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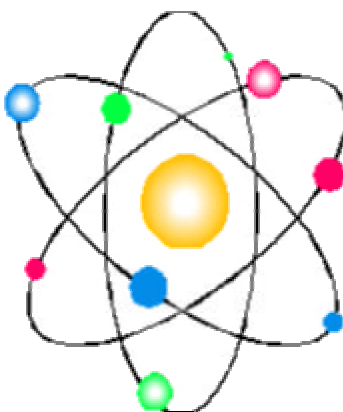
The Sky’s The Limit: Recent Trends in Asbestos Liabilities

By: Christine Fleming

In the United States, both the frequency and costs of asbestos-related claims have soared in recent years. Current estimates of ultimate liabilities have sharply increased over the past year. Companies are fleeing for bankruptcy protection, insurers face billions of dollars in estimated liabilities, federal legislation offers no relief -- while the number of plaintiffs’ attorneys continues to multiply. The rating agencies are aware of these current issues, and have indicated that they will expect ground-up reserve assessments of asbestos-related liabilities, supported by independent actuarial reviews. This article explores these recent trends and emerging issues in the area of asbestos-related liabilities, and attempts to forecast what lies ahead.

“Please Prepare for Take Off”

Estimates for asbestos liabilities in the United States have risen dramatically in the past year, ranging from \$50 billion to \$200 billion in ultimate asbestos liabilities. A.M. Best’s recent estimate of \$65 billion is a 63% increase over its last estimate of \$40



billion. It is widely believed that neither asbestos defendants, nor their insurers, are adequately reserved to absorb these claims. Currently, companies have approximately \$15-25 billion reserved for future asbestos claims; U.S. insurers have only \$10.3 billion in reserves for these liabilities.

Approximately thirty property/casualty insurers absorb 90% of asbestos-related losses. Asbestos payments have comprised about 15% of total property/casualty insurance payments in the past two years, and this percentage is expected to increase in the future. Many property/casualty insurers are facing a funding shortage and earnings drag caused by asbestos

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Insurance Company Solvency: What If My Insurer Can’t Pay My Claims?

By: William L. Granahan, CIC, LIA, CMC
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Rating agency analysts predict that about one-third of today’s property and casualty insurers will lose their autonomy or exit their primary markets in the next five years. In 1992 the losses caused by Hurricane Andrew and other natural catastrophes caused over sixty property-casualty insolvencies. The recent World Trade Center disaster, adverse claim experience, inadequate rates, “loose” underwriting and, in some cases, higher claim reserve requirements have caused a market that is hardening beyond most predictions. Insurance companies are struggling with profitability and experiencing rating downgrades. The demise of Reliance National is a glaring example of what can happen to an insurer that suffers from some or all of the above problems and may be just a sample of future company insolvencies.

What do you do if your insurance company is declared insolvent and unable to pay your claims? What if your insurer cannot pay your \$1M property loss resulting from a fire in your storage warehouse; a multi-million dollar third-

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liabilities, a situation closely watched by the rating agencies. In a recent study, A.M. Best estimated an ultimate survival ratio of 12 for asbestos liabilities. It should be noted, however, that this A.M. Best ratio is not the one normally calculated by insurance companies. Typically, insurers estimate the survival ratio by comparing reserves to the average of the past three years' payments. In the A.M. Best report, the survival ratio is calculated as ultimate discounted required reserves to expected paid losses. If the A.M. Best survival ratio were calculated using an average of the past three years payments on an undiscounted basis, one would expect the ratio to be much higher than 12.

The surge in frequency and costs has taken its toll on individual companies:

- Foster Wheeler saw 13,300 new claims reported in the first quarter of 2001, and spent \$56.2 million in 2000 on asbestos-related litigation, up 39% from 1999;
- Crown Cork & Seal spent over \$90 million in 2000 on asbestos litigation, and had a charge of \$199 million, mostly for future asbestos claims;
- W.R. Grace has seen an 81% increase in the number of claims filed in 2000 from 1999;
- The number of claims reported in 2000 to the Johns Manville Trust has doubled from 1999.

In the past, many companies were members of the Center for Claims Resolution (CCR), which was set up to broker asbestos settlements on behalf of its member companies in the wake of a flood of claims being filed each year in the legal tort system. The CCR settled some 350,000 claims at a cost of \$5 billion. Claims were efficiently settled in bulk, with little in-depth, individual scrutiny. However, as more and more major producers sought protection from their creditors through Chapter 11, the costs of such settlements were falling on fewer and fewer players. In addition, the nature of the CCR actually may have drawn plaintiffs to file claims, assured that they would receive some crumbs in the large "inventory settlements."

For these and other reasons, in February 2001 the CCR stopped settling claims on behalf of its members. Companies and their insurers are now separately developing methods and philosophies on how to handle these claims. Companies are increasingly filing for protection in bankruptcy court as a last resort. Insurers are demanding stricter scrutiny of claims and claims settlements, including rejection of the CCR's inventory settlement approach. Policyholders are required to meet more rigorous standards regarding claims handling, evidence of causation, and proof of injury before the insurer

will accept coverage of the claim. For example, Equitas had indicated that they will require greater medical evidence in support of claims, particularly for bulk settlements. In some cases, insurers are suing bankrupt policyholders to void coverage, on the theory that reorganization under Chapter 11 (which takes control of claims away from the insurers) is a breach of the policy agreement.

"Ladies and Gentlemen, We are Currently Ascending"

Varied as the estimates are, there is little disagreement as to the direction these claims are headed. Both the frequency and severity of asbestos claims have increased sharply in recent years, and very few would disagree that this upward trend will continue. Several reasons are cited for this phenomenon. First, asbestos claims are now being made against companies who, only a few years ago, believed they were safely beyond the reach of the plaintiffs' bar. Having exhausted most of the cover from the "first tier" manufacturing and mining companies, redress is being sought from the second tier of companies (i.e., those who incorporated asbestos in their products) and from peripheral companies with only an indirect relationship. Furthermore, successor liability is being sought as a result of mergers and consolidations. It is not uncommon today to see companies such as Dow Jones, Met Life, and Campbell's Soup added to the list of diverse defendants in a plaintiff's complaint alleging asbestos-related injuries. Indeed, the number of defendants being targeted has increased to over 2000, a tenfold increase in ten years. For many of these defendants, the only means of survival is through reorganization under Chapter 11 of the bankruptcy code.

Second, plaintiffs' attorneys are becoming more imaginative in bringing claims. There has been a trend toward filing claims in which the individual claimant has suffered no injury (i.e., those individuals with physical evidence of asbestos exposure, but no incapacitation or injury from that exposure). The filing of such claims may be required pursuant to applicable statutes of limitations. This trend may also have been motivated in part by recent U.S. Supreme Court rulings, holding that a plaintiff is not required to show specific medical conditions in order to bring a claim. Attorneys are "packaging" the non-injury claims together with mesothelioma claims, as an incentive for defendants to pay on the non-injury claims in order to avoid the uncertainty of a jury trial outcome on the mesothelioma claim.

Third, asbestos claims that were being filed as products claims are increasingly being classified as premises/operations claims. These separate types of coverage within a general liability policy have one very important difference: products coverage typically contains an aggregate limit, whereas premises/operations coverage often does not. Claims that were previously filed and settled under a products theory of liability may not have released the premises/operations coverage of the GL policy. These claims are being reopened, and insurers, particularly at the primary and lower

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levels of coverage, are feeling the pinch. Plaintiffs' attorneys are also targeting new sources of insurance. In addition to bringing claims against peripheral defendants, claimants are now seeking funds from third-party insurance, property owners' policies, liability policies of contractors and subcontractors, and errors and omissions policies of design professionals.

Fourth, in 1997 and 1999 the U.S. Supreme Court struck down two multi-billion dollar class action settlements, citing several reasons, including a fear that funds would be exhausted before all claims are paid, and that the class itself was not well-defined due to the variety of injuries involved. These decisions have led to a rush of claims being filed, with claims roughly doubling within a year after each decision. Although, as discussed above, many such claims are thought to involve "non-injured" claimants, serious injury claims are still emerging and will for several years. Mesothelioma, a type of lung cancer, has an average latency period of forty years, and can have a latency period of up to sixty years. With workers exposed to asbestos at least through the mid-1970's, it is expected that mesothelioma claims will continue to emerge through 2015-2025. Juries have awarded tens of millions of dollars in damages to mesothelioma plaintiffs.

Finally, there has been little progress made in the area of federal legislation. In both its decisions, the U.S. Supreme Court implied that the "elephantine mass" of asbestos litigation might be best handled by congressional action. Proposed bill H.R. 1283, the "Fairness in Asbestos Compensation Act," died last year under the weight of Democratic and Republican criticism. That Act proposed creating an Asbestos Resolution Corporation to handle claims, specifically defining the types of injuries that warrant compensation, lifting statutes of limitations, and restricting the amount of fees that plaintiffs' attorneys can collect. It is unlikely that new, effective legislation will be proposed and passed in the near future.

"We Have Not Reached Our Cruising Altitude"

Although the question of "how much" will continue to be disputed, there is little doubt that asbestos-related costs will increase well into the future. Some predict that this trend will continue for the next five to ten years, before leveling off in the following twenty years. New companies are being sued, new insurance is being sought, and new theories of liability are being tested in the courts. Companies that were long-standing defendants are fleeing for shelter under Chapter 11. Insurers are demanding more stringent claims requirements from their policyholders. Rating agencies are expecting ground-up estimates of these liabilities from insurers. With the demise of the CCR, recent U.S. Supreme Court rulings, flailing congressional action, and little hope that these claims will be "centralized" or handled consistently in the near future, it appears that companies and their insurers must face the issues surrounding these claims for a long time to come. ■

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party lawsuit resulting from a "slip and fall" on your property; a professional liability lawsuit resulting from your alleged malpractice in a case in which the patient died; a sexual harassment claim brought by one of your employees; or your "open" Workers Compensation claims?

Would you be forced to "self-insure" these large, expensive claims simply because you were unaware of an insurer's financial troubles? What can you do to protect yourself from such an event?

Financial Ratings and Rating Agencies

The first thing you can do is to regularly verify your current insurers' ratings by one or more of the major rating agencies such as A. M. Bests, Conning & Company, Moody's Investor Services, Standard & Poor's Corp., Duff & Phelps Credit Rating Company, Demotech and Weiss Ratings. Ratings can be obtained from the insurance company, the Insurance Library in your state, your agent or insurance consultant or, in many cases today, the website of the rating agency – for instance, www.ambest.com.

Understanding Agency's Ratings

In addition to asking for the ratings, you should request a detailed explanation of the agency's rating system in order to understand what your insurer's rating means. Each agency has a unique formula and their rating systems need some explanation in order to adequately evaluate the insurer's current financial stability.

Generally insurance carriers are rated based on data such as written premiums, outstanding/anticipated claims, reserves, claims paying ability and a number of other financial quotients that may differ with the type of insurance in question. In addition, they consider other issues such as market conditions, volatility of lines written, product and geographic diversification, legal/economic developments, management philosophy/expertise, and overall performance and stability. Most ratings include an evaluation of the following:

- ◆ Liquidity
- ◆ Leverage
- ◆ Investments (quality; diversification; performance)
- ◆ Risk Based Capitalization
- ◆ Profitability (loss ratio; combined ratios; return on assets)
- ◆ Debt

Needless to say, if you see indications that your insurer's ratings are declining, you should monitor, or have your consultant monitor the financial "health" of that carrier on a regular basis. Generally, if a carrier reaches a "B" rating or lower with Bests, a BB with S&P, a Baa with Moody's or a

BB1 with Duff & Phelps, for example, these all indicate only a marginal ability of the carrier to pay claims in adverse underwriting or investment conditions. You should consider replacing your coverage with another carrier if you encounter these ratings.

Insurance Company Insolvency

But what if you are blindsided and your insurance carrier goes bankrupt without any warning? It has happened more often than most insureds or consumers suspect and the ramifications are not always pleasant. Insurance companies can be declared insolvent due to illegal conduct, such as fraud or embezzlement, and/or due to inadequate reserve funds to pay outstanding and anticipated claims.

An insurer is placed in liquidation by the Insurance Commissioner in the state where that company is domiciled (licensed). However, before a company is declared insolvent, there is a full court proceeding which reviews the company's financials, recent claims audits and actuarial reports. Some states issue an Order of Rehabilitation which allows the Insurance Commissioner to take over the troubled carrier before insolvency occurs and to assist the company in regaining its financial solvency.

If, however, there is an order of liquidation or receivership with a finding of insolvency, the insurance company's policies are canceled and its policy holders are given thirty days from the date of liquidation or policy expiration (depending on the state) to find another insurer to cover all claims going forward.

But what about claims that already exist or claims that will occur (if the policy is on an occurrence basis) and are covered under the canceled policy? Many states limit "new" claims to those "occurring" within sixty days after the declaration of insolvency. Occurrence-based policies that would normally cover all claims that "occur" during the policy period, although not brought until years later (incurred but not reported - IBNR), may not be covered at all. **In this case your new policies should be endorsed to cover retroactive periods that are appropriate.**

Guaranty Funds

The monies to pay covered claims of an insolvent insurer come from the distribution of the insolvent carrier's assets (usually at \$.70 on the dollar) and a state emergency reserve called a "guaranty fund". It is important to note, however, that the guaranty fund is not funded prospectively.

All insurers licensed to write business in the domiciled state are required to pay post-insolvency charges at percentages normally based on a uniform percentage of the amount of net premium written in that state in the last full calendar year, up to the total amount sufficient to discharge the obligations of the insolvent insurer. The total payment by each insurer is often limited or capped at 1% to 2% of the net direct written premium written in each line of insurance. The fund

contributors usually are given thirty days to provide their share of the guaranty fund's obligation and separate funds are collected per line of insurance written by the insolvent carrier (i.e. workers compensation; property; general liability; etc.).

The fund, under the direction of the state commissioner's office, pays and discharges all covered claims and loss adjustment service costs but often utilizes a third party claims payer (TPA) to handle, process and pay all claims. Claim expenses include all covered expenses in the policy including litigation costs, claim administration, and court awarded damages. **Unfortunately most states have statutory payment caps on most claims that range from \$100,000 to \$300,000, while California has a \$500,000 cap and New York a \$1,000,000 cap.**

However, the guaranty fund presents some inherent problems for an insured that now must rely on this fund to pay its claims. Since the fund is only "funded" after an insurance carrier is declared insolvent with monies coming from the other insurers licensed to business in the state, you will likely experience a delay in the payment of many claims. In addition, the statutory limits clearly expose the insured to claims that exceed these caps and could leave the insured with the better part of a multi-million dollar claim to pay after the fund satisfies its obligations.

Summary

In summary, the following are warning signs that your insurer may be in trouble:

- ◆ Rating downgrades;
- ◆ Management turnover;
- ◆ Excessively low premiums;
- ◆ Excessive delay in settling claims;
- ◆ Large number of complaints;
- ◆ Large growth of premiums written to surplus.

If your insurer is declared insolvent, the following are some very important things you can do:

- ◆ Find replacement coverage immediately;
- ◆ File all known claims with guaranty fund;
- ◆ File a policyholder protection claim for IBNR claims;
- ◆ Identify any retentions or claims in excess of state limits that will not be covered and develop a plan for funding those claims;
- ◆ Identify any gaps in coverage that may be caused by having to replace coverage with a new carrier and policy.

Finally, you should choose your insurance carrier carefully. A non-admitted carrier is not subject to the guaranty fund and you will always be asked to sign an affidavit acknowledging this fact prior to binding coverage. ■