

## **1 Introduction**

In this paper I use the term “*latent claims*” to refer to claims arising out of a disease contracted by exposure to an external disease causing agent where there is a considerable lapse of time between the exposure and the manifestation of symptoms in the injured party. The most common examples of latent claims in the context of insurance are those diseases caused by exposure to asbestos, particularly the disease known as mesothelioma, although there are several other examples such as diseases related to lead based paint and tobacco.

This paper is written by a reinsurance practitioner not a lawyer. Its message is that insurers should carefully consider how they manage claims arising out of latent diseases and how they communicate with reinsurers in relation to those claims to ensure that they do not jeopardize their rights under any relevant reinsurance protection. It might be considered a imprudent practice these days for an insurer to commit to a large settlement without ensuring that he has reinsurance backing.

## **2 The Issue**

Latent diseases have raised challenging issues for insurance and reinsurance law as well as tort law. The insurance and reinsurance policies written up to the 1970’s did not anticipate claims arising from latent diseases. As these claims have emerged the insurance industry and the judiciary have had to reinterpret the contracts to determine whether coverage is available.

The problems largely arise out of the fact that, generally, a long period of time will have elapsed between the injured party’s exposure to the disease causing agent and the manifestation and diagnosis of disease. That means that the claims are being considered many years after the allegedly wrongful conduct in a different legal and social environment.

Often it is not possible to accurately determine the person or persons who caused the injury or to apportion responsibility fairly between competing entities.

If one of the tenets of tort law is to attribute responsibility to the person and activity that caused the injury and therefore act as a deterrent it fails in that regard in the case of latent

diseases where often the activity complained of has ceased before symptoms of disease manifest<sup>1</sup>.

The long delay between the impugned activity and the making of a claim also means that insurance and reinsurance policies are being examined and, perhaps, massaged many years after they were underwritten.

### **3 History**

Mass litigation in relation to latent diseases has a relatively short history and, as so often is the case in tort law reform, we need to look to the United States to find its beginnings.

In 1974 in the seminal case of *Borel v. Fibreboard Paper Products*<sup>2</sup> the United States Court of Appeals for the Fifth Circuit found in favour of a plaintiff suffering from mesothelioma against a manufacturer of asbestos insulation products. The number of asbestos claims that have been notified since *Borel* is frightening. It is predicted that eventually they will number between one million and three million.

The next mass litigation began in 1978 when around 250,000 Vietnam War veterans sued the US government and manufacturers of Agent Orange<sup>3</sup> for diseases related to that defoliant. That case settled for USD180m.

Other latent disease claims followed the asbestos and Agent Orange litigation relating to diethylstilbestrol (DES)<sup>4</sup> and the intrauterine contraceptive device the Dalkon Shield<sup>5</sup>.

Then, in 1994 various US states began to sue tobacco companies for costs incurred as a result of tobacco related illnesses<sup>6</sup>.

### **4 Financial Impact**

The above claims, and other like them, have imposed a huge financial burden on the insurance industry.

The difficult nature of these claims and the potential financial impact on companies has cause tensions to occur between insurers and reinsurers.

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<sup>1</sup> Donald G Gifford of the University of Maryland explores this issue in his 2004 paper "The Peculiar Challenges Posed By Latent Diseases Resulting From Mass Products".

<sup>2</sup> 419 US 869, 42 L.Ed 2d 107, 95 S.Ct 127

<sup>3</sup> Agent Orange was a defoliant used by the US military in Vietnam. It has been linked to various cancers and birth defects in the offspring of people exposed.

<sup>4</sup> DES was used to prevent miscarriage. It caused cancer in some mothers and their daughters. Approximately 430,000 plaintiffs have been identified.

<sup>5</sup> The Dalkon Shield caused pelvic inflammation and septic abortions. AH Robins was the only manufacturer. Robins went bankrupt having established a fund of USD2.5b. to compensate victims.

<sup>6</sup> The actions brought by the states settled for USD246b.

In 2003 Standard and Poors published a report called “Asbestos Driving a Wedge Between Insurers and Reinsurers”<sup>7</sup> the basic premise of which was that there was an inconsistency between the level of reserves carried by insurers in relation to asbestos claims and those carried by reinsurers for those same claims. In other words, the asset carried by insurers was not matched by a corresponding liability in the balance sheet of the reinsurers. The suggestion seems to be that insurers are overly optimistic about the amount they will recover from reinsurers.

The report also makes the worrying observation that there appears to be a significant shortfall of USD25b. between the reserves currently carried by the US insurance industry for asbestos claims and the amount it is expected to pay.

Tillinghast-Towers Perrin published a report in March 2006 which estimated that US asbestos losses would eventually total USD200b. with US insurers bearing 30% of that amount and foreign insurers bearing 31%<sup>8</sup>.

It is interesting to observe that total tort costs in US increased from 0.62% of GDP in 1950 to 2.23% of GDP in 2003. During that same period the per capita cost of the tort system per annum showed a similar trend increasing from USD91 to USD845<sup>9</sup>. If we apply those percentages to Australian GDP and population it is clear the tort system in Australia is relatively under-developed, perhaps by 50%.

The big question for the Australian market is whether the US experience will be repeated in Australia. It is reported<sup>10</sup> that consumption of asbestos in US peaked in 1973 with asbestos related deaths peaking about 20 to 25 years later. It is suggested<sup>11</sup> that the peak in asbestos related deaths in Australia will probably occur around 2010 so there is some development left.

But there are fundamental social and legal differences that might make the Australian experience quite different to that in US<sup>12</sup>. The writer is of the opinion that Australia will not face the exactly the same issues or to the same extent as those confronted in US but that is not to say that we will avoid the issues altogether.

The S&P report referred to above also noted, perhaps not surprisingly, that reinsurance disputes were becoming more common and bitter.

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<sup>7</sup> The S&P report has been cited in Insurance Journal (1 April 2003) & Risk and Insurance (1 Sept 2003).

<sup>8</sup> Insurance Information Institute, September 2006.

<sup>9</sup> US Tort Costs: 2004 Update, Towers Perrin Tillinghast.

<sup>10</sup> See, for example, Risk: Legal Issues in Insurance Coverage, Winter 2004, “Comparing US and UK Asbestos Liability”.

<sup>11</sup> Various reinsurers have examined this question.

<sup>12</sup> The absence of juries & punitive damages to name just two differences.

In May 2004 Brian S Brown and Claus S Metzner<sup>13</sup> posited that the reinsurers' proportional contribution to asbestos claims in US would decline relative to the contribution by insurers in future.

## 5 Reinsurance Disputes

Most reinsurance disputes in the past have been resolved somewhat privately. But that situation is now changing.

The dispute between *Hartford Accident Indemnity Company* and various Lloyd's Underwriters and London company market participants is a good illustration of the different views that might be taken to how much of a claim will be met by reinsurers.

In that case, Hartford settled 17,000 asbestos claims on behalf of its insured, MacArthur Corporation for USD1.15b. Hartford sought to recover USD117m, from its higher layer excess of loss reinsurers in London on the basis that it should only bear one retention per year. The London market argued that there were multiple occurrences and therefore Hartford must bear multiple retentions. The Connecticut Supreme Court will determine an appeal on this point and a decision is expected during 2007.

Further evidence of a falling out over asbestos claims is the litigation commenced by *Associated International Insurance Company* against certain London market underwriters, Equitas and its US lawyers alleging Unfair Business Practice in imposing, during 2001, much more stringent claims reporting requirements for asbestos claims<sup>14</sup>.

The 2001 Requirements dictate that all asbestos claims submissions from insurers must include:

- A specific medical diagnosis that the injured party's condition was caused "in substantial part by exposure to asbestos";
- A verified statement that the injured party was exposed to a product of the insured which contained asbestos;
- A certification under oath that the claim meets the requirements of the London Market Direct "Insurance Requirements".

Shortly after the above requirements were introduced for direct insurers, similar requirements were introduced for reinsurers and it is the Reinsurance Requirements that have proved to be the more controversial. This is largely because the reinsurers do not possess the information is required and for them to acquire it would be difficult and expensive.

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<sup>13</sup> In an article called "Reinsurance Carriers Expected to Play Smaller Role in Future Asbestos Losses".

<sup>14</sup> The Direct Reporting Requirements and the Reinsurance Requirements

## 6 Policy Triggers

One of the difficult areas, almost imponderable, that the courts have had to wrestle with in the area of latent disease is the question of which insurance policy period is required to respond to a claim. In the US the courts have flirted with several theories<sup>15</sup>.

- The “*Exposure*” theory, as the name suggests, requires the policy in force when the injured party was exposed to the damaging agent to respond.
- The “*Manifestation*” theory holds the policy in force when there is a recognizable injury responds.
- The “*Double Trigger*” theory combines “*Exposure*” and “*Manifestation*” and so policies at both times will be caught.
- The “*Injury in Fact*” theory exposes those policies in force at the time that damage actually occurs.
- And, of course, the best theory of all is the “*Continuous*” or “*Triple*” Trigger theory which catches all policies from first exposure until last injury.

### 6.1 Orica Case

In the New South Wales case of *Orica Limited & Anor v. CGU Insurance Limited*<sup>16</sup> the Court of Appeal had to consider which statutory Workers Compensation policy period should respond to a claim for mesothelioma.

Whilst this case relates to a claim arising under a statutory policy, the decision has a broader importance.

The facts in that case were that the injured party had been exposed to asbestos in the course of his employment with Orica’s predecessor companies from 1959 to 1961. The disease of mesothelioma was diagnosed in 2001.

Orica settled the injured party’s common law claim for AUD240,000 in 2002. Orica claimed against CGU under the three workers’ compensation policies in force for 1959, 1960 and 1961. Orica argued that it was entitled to recover the full limit of indemnity of AUD60,000 in each year, a total recovery of AUD180,000 plus certain costs.

The case came before Spigelman CJ, Mason P and Santow JA in the New South Wales Court of Appeal. The decision is interesting because of its practical implications.

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<sup>15</sup> The authorities for the following trigger theories are set out in many publications and they not repeated in this paper.

<sup>16</sup> [2003] NSWCA 331

The policy wording followed the statutory formulation. The policy imposed an obligation on the insurer if, during the currency of the policy, “the Employer shall be liable” to pay statutory compensation or damages. The question therefore was when did the Employer become liable to pay damages. If it was during the period 1959 to 1961 then the CGU policy or policies would respond.

Spigelman CJ and Mason P held that CGU was off the hook. They held that the employer’s liability did not accrue until some time after the policies had expired, probably when the symptoms became manifest<sup>17</sup> although they conceded (obiter) that “injury” had occurred during the period of exposure.

Santow JA, on the other hand, held that the employer’s liability came into existence at the time of injury, that is during the period of exposure.

## **6.2 Bolton Case**

The English Court of Appeal had the opportunity to consider when a loss occurs under a Public Liability policy in *Bolton Metropolitan Borough Council v Municipal Mutual Insurance Limited & Commercial Union Assurance Company Limited*<sup>18</sup>.

That case involved a victim of mesothelioma who was exposed to asbestos during the 1960’s and died in 1991. Bolton settled the claim brought by the victim’s widow and sought to claim against Municipal Mutual who was the insurer when the mesothelioma became manifest. Municipal Mutual denied liability saying that Commercial Union, who was the insurer at the time of exposure, was the appropriate insurer to meet the claim.

The Public Liability policy in question indemnified the insured against a liability arising out of “bodily injury” occurring “during the currency of the policy”.

The Court of Appeal held that Municipal Mutual was liable to indemnify Bolton in relation to this claim. Lord Justice Longmore<sup>19</sup> said, at paragraph 15, “the contract between the parties is an agreement to indemnify against liability. It cannot be right that, at the stage of initial exposure or initial bodily reaction to such exposure, there could be a liability on the part of Bolton in respect of which they could require to be indemnified under any public liability insurance policy. Mr Green could not have sued for personal injury at that stage because he has suffered no injury at that stage”. Lord Justice Longmore expressly disavowed the US theories of “multiple” or “triple” triggers<sup>20</sup>.

The decisions in both Bolton and Orica seem, at least from an industry viewpoint, to be counter-intuitive. The decisions shatter the nexus between wrongful conduct and sanction.

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<sup>17</sup> When the injured party’s cause of action was complete.

<sup>18</sup> [2006] EWCA Civ 50.

<sup>19</sup> With whom Lady Justice Hallett and Lord Justice Auld agreed.

<sup>20</sup> At paragraph 24.

Applying the reasoning to Public Liability policies only, it means that the insurance claim is shifted from a period when the insured had cover to a period where he might not have cover due to the inclusion in the insurance policy of an asbestos exclusion.

Further, even if the latter insurance policy does provide indemnity, it is likely that the reinsurance contracts will include an asbestos exclusion.

## **7 Excess of Loss Reinsurance**

Reinsurance protection of a liability portfolio is often provided by excess of loss treaties. Under excess of loss treaties the reinsured retains the first dollar amount of each “claim” with reinsurance being bought in layers for amounts in excess of the reinsured’s retention. It therefore becomes critical to determine what constitutes a “claim” for the purposes of the reinsurance protection. This is often a difficult issue when dealing with latent diseases.

The US courts have generally construed liability policies in such a manner as to maximize coverage for latent diseases. A claim might consist of thousands of individual claims for relatively small amounts but which in the aggregate constitute a very large claim. But excess of loss reinsurance treaties might not allow such aggregation. For example, in the case of asbestos claims, and in the absence of any “aggregating” language in the treaties, each injured party might constitute a “claim” in which case the reinsured might be denied reinsurance coverage entirely.

### **7.1 Insurance Contracts Act**

It is worth noting, in passing, that the *Insurance Contracts Act 1984 (Cth)* does not apply to reinsurance contracts<sup>21</sup> so we must look to the common law or other statutory provisions<sup>22</sup> for guidance. This means, of course, that the “consumer protection” type provisions of the ICA with which insurers are so familiar may not be available to protect the insurer in terms of its relationship with its reinsurers.

To date, the courts in Australia have not had the opportunity to consider many reinsurance disputes so we generally look to the UK courts for persuasive authority.

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<sup>21</sup> Section 9 (1) (a).

<sup>22</sup> See, for example, the Insurance Act 1902 (NSW) which, arguably, applies to certain contracts of reinsurance.

## **7.2 Utmost Good Faith**

Contracts of insurance are contracts of the utmost good faith<sup>23</sup> and there is no doubt that a contract of reinsurance is also a contract of the utmost good faith. This duty extends to the manner in which underlying claims are managed. It is not acceptable for an insurer to favour its own position over that of a reinsurer or to favour one reinsurer over another.

## **7.3 Follow the Fortunes**

The concept of “follow the fortunes” is often mentioned when contracts of reinsurance are discussed but it is important to understand the limitations of this concept.

“Follow the Fortunes” is a feature of proportional<sup>24</sup> reinsurance where the reinsured and the reinsurer share the risk from the ground up. If, for example, a quota share treaty provided that 50% of all premium (and risk) was to be ceded to the reinsurer, it would generally be understood that the reinsurer would allow the reinsured to make all decisions in terms of underwriting and claims management and provided the reinsured acted in a proper and businesslike manner<sup>25</sup> the reinsurer would follow those decisions.

But the situation is not so clear cut in the case of excess of loss reinsurance where the reinsured and the reinsurer are not sharing the risk from the ground up. In the case of excess of loss reinsurance, in the absence of express provision to the contrary, the concept of “follow the fortunes” is, in the writer’s opinion, not applicable. In such cases, the reinsurer will look to the terms of the reinsurance contract to determine whether a claim is payable or not.

Excess of loss treaties will often require that the claim under consideration comes within the terms of the underlying policy and within the terms of the reinsurance contract. And the reinsurance contract will generally contain many conditions and exclusions which need to be considered.

Insurers should not assume that reinsurers will blindly follow their settlements of latent disease claims unless there is clear language to that effect in the reinsurance contract.

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<sup>23</sup> Section 13 of the Insurance Contracts Act 1984 (Cth) provides that “A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith”.

<sup>24</sup> In proportional reinsurance the reinsurer receives a set percentage of all premiums written by the reinsured with respect to the class of business covered and pays the same percentage of all claims from the ground up.

<sup>25</sup> *Insurance Company of Africa v Scor (UK) Reinsurance Co Ltd* [1985] 1 Lloyd’s Rep 312.

## **7.4 Period**

The “Period” of cover in an excess of loss treaty will often be expressed to be “losses occurring during” 12 months at (the inception date).

In the context of the Bolton case it is interesting to consider whether the trigger of the reinsurance contract is the same as the trigger of the underlying policy.

## **7.5 Limit and Deductible**

The “Limit”<sup>26</sup> and Deductible<sup>27</sup> in an excess of loss treaty are expressed to apply to each and every loss. The definition of what will constitute “each and every loss” will vary. A fairly standard approach is to define “each and every loss” as all claims arising out of one “event”.

In the context of latent disease claims the definition is very important as it will determine the extent to the aggregation of claims will be allowed.

## **7.6 Indexation**

Many excess of loss treaties will include a “Stability” clause. The effect of this clause is to increase the Deductible and Limit under the treaty as time goes by so that they retain the same “real” value as they had at the inception of the treaty. The indexation factor will generally relate to changes in average weekly earnings or similar. The Stability Clause can dramatically increase the amount retained by the reinsured over time.

## **7.7 Loss Reporting**

A feature of excess of loss reinsurance is that the reinsurer will not have a financial interest in all claims that come within the terms of the treaty. The reinsured is not, therefore, required to report all claims to the reinsurer. It is only claims of a particular type<sup>28</sup> or which reach a certain monetary value<sup>29</sup> which the reinsured is required to report. In relation to those claims, the reinsured is required to report as soon as reasonably practicable and thereafter to keep the reinsurer informed of developments. The failure to comply with a loss reporting provision is not fatal to the reinsured’s claim unless the requirement is expressed to be a condition precedent to liability<sup>30</sup> or the reinsurer can prove that he was prejudiced by the late notification<sup>31</sup>.

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<sup>26</sup> Amount of cover.

<sup>27</sup> Amount of a claim borne by the insurer.

<sup>28</sup> For example, brain damage or spinal damage.

<sup>29</sup> Usually expressed as a percentage of the deductible

<sup>30</sup> To express a reporting requirement as a condition precedent is relatively uncommon.

<sup>31</sup> authority

An insurer's reporting of claims to reinsurers should be meaningful. There has been a tendency, when an insurer itself is first notified of a latent disease claim, to send a fairly meaningless notification to all reinsurers that could possibly have any involvement in the claim no matter how remote the possibility. Whilst the sending of a notification to all reinsurers is not to be discouraged, it is important that the notification actually conveys some useful information.

### **7.8 Claims Co-operation**

Excess of loss treaties will generally contain a "Claims Co-operation" clause. These clauses vary in their precise intent and effect but will usually require the reinsured to keep the reinsurer informed and to invite his input into decisions. This is necessarily a vague requirement and exactly what would constitute a failure to co-operate in any given situation is not clear.

In any given situation it might also be difficult for a reinsurer to establish that it suffered any loss as a result of the insurer's failure to "co-operate" in the management of a claim. You can imagine a situation where an insurer settles a contentious claim without the approval of a reinsurer. The only way to determine that the outcome would have been different had the insurer "co-operated" would be to litigate the facts of the underlying claim. That would often not be feasible.

### **7.9 Inspection of Records**

A valuable right is extended to the reinsurer in the ubiquitous "Inspection of Records" clause. This clause will allow the reinsured to visit the office of the reinsured during normal office hours after having given reasonable notice and to inspect all records relating to the relevant reinsurance contract. Even in the absence of an express inspection clause, many people argue that the right exists pursuant to an implied term of the contract.

The precise terms of inspection of records clauses vary and a question sometimes arises as to what records exactly they allow the reinsurer to inspect.

The reinsurer will pay its own expenses incurred in carrying out an inspection of records and they can be considerable. But the cost to the insurer in terms of management time should not be underestimated. An inspection might last many weeks and involved hundreds of records.

## **7.10 Exclusions**

The typical excess of loss treaty will contain a schedule of “Exclusions” representing those risks which the reinsurer is not prepared or able to accept and those claims that it will not pay. Such lists might be quite extensive.

Asbestos exclusions started to appear in excess of loss treaties in the early 1980’s. At first they were somewhat unsophisticated. A common clause from that era excluded claims arising out of “asbestosis or related diseases”. The point has not been taken in Australia, at least to the writer’s knowledge, but it must be arguable, that such an exclusion would not exclude claims for mesothelioma given the quite different aetiology<sup>32</sup> of that disease.

As time went by the asbestos exclusions became more sophisticated. A typical clause from the mid-nineties would exclude:

“Personal Injury.....caused by or arising directly or indirectly out of or in connection with any mining, handling, processing, manufacture, sale, transportation, distribution, storage or use of asbestos products or asbestos contained in any products...”

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<sup>32</sup> It could be argued that asbestosis is a cumulative, dose-related condition which is fundamentally different to mesothelioma which could be the result of a brief exposure.