limitations are written into the policies by insurers as treatment stipulations, financial stipulations, and more burdensome cost-sharing arrangements. Treatment stipulations severely limit access to covered care, whether the treatment is inpatient, outpatient, or nutritional. Treatment stipulations typically include insurers offering only ten to fifteen days for hospitalization, residential, and inpatient treatment,[83] ten to fifteen sessions for outpatient treatment,[84] and merely one nutritional visit annually.[85] This limited amount of covered treatment for anorexia nervosa conflicts with the American Psychiatric Association's treatment guidelines for the disorder.[86] This dichotomy is illustrated by the typical anorexic

---

76. Cook, *supra* note 17, at 347. This discrepancy is demonstrated by a contested plan in one case, which provided 120 days of hospitalization annually for medical treatment, but only thirty days of hospital care annually for psychiatric treatment. Simon v. Blue Cross & Blue Shield of Greater N.Y., 536 N.Y.S.2d 431, 431-32 (N.Y. App. Div. 1989).

77. *See* Weirich & Sharma, *supra* note 73, at 470; Kaplan, *supra* note 75, at 328.

78. *See* Weirich & Sharma, *supra* note 73, at 470; Kaplan, *supra* note 75, at 328.

79. Weirich & Sharma, *supra* note 73, at 470; Kaplan, *supra* note 75, at 328.

80. Kaplan, *supra* note 75, at 328.

81. Menaged, *supra* note 12.

82. *Hearing on Promoting Healthy Eating*, *supra* note 10.

83. *Id.*

84. Litman, *supra* note 13.

85. Golden et al., *supra* note 23, at 499.

86. *See* AM. PSYCHIATRIC ASS'N, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH EATING DISORDERS 14-16, 29-40 (2d ed. 2000), *available at*

HeinOnline -- 12 Conn. Ins. L.J. 595 2005-2006

individual requiring more than six weeks of inpatient therapy, hospitalization, or residential treatment as well as lengthy follow-up outpatient care to achieve recovery.[87]

When utilizing financial stipulations, either alone or in conjunction with treatment stipulations, the amount covered by insurers falls far short of the estimated treatment costs. The Ohio Department of Health estimates that the cost of inpatient treatment is about $100,000 and the cost of outpatient treatment is around $30,000 per incident of the disorder, but insurers often cap their coverage at $40,000 for inpatient care and $10,000 for outpatient care.[88] This means that the patient or the patient's parents must finance on average $80,000 of care, which is nearly two-thirds of the cost of the treatment, per incident of the disorder. This is in stark contrast to the out-of-pocket expense of only $1,800 that a family would pay for the treatment of a physical injury with $60,000 of expenses.[89] Moreover, even prior to the exhaustion of insurance coverage, individuals with anorexia are more likely to encounter higher cost-sharing arrangements, such as deductibles and copayments, than individuals with a physical illness.[90]

---

http://www.psych.org/psych_pract/treatg/pg/Practice%20Guidelines8904/EatingDisorders_2e.pdf. For example, the American Psychiatric Association ("APA") emphasizes that the risk of relapse decreases the closer the patient is to ideal weight at the time of discharge, and recommends controlled weight gain of patients at a rate of two to three pounds per week for most inpatient programs and a half to one pound per week for most outpatient programs to avoid compromising the patient's safety. *Id.* at 15, 30-31. Given that anorexia nervosa by definition is weight loss of at least fifteen percent of ideal weight, see *supra* note 19, restoration of ideal body weight at the APA's recommended rate cannot be achieved in ten to fifteen days unless the patient's ideal body weight is forty pounds.

87. *Hearing on Promoting Healthy Eating*, *supra* note 10.

88. Litman, *supra* note 13.

89. U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 427 (1999), *available at* http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c6.pdf. This suggests that a family would only pay $3,900 out-of-pocket for a physical treatment expense of $130,000.

90. U.S. GEN. ACCOUNTING OFFICE, PUBL'N NO. GAO/HEHS-00-95, MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED 6 (2000), *available at* http://www.gao.gov/archive/2000/he00095.pdf.

HeinOnline -- 12 Conn. Ins. L.J. 596 2005-2006

3. Effects of the Mental Illness Limitations with Respect to Anorexia Nervosa

When insurance coverage is exhausted, patients are left with the difficult choice of privately paying for the remainder of the expensive treatment or abandoning necessary treatment.[91] Regardless of the decision, there are serious consequences. Families that manage to finance the treatment must typically resort to drastic financial measures, such as home re-mortgaging.[92] Even after undertaking these drastic measures, these families and individuals are left with tremendous medical bills[93] that may result in total financial ruin.[94] Further, the effect of the financially distressed family can be destructive on the patient's recovery as it was for Anna Westin.[95]

Despite the efforts of individuals and families to do everything possible to finance the remaining treatment, the financial burden is often prohibitive. As a result, the majority of patients receiving inpatient treatment are now discharged long before achieving their ideal body weight.[96] As discussed previously, discharge prior to achieving this threshold weight results in a doubled likelihood of relapse or readmission.[97] Not surprisingly, the rate of relapse or readmission has more than doubled since the proliferation of mental illness limitations.[98]

This perpetuating cycle of illness that is caused by inadequate treatment affects the patient and the patient's family. Most importantly, more patients are continually in a life-threatening situation or what will become a life-threatening situation. In a survey of eating disorder specialists, not only did all of the specialists believe that their patients are suffering relapses as a consequence of coverage limits, but also virtually all

---

91. OFFICE OF THE N.Y. STATE ATT'Y GEN., *supra* note 14.

92. *Id.*

93. *Id.* For example, Donna Thompson's employer sponsored health benefit plan covered twenty therapy visits and twenty hospital days annually. Dara Mayers, *Eating Disorder Outrage*, GLAMOUR MAG., Nov. 2001. After battling anorexia for twenty years, Donna was $60,000 in debt from trying to finance the remainder of necessary treatments. *Id.* Still, due in part to the lack of treatment, Donna had not achieved recovery. *Id.*

94. Rome et al., *supra* note 23, at 105.

95. *Id.*; *see supra* text accompanying notes 1-2.

96. Lisa Berzins, Ph.D., Is that Real Vomit? A Clinician's Battle for Reimbursement at the Housing Briefing on A Matter of Life or Death: A Congressional Briefing on Eating Disorders and Access to Care (June 13, 2002), http://www.eatingdisorderscoalition.org/congbriefings/061302/housebriefing061302.html#berzins (last visited Jan. 22, 2006).

97. *See supra* text accompanying note 12.

98. Menaged, *supra* note 12.

of the specialists believed that patients are placed in life-threatening situations because of early discharge.[99]

Insurers themselves are financially affected by this perpetuating cycle of illness. The recycling of the chronically anorexic eventually leads to costly physical health consequences that can not be classified as mental illnesses, such as complications from osteoporosis, kidney problems, and cardiac episodes.[100] As noted by the President and CEO of the California Association of Health Plans, it would be more cost effective for insurers to treat anorexia then to fund the increased care and treatment costs that result from protracted anorexia, such as major medical complications.[101]

The effects of the mental illness limitations on the treatment of anorexia nervosa, however, reach further than just the patient, the patient's family, and the long term costs for the insurers. Employers are also affected by the loss in productivity caused by either the patients themselves or their parents being absent from work, and society is affected by an increased likelihood that an untreated individual will end up on disability due to being unable to work.[102]

4. Court Interpretations of Mental Illness Limitations

Courts play a role in granting access to treatment for anorexia nervosa by interpreting mental health provisions in insurance plans. Court involvement often arises when an aggrieved employee claims that his or her disability has been wrongly classified as a mental condition instead of a physical impairment.[103] This litigation is premised on the ERISA's cause of action for the improper denial of benefits under the terms of an employee benefit plan.[104]

---

99. *Hearing on Promoting Healthy Eating*, *supra* note 10.

100. *See* Rome et al., *supra* note 23, at 106 (stating that health care costs will increase when care will have eventually be delivered at a higher price under a different diagnosis, such as complications from osteoporosis); *see also supra* notes 23-24 and accompanying text.

101. Anne M. Peterson, *Eating Disorders: Is Your HMO Anorexic?*, PROLIX, May 8, 1998, http://www.danceart.com/prolix/AnorexicHMO.htm.

102. Menaged, *supra* note 12; *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 89, at 411-12 (discussing the $79 billion indirect costs that mental illnesses, in general, impose upon the economy of the United States).

103. Weirich & Sharma, *supra* note 73.

104. 29 U.S.C. § 1132(a)(1)(B) (2000) (stating that a civil action may be brought by a participant or a beneficiary "to recover benefits due to him under the terms of his plan"); *see e.g.*, Phillips v. Lincoln Nat'l Life Ins. Co., 774 F. Supp. 495, 496 (N.D. Ill. 1991).

HeinOnline -- 12 Conn. Ins. L.J. 598 2005-2006

The courts have adopted three approaches in making the physical-mental distinction. Not surprisingly, each approach focuses upon one of the three common conceptions of illnesses, which are the origins, symptoms, and treatment.[105] Depending upon the approach the court uses, individuals who suffer from the same disorder and are covered under similar insurance policies, may receive treatment in one jurisdiction, but not in another jurisdiction due to the court's classification of the disorder as a physical or mental illness.[106] The physical-mental distinction with respect to anorexia nervosa is far from clear[107] and thus, regardless of which approach a court adopts, the judicial decisions are prone to being inconsistent.

The primary court decision with respect to the coverage of anorexia nervosa is the decision of the Supreme Court of New York in *Simons v. Blue Cross & Blue Shield of Greater New York*.[108] In *Simons*, the plaintiff filed an action on behalf of his daughter to recover $60,000 in hospital costs associated with the treatment of anorexia nervosa.[109] The insurance policy offered 120 days of hospitalization annually for appropriate medical treatment, but the insurer had applied the thirty day annual limit of hospitalization for the treatment of psychiatric disorders.[110] The court found that medical treatment had been provided to alleviate her particular physical problem of malnutrition, and the treatment for malnutrition was the same regardless of the cause of the malnutrition.[111] Based on this logic, the court found that the plaintiff's insurance contract required the insurer to pay the benefits for the hospitalization.[112] Importantly, the court noted that psychological counseling did "not negate that the fundamental nature of the treatment" was medical.[113]

However, the holding in *Simons* has an important shortcoming. As an individual's treatment shifts to being more psychiatric in nature as physical

---

105. Cook, *supra* note 17 (describing the three approaches adopted by the courts).

106. *Compare* Ark. Blue Cross & Blue Shield v. Doe, 733 S.W.2d 429, 430-32 (Ark. Ct. App. 1987) (focusing on the origins of bipolar affective disorder to hold that bipolar disorder is a physical illness and as such is not subject to the mental illness limitation in the policyholder's plan), *with* Equitable Life Assurance v. Berry, 260 Cal. Rptr. 819, 824 (Cal. Ct. App. 1989) (focusing on the symptoms or the manifestations of bipolar disorder to hold that bipolar disorder is a mental illness and thus is not covered by the policyholder's plan).

107. *See supra* Part I.A-C.

108. Simon v. Blue Cross & Blue Shield of Greater N.Y., 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

109. *Id.* at 432.

110. *Id.*

111. *Id.* at 434-35.

112. *Id.* at 435.

113. *Id.* at 434.

HeinOnline -- 12 Conn. Ins. L.J. 599 2005-2006

weight begins to stabilize,[114] the fundamental nature of the treatment would shift to being psychological and the insurer would not be required to provide payment, even if the treatment is necessary to achieve recovery.

The occasion of litigating a claim on the grounds of an improper denial of coverage is not a viable solution for individuals and families confronted by truncated coverage in insurance policies for the treatment of anorexia nervosa. The potential for inconsistency and uncertainty in the judicial decisions affords the plaintiffs only limited prospects for gaining further access to or reimbursement for treatment.[115] Moreover, the cost associated with hiring counsel and litigating a claim may be prohibitively expensive and may deter potential plaintiffs from seeking relief from the courts.[116] Even without the uncertainties and financial costs of litigation, the disclosure of their personal history of self-starvation, which may include other psychological disorders and suicidal tendencies, on public record may inhibit individuals from seeking legal relief.[117] Given these risks, it is unsurprising that there have been only a limited number of reported cases litigating an improper denial of coverage for anorexia.

C. PARITY LEGISLATION: IN GENERAL

All mental health parity legislation[118] is not created equally. Moreover, the utilization of the term parity does not necessarily mean that true parity is established between the coverage provided for mental conditions and the coverage provided for physical conditions. This is because much of the enacted legislation concerning mental health parity still permits insurers to write varying rates, terms, and/or conditions into their policies with respect to the treatment of anorexia nervosa. To determine the extent of protection afforded to an individual with anorexia nervosa by any particular enactment of mental health parity legislation one must examine four elements of the mental health parity legislation. These four elements are: (1) the statutory definition of mental illness, (2) the type of benefit mandate in the legislation, (3) the terms and conditions that the legislation permits

---

114. Fisher et al., *supra* note 6, at 429.

115. *See supra* notes 104-105 and accompanying text.

116. Sara Noel, Comment, *Parity in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment Under the Mental Health Parity Act of 1996 and the Mental Health Equitable Treatment Act of 2001*, 26 HAMLINE L. REV. 377, 405 (2003).

117. *See id.*

118. Parity refers to the effort to treat mental health financing on the same basis as financing for general health services. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 89, at 424.

HeinOnline -- 12 Conn. Ins. L.J. 600 2005-2006

insurers to include within their policies, and (4) the exemptions from coverage under the parity legislation.

The first key element to determining whether anorexia nervosa receives any protection under the mental health parity legislation is the statutory definition of mental illness or mental health benefit. There generally exist four different types of statutory definitions of mental illness that are utilized in parity legislation on the federal and state levels. These are severe or serious mental illness, insurer defined mental illness, biologically-based mental illness, and diagnosable mental conditions as defined by the DSM or the ICD.[119] In most instances, anorexia nervosa is only clearly included under the statutory definition of mental illness when the parity legislation defines mental illness as the diagnosable mental conditions described in the DSM.[120]

The second element that must be observed to determine the extent of protection for anorexia nervosa under the parity legislation is the type of benefit mandate included for the mental health benefits. The three different types of benefit mandates are mandated-benefits, mandated-offering, and mandated-if-offered.[121] The most comprehensive is the mandated-benefit construction because it requires insurance plans to provide coverage that satisfies a minimum coverage standard for mental health.[122] A mandated-offering statute requires the insurance plan to merely offer mental health coverage to the plan members, with the purchase option under insured plans often left up to the employer rather than the individual employee.[123] The least comprehensive is the mandated-if-offered statute, which requires an employer to provide equal coverage for mental health services as for physical health services, but if and only if the employer decides to offer any mental health coverage in the insurance policy.[124] Consequently, when a mandated-if-offered statute is enacted, an insurer or employer can avoid the requirements of the parity legislation simply by omitting all coverage of mental illnesses from its insurance policy since there is no legal obligation that mental health services be provided.[125]

The third key element to determine the effectiveness of parity legislation examines the terms and conditions of coverage that an insurer may still legally write into insurance policies with respect to mental

119. *See infra* Part II.D-E.
120. *See infra* Part II.D-E.
121. Kaplan, *supra* note 75, at 351-52.
122. *Id.* at 351.
123. *Id.* at 352.
124. *Id.*
125. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 601 2005-2006

illnesses. While comprehensive parity legislation would require insurance policies to have the same terms and conditions for the coverage of anorexia nervosa as for physical illnesses,[126] less comprehensive parity legislation may still legally permit unequal terms and conditions for the coverage of anorexia nervosa including treatment stipulations, financial stipulations, and cost-sharing arrangements, such as deductibles and copayments.[127] All of these terms and conditions are often utilized by insurers to limit benefits for the treatment of anorexia.[128]

The fourth key element to determining the effectiveness of parity legislation is the exemptions contained within the parity legislation. There are two common exemptions in parity legislation. These are the small employer exemption and the cost increase exemption.[129] The small employer exemption permits employers with a workforce under a statutorily defined size, typically less than twenty-five or fifty employees, to be in noncompliance with the mental health parity legislation.[130] The cost increase exemption does not require compliance for employers that experience cost increases from the coverage of mental illnesses that result in total plan cost increases above a statutorily defined percentage, typically one or two percent.[131]

D. FEDERAL PARITY LEGISLATION

Congressional recognition of the parity issue between the coverage for mental and physical conditions in the 1990s has not translated into an automatic success for the individuals and organizations advocating for the coverage of eating disorders. The sole piece of federally enacted parity legislation, the Mental Health Parity Act of 1996 ("MHPA of 1996"),[132] fails to definitively provide insurance coverage for anorexia nervosa under the same rates, terms, and conditions as physical and surgical conditions.

---

126. *Id.* at 355.
127. *See infra* Part II.D.-E.
128. *See supra* Part II.B.2.
129. Kaplan, *supra* note 75, at 357-58.
130. *See infra* Part II.D.-E.
131. *See infra* Part II.D.-E.
132. Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, § 702 (codified as amended at 42 U.S.C. § 300gg-5; 29 U.S.C. § 1185a).

HeinOnline -- 12 Conn. Ins. L.J. 602 2005-2006

1. Precursor Legislation

The initial proposals for mental health parity were the Equitable Health Care for Severe Mental Illness Acts of 1992,[133] 1993,[134] and 1995,[135] with each piece of legislation including limited parity for only severe mental illnesses. Even though anorexia nervosa has the highest mortality rate of all mental illnesses,[136] each act failed to include anorexia nervosa within the statutory definition of severe mental illness[137] and anorexia nervosa was thus outside the scope of the legislation.

Although the Equitable Health Care for Severe Mental Illness Act of 1992 ("1992 Act") did not include a statutory definition of severe mental illness,[138] the drafting of the congressional findings in the 1992 Act indicates the congressional intent to define severe mental illnesses as only biologically-based mental illnesses. While biology is one factor in the etiology of anorexia nervosa,[139] the disorder is not commonly considered a biologically-based mental illness.[140] The intent to define severe mental illnesses as biologically-based mental illnesses under the 1992 Act is illustrated in the 1992 Act's eleventh congressional finding, which states, in

---

133. Equitable Health Care for Severe Mental Illness Act of 1992, S. 2696, 102d Cong. §§ 1-5 (1992). Senator Domenici, for himself and Senator Danforth, introduced the bill not only as a model plan, but also as a statement that Congress must consider severe mental illnesses as well as other severe illnesses when reforming health care). 138 CONG. REC. S6490, 6490 (1992).

134. Equitable Health Care for Severe Mental Illness Act of 1993, S. 671, 103d Cong. §§ 1-6 (1993). Senator Domenici, for himself and nine other senators, reintroduced the bill in 1993 to ensure that the issue of commensurate treatment for severe mental illnesses remained an important factor in the health care debate. 139 CONG. REC. S4017, 4018 (1993).

135. Equitable Health Care for Severe Mental Illness Act of 1995, S. 298, 104th Cong. §§ 1-6 (1995). Senator Domenici, for himself and Senator Wellstone, introduced the bill stating that its goal was to provide coverage of treatment for individuals with severe mental illnesses commensurate with the coverage of treatment for individuals with other diseases. 141 CONG. REC. S1848, 1848 (1995).

136. Patrick, *supra* note 9.

137. S. 2696, 102d Cong. §§ 1-5 (1992); S. 671, 103d Cong. § 6 (1993); S. 298, 104th Cong. § 6 (1995).

138. S. 2696, 138 CONG. REC. 6490-91 (1992).

139. *See supra* Part I.B.

140. *Mental Health Parity: Hearing Before the H. Comm. on Education and the Workforce*, 107th Cong. (2002) [hereinafter *Hearing on Mental Health Parity*] (statement of Lee Dixon, Group Director, Health Policy Tracking Service National Conference of State Legislatures) (stating that the biologically-based mental illnesses are most commonly considered to be schizophrenia, schizo-affective disorder, delusional disorder, bipolar disorders, major depression, panic disorder, paranoia, autism, and obsessive-compulsive disorders).

HeinOnline -- 12 Conn. Ins. L.J. 603 2005-2006

part, "severe mental illness, such as schizophrenia, depression, or manic depressive illness."[141] These are the only illnesses specifically listed in the congressional findings[142] and each is among the most commonly considered biologically-based mental illnesses.[143] Thus, this congressional finding in conjunction with the sixteenth congressional finding, which states that "both normal and abnormal structure and function of the brain has been learned . . . but millions of severely mentally ill people have yet to benefit from . . . advances in clinical and basic neuroscience,"[144] strongly indicates a congressional intent for the statutory definition to only encompass biological mental illnesses and consequently, to exclude anorexia nervosa.

This congressional intent to only provide parity for biologically-based mental illnesses was clarified in the subsequent Equitable Health Care for Severe Mental Illness Acts of 1993 and 1995. These two acts defined severe mental illness as "an illness that . . . includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder."[145] These statutory definitions included only those mental illnesses commonly considered to be biologically based.[146]

Even if Congress had succeeded in passing one of the Equitable Health Care for Severe Mental Illness Acts, the decision to define severe mental illness in terms of biologically-based mental illnesses would have deprived patients with anorexia nervosa of "health care coverage, whether provided through public or private health insurance . . . in a manner that is equitable and commensurate with that provided for other major physical illnesses."[147]

---

141. S. 2696, 102d Cong. § 2(11) (1992).

142. S. 2696, 102d Cong. § 2(1)-(18) (1992).

143. *See Hearing on Mental Health Parity, supra* note 140 (stating that the biologically-based mental illnesses are most commonly considered to be schizophrenia, schizo-affective disorder, delusional disorder, bipolar disorders, major depression, panic disorder, paranoia, autism, and obsessive-compulsive disorders).

144. S. 2696, 102d Cong. § 2(16) (1992).

145. S. 671, 103d Cong. § 6 (1993); S. 298, 104th Cong. § 6 (1995).

146. *See Hearing on Mental Health Parity, supra* note 140 (stating that the biologically-based mental illnesses are most commonly considered to be schizophrenia, schizo-affective disorder, delusional disorder, bipolar disorders, major depression, panic disorder, paranoia, autism, and obsessive-compulsive disorders).

147. S. 2696, 102d Cong. § 3(a)(2) (1992); S. 671, 103d Cong. § 3(a)(2) (1993); S. 298, 104th Cong. § 3(a)(2) (1995). To be equitable health care coverage under these bills, the coverage for the treatment of severe mental illnesses had to provided so that it "(1) is not more restrictive than coverage provided for other major physical illnesses[,] (2) provides adequate financial protection to persons requiring the medical treatment for severe mental

HeinOnline -- 12 Conn. Ins. L.J. 604 2005-2006

In other words, patients with anorexia nervosa would still have been legally subject to restrictive mental health limitations included in insurance policies.

2. The Mental Health Parity Act of 1996

The Mental Health Parity Act of 1996 is one of the recently enacted federal health benefits regulations amending the ERISA[148] and consequently, it is applicable to both insured employment-based health benefit plans and self-insured employment-based health benefit plans.[149] While the MHPA of 1996 applies to all employment-based health benefit plans, the legislation is limited and falls far short of establishing true parity for mental illnesses generally and for anorexia nervosa specifically.

A key limitation of the MHPA of 1996 is the very definition of a "mental health benefit" in the legislation.[150] Unlike the precursor legislation to the MHPA of 1996, the MHPA of 1996 does not exclude anorexia nervosa from the statutory definition of mental illness by defining that term biologically. However, the MHPA of 1996 still fails to definitely include anorexia nervosa in its definition of mental illness. Under the MHPA of 1996, the employer or insurer is allowed to define what constitutes a mental health benefit.[151] Thus, mental health benefits for the treatment of anorexia nervosa could be excluded from the Act's scope by the plan's definition of mental health services.[152]

A second problem with the MHPA of 1996 is the construction of the benefit mandate. In drafting the Act, Congress employed the least comprehensive benefit mandate type, the mandated-if-offered statutory construction. As previously discussed, this means the MHPA of 1996 does not require that any mental health benefits be either provided or offered as

---

illness[,] and (3) is consistent with effective and common methods of controlling health care costs for other major physical illnesses." S. 2696, 102d Cong. § 4(a) (1992); S. 671, 103d Cong. § 4 (1993); S. 298, 104th Cong. § 4 (1995).

148. *See* 29 U.S.C. § 1185a (2000).

149. *See supra* text accompanying notes 69-70.

150. 29 U.S.C. § 1185a(e)(4).

151. *See id.* A mental health benefit is a "benefit[] with respect to mental health services, as defined under the terms of the plan . . . ." *Id.*

152. Maggie D. Gold, Comment, *Must Insurers Treat All Illnesses Equally? Mental vs. Physical Illness: Congressional and Administrative Failure to End Limitations to and Exclusions From Coverage for Mental Illness in Employer-Provided Health Benefits Under the Mental Health Parity Act and the Americans with Disabilities Act*, 4 CONN. INS. L.J. 767, 784 (1997).

HeinOnline -- 12 Conn. Ins. L.J. 605 2005-2006

part of any employment-based health benefit plan.[153] Rather, the MHPA of 1996 only requires those employers voluntarily deciding to provide mental health benefits under their employment-based health benefit plans to comply with the Act.[154] Consequently, Congress created an incentive structure for employers not to provide benefits for anorexia nervosa, because additional financial burdens are placed only on those employers voluntarily including mental health benefits.

Even if an employer or insurer includes mental illness services for anorexia nervosa in its definition section thereby making those benefits subject to the MHPA of 1996, the legislation fails to provide true parity for the treatment of anorexia nervosa for two reasons.

First, the legislation only creates parity in terms of maximum annual and lifetime dollar limits.[155] Except for this imposition, the MHPA of 1996 expressly provides that it does not affect the "terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits."[156] Thus, private insurance plans and coverage may continue to restrict treatment for anorexia through treatment stipulations, such as providing only ten days of inpatient treatment annually, and through the provision of treatment at an increased financial burden to the insured by means of higher cost-sharing arrangements.[157]

---

153. *See* 29 U.S.C. § 1185a(b)(1) (providing that the MHPA of 1996 shall not be construed as requiring the provision of any mental health benefits by a group health plan or insurance coverage in connection with a group health plan).

154. *Compare* 29 U.S.C. § 1185a(b)(1) (2000) (providing that the MHPA of 1996 shall not be construed as requiring the provision of any mental health benefits by a group health plan or insurance coverage in connection with a group health plan), *with id.* § 1185a(b)(2) (providing a group health plan providing mental health benefits shall not be affected in its terms and conditions except as specifically required by subsection (a) of the MHPA of 1996), *id.* § 1185a(a)(1) (discussing parity in the application of aggregate lifetime limits in group health plans providing both medical benefits and mental health benefits), *and id.* § 1185a(a)(2) (discussing parity in the application of annual limits in group health plans providing both medical benefits and mental health benefits).

155. *See id.* § 1185a(a)(1)(A)-(C) (discussing lifetime limits); *id.* § 1185a(a)(2)(A)-(C) (discussing annual limits). A group health plan providing mental health benefits must establish no limit for all benefits, an inclusive limit for all benefits, or separate limits for mental health services that are no more restrictive than those for physical benefits. *Id.* § 1185a(a)(1)(A)-(B), (a)(2)(A)-(B). Otherwise, an average aggregate lifetime or annual limit will be applied to the plan. *Id.* § 1185a(a)(1)(C), a(a)(2)(C).

156. *Id.* § 1185a(b)(2).

157. *See supra* notes 84, 90. The U.S. General Accounting Office found that sixty-five percent of employers that changed annual or lifetime limits to comply with the MHPA of 1996 made another mental health feature of their plans more restrictive. U.S. GEN.

HeinOnline -- 12 Conn. Ins. L.J. 606 2005-2006

Second, the MHPA of 1996 fails to provide true parity because it includes two exemptions, one for small employers[158] and one for increased costs.[159] Through the small employer exemption, the MHPA of 1996 automatically exempts employers with fewer than fifty employees from scrutiny.[160] This means more than 32 million employees, nearly thirty percent of all U.S. workers, are outside the scope of the Act.[161] The increased cost exemption makes the MHPA of 1996 inapplicable if its application generates an increased cost to the health plan of one percent or more.[162]

The statutory provisions of the MHPA of 1996 including the definition of mental health benefit, the mandate type, the terms and conditions, and the exemptions indicate that this Act has had little impact in resolving the current restrictive mental health limitations for the treatment of anorexia nervosa under private insurance plans. This is a continuing problem for those with anorexia nervosa because Congress, due to its failure to pass new mental health parity legislation, has repeatedly extended the effective period of the MHPA of 1996 to the present time.[163]

3. Is the Paul Wellstone Amendment a Solution?

The most recent proposed legislation to amend the MHPA of 1996 is the Paul Wellstone Mental Health Equitable Treatment Act of 2005 ("Wellstone Amendment").[164]

ACCOUNTING OFFICE, *supra* note 90, at 13. While these employer health benefit plans most frequently made outpatient treatment and hospitalization more limited, increases in copayments and coinsurance were also common. *Id.*

158. 29 U.S.C. § 1185a(c)(1)(A)-(C) (2000).

159. *Id.* § 1185a(c)(2).

160. *Id.* § 1185a(c)(1)(A)-(B). A small employer, for purposes of the MHPA of 1996, is "an employer who employed an average of at least 2 but no more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year." *Id.* § 1185a(c)(1)(B).

161. *See* U.S. SMALL BUS. ADMIN., EMPLOYER FIRMS, ESTABLISHMENTS, EMPLOYMENT, ANNUAL PAYROLL AND RECEIPTS FOR SMALL FIRM SIZE CLASSES, 2003, http://www.sba.gov/advo/research/us_03ss.pdf.

162. 29 U.S.C. § 1185a(c)(2) (2000). The MHPA of 1996 is inapplicable to a group health plan or health insurance coverage offered in connection with such a plan "if the application . . . results in an increase in the cost under the plan (or such coverage) of at least 1 percent." *Id.*

163. Congress first extended the MHPA of 1996 to December 31, 2002 and then to December 31st of the subsequent years of 2003, 2004, 2005, and 2006.

164. Paul Wellstone Mental Health Equitable Treatment Act of 2005, H.R. 1402, 109th Cong. §§ 1-5 (2005).

HeinOnline -- 12 Conn. Ins. L.J. 607 2005-2006

There are three positive changes in the Wellstone Amendment as currently drafted. First, the Wellstone Amendment definitively includes anorexia nervosa in its statutory definition of a mental health benefit by defining a mental health benefit as "a benefit with respect to services, as defined under the terms and conditions of the plan or coverage, for all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR), or the most recent edition. . . ."[165] Since anorexia nervosa is included within the DSM-IV-TR,[166] services for anorexia nervosa are a mental health benefit under the Wellstone Amendment. A second positive change in the Wellstone Amendment is its more comprehensive regulation of the terms and conditions of coverage. The Wellstone Amendment increases the level of parity between the terms and conditions for the coverage of mental illnesses with those of physical illnesses by requiring the same financial stipulations, treatment limits, and cost-sharing arrangements.[167] The third positive change provided by the Wellstone Amendment is that no exemption is provided for increased cost to employers.[168]

These positive changes are somewhat limited by continued utilization of a mandated-if-offered construction and the small employer exemption. Since a mandated-if-offered construction is utilized by the Wellstone Amendment,[169] the Wellstone Amendment like the MHPA of 1996 does not require that mental health benefits either be provided or even offered as part of the employment-based health benefit plan.[170] Thus, parity is only required if the employer voluntarily offers mental health benefits. Moreover, the incentive for employers to exclude mental health benefits entirely will probably be greater under the Wellstone Amendment than

---

165. H.R. 1402 § 2(a)(f)(3). The Diagnostic and Statistical Manual of Mental Disorders is one of the two major diagnostic classification systems, with the other being International Statistical Classification of Diseases and Related Health Problems. Katherine Halmi, *Pscyhopathology of Anorexia Nervosa*, 37 INT'L J. EATING DISORDERS S20, S20 (2005).

166. *See* AM. PSYCHIATRIC ASS'N, *supra* note 18.

167. *See* H.R. 1402 §§ 2(a)(a), 3(a)(a).

168. *See* H.R. 1402 §§ 1-5.

169. *See* H.R. 1402 § 2(a)(b)(1), 3(a)(b)(1) (providing that the statutory language shall not "be construed as requiring a group health plan . . . to provide any mental health benefits").

170. Paul Wellstone Mental Health Equitable Treatment Act of 2005, H.R. 1402, 109th Cong. §§ 2(a), 3(a) (2005) (imposing parity only on those group health plans and coverage connected with those plans that "provide[] both medical and surgical benefits and mental health benefits," and stating that nothing shall be construed as requiring the provision of any mental health benefits by a group health plan and the insurance coverage offered in connection with such a plan).

HeinOnline -- 12 Conn. Ins. L.J. 608 2005-2006

under the MHPA of 1996. This is because an employer's costs to provide coverage for all DSM-IV-TR mental illnesses under the Wellstone Amendment[171] will presumably be greater than its costs to provide coverage for the mental illnesses that the employer specifically chooses to define as constituting a mental health benefit under the MHPA of 1996.[172] Also like the MHPA of 1996, the Wellstone Amendment contains a small employer exemption for employers with fewer than fifty employees.[173] Consequently, the Wellstone Amendment would perpetuate the problem of having nearly thirty percent of all U.S. workers deprived of the protections afforded by the legislation.[174]

Even if the improvements in the Wellstone Amendment are not carved out during the congressional process, there exist two primary reasons why the Wellstone Amendment would still fall short of providing the substantive requirements for employment-based health benefit plans in terms of the benefits for the treatment of anorexia nervosa sought by the organizations advocating for the coverage of eating disorders. First, despite the current draft of the Wellstone Amendment eliminating restrictive treatment stipulations, financial stipulation, and cost-sharing arrangements, the Wellstone Amendment would still permit other managed care practices, such as the application of medical necessity, to limit coverage.[175] While these general managed care practices serve an important function in containing costs for necessary treatments,[176] these practices can be inappropriately utilized to restrict access to care for anorexia nervosa.[177] Second, the Wellstone Amendment would fail to

171. *See supra* note 165 and accompanying text.

172. *See supra* notes 151-52 and accompanying text.

173. H.R. 1402 § 2(a)(c), 3(a)(c).

174. *See supra* note 161.

175. H.R. 1402, §§ 2(a)(a), 3(a)(b)(2) (providing that nothing shall be construed "to prevent the medical management of mental health benefits, including through . . . utilization review and utilization management practices, preauthorization, and the application of medical necessity and appropriateness criteria . . .").

176. *See Insurance Coverage of Mental Health Benefits: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 107th Cong. 39-76 (2002) (statement of Kay Nystul, Psychiatric Registered Nurse, Certified Case Manager, and Clinical Management Coordinator Wausau Benefits, Inc.).

177. For instance, in *State v. Blue Cross & Blue Shield of Minnesota*, the state alleged in part that Blue Cross and Blue Shield of Minnesota (BCBSM) unlawfully denied medically necessary eating disorder treatment. Amended Complaint at 1, State v. Blue Cross & Blue Shield of Minn. (D. Minn. 2000), *available at* http://www.ag.state.mn.us/consumer/pdf/news/ comp_bluecross_10300.pdf. It described how BCBSM denied coverage for Anna Westin's treatment for anorexia even though multiple physicians had warned that intensive treatment was essential to her restore her

protect all individuals suffering from anorexia nervosa because the amendment is essentially voluntary in nature due to the mandated-if-offered construction and because the amendment perpetuates the small employer exemption, which deprives nearly thirty percent of the U.S. workforce of any protection absent state enacted mental health parity legislation.[178]

E. MENTAL HEALTH PARITY LEGISLATION IN THE FIFTY STATES

Since the MHPA of 1996 only provides limited protection to individuals with anorexia nervosa and other mental illnesses, the legislatures of some states have decided to enact more protective mental health parity legislation. Considerable variance exists between the various states' mental health parity legislation,[179] but generally despite some states enacting legislation more protective of individuals with anorexia nervosa than the federal legislation, the amount of protection for anorexia nervosa provided by the states is still quite limited.[180]

State enacted mental health parity legislation contains two broad types of limitations. First, like the federal mental health parity legislation, limitations can exist in state enacted mental health parity legislation as a result of the statutory definition of mental illness, the type of benefit mandate, the terms and conditions permitted in the policies, and the exemptions contained in the legislation.[181] Second, unlike the federal mental health parity legislation, the two-tiered regulatory scheme under the ERISA prevents state enacted mental health parity legislation from applying to all employment-based health benefit plans.[182]

State enacted mental health parity legislation inherently does not apply to all employment-based health benefit plans because of the two-tiered regulatory scheme created by the ERISA. As previously discussed, under this two-tiered regulatory scheme insured plans, but not self-insured plans, must comply with state enacted insurance regulations in addition to federal

---

mental and physical health. *See id.* at 1, 10; *see also* The Anna Westin Foundation, http://www.annawestinfoundation.org/insurance.htm (last visited Jan. 22, 2006). The state eventually reached an $8.2 million settlement with BCBSM. Maura Lerner & Josephine Marcotty, *Blue Cross Settlement is Praised as Example*, STAR TRIB., June 20, 2001, at 1A, *available at* 2001 WLNR 10303012.

178. *See supra* notes 169-74 and accompanying text.

179. *Compare* 36 OKLA. STAT. ANN. tit. 36, §§ 6060.10-.13 (West Supp. 2006), *with* CONN. GEN. STAT. § 38a-514(a)-(l) (2005).

180. *See infra* Part II.E.3.

181. *See infra* Part II.E.1-.3.

182. *See supra* notes 67-70 and accompanying text.

HeinOnline -- 12 Conn. Ins. L.J. 610 2005-2006

insurance regulations.[183] While the MHPA of 1996 applies to all employment-based health benefit plans by amending the ERISA,[184] the state enacted mental health parity legislation applies only to insured plans and not to self-insured plans.[185] Since more than half of all employees with employment-based health benefits are covered by self-insured plans,[186] many employees will not benefit even if a state enacts more generous parity protection for the insurance coverage of anorexia nervosa than is federally mandated.

1. States without Enacted Mental Health Parity Legislation

The general trend of enacting mental health parity legislation has not been a uniform trend at the state level. Eight states including New York, which is one of the most populous states in the nation,[187] have failed to enact mental health parity legislation.[188] In these states, employment-based health benefit plans may still legally contain restrictive limitations to the coverage for anorexia nervosa except as prohibited by the federal mental health parity legislation,[189] but the federal legislation as previously discussed does little to reduce the restrictive limitations in regards to coverage for anorexia nervosa.[190]

---

183. *See supra* note 69 and accompanying text.

184. *See* 29 U.S.C. § 1185a (2000).

185. Kaplan, *supra* note 75, at 345.

186. Korobkin, *supra* note 61, at 109.

187. U.S. Census Bureau, State Rankings-Statistical Abstract of the United States: Resident Population-July 2005, http://www.census.gov/statab/ranks/rank01.html.

188. The eight states are Alaska, Idaho, Michigan, New York, Ohio, Oregon, Wisconsin, and Wyoming. *See* ALASKA STAT. § 21.54.100-.170 (2006); IDAHO CODE ANN. §§ 41-801 to 41-1846, 42-2201 to 41-2223 (1996 & Supp. 2002); MICH. COMP. LAWS SERV. § 500.3501-.3650 (LexisNexis 2001 & Supp. 2006); N.Y. INS. LAW §§ 3101 to 3113, 3201 to 3237 (McKinney 2005); OHIO REV. CODE ANN. § 3923.28 (LexisNexis 2002) (establishing only that a group policy providing coverage for mental or emotional disorders shall provide at least $500 annually for mental disorders without establishing parity); OR. REV. STAT. ANN. § 743.556(1), (6), (10), (12) (2005) (mandating minimum payment amounts treatment associated with a mental condition, but not establishing parity); WIS. STAT. ANN. § 632.89 (West 2004 & Supp. 2006) (mandating minimal amounts of coverage for the treatment of mental illnesses but not attempting to establish parity); WYO. STAT. ANN. §§ 26-15-101 to 26-15-136, 26-19-101 to 26-19-204 (LexisNexis 2005). *But see* 2005 Or. Law Ch. 705 (S.B. 1) (effective Jan. 1, 2007) (amending OR. REV. STAT. ANN. § 743.556 to create mental health parity legislation).

189. *See* 29 U.S.C. § 1185a(a)(1)-(2) (2000) (discussing parity in the application of aggregate lifetime and annual limits to mental health benefits in group health plans providing medical benefits and mental health benefits).

190. *See supra* Part II.D.2.

HeinOnline -- 12 Conn. Ins. L.J. 611 2005-2006

2. States with Enacted Mental Health Parity Legislation

As with federal mental health parity legislation, the statutory definition of mental illness included within any state enacted mental health parity legislation is critical to whether any protection is afforded to individuals with anorexia nervosa under the legislation. The variance in state enacted parity legislation reflects, in part, the on-going debate as to whether parity should be extended to all individuals with mental illnesses or limited to only a subset of mental illnesses. In almost half of the states with mental health parity legislation, the legislature has either clearly excluded or failed to clearly include anorexia nervosa in the statutory definition of mental illness.

a. States with parity legislation excluding anorexia nervosa

Anorexia nervosa is clearly excluded from the statutory definition of mental illness in the parity legislation of fifteen states.[191] Nine of these states statutorily define mental illness as biologically-based mental illnesses.[192] In each of these states biologically-based mental illnesses are limited to schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and obsessive compulsive disorder.[193] Six of these

191. The fifteen states are Colorado, Hawaii, Illinois, Iowa, Kansas, Massachusetts, Montana, Nebraska, Nevada, New Jersey, Oklahoma, South Carolina, South Dakota, Texas, and Virginia. *See* COLO. REV. STAT. ANN. § 10-16-104(5.5)(a)(II) (West 2006); HAW. REV. STAT. ANN. §§ 431M-1, 431M-5(c) (2005); 215 ILL. COMP. STAT. ANN. 5/370c(b)(2) (West Supp. 2006); IOWA CODE ANN. § 514C.22.3 (West Supp. 2006); KAN. STAT. ANN. § 40-2,105a(c) (Supp. 2005); MASS. GEN. LAWS ANN. ch. 176G § 4M(a) (West Supp. 2006); MONT. CODE ANN. §§ 33-22-702(4)(a)-(c), 33-22-703, 33-22-706 (2005); NEB. REV. STAT. ANN. § 44-792(5)(b) (2004); NEV. REV. STAT. ANN. § 689B.0359.8 (LexisNexis 2003); N.J. STAT. ANN. § 17B:27A-7.5.a. (West 2006); OKLA. STAT. ANN. tit. 36, § 6060.10.3 (West Supp. 2006); S.C. CODE ANN. § 38-71-290(B) (Supp. 2005); S.D. CODIFIED LAWS § 58-17-98 (2004); TEX. INS. CODE ANN. § 1355.001(1) (Vernon 2006); VA. CODE ANN. § 38.2-3412.1:01.E (2002 & Supp. 2006).

192. The nine states are Colorado, Iowa, Massachusetts, Nebraska, Nevada, New Jersey, Oklahoma, South Dakota, and Virginia. *See* COLO. REV. STAT. ANN. § 10-16-104(5.5)(a)(II) (West 2006); IOWA CODE ANN. § 514C.22.3. (West Supp. 2006); MASS. GEN. LAWS ANN. ch. 176G § 4M(a) (West Supp. 2006); NEB. REV. STAT. § 44-792(5)(b) (2004); NEV. REV. STAT. ANN. § 689B.0359.8 (LexisNexis 2003); N.J. STAT. ANN. § 17B:27A-7.5.a (West 2006); OKLA. STAT. ANN. tit. 36, § 6060.10.3 (West Supp. 2006); S.D. CODIFIED LAWS § 58-17-98 (2004); VA. CODE ANN. § 38.2-3412.1:01.E (2002 & Supp. 2006).

193. COLO. REV. STAT. ANN. § 10-16-104(5.5)(a)(II) (West 2006); IOWA CODE ANN. § 514C.22.3. (West Supp. 2006); MASS. GEN. LAWS ANN. ch. 176G § 4M(a) (West Supp. 2006); NEB. REV. STAT. ANN. § 44-792(5)(b) (2004); NEV. REV. STAT. ANN. § 689B.0359.8

HeinOnline -- 12 Conn. Ins. L.J. 612 2005-2006

states include panic disorder[194] and three of these states include several additional disorders within the definition of a biologically-based mental illness.[195] The failure of these state legislatures to include anorexia nervosa in the statutory definition of a mental illness bars individuals with anorexia nervosa from having the increased insurance coverage.

The Massachusetts mental health parity statute is representative of the state statutes using the biologically-based mental illness definition and is illustrative of the difficulties created for individuals seeking coverage for anorexia nervosa. The Massachusetts statute provides for "mental health benefits on a nondiscriminatory basis" for nine biologically-based mental illnesses.[196] This list of illnesses does not include anorexia nervosa.[197] This means that despite parity legislation employment-based health benefit plans within the state of Massachusetts can still legally impose mental health limitations with regards to the diagnosis and treatment of anorexia nervosa, except as these restrictive practices might conflict with the limited relief provided by the federal statute.

In addition to legislative amendment, the Massachusetts statute provides a general mechanism for the addition of disorders to the list of statutorily defined biologically-based mental disorders by providing that "any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance" may be added to the list of covered disorders.[198] Various organizations and individuals have invoked this provision and requested that the Commissioner of Mental Health designate eating disorders, such as anorexia, as biologically-based mental disorders under

---

(LexisNexis 2003); N.J. STAT. ANN. § 17B:27A-7.5.a. (West 2006); OKLA. STAT. ANN. tit. 36, § 6060.10.3 (West Supp. 2006); S.D. CODIFIED LAWS § 58-17-98 (2004); VA. CODE ANN. § 38.2-3412.1:01.E (2002 & Supp. 2006).

194. COLO. REV. STAT. ANN. § 10-16-104(5.5)(a)(II) (West 2006); MASS. GEN. LAWS ANN. ch. 176G, § 4M(a)(7) (West Supp. 2006); NEV. REV. STAT. ANN. § 689B.0359.8 (LexisNexis 2003); N.J. STAT. ANN. § 17B:27A-7.5.a. (West 2006); OKLA. STAT. ANN. tit. 36, § 6060.10.3 (West Supp. 2006); VA. CODE ANN. § 38.2-3412.1:01.E (West 2005).

195. MASS. GEN. LAWS ANN. ch. 176G, § 4M(a) (West Supp. 2005); N.J. STAT. ANN. § 17B:27A-7.5.a (West 2005); VA. CODE ANN. § 38.2-3412.1:01.E (2002 & Supp. 2006).

196. MASS. GEN. LAWS ANN. ch. 176G, § 4M(a)(1)-(9) (West Supp. 2006). The nine mental illnesses are schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, as well as affective disorders. *Id.*

197. *See id.*

198. *Id.* § 4M(a)(10).

HeinOnline -- 12 Conn. Ins. L.J. 613 2005-2006

the statute.[199] Moreover, in 2005, Representative Kay Khan introduced House Bill 3024 to amend the Massachusetts statute to include eating disorders as biological illnesses.[200]

The advocates for adding anorexia posit that eating disorders are not just severe illnesses meriting full parity, but also are biologically-based mental illnesses.[201] In determining whether a condition is biologically-based, three factors have been suggested for consideration. These are (1) reliable evidence supporting a biological or genetic basis of the condition, (2) the existence of comorbid mental disorders that are biologically-based, and (3) the severity of the condition and its effect on systemic health.[202] It is possible that this is a self-serving list of criterion given that anorexia nervosa satisfies all three conditions, but there is definitely evidentiary support that there is, at a minimum, a biological component to anorexia nervosa.[203] It remains to be seen whether the legislature or the Commissioner will find this biological component sufficiently strong to incorporate anorexia nervosa into the statutory definition.

While the Massachusetts statute is representative of state enacted parity legislation that excludes anorexia from the definition of biologically-based mental illness, the Massachusetts statute is uniquely broad in its coverage for children and adolescents under the age of nineteen. The Massachusetts statute provides parity for all non-biologically-based mental disorders described in the most recent addition of the DSM if the mental disorder "substantially interfere[s] with or substantially limit[s] the functioning and social interactions" of the child.[204]

Although appearing to entitle a child with anorexia nervosa to nondiscriminatory mental health benefits, it is not evident that this has always occurred in practice. Massachusetts insurers may deny treatment to a child with anorexia nervosa irrespective of this statutory provision by asserting that the eating disorder does not "substantially interfere or substantially limit" the particular child in question. Many children afflicted with the disorder are high achievers and perfectionists,[205] which provides

---

199. Letter from John McDonough, Executive Director, Health Care for All, & Laurie Martinelli, Executive Director, Health Law Advocates, to Commissioner Elizabeth Childs 1 (May 21, 2004) [hereinafter Letter from McDonough & Martinelli], *available at* http://www.hla-inc.org/public/edpetition.pdf.

200. H.R. 3024, 184th Gen. Court, 2005-2006 Sess. (Mass. 2005), *available at* http://www.mass.gov/legis/bills/house/ht03pdf/ht03024.pdf (last visited Jan. 22, 2006).

201. Letter from McDonough & Martinelli, *supra* note 199, at 2-5.

202. *Id.* at 3.

203. *See supra* Part I.B.

204. MASS. GEN. LAWS ch. 176G, § 4M(c) (West Supp. 2006).

205. *See supra* notes 36-39 and accompanying text.

an appearance or argumentative basis that the disorder's effects are not substantially limiting in the particular instance. While there is no conclusive evidence that this occurs, a review of external appeals in Massachusetts revealed that a substantial percentage of successful mental health external appeals during a two year period involved the treatment of eating disorders.[206] While this problem is limited under the Massachusetts statute to the insurance coverage of children under the age of nineteen, it is a key problem in the mental health parity legislation for all individuals who receive coverage in the three states that are discussed below.

b. States with parity legislation that neither clearly includes nor excludes anorexia nervosa

Three states statutorily define mental illness in their legislation in such a way that the inclusion or exclusion of anorexia nervosa under the definition is dependent upon the particular case.[207] For example, the Indiana statute defines a mental illness as a psychiatric disorder that "impairs the individual's ability to function" and moreover, that "substantially disturbs an individual's thinking, feeling, or behavior."[208] While anorexia nervosa impairs an individual's capacity in all three of these areas,[209] the use of the term "substantially disturbs" may be problematic in particular cases. As described in the preceding subpart, many individuals with anorexia are perfectionists and high achievers, giving an appearance or an argumentative basis that the disorder's effects are not substantially disruptive.[210]

Limited effective relief is provided by the parity legislation of these states. Although the individual suffering from anorexia can appeal the decision if services are denied, this would require delay in treating an individual who is suffering from a potentially deadly disorder. Even when the insurer agrees that anorexia nervosa is included under the definition in a particular case, the anorexic individual will frequently have the same problems as anorexic individuals living in those states with parity legislation that clearly includes anorexia nervosa in the statutory definition

206. Letter from John McDonough, *supra* note 199, at 2.

207. These three states are Indiana, New Mexico, and North Carolina. *See* IND. CODE ANN. § 12-7-2-130(1), 27-8-5-15.5, 27-13-7-14.8 (LexisNexis 2006); N.M. STAT. § 59A-23E-18.F. (2000); N.C. GEN. STAT. § 122C-3(21)(i)-(ii) (2001).

208. IND. CODE §§ 12-7-2-130(1), 27-8-5-15.5 (LexisNexis 2006).

209. *See supra* Part I.A.

210. *See supra* Part II.E.2.a.

HeinOnline -- 12 Conn. Ins. L.J. 615 2005-2006

of mental illness. These problems will be examined in the following subpart.

c. States with parity legislation including anorexia nervosa

While eighteen states have enacted parity legislation that either excludes or does not clearly include anorexia nervosa in the legislation's definition of mental illness, there are twenty-four states that clearly include anorexia nervosa within their parity legislation's definition of mental illness.[211] In these twenty-four states, the parity legislation defines mental illness with varying degrees of expansiveness. Although three of the twenty-four states define mental illness in terms of certain biological mental illnesses,[212] the majority of these states have drafted more expansive definitions of mental illness.[213]

---

211. These twenty-four states are Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, New Hampshire, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington, and West Virginia. *See* ALA. CODE § 27-54-4(a) (LexisNexis Supp. 2005); ARIZ. REV. STAT. ANN. § 20-2322.F. (2002); ARK. CODE ANN. § 23-99-503(6) (2004); CAL. HEALTH & SAFETY CODE § 1374.72(d) (West 2000); CONN. GEN. STAT. § 38a-514(a) (2005); DEL. CODE ANN. tit. 18, § 3577(a)(3) (Supp. 2005); FLA. STAT. ANN. § 627.668(1) (West 2005); GA. CODE ANN. § 33-24-29(a)(2) (West 2006); KY. REV. STAT. ANN. § 304.17A-660 (West 2001); LA. REV. STAT. ANN. § 22:669A.(1)(b)(vii) (2004 & Supp. 2006); ME. REV. STAT. ANN. tit. 24-A, § 2843.5-C (Supp. 2006); MD. CODE ANN., HEALTH-GEN. § 19-703.1(c)(1) (LexisNexis 2005); MINN. STAT. ANN. §§ 62Q.47, 62Q.53 (West 2003 & Supp. 2006); MISS. CODE ANN. § 83-9-37(f) (1999); MO. ANN. STAT. § 376.1550.2(4) (West Supp. 2006); N.H. REV. STAT. ANN. §§ 415:18-a.V(i), 417-E:1.II (LexisNexis 2004 & Supp. 2006); N.D. CENT. CODE § 26.1-36-09.1 (Supp. 2005); 40 PA. STAT. ANN. § 764g(a)(1) (West 1999); R.I. GEN. LAWS § 27-38.2-2(2) (2002); TENN. CODE ANN. § 33-1-101(16) (2001 & Supp. 2006); UTAH CODE ANN. § 31A-22-625(1)(d)(i) (2005); VT. STAT. ANN. tit. 8, § 4089b(a)(2) (2001 & Supp. 2005); WASH. REV. CODE ANN. § 48.44.341(1) (West Supp. 2006); W. VA. CODE ANN. § 33-16-3a(a)(1) (LexisNexis 2006).

212. DEL. CODE ANN. tit. 18, § 3577(a)(3) (Supp. 2005); N.H. REV. STAT. ANN. §§ 415:18-a.V(i), 417-E:1.II (LexisNexis 2004 & Supp. 2006); 40 PA. STAT. ANN. § 764g(a)(1) (West 1999).

213. *See* ALA. CODE § 27-54-4(a) (LexisNexis Supp. 2005); ARIZ. REV. STAT. ANN. § 20-2322.F (2002); ARK. CODE ANN. § 23-99-503(6) (2004); CAL. HEALTH & SAFETY CODE § 1374.72(d) (West 2000); CONN. GEN. STAT. § 38a-514(a) (2005); FLA. STAT. ANN. § 627.668(1) (West 2005); GA. CODE ANN. § 33-24-29(a)(2) (West 2006); KY. REV. STAT. ANN. § 304.17A-660 (West 2001); ME. REV. STAT. ANN. tit. 24-A, § 2843.5-C.A-1 (Supp. 2006); MD. CODE ANN., HEALTH-GEN. § 19-703.1(c)(1) (LexisNexis 2005); MISS. CODE ANN. § 83-9-37(f) (1999); MO. ANN. STAT. § 376.1550.2(4) (West Supp. 2006); N.D. CENT. CODE § 26.1-36-09.1 (Supp. 2005); R.I. GEN. LAWS § 27-38.2-2(2) (2002); TENN. CODE

HeinOnline -- 12 Conn. Ins. L.J. 616 2005-2006

These more comprehensive statutory definitions of mental illness are almost exclusively drafted in terms of the diagnosable mental conditions described in either the DSM-IV or the ICD.[214] While several states exclude a few conditions provided for in either the DSM-IV or the ICD, none exclude anorexia nervosa. Connecticut's parity legislation is representative; it initially defines mental conditions to mean "mental disorders, as defined in the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders,'" but then states that it "does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental in the most recent edition" of the DSM.[215]

While twenty-four states include anorexia nervosa within their parity legislation's definition of mental illness, the comprehensiveness of benefits with respect to the insurance coverage provided in the legislation of these twenty-four states varies greatly. This variance is due to the differences in the types of benefit mandates, the terms and conditions permitted under the policies, and the statutory exemptions.

The most comprehensive type of benefit mandate is mandated-benefits.[216] States with mandated-benefit statutes require insurers to provide some minimal insurance coverage for mental illnesses.[217] Fifteen

---

ANN. § 33-1-101(16) (2001 & Supp. 2006); UTAH CODE ANN. § 31A-22-625(1)(d)(i) (2005); VT. STAT. ANN. tit. 8, § 4089b(a)(2) (2001 & Supp. 2005); WASH. REV. CODE ANN. § 48.44.341(1) (West Supp. 2006). *But see* LA. REV. STAT. ANN. § 22:669A.(1)(b)(vii) (2004 & Supp. 2006); W. VA. CODE ANN. § 33-16-3a(a)(1) (LexisNexis 2006).

214. *See* ALA. CODE § 27-54-4(a) (LexisNexis Supp. 2005); ARK. CODE. ANN. § 23-99-503(6) (2004); CAL. HEALTH & SAFETY CODE § 1374.72(d) (West 2000); CONN. GEN. STAT. § 38a-514(a) (2005); FLA. STAT. ANN. § 627.668(1) (West 2005); GA. CODE ANN. § 33-24-29(a)(2) (West 2006); KY. REV. STAT. ANN. § 304.17A-660 (West 2001); MD. CODE ANN., HEALTH-GEN. § 19-703.1(c)(1) (LexisNexis 2005); MISS. CODE ANN. § 83-9-37(f) (1999); MO. ANN. STAT. § 376.1550.2(4) (West Supp. 2006); R.I. GEN. LAWS § 27-38.2-2(2) (2002); UTAH CODE ANN. § 31A-22-625(1)(d)(i) (2005); VT. STAT. ANN. tit. 8, § 4089b(a)(2) (2001 & Supp. 2005); WASH. REV. CODE ANN. § 48.44.341(1) (West Supp. 2006). *But see* ARIZ. REV. STAT. ANN. § 20-2322.F (2002) (stating that "mental health benefits does not include benefits for the treatment of substance abuse or chemical dependency"); TENN. CODE ANN. § 33-1-101(16) (2001 & Supp. 2006) (providing that "mental illness means a psychiatric disorder, alcohol dependence, or drug dependence, but does not include mental retardation or other developmental disabilities"); N.D. CENT. CODE § 26.1-36-09.1 (Supp. 2005).

215. CONN. GEN. STAT. § 38a-514(a)(1)-(7) (2005).

216. *See* Kaplan, *supra* note 75, at 325.

217. *Id.*

of the twenty-four states have mandated-benefit statutes.[218] For example, Connecticut and Maryland have both enacted mandated-benefit parity legislation.[219] While mandated-benefit statutes appear to give comprehensive benefits to individuals afflicted with anorexia nervosa, the terms and conditions of the statute as well as the exemptions must be carefully considered.

Mandated-benefit statutes may be more or less comprehensive depending on the terms and conditions. Not all parity legislation with mandated benefits for anorexia nervosa require the provision of those benefits at the same rates, terms, and conditions as for other medical services.[220] Connecticut's parity legislation provides such comprehensive coverage to individuals with anorexia nervosa by simply stating that an insurance policy may not "establish any terms, conditions or benefit that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions. . .[,]"[221] but in comparison Pennsylvania's parity legislation permits different cost-sharing arrangements, including but not limited to, deductibles, copayments, and out-of-pocket limits.[222]

Mandated-benefit statutes may be more or less comprehensive depending on the inclusion of exemptions. The more comprehensive state enacted parity legislation, such as the parity legislation in Connecticut, does not include exemptions.[223] However, the parity legislation of some states contain a small employer exemption, such as Pennsylvania,[224] an

---

218. *See* ARK. CODE ANN § 23-99-506(a) (2004); CAL. HEALTH & SAFETY CODE § 1374.72(a) (West 2000); CONN. GEN. STAT. § 38a-514(b) (2005); DEL. CODE ANN. tit. 18, § 3577(b) (Supp. 2005); LA. REV. STAT. ANN. § 22:669A(1)(a) (2004 & Supp. 2006); ME. REV. STAT. ANN. tit. 24-A, § 2843.4, 2843.5-C.B (Supp. 2006); MD. CODE ANN., HEALTH-GEN. § 19-703.1(b)(1) (LexisNexis 2005); MISS. CODE ANN. § 83-9-39(1)(a) (Supp. 2006); MO. ANN. STAT. § 376.1550.01 (West Supp. 2006); N.H. REV. STAT. ANN. §§ 415:18-a.IV(a), 417-E:1.II (LexisNexis 2004 & Supp. 2006); N.D. CENT. CODE § 26.1-36-09.1 (Supp. 2005); 40 PA. STAT. ANN. § 764g(c) (West 1999); R.I. GEN. LAWS § 27-38.2-1 (2002); WASH. REV. CODE ANN. § 48.44.341(2) (West Supp. 2006); W. VA. CODE ANN. § 33-16-3a (LexisNexis 2006).

219. *See* CONN. GEN. STAT. §38a-514(b) (2005) (stating that "no such group policy shall establish . . ."); MD. CODE ANN., HEALTH-GEN. § 19-703.1(b)(1) (LexisNexis 2005) (stating that each health insurance policy or contract "may not discriminate against individuals with mental illness . . . by failing to provide benefits for the diagnosis and treatment of these illnesses . . .").

220. Kaplan, *supra* note 75.

221. CONN. GEN. STAT. § 38a-514(b) (2005).

222. 40 PA. STAT. ANN. § 764f(c)(4) (West 1999).

223. *See, e.g.*, CONN. GEN. STAT. § 38a-514(a)-(l) (2005).

224. *See, e.g.*, 40 PA. STAT. ANN. § 764g(b) (West 1999) (stating the requirements of mental illness coverage only applies to groups of fifty or more employees).

HeinOnline -- 12 Conn. Ins. L.J. 618 2005-2006

increased cost exemption, such as West Virginia,[225] and some states provide for both exemptions, such as Arkansas.[226] The small employer exemption and the cost increase exemption contained in state enacted parity legislation are the functional equivalent of these exemptions in the MHPA of 1996.[227]

Besides the most comprehensive mandated benefit construction used in the mental health parity legislation of fifteen states, there are two less comprehensive types of benefit mandates used in the parity legislation of the other nine states.[228] Five of these states have enacted mandated-offerings statutes[229] and four of these states have enacted mandated-if-offered statutes.[230] The restrictive terms and conditions contained in the more comprehensive mandated-benefit statutes, such as durational limits and cost-sharing arrangements, are even more prevalent in these less comprehensive types of state enacted parity legislation.[231] As pervasive as these restrictive terms and conditions is the small employer exemption,

---

225. *See, e.g.*, W. VA. CODE ANN. § 33-16-3a(a)(2) (LexisNexis 2006) (providing an exemption for employers with anticipated or actual increased costs exceeding either one percent or two percent dependent upon the size of the business).

226. *See, e.g.*, ARK. CODE ANN § 23-99-504(8) (2004) (providing an exemption for the health benefit plans of small employers conditioned upon the health care insurers offering purchasers the option to purchase a plan which meets all the requirements of the parity legislation); *id.* § 23-99-505 (providing an exemption for health benefit plans which will experience an increase in cost of at least one and one-half percent under the parity legislation).

227. *Compare* W. VA. CODE ANN. § 33-16-3a(a)(2) (LexisNexis 2006), *and* 40 PA.. STAT. ANN. § 764g(b) (West 1999), *with* 29 U.S.C. § 1185a(c)(1)-(2) (2000).

228. *See* ALA. CODE § 27-54-4(a) (LexisNexis Supp. 2005); ARIZ. REV. STAT. ANN. § 20-2322.A (2002); FLA. STAT. ANN. § 627.668(1) (West 2005); GA. CODE ANN. § 33-24-29(c) (West 2006); KY. REV. STAT. ANN. § 304.17A-661(1) (West Supp. 2005); TENN. CODE ANN. § 56-7-2360(a)(1) (2000); UTAH CODE ANN. § 31A-22-625(2)(a) (2005); VT. STAT. ANN. tit. 8, § 4089(a) (2001 & Supp. 2005) (applying only to group policies providing coverage on an expense incurred basis).

229. *See* ALA. CODE § 27-54-4(a) (LexisNexis Supp. 2005); FLA. STAT. ANN. § 627.668(1) (West 2005); GA. CODE ANN. § 33-24-29(c) (West 2006); UTAH CODE ANN. § 31A-22-625(2)(a) (2005); VT. STAT. ANN. tit. 8, § 4089(a) (2001 & Supp. 2005) (applying only to group policies providing coverage on an expense incurred basis).

230. ARIZ. REV. STAT. ANN. § 20-2322.A (2002); KY. REV. STAT. ANN. § 304.17A-661(1), -669(1) (West Supp. 2005); MINN. STAT. ANN. § 62Q.47, 62Q.53 (West 2003 & Supp. 2006)TENN. CODE ANN. § 56-7-2360(a)(1) (2000).

231. *See* ARIZ. REV. STAT. ANN. § 20-2322.D.2-.3 (2002); FLA. STAT. ANN. § 627.668(2)(a), (b) (West 2005); GA. CODE ANN. § 33-24-28.1(c) (West 2006); TENN. CODE ANN. § 56-7-2360(c) (2000); UTAH CODE ANN. § 31A-22-625(1)(b)(ii) (2005).

HeinOnline -- 12 Conn. Ins. L.J. 619 2005-2006

which five of these nine states drafted into their mental health parity legislation.[232]

3. Effectiveness of State Enacted Mental Health Parity Legislation for Providing Sufficient Treatment

Considerable variance in the requirements for the insurance coverage of mental illnesses generally and anorexia nervosa specifically exists in the mental health parity legislation enacted by the states. Even the most comprehensive state parity legislation, such as that of Connecticut, is of limited effectiveness for three primary reasons.

First, the treatment of anorexia nervosa in terms of its length and the level of care (for example, inpatient treatment versus outpatient treatment) may still be adversely affected by general managed care practices. The level of care and the length of care may still be controlled by managed care companies through managed care practices such as determinations of medical necessity and utilization reviews. The Connecticut General Assembly recently released a study concerning the status of mental health parity under the comprehensive Connecticut statute, and the findings contained in this study suggest that insurers under comprehensive state parity legislation might rely more heavily on general managed care practices to limit insurance coverage for anorexia.[233] The responses of mental health care providers in the Connecticut study reveal that insurers are still limiting coverage in terms of the level of and the length of care.[234]

---

232. *See* ALA. CODE § 27-54-4(b)(3) (LexisNexis Supp. 2005); ARIZ. REV. STAT. ANN. § 20-2322.D.2. (2002); GA. CODE ANN. § 33-24-29.1(b) (West 2006); KY. REV. STAT. ANN. § 304.17A-669(2)(a) (West Supp. 2005); TENN. CODE ANN. § 56-7-2360(a)(5) (2000). While Utah's statute does not contain an exemption for small employers, the statute requires insurers to offer, at the minimum, "50/50 mental health coverage," meaning the health benefit plan must pay for only fifty percent of covered services. *See* UTAH CODE ANN. § 31A-22-625(1)(b)(i), (2)(a) (2005).

233. *See* LEGISLATIVE PROGRAM REVIEW & INVESTIGATIONS COMM., CONN. GEN. ASSEMBLY, MENTAL HEALTH PARITY: INSURANCE COVERAGE 7-17 (2005), *available at* http://www.cga.ct.gov/2005/pridata/Studies/pdf/Mental_Health_Parity_Findings_and_Recs.pdf.

234. *See id.* at 7-8. While seventy-one percent of the mental health service providers indicated that the law has had a positive impact on expanding access to mental health services, about fifty percent rated obtaining inpatient admissions, intensive outpatient treatment, and additional outpatient visits as "somewhat difficult," and rated obtaining inpatient continued stay and partial hospitalization treatment as "very difficult." *Id.* at 2, 7. Moreover, eighty-five percent of providers surveyed changed the frequency of treatment visits and twenty-four percent had changed treatment from inpatient to outpatient because of utilization review by insurers. *Id.* at 8.

HeinOnline -- 12 Conn. Ins. L.J. 620 2005-2006

These responses by the mental health providers are corroborated by the data collected from insurers.[235] For instance, the information from the insurers revealed that while the number of enrollees being admitted for inpatient hospital services increased, the average length of stay remained stable at about six days.[236] Moreover, while there has been an increase in the average number of outpatient visits, the average number of days still remains under ten days.[237] Although the data was collected only with regards to mental health services generally and not anorexia nervosa specifically, the data suggests that while access to initial treatment has improved, patients with anorexia nervosa will still encounter difficulty in obtaining the necessary length of treatment and level of care.[238]

The second primary reason for even the most comprehensive state parity legislation being of limited effectiveness is that many employees and their dependents do not benefit from the state parity legislation. The small employer exemption drafted into the parity legislation of many states is one reason many employees and their dependents do not benefit from the legislation. For instance, Pennsylvania's parity legislation provides for a small employer exemption, and it is estimated that small businesses constitute fifteen to twenty percent of the total health care insurance market in the state.[239] In addition to the legislative decision made by some states to exempt small employers, all self-insured employers, regardless of size, are exempt automatically from state mental health parity mandates due to the

---

235. While data was provided by the six largest licensed health insurers in the state, which are Anthem Blue Cross, Aetna, CIGNA, ConnectiCare, Health Net, and Oxford, the study focuses upon the data of the three insurers that provided fairly complete information. *Id.* at 10.

236. *Id.* at 13-14. Since Connecticut's comprehensive parity statute became effective in 2000, the average length of inpatient stay across plans was between four to eight days. *Id.* at 14. Prior to its enactment, the average length of inpatient stay across plans ranged between four and nine days. *Id.* Only two plans were able to provide the average number of outpatient visits over time. While both plans show that the average number of visits in 2004 was greater than in any other year examined, the average number of days under both plans remains under ten days. *Id.* at 14.

237. *Id.* at 14-15. It should be noted that only two insurers were able to provide relevant data. *Id.*

238. Studies on national data sets corroborate that more individuals have access to mental health care under parity systems, but there is not necessarily more use per individual. NAT'L INST. OF MENTAL HEALTH, DEP'T OF HEALTH AND HUMAN SERVS., PUBL'N NO. 00-4787, INSURANCE PARITY FOR MENTAL HEALTH: COST, ACCESS, AND QUALITY 15, *available at* http://www.nimh.nih.gov/publicat/nimhparity.pdf.

239. *Creation of a Healthcare Benefit Plan for Small Business Employers: Public Hearing Before the H. Policy Comm.*, 2003-2004 Sess. (Pa. 2004) (testimony of Pennsylvania Insurance Department), *available at* http://www.ins.state.pa.us/ins/lib/ins/whats_new/testimony051804.pdf.

HeinOnline -- 12 Conn. Ins. L.J. 621 2005-2006

two-tiered regulatory system created under the ERISA. This automatic exemption for self-insured employers causes a large percentage of employees with insurance to be deprived of the more generous state parity legislation. In Connecticut, more than forty percent of insured employees are covered under self-insured plans, whereas in the nation, more than half of all insured employees are covered by self-insured plans.[240] Between the automatic exemption for self-insured plans and the legislative decision of many states to exempt small employers, state mental health parity legislation that provides protection for insurance coverage of anorexia generally affects a small number of people.[241]

The third reason even the most comprehensive state parity legislation, such as that of Connecticut, is of limited effectiveness is that the legislation generally does not extend to public health insurance programs. This is critical because anorexia nervosa afflicts individuals of all socio-economic classes. Public health insurance programs provide coverage to approximately 79 million individuals (or twenty-seven percent of the population).[242] As the next part explores, concerns about appropriate insurance coverage for the treatment of anorexia nervosa also exist in the public insurance.

III. PUBLIC HEALTH INSURANCE & ANOREXIA NERVOSA

A. PUBLIC HEALTH INSURANCE

Public health insurance includes Medicare, Medicaid and the State Children's Health Insurance Program ("SCHIP").[243] The percentage of individuals covered by public health insurance is approximately twenty-seven percent or 79 million individuals.[244] Medicaid, which is jointly funded on the state and federal levels, provides fifty-five percent of public funding for children.[245] The 12 million children enrolled in Medicaid and SCHIP public insurance programs generally have coverage for a wide

240. Korobkin, *supra* note 61, at 109. In 2003, a Kaiser Family Foundation report showed fifty-two percent of workers with employment-based health benefit plans are covered by a self-insured plan and previously, fifty-six percent were covered according to a KPMG study. *Id.*

241. Mari C. Kjorstad, *The Current and Future State of Mental Health Insurance Parity Legislation*, 27 PSYCHIATRIC REHABILITATION J. 34, 38 (Summer 2003).

242. CARMEN DENAVAS-WALT ET AL., *supra* note 54.

243. *Id.*

244. *Id.* This figure includes individuals covered by military health care. *Id.*

245. Boison, *supra* note 58, at 194.

HeinOnline -- 12 Conn. Ins. L.J. 622 2005-2006

range of mental health benefits.[246] Although little is known about the extent to which children in public insurance programs receive mental health services and particularly services for anorexia nervosa, available data suggests that in some states children may not be receiving the necessary services for the treatment of anorexia nervosa.[247]

1. Medicaid

The Medicaid benefit package for children is one of the most comprehensive of any private or public insurance plans in the nation.[248] Medicaid's broader coverage for the treatment of mental illnesses in children is largely due to the requirements of Medicaid programs to not only provide beneficiaries up to the age of twenty-one[249] with early and periodic screening, diagnosis, and treatment ("EPSDT") screenings "to determine the existence of certain physical or mental illnesses or conditions,"[250] but also to cover all necessary health care "to correct or ameliorate . . . physical and mental illnesses and conditions" detected through such EPSDT screenings.[251] The EPSDT screening consists, in part, of a comprehensive history, which is intended to incorporate a mental health assessment.[252]

In contrast to the treatment coverage for children, Medicaid provides more limited treatment for individuals over the age of twenty-one. On the positive side, Medicaid enrollees seeking treatment for mental illnesses are

246. U.S. GEN. ACCOUNTING OFFICE, PUBL'N NO. GAO-02-813, MENTAL HEALTH SERVICES: EFFECTIVENESS OF INSURANCE COVERAGE AND FEDERAL PROGRAMS FOR CHILDREN WHO HAVE EXPERIENCED TRAUMA LARGELY UNKNOWN 3 (2002), *available at* http://www.gao.gov/new.items/d02813.pdf.

247. *See id.* at 13.

248. Abigail English & Madlyn Morreale, *A Legal and Policy Framework for Adolescent Health Care: Past, Present, and Future*, 1 HOUS. J. HEALTH L. & POL'Y 63, 84 (2001).

249. 42 U.S.C. § 1396a(a)(43)(A)-(C) (2000) (explaining that a state plan must inform all eligible individuals under twenty-one years old of the availability of EPSDT screenings, provide all requested EPSDT screenings, and also arrange for all corrective treatment arising out of such screenings).

250. *Id.* § 1396d(r)(1)(A)(ii).

251. *Id.* § 1396d(r)(5). A state must provide the necessary medical care and services to correct or ameliorate a mental illness detected in an EPSDT screening regardless of whether the medical care and services are covered under the plan of that state. *Id.*

252. *See id.* § 1396d(r)(1)(B)(i). Yet, unlike some states that have screening protocols for health care providers to follow, the Health and Human Service's Centers for Medicare & Medicaid Services considers "any encounter with a health care provider to be a screening sufficient to identify and require the provision of needed services." U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 17.

HeinOnline -- 12 Conn. Ins. L.J. 623 2005-2006

not subject to day or visit limitations.[253] Yet, Medicaid programs do not permit federal funding to be used for services provided in a psychiatric hospital to beneficiaries between twenty-one and sixty-five years old.[254] Also, some Medicaid programs, like the Connecticut Medicaid program, will not provide transportation to a mental health agency if the primary diagnosis is an eating disorder.[255]

Although possessing coverage for mental health services on paper, eligible participants in Medicaid programs may encounter impediments to obtaining these covered services.[256] First, there are difficulties with accessing the EPSDT screenings and all the required mental health services that flow from such screenings. The percent of comprehensive EPSDT screening is only six percent of all children enrolled in Medicaid, which severely restricts access to necessary services.[257] Even if a child receives a comprehensive screening and the needed mental health services for the treatment of anorexia are identified, several states have been adjudicated in violation of the EPSDT requirements by not providing all necessary mental health services to children.[258]

Second, there are difficulties in locating providers to treat specialized mental health needs,[259] such as those presented by anorexia nervosa.[260] While some agencies receiving public funds do provide treatment and occasionally outstanding treatment, many of the hospitals and treatment centers accepting Medicaid have no staff members with experience in treating eating disorders.[261] Providers and specialized providers are discouraged from participating in Medicaid because of the low reimbursement rates and the delayed payments from states.[262]

---

253. U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 27.

254. Nat'l Conf. of State Legislatures, Mental Health: Frequently Asked Questions, http://www.ncsl.org/programs/health/forum/FAQ_MentalHealth.htm (last visited Jan. 22, 2006).

255. Berzins, *supra* note 96.

256. U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 19.

257. Letter from the Mental Health Liaison Group to Candidate 5 (July 2004), *available at* http://www.mhlg.org/07-13-04.pdf.

258. U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 24; *see, e.g.*, Rosie D. v. Mitt Romney, 410 F. Supp. 2d 18, 22, 54 (D. Mass. 2006) (holding that the Commonwealth of Massachusetts violated the EPSDT provisions by failing to offer necessary medical services and to arrange these medical services with reasonable promptness to children).

259. *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 19.

260. Pauline Powers, Getting Coverage for Eating Disorders Treatment, http://www.edreferral.com/coverage_for_ed.htm (last visited Jan. 22, 2006).

261. *Id.*

262. U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 19.

HeinOnline -- 12 Conn. Ins. L.J. 624 2005-2006

2. SCHIP Programs

The extent of coverage for mental health services and the required amount of cost-sharing varies across the state developed SCHIP programs.[263] Several SCHIP programs generally offer the same extensive coverage of mental health benefits as the respective state's Medicaid program.[264] While some of these SCHIP programs, such as the Minnesota SCHIP program, offer extensive mental health coverage without requiring the beneficiaries to make any out-of-pocket expenses, other SCHIP programs, such as the programs in Massachusetts and Georgia, require limited cost-sharing by the beneficiaries.[265]

In contrast, the SCHIP programs in other states generally offer less extensive coverage than under the respective state's Medicaid program,[266] with the coverage restrictions and exclusions typically pertaining to mental health services.[267] The restrictions may consist of fewer covered services, financial limits, or treatment limits. The services that may be excluded from coverage are important to the treatment of anorexia nervosa, such as inpatient psychiatric care,[268] residential care, and family therapy.[269] Moreover, the EPSDT screenings and the covered treatments arising from such screenings may be critical to identifying and treating anorexia nervosa, but these services may not be required for all children enrolled in a SCHIP program.[270] Even when treatment is covered under a state's SCHIP program, the beneficiaries with anorexia nervosa may encounter treatment and financial limitations to coverage. In some states, there are treatment limitations as low as thirty days of inpatient treatment and twenty days of outpatient treatment annually,[271] monthly premiums as high as nine dollars per child or twenty-seven dollars per family,[272] and copayments of

263. *See id.* at 20.

264. *Id.*

265. *Id.*

266. *Id.* at 21.

267. U.S. GEN. ACCOUNTING OFFICE, PUBL'N NO. GAO/HEHS-00-86, MEDICAID AND SCHIP: COMPARISONS OF OUTREACH, ENROLLMENT PRACTICES, AND BENEFITS 9 (2000), *available at* http://www.gao.gov/new.items/he00086.pdf. Typically, these SCHIP programs also restrict vision services. *Id.*

268. *See id.* at 25; *see also supra* Part I.C.

269. U.S. GEN. ACCOUNTING OFFICE, *supra* note 246, at 22.

270. *See id.* at 21.

271. U.S. GEN. ACCOUNTING OFFICE, *supra* note 267, at 25.

272. U.S. GEN. ACCOUNTING OFFICE, PUBL'N NO. GAO-04-491, MEDICAID AND SCHIP: STATES' PREMIUM AND COST SHARING REQUIREMENTS FOR BENEFICIARIES 16 (2004), *available at* http://www.gao.gov/new.items/d04491.pdf. New York's SCHIP program mandates monthly premiums of nine dollars per child or twenty-seven dollars per family

HeinOnline -- 12 Conn. Ins. L.J. 625 2005-2006

three dollars or ten percent of allowable charges for each outpatient hospital visit or admission.[273]

Even barring the limitations of Medicaid and SCHIP programs, there is a great potential for the beneficial effects of providing public health care to adolescents with anorexia nervosa to be diminished or undone by the failure to provide health insurance to the young adults that are aged out of programs like Medicaid and SCHIP.[274] The following part examines the problems of uninsured individuals suffering from anorexia, particularly focusing on the problem of adolescents being aged out of insurance, whether private or public, during a critical age period with respect to the onset and recovery from anorexia nervosa.

IV. THE UNINSURED & ANOREXIA NERVOSA

Unlike many industrialized nations,[275] the United States does not maintain universal insurance for its citizens. Consequently, despite the existence of private and pubic health insurance, almost sixteen percent of the population lacked health insurance coverage in 2004.[276] The fastest-growing age group in the population without health insurance is young adults between the ages of nineteen and twenty-nine.[277] In this age category there are more than thirteen million uninsured,[278] and an additional eight million uninsured children under eighteen years of age.[279]

Many young adults who previously had health insurance under their parents' policy or public insurance programs are phased out at the age of nineteen or upon graduation from high school or college.[280] While some

---

from families with income between 133 and 185 percent of the federal poverty level and mandates monthly premiums of fifteen dollars per child or forty-five dollars per family from families with income above 185 percent of the federal poverty level. *Id.*

273. *Id.* at 44. The Utah SCHIP program requires a three dollar copayment or ten percent of allowable charges for each outpatient hospital visit or admission. *Id.*

274. English & Morreale, *supra* note 248, at 107.

275. Industrialized nations maintaining universal insurance include Canada, Germany, and England. Maltz, *supra* note 57, at 365.

276. DENAVAS-WALT ET AL., *supra* note 54.

277. Sara R. Collins et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help?*, ISSUE BRIEF (Commonwealth Fund), May 2005, at 1, *available at* http://www.cmwf.org/usr_doc/649_Collins_ritepassage_2005update.pdf.

278. *Id.*

279. DENAVAS-WALT ET AL., *supra* note 54.

280. Collins et al., *supra* note 277. Medicaid and SCHIP classify individuals as adults on their nineteenth birthday, and most individuals who were eligible as children for the public insurance programs become ineligible, unless they are disabled or very low-income parents. *Id.* at 4.

HeinOnline -- 12 Conn. Ins. L.J. 626 2005-2006

individuals phased out of insurance coverage are able to obtain new insurance coverage, other individuals are unable to find new insurance. One reason individuals with anorexia nervosa might be unable to find new insurance coverage is that they lack eligibility due to preexisting condition exclusions.[281] Another reason is that many individuals in this age category are unemployed or only temporarily employed, causing the expense of comprehensive insurance coverage to be prohibitive.[282]

Unfortunately the age category that represents one of the largest and fastest-growing segments of the population without health insurance is also the most in need of comprehensive insurance coverage for the treatment of anorexia nervosa. The incidence rates for anorexia nervosa are the highest for females between the ages of fifteen and nineteen,[283] and the typical length of time necessary for the achievement of recovery is four to five years.[284] This means that adolescents, particularly females, have a critical need for insurance coverage for the treatment of anorexia nervosa between the ages of fifteen and twenty-four years of age. This critical need is not currently being satisfied.

CONCLUSION

The epidemic of anorexia nervosa poses a substantial threat to the livelihood of millions of Americans, particularly adolescent females. While it is debatable whether anorexia nervosa is a mental illness or a physical illness, two facts are clear. One is that effective treatment does exist for anorexia nervosa, and the second is that a full course of treatment is essential for a patient to achieve lasting recovery and circumvent a perpetuating cycle of illness. While there is effective treatment for anorexia, individuals typically do not receive the necessary full course of treatment because it is prohibitively expensive for them to finance.

The American insurance system not only failed Anna Westin, but also fails thousands of individuals like Anna Westin annually. In a word, the insurance system is anorexic when it comes to the treatment of anorexia nervosa. Insurers, both private and public, have adopted a pennywise but pound foolish approach to financing the treatment of anorexia nervosa. By restricting insurance coverage for the costs at the onset of the disorder, insurers only delay the need to pay later for costlier major medical complications associated with protracted anorexia. Although there is no

281. Rome et al., *supra* note 23, at 105.
282. *Id.*; Collins et al., *supra* note 277.
283. Hoek & van Hoeken, *supra* note 6, at 388.
284. Golden et al., *supra* note 23, at 498.

HeinOnline -- 12 Conn. Ins. L.J. 627 2005-2006

clear and simple answer, an examination of the shortcomings of the insurance system and limited legislative redress will make it possible to start planning a better path to recovery for both our anorexic children and our anorexic insurance system.

HeinOnline -- 12 Conn. Ins. L.J. 628 2005-2006

THE FUTURE OF THE NATIONAL FLOOD INSURANCE PROGRAM IN THE AFTERMATH OF HURRICANE KATRINA

*Quynh T. Pham**

INTRODUCTION

Flooding is the most common and most costly natural disaster in the United States.[1] Between 1955 and 1999, floods caused an average of $6 billion in damages per year in the United States and killed about 100 people each year.[2] With the exception of three states, every other state has suffered flood-related deaths between 1989 and 1999.[3] Flooding from hurricanes killed more than 15,000 people and washed away entire communities from the year 1900 through the mid 1960s.[4] Recent flooding from Hurricanes Katrina and Rita provide grim reminders that flooding remains the second leading cause of death from natural disasters.[5] Hurricane Katrina caused death, destruction, and economic interruption never seen before in our nation's history. After Katrina, Congress approved $60 billion to fund the Federal Disaster Relief Fund to aid in the clean up and recovery of areas in the states of Mississippi, Louisiana, and Alabama.[6]

As a matter of national policy, Congress enacted the National Flood Insurance Act, which created the National Flood Insurance Program to share the risk of flood damage by making flood insurance available and

---

* Candidate for Juris Doctor, University of Connecticut School of Law, 2007; B.A. (Economics), University of Connecticut, May 2004. The author would like to thank the members of the Connecticut Insurance Law Journal for their support and encouragement.

1. RICHARD J. TOBIN & CORINNE CALFEE, THE NATIONAL FLOOD INSURANCE PROGRAM'S MANDATORY PURCHASE REQUIREMENT: POLICIES, PROCESSES, AND STAKEHOLDERS – EVALUATION OF THE NATIONAL FLOOD INSURANCE PROGRAM 1 (Mar. 2005), http://www.fema.gov/pdf/nfip/mandpurch_0305.pdf.

2. *Id.*

3. *Id.*

4. ROBERT P. HARTWIG, THE FUTURE OF NATIONAL FLOOD INSURANCE PROGRAM 2 (Oct. 18, 2005), www.server.iii.org/yy_obj_data/binary/745025_1_0/NFIP_Testimony.pdf (written testimony for the Senate Committee on Banking, Housing and Urban Affairs).

5. *Id.*

6. Office of the Governor, *Information Relating to the Federal Appropriations for Katrina Recovery*, THE SUN HERALD, Jan. 5, 2006, at A1.

affordable to property owners in need of such protection.[7] The National Flood Insurance Program was meant to be self-supporting, but the program is now operating at a deficit stemming from $23 billion in claims from hurricane victims.[8] Recent events indicate that the program has not been as effective as Congress hoped. Senator Richard Shelby of Alabama admitted, "We've got to make major changes."[9] Wayne T. Gilchrest, Chairman of the House Subcommittee on Fisheries, Conservation, Wildlife and Oceans called the National Flood Insurance Program "a huge burden that is only going to get worse."[10] Indeed, the National Flood Insurance Program's revenues are often insufficient to meet its obligations. This comment gives a brief overview of the National Flood Insurance Act and highlights key changes enacted with the purpose of improving and expanding the program. The discussion will turn to the program's problems of inadequate funds, non-compliance among lenders and borrowers, disincentive to purchase flood polices, and concludes by bringing forth possible ways the National Flood Insurance Program can resolve these issues.

I. THE NATIONAL FLOOD INSURANCE ACT

In 1968, Congress enacted the National Flood Insurance Act, which created the National Flood Insurance Program ("NFIP").[11] Effective January 28, 1969, the NFIP is a federally subsidized insurance program that provides flood insurance at or below actuarial rates.[12] Congress created this program to remedy the fact that flood insurance was not readily available from private insurance companies.[13] In its declaration of purpose for the establishment of the NFIP, Congress found that flood disasters placed a burden on the nation's resources by creating personal hardships and economic distress that required disaster relief measures supported by the entire nation. Congress also discovered that current programs were

---

7. 42 U.S.C. § 4001 (2000).

8. Joseph B. Treaster & Cornelia Dean, *Yet Another Victim of Katrina; Federal Flood Insurance Program Is Itself Under Water*, N.Y. TIMES, Jan. 6, 2006, at C1.

9. *Id.*

10. *Id.*

11. Pub. L. No. 90-448, 82 Stat. 572 (1968) (codified as amended at 42 U.S.C. § 4001 (2000). HARTWIG, *supra* note 4, at 2. The Act was revised in 1973, 1977, 1994, and 2004. TOBIN & CALFEE, *supra* note 1, at 1.

12. FEDERAL EMERGENCY MANAGEMENT AGENCY, ANSWERS TO QUESTIONS ABOUT THE NATIONAL FLOOD INSURANCE PROGRAM (May 2004), http://www.fema.gov/pdf/nfip/fo84_qanda.pdf [hereinafter ANSWERS].

13. *Id*

HeinOnline -- 12 Conn. Ins. L.J. 630 2005-2006

insufficient to protect against growing exposure to flood losses.[14] For those reasons, Congress intended to establish a method of risk sharing through a Federal flood insurance program. The program would eventually make flood insurance coverage available to anyone who needed protection.[15]

Before the passage of the National Flood Insurance Act in 1968, the government generally responded to flood disasters by building dams, levees, and other structures to hold back floodwaters.[16] The government continued to expend large sums of money annually in federal disaster assistance for flooding despite these efforts to minimize damage.[17] In addition, property owners could not obtain flood insurance through the private sector because the insurance industry was hesitant and unwilling to underwrite and bear the risk of flood.[18] The Act provides opportunities for every property owner to purchase flood insurance to protect the structures on his or her property, gives incentives for communities to adopt ordinances to mitigate the hazards of flood, and makes federally subsidized insurance available for improved real estate or mobile homes within participating communities.[19] The ultimate purpose of the NFIP is to decrease federal assistance for flood damages, but the program's more immediate concern is to make flood insurance available to property owners.

> [I]f such a program is initiated and carried out gradually, it can be expanded as knowledge is gained and experience is appraised, thus eventually making flood insurance coverage available on reasonable terms and conditions to persons who have need for such protection.[20]

---

14. 42 U.S.C. § 4001(a) (2000); H.R. REP. NO. 90-1585, at 89-96 (1968); S. REP. NO. 93-582, at 2-3 (1973).

15. *Id.*

16. *See* ROBERT P. HARTWIG & CLAIRE WILKINSON, THE NATIONAL FLOOD INSURANCE PROGRAM, INSURANCE INFORMATION INSTITUTE 2 (Oct. 2005), http://server.iii.org/yy_obj_data/binary/745030_1_0/FloodWhitePaper.pdf,. This approach did not reduce losses or discourage development in flood zones but may have encouraged additional development. The public also overlooked building techniques that would reduce flood damage. ANSWERS, *supra* note 12. *See also* HARTWIG & WILKINSON, *supra*, at 2 (Congress created the program in response to the rising cost of tax-payer funded assistance and relief for damages caused by floods).

17. FEDERAL EMERGENCY MANAGEMENT AGENCY, MANDATORY PURCHASE GUIDELINES 1 (Sept. 1999), http://www.fema.gov/pdf/nfip/mandpur1.pdf [hereinafter MANDATORY PURCHASE GUIDELINES].

18. *Id.*

19. *Id.*

20. 42 U.S.C. § 4001(a)(4) (2000).

HeinOnline -- 12 Conn. Ins. L.J. 631 2005-2006

The Federal Insurance Administration ("FIA") of the Federal Emergency Department ("FEMA") has administered the National Flood Insurance Program since 1979.[21] The FIA has since been reorganized with other operations under the Mitigation Department,[22] which became part of the U.S. Department of Homeland Security in 2003.[23]

The 1968 Act established the basic structure for the National Flood Insurance Program that continues to operate today.[24] Central to the program is an agreement between a community and the Federal Government that flood insurance would be available for the properties in that community upon its adoption and enforcement of floodplain management ordinances aimed at minimizing future flood risks.[25] In the early days of the program, participation was strictly voluntary, and the rate of participation remained relatively low. To address the low participation rate, the Government implemented the National Flood Disaster Act of 1973, and the provisions under this Act achieved the desired nationwide response to flood threats.[26] The 1973 Act authorized FEMA to grant premium subsidies to create incentives for communities and property owners to accept the program's requirements, and within seven years, nearly every community with flood hazard agreed to join the program.[27] The 1973 Act added a mandatory purchase requirement for properties in flood-prone areas not previously covered under the voluntary program.[28] To further bolster participation, in 1983 FEMA began the Write Your Own ("WYO") Program, under which private insurers are authorized to market NFIP flood coverage packaged with typical property insurance policies.[29] Under this program, FEMA bears the risk for the direct insurance program and serves as a guarantor for WYO insurers. In the 1990s the government

---

21. THOMAS L. HAYES & SHAMA S. SABADE, NATIONAL FLOOD INSURANCE PROGRAM,-ACTUARIAL RATE REVIEW 1 (Nov. 30, 2004), http://www.fema.gov/pdf/nfip/rate_rev04.pdf. *See also* ANSWERS, *supra* note 16.

22. HAYES & SABADE, *supra* note 21, at 1-2.

23. *Id.* at 1. *See also* HARTWIG & WILKINSON, *supra* note 16, at 3 (FEMA is part of the Department of Homeland Security's Emergency Preparedness and Response Directorate).

24. HAYES & SABADE, *supra* note 21, at 2.

25. *Id.* at 2. *See generally* ANSWERS, supra note 12.

26. HAYES & SABADE, *supra* note 21, at 2; HARTWIG & WILKINSON, *supra* note 16, at 3.

27. HAYES & SABADE, *supra* note 21, at 2.

28. HARTWIG & WILKINSON, *supra* note 16, at 3.

29. FEDERAL EMERGENCY MANAGEMENT AGENCY, LEGAL REFERENCES, (Sept. 1999), http://www.fema.gov/pdf/nfip/mpappl.pdf; 44 C.F.R. § 62.23 (2005). *See also* HARTWIG & WILKINSON, *supra* note 16, at 3 (Flood damage is typically not covered under homeowner's insurance but is covered by sections of the standard auto policy and under certain special commercial insurance policies).

HeinOnline -- 12 Conn. Ins. L.J. 632 2005-2006

reinforced its objective to expand mandatory flood insurance purchase by enacting the National Flood Insurance Act of 1994.[30] The 1994 Act expanded the mandatory flood insurance purchase requirement and prohibited further flood disaster assistance for properties that did not maintain flood insurance.[31] In 2004 the Flood Insurance Reform Act was passed to reauthorize the NFIP through 2008.[32]

A community is eligible to join the NFIP when it agrees to adopt and enforce floodplain management measures that both regulate new construction and ensure that improvements to existing buildings within the Special Flood Hazard Areas[33] ("SFHA") are designed to minimize flood damage.[34] Flood insurance is available to property owners in NFIP communities whether or not the property is located in a floodplain, and in fact, one in four claims come from outside the designated floodplains.[35] Initially, flood insurance was only available through agents who worked directly with the Federal Insurance Administration ("FIA"), but since 1983 this program has been supplemented with the WYO Program.[36] The goal of the WYO program was to increase policy counts and expand the geographic distribution.[37] Implementation of the WYO resulted in a drastic increase in the number of NFIP policies. From 1985 to 2004, the number of NFIP policies rose from 2 million to 4.7 million in about 20,000 communities.[38] The WYO Program permits insurance companies to pool together to issue flood insurance policies under the NFIP.[39] In order to become a WYO company, an insurance company enters into a contract with the FIA,[40] called the Financial Assistance/Subsidy Arrangement.[41] The insurance companies then adjust,[42] settle, pay, and defend claims arising out of the NFIP flood policies.[43] The agreement also includes an allowance for expenses such as writing policies and administering claims.[44]

---

30. HAYES & SABADE, *supra* note 21, at 2.

31. *Id.*

32. *See* HARTWIG & WILKINSON, *supra* note 16, at 3.

33. An SFHA is an area within a floodplain having 1 percent or greater chance of flooding in any given year, and these areas are designated on maps issued by FEMA. *Id.*

34. *Id.*

35. *Id.* at 4.

36. *Id. See also* 42 U.S.C. § 4051(a)(1) (2000).

37. HARTWIG & WILKINSON, *supra* note 16, at 4.

38. *Id.* at 8-9.

39. 42 U.S.C. § 4051(b) (2000).

40. 42 U.S.C. § 4082(a) (2000).

41. HARTWIG & WILKINSON, *supra* note 16, at 4.

42. *Id.*; 42 U.S.C. § 4082(a)(1)-(3) (2000).

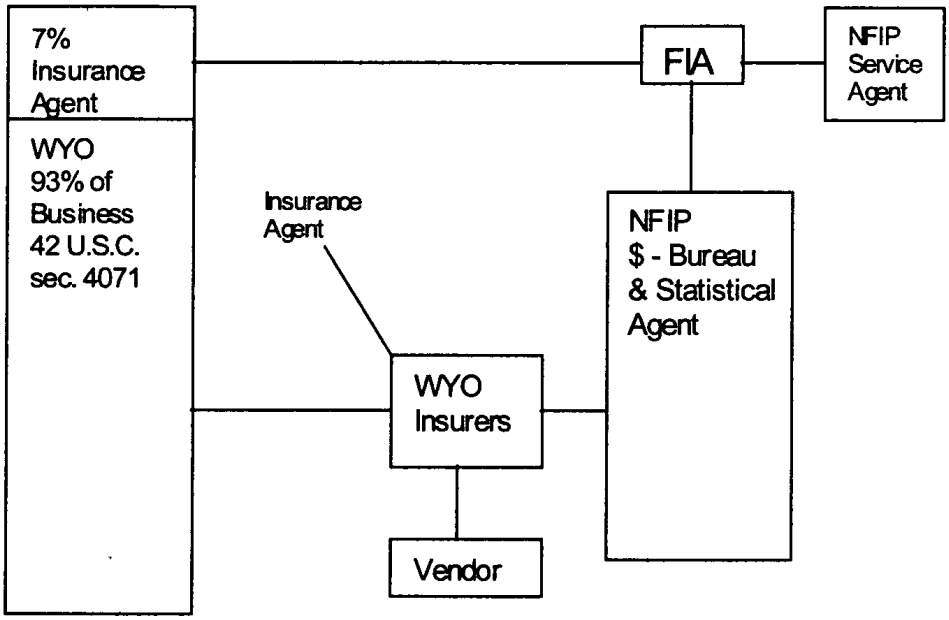
43. HARTWIG & WILKINSON, *supra* note 16, at 4.

44. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 633 2005-2006

As of 2004, ninety-six percent of all flood insurance policies in the United States are WYO policies.[45] Figure 1 demonstrates the two methods homeowners may use to obtain flood insurance policies under the NFIP.

FIGURE 1. Obtaining NFIP Insurance[46]



II. TOWARDS ECONOMIC EFFICIENCY

Recent flooding events demonstrate that the National Flood Insurance Program needs to adopt a formal policy of actuarially sound pricing for flood policy premiums that account for losses from extreme disasters like Hurricane Katrina.[47] Efficient pricing is a crucial factor in effecting an insurance program that successfully reduces subsidies, discourages unwise

45. 4,386,931 out of 4,558,696 total policies are WYO policies. INSURANCE INFORMATION INSTITUTE , FLOOD INSURANCE, , http://www.iii.org/media/facts/statsbyissue/flood (Nov. 22, 2005) [hereinafter FLOOD INSURANCE].

46. MANDATORY PURCHASE GUIDELINES, *supra* note17, at 2.

47. HARTWIG, *supra* note 4, at 3.

HeinOnline -- 12 Conn. Ins. L.J. 634 2005-2006

development, and decreases the risk of shortfall for taxpayers.[48] The NFIP should have a pricing program that generates a cash flow that covers not only expected annual losses in a normal year, but also allows for a sufficient surplus from which to respond to major catastrophes like Hurricanes Katrina and Rita.[49] The National Flood Insurance Program is funded by the premiums it collects and is self-supportive for the "average historical lost year."[50] The 1968 Act established the National Flood Insurance Fund, and the premiums collected from individual property owners are deposited into this fund.[51] The premiums also pay for operating and administrative expenses, including the expense allowances extended to WYO insurers.[52] The NFIP can borrow up to $1.5 billion from the United States Treasury when premiums alone cannot support the yearly cost of damages and expenses.[53] Before 1986, Congress annually appropriated tax dollars to pay for operating costs such as salaries, program expenses, and the costs of flood hazard mapping and floodplain management.[54] However, from 1986 to the early 1990s Congress stopped allocating federal funds to cover these costs.[55] Even though Congress transferred premiums to salary and expense accounts and emergency management accounts from 1987 to 1992, it did not authorize the NFIP to pass this cost to policyholders via premium charges.[56] These transfers resulted in loss reserves in the National Flood Insurance Fund of approximately $597 million.[57] Since then, Congress has required policyholders to pay a Federal policy fee to cover these operating costs.[58] This rate does not include fees such as agent commissions, company expense allowances, or state or local taxes, and is not considered to be part of the policy premium for accounting and WYO

48. *Id.* "While . . . in a 'normal' year the program does not operate with a deficit, in a world of insurance there is no such thing as 'normal,' only an average of extremes." *Id.*

49. *Id.* at 4.

50. HARTWIG & WILKINSON, *supra* note 16, at 6.

51. *Id.*

52. *Id.*

53. *Id. See generally* FEMA, SIGNIFICANT FLOOD EVENTS, 1978 – FEBRUARY 28, 2006, http://www.fema.gov/business/nfip/statistics/sign1000.shtm (Jan. 7, 2006) [hereinafter SIGNIFICANT FLOOD EVENTS]. Initially the program granted $1 billion in borrowing authority, and this amount was increased to $1.5 billion in 1996. HAYES & SABADE, *supra* note 21, at 3.

54. HARTWIG & WILKINSON, *supra* note 16, at 6. *See also* HAYES & SABADE, *supra* note 21, at 3-4 (From 1987 to 1992 Congress transferred policy premiums to salary and expense accounts and the emergency management accounts).

55. HAYES & SABADE, *supra* note 21, at 4.

56. *Id.*

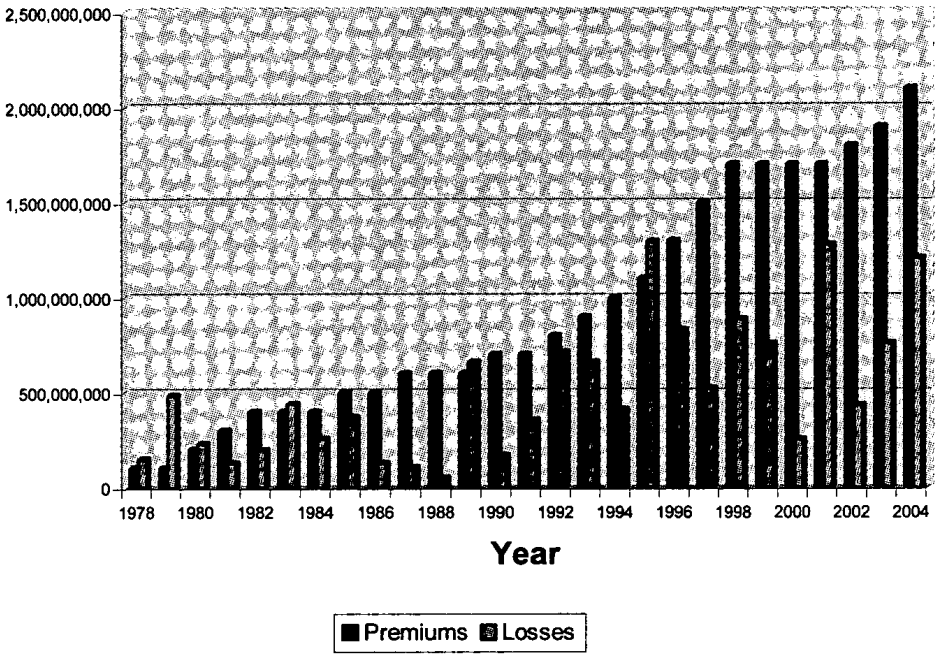
57. *Id.*

58. HARTWIG & WILKINSON, *supra* note 16, at 7.

HeinOnline -- 12 Conn. Ins. L.J. 635 2005-2006

reporting purposes.[59] Figure 2 compares the total premium to the total losses per year from 1978 to 2004.

FIGURE 2. Premiums and Losses by Calendar Year 1978-2004[60]



FEMA has emphasized that its goal is to generate a premium level that, at a minimum, is sufficient to cover expenses and losses. In general terms, Figure 2 demonstrates that during the years 1978 through 2004 this goal was met. In years when the revenue exceeds the loss payout, the balance after expenses is carried over to the following year.[61] In theory, funding of the NFIP has been consistent with this goal. However, in a year when flood damage is extremely high, the program faces a shortage of funds. For example, through October 2005, the amount paid in damages for the year 2005 was a staggering $8.35 billion.[62] At the end of fiscal year 2004, the National Flood Insurance Fund carried a balance of approximately $1.1

59. HAYES & SABADE, *supra* note 21, at 4.
60. HARTWIG & WILKINSON, *supra* note 16, at 8-11.
61. HAYES & SABADE, *supra* note 21, at 3.
62. SIGNIFICANT FLOOD EVENTS, *supra* note 53.

HeinOnline -- 12 Conn. Ins. L.J. 636 2005-2006

billion, but the NFIP still must pay outstanding claims stemming from hurricanes that occurred in the fall of 2004.[63] Assuming the total premium level remains approximately $2 billion and the NFIP borrows $1.5 billion from the U.S. Treasury, the damages drastically exceeded the funds available to pay these claims. In the past, the NFIP has borrowed on three occasions from the Treasury, and these loans have been repaid. [64] The NFIP borrowed $11 million following the 1993 Midwest Flood, $922 million in fiscal year 1998 to pay for losses incurred in 1995 and 1996, and $650 million in 2001.[65] Despite its positive balance during most of the years in the period from 1978 to 2004,[66] the NFIP has not had sufficient funds available to respond to catastrophic events such as the Midwest Flood. The aftermath of Hurricanes Katrina and Rita further illustrates the program's weakness in funding and its inability to meet its goal of having a "fiscally sound rating and coverage structure."[67] The fund is clearly vulnerable to shortages and the need to borrow from the Treasury to cover those losses.[68] NFIP Financial Reports from 1996 to 2001 confirm that total revenue is insufficient to sustain total expenses,[69] and the net income for fiscal year 2005 is expected to plunge into the negatives as the program accounts for the damage caused by Hurricanes Dennis, Katrina, Rita, Tammy, and Wilma.

---

63. HAYES & SABADE, *supra* note 21, at 3.

64. *Id.*

65. *Id.*

66. See *infra* note 45.

67. HAYES & SABADE, *supra* note 21, at 1.

68. *Id.* at 4.

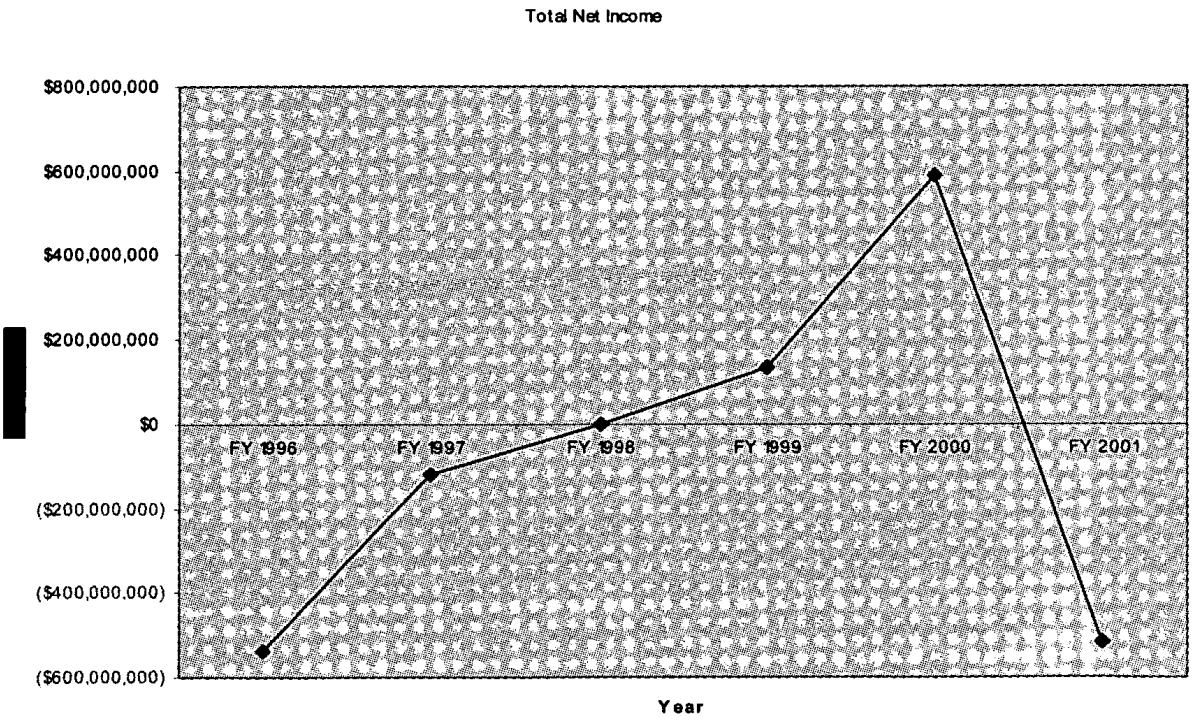
69. NATIONAL FLOOD INSURANCE PROGRAM 2000 STAKEHOLDER'S REPORT 2 (2000), http://www.fema.gov/pdf/nfip/sh2000.pdf; NATIONAL FLOOD INSURANCE PROGRAM, FINANCIAL AND STATISTICAL COMPENDIUM FISCAL YEAR 2001 6 (2001), http://www.fema.gov/pdf/nfip/sh2001.pdf.

HeinOnline -- 12 Conn. Ins. L.J. 637 2005-2006

FIGURE 3 NIFP Net Income and Losses for Fiscal Years 1996-2001[70]

	Total Revenue	Total Expenses	Net Income (Loss)
FY 1996	$972,927,000	$1,509,345,000	($536,418,000)
FY 1997	$1,090,653,000	$1,207,862,000	($117,209,000)
FY 1998	$1,278,950,000	$1,279,549,000	($599,000)
FY 1999	$1,415,834,000	$1,284,031,000	$131,803,000
FY 2000	$1,475,195,000	$887,208,000	$587,987,000
FY 2001	$1,603,068,818	$2,121,605,194	($518,536,376)

FIGURE 4. Net Income and Losses Fiscal Years 1996-2001



The NFIP must now borrow an estimated $10 to $30 billion from the U.S. Treasury to meet demands of fiscal year 2005.[71] Hurricane Katrina

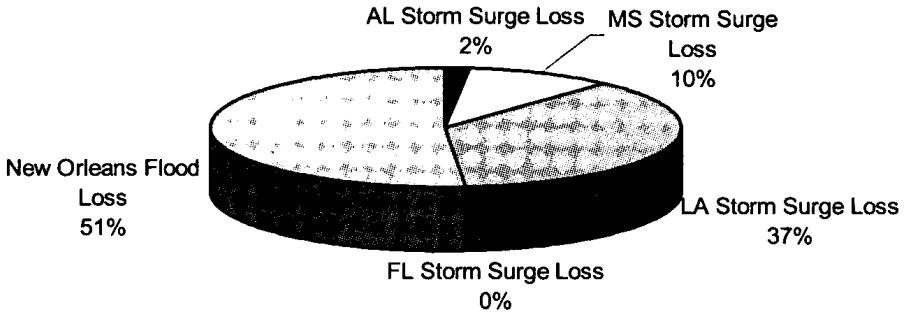
70. SIGNIFICANT FLOOD EVENTS, *supra* note 62.

71. HARTWIG, *supra* note 4.

> The typical homeowner's insurance excludes
>
> water damage, meaning any loss caused by, resulting from, contributed to or aggravated by: flood, surface water, waves, tidal water

caused $44 billion in flood and storm surge damage, with eighty-eight percent of the damage in Louisiana. Most of this loss was uninsured, as fewer than ten percent of homeowners had purchased flood coverage.[72] Approximately 275,000 homes were destroyed and others were severely damaged.[73]

FIGURE 5. Property Damage from Hurricane Katrina Flood and Storm Surge[74]



---

or overflow of any body of water, or spray from any of these, whether or not driven by wind...[w]ater or water-borne material which backs up through sewers or drains, or which overflows or is discharged from a sump pump, sump pump well or other system that is designed to remove subsurface water which is drained from the foundation area; or...[w]ater or water-borne material below the surface of the ground, including water which exerts pressure on, or flows, seeps or leaks through any part of a building, sidewalk, foundation, driveway, swimming pool or other structure or water that causes earth movement...whether or not the water damage is caused by or results from human or animal forces or any act of nature.

Id. at 11 (emphasis omitted).

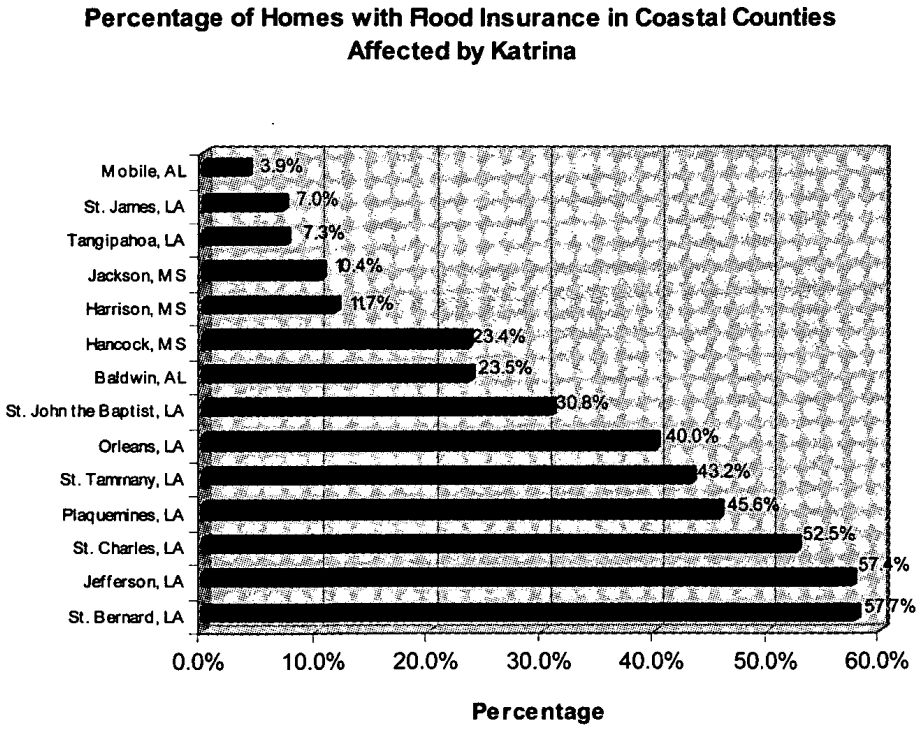
72. *Id.* at 4, 8, 9.

73. *Id.* at 4. Hurricane Katrina destroyed ten times the number destroyed by Hurricane Andrew and more than the four storms that hit Florida in 2004. *Id.* at 4, 8, 9.

74. *Id.*

The $44 billion in losses from Hurricane Katrina alone is about twenty-two times the $2 billion the NFIP collected in premiums in 2004. Without aid authorized by Congress, the NFIP would be bankrupt.[75] Another problem is that many of the damaged properties do not have flood insurance. In Louisiana, the percentage of homes affected by Hurricane Katrina that had flood insurance ranged from 57.7 % in St. Bernard County to 70 % in St. James County.[76] Homes with flood insurance ranged from 10.4 % to 23.4 % in Mississippi, and in Alabama, the numbers ranged from 3.9 % in Mobile to 23.5 % in Baldwin.[77]

FIGURE 6. Homes with NFIP Insurance in Coastal Counties Affected by Katrina [78]



75. Private insurers are expected to pay up to $60 billion from Hurricane Katrina alone. HARTWIF, *supra* note 4, at 3.

76. FLOOD INSURANCE, *supra* note 45.

77. *Id.*

78. *Id.*

Nationwide, only about forty-nine percent of single-family homes located in Special Flood Hazard Areas ("SFHA") have flood insurance.[79] The figures for the southern area of the United States are more optimistic. In the south, sixty-one percent of single-family homes in SFHAs are insured.[80] However, outside of the SFHAs, the market penetration rate remains at one percent.[81] The frequent shortage of funds and low market penetration rates suggest a structural problem that creates a disincentive to comply for lending institutions, state and local governments, and property owners. To correct the problems, the NFIP must immediately adopt actuarially sound rates that reflect the true costs of insuring against flood damages.[82] Additionally, to avoid a repeat of future human and economic tragedies on the scale of Hurricanes Katrina and Rita or worse, the NFIP needs to dramatically increase participation rates and improve market penetration rates.[83]

III. ACHIEVING COMPLIANCE

In addition to improving the accuracy and economic soundness of the actuarial rates, the NFIP must enact measures to increase compliance with the Mandatory Flood Insurance Purchase Requirement. The 1968 Act made flood insurance available to owners of "improved" real estate or mobile homes situated in floodplains if their community participated in the NFIP.[84] Under the NFIP, "improved real estate," means any walled and roofed building, including mobile homes.[85] At the outset, it was at the property owners' discretion whether or not to purchase flood insurance for his or her property. However, as it became more apparent that very few property owners understood the importance of having flood insurance coverage, Congress enacted the Flood Disaster Protection Act of 1973. The Act mandated flood insurance coverage for many properties by prohibiting lending institutions from making, increasing, extending, or renewing any loan for properties in SFHAs unless the property securing the loan was covered by flood insurance for the life of the loan.[86] Despite this mandatory provision, fewer than twenty-five percent of eligible properties

79. *Id.*
80. *Id.*
81. *Id.*
82. HARTWIG, *supra* note 4.
83. *Id.*
84. MANDATORY PURCHASE GUIDELINES, *supra note 17,* at 1.
85. The Act defines real estate as real estate upon which a building is located. *Id.*
86. *Id.* at 2.

HeinOnline -- 12 Conn. Ins. L.J. 641 2005-2006

were actually covered and market penetration continued to be inconsistent, varying from as low as ten percent to as high as seventy-five percent in certain coastal communities.[87]

Presently, the NFIP estimates that only slightly more than two million of the ten million households in SFHAs had flood insurance,[88] and taxpayers continue to suffer from mounting disaster relief payments. Lenders and homeowners have not been in compliance with the mandatory provision of the 1978 Act. Federally regulated lending institutions have been lax in enforcement, and as a result, homeowners simply did not buy flood insurance or neglected to renew their policies.[89] To improve enrollment rates, The National Flood Insurance Reform Act of 1994 contains measures aimed at improving compliance and increasing nationwide participation.[90] The 1994 Act requires federal agency lenders to develop regulations aimed at enforcing the previous prohibition that lenders not make, increase, extend, or renew any loan unless the owner has purchased flood insurance.[91] The Act requires that:

> [N]o Federal officer or agency shall approve any financial assistance for acquisition or construction purposes for use in any area that has been identified by the Director as an area having special flood hazards and in which the sale of flood insurance has been made available under the National Flood Insurance Act, unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost.[92]

Thus, in order to secure a mortgage, homeowners in SFHAs are now required to purchase flood insurance as a condition of closing and to maintain the policy for the term of the loan.[93] The 1994 Act also imposes escrow requirements for flood insurance and "mandatory provisions for

87. *Id.*

88. *Id.* at 3.

89. *Id.*

90. MANDATORY PURCHASE GUIDELINES, *supra* note 17, at 3; 103 Pub. L. No. 325, Title V, 108 Stat. 2160, 2255-87 (Sept. 23, 1994).

91. *Id.*

92. 42 U.S.C. § 4012a(a) (2000). The development or project costs does not include the estimated land cost. Further, the amount of insurance required does not need to exceed the outstanding principal of the loan, nor is it required beyond the terms of the loan. *Id.*

93. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 642 2005-2006

'forced-placement' of flood insurance."[94] Persons who have received disaster assistance are barred from future aid if they fail to purchase flood insurance.[95]

The centerpiece of the Act is the imposition of new obligations and requirements on those who service mortgages as well as mortgage originators. The Act applies to federally regulated primary lenders and secondary market entities only, and not to entities that are not federally regulated and do not sell loans to the Federal National Mortgage Association ("Fannie Mae") and the Federal Home Loan Mortgage Corporation ("Freddie Mac").[96] The applicable lenders include federally backed lenders, government-sponsored enterprises ("GSEs"), and federal agency lenders.[97] The 1994 Reform Act does not apply to unregulated private financial institutions that engage primarily in the purchase of mortgage loans, unregulated mortgage bankers or brokers who only serve as loan originators, private mortgage lenders, and State regulated lending institutions that are not tied to federal oversight.[98] Thus, three categories of owners are required to purchase flood insurance: (1) those who received their loans from federally regulated institutions and those whose loans were secured by improved real estate or manufactured home; (2) those whose loans have been purchased by Fannie Mae or Freddie Mac; (3) property owners in participating SFHA communities who received Federal financial assistance for the acquisition and construction purposes.[99]

The 1994 Reform Act was designed to strengthen compliance with the mandatory purchase requirements set forth by the Flood Disaster Protection Act of 1973,[100] with the primary objective of improving enrollment and increasing total premiums. Generally, when a lien is taken as security for a loan on improved real estate or a mobile home, the lenders must determine and document whether the building is located in an SFHA, require that the property owner purchase flood insurance to the requisite limit, and ensure that owner maintains a flood policy for the duration of the term of the

94. 42 U.S.C. § 4012a(d) (2000). MANDATORY PURCHASE GUIDELINES, supra note 17, at 4.

95. 42 U.S.C. § 4012a(d) (2000).

96. MANDATORY PURCHASE GUIDELINES, *supra* note 17, at 4; U.S.C. § 4012a(a) (2000). Notice requirements that complement the substantive requirements are found at 42 U.S.C. § 4104a-b (2000).

97. MANDATORY PURCHASE GUIDELINES, supra note 17, at 19.

98. *Id.*

99. TOBIN & CALFEE, *supra* note 1, at iv.

100. MANDATORY PURCHASE GUIDELINES, *supra* note 17, at 5.

HeinOnline -- 12 Conn. Ins. L.J. 643 2005-2006

loan.[101] Additionally, if the property is determined to be in an SFHA subsequent to the approval the loan, the lender is expected to follow up on the property's flood hazard status and require flood insurance coverage.[102] The amount of coverage must either be at least equal to the outstanding principal balance of the loan or the maximum amount of coverage made available by the 1994 Reform Act for the particular type of property, whichever is lower.[103] The maximum amounts of flood insurance available for various types of properties are shown in Figure 7.

FIGURE 7. Maximum NFIP Coverage.[104]

Building Coverage	*Emergency Program*	*Regular Program*
Single-family dwelling	$35,000	$250,000
2-4 family dwelling	$35,000	$250,000
Other residential	$100,000	$250,000
Non-Residential	$100,000	$500,000
Contents Coverage		
Residential	$10,000	$100,000
Non-Residential	$100,000	$500,000

The amount of insurance a property owner must purchase depends largely on the amount of financial assistance that the property owner is seeking or the outstanding principal of the loan, and homeowners can purchase up to $250,000 through the NFIP for their homes.[105] To comply with the Act, lenders must also send notices that publicize NFIP insurance coverage requirements and explain whether federal disaster relief assistance is available to the properties situated in an SFHA. This notice must be given within a reasonable time before the completion of the transaction.[106] The notice, called the Notice of Special Flood Hazard and Availability of Federal Disaster Relief Assistance, must have a general warning concerning the risk of flooding in the area, a description of the mandatory purchase requirements, and an explanation of the eligibility requirement to receive disaster relief.[107] Most importantly, the notice must

101. *Id.* The extension of credit may be in the form of a loan, refinancing, consolidation, or renewal of an existing credit. *Id.* at 19.

102. *Id.* at 5.

103. *Id.* at 19.

104. *Id.* at 22. 42 U.S.C. § 4013(b) (2000).

105. TOBIN & CALFEE, *supra* note 1, at iv.

106. MANDATORY PURCHASE GUIDELINES, *supra* note 17, at 30.

107. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 644 2005-2006

discuss the availability of flood insurance coverage, including the various sources from which to obtain coverage: from an NFIP Servicing Agent, a WYO insurer, or a private flood insurer.[108]

To further emphasize the importance of compliance, Congress has also authorized the imposition of civil monetary penalties on those lenders that have violated the mandatory purchase requirement.[109] As a result, the agencies have imposed penalties in almost one hundred instances for violations of the requirement, which typically involve a failure to determine whether the property is in an SFHA or failure to place flood insurance premiums into escrow.[110] Figure 8 summarizes some key legislative efforts from 1968 to 1994 to shape and enforce compliance of the mandatory purchase requirement.

FIGURE 8. Key Legislations from 1968 to 1994.[111]

	National Flood Insurance Act 1968	**Flood Disaster Protection Act of 1973**	**National Flood Insurance Reform Act of 1994**
Availability	Available in participating communities	Available in participating communities	Available in participating communities
Purchase	Voluntary	Mandatory for: ▪ Buildings or manufactured home in an SFHA that is receiving a long from a regulated lender; ▪ Buildings that were acquired or constructed using federal financial assistance.	Mandatory for: ▪ Buildings or manufactured home in an SFHA that is receiving a long from a regulated lender; ▪ Buildings that were acquired or constructed using federal financial assistance. ▪ Buildings whose loan is purchased by Freddie Mac or

108. *Id.*

109. TOBIN & CALFEE, *supra* note 1, at v.

110. *Id.* Although FEMA does not have a primary role in enforcing the requirement, it has a direct interest in compliance to promote key objectives. *Id.* at vi.

111. *Id.* at 4-7.

HeinOnline -- 12 Conn. Ins. L.J. 645 2005-2006

			Fannie Mae.
Responsibilities of Regulated Lenders	None	Require flood insurance for buildings or manufactured homes located in NSHA. Ensure that flood insurance policy is maintained for the term of the loan	Determine whether the building or manufactured home is located in an SFHA. Perform hazard determination and complete form. Provide notice of availability of flood insurance to borrowers, lenders and servicers. Ensure that flood insurance is maintained for the term of the loan. Escrow for flood insurance premiums. Force place flood insurance in the event of non-renewal or insufficient coverage.
Federal Agencies that provide financial assistance	None	No financial assistance for acquisition or construction unless the building, manufactured home, or personal property in question is covered by flood insurance for the term of the loan. Prohibited in SFHAs in nonparticipating communities after	Federal agencies making direct loans cannot make, increase, extend, or renew any loan secured by improved real estate or manufactured home in an SFHA unless the building of manufactured home and any personal property securing the loan is covered by flood insurance for

HeinOnline -- 12 Conn. Ins. L.J. 646 2005-2006

		July 1, 1975.	the term of the loan.
Sanctions for Noncompliance	None	None	Civil money penalties against regulated lenders and GSEs.

A brief glance at the number of policies in existence as of December 31, 2004 shows that ninety-five percent of the 4.56 million federal flood insurance policies were for residential properties.[112] Of the ninety-five percent, sixty-nine percent of the residential policies were for single-family residential properties and twenty percent covered condominiums.[113] Thus, to achieve optimal compliance, the NFIP should focus on the residential housing market.[114] Figure 9 shows that in 2004, sixty-eight percent of Americans are homeowners, that is, almost seven in ten residences are owner-occupied.

FIGURE 9. Rate of Homeownership in 2004.[115]

Type of Structure and Number of Units	*Number of Occupied Housing Units*	*Percentage of Total Occupied Housing Units*	*Owner-Occupied*	*Home-ownership Rate*
Detached Single Unit	67,753,000	64%	59,642,000	88%
Attached Single Unit	6,272,000	5.9%	3,679,000	58.7%
2-4	8,474,000	8.0%	1,426,000	26.8%
5-9	5,135,000	4.9%	501,000	9.8%
10-19	4,468,000	4.2%	485,000	10.9%
20-49	3,294,000	3.1%	389,000	11.8%
50 or more	3,592,000	3.4%	601,000	16.7%
Manufactured home or trailer	6,854,000	6.5%	5,514,000	80.4%
Total	**105,842,000**	**100%**	**72,238,000**	**68%**

112. *Id.* at 18.
113. *Id.* at 18-19.
114. *Id.* at 18 (compiled from data from the U.S. Department of Commerce).
115. TOBIN & CALFEE, *supra* note 1, at 21-22.

HeinOnline -- 12 Conn. Ins. L.J. 647 2005-2006

Of the 72,238,000 owner-occupied units, an overwhelming 62.9% have a regular or home-equity mortgage and reverse mortgage.[116] Between 1998 and 2003 conventional loans were used to finance the majority of purchases.[117] Based on these statistics, a good starting place to monitor and enforce mandatory flood insurance requirements is in residential mortgages. However, the Census Bureau does not collect data that distinguishes between mortgages made by regulated versus non-regulated lenders, and most homebuyers are not informed as to whether their loans have been sold to an institution required to comply with the 1994 Reform Act.[118] Furthermore, the data does not reveal which of the structures are located in SFHAs.[119] As a result, enforcement is hindered by an information problem, that is, the NFIP currently has no means of monitoring the proportion of mortgages subject to the mandatory purchase requirement.[120]

The mandatory requirement purchase requires regulated lenders to determine whether the building or manufactured home is located in an SFHA, [121] perform a hazard determination, provide notice of availability of flood insurance to borrowers, lenders and servicers, ensure that flood insurance is maintained for the term of the loan, escrow for flood insurance premiums, and force-place flood insurance in the event of non-renewal or insufficient coverage.[122] These requirements create "an adverse selection process," that according to president of the National Lenders' Insurance Counsel is "fraught with perplexing, inconsistent and sometimes unworkable rules that create seemingly endless customer service and compliance issues."[123] In addition to the varied interpretation of the requirement among the different entities, the complexity of the requirement and misinformation also frustrate compliance.[124]

Additionally, there are numerous challenges to the accurate determination of whether an improved real estate or manufactured home is

---

116. *Id.* at 23.

117. *Id.* at 24.

118. *Id.*

119. *Id.* Fannie Mae and Freddie Mac have the number of loans they purchased, but they do not know the number of mortgages they did not purchase and the proportion of loans not purchased that nonregulated lenders originated. *Id.* at 31.

120. TOBIN & CALFEE, *supra* note 1, at 24.

121. Regulated lenders are those regulated by one or more of the federal regulatory agencies and include commercial banks, savings institutions, credit unions, and farm credit institutions. *Id.*

122. *See infra* note 102.

123. TOBIN & CALFEE, *supra* note 1, at 32.

124. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 648 2005-2006

located in an SFHA. Lenders face tremendous difficulties in monitoring map changes.[125] Deciding the exact placement of the property in question when it is located on or near the boundary of SFHA continues to be a challenge.[126] Some lenders contract with private companies that specialize in making this determination, but the problem is that the lenders do not monitor and are unaware of the processes these vendors use to make flood determinations.[127] Prior to the existence of these flood-determination vendors, the FIA decided that sufficient compliance involves exercise of due diligence and good faith.[128] Today, vendors are required by the 1994 Reform Act to guarantee the accuracy of their information, although the definition of "guarantee" remains inconsistent among the vendors.[129] Moreover, there is no set legal or monetary liability for inaccurate information.[130] The NFIP needs to improve accuracy by increasing the uniformity of the flood-determination industry. Furthermore, legal liability and monetary penalties should be clearly delineated in the event that inaccurate information is given, especially since this determination is the basis for compliance with the mandatory purchase requirement. More troubling is the fact that legislation does not require applicable lenders to review loan portfolios to determine whether the property has adequate flood coverage.[131]

Moreover, lenders are required to provide written notices to the borrower and servicer, supplying the following information within a reasonable time before the transaction is completed. The notice must inform the borrower whether his or her property is located in SFHA, educate the property owner on the mandatory purchase requirement of the NFIP, emphasize the availability of flood insurance, and detail any other necessary information.[132] However, according FEMA more than 3000 participating communities did not have policyholders in 2004, and 7000 other communities had ten or fewer policyholders.[133] Shockingly, some

125. *Id.* at 33.

126. *Id.* at 34.

127. *Id.* More than 100 companies provide flood determinations. Many only service limited geographic areas, such as for a single state. The largest firms provide service in most or all states, including the District of Columbia, Guam, Puerto Rico, and the Virgin islands. The determinations provided vary from a few thousand to several millions per year. *Id.* at 35.

128. *Id.*

129. TOBIN & CALFEE, *supra* note 1, at 35.

130. *Id.*

131. *Id.* at 40.

132. *Id.* at 40-41.

133. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 649 2005-2006

property owners were told that they could not purchase flood insurance because their properties are located in SFHA, while others were told that they are not eligible because their homes are not in SFHAs.[134] In fact, a 1999 survey of consumers conducted for FEMA found that twenty-six percent believed that "you can't buy flood insurance if you are located in a high-risk area."[135] One major problem is that agents often do not have knowledge of flood insurance. A review of the response to Hurricane Isabel recommended that the NFIP develop rigorous training programs for insurance agents after finding "wide frustration with the lack of familiarity insurance professionals had with the flood program."[136] As a result, the Flood Insurance Reform Act of 2004 aimed to correct this problem by requiring FEMA to establish education and training requirements for agents working with flood insurance.[137] This does not adequately address the issue since state insurance regulators, not FEMA, are responsible for training and licensing of insurance agents.[138] However, something must be done because the NFIP simply cannot achieve compliance when insurance agents misinform property owners when it comes to the availability and requirements for flood coverage.

As previously mentioned, lenders are also prohibited from making, increasing, extending, or renewing any loan unless the real estate or manufactured home is covered by flood insurance in an amount at least equal to the lesser of the outstanding balance of the loan or the maximum NFIP limit of coverage.[139] The problem with applying this provision is that no laws or regulations specify how property owners must demonstrate that the property is covered.[140] Therefore, forms of proof range from copies of the policy's declaration page, to paid receipts, and to a wide range of other documents.[141] A more serious problem is that lenders interpret the coverage requirement differently.[142] Here are a few possible interpretations of the requirement: (1) flood insurance coverage must be equal to the value of the property or to the maximum NFIP coverage, whichever is greater; (2) coverage must equal the full balance of the loan even when part of the loan is for land; or (3) coverage must be equal to that of the owner's hazard

134. *Id.* at 41.

135. TOBIN & CALFEE, *supra* note 1, at 41, n.42 (extracted from study by KRC Research & Consulting in 1999).

136. *Id.* at 40, 41.

137. *Id.* at 42.

138. *Id.*

139. *Id.* at 43.

140. *Id.*

141. TOBIN & CALFEE, *supra* note 1, at 43.

142. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 650 2005-2006

or homeowner's insurance.[143] The inconsistency often results in inadequate coverage relative to the value of the property.[144]

Still, FEMA and federal regulatory agencies continue to disagree about whether escrows are required for loans on multi-family dwellings with more than five units.[145] FEMA insists that such loans are subject to the escrow requirement, while the federal regulatory agencies state that they are not. Therefore, FEMA tells lenders to impose escrow requirements on such loans but the federal regulatory agencies do not enforce this requirement.[146] In addition, although lenders are required to ensure flood insurance coverage for the duration of the loan, retention of policies continues to be a pervasive problem, largely because information that would assist in determining whether the policyholder should be retaining the insurance remains unavailable.[147] An estimate from the year 2004 finds that as many as 500,000 policyholders each year cancel or do not renew their policies; most problematic is that the portion of these policyholders who were obligated to retain flood insurance for the term of loan remains unknown.[148]

Finally, the force-placed provision mandates that if there is evidence that the homeowner does not have flood coverage or that the coverage is less than the minimum amount required at any time during the life of the loan, lenders must purchase insurance on behalf of the property owner.[149] The additional coverage must be equal to the difference between that which is already in place and the lesser of the outstanding balance for maximum NFIP coverage.[150] In practice, fulfilling this obligation is not feasible because there is an information asymmetry that makes compliance costly and burdensome. [151] Property owners who never purchased coverage or who cancelled or failed to renew would not volunteer this information and it would be costly in time, money, and manpower for lenders to gather this information.[152]

These are just a several core issues hindering compliance. Although there are penalties for violations, the cost of monitoring the lenders can

---

143. *Id.* at 43,44.
144. *Id.* at 44.
145. *Id.* at 45.
146. *Id.*
147. TOBIN & CALFEE, *supra* note 1, at 45. The GAO noted in 2002 that FEMA is concerned that "significant noncompliance problems" exist. *Id.*
148. *Id.* at 45,46.
149. *Id.* at 46.
150. *Id.*
151. *Id.*
152. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 651 2005-2006

place a huge burden on FEMA. If the goal of the NFIP is to increase participation and premium revenue, the NFIP needs to develop a method of continuous assessment of compliance with the mandatory purchase requirement in addition to enacting policies that are tailored to this purpose.

IV. ALIGNING THE INCENTIVE TO PARTICIPATE WITH THE GOALS OF THE NFIP

Despite the NFIP's efforts to increase awareness through marketing campaigns, market penetration rates remain relatively low. One might think, "If industry can successfully flood American homes with overpriced soft drinks with no nutritional value sold primarily on the basis of taste, then the National Flood Insurance Program should be able to market its insurance, which promotes safety and security of life, with relative ease."[153] However, of the estimated 72 million owner-occupied structures,[154] only 4.7 million property-owners purchased flood insurance through the NFIP.[155]

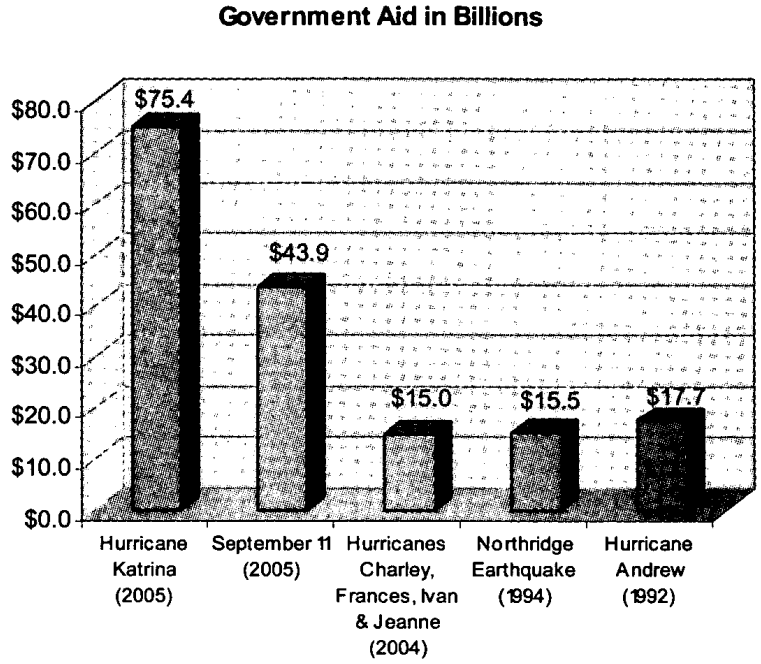
There are significant problems with the administration of the NFIP, notably the inability of the NFIP to educate, market, write policies, and monitor compliance in SFHA as well as non-SFHA zones. However, the most pressing concern is that the NFIP is not operating efficiently due to constant shortage of funds caused by sub-optimal premium pricing and ineffective market penetration. This is an incentive problem. Property owners currently have economic incentives *not* to buy flood insurance.[156] First, property owners misperceive risk and often underestimate the chance of their properties being damaged by floods. A property owner might think that the risk of "living in a 1-in-100 year flood plain" translates to a one percent chance that there will be a flood in one hundred years.[157] In fact, such property has a twenty-six percent chance of being flooded during a thirty-year mortgage.[158] Compounded with this misperception of risk is the fact that most people will decline to pay what they believe is an extra fee for the insurance, especially when there is a widespread belief that government aid is readily available after most flood events.[159] Figure 10

153. TOLBIN & CLAFEE, *supra* note 1, at 1.
154. See *supra* note 106.
155. HARTWIG, *supra* note 4.
156. *Id.*
157. *Id.*
158. *Id.*
159. *Id.* at 5.

HeinOnline -- 12 Conn. Ins. L.J. 652 2005-2006

illustrates the rising cost to taxpayers of government aid after major catastrophic events in 2005 dollars.

FIGURE 10. Government Aid After Major Catastrophes.[160]



As of September 2005, the cost to taxpayers in disaster relief for Hurricane Katrina is almost doubled the amount spent for September 11th. Generous government aid reinforces the erroneous belief that flood insurance is unnecessary. Indeed, a study by Camerer and Kunreuther in 1989 reveals considerable evidence that people tend to ignore small probability, high consequence events such as flood. Nevertheless, an effective insurance program should help minimize this problem.[161] Another way to correct this problem is to authorize lenders to purchase the flood insurance at the expense of the homeowner if he or she fails to buy coverage.[162] However, this does not rectify the core problem, that is,

160. *Id.* at 10 (data taken from the United States Budget Committee as of September 2005).

161. James Chivers & Nicholas E. Flores, *Market Failure in Information: The National Flood Insurance Program*, 78:4 LAND ECON. 515, 516 (Nov. 2002).

162. *Id.* at 6.

HeinOnline -- 12 Conn. Ins. L.J. 653 2005-2006

property owners have no incentive to hedge against the risk of flooding by purchasing flood insurance.

In response to the problem of shortage, the Senate Banking Committee has been preparing to overhaul the NFIP by raising premiums and creating a cost structure that operates more like a private insurance company.[163] Committee Chairman Richard Shelby emphasized, "We don't have the luxury of doing nothing. We have to make this program as actuarially sound as possible."[164] The administrator of the NFIP had asked Congress to eliminate discounts on as many as 1.2 million policies.[165] The NFIP also asked Congress to expand the mandatory purchase requirements to properties in areas known as 500-year flood plains, with a 0.2% chance of flooding in any year, and to properties protected by levees and dams.[166] The NFIP estimated that this extension would result in additional policies taken out to cover four to six million properties.[167] Experts agree that subsidies must be scaled back, and legislation will probably roll back the $1.3 billion in annual subsidies.[168] Additionally, the Congressional Budget Office has estimated that, without the subsidies, average premium for "risky" properties currently priced at $710 a year would increase to $1800.[169]

Congress must raise premiums, eliminate subsidies, and expand the mandatory purchase requirement in order to preserve the fiscal integrity of the NFIP. More importantly, Congress must enact certain regulations to bolster compliance among lenders and property owners. There are three elements crucial to increasing compliance: uniform regulations, a standard system of enforcement and penalty, and education. Congress must simplify the mandatory purchase requirements and create a uniform body of regulations that would be applicable to all NFIP entities. The regulations must address the areas where enforcement has been lax. For example, Congress needs to improve accuracy in determining whether the property is located within an SFHA. One way to do this is to impose uniform standards on flood-determination vendors. Another problem is the inconsistent interpretations of renewal and coverage requirements.

---

163. Michael Shroeder, *Massive Hurricane Claims Force U.S. Flood Insurance Overhaul*, WALL ST. J., Jan. 26, 2006, at A6.

164. *Id.*

165. *Changes are Sought in Flood Insurance*, N.Y. TIMES, Jan. 26, 2006, at A16.

166. *Id.*

167. *Id.*

168. Michael Shroeder, *Massive Hurricane Claims Force U.S. Flood Insurance Overhaul*, WALL ST. J., Jan. 26, 2006, at A6.

169. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 654 2005-2006

Possible regulation could mandate that homeowners keep a copy of their NFIP policy as proof of enrollment. Congress should create one uniform coverage requirement. One option is to make the amount of coverage required be equivalent to the value of the property, or the maximum NFIP coverage, whichever is the greater value. Further, there should be an escrow requirement for the duration of the loan, and lenders should be obligated to review loan portfolios every five years for compliance with the NFIP. Congress should place the responsibility of enforcement on regulated lenders and other NFIP entities and penalize these entities should they fail to maximize compliance. Most importantly, Congress must develop rigorous training programs to educate insurance agents on NFIP flood policies and requirements. Proposed regulation in this area should focus on enhancing the quality and knowledge of insurance agents. For example, regulations can require a certain amount of training per year or as part of the licensing agreement in general.

The current consensus is that the NFIP is inadequately funded, and that Congress must raise premiums and restructure the program to function like a private insurance company. Expanding the mandatory purchase requirement would increase revenues significantly only with proper monitoring and compliance. Currently, compliance is monitored by different agencies and lending institutions. Establishing uniform standards and a common regulatory body for the NFIP might lessen the burden of monitoring several separate organizations. In addition, the NFIP must invest resources into educating and informing the nation about the benefits of the program and urge state regulators to implement mandatory NFIP training for all insurance agents. There are no perfect solutions to the problems facing the NFIP, but the program would benefit by overhauling rates and educating homeowners, insurers, insurance agents, and mortgage lenders on the risks of flood disasters and the importance of having flood policies.

CONCLUSION

Flooding has historically been one of the most costly natural disasters. Taxpayers have been, and continue to be, burdened by the expenses of large sums of money in disaster relief after major flood events. To alleviate this burden, Congress passed the National Flood Insurance Act in 1968 to make flood insurance available at affordable rates to those who need coverage. The Act created the National Flood Insurance Program and was intended to encourage communities to take preventive and protective measures against damages from flooding. However, the NFIP has not

HeinOnline -- 12 Conn. Ins. L.J. 655 2005-2006

achieved economic efficiency and does not operate to its full potential due to actuarially inaccurate premium pricing. Further, widespread inconsistencies in the administration and regulation of the mandatory purchase requirements resulted in non-compliance, lower rates of market penetration, and uninformed insurance agents and borrowers. To operate at its potential, the NFIP needs to increase premium revenues, enhance compliance, and engage in policy changes that will educate, encourage and give incentive to homeowners to purchase flood insurance coverage.

HeinOnline -- 12 Conn. Ins. L.J. 656 2005-2006

REASONABLE EXPECTATIONS IN THE SPHERE OF LIBERTY: A THEORY OF ACCIDENTAL DEATH INSURANCE COVERAGE

*Catherine Spain**

INTRODUCTION

The following scenarios come from cases involving accidental death, or double indemnity, [1] claims: 1) the family of a farmer who died of blood poisoning after mistakenly puncturing himself with a nail is denied accidental death coverage; 2) the estate of a woman found drowned in her Jacuzzi after ingesting Valium and alcohol is granted accidental death coverage; 3) a cocaine user's overdose is held to be accidental, and coverage is provided; 4) a man is killed in an accident while driving home, but his survivors are denied double indemnity because he had consumed one alcoholic drink; 5) the survivors of a rapist whose victim killed him in self-defense are granted accidental death coverage; 6) the wife of a man found hanging from a noose used to limit his oxygen supply, thereby intensifying his orgasm during masturbation, is denied coverage.

Laypersons may assume there is a cogent legal theory that explains this mixed bag, a representative sampling of accidental death coverage rulings. Lawyers may surmise that some little-known insurance doctrine flows darkly through this legal area, delivering souls to their destinies like Charon on the river Styx. There is no such explanation. Rather, examination of accidental death cases reveals a semantic distinction by which insurers violate policyholders' reasonable expectations,[2] the

---

* Candidate for Juris Doctor, University of Connecticut Law School; Bachelor of Arts, Yale University. The author wishes to thank the members of the CONNECTICUT INSURANCE LAW JOURNAL for their assistance and friendship, Professor Tom Baker for his guidance, and Professor Thomas Morawetz for his suggestions and encouragement.

1. Accidental death insurance coverage, a feature of some life insurance policies, provides double indemnity (twice the life insurance payment) to the deceased's beneficiary in cases of accidental death.

2. The reasonable expectations doctrine first appeared in a 1970 law review article by Robert Keeton: "the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970). In contract law, expectation is the prospect of gain a party expects from having entered a contract. This principle is "easily the most important single idea in the whole

HeinOnline -- 12 Conn. Ins. L.J. 657 2005-2006

misapplication of a negligence test to crimes, and a contradictory corpus with little precedential integrity.

Part I of this Comment establishes that the reasonable expectations of policyholders are violated inasmuch as the means/results distinction—a characteristic feature of accidental death policies – distorts the definition of "accident." Part IIA demonstrates that the currently disfavored position[3] of denying accidental death coverage for deaths resulting from the insured's criminal activity is preferable to the current majority position, which applies a foreseeability inquiry to determine whether death was accidental.[4] While the latter position results in both denying coverage of deserving claims and providing coverage for undeserving claims, the former position, as Part IIB illustrates, incorporates the relevant issue of culpability. Part IIC explains that when it comes to first-party insurance, the insurance doctrines of promoting deterrence and discouraging moral hazard may outweigh considerations of compensation. Part IIIA defends the right of beneficiaries to be compensated for accidental deaths not involving illegal activity. Finally, Part IIIB suggests that insurers must explain express exclusionary clauses for deaths caused by high-risk but legal activities, or in accordance with *contra proferentum*,[5] pay the double indemnity to the insured's beneficiaries when such accidental deaths occur. This Comment additionally proposes that both the insurer and the insured would benefit were the insurance industry to offer high-risk accidental death policies to those who are willing to pay higher premiums because they engage in risky but legal activities.

---

contracts field." MARVIN A. CHIRLSTEIN, CONCEPTS AND CASE ANALYSIS IN THE LAW OF CONTRACTS 4 (4th ed. 2001).

3. In cases of unlawful activity resulting in accidental death, courts generally follow one of two approaches. A minority of courts bars coverage if the insured's violation of the law caused the death; a majority of courts allows recovery. ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 470 (3d ed. 2002).

4. Most courts inquire as to "whether the occurrence was a foreseeable consequence of the acts of the insured." *Id.*

5. *Contra proferentum* represents that ambiguities in a contract are to be construed against the drafter. Under *contra proferentum* (literally "against the party that proffers"), a term is generally considered to be ambiguous if it is fairly susceptible to two different reasonable interpretations. *See generally* Eugene R. Anderson and James J. Fournier, *Why Courts Enforce Insurance Policyholders' Objective Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L. J. 335 (1998).

HeinOnline -- 12 Conn. Ins. L.J. 658 2005-2006

I. THE AMBIGUOUS "MEANS"/"RESULTS" DISTINCTION

Words have a longer life than deeds.
-*Pindar*, NEMEAN ODES

A. A DISTORTED DEFINITION

Accident insurance was introduced to America by James G. Batterson, a Connecticut architect who discovered it when he bought a rail ticket in England.[6] From its inception, accident insurance fulfilled a dual purpose as a protector of hapless victims and their beneficiaries and as a profit maker for insurers.[7] When accident insurance became popular in the mid-1800s, few people had life insurance policies, and workers' compensation did not yet exist.[8] The first accident policies, purchased for pennies with rail tickets, covered "any personal injury whatever incident to, and consequent on, railway traveling."[9] The insurance sold well because it was affordable and because the train wrecks of the time were well publicized,[10] creating fear, "the necessary ingredient for success."[11] With the advent of widespread health and life insurance coverage, accidental death insurance evolved from a product that secured "against the dangers of rail travel, to a general purpose sweetener used to promote the sale of other products,"[12] namely, more comprehensive insurance policies.

In the realm of accidental death insurance, the definition of "accident" has been complicated by insurance policies' distinction between accidental

---

6. Adam F. Scales, *Man, God and the Serbonian Bog: The Evolution of Accidental Death Insurance*, 86 IOWA L. REV. 173, 185 (2000).

7. *Id.*

8. *Id.* at 186.

9. *Id.* at 180.

10. *See* EDWIN J. FAULKNER, ACCIDENT AND HEALTH INSURANCE 10 (1940).

11. Scales, *supra* note 6, at 186. *See generally* Cass R. Sunstein, *Hazardous Heuristics*, 70 U. CHI. L. REV. 757, 758 (2003). According to Sunstein, human nature tends to magnify sensationalized risks and disregard the more mundane, albeit likely, dangers by way of the "availability heuristic." This suggests that the public demand for insurance against an easily imagined harm will be greater than the public demand for insurance against a harm which is more difficult to imagine. "We would therefore predict that easily imaginable harms would lead to relatively greater private precautions and relatively greater governmental concern. Well-organized private groups should, and do, take advantage of this heuristic, attempting to publicize visible examples of harms to which they seek to draw attention."

12. Scales, *supra* note 6, at 189.

HeinOnline -- 12 Conn. Ins. L.J. 659 2005-2006

"means," or causes, and accidental "results."[13] Generally, injuries from "external, violent, and accidental means" have been covered, while the accidental results of actions voluntarily undertaken have not.[14] This distinction was explained in a 1979 case: "the motivating, operative and causal factor must be accidental in the sense that it is unusual, unforeseen and unexpected. Under the majority view the emphasis is upon the accidental character of the causation—not upon the accidental nature of the ultimate sequence of the chain of causation."[15]

Refusing coverage for "accidental results" not due to "accidental means" has allowed insurance companies, through their insurance policies, to require that an accident be the sole cause of death for accidental death coverage to be granted. Where the insurer can point to any deliberate action that led to an accidental death, supposedly making death foreseeable, accidental death coverage has been denied. Courts have enforced the means/results distinction by upholding insurance policy contracts, often ruling that accidental results, if caused by non-accidental means, are somehow non-accidental.

In *International Travelers Association v. Bettis*, the court held that "the rule seems to be established...that in order to find that injury [was] effected by accidental means, *the element of accident must be found in that which produced the injury* rather than in the mere fact that the injury occurred."[16] Accidental coverage was denied in *Bettis* in spite of the fact that the policyholder's death was caused by blood poisoning brought on by an injury that occurred when he was repairing a fence.[17] Though the death was the result of an accident, the court held that it was not clear that death was caused by accidental means.[18] The policy requiring the accidental death to be caused *solely* by accidental means was and is typical of accidental death insurance policies.[19]

---

13. LEE R. RUSS, COUCH ON INSURANCE §140:1 (3d ed. 2005). "A major source of dispute and confusion in the field of accident insurance is whether harm resulting from conduct which is wholly or primarily voluntary may nonetheless be considered to be an accident, accidental, or the result of accidental means." *Id.*

14. *Id.* at § 140:12: General Rule that Foreseeable Consequences Are Not Accident or By Accidental Means. The basic analysis focuses on the deliberate or voluntary conduct of the insured.

15. Linder v. Prudential Ins. Co. of Am., 250 S.E.2d 662, 665 (N.C. Ct. App. 1979).

16. Int'l. Travelers Ass'n. v. Bettis, 120 Tex. 67, 76 (1931) (emphasis added).

17. *Id.* at 72.

18. *Id.* at 76.

19. RUSS, *supra* note 13, at §139:13.

HeinOnline -- 12 Conn. Ins. L.J. 660 2005-2006

The means/results distinction defies the common conception that an accident is a fortuitous[20] and sudden[21] event, regardless of whether accidental or non-accidental means led up to it. Benjamin Cardozo said as much when he proclaimed that an accidental death occurs when a person dies "in such a way that his death is spoken of as an accident."[22] In *Lewis v. Ocean Accident & Guarantee Corporation,* a case with facts similar to those of *Bettis,* Judge Cardozo held that an accidental death had occurred where the insured pricked a pimple which then became infected and caused him to die of blood poisoning.[23] Whether or not such a death was foreseeable, it certainly was unexpected and accidental.

Popular understanding, which suggests that an accident is an unfortunate event resulting from bad luck or carelessness but not intentional wrongdoing,[24] provides an extra-textual basis for resolving coverage disputes.[25] The reasonable expectations of the policyholder are defined at least to some degree by the average person's understanding.[26] Since the advent of accidental insurance litigation, the reasonable expectations of the average policyholder have sometimes trumped even contrary policy language.[27] Whereas contract law encourages upholding

---

20. "The public policy underlying the fortuity requirement is so strong that if the insurance policy itself does not expressly require that the loss be accidental, courts will imply such a requirement. The fortuity principle is often expressed with reference to certainty: losses that are certain to occur, or which have already occurred, are not fortuitous." JERRY, *supra* note 3, at 451.

21. Support for the proposition that an accidental death must result from a sudden event can be found in the time limit that is standard in accidental death policies. "Most accidental death benefit endorsements to life insurance policies (so-called double indemnity provisions) require that the accidental death result within a specified number of days." *Id.* at 502.

22. Lewis v. Ocean Accident & Guarantee Corp., 120 N.E. 56, 57 (N.Y. 1918). Judge Cardozo explained why the "accidental means" and "accidental results" distinction is illogical in this way: "Unexpected consequences have resulted from an act which seemed trivial and innocent in the doing. Of itself, the scratch or the puncture was harmless. Unexpectedly it drove destructive germs beneath the skin, and thereby became lethal. To the scientist who traces the origin of disease there may seem to be no accident in all this...But our point of view in fixing the meaning of this contract must not be that of the scientist. It must be that of the average man. Such a man would say that the dire result, so tragically out of proportion to its trivial cause, was something unforeseen, unexpected, extraordinary, an unlooked-for mishap, and so an accident. The test – the one that is applied in the common speech of men – is also the test to be applied by the courts."

23. *Id.*

24. "Accident" at Merriam-Webster's Dictionary On-Line at http://www.m-w.com/dictionary/accident.

25. Scales, *supra* note 6, at 236.

26. *Id.*

27. *Id.*

policy exclusions that limit coverage, it does not support manipulation of the plain meaning of words. Inasmuch as the means/results distinction violates policyholders' reasonable expectations, it must be construed against the drafter-insurer.

B. REASONABLE EXPECTATIONS: THE AVERAGE PERSON'S UNDERSTANDING

That the means/results distinction has disproportionately favored the insurer at the expense of the insured is not surprising in light of the fact that it was created by insurance companies.[28] Steadily utilized by courts, the ambiguous means/results distinction has empowered judges to make judgments on a case-by-case basis. Whereas many courts have mistakenly called accidents non-accidents, as in *Bettis*,[29] other courts have invoked the means/results difference to order coverage in spite of the exclusions of the policy.[30]

In *Olson v. American Bankers Insurance Company*, for example, the court held that the death of a woman who had ingested alcohol and Valium and drowned in her hot tub was accidental even though the accident policy excluded death due "in whole or in part, directly or indirectly, from...the influence of any intoxicant."[31] A toxicological report indicated a .14 blood alcohol level, as well as the presence of diazepeam and nordiazepam, in the deceased.[32] Though it is hard to fathom that the drowning of an inebriated person was not due at least "in part" or "indirectly" to her inebriation, the court found the woman's death to be accidental because a scrape on her

---

28. "Beginning in the 1860s, and accelerating by the 1880s, insurers devised a distinction between 'accidental means' and 'accidental results'...insurers defined another class of injuries for which there was no coverage: those which were merely 'accidental results' of actions voluntarily, and thus not accidentally, undertaken." Scales, *supra* note 6, at 208.

29. Another case where an accidental death was held to be non-accidental is Runge v. Metropolitan Life Ins. Co., 537 F.2d 1157, 1159 (4th Cir. 1976), in which the decedent accidentally died during autoerotic asphyxiation – a practice that heightens orgasm during masturbation by cutting off one's oxygen supply. *See infra* Part III of this Comment. The death was held to be non-accidental because "death under these circumstances was a natural and foreseeable, though unintended, consequence." *Runge*, 537 F.2d at 1159.

30. *See generally* Hoffman v. Life Ins. Co. of N. Am., 669 P.2d 410 (Utah 1983) for a discussion on the ambiguity of "accident." In *Hoffman*, Utah's Supreme Court remanded the case to the trial court that failed to define "accident" in its conclusions of law. "It is impossible to know what legal standard was attributed to that term."

31. Olson v. American Bankers Ins. Co., 30 Cal. Ct. App. 816, 821 (1994).

32. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 662 2005-2006

elbow "could have been caused by a fall in the hot tub."[33] The court proffered the theoretical fall in the hot tub as an accidental means, even though Valium and liquor likely contributed to the fall.

Whereas *Bettis* complicates the meaning of "accident," *Olson* additionally complicates issues of causation by offering up speculative means, like so many banana peels lying around the Jacuzzi. Clearly, the means/results doctrine has been used to deny deserving parties but to reward others even in violation of a contract. Courts may find the ambiguity of the means/results distinction useful in filling moral as well as causal voids, providing a convenient escape from supplying coverage for reprehensible behavior. But should courts be charged with deciding what is reprehensible? Though the blood-infected farmer in *Bettis* and the drunken Jacuzzi owner in *Olson* were both criminally innocent, the farmer, who seems the less blameworthy of the two, is the one who was denied coverage.

Conspicuously absent from legal discussions in *Bettis* and *Olson* is the issue of fault, even though "accident" is defined as "an unexpected happening causing loss or injury which is *not due to any fault or misconduct on the part of the person injured* . . . an unfortunate event resulting especially from carelessness or ignorance."[34] Whereas cases in which the deceased had a disease or medical condition that led to death are clearly non-accidental,[35] cases involving deaths caused at least in part by immoral or reckless behavior on the part of the deceased pose questions unanswered by the means/results distinction.

How much immorality, recklessness or wrongdoing makes a death non-accidental? The legislature, and not the courts, is charged with deciding what is reprehensible by way of criminal law. The proper limit on accidental death coverage awards is not to be found in the ambiguities of the meaning of "accident." Coverage of accidental deaths should rather be denied where coverage is expressly excluded by the policy or where the death was caused by the policyholder's intentional criminal conduct.

---

33. *Id.*

34. "Accident" at Merriam-Webster's Dictionary On-Line at http://www.m-w.com/dictionary/accident.

35. Accidental death benefits were not available to the beneficiary of a woman who died of a hemorrhage caused by the rupture of a preexisting cerebral aneurism. The policy required an accident to be the predominant cause of death. *See generally* Carrol v. CUNA Mut. Ins. Soc'y, 894 P.2d 746 (Colo. 1995).

HeinOnline -- 12 Conn. Ins. L.J. 663 2005-2006

II. DENYING COVERAGE OF ACCIDENTAL DEATHS RESULTING FROM INTENTIONAL CRIMINAL ACTS

Iudex damnatur ubi nocens absolvitur.[36]
-Publilius Syrus, First Century B.C.

A. OUTSIDE THE SPHERE OF LIBERTY

Accidental death insurance is a first-party insurance in which indemnity is paid upon the occurrence of a loss to the insured or the insured's beneficiary.[37] Coverage is generally denied where the deceased intentionally attacked another person.[38] Liability, or third-party, insurance policies likewise typically exclude coverage "for injury or damage intentionally caused by the insured."[39] Whether a coverage dispute involves liability insurance or accidental death insurance, determining what was or was not intended is not always obvious. If the insured was attacked and stabbed to death without provocation, the insured would describe her own death as an accident; the insured would say that death was fortuitous, unforeseen, and unintended by her. The same would be true if the insured were killed by a bolt of lightening; the insured would say that death was an accident.[40] The deceased in each case did not intend to cause death or circumstances in which death might result.

Most cases are more difficult. To address this, three constructions of intention have developed in the context of insurance coverage generally.[41] One view, yielding the least coverage, is that if the intentional act by the insured results in injuries or damage that are a natural and probable result of the act, the loss is intentional, and not accidental.[42] The second approach is that a loss is accidental unless the insured intended the act and also intended some kind of damage or injury, whether or not the damage or injury intended was the damage or injury that occurred.[43] The third

---

36. The judge is condemned when the criminal is absolved.

37. JERRY, *supra* note 3, at 49-50.

38. *Id.* at 472.

39. *Id.* at 479. The fact that the insured designates a beneficiary to receive the proceeds of the policy does not mean that the insurance is third-party, or liability insurance. *Id.* at 50.

40. *Id. See also* Cole v. State Farm Mut. Ins. Co., 753 A.2d 533, 535, 544 (Md. 2000) (holding that the death of the insured, who was fatally shot while sitting in her car, was an accidental death).

41. JERRY, *supra* note 3, at 483.

42. *See* St. Paul Ins. Co. v. Talladega Nursing Home, Inc., 606 F.2d 631, 634 (5th Cir. 1979).

43. *See* Allstate Ins. Co. v. Dillard, 859 F. Supp. 1501, 1503 (M.D. Ga. 1994).

HeinOnline -- 12 Conn. Ins. L.J. 664 2005-2006

approach, allowing for the most coverage, is that the injury suffered must be what the insured specifically intended for the result to be considered intentional and not accidental.[44]

These three foreseeability tests are inadequate when applied to violations of criminal law, for whereas criminal law represents a societal conception of what harms are punishable and what limits on freedom are justified,[45] insurance is generally understood to cover losses due to fortuity and negligence but not intentional behavior.[46] Insurance creates a situation "where individuals are relieved from burdens at the expense of the collective, *but with the availability of the remedy at least in part conditioned upon the proper conduct of the party seeking it.*"[47] Departing from the realm of the accidental,[48] reckless and intentional acts fall within the domain of criminal law, which exists to address and deter such acts[49] and to provide retribution.[50] Proposing that the same dividing line should be applied to accidental death insurance coverage is hardly radical.[51] Criminal law addresses conduct beyond the scope of the accidental, identifying that which society has deemed to be "demonstrably harmful."[52] What lies outside criminal behavior is the "sphere of liberty – a sphere in

---

44. *See* Providence Mut. Fire Ins. Co. v. Scanlon, 638 A.2d 1246, 1247-48 (N.H. 1994).

45. STEPHEN A. SALTZBURG ET AL., CRIMINAL LAW 1 (2d ed. LEXIS Publishing 2000).

46. 17 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS § 49:115 (4th ed. West Group 2000) (1920).

47. Mark W. Dykes, *Occurrences, Accidents, and Expectations: A Primer of These (and Some Other) Insurance-Law Concepts*, 2003 UTAH L. REV. 831, 836 n.11 (2003) (emphasis added).

48. Negligence on the part of the insured does not bar a death from being treated as accidental. Alan Stephens, Annotation, *Accident or Life Insurance: Death by Autoerotic Asphyxiation as Accidental* 62 A.L.R.4th 823, 828 (1988).

49. *See* MODEL PENAL CODE § 1.02(1)(a)-(e) (1962). Under the Model Penal Code the general purposes of the provisions governing the definition of offenses are: "(a) to forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens substantial harm to individual or public interests; (b) to subject to public control persons whose conduct indicates that the are disposed to commit crimes; (c) to safeguard conduct that is without fault from condemnation as criminal; (d) to give fair warning of the nature of the conduct declared to constitute an offense; (e) to differentiate on reasonable grounds between serious and minor offenses." *Id.*

50. "Only the law of retribution (*jus talionis*) can determine exactly the kind and degree of punishment; it must be well understood, however, that this determination [must be made] in the chambers of a court of justice (and not in your private judgment)." IMMANUEL KANT, THE METAPHYSICAL ELEMENTS OF JUSTICE: PART I OF THE METAPHYSICS OF MORALS 101 (John Ladd trans., Bobbs-Merrill Educ. Publishing 1965) (1797).

51. "[P]ublic policy prohibit[s] the indemnification of an insured for harm caused by intentional misconduct." WILLISTON & LORD, *supra* note 46, at § 49:115.

52. SALTZBURG, *supra* note 45, at 1-3.

HeinOnline -- 12 Conn. Ins. L.J. 665 2005-2006

which government is not justified in interfering with the freedom of individuals."[53]

Foreseeability inquiries create little precedential power when applied to crimes because they disregard the most basic of public policies – the law.[54] Under foreseeability tests, accidental death coverage for deaths resulting from drug overdoses and drunk driving has been both denied and awarded. In some cases, cocaine overdoses have been held to be accidental if unintended; in other cases, cocaine overdoses have been held to be non-accidental because they are reasonably foreseeable.[55]

Comparing two drunk-driving cases illustrates the logic of considering criminal law in determining insurance coverage disputes.[56] In each case a survivor of the decedent sought to recover double indemnity, claiming the death was accidental. Recovery was denied where the decedent had alcohol in his body in *Life & Casualty Insurance of Tennessee v. Crawford*.[57] The policy prohibited double indemnity coverage for death if the insured had alcohol in his body "in any degree." By failing to distinguish between alcohol "in any degree" and legal drunkenness, the policy failed to cover accidental deaths in which the insured may have been innocent, and for which he would have reasonably expected coverage. Legal drunkenness, because it signifies impairment of a driver's faculties, would have been a fairer standard by which to examine whether the decedent should be held responsible for the accidental death.

In *Greene v. J.C. Penney Life Insurance Company*,[58] the court determined that a state-approved policy exclusion denying coverage for losses occurring while the insured's blood alcohol level was at least .10%,

---

53. *Id.*

54. This assumes that law is established by a legitimate government in a free society, and not, for example, the product of a regime like the Nazi puppet government that controlled Croatia from 1941 to 1945. *See* Alperin v. Vatican Bank, 242 F. Supp. 2d 686, 687-88 (N.D. Cal. 2003).

55. *Compare* O'Toole v. N.Y. Life Ins. Co., 671 F.2d 913, 1914-15 (5th Cir. 1982) (holding that the death of the insured from a self-administered injection of cocaine was accidental) *with* Lloyd v. First Farwest Life Ins. Co., 773 P.2d 426, 427 (Wash. Ct. App. 1989) (holding that one who illegally ingests a controlled substance cannot successfully claim that resulting injury was an accident where the substance is known to be dangerous).

56. *Compare* Life & Cas. Ins. of Tenn. v. Crawford, 72 So. 2d 858 (Ala. 1954) (denying recovery where decedent had alcohol in his body "in any degree") *with* Greene v. J.C. Penney Life Ins. Co., 23 F. Supp. 2d 1351, 1353 (M.D. Fla. 1997) (determining that an exclusion of coverage for losses occurring while the insured's blood alcohol level was .10% or higher was valid where insurer obtained approval from the Director of the Illinois Department of Insurance).

57. *Crawford*, 72 So. 2d at 858.

58. 23 F. Supp. 2d 1351 (M.D. Fla. 1997).

HeinOnline -- 12 Conn. Ins. L.J. 666 2005-2006

or legally drunk, was valid.[59] The decedent's blood alcohol level was .20%.[60] The policy's application of legal standards endorsed the objective policyholder's reasonable expectation that for purposes of accidental death coverage, an accident cannot include a criminal event. This system would have provided coverage in the *Crawford* case, bringing about a more satisfactory result. Though the *Crawford* case pre-dated blood alcohol tests, an investigation into how much the decedent had drunk before driving would have aided the court in ascertaining whether the decedent was drunk or sober, in which case the fact that he had had one drink could have been deemed irrelevant.

Crawford exemplifies that the insurer's imposition of demands stricter than those imposed by law can result in denying benefits to someone who deserved them. Though insurance policy language should "not be read in a vacuum,"[61] one gets the feeling policy language is indeed read in a vacuum when one court rules to provide double indemnity for a fatal cocaine overdose and another court rules to deny coverage because the decedent had a tiny amount of alcohol in his bloodstream. The Model Penal Code states that a goal of criminal law is to give fair warning of the nature of conduct that constitutes an offense. Insurance companies should benefit from this goal by requiring insured parties who expect coverage to act within the sphere of liberty.

B. THE DEBACLE OF APPLYING A TORT DOCTRINE TO CRIME

A disturbing example of how applying a foreseeability test to a crime can result in insurers, and therefore policyholders, paying for criminal conduct is *Valley Dental Association v. Great-West Life Assurance*.[62] In the fall of 1987, Gregory Christensen stopped his car along the side of the road to pick up a fifteen-year-old hitchhiker.[63] He drove off the road, forced the girl at knife-point to perform oral sex on him, and sexually assaulted her.[64] Following the assault, Christensen grabbed the girl by the throat, saying "I have to kill you."[65] The girl took the knife and stabbed

59. *Id.* at 1355. On the basis of the Court's determination that the subject insurance policy was specifically approved in its present form by the Director of the Illinois Department of Insurance, the Plaintiffs' motion for summary judgment was denied.

60. *Id.* at 1353.

61. Ceci v. Nat'l Indem. Co., 225 Conn. 165, 168 (1993).

62. 173 Ariz. 327 (1993).

63. *Id.* at 328.

64. *Id.*

65. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 667 2005-2006

Christensen, severing his femoral artery, which caused him to bleed to death.[66]

Claiming that Christensen's death was accidental, Christensen's survivors sought to collect double indemnity on his group insurance policy.[67] The policy included a provision for double payment in cases of death due to bodily injury "caused solely by accidental means."[68] The trial court ruled in favor of the beneficiaries, deeming Christensen's death an accidental one.[69] The Court of Appeals reversed, reasoning that because it is foreseeable that someone who is attacked will try to defend herself, the death of an attacker cannot be accidental.[70]

Though the appeals court's conclusion seems right, its reasoning is flawed. First, if foreseeability determines whether a death is accidental, a question arises as to whether objective or subjective foresight should be applied.[71] Some courts have held that the insurer must pay out accidental death coverage if the deceased lacked foresight. "Where the insured suffers from a mental disease or defect so that he is not likely to be able to appreciate the consequences of his conduct in light of the probable consequences, then the test is subjective, and death may be accidental even though a rational person in the same circumstances would have expected death to be the probable result of his conduct."[72] Other courts have held that foreseeability is not a subjective standard, but an objective one: if the average man would call result "something unforeseen, unexpected, extraordinary, an unlooked-for mishap," then the death was accidental.[73] Where the insured's death resulted, "unexpectedly, from an affirmative choice by the insured to expose himself or herself to a known peril which reasonable and ordinary prudence would deem dangerous, recovery under an accidental death policy will be denied; the standard is an objective one:

---

66. *Id.*

67. Valley Dental Ass'n v. Great-West Life Assurance, 173 Ariz. 327, 328 (1993).

68. *Id.*

69. *Id.* at 329.

70. *Id.* at 330.

71. "If advocates of the objective view truly stood the courage of their convictions, there could be no accidents, except perhaps for the actions of a sleepwalker. If those who espouse the subjective view were to be equally as firm, however, there would always be accidents absent a confession by the insured that the result was intended from actions taken. Neither result is acceptable." Dykes, *supra* note 47, at 879.

72. *See* Hoffman v. Life Ins. Co. of N. Am., 669 P.2d 410, 419 (Utah 1983).

73. "This test – the one that is applied in the common speech of men – is also the test to be applied by the courts." Lewis v. Ocean Accident & Guarantee Corp. 120 N.E. 56, 57 (N.Y. 1918).

HeinOnline -- 12 Conn. Ins. L.J. 668 2005-2006

not what the insured understands or believes, but what a reasonable person ordinarily would expect by such conduct."[74]

The appeals court in *Valley Dental*, acknowledging the division in case law according to the two tests, claimed that whether the objective or subjective test was applied, "by any definition, Christensen's death was not an accident."[75] Christensen should have had foresight because "it was he who was armed with a knife and the intent to kill and, *as was certain*, the victim struggled against death and seized the weapon to defend herself."[76] But what if added to the above story were the facts that Christensen had no weapon and that the hitchhiker, an expert at karate, killed Christensen with one swift kick to the head? Would Christensen's death then be "unforeseeable," or accidental enough to require the insurer to pay the double indemnity?

Though a majority of courts would currently bar coverage in a case such as the *Valley Dental* scenario because "as a general rule, if one advances on another...and the person dies in the encounter, the death is not accidental,"[77] courts nonetheless justify use of the rule not because such an attack is intentionally criminal, but because the attack makes a counter-attack foreseeable. Regarding cases where the insured dies while intentionally engaging in criminal conduct that falls short of an attack, courts generally follow one of two approaches.[78] While a minority "implies a clause in the policy, based on public policy, that if a loss occurs resulting from the insured's violation of the law, no coverage results,"[79] "most courts reject this approach, reasoning that if an innocent beneficiary is suing for a recovery under the policy, the loss is fortuitous *from the point of view of the beneficiary*." [80]

This squarely contradicts an established legal principle regarding first-party insurance coverage, namely that the fortuity of the death is to be determined "from the insured's viewpoint."[81] A determination as to whether a party's failure to avoid certain conduct lacked foresight, resulting in negligence, is used in torts to determine whether the actor is liable. Applying a foreseeability test from the point of view of the beneficiary to

74. 43 AM. JUR. 2D *Insurance* § 575 (2005). *See* Gaddy v. Hartford Life Ins. Co., 218 F. Supp. 2d 1123 (E.D. Mo. 2002).

75. Valley Dental Ass'n v. Great-West Life Assurance, 173 Ariz. 327, 330 (1993).

76. *Id.* (emphasis added).

77. *Id.* at 472.

78. *Id.* at 470.

79. *Id.*

80. *Id.* (emphasis added).

81. JERRY, *supra* note 3, at 470.

the insured's criminal act in *Valley Dental* results in inquiring whether a reasonable beneficiary would foresee her husband (assuming Christensen named his wife as his beneficiary) being stabbed to death after raping someone. Applying a foreseeability test from the point of view of the policyholder to the same criminal act results in inquiring whether a reasonable person would foresee being stabbed to death after raping someone. Neither inquiry is appropriately applicable to a serious crime. A foreseeability or negligence test that does not acknowledge right and wrong is inadequate for determining insurance coverage of the criminally culpable.

C. COMPENSATION, DETERRENCE, AND OTHER GOALS OF INSURANCE

It is not only against public policy to subsidize illegal acts; it is against the principles of insurance law. The insurance industry attempts to function as a "moral enterprise 'deeply interested in the growth of public and private honor,'" with an "obligation to exclude the immoral."[82] The insurance system was formed by allowing voluntary policyholders to pay a moderate amount of money so that if an unforeseen circumstance which required a large amount of money were to occur, the needed coverage could be gotten. Though the insurer may limit coverage by the use of exclusions, intentional criminal act exclusions should be generally adopted by insurance companies in keeping with the moral-based goals of the industry. To apply accidental death policyholder premiums to compensate for criminal acts would subsidize crime with policyholders' fees.

Although the compensation principle requires compensating innocent beneficiaries, the deterrence principle requires avoiding subsidizing illegal acts. Compensating beneficiaries is a goal of insurance that must be balanced with competing insurance goals of deterrence and fairness to policyholders. Unfortunately, this has not always been clear, especially to juries interpreting homeowner's insurance policies. Under homeowners' insurance policies, coverage has been provided in violation of policy exclusions for second-degree manslaughter, sexual assault of minors, and

82. Tom Baker, *On the Genealogy of Moral Hazard,* 75 TEX L. REV. 237, 254 (1996), *quoting* Thomas S. Chard, *Morals and Moral Hazard as Related to Underwriting, Address Before the Fire Underwriters' Association of the Northwest* (Sept. 22, 1875), in PROCEEDINGS OF THE SIXTH ANNUAL MEETING OF THE FIRE UNDERWRITERS' ASS'N OF THE NORTHWEST 28, 32 (1875), and James Bergen, *Fraud Upon Underwriters*, 2 HUNT'S MERCHANTS' MAG. & COM. REV. 296, 297 (1840).

HeinOnline -- 12 Conn. Ins. L.J. 670 2005-2006

vehicular homicide.[83] In a particularly egregious case, *Economy Fire & Casualty Company v. Haste*,[84] an insurance company was forced to pay $2.5 billion in wrongful death claims because the jury deduced that the crimes of the policyholder, a sadistic serial killer, were outside of the policy exclusion of intentional losses.[85] Though the policyholder intended to rape and torture his victims, according to the jury it was not clear that he intended to kill them.[86]

Denial of insurance coverage for intentional harm done by insured parties is not a denunciation of compensation, but "a testament to the strength of the public policy prohibiting the indemnification of an insured for harm caused by intentional misconduct."[87] Policyholders do not sign on to contribute to damages caused by insured serial killers. "Stated simply, the laudable goal of compensating innocent victims must give way to the consistently expressed and undoubtedly well-based fear that any other result would encourage – or at least remove any disincentive from – misconduct by insureds."[88]

Deterrence through denial of coverage for deaths caused by the deceased's intentional criminal behavior discourages acts which damage policyholders, and in turn, society. Directing funds paid by all policyholders to compensate for illegal acts damages policyholders by raising the cost of insurance premiums to pay for illegal acts.[89]

> The insurer bases its rates on the probabilities of fortuitous losses; if the insured is in control of the insured risk, which is the case if the policy covers intentional acts, the ability of the insurer to calculate fair rates is frustrated. Moreover, public policy forbids contracts indemnifying a person against loss resulting from his own willful wrongdoing. An insured should not be able to act wrongfully, all the time knowing

---

83. Daniel C Eidsmoe and Pamela K. Edwards, *Home Liability Coverage: Does the Criminal Acts Exclusion work where the "Expected or Intended" Exclusion Failed?* 5 CONN. INS. L.J. 2, 707 (1999).

84. 824 S.W.2d 41 (Mo. Ct. App. 1991).

85. *Id.*

86. *Id.* at 46.

87. WILLISTON & LORD, *supra* note 46, at § 49:115.

88. *Id.*

89. *See generally* A. DENNING, THE CHANGING LAW (1953): "Underlying all the law of restitution is the conception that no one should unjustly enrich himself at the expense of his neighbour." *Id.* at 65.

> that the insurer will pick up the tab for any damages or injury the insured causes.[90]

Though some may argue that deterrence has no place in accidental death insurance because the wrongdoer is dead, deterrence applies to potential wrongdoers as well. Likewise, though some may argue that criminal law reflects a society's prejudices or biases, the criminal justice system nonetheless remains society's best determiner of what can be agreed upon as wrongful. Judge-created systems are less dependable than criminal law, as demonstrated by the "deliberate intention" exclusion experiment in California. The Supreme Court of California held that where an insured "deliberately intended" a loss, the loss would be excluded from insurance coverage.[91] Confusion ensued. Courts, including the California Supreme Court, were not faithful to the deliberateness standard; rather, they "adopted an expansive rule of no coverage even though the punitive damages and/or penalty may have been based on conduct that was merely negligent or reckless but not intentional in the sense of being deliberative."[92] Using criminal law as a gauge of what may be covered by insurance payment is not only easier to administer than requiring judges to define "deliberate intention" on a case-by-case basis; it is also more consistent and therefore more fair.

Finally, criminal law is useful in defeating moral hazard, or the risk that an insured party will act less cautiously than a non-insured party because of his knowledge that others will bear the burden of any economic loss he causes.[93] "Unlike the applicant who presents a greater-than-usual physical hazard, the applicant who presents a greater-than-usual moral hazard cannot obtain insurance at a higher price."[94] A judgment about right and wrong—absent in the foreseeability doctrine—is found in the insurance concept of moral hazard:

> This resistance to insuring moral hazards lies in great tension with the apparent faith in the moral scientists' doctrine of chances. Not all of life, it seems, was to be ceded to the field of Hazard. What remained to be left

---

90. JERRY, *supra* note 3, at 479.

91. James M. Fischer, *The Exclusion from Insurance Coverage of Losses Caused by the Intentional Acts of the Insured: A Policy in Search of a Justification*, 30 SANTA CLARA L. REV. 95, 99-100 (1990).

92. *Id.* at 100.

93. Dykes, *supra* note 47, at 835.

94. Baker, *supra* note 82, at 253.

HeinOnline -- 12 Conn. Ins. L.J. 672 2005-2006

> outside was the realm of evil: crime, fraud, and the suspicious "other."[95]

The typical intentional act exclusion of liability policies is meant to guard against moral hazard.[96] But the distinction between negligence and intent, sometimes difficult to discern, is the fault-line that differentiates torts from crimes.[97] If the legitimate purposes of an intentional act exclusion are punishment and deterrence,[98] then the courts should recognize the intentional act exclusion that is available to them in existing criminal laws. Civil suits and criminal trials are available venues to compensation for victims of torts and crimes.[99] Whereas civil suits can provide monetary damages, criminal trials provide justice, retribution, and closure. Conversely, accidental death insurance, conceived to counter the uncertainty of fate by spreading risk among law-abiding policyholders, should prevent loss from fortuity and negligent acts but not from criminal ones.[100]

III. DEMANDING COVERAGE NOT EXPRESSLY EXCLUDED

> It is not in giving life but in risking life that man is raised above the animal.
> *-Simone de Beauvoir*

A. ALLOWING LEGAL RISK TAKING

The distasteful or even weird quality of a legal but physically hazardous practice does not justify denial of accidental death coverage. In insurance terms, the difference is between two risks, moral hazard and physical hazard. The "answer to most physical hazards [is] a higher premium rate, not a refusal to insure."[101] The historical difference in the treatment of physical as opposed to moral hazards by the insurance industry

---

95. *Id.* at 254.

96. *Id.*

97. Dykes, *supra* note 47, at 847.

98. Fischer, *supra* note 91, at 172.

99. "[C]onsumers already have insurance for a very substantial percentage of accidental injuries or deaths; that is, they have tort law." Steven P. Croley & Jon D. Hanson, *The Nonpecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law*, 108 HARV. L. REV. 1785, 1888 (1995).

100. Negligent creation of risks does not prevent the result from being accidental. Stephens, *supra* note 48, at 823.

101. Baker, *supra* note 82, at 253.

HeinOnline -- 12 Conn. Ins. L.J. 673 2005-2006

would support insuring high-risk legal behavior while refusing to insure the morally hazardous, including the intentionally criminal. Therefore, physical hazards must be expressly excluded from coverage or the insurer should pay for accidental death resulting from such a hazard. If there is no exclusion, unintended non-criminal deaths should be covered, and double indemnity should be paid.

An intentional criminal act exclusion not only condemns that which is criminal; it permits that which is legal, thereby decreasing rulings based on social stigma. To illustrate, grappling with exclusions of deaths "due to self-inflicted injury,"[102] courts have reached diverse holdings in autoerotic asphyxiation-related accidental deaths,[103] giving them little predictive power.[104] This diversity of holdings in cases involving stigma may be due to the fact that different judges attach stigmas to different activities, and in varied degrees. It is untenable for courts to sort through "this large, shifting, and complex array of moral and social judgments case by case."[105]

Misapplying moral judgments, rulings denying accidental death coverage for deaths from autoerotic asphyxiation have stigmatized and to some degree blamed the deceased. The unnecessary rehashing of tawdry details of autoerotic asphyxiation cases demonstrates condemnation of unusual sexual behavior. Cross-dressing and pornographic photographs found at the scene of death in such cases have been described as evidence of mental illness and of a practice which most people view with "prejudice, disgust, and curiosity."[106]

In *Runge v. Metropolitan Life Insurance Company*, the court denied accidental coverage for a death that occurred under "very bizarre circumstances."[107] The decedent had formed a noose that he used to vary his oxygen supply by semi-dangling. Limiting the supply of oxygen to his brain increased the euphoria of his orgasm while he masturbated. "At the time he reached orgasm the asphyxia was accentuated to the degree that the decedent lost consciousness, his body relaxed, and he was hanged to death."[108]

---

102. Sam Erman, *Word Games: Raising and Resolving the Shortcomings in Accident-Insurance Doctrine that Autoerotic-Asphyxiation Cases Reveal*, 103 MICH. L. REV. 2172, 2200 (2005).

103. Autoerotic asphyxiation is the unintended death of someone who has intentionally limited his air supply during masturbation to optimize the pleasure of orgasm; the practice is sometimes called autoerotic hanging.

104. Erman, *supra* note 102, at 2183.

105. *Id.* at 2188.

106. Erman, *supra* note 102, at 2189.

107. Runge v. Metro. Life Ins. Co., 537 F.2d 1157, 1158 (4th Cir. 1976).

108. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 674 2005-2006

The court held that "death under these circumstances was a natural and foreseeable, though unintended, consequence of Runge's activity."[109] The opinion cites cases in which insurance coverage was denied on the basis of intentional conduct, foreseeability, and lack of accidental means. "[I]f the death of the insured, although in a sense unforeseen and unexpected, results directly from the insured's voluntary act *and aggressive misconduct*, or where the insured *culpably* provokes the act which causes the injury and death, it is not death by accidental means."[110] And "it is generally held that if the insured voluntarily *provokes or is the aggressor* in an encounter, and knows, or under the circumstances should reasonably anticipate, that he will be in danger of death...his death or injury is not caused by an accident."[111]

The opinion in *Runge* injects condemnation into a situation where the deceased did not act aggressively, provoke anyone, or break any law. The holding lumps practitioners of autoerotic asphyxiation with "aggressors." Because Runge meant no harm, and broke no law, his insurance company should have paid his wife the double indemnity coverage. Indeed, if the answer to physical hazards is a higher premium rate, not a refusal to insure, then high-risk accidental death policies should be available to a pool of those who participate in high-risk but legal activities, whether sky-diving or autoerotic asphyxiation. Risk takers in a position to negotiate could perhaps opt to pay higher premiums to insure their beneficiaries against their own accidental deaths. But are consumers in a position to negotiate insurance contracts? *Contra proferentum*, a basic premise of insurance law,[112] suggests that the answer is no.

B. A CONTRACT CONSTRUED AGAINST THE DRAFTER

Forming an insurance policy contract involves several steps.[113] During the initial contact between the consumer and the insurance representative, the representative typically explains what the insurer might provide in the way of a product.[114] The prospective applicant may communicate what

---

109. *Id.* at 1159.

110. Smith v. Combined Ins. Co. of Am., 202 Va. 758, 761 (1961) (emphasis added).

111. Wooden v. John Hancock Mut. Life Ins. Co., 205 Va. 750, 755 (1965) (emphasis added).

112. Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996).

113. JERRY, *supra* note 3, at 219.

114. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 675 2005-2006

coverage he or she expects to receive.[115] If the consumer submits an application for coverage, this application is the offer.[116] The insurance company will evaluate the application to determine whether to assume the risk of coverage for the applicant. If the company, after investigation, decides to assume the risk, it will issue the policy. This is the acceptance. The mechanics of offer and acceptance fulfill the mutual assent required to form a contract.

Insurance policies are contracts of adhesion,[117] standardized-form contracts drafted by one party, to be signed by the party in a weaker position who has little choice about the terms.[118] "The predictable consequence is that over time more and more risks are shifted to the adhering party."[119] This risk shifting is achieved in part by express exclusions, such as the intentional act exclusion, that deny coverage for deaths under certain circumstances.[120]

Because contracts of adhesion "are generally intended to minimize the seller's risks and responsibilities...and impose burdens or other limitations on the buyer,"[121] judges of coverage disputes view such contracts with heightened scrutiny. Some commentators argue that contracts of adhesion should not be afforded the presumption of enforceability that applies to contracts that are individually negotiated.[122] The relationship between the insurer and the insured, characterized as "fiduciary in nature," implies that the rights and obligations of the parties are not the same as those of private parties with equal bargaining power negotiating a contract.[123]

---

115. *Id.*

116. *Id.* at 221-22.

117. Fischer, *supra* note 91, at 101.

118. BLACK'S LAW DICTIONARY 259 (7th ed. 2000).

119. Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, *in* RANDY A BARNETT, PERSPECTIVES ON CONTRACT LAW 369, 374 (2d ed. 2001).

120. Insurance policies, for example, may exclude coverage for losses resulting from operating a motor vehicle, having sex with a minor, or punitive damages. Fischer, *supra* note 91, at 123. The policy in *Bettis* stated,

> The accident insurance under this policy does not cover any injury, fatal or otherwise, received directly or indirectly as a result of, or that is contributed to, by said member . . . being in any degree under the influence of a narcotic or intoxicating liquor; or while riding or as a result of riding in a hydroplane, aeroplane or ballone . . . or riding or driving in any automobile race; or while riding or as a result of riding a motorcycle.

Bettis, supra note 16, at 71-72.

121. CHIRLESTEIN, *supra* note 2, at 76.

122. BARNETT, *supra* note 119, at 342.

123. Fischer, *supra* note 91, at 100-01.

HeinOnline -- 12 Conn. Ins. L.J. 676 2005-2006

Contra proferentum directs that ambiguities in a contract be interpreted against the drafter, who is almost always the insurer.[124] More rigorously applied in insurance than in other contracts,[125] *contra proferentum* "might be understood as the awarding of expectation damages for breach of the 'promise' of coverage afforded by the ambiguous provision."[126] Because the drafter has control over the language used in the policy and is in a better position to bear the cost of "determining the optimal degree of clarity in policy provisions,"[127] the drafter must provide coverage that is reasonably expected.[128] The promise which *contra proferentum* protects is that "the objectively reasonable expectations of the policyholder as to coverage will be honored, notwithstanding contrary policy language"[129] such as exclusions.

Although the standard forms characteristic of contracts of adhesion create the benefit of reduced transaction costs and policy premiums,[130] such forms can prevent bargaining by allowing insurance companies "to impose a new feudal order of their own making upon a vast host of vassals."[131] Competition among insurers does not remove this problem because there is a tendency for insurers to gravitate toward similar policy language, which effectively standardizes forms even in the absence of insurers' cooperation to do so.[132] In addition, shopping around for the best policy can protect consumers only when shopping is a widespread activity.[133]

---

124. Abraham, *supra* note 112, at 531.

125. Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599 (2d Cir. 1947), *cert denied*, 331 U.S. 849 (1947).

126. Abraham, *supra* note 112, at 535.

127. *Id.* at 534.

128. "The potential for overreaching, unfairness, and deception in this process is greater than in the classic bargaining model. It is the judiciary's – and ultimately society's – concern about the potential harshness to consumers that has prompted heightened judicial scrutiny of insurance contracts." JERRY, *supra* note 3, at 238. *See generally* Gerhardt v. Cont'l Ins. Co., 225 A.2d 328 (N.J. 1966).

129. Abraham, *supra* note 112, at 559 (emphasis in original).

130. The benefit of cooperative ratemaking cannot be achieved without standardization of the product being marketed. JERRY, *supra* note 3, at 237.

131. Friedrich Kessler, *Contracts of Adhesion – Some Thoughts About Freedom of Contracts*, 43 COLUM. L. REV. 629, 640 (1943).

132. JERRY, *supra* note 3, at 237.

133. When contracts of adhesion become commonplace, even the individual who reads and understands is essentially helpless. The consumer's experience of modern commercial life is one not of freedom in the full sense posited by traditional contract law, but rather one of submission to organizational domination, leavened by the ability to choose the organization by which he will be dominated. Rakoff, *supra* note 119, at 376.

HeinOnline -- 12 Conn. Ins. L.J. 677 2005-2006

Since policy exclusions within insurance policies operate under judicial suspicion,[134] the insurer bears a heavy burden to draft exclusionary clauses in clear language comprehensible to lay persons.[135] If the insurer seeks a broad exclusion for certain acts, it should use specific, express language.[136] Though in the past courts have held that a party is not entitled to relief from a contract on account of a failure to read it,[137] a number of courts have held that a policyholder who fails to read an insurance policy and has no knowledge of a particular provision in a policy that is contrary to an oral representation made by the insurance representative is entitled to coverage.[138] Moreover, courts have held that if a policy is issued upon an oral application and the insured fails to read the policy, the insured is nevertheless entitled to assume that the policy conforms with the application and covers the risk for which insurance was sought.[139]

The principle of honoring reasonable expectations "does not deny the insurer the opportunity to make an explicit qualification effective by calling it to the attention of a policyholder at the time of contracting, thereby negating surprise to him."[140] An insurance representative should explain exclusions to the policyholder, since even if a policyholder fails to thoroughly study the contract, his expectations may be honored "as long as they are objectively reasonable."[141] Insurers "ought not to be allowed to use qualifications and exceptions from coverage that are inconsistent with the reasonable expectations of a policyholder."[142] It is no surprise that expectations-principle cases tend to involve 'fine print' exclusions.[143] Requiring an insurance representative to explain the terms, including exclusions, to the policyholder, and to have the policyholder sign a form

---

134. Fischer, *supra* note 91, at 155.

135. Stewart v. Estate of Bohnert, 101 Cal. App. 3d 978, 988 (1980).

136. Fischer, *supra* note 91, at 118.

137. JERRY, *supra* note 3, at 235. *See, e.g.,* Dahlke v. John F. Zimmer Ins. Agency, 515 N.W.2d 767 (Neb. 1994).

138. Jurisdictions are divided on whether the insured has a duty to read the insurance policy. JERRY, *supra* note 3, at 236.

139. *See, e.g.,* Fli-Back Co., Inc. v. Philadelphia Mfrs. Mut. Ins. Co., 502 F.2d 214 (4th Cir. 1974); Kelly v. South Car. Farm Bureau Mut. Ins. Co., 450 S.E.2d 59 (S.C. 1994); Rempel v. Nationwide Life Ins. Co, Inc. 370 A.2d 366 (Pa. 1977).

140. Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 968 (1970). There is likewise little consensus on whether the insurer has a duty to explain coverage to the insured. In most jurisdictions, if the terms of a policy are clear, explicit, and unambiguous, the insurer has no duty to explain the policy or its exclusions to the insured. JERRY, *supra* note 3, at 236.

141. Keeton, *supra* note 140, at 967.

142. *Id.* at 968.

143. Abraham, *supra* note 112, at 559.

HeinOnline -- 12 Conn. Ins. L.J. 678 2005-2006

stating that he or she has read and understood the exclusions would protect the insurer from being ordered by a court to provide coverage in violation of the contract.

When it comes to a contract of adhesion, the terms of a contract can be defeated by reasonable expectations.[144] Intended to protect the parties' autonomy and maximize both the parties' and society's welfare,[145] freedom of contract may consist "in the absence of governmental meddling except when a substantial public policy justifies that intervention."[146] But freedom of contract may not conflict with statutes, [147] and contracts contrary to established law are unenforceable.[148] Furthermore, governmental meddling in the form of stigmatizing insured parties should not replace definitions of what is criminal. Otherwise, as *Valley Dental* and *Runge* illustrate, policyholders' accidental death insurance premiums might compensate the death of a violent rapist but deny coverage of a death brought on by a foolhardy quest for the ultimate orgasm.

Because it would benefit both the insurance company, which would collect more money, and the insured, whose protection would be secured, insurers should offer an optional high-risk accidental death policy, for which the consumer could pay a higher premium. In keeping with commercial realities, the high-risk policy would be a standardized-form contract. In accordance with *contra proferentum*, insurers would draft such policies carefully, and insurance agents would explain them to consumers at the time of contracting. This would further insurance goals within a free society. As long as an individual doesn't break the law, he or she is free to auto-race at Daytona, work as an astronaut for NASA, or take other life-threatening, legal risks.

144. "The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Keeton, *supra* note 140, at 967.

145. *See generally* Robert A. Hillman, *Court Adjustment of Long-Term Contracts: An Analysis Under Modern Contract Law*, 1987 DUKE L.J. 1, 1-33 (1987).

146. Rakoff, *supra* note 119, at 378.

147. JERRY, *supra* note 3, at 227.

148. *Id.*

HeinOnline -- 12 Conn. Ins. L.J. 679 2005-2006

CONCLUSION

How would our introductory examples be treated under the proposals suggested by this Comment? The beneficiaries of the farmer who unintentionally punctured himself with a nail and subsequently died of blood poisoning would collect accidental death coverage because his death was accidental. The drowning of the woman who ingested pills and alcohol against her doctor's orders would be covered unless barred by a policy exclusion because the pills were legal and there was no indication of suicide. Death caused by cocaine overdose would not be indemnified under an accidental death policy because cocaine use is intentionally criminal. The survivors of the man who had one drink at a bar and was then killed in an accident while driving home would receive accidental death coverage because the man was not legally drunk. The survivors of the rapist killed by his victim would not be compensated because the rapist's death resulted from his intentional crime. The widow of the man who died of autoerotic asphyxiation would be compensated, as his conduct was legal and his death was unexpected.

In keeping with its purpose to allow policyholders to pay a moderate amount to prevent unintentional losses, the insurance industry should make intentional criminal act exclusions standard in their policies. Where insurance policies fail to exclude coverage of intentional criminal acts, judges should declare coverage of deaths resulting from such acts to be in violation of established law and public policy. This would free courts of the traditional means/results distinction, and serve to enforce the intentional acts exclusions at the root of many coverage disputes. Expecting an accidental death policy to cover an accidental death brought about by the insured's criminal conduct is, according to this Comment, not reasonable, because "accident" connotes blamelessness and because subsidizing crime is against the law.

Where the insured's intentional but legal conduct leads to death, the limit on enforcing policy exclusions should be the doctrine of reasonable expectations. Since the terms of the insurance contract are to be construed in accordance with the reasonable expectations of a layperson, complications of the definition of "accident" created by the means/results distinction create an ambiguity, thereby triggering *contra proferentum*. Insurers must explain policy exclusions for deaths caused by high-risk but legal activities or pay the double indemnity to the insured's beneficiaries when such deaths occur. Because insurance policies are contracts of adhesion, exclusions that violate reasonable expectations will likely not be upheld by courts. An alternative product proposed by this Comment is the

HeinOnline -- 12 Conn. Ins. L.J. 680 2005-2006

high-risk accidental death policy for those who acknowledge that they participate in high-risk but legal activities. Insurers should fulfill reasonable expectations, but only within the sphere of liberty.

HeinOnline -- 12 Conn. Ins. L.J. 681 2005-2006

HeinOnline -- 12 Conn. Ins. L.J. 682 2005-2006

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

Edited by Emmanuelle Regine Francois[*]

Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 MO. L. REV. 723 (2005).

Subrogation is a mechanism of equity, thus preventing unjust enrichment on the part of the insured. It usually occurs within the context of property and casualty coverage, however courts are more reluctant to allow subrogation to occur in life, death and medical policies due to the difficulty of calculating specific losses. It allows an insurer to place itself in the shoes of the insured and acquire the rights that the insured has against the third party tortfeasor. With subrogation the insurer is ideally allowed to recover a portion of the claim that it indemnified on behalf of the insured.

Subrogation has benefits and detriments. For example, one positive aspect is that subrogation allows insurance premiums to remain low because insurers are able to recover future costs associated with some risk. However, opponents of subrogation find that it disrupts the process of settlement between the insured and a third party by complicating and prolonging the process.

Within the context of subrogation, common law imposes the "made whole doctrine" in order to prevent the insurer from asserting its rights unless the insured has received full compensation for damages from the third party. Author, Johnny Parker, provides a state-by-state survey of the effect of the made whole doctrine on subrogation. The results of the survey demonstrate that different states have taken different approaches to the made whole doctrine. Some courts have agreed that the made whole doctrine may be made inapplicable by the intent of both parties in their agreement. Other jurisdictions approach the issue differently, by not allowing modification to the made whole doctrine. The remaining states permit a balancing test while affording greater weight to the made whole doctrine.

---

* Candidate for Juris Doctor, University of Connecticut School of Law, 2006; Bachelor of Arts, American University, Washington, D.C. 2001. I would like to thank Professor Jeffrey Thomas for his assistance in composing this section.

In all, the made whole doctrine tries to achieve fairness in the subrogation context. As demonstrated by the state-by-state survey, subrogation coupled with the made whole doctrine has resulted in different approaches. Whatever the approach, Parker suggests that it should take into account the reasonable expectation of the parties and the public's interest.

Michelle E. Boardman, *Known Unknowns: The Illusion of Terrorism Insurance*, 93 GEO. L.J. 783 (2005).

Prior to September 11, 2001, the insurance market underestimated the risk of terrorism. However after the losses of 9/11, many reinsurers pulled out of the terrorism market, leading to insurers trying to pull out of the market as well, or excluding coverage for terrorism risk. As a result, the federal government responded by enacting The Terrorism Risk Insurance Act (hereinafter "TRIA"). TRIA provided compensation for some of the losses and made void any terrorism exclusions that were in place at the time, in an effort to make insurers accountable and provide an incentive for insurers to remain in the market.

Michelle Boardman states that most of the losses from 9/11 were covered since they involved property losses. However, there is a concern that if the U.S. suffers another attack it is unlikely to come in the same method, thus likely falling within the exclusions of the insurance contracts. For example, nuclear, biological, and chemical risks are currently excluded from most insurance policies in accordance with state law, as was the current market practice prior to September 11th.

Boardman explains that the assertion that terrorism risk is uninsurable results from the fact that it is actuarially difficult to calculate or predict due to the short and unpredictable history that the U.S. has had in this matter. As 9/11 illustrates, the magnitude of loss and the frequency of such loss cannot be ascertained because terrorist organizations operate randomly in order to maximize shock and loss. When reinsurers pulled out the market due to 9/11, ordinary insurers had to remain in the market initially since they are governed by state laws, which prohibited them from following suit. As a result the insurers were more exposed without the reinsurers and had to abide by their contractual obligations. Many insurance companies used their reserves in order to meet the obligation to policyholders. However, it is very difficult for insurance companies to estimate the reserves needed in the event of another attack.

Also, it is difficult to determine the probability of the occurrence, the amount of loss, and the price to set for premiums in order to indemnify the

HeinOnline -- 12 Conn. Ins. L.J. 684 2005-2006

event when it occurs. Such uncertainties are similar to those which make war an uninsurable risk.

Boardman asserts that it is not that terrorism risk is uninsurable; but rather that with all the unknowns facing the insurance company, it may be prohibitively expensive for the insurance company and the insured. Additionally, the public would rather rely on a government subsidy like TRIA. Since no data exists on which to predict terrorism risk in the future, it is very difficult for insurers to begin to forecast this risk. Consequently, the risk remains today uninsurable.

John V. Jacobi, *Government Reinsurance Programs and Consumer-Driven Care*, 53 BUFF. L. REV. 537 (2005).

Author, John Jacobi, begins this article by declaring that the United States spends more than any other nation on health care, but provides uneven coverage for many. As a result of this uneven coverage, two victims have been created: the uninsured or underinsured and the safety net hospitals. First the uninsured or underinsured include low-income individuals who are not able to receive preventive care, and tend to use the system when they are severely ill. Also, there is a trend of shrinking of services for the individuals who are insured, resulting in more people joining the uninsured or underinsured category. The second victim, safety net hospitals, are the facilities that most serve the uninsured or low-income individuals. Safety net hospitals include nonprofit and public hospitals, public health departments or clinics. These facilities provide medically necessary care at the most urgent time to individuals who are often unable to pay. Thus safety net facilities survive on donations or government subsidies.

As a result of the disparity, various reforms have been suggested to deal with providing health coverage. One such method is universal coverage. Research has been done in this area, but no concrete program has been implemented to achieve universal coverage and care in a manner that would mirror other countries.

The other reform suggestion is consumer-directed health care in the form of health savings accounts. This method of health coverage allows the consumer substantial control over their care by utilizing funds from an account. It is based on the notion that if consumers control their own health care, it will reduce consumption.

The next reform idea is based on a government reinsurance program. This plan arose since insurers were unwilling to insure high risk people. As such, the government reinsurance program provides coverage for

HeinOnline -- 12 Conn. Ins. L.J. 685 2005-2006

individuals or small [companies] when their claims exceed a threshold amount. The program is usually beneficial to the high risk pool who are otherwise denied coverage or cannot afford health care because the premiums are prohibitively expensive. As part of this program, the government still allows the insurance companies to insure, while acting as the reinsurer of the risk in order to make health care manageable for high risk individuals.

Jacobi, however, states that these reforms fail to encompass the whole concern of uneven distribution of health care. As a result, he suggests a strategy to help address the disparity by combining components from the reinsurance government programs and consumer driver health care. Jacobi's strategy attempts to be extended to the whole population. His program would place the government as a reinsurer for private health insurance, thus leaving the current infrastructure intact. It would moderate the concern that high risk individuals tend to want insurance products, since everyone would equally benefit from the reinsurance. This program would try to subsidize the existing private insurance program, while at the same time stabilizing the market for insurers and for individuals.

Jacobi's strategy would ultimately allow the government to absorb the catastrophic or high risk component that insurers do not want to take responsibility for. This synthesis would result in private insurance companies absorbing the risk of routine and preventive coverage. Consequently, this would decrease premiums and overall moderate the distribution of health care.

Aviva Abramovsky, *The Enterprise Model of Managing Conflicts of Interest in the Tripartite Insurance Defense Relationship*, 27 CARDOZO L. REV. 193 (2005).

The author of this article examines the similarities of conflict of interest that often exist in the tripartite insurance relationship with a criminal enterprise.

He analogizes the tripartite civil system in the insurance defense relationship to a criminal enterprise. For example, counsel or "house counsel" for a criminal enterprise is paid by the leadership of the organization, which is often not the individual defendant that the attorney is representing. The house counsel is usually retained by the enterprise to defend its matters as a repeat player, but still has the duty to represent the defendant on the one time basis. In the same manner the insurance company retains counsel to defend claims for its policyholder, likewise as a repeat purchaser of services. The counsel is paid by the insurance

HeinOnline -- 12 Conn. Ins. L.J. 686 2005-2006

company, but more importantly the insurance companies, in the retention of its attorneys, provide guidelines and standards for the attorneys to follow. These guidelines do not truly capture the policyholder's interest, thus having some influence over the attorney.

The author suggests that insurance companies have characteristics similar to a criminal enterprise in their attorney-client relationships because, like a criminal enterprise, attorneys seek continuity of employment from the enterprise or insurance company. In the criminal enterprise context, any of the parties, such as the government or the judge, may seek to disqualify the house counsel of the enterprise on the basis of the conflict of interest. Specifically, the cases discussed have illustrated that the enterprise method of payment undermines the attorney-client relationship and the integrity of the adversarial system. In the same manner, through the guidelines imposed by the insurance company, the attorney is influenced because of his desire to continue being retained for future matters. The author suggests that there is an inherent danger or possibility of a conflict of interest, although it may not materialize in every situation.

Some states have tried to address the concerns with the tripartite relationship by stressing disclosure. These courts require disclosure of the relationship and the pecuniary interest within the relationship in order to safeguard the interest of the third party in the tripartite relationship. The inherent danger that exists within a tripartite relationship due to the pecuniary interest should be addressed with equal vigor in the civil insurance defense relationship as is being done in the criminal system in order to safeguard the rights of all involved.

Jeremy A. Herschaft, *Not Your Average Coffee Shop: Lloyd's of London—A Twenty-First Century Primer on the History, Structure, and Future of the Backbone of Marine Insurance*, 29 TLNMLJ 169 (2005).

This article describes the origins, structure, and future of Lloyds of London in the maritime industry.

In 1687, Edward Lloyd opened a coffee house near the Thames River in downtown London. In the coffee shop, captains and ship men would meet there to conduct their business. At such time, an individual would approach a broker who would try to procure a policy on behalf of these individuals.

In 1871 Lloyd received its official incorporation through an act of Parliament, whereas it regulates and oversees the competition for underwriting business. But as stated clearly in the article, Lloyd is not an

HeinOnline -- 12 Conn. Ins. L.J. 687 2005-2006

insurance company, and therefore it does not receive premiums from individuals.

Initially, an individual would absorb a risk and be personally liable for the loss, if it occurred. However, with the development of the Name, syndicate and the underwriting agent, the structure changed. The underwriting agent would collect a risk through a partnership with the Names. A Name is a partner/member who decides to absorb a percentage of the risk. If the risk materialized, then the Name would be subject to the percentage of his investment. From this arrangement grew the Lloyd's syndicate. In order to be called a Name and be allowed to participate in the Lloyd market, a Name must become a member, thus meeting specific requirements. The process begins with a broker presenting the risk to the underwriting agent. Thereafter the broker and the underwriter agent would negotiate to underwrite the risk until he underwrites 100% of the risk.

Today, Lloyd's structure continues to use the method described above to transact maritime insurance. However, one major structural change is that Lloyd expanded Name membership to corporate investors. This expansion occurred as a result of several maritime related catastrophes leading to a flight of individual's Names from the market. At such time, the Lloyd had to act quickly in order to fill the void. Today, corporate capital accounts for 87.5% of the Lloyd market share.

All in all, Lloyd is a unique underwriting structure that continues to change in order to meet the needs of its clientele.

Robert J. Rhee, *Terrorism Risk in a Post-911 Economy: The Convergence of Capitol Markets, Insurance, and Government Action*, 37 ARIZ. ST. L.J. 435 (2005).

The September 11th catastrophe was the single largest occurrence in the insurance industry, with enormous costs and an exodus from the terrorism market by many reinsurers. As a result Congress enacted the Terrorism Risk Insurance Act of 2002 (hereinafter "TRIA"). The legislation allowed the government to act as a federal reinsurer in order to stabilize the insurance market. TRIA is a three-year program with a sunset date, unless extended, on December 31, 2005. [may want to revise this since the time has passed]

As September 11th demonstrates, terrorism is a long-term problem and as such the government and the private market should work together to find a solution to insure terrorism risk. One of the author's concerns about terrorism as a risk is that it will be never be as actuarially certain as other risk like auto or life insurance. The high severity, low frequency

HeinOnline -- 12 Conn. Ins. L.J. 688 2005-2006

component of terrorism brings up the question of the most efficient means of absorbing and transferring the risk and how it should be done. Although Rhee acknowledges that ex-ante government involvement in the war against terrorism is the favored solution by the private market, he objects to this alternative. According to him, it would disincentivize the private market to develop a reinsurance solution.

Catastrophe securitization is the alternative that the author suggests. This option provides an additional source of capital because it can underwrite more risk. Securitization should be stimulated by the government because this option allows the re-entry of the private market as the most efficient means of assessing and transferring risk. Government involvement may reduce the cost.

Terrorism coverage through the private market reinsurance is the most cost efficient manner of insuring terrorism risk compared to securitization. But in the future the market structure may provide a manner for securitization to be a cheaper option. In any event, government involvement would need to stimulate such a program

In all, the private market may be able to find a manner of transferring its terrorism risk, especially in light of the September 11th catastrophe. However such a solution faces many obstacles to implementation, and will take years to develop.

Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005).

The author begins the article with an anecdote of a employer receiving a higher bid from various health care provider organizations than anticipated and thus ending its relationship with their health maintenance organization ("HMO") due to the cost associated. As such, many individuals such as doctors, nurses, retirees and the like will have to change providers or opt out for higher payment in services.

Kaplan asserts that most Americans receive health care insurance through their employer with larger sized employers more apt to offer such services than smaller employers. There are benefits and disadvantages for employees receiving health insurance from an employer. And undoubtedly, employers have incentives to provide the coverage, more specifically tax benefits from the federal government. For employers, the tax incentive earned from providing such a benefit is more attractive than increasing employee wages and salaries and allowing the employee to buy such services on her own. However on the employee side, there are two

HeinOnline -- 12 Conn. Ins. L.J. 689 2005-2006

consequences of such benefit: over-utilization of health care and over-insurance. These two consequences augment costs of providing the benefit to employees and such costs are passed to the employer buying such service.

One response to the consequences derived from the employer-issued policies is health savings accounts. In 2003, Congress authorized health savings accounts, which are saving accounts used to pay for medical care with a high deductible insurance plan. Health savings accounts include many components such as the plan's high annual deductible, its limits on out-of-pocket expenses and covered services. The saving component is used to pay for preventive/normal care and the insurance plan annual deductible. For example, health savings accounts must have an annual deductible of at least one thousand dollars ($1,000) per individual or two thousand dollars ($2,000) for family coverage.

Through health savings accounts, the account holder contributes tax-free money to the account or trust for future qualified medical care. Such funds may be kept in the account indefinitely and may be invested until they are needed for medical expenses. Balances roll over from year to year until all monies are used by the account holder, or spouse.

One last important feature of health savings accounts is the fact that the individual controls his or her health care. Some critics believe that can lead to individuals being reluctant to use the funds for routine/preventive care in hopes to use the account as a saving/investment mechanism. However, one positive aspect is that in allowing individuals to control their health care, individuals may be more cautious in seeking discretionary services and may price shop.

According to Kaplan, health savings accounts allow consumers to be conscious and to take control of their medical care. Health savings accounts counter the consequences of over-insurance and utilization that occur in the industry when employers provide the benefit to employees. Health savings accounts empower consumers through the account to understand the financial implications of this service.

HeinOnline -- 12 Conn. Ins. L.J. 690 2005-2006