Testimony of

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Committee on the Judiciary
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Solving the Asbestos Litigation Crisis:
S.1125, the Fairness in Asbestos Injury Resolution Act of 2003
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Statement of Jennifer L. Biggs, FCAS, MAAA
Quantification of the Economic Impact of S.1125

Mr. Chairman and Members of the Committee: Thank you for allowing me to testify today. My name is Jenni Biggs. I am a consulting actuary with Tillinghast ?{ Towers Perrin and a principal of Towers Perrin. I am a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. My consulting practice focuses on quantifying the asbestos liabilities of insurance and reinsurance companies as well as corporate defendants named in asbestos lawsuits.

In May of 2001, my colleagues and I released our estimate of the ultimate loss and expense liabilities projected to result from U.S. asbestos exposure. Our estimate of $200 billion has since been widely quoted. During this testimony, I will explain how we anticipate our $200 billion estimate will change if Senate Bill 1125, the Fairness in Asbestos Injury Resolution Act of 2003 (or the ¡§Fair Act¡¨) is enacted.

First, I will briefly discuss how we arrived at the $200 billion estimate. Then I will step through how our underlying assumptions change, considering the provisions of the proposed legislation. Specifically, I will quantify the impact of removing frictional costs (or defense and plaintiff attorney expenses) from the system and implementing specific medical criteria with claim awards that vary by Disease Level as defined in S.1125. Finally, I will comment on the sensitivity of the prospective payments from the proposed Trust to various underlying assumptions.

TILLINGHAST¡¦S $200 BILLION ESTIMATE

Tillinghast¡¦s $200 billion estimate of ultimate asbestos loss and expense includes both past payments and projected future payments. The RAND Institute for Civil Justice recently estimated that $70 billion in asbestos claims were paid through year-end 2002. Thus our $200 billion ultimate figure translates to $130 billion of estimated future payments. This $130 billion estimate is based on assumptions consistent with the deterioration in the asbestos litigation environment observed by 2001. The litigation environment has not improved since our study was completed, as shown by the increase in the number of claims filed in 2001¡V2002 , the number of defendants seeking bankruptcy protection , and the number of newly identified defendants .

The analysis underlying our $200 billion estimate was quite robust. We used two approaches: top-down and bottom-up. The top-down method or macro approach focused on claimants by disease type and the awards that would be paid to each. The bottom-up approach focused on the amounts that each defendant in the litigation would be called upon to pay. It is important to understand that a single claimant typically sues an average of 60 defendants. Additionally, a single defendant might be sued by as few as 1 or as many as hundreds of thousands of claimants. For the bottom-up analysis, we analyzed the defendants in homogeneous groupings, or Tiers, that are defined according to a defendant¡¦s profile in the litigation.

Additionally, using the bottom-up approach, we estimated the portion of individual defendant payments that would be commercially insured versus retained by the defendants. Of the insured costs, we also estimated the portion

expected to remain with the U.S. insurance industry versus the amount expected to be paid by the non-U.S. insurers and reinsurers. In total, we estimated that $78 billion of the $200 billion ultimate would be retained by the defendants and that $122 billion would be insured. Of the insured amount, we estimated that $55 - $65 billion would be covered by U.S. property / casualty insurers and reinsurers. As of year-end 2002, approximately $45 billion of this amount was recognized by the U.S. insurance industry, as reported in Note 29 of their statutory financial statements.

Reduction Due to Elimination of Frictional Costs

An important feature of the proposed legislation is the elimination of plaintiff and defense attorney fees. To put this in perspective, Tillinghast¡¦s $200 billion estimate of ultimate asbestos loss and expense is significantly reduced when these frictional costs are removed. Of the $130 billion remaining to be paid, we estimate that approximately $28 billion (or 21.5%) relates to defense costs. Of the remaining $102 billion, we estimate that approximately $41 billion (or 40%) will go to plaintiff attorneys. Therefore, out of the original $130 billion estimate of future payments, less than half, or only $61 billion is expected to reach the claimants. Our conclusion is consistent with the findings of RAND: transaction costs have consumed more than half of total spending.

QUANTIFICATION OF THE ECONOMIC IMPACT OF S.1125

Under S.1125, we estimate an indicated Trust balance as the sum of four components:

(1) Indemnity awards associated with claims that will first be filed from 2003 through 2049;
(2) Indemnity awards associated with claims that are currently pending, but will be dismissed and re-filed against the Trust;
(3) A negative cost, or reduction in benefit payments for awards from collateral sources; and
(4) Costs for medical monitoring for claimants in Disease Levels I and II.

Medical Criteria and Specified Claim Awards

S.1125 establishes eight Disease Levels with corresponding awards. This feature is intended to ensure that compensation goes to asbestos victims that have a measurable asbestos-related impairment, while providing medical monitoring to claimants who meet the criteria for Disease Levels I and II.

In order to project indemnity awards under the proposed legislation, claim filings are multiplied by the specific awards for each Disease Level. Claims against the Trust are assumed to include those filed for the first time from 2003-2049 as well as those that are currently pending in the U.S. court system that will be dismissed and potentially re-filed against the Trust.

Future Claim Filings. Since the asbestos problem began in the 1970s, there have been numerous projections of the number of future asbestos claims that will be filed by disease type. In May 2001 Tillinghast projected that 1 million claimants would ultimately file asbestos claims that meet the minimum Level I Disease Criteria. However, given the significant increase in publicity relating to asbestos claims and compensation, as well as the potential ability to bring claims to a trust in a non-litigious environment with pro-bono legal assistance, we have increased our projections of future mesothelioma claims. The increase reflects an increase in the propensity for victims of mesothelioma to seek compensation for this fatal disease. Our resulting projections assume that there will be approximately 41,000 future mesothelioma claim filings.

We relied upon information provided by the Claims Resolution Management Corporation (CRMC) to map the historical claims filed against the Manville Trust (which are categorized by disease according to the 1995 Trust Distribution Process (TDP)) into the eight Disease Levels defined in the 2002 Manville TDP.

Using the transition matrix provided by the CRMC, we restated the historical Manville claims to the 2002 TDP Disease Levels, and used the resulting distributions by Disease Level to refine Tillinghast¡¦s projections of future claims from three categories (i.e., mesothelioma, lung cancer, and all other) into the eight Disease Levels included in the proposed legislation. For example, the historical Manville data shows that total lung cancer claims have been

distributed as 40% Lung Cancer One and 60% Lung Cancer Two using the 2002 TDP Disease Level definitions. Therefore, we assumed that 40% of Tillinghast¡¦s total projected lung cancer claims relate to Lung Cancer One (or Disease Level VI). Similarly, we used information regarding the distribution of historical claims to Disease Levels I ¡V V to allocate Tillinghast¡¦s projections of future non-malignant claims to Disease Level.

We assumed that 25% of Lung Cancer One and Two claims will correspond to non-smokers.

We note that the CRMC outlined some differences between the 2002 Manville TDP Disease Levels and the levels currently outlined in S.1125 . With the exception of Disease Level VI / Lung Cancer One claims as discussed below, my analysis assumes that any differences between the two sources were unintentional, and that the proposed legislation will be modified to include medical criteria that are identical to those defined in the 2002 Manville TDP. This assumption validates the use of the historical Manville data for the projection of future claim filings by Disease Level.

We note that as originally drafted, S.1125 potentially allows significantly more Lung Cancer One (or Disease Level VI) claims to be compensated than has been allowed under the Manville Trust 1995 TDP or 2002 TDP. Unless otherwise identified, we assumed that the medical criteria for Disease Level VI Lung Cancer One claims as described in the bill will be modified to be consistent with the historical data from the Manville Trust. However, we also provide estimates of the potential costs associated with additional Lung Cancer One claimants that could receive compensation under less stringent requirements for underlying asbestos disease or significant occupational exposure.

Pending Claim Filings. As an upper bound, we assumed that there are currently 300,000 claims pending in the U.S. Court system. Of these pending claims, we assumed that 23% will fail to meet the medical criteria for any of the eight defined Disease Levels. This percentage is based on the historical number of claims that are estimated to fail to meet the minimum medical criteria under the Manville Trust 2002 TDP.

We assumed that the resulting 230,000 of re-filed claims will have the same distribution by Disease Level as Tillinghast¡¦s original projections of future claim filings (i.e., excluding the additional projected mesothelioma and Lung Cancer One claims discussed above).

Specific Claim Awards. The proposed legislation outlines specific claim awards for each Disease Level as shown below.

S.1125 Claim Awards
Disease Level Disease / Condition Award
I Asymptomatic Exposure 0
II Asbestosis / Pleural Disease A 0
III Asbestosis / Pleural Disease B 40,000
IV Severe Asbestosis 400,000
V Other Cancer 200,000
VI ¡V Smoker Lung Cancer One 0
VI ¡V Non-smoker Lung Cancer One 50,000
VII ¡V Smoker Lung Cancer Two 100,000
VII ¡V Non-smoker Lung Cancer Two 400,000
VIII Mesothelioma 750,000

We have not estimated the potential reduction to the prospective payments from the Trust due to the effect of multiple injuries.

Future Inflation. As currently drafted, the proposed legislation does not address increases in the awards to reflect future inflation. We tested the sensitivity of the prospective payments to indexed awards increasing at 2.5% per year, as well as a range of other future inflation assumptions.

Collateral Sources

Under the proposed legislation, the awards summarized above will be reduced by the amount of benefits already received.

We are not aware of any publicly available data disclosing settlements to individual plaintiffs that would allow us to estimate the awards already collected by claimants with pending claims. Therefore, we conservatively assumed no offset to the prospective payments from the Trust for collateral sources in the estimates contained herein.

Medical Monitoring Costs

The proposed Trust will cover medical monitoring costs for claimants meeting the criteria for Disease Levels I and II. These tests are to be conducted every three years and be paid from the Trust to the extent that they are otherwise uninsured.

To estimate medical monitoring costs, we estimated the cost of chest x-rays and spirometry pulmonary function tests (PFTs) and the portion of these costs expected to be covered by private insurance or Medicare. We estimated the number of Disease Level I and II claimants that we expect to be uninsured, insured by private insurance, or insured by Medicare. We trended the medical costs forward through 2049 using an overall medical inflation rate of 5% and assumed that the average claimant will undergo five medical monitoring tests to be conducted every three years over fifteen years from the time that the claimant qualifies for Disease Level I or II. (Note that the average age of claimants against the Manville Trust is currently over 65.)

In total, we projected medical monitoring costs of $0.4 billion.

CONCLUSIONS

We calculated the prospective payments from the Trust as follows:

Tillinghast Projections ($billions)
Component Without Inflation of
Claim Awards With 2.5% Annual Increase to Claim Awards
Future Filings $36.0 $49.4
Re-Filed Pending 10.3 10.4
Collateral Offset (0.0) (0.0)
Medical Monitoring 0.4 0.4
TOTAL $46.7 $60.2

Thus the $108 billion appears to be more than adequate compared to Tillinghast¡¦s best estimate of future costs under S.1125, even if future awards are indexed to reflect a 2.5% increase per year, given a more stringent definition of Lung Cancer One claims consistent with the Manville 2002 TDP.

We note that the estimates provided above are on a nominal (or undiscounted) basis. Nominal estimates are appropriate for comparison with the nominal value of the Trust of $108 billion. Discounted estimates would be lower; however, discounted estimates should be compared to the net present value of the Trust, recognizing that the $108 billion will not be placed into the Trust at inception. We did not provide a comparison of the net present value estimates, because the timing of contributions into the Trust is not fully documented in S.1125.

Additionally, we have not evaluated the cash flow of contributions to or payments from the Trust and our estimates do not include potential borrowing costs to cover a cash shortfall in a given year.

Sensitivity Testing

Estimates of the prospective payments are very sensitive to assumptions regarding the number of future claims (especially mesothelioma), potential indexing of future award amounts, and the definition of Lung Cancer One Claims.

For example if Tillinghast¡¦s projection of future mesothelioma claims is increased by 10%, then indicated payments from the Trust would increase by approximately $3.1 billion to reflect approximately 4,100 additional mesothelioma claims.

Future claim filing projections. For comparison, we also projected the prospective payments using future claim projections prepared for and provided by The Manville Trust which range from 0.6 to 2.4 million under the Manville 2002 TDP. In total, these future claims projections are higher than the Tillinghast projections contained herein, but the number of mesothelioma claims are similar. (We note that the majority of prospective payments from the Trust will be made to compensate mesothelioma claimants and that differences in projections of the future filing of claims in other Disease Levels have a lesser impact.)

We also added a provision for re-filed pending claims to the Manville scenarios. We assumed 230,000 additional claims for each of the Manville Minimum, Mid-Range, and Maximum Scenarios. The re-filed claims were distributed to Disease Level according to the Manville Mid-Range projection of future filings.

Projections of Prospective Payments ($billions)
No Inflation of Future Awards
Component Tillinghast Manville Minimum Manville
Mid-Point Manville
Maximum
Future Filings $36.0 $28.3 $41.8 $62.5
Re-Filed Pending 10.3 7.8 7.8 7.8
Collateral Offset (0.0) (0.0) (0.0) (0.0)
Medical Monitoring 0.4 0.6 1.1 2.0
TOTAL $46.7 $36.8 $50.7 $72.3

Even under the Manville ¡§Maximum¡¨ projection of future claim filings, the prospective payments remain well below $108 billion if future awards by Disease Level are not trended, given modification of the Lung Cancer One criteria to be as stringent as the definition under the Manville 2002 TDP.

Future Award Amounts. If future awards are assumed to trend upward at 2.5% per year, then the prospective payments increase as follows:

Projections of Prospective Payments ($billions)
Future Awards Trended at 2.5% Per Year
Component Tillinghast
Projection Manville Minimum Manville
Mid-Point Manville
Maximum
Future Filings $49.4 $38.7 $56.8 $84.6
Re-Filed Pending 10.4 7.9 7.9 7.9
Collateral Offset (0.0) (0.0) (0.0) (0.0)
Medical Monitoring 0.4 0.6 1.1 2.0
TOTAL $60.2 $47.2 $65.8 $94.5

If future awards are trended upward at 2.5% per year, then the prospective payments from the Trust again remain below $108 billion, given modification of the Lung Cancer One criteria to be as stringent as the definition under the Manville 2002 TDP.

The Tillinghast projections do not reach $108 billion for trend rates below 6.9% applied to future awards. The Manville Maximum projections do not reach $108 billion until a trend of 3.6% is applied to future awards.

Potential Additional Lung Cancer One Claims. As noted previously, as currently drafted S.1125 potentially allows more Lung Cancer One (or Disease Level VI) claims to be compensated than has been allowed under the Manville Trust 1995 TDP or 2002 TDP. The requirements for underlying asbestos disease or occupational exposure to

asbestos are less stringent. The 1995 TDP required fifteen years of heavy occupational exposure to asbestos (i.e., visible asbestos dust). The 2002 TDP evaluates all Lung Cancer One claims individually and expects no significant compensation if there is no evidence of either an underlying bilateral asbestos-related nonmalignant disease or significant occupational exposure (five years), especially if the claimant is also a smoker.

However, S.1125, as currently drafted does not require underlying asbestos-related disease and merely requires six months of occupational asbestos exposure prior to December 31, 1982. Thus, potentially thousands of claimants that were not historically eligible for compensation under the Manville Trust 1995 TDP and 2002 TDP could be eligible for compensation under S.1125. Additionally, while the impact of changes toward more stringent criteria can be evaluated using the historical Manville Trust claim filing data (i.e., identifying which claims would be eliminated), the impact of expanding the definition of claimants qualifying for Lung Cancer One is more difficult to quantify.

To estimate the number of additional Lung Cancer One Cases (i.e., those who would potentially qualify under S.1125, but would not have qualified under the Manville TDP), we obtained the annual number of lung cancer diagnoses. For 2003, 171,900 cases are projected (91,800 male and 80,100 female) according to the American Cancer Society. Additionally, smoking is considered responsible for 87% of lung cancers. Thus, we estimated the total number of additional lung cancer cases relating to non-smokers as follows:

?Þ 2003 Base = [(100% x 91,800 male + 3.8% of 80,100 female) ¡V (existing Disease Level VI: Lung Cancer One and Disease Level VII: Lung Cancer Two cases)] x 13% not attributable to smoking.
?Þ The 2003 Base was projected through 2049 assuming the same pattern as for the original Lung Cancer One Claims.
?Þ The resulting projection was multiplied by a judgmentally selected factor of 80%, assuming that this percentage of lung cancer cases would be able to meet the S.1125 six-month occupational exposure criteria and would pursue recovery from the Trust.

Based on these assumptions, we projected an additional 172,000 Lung Cancer One claims for non-smokers that would not have met the Disease Level VI criteria under the Manville 2002 TDP. Each of these additional claimants would be awarded $50,000, for a potential additional $8.6 billion of indicated payments from the Trust (or an additional $11.8 billion if future awards are trended at 2.5% per year).

We also increased the Manville projections to include our estimate of additional Lung Cancer One claims, due to the less stringent definition under S.1125, and have used a range of estimates to approximate the Manville scenarios.

Additional payments relating to potential additional Lung Cancer One claims that would not qualify for compensation under the Manville 2002 TDP are estimated as follows:

Additional Lung Cancer One Claims ($billions)
Future Award
Trend Assumption Tillinghast Manville Minimum Manville
Mid-Point Manville
Maximum
0% $8.6 $6.7 $8.6 $10.1
2.5% $11.8 $9.2 $11.8 $13.9

If these additional lung cancer costs are added to the prospective payment estimates provided above, the Manville Maximum projection reaches $108 billion, when future awards are trended at 2.5% per year.

Projections of Future Payments ($billions)
Future Awards Trended at 2.5% Per Year
Including Additional Lung Cancer One Claims
Component Tillinghast Manville Minimum Manville
Mid-Point Manville
Maximum
Future Filings $61.1 $47.9 $68.6 $98.5

Re-Filed Pending 10.4 7.9 7.9 7.9
Collateral Offset (0.0) (0.0) (0.0) (0.0)
Medical Monitoring 0.4 0.6 1.1 2.0
TOTAL $72.0 $56.4 $77.6 $108.4

Closing

In conclusion, reasonable projections of prospective payments of the specific awards for individuals meeting the medical criteria used to define the eight Disease Levels in S.1125 are at or below $108 billion if future awards are trended at 2.5% or less.