

THE EFFECT OF THE US LEGAL ENVIRONMENT ON CASUALTY INSURANCE BUSINESS

WRITTEN IN THE LONDON MARKET

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N.B. The structure of the paper is such that Sections A and B are likely to be of interest to all GIRO members, whereas some of the following sections may be considered to be rather detailed for those without London Market experience. However, the style is relatively light and it is hoped that the majority of readers will find it sufficiently interesting to pursue it to the end.

A. Introduction

It soon becomes apparent to a new entrant to an underwriting organisation writing US casualty insurance business in the London market that the business is significantly different from the liability insurance traditionally written in the UK domestic market. It takes a little longer to appreciate to what extent this arises from the legislative framework against which the original business is conducted.

It is the intention of this note to explain the main areas relevant to casualty insurance in which the legislative environment in the US differs from that in UK. The note concentrates on casualty insurance, since in the field of property insurance the legislative environment is less significant.

It is hoped that, in addition to its general interest to all members of GIRO (and indeed to actuaries outside GIRO), the note will be particularly useful to any new participants in the London market and enable them to get their bearings rather more quickly than those who were earlier in the field.

B.1. Structure of the Legal Environment

In the United States, the jury system of trial is in use for all cases in the primary courts, including cases for civil damages. It is only on appeal that cases are decided by professional judges, as applies in all civil damage cases in UK. Not only the liability but also the quantum is in the hands of the jury in a US primary court. This system can result in some extremely high awards being made, although it is not true that all Court decisions are in line with those headline-hitting ones which tend to be quoted in the British press.

American attorneys often provide services on a contingency fee basis. This is the system under which they are allowed to accept cases with their fee contingent on the success of the case, this often being expressed as a percentage of the eventual claim awarded, or as a percentage which reduces as the award increases. The proportion of the attorney's "take" can be as high as a third. This practice is not permitted in UK.

Whilst there are some federal laws which are relevant to insurance business, the vast majority of the legislation is determined at state level and there are very important differences in the regulations from one state to another. It is imperative that an underwriter is au fait with the legislation relating to the particular state from which his business emanates, and keeps his knowledge up-to-date.

Another structural feature of the US legal system is the law relating to discovery. Under this, any individual or corporation involved in a legal case can sometimes be compelled to disclose (and provide copies of) any relevant documents. This includes disclosing the existence and details of insurance policies.

B.2. Unique Features of the Legal System

There are quite a number of features of the American legal system which we, in UK, find unusual. Some of these have serious impact on the casualty insurance market and the more important are outlined in this section.

One very significant doctrine enshrined in US law is the principle of joint and several liability. Under this principle an individual or corporate body which is found liable for any part of an action leading to an award of damages can be forced to bear the full amount of the damages. Under UK law, each defendant is only held responsible to the extent of his liability for the action.

Another unusual feature of the system is the idea of a class action. This is a device by which an individual who believes he is one of a group of people who has a legal claim against another individual or corporate body, can take legal action on behalf of the whole group. In the event of a successful conclusion to the case, all other members of the group may participate in the settlement, although they are not precluded from taking their own action if they believe the settlement is inadequate. It should be noted that the original idea of a class action was socially desirable in that it enabled aggrieved parties to obtain legal redress without each being subject to the disincentive of substantial legal costs. However, when taken in conjunction with other factors, some very odd results can arise.

Under US law, an individual or corporation can be subject to an award for punitive damages in addition to the compensation award with which we are familiar in UK. This can occur when they have acted recklessly or fraudulently (e.g. if they knowingly prejudice the safety of members of the public for personal gain). The award is paid to the individual who successfully brings the case, although in many ways it more logically represents a fine on the "guilty" party. Some of these punitive damage awards run into tens or even hundreds of millions of dollars, although they are often decimated on appeal. Depending on which state is involved, such awards may be covered under insurance policies.

It is a basic tenet of law that participants in a legal action will act in good faith in the conduct of their case. Anyone who is found not to be following this rule may be the subject of a bad faith action. Awards resulting from such actions are usually referred to in any relevant insurance policies as extra-contractual obligations (E.C.O.) - they may or may not be covered.

Under US law, insurers have an obligation to defend a policyholder who is sued for damages which are covered under the policy. Failure to do so may result in a bad faith action against the insurer. By comparison, UK insurers are only likely to bear such costs if they believe that such action is likely to be in their overall interests in terms of the ultimate settlement costs of the claim. The effect of this can be quite serious, especially when it is also borne in mind that many policies cover expenses in addition to the policy limit and that in some circumstances it may prove necessary to employ two attorneys to avoid a conflict of interests and the possibility of a bad faith action.

No fault is a system of compensation for injuries caused in accidents under which it is not necessary to prove negligence in order to obtain compensation from a third party who is involved. Such a system applies to automobile insurance in some US states. In UK the idea was mooted by the Pearson Commission in the mid-1970's, but has never been taken up.

One further peculiar feature of the US legal system is the availability of a status known as Chapter 11 Bankruptcy. This is used as a device whereby a company can continue trading in a "sheltered" environment whilst it is sorting out its finances. The "shelter" appears to protect it from law suits in certain circumstances. The particular use to which this has been put recently occurred in the case of Johns Manville, the biggest producer of asbestos and asbestos products in USA. They have been in Chapter 11 since August 1982, having been the subject of a vast number of legal suits arising out of asbestos-related diseases in the period leading up to their filing for Chapter 11. In the past four years, they have been immune from further suits although they have been able to continue trading. This was considered in some quarters to be an abuse of the Chapter 11 status.

The concept of strict or absolute liability has its origins in common law, and holds that whenever an injury is sustained, the person, firm or corporation causing the injury is liable for damages. Over time, the concept has come to be fault concept, whereby liability was imposed only if due care for the safety of others was not exercised. However, there are still situations where strict liability applies, usually in relation to possession of dangerous materials or use of dangerous processes. This can affect products liability if a product is sold in a defective or dangerous condition.

In addition to these unique features of the US system, there are other areas in which the system differs from that on this side of the Atlantic. Among these are such items as the Statutes of Limitations in use. Whilst, like so many factors, these differ from state to state, as a general rule the length of time available in which to take legal action is rather greater in US than in UK, especially in relation to cases involving children.

B.3. General Environmental Factors

The US judiciary have a tendency in some states to interpret the law in a manner designed to promote what they see as the public good. This manifests itself particularly in their taking the side of the private individual in a court battle with a giant corporation, apparently almost irrespective of the legal intricacies of the case. These judges look on themselves, at least in part, as social engineers.

Two inter-related factors which also impact on the general legal environment are the number of attorneys and the litigious nature of the American people. It is a moot point which of the two factors comes first, but it is apparent that American citizens resort to legal action much more readily than their UK counterparts. In part, this may be due to some of the other factors mentioned above, such as the contingent fee system and the fact that what used to be "bread and butter" work for attorneys has been eroded by the no fault automobile laws, creating a substantial supply of attorneys. It is undoubtedly true that even in this respect there is enormous variation between states.

Many of the above features inter-relate in the so-called "Deep Pocket" principle.

"Deep Pocket" is the term used to describe the situation where a litigant looks round to sue the person or corporation with the largest financial purse irrespective of the apportionment of blame. In other words, the individual with the deepest pocket pays.

Take the following case which actually happened:-

Person "A" was driving through green traffic lights and was struck and subsequently injured by Person "B" driving across the flow of traffic, having ignored the red light. Person "B" was obviously at fault but being unemployed and uninsured was not worth suing. The contingent fee system encouraged Person "A" to seek legal redress from the city authorities - but on what basis? After much probing the Attorney discovered that the traffic lights at the junction were of the old type and instead of having the regulation diameter of 8.1/2" say, were in fact 8" wide. The case was won on this argument, even though Person "B" was found to have had over the legal limit of alcohol in his blood. Person "A" was awarded a sum in excess of \$1 million.

The "Deep Pocket" principle reflects the profiteering litigious society now prevalent in the United States. Awards are frequently made based on the defendant's ability to pay as opposed to their degree of guilt.

C.1. Directors' and Officers' Liability

This is a class of business which is of relatively lesser importance outside North America, where it is a fairly major line of business. The idea is to protect directors and officers of corporations against legal actions brought by third parties who believe their interests have been prejudiced by decisions made by the directors and officers in the course of their duties.

A large proportion of the claims arising under this class of business are brought by shareholders of the company in question using the contingent fee system and a class action. This is the reason the class has assumed such importance in US, vis-a-vis other countries.

In fact, this has given rise to a small body of people known as "professional shareholders" who have small shareholdings in a large number of public corporations, in the "hope" that something will happen to prejudice the value of their shares. A professional shareholder will act together with an attorney working on a contingent fee basis to sue the directors and/or executive management of a company on the grounds that the shares have performed badly due to poor decisions. If a successful suit is brought on behalf of all the relevant shareholders, the contingent fees generated by the awards will adequately compensate the team for their efforts.

C.2. Medical Malpractice

Due to the greater propensity to sue in the US (for reasons covered in other parts of this paper) Medical Malpractice insurance is of vastly greater importance there than anywhere else. Medical Malpractice claims frequency and severity are much greater in the US and therefore malpractice insurance cost is very high with a large number of claims in excess of \$1M. In some places it is in fact so high for obstetricians and gynaecologists that these practitioners are not available and expectant mothers are reported to be crossing state lines to obtain medical assistance at birth!

A plaintiff wishing to obtain redress for an operation which goes wrong can sue the anaesthetist or any other physician involved and/or the hospital in which the operation took place. Medical Malpractice insurance is therefore required by individual doctors and also by hospitals.

There are a number of insurance companies which insure doctors e.g. Aetna, St. Paul and CNA. In the early to mid 1970's, there was a crisis in the Medical Malpractice insurance field when doctors could only obtain insurance at what they considered excessive premiums. A direct effect of this was that a large number of doctor-owned insurance companies were created to reduce the cost of insurance. However, reinsurance, particularly excess of loss, was still essential. Unwilling to reinsure with the companies with which they had previously been insured, the doctor companies looked elsewhere. This is a major reason why a large proportion of Medical Malpractice reinsurance comes into the London market. Since the mid-70's, premium rates have not kept up with increases in claims cost. Large losses have been made by insurers and reinsurers in recent underwriting years and several participants have stopped writing this class of business. With the reduced capacity, substantial increases in rates have been obtained since the latter part of 1984 (to possibly profitable levels).

Doctors buy insurance for various limits of indemnity. These can be divided into basic limits and excess limits with separate rates being charged. Basic limits were commonly \$100,000/\$300,000 i.e. \$100,000 single event limit and \$300,000 aggregate during the policy year, although higher basic limits such as \$1M/\$3M are now more common. Excess limits can go up to \$10M which may be required by surgeons, obstetricians etc. Rates vary considerably by class of doctor and state. The extent of this variation is illustrated by the fact that a typical rating scale charges 10 or 12 times as much for a neurosurgeon, at the top end of the scale, as for a family practitioner carrying out no surgery, at the bottom end. Likewise the rates for a particular speciality in Florida or New York is typically more than 7 times its equivalent in Arkansas.

Traditionally Medical Malpractice insurance has been written on an occurrence basis but is now changing to claims made and will probably be entirely claims made in the very near future - see Section D.1.

Reinsurance of doctor-owned companies into London is usually layered. The primary excess layer is often the difference between \$1M and \$250,000 (say) with the deductible indexed at a simple rate of 10% p.a., but true inflation-linking is rarely, if ever, encountered. Such a layer is commonly rated on a burning cost basis with maximum and minimum rates being percentages of subject premium income. Higher layers would normally be rated as a percentage of subject premium income or an excess cession basis (i.e. the original rate charged for the cover less a ceding commission which could be 30%).

Hospitals also require reinsurance in excess layers. Also common is umbrella cover (a type of coverage which is quite common in the US and just sits over the top of any other insurance coverage to provide a general protection) with the hospital's third party claims, car fleet etc. also being covered, often with different deductibles and limits for each type of cover. Premium rates are often adjusted on total OBE (occupied bed equivalent) with doctors, beds, out-patient visits etc. each being expressed as so many OBE's.

A major consideration for insurers and reinsurers of medical malpractice business is "clash" cover as a single claim may include elements from different doctors and also from a hospital.

Particular features of medical malpractice are the very high trends in both severity and frequency. Frequency can be extremely volatile. Severity is more stable (apart from very large claims) with the average severity trend being historically between 15% and 25% per annum.

Factors which could moderate the trends are:-

1. Structured settlements - i.e. payments by instalments.
2. The truncation effect of policy limits (but not for unlimited cover).
3. Lower economic inflation.
4. Loss control programmes.
5. Strengthening of underwriting with maturity of programmes (with many doctor-owned companies now being 10 years of age or more).
6. Tort Reform.

Adverse factors are:

1. Economic constraint on the quality of health care.
2. Increasing social expectations with improving medical technology.
3. Increasing costs of medical care with improving medical technology.
4. Medical Malpractice crisis publicity leading to greater public awareness and propensity to litigate.

C.3. Workers Compensation

Whereas in the UK, compensation to workmen injured in the course of their duties is provided under Employers Liability statutes (the old Workers Compensation laws having been superceded), in the US both types of legislation are found in conjunction with each other, although Employers Liability is of relatively lesser significance.

Background History

The concept of financial compensation to workers for industrial injuries has been in force in the USA for over 150 years. In 1837 however, with the decision of Priestly v Fowler the common law took a nose dive as far as the worker was concerned. Under this new branch of the common law, the employer was held responsible for, among other things -

1. A safe place of work.
2. Machinery, tools and material reasonably safe in relation to the work to be done.
3. Adequate safety rules.
4. Sufficient warning of dangers.

If the employer failed in any of these duties the employee could sue and recover damages, but subject always to the defence of the employer. Herein lies the twist. A common defence for the employer in resisting these suits was "the doctrine of the assumption of risk", whereby a worker on entering employment assumed the ordinary hazard of industrial injury. By continuing to work in an unsafe environment the worker was deemed to voluntarily assume the risk of danger and in so doing waive any claim for damages in case of injury. The doctrine led to the invidious situation where a member of the public had more rights to sue an employer than any member of the workforce. Inevitably, thousands of men unable to continue work through industrial injury ended up with nothing. Since those times the inadequacies of the common law have been eradicated through a series of State and Federal statutes.

Workers Compensation Statutes

Under the Worker's Compensation statutes an injured employee relinquishes the right to sue his/her employer for employment related injuries in return for a statutorily imposed mechanism providing specific scheduled benefits. For the most part this is funded by insurance. Workers Compensation provides an efficient method of compensating injured employees and their families. Pre-determined levels of awards allow for prompt payment and eliminates in the main the possibility of lengthy legal battles.

Workers Compensation usually provides for:

1. All expenses associated with medical care and treatment. In severe cases this can continue indefinitely until the employee dies.
2. A benefit, which may be indexed, payable weekly or monthly for the duration of injury.
3. A spouse's benefit, which may be indexed, payable from the date of death of the employee.

Each of the 50 U.S. States has Workers Compensation statutes which prescribe varying levels of benefits. Protection through Workers Compensation insurance provides the employer with an effective method for compensation to employees and their families for work-related injuries or diseases as prescribed by law.

The U.K. in contrast has no structural framework of compensation to injured employees. Any financial redress over and above that provided by the Welfare State would have to be channelled through the Courts if it was not voluntarily forthcoming from the employer.

Employers Liability Legislation

In the U.S., Employers Liability insurance protects employers when suits are filed against them for employment-related incidents that are not compensated under Workers Compensation coverage. In contrast to Workers Compensation -

1. liability must be legally assessed in Court
2. damages arising are not predetermined
3. legal proceedings can be lengthy
4. damages are usually assessed as a lump sum as opposed to a series of lifetime payments
5. awards are not necessarily confined to the employee. Damages may be awards to a spouse, child, parent, brother or sister or any other associated third party.
6. expenses can be high

Although Workers Compensation is usually considered to be the exclusive remedy of covered employees for work-related injuries, there are several reasons why Employers Liability protection is desirable. Certain States for example do not make Workers Compensation insurance compulsory or do not require the statutory coverage unless an employer has a certain minimum number of employees. In either situation Workers Compensation is voluntary.

There may also be instances when an injury or disease is not considered to be work-related and therefore not compensatory under the statutory coverage. Nevertheless, the employee may still feel the employer is accountable and proceed with legal action. Additionally, aggrieved relatives may file suit for loss of companionship, comfort and affection arising from the disabled worker's loss of physical and psychological attributes.

Finally, employers are increasingly being confronted with claims and suits in so called "third-party-over" actions. These arise when an injured employee sues a negligent third party (regardless of Workers Compensation benefits received). In turn, the third party sues the employer for contributory negligence.

Workers Compensation and Employers Liability Policy

Given the similarity of a claim associated with the same employer it is common to combine both coverages under a single policy. The joint Workers Compensation and Employers Liability policy contains principally two areas of coverage:

Part One - The major part of the policy covers Workers Compensation under which the insurer agrees to pay the benefits required by the Workers Compensation laws of the State.

Part Two - This is the Employers Liability section, which protects the insured against liability imposed by law for injury to employees in the course of employment which is not covered under the Workers Compensation section.

In addition to these main areas there may be other incidental coverage which varies by State.

C.4. Products and General Liability

Cover is given under the Insurance Services Office's Commercial and General Liability (CGL) form. It is very complex and there are a multitude of extensions and exclusions. At the time of writing, the 1973 form is in the process of being replaced by the 1986 version, but great problems are being experienced, particularly over the claims made wording. There may eventually be significant differences in cover between the forms filed in different states.

The three main sections of the 1986 cover are:-

- A. Bodily Injury and Property Damage Liability
- B. Personal Injury and Advertising Injury Liability
- C. Medical Payments

Section A cover is the most important and is divided into two types of occurrence:

- (i) Premises and ongoing operations
- (ii) Products and completed operations

The second of these is the source of many of the problems in US casualty business. There is a major IBNR problem, as a fault which occurs at any time in the life of a product is a liability on the policy in force at the time it was sold. As discussed in the next section the industry has attempted to address this problem through the development of the claims made policy.

Most US asbestosis claims are brought under products liability policies rather than employers liability as they generally are in UK. The injured worker chooses to sue the producer in tort rather than or in addition to taking the WCA benefits available.

The cover has suffered particularly from the legislative influences described in Section B. The basis of legal action has largely changed from negligence by the manufacturer to "duty to exercise reasonable care" or "duty to provide warning of inherent dangers that are not obvious to the purchaser". A number of court decisions seem almost to impose absolute liability on the vendors of some products.

Some products liability claims have been successfully brought on the basis that it is not certain which of a variety of products the claimant actually used, but that the manufacturers of them all should share the total liability in proportion to their market share. For instance, it may be known that a baby's deformity was caused by a certain type of drug, but there may be no evidence as to which drug company made the particular tablets taken by the mother during her pregnancy. Makers of that type of drug contribute to the damages in proportion to their individual market share, unless they can demonstrate that their product was not responsible.

Section B of the form covers a number of actions against the insured where there has been no physical injury or damage and there may not even have been any economic loss. Personal Injury includes defamation, malicious prosecution and false imprisonment. Advertising Injury covers suits from a competitor arising from inaccurate or misleading advertising.

Section C covers costs of necessary medical treatment to certain members of the public following accidents arising on the insured's premises or from his operations. The insurance cover is not limited to events where the insured is legally liable to the third party. There is a large element of goodwill in the cover, but this is not completely altruistic; prompt payment of medical expenses may reduce the chances of a large suit against the insured at a later date.

There are several major differences between the 1973 and 1986 forms:-

- (i) For the 1986 Section A cover, there are both claims made and occurrence versions (1973 was occurrence only), but the claims made version has been rejected by a number of states.
- (ii) The 1986 form has a pollution exclusion that is almost absolute in scope. Pollution cover can be provided in two ways. If the risk is deemed minimal, the insurer can remove the exclusion by endorsement. In other cases a separate pollution cover must be bought, on a claims made basis only. At the time of writing, the form for this cover has not been approved. The standard form does have pollution cover for products and completed operations.
- (iii) The 1973 form has no overall annual aggregate limit on claims although there are limits per occurrence (separate limits for bodily injury and property damage). The 1986 form has annual aggregate limits (separate ones for premises/operations and products/completed operations), and the occurrence limit applies to the sum of the two. The annual aggregate limits may result in claims moving from the primary policy to overlying or umbrella policies.

One of the controversial features of the ISO CGL policy form was the treatment of defence costs. The initial proposal had all defence costs applying against the policy limit (to the detriment of the policyholder). This was met with opposition by regulators and consumer groups. The current compromise position is that defence costs are provided automatically up to 50% of the policy limit. Any costs over and above this amount would be charged against the policy limit.

US casualty policies all have per occurrence limits of liability. A standard primary policy will have a relatively low limit of, say, \$300,000. Extra cover can be bought in two ways:-

- (i) The primary policy can be endorsed to a higher limit, the premium being increased by a standard factor.
- (ii) A separate excess layer policy may be taken, with a per occurrence deductible equal to the limit on the primary. Excess and primary layers may be written by different insurers. Excess layers tend only to be used on the larger commercial risks.

A significant feature of products liability coverage is that an insured may be able to aggregate all his claims from a policy year. He therefore only suffers his primary policy deductible once. There have been problems where the primary policy had this feature but the excess layer was on a per occurrence basis.

Standard excess of loss reinsurances (and LMX covers) were on a per occurrence basis and an Aggregate Extension Clause was introduced to allow the annual aggregation of products claims to move from the direct writers to the reinsurance market. As a result, a large proportion of asbestosis losses has ended up with the reinsurers. Aggregate Extension Clauses are now being removed.

D.1. Claims Made Coverage

For several years, U.S. Professional Indemnity business (such as Errors and Omissions, Directors and Officers) has been successfully written on a claims made basis. With the attempted conversion of the much larger Commercial General Liability (CGL) class from occurrence based to claims made, a hornet's nest seems to have been opened.

What is "claims made"?

Whereas the current occurrence based coverage means that the insurers of the policy in effect at the time the event happens are liable, a claims made basis passes the liability to the insurers of the policy in force when the claim is notified to the insurers (or sometimes, in PI business, when the incident is notified to the insurers).

Why claims made?

From the point of view of the insured, there is a much greater likelihood of the insurers still being around. If the event occurred many years ago and the insurer has since gone bust, then an occurrence based claim has less value. From a cash flow point of view, the smaller premium payable initially under a claims made policy would assist other business needs.

It assists the rating process by permitting a more accurate assessment of the risks involved. The claims for the previous years will have mostly been notified, whereas in an occurrence based policy many claims will still be unknown. Any increase in premium rates will therefore be more confidently (and justifiably) proposed.

The insurance company must reserve for future claims. On a claims made basis there is far less IBNR - the major unknown - which for U.S. casualty business written on an occurrence basis can be substantial even after ten years. This, therefore, increases the ability of the insurance company to manage its affairs prudently, to its benefit and that of its insureds. U.S. casualty IBNR reserving has been complicated in recent years by latent claims, such as asbestosis and environmental pollution, to which further reference will be made in Section G. Such problems would have been eased somewhat if the relevant policies had been on a claims made basis.

However, claims made does leave the insurer open to adverse selection. An expected imminent large claim might tempt the insured to purchase a higher excess limit or even change to an unsuspecting new insurer (although see "discovery" below).

Additional Features

There are several versions of the claims made coverage, of which features of the Insurance Services Office CGL type will be described below:

(a) Retroactive date (RD)

This is possibly the most controversial of the aspects of the proposed ISO claims made coverage. If an insurer can impose an RD then any events occurring before that date are excluded (i.e. it excludes prior acts, or nose cover). This has the effect of considerably reducing the exposure for the initial policy year. The prior year exposure will usually be covered under existing occurrence based contracts.

The ISO version permits the insurer to advance the RD if one of four conditions is satisfied:

- (i) There is a substantial change in the insured's operation.
- (ii) The insured fails to provide known information about the nature of the risk to the insurer.
- (iii) The insured agrees.
- (iv) There is a change of insurer.

(b) Mini & Midi Tails

The current ISO claims made proposal includes an automatic tail provision to extend the claims reporting period. There are actually two components:

A Mini Tail is included in the basic policy - hence no additional charge is made. The claims reporting period is extended by sixty days in the event of the policy not being renewed. The Mini Tail occurs to claims occurring before the policy expiry date that are unknown at that date, but subject to any retroactive date. The policy limits are not increased.

If an event has occurred within the required period, no claim has been made, but the physical occurrence of the event has been notified within the period (or sixty days after - see Mini Tail), then a claim is permitted within five years of the policy expiry date under the Midi Tail provision (some versions give three years instead). Again no extra charge is made and the policy limits are not increased.

- (c) Discovery, Optional Extension of Reporting Period, or Tail Cover. An extra charge is made for this option, (up to twice the basic annual premium). If a policy is not renewed or is renewed by an occurrence based policy, there is clearly a gap in coverage. This option fills the gap. It reacts if the Mini and Midi Tails are inapplicable or inadequate. It contains a separate aggregate limit equal to that under the original policy (i.e. one reinstatement).

A Mini Tail or Midi Tail are cancelled on another insurance purchase, but this option remains, sitting above the new policy as excess insurance effective if the aggregate limits of the new policy are exceeded.

(d) Laser Endorsement

This is used to exclude further losses from the same basic cause. From the insured's point of view, cover may be lacking, disastrously. A manufacturer may not commence production if he cannot obtain cover, but if cover is obtained then withdrawn, he may suffer extensive financial losses. However, the aim is to permit an early retroactive date but to exclude a particularly risky prior act.

Wordings Related to the Claims Made Series

One particular feature of the claims made wording is that once the claims made date has been fixed, all subsequent claims arising from the same accident are related back to that date, thus fixing the policy year of the claim.

Claims made provides effective insurance against losses not resulting from an accident or occurrence e.g. a continuing process. However, allocation problems arise when the exposure straddles the retroactive date.

A claim must be in writing for the ISO CGL type (or sometimes by telephone is permissible), but must be a claim for actual financial damages and not just notification of an occurrence (but see Midi Tail). This contrasts with the Professional Indemnity cover where notification of an occurrence may be deemed to trigger the coverage.

Conclusion

There are many gaps in cover which the abolition of the retroactive date would do much to fill.

Lack of understanding by the insured leaves scope for future complaints and adverse judicial decisions against insurers.

The discussion has clearly focussed public opinion on the types of cover and the problems faced by insurers.

Severe problems may be felt by vendors of umbrella insurance (policies that pick up the claims that fall through other covers) which might be extended in its exposure to fill the gaps.

Unlimited extended reporting will result in more restrictive treaty wordings. The acceptance, or otherwise, of claims made cover varies by State.

If the proposed CGL claims made basis is rejected, a poorer alternative would result. One option open to the underwriters would be increasing use of sunset clauses leaving vast gaps in exposure. (Sunset clauses restrict the acceptance of liability to claims notified within say 5 years of policy inception).

D.2. Exclusions

The subject of policy provisions and exclusions could cover a great deal of space. In fact, textbooks have been written on the topic, and the interested reader would do well to refer to these. The textbooks used for the property/casualty insurance exams, produced by CPCU, would be a good starting point.

For the purposes of this paper, it is most important to consider the care which is required in wording policy exclusions, and the possibility that the courts will not allow the exclusions to hold up.

As an example, consider the fact that most liability policies written in the U.S. have a pollution exclusion, whereby the policy will cover only damage due to "sudden and accidental" pollution. In cases involving toxic waste seepage, over a period of time, some courts have interpreted "sudden" to mean unexpected or unprepared for, and "accidental" as causing results which are neither expected nor intended from the standpoint of the insured. Consequently, the pollution liability exclusion in these instances was not upheld.

Largely because of this interpretation, the ISO claims made policy contains an absolute pollution exclusion for both gradual and sudden and accidental pollution, including the absolute exclusion of all clean-up cost obligations.

As a second example, most homeowners insurance policies in the U.S. contain an exclusion of damages caused by earth movement. In a California case, a contractor was negligent in building a house. When the earth beneath the house began to settle, the house separated. The insurance company denied the claim, citing the earth movement exclusion. The court ruled, however, that if two or more causes combined to produce a loss, that loss will be covered if any of the causes is not specifically excluded. This has been called the "concurrent causation" concept.

The important points to keep in mind when considering policy exclusions are:

- (i) Significant judicial differences exist among the states. For example, the states are currently divided as to whether punitive damages are insurable.
- (ii) In general, the more liberal courts deem to be tending toward the view that, if an insured could have reasonably expected coverage, then that coverage is upheld.
- (iii) Sound underwriting cannot be replaced by selective policy wording. That is to say that wholesale policy exclusions cannot turn a poor risk into an acceptable one.

E.1. Authorisation and Control of Insurers.

Regulation of an insurance company in the United States is essentially within the jurisdiction of the state in which the company is domiciled. State regulation is generally conducted within three agencies of government - the legislature, the courts and the insurance department.

Legislature: Within (US) constitutional limitations, state legislatures have the power to make and amend the insurance law. Most states have an insurance "code" which sets the standards for such things as formation and licensing of insurers, rate filings, licensing of agents and brokers, etc. The legislature thus defines the framework within which the business of insurance is conducted in the state.

Courts: The role of the courts with regard to insurance regulation is primarily related to the function of deciding cases of conflict between companies and policyholders. The courts also enter the picture in evaluating the constitutionality of regulations or orders promulgated by the insurance department.

Insurance Department: The Insurance Department of a state plays the most prominent role in the day-to-day regulation of insurers. While the legislature establishes the rules, it is the Insurance Department which makes sure that all companies abide by these rules. Some of the more significant roles of the Department (acting through the Commissioner of Insurance) are:

- Licensing. The Commissioner of Insurance has the power to provide a licence or certificate of authority to transact insurance business in his state. Insurers need to meet minimum capital and surplus requirements, which vary substantially by state and by line of business. An insurer which is not licensed may still operate in a state in one of two ways. Non-licensed companies writing insurance business are governed by surplus lines laws. Most states require that risks be placed, wherever possible, with insurers authorized to do business in the state (admitted carriers). The excess and surplus lines market exists for those risks for which coverage cannot be found in the admitted market. The volume of business in the excess and surplus lines market is therefore related to the underwriting cycle in the US, with more business placed when the underwriting is restricted (as in the current environment). Surplus lines laws usually address the placement of insurance with surplus lines companies, taxation of such companies, and minimum funding requirements.

Reinsurance may also be placed with non-admitted insurers. However the ceding company may not take credit for reserves ceded to unauthorized insurers unless it holds funds or letters of credit against the amount of reserves.

Most of the US business written in the London Market is excess and surplus lines or reinsurance business. The actuary working in this market is advised to become familiar with the state laws governing this business.

- Examination of Insurer Condition. Statutes typically require the Commissioner to periodically examine the financial condition of the insurers domiciled in his state. The examination is comprehensive, covering assets, liabilities (including a review of loss reserves), accounting procedures, reinsurance, etc. Most states require such an examination every three years.

- Annual Statement. While the thorough examination is typically conducted every three years, the Commissioner also has the right to require of every casualty insurer operating in his state an annual statement of condition. While there are some differences in the annual reporting requirements among the states, the National Association of Insurance Commissioners (NAIC) has succeeded in standardizing the form of the report.

- Rates. The Insurance Commissioner has the authority to regulate premium rates. The degree of control varies both by state and by line of business. Some states require prior approval of rate filings, some allow rates to be used after a specified time after filing with the department, and others only require that rates be filed on an informational basis upon implementation by the company.

In the US, the casualty actuary has a well established role in the ratemaking process. It is the actuary who is often called upon to demonstrate or testify that the rate is adequate/reasonable/necessary. The two largest ratemaking organizations (Insurance Services Office and National Council on Compensation Insurance) are composed largely of actuaries. Many insurance companies have actuarial departments devoted to monitoring and promulgating the company's rate levels.

Conclusion. The "insurance environment" in a state is created by a combination of legislative, judicial and regulatory activity. Differences among the states are significant, particularly in the judicial climate and the Insurance Commissioner's attitude toward regulation. Any entrant into the US insurance market should be aware of the differences.

E.2. Special State Legislation and Tort Reform

As has already been intimated in the previous section there is considerable variation between states in the detail of the legislation pertaining to insurance business. This affects all the areas in which state legislatures have any authority, such as licensing, examination and rate control.

However, there is currently a spate of new laws being passed in the specific area of insurance concerned with the availability of coverage, arising out of the recent capacity shortage and hardening of the market. Some of these have been rushed to such an extent that the precise implications are unclear.

The variety of ways in which different states have approached the problem has resulted in a real minefield for casualty underwriters in trying to keep abreast of developments. It can also have a serious impact on the actuary's use of historical results as a basis for future rating.

Virtually all states have now passed or proposed laws in this connection, and it would not be appropriate to attempt a complete summary in this paper. However, the following indicates the variety of different approaches involved:-

Several states have taken an approach which appears to be basically antagonistic to the insurance industry. Such states have concentrated on legislation making it illegal, to fail to renew commercial insurance coverage. Some restriction has also been placed on rate increases. Whilst in the short-term this may have some impact on the availability of coverage, this may be reversed in the longer term as insurers become less willing to write new business in the state for fear of being tied into loss-making business. States such as New Jersey, Delaware and Oregon have taken this type of position.

Other states have used an approach more in line with that advocated within the insurance industry. The type of action which they have taken includes the following:

- introduction of a limitation on awards for "non-economic" loss - e.g. awards for pain and suffering and loss of companionship. Such legislation has subsequently been challenged as unconstitutional, but the challenge appears to have failed.

- elimination of joint and several liability for non-economic losses. In some states such action has been restricted to cases where the plaintiff is not responsible at all for the damages and in hazardous waste cases.

- imposition of the use of period payments rather than a lump sum if either party so desires.

- restriction of the contingent fee system.

A federal bill has been mooted, which may take a similar position to the above.

The enclosed summary (which has been considerably overtaken by events since the end of 1984) gives a fuller indication of the types of action taken or contemplated by state.

Tort Reform (see below for index)

State	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Alabama	A							A			B	B	A
Alaska	A			A				A	A	A			B
Arizona	A	A		B					B		A	X	A
Arkansas	A							A	A				A
California	A	B		A		B		B		A	A	A	
Colorado		A	A				A				B	A	
Connecticut	A								A				
Delaware		A		A	A			A	A	A	A	A	A
Florida	A	A	A	B	A		B	A	X	A	A		A
Georgia	A										A		
Hawaii	A	A					A		A		A		
Idaho		Y		Y	B	Y			A				A
Illinois	A		A	A		X	A	A	X	A	B		
Indiana	B	B				B	B		B		B	B	
Iowa	A	A		B							A	A	
Kansas	A	A	A	A			A	A	A		B	A	
Kentucky	A					X	X				A		
Louisiana	B				A	A	B		B		A	A	A
Maine	A								A		A		
Maryland	A	A						A	A		A	A	
Massachusetts	A		B						B		A	A	
Michigan		A			A			A			A		A
Minnesota											A		
Mississippi	A										A	A	
Missouri	A								X		A	A	
Montana									B		A		
Nebraska	A	B	A	B		B	B		B		A		A
Nevada					A				Y	A	A		A
New Hampshire	X	X	X	X	X	X		X	A	X	X	X	X
New Jersey		A							B				
New Mexico	A					A	A	A	A		A	A	
New York	A	A		A					A		A	A	
North Carolina	A						A				A	A	A
North Dakota				X		X	X	X	Y	X	A		X
Ohio	A			A	B	A			B		A	X	
Oklahoma		A			A					A	A		A
Oregon		A				A	A	A			A		A
Pennsylvania		X	A	X			A		X				
Rhode Island	A	Y	Y	A					Y	A	A	Y	
South Carolina						A	A	A			A		
South Dakota				A		A					A	A	
Tennessee	A	A		A	A				Y	A	B		A
Texas	A					A				A	A	X	
Utah	A										B	A	
Vermont													A
Virginia					A	A			A				A
Washington	A	A		A				A			A		B
West Virginia													
Wisconsin	A	A				A	A	B	B		A	A	
Wyoming		A					A				A	A	

Index -
A = Provision exists or imminent
B = Provision deemed constitutional
X = Provision deemed unconstitutional
Y = Provision repealed or expected to be repealed

Table of Tort Reform Provisions - Key

The column headings have the following meanings:

- (1) Ad Damnum - The amount of damages sought by the plaintiff in the initial pleadings. Tort reform legislation calls for their elimination.
- (2) Contingency Fees - Reforms include the imposition of a sliding scale, restricted fees or the requirement to obtain court approval.
- (3) Awarding Costs - If the plaintiff is deemed to have brought the action frivolously, reform legislation provides that he can be found liable for the defence costs, whereas previously each party would pay his own.
- (4) Collateral Source Benefits - Reform allows the introduction of evidence that the claimant has been compensated or reimbursed by a source other than the defendant, thus permitting the award to be reduced by the value of such other benefits.
- (5) Expert Witness - Reform lays down guidelines on the use of so-called expert witnesses to reduce the scope for abuse.
- (6) Limits on Liability - Reforms place a cap on certain types of damages, especially for medical malpractice claims.
- (7) Patients Compensation Fund - Introduction of these government operated mechanisms provide for the payment of the excess of a settlement over an amount set by law.
- (8) Periodic Payments - Reforms provide for the statutory use of these as compensation in certain circumstances. Their value is often considerably less than the traditional lump sum.
- (9) Pre-trial Screening Panels - These are pre-trial hearings whose rulings are not binding, but whose decision may be permitted as evidence in any later lawsuit. Reforms establish these panels.
- (10) Res Ipsa Loquitur ("The thing speaks for itself") - This is a common law doctrine that in some courts precludes the jury from reaching any decision other than guilty if the plaintiff shows that the defendant caused the injury using an instrument which is not normally dangerous if used in a non-negligent fashion. Reforms codify this doctrine, laying down limits on when it may be applied - e.g. if a foreign object is left in a body after an operation.
- (11) Statute of Limitations - Reforms to tighten these (see Sect B.2.)
- (12) Special Statute of Limitations for Minors - Traditionally, the period of the statute does not commence until the age of majority in the case of a minor. Reforms provide for the period to commence at an earlier date.
- (13) Standards of Care - Reform of the level of health care assumed to be provided following an accident, based on the level practiced in the locality (community, state or nation).

F. Claims Frequency Problems

There are several factors which combine to cause the relatively high frequency of claims on US casualty business written in the London Market.

One of the foremost of these is the contingency fee system which results in the removal of the impediment which often exists in UK to injured persons taking legal action, namely the risk of incurring high legal costs in fighting an unsuccessful action. In fact, the situation in US is not merely neutral in this respect, since the contingency fee system leads to the phenomena of "ambulance chasers" and "ten percenters", who track down injury victims and offer to provide them with legal services.

An example of this was seen following the recent accident at the chemical plant at Bhopal in India, when the victims were offered the services of a number of different US attorneys who believed they could successfully bring a case against the plant owners, Union Carbide, in the US courts. So far, this appears to have been unsuccessful.

In addition, the greater awareness of legal matters and more litigious nature of the US population results in a greater proportion of potential claimants bringing an action.

In London, where much of the business is written subject to a substantial excess, the frequency of claims is also significantly affected by the ground-up size of the claims experienced in US. The gearing effect of the excess is particularly important here. Special factors causing the large ground-up claim size are the jury system of awards (with the jury tending to see an insured defendant as having the availability of a bottomless purse), the contingent fee system (the awards sometimes being effectively grossed up for an assumed percentage fee), joint and several liability and discovery (which together tend to concentrate the awards where the insurance is) and punitive damages (which can enormously inflate the basic award).

Taking all these factors together, it can be seen that the claims frequency on an American casualty insurance or reinsurance policy can be many times that on what appears, superficially, to be a similar contract emanating from other parts of the world.

G. Latent Claims

The term Latent Claims can be used to describe claims now arising from events occurring many years previously. This includes asbestos related claims (both bodily injury and property), environmental pollution, the similar problem of toxic chemicals and pesticides in agriculture, and possible future types such as lung cancer caused by cigarettes.

General

Some of the most difficult problems in liability reserving arise from the emergence of latent claims. It is often difficult or impossible to calculate the total potential exposure involved. The delay in notification can be very long indeed (over 50 years has occurred in practice). Large scale increases in reserves may arise from one court ruling.

Asbestos Related Claims

Asbestos related bodily injury claims and the cost of removal of asbestos in property are distinct types of claims. Whereas the former is prevalent, the latter is in its infancy.

Asbestos claims have been subjected to a large amount of Court exposure in the U.S. The progressive, rather than sudden nature of asbestosis, mesothelioma, etc. has caused problems in interpretation of policy covers and subsequent delegation of liability.

Initially three theories arose as to the way in which the coverage was determined:-

(i) Exposure theory.

All companies providing cover during the victim's exposure to asbestos are joint and severally liable. These Courts believe this theory more closely represents the expectations of the insurer when the contract was accepted.

(ii) Manifestation theory.

The insurance companies providing cover at the time the injuries manifest or are diagnosed are liable. Some courts reject the exposure theory and find that the CGL provisions support a manifestation theory.

(iii) Injury in fact theory.

This theory rejects the above. The insured must prove an injury in fact during the policy cover to submit a claim. This is far more restrictive and passes the onus to the insured.

The Keene or "triple trigger" theory as set out in *Keene vs Insurance Company of North America* gives the insured the best of all worlds by using the most favourable of the three theories. However, a recent Court Decision restricts the Keene theory, stating that injuries must have occurred within the policy period.

Whichever theory is found applicable a massive additional amount of Court costs inevitably occurs. Mainly to circumvent these costs, the Asbestos Facility was created to co-ordinate the insurers and asbestos producers into, as far as possible, one body. In some cases the costs exceeded the damage payments and a high proportion of damage payments went to attorneys. Under the Facility, awards are standardised and only if the claimant is dissatisfied does the case proceed to Court.

Until end 1982 US\$400 million had been paid out by insurance companies for asbestos related claims. Studies now suggest that over the next 30 years anything between US\$8 billion and US\$80 billion might be the final total.

Since the Facility was inaugurated in June 1985, 80% of producers and 70% of direct insurers have supported it. As a direct result the number of attorney firms involved in asbestos litigation has fallen from 1,000 to 63.

Environmental Pollution

Now that the problems of asbestos have manifested themselves, environmental pollution claims have greatly expanded (claims potential has always existed with one or two claims going back to the 19th century) and could prove far worse. Chemicals that were supposedly safely stored many years ago have seeped out or otherwise contaminated property or people. Proving when pollution commenced, of course, is even more difficult than for asbestos e.g. a seeping storage tank. The Environmental Protection Agency seeks ways of cleaning out hazardous waste sites. A "Superfund" was created in 1980 by the EPA to pay for this, the money recoverable from insurance companies. With average sites costing US\$10 million, and over 800 designated dump sites already, the total bill could be enormous.

In fact, since 1975 a policy specifically to cover environmental pollution damage has existed but has been unsuccessful because:-

- (i) After the required survey any sites likely to give rise to pollution claims are declined,
- (ii) The policy is on a claims made form so previously identified Superfund sites are normally excluded,
- (iii) Exclusion clauses result in the omission of risks failing to comply with the environmental standards.

Much attention has been focused on the pollution exclusion clause in CGL policies. This removes cover with a discharge, dispersal, release or escape of pollutants but NOT if it is sudden or accidental. However, some Courts have interpreted the wording in favour of the insured with some rather unusual and unexpected verdicts e.g.

- (i) Even if the insured takes care to use a contractor for the disposal of waste, mishandling by the contractor is deemed an "accident".
- (ii) The use of a licenced waste disposal site with waste seepage into the water basin is an "accident".
- (iii) The accumulation of waste or a chemical reaction of waste is "sudden and accidental".
- (iv) The use of a "test well".

Clearly, these cases go far beyond the original intent of the exclusion clause wordings. It is therefore little comfort for insurers with large exposure to have these exclusion clauses.

The insurance market is getting together to form a united front (as happened late in the life of asbestos claims), although this is currently still in the embryonic stage.

Future Latent Claims

It is clearly in the interest of actuaries reserving for the future to identify potential future latent claims. These can then be closely monitored in U.S. Court actions:-

(i) Cigarettes and Lung Cancer

Several actions have been taken against cigarette manufacturers (so far all unsuccessful) to recover damages for injuries caused by lung cancer. The first was by the dependants of Nat King Cole against Reynolds.

(ii) Pesticides

Modern day farming makes increasing use of chemistry to improve crop yields. The long term effects of consumption of small amounts of these chemicals is unknown.

(iii) Radiation

Possibly the largest claims could result from long term exposure to radiation:-

- (a) The ambient levels in the atmosphere are rising.
- (b) Televisions emit small amounts which are strongest near the tube.
- (c) V.D.U. operators are especially at risk and as a precaution pregnant employees can be excused using a computer terminal.
- (d) Microwave ovens with faulty units have already been the subject of claims.
- (e) The increasing use of nuclear power for various purposes, both military and peaceful, brings with it the the risk of serious nuclear accident. It is not difficult to imagine the flood of compensation claims which would have followed the Chernobyl accident had it occurred in the United States.

H. Future of the US Tort System

In the above paragraphs, attention has been drawn to some of the problems arising from the US tort system over recent years. Such problems are not so much an inherent effect of the system as a consequence of the way in which it has been interpreted by some members of the legal fraternity. However, due to the precedents thus set, there was serious risk of the trends being extrapolated to such an extent that, in the words of one well-known American "You ain't seen nothing yet".

It is clear that the adverse effects of this scenario are beginning to get through to a sufficiently influential proportion of US attorneys that some action is being taken. The principal factor influencing this is the growing non-availability of insurance in certain of the more exposed classes. The action being taken has been dealt with, at least at a superficial level in Section E.2. of this paper, but as pointed out there, the situation is extremely fluid and subject to almost daily change.

It is hoped to have an update of the current position at the GIRO seminar, but it is clearly a case of today's future being tomorrow's present. Thus any prognostication of the way in which events will move is liable to be made to look either obvious or ridiculous by subsequent happenings. The following possibilities do exist, but no attempt is being made to fix probabilities to them:

- (i) The US liability insurance crisis worsens, with cover unavailable across wide areas of demand.
- (ii) Underwriters ignore the problems of the recent past and provide coverage regardless and probably with disastrous results.
- (iii) The current spate of tort reform legislation is a temporary respite to underwriters until attorneys find new loopholes and methods of exploiting the system for the benefit of their clients and themselves.
- (iv) The trend to tort reform legislation continues and the US legal system becomes increasingly similar to those in other countries.
- (v) Federal action reduces the freedom of the individual state legislatures, causing an increasing uniformity in the legal environment.

What is certain is that the next few years will provide plenty of talking points for students of the American legal system. Any actuaries with an interest in US casualty insurance would be well advised to watch this space!