Seeking Solutions to European Asbestos Claiming: Will it be FAIR?

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Introduction

(1) Asbestos-related deaths in the European Union (EU) will dwarf the United States' experience. The EU consumed more asbestos per capita than the United States, ceased using asbestos more recently than the United States, and used a more dangerous form of asbestos than the United States. As a result, the EU and United States are at very different points in the lifecycle of asbestos-related diseases. U.S. mesothelioma cases peaked at 3,000 during the late 1990s.[1] In contrast, EU mesothelioma cases will peak in the tens of thousands during the 2020s. The UK alone will peak at more than 1,750 British males with mesothelioma around 2025, which is 70 percent of the US male peak.[2,3] In short, while the United States is over halfway through the legacies created by industrial use of asbestos, the EU has just begun this long journey.

(2) Bates White, LLC, has followed the U.S. experience with interest. Our founding partner, Dr. Charles Bates, has been measuring the quantity and costs of asbestos-related claims for over 15 years. Most recently, he testified before the U.S. Senate Committee on the Judiciary regarding the proposed Fairness in Asbestos Injury Resolution (FAIR) Act of 2005.[4] Over the course of the FAIR Act analysis, Bates White became familiar with many of the issues associated with enacting a no-fault trust fund to compensate asbestos-related claims. Dr. Bates concluded that the proposed national trust was grossly underfunded because it substantially increased the compensation for smokers with lung cancer relative to the U.S. tort environment.[5]

(3) As the EU grapples with the difficult problems associated with asbestos-related disease, it faces three fundamental issues. First, who will receive compensation? For some diseases, such as mesothelioma, asbestos is the only established cause. For other diseases, such as lung cancer, there is an epidemiological link to asbestos, but other factors are the primary cause. In the case of lung cancer, smoking is the primary cause. In general, it is unclear what constitutes a compensable injury.

(4) The United States dealt with this question through its tort system. The U.S. tort system has maintained a relatively stable treatment of individuals with malignant conditions through time. Specifically, it generally compensates individuals with mesothelioma, occasionally compensates individuals with lung cancer, and rarely compensates individuals with other cancers. In contrast, the treatment of individuals with nonmalignant conditions has varied

dramatically through time. Currently, these individuals receive little compensation, but as recently as five years ago these individuals received more than half of all asbestos-related dollars paid out through the U.S. tort system.

(5) Second, how will that compensation be funded? Three distinct groups will cover the vast majority of these expenditures: the companies (both domestic and international) involved in the manufacture, distribution, and installation of asbestos-containing products; their insurers; and the general taxpayer. The allocation of expenditures across these three groups and within each of the groups presents a major challenge. To date, the United States has allocated expenditures through the tort system. This approach produced high transaction costs and numerous bankruptcies, which lead the U.S. Congress to consider a national trust via the FAIR Act. The inability to agree on the allocation of costs was a key factor in the ultimate failure of the Act.

(6) Third, what procedures will be used for transnational claims? Social norms for the level of compensation and the funding mechanism for that compensation vary across EU member countries. Further, the typical European claimant will have received asbestos exposure from products originating in multiple countries, which raises the question as to which country the claimant should file in.

(7) Below is a more detailed discussion of each of these three questions. Frequently, we reference the U.S. experience to assess the relative strengths and weaknesses of various approaches.

Who will receive compensation?

(8) There are no easy answers concerning who will receive compensation. Even diseases with the strongest epidemiological link to asbestos exposure and clear physical harm have some controversy.[6] These diseases include mesothelioma, lung cancer in the presence of asbestosis, and impaired asbestosis. For example, not all mesothelioma is caused by occupational exposure to asbestos. The results in peer-reviewed studies range from under 10 percent of U.S. cases categorized as idiopathic (of unknown cause) to over 20 percent of all cases categorized as idiopathic. The FAIR Act attempted to exclude idiopathic claimants by imposing occupational exposure criteria. For example, the FAIR Act required "evidence of 12 or more weighted years of substantial occupational exposure" in order to receive

compensation for most lung cancers and only "credible evidence of identifiable asbestos exposure" with no duration requirement in order to receive compensation for mesothelioma.

(9) In contrast to the above conditions, lung cancer without asbestosis, other cancers, and unimpaired nonmalignant lung disease either lack a strong epidemiological link to asbestos exposure or present limited health consequences. Unimpaired nonmalignant claimants fall into the latter category. During the late 1980s and early 1990s the U.S. tort system established the compensability of unimpaired nonmalignant claimants. In response, entrepreneurs created for-profit screening companies that recruited these claimants. These screening companies hired doctors who made expedient "tort" diagnoses of asbestos-related diseases as opposed to complete medical diagnoses. U.S. District Court Judge Janis Graham Jack said that the mass medical screenings used to diagnose silica-related injuries (and also asbestos-related injuries) were "driven neither by health nor justice…they were manufactured for money."[7] By 2005, the U.S. tort system had reversed its earlier position and generally no longer finds unimpaired non-malignant claims compensable.

(10) Although unimpaired claimants once received tort awards, the U.S. tort system rarely viewed individuals with other (non-lung) cancers as having meritorious claims. Less than one percent of asbestos-exposed individuals who develop one of these other cancers file a tort claim. Further, those that do file receive compensation similar to that of an unimpaired non-malignant claimant. This outcome may be attributable to the lack of epidemiological evidence connecting these cancers to asbestos exposure. Specifically, a 2006 Institute of Medicine survey found insufficient evidence to establish a causal relationship between asbestos exposure and colorectal, esophageal, pharyngeal, and stomach cancers. This same study found sufficient evidence to establish a quantitatively small and statistically significant causal relationship between asbestos exposure and laryngeal cancer (a rare form of cancer).[8]

(11) Similar to other cancer claimants, the U.S. tort system rarely considered smokers with lung cancer, who did not also have asbestosis, as having meritorious claims. Epidemiological evidence demonstrates that asbestos exposure among smokers increases their odds of lung cancer. However, in the absence of asbestosis, the epidemiological evidence is varied; if a causal link remains, it is definitely weaker. Moreover, epidemiological evidence clearly demonstrates that smoking accounts for the vast majority of the lung cancer within this group. Those exposed to asbestos face at most a 20 percent increase in the probability of lung cancer relative to those not exposed. Those who smoke face a 2,000 percent to 3,000

percent increase in the probability of lung cancer relative to nonsmokers. Thus, the impact of smoking is at least 100 times that of asbestos exposure.

(12) In contrast to the U.S. tort system, the FAIR Act would have compensated many individuals with lung cancer in the absence of asbestosis. This change would have dramatically reallocated the dollars spent on malignant claimants. Historically, individuals with lung cancer accounted for about 10 percent of compensation in the U.S. tort system and 25 percent of compensation among malignant conditions. Under the FAIR Act, lung cancer would have exceeded $100 billion, and may have been as high as $300 billion, and accounted for well over 50 percent of all proposed compensation. The FAIR Act failed to increase funding requirements to match this increase in compensation. As a result, the Act would have been substantially underfunded.

(13) Once policy makers have decided which conditions are compensable, they must decide the level of compensation. Possible institutions for resolving the level of compensation include the government, the worker compensation system, and the tort environment. Overall, the level of compensation depends on numerous factors. Possible factors to include in determining compensation are the level of harm, the likelihood that asbestos was the cause, and the relevant social norms.

How will compensation be funded?

(14) Three distinct groups will cover the vast majority of asbestos-related expenditures: the companies involved in the manufacture, distribution, and installation of asbestos-containing products; their insurance companies; and the general taxpayer. Governments can directly allocate expenditures to these three groups or defer that responsibility to the tort system.

(15) The U.S. government simultaneously deferred this responsibility to the tort system and invoked sovereign immunity to prevent claimants from suing the government, thus precluding recovery from the general taxpayer. The tort system proved to be a costly method of determining compensation. First, U.S. asbestos claimants have received only one in three dollars spent on this litigation. The other two dollars go to costs incurred by companies, insurers, and council for all the parties. The U.S. Supreme Court stated, "the elephantine mass of asbestos cases … defies customary judicial administration and calls for national legislation."[9] Second, the U.S. tort environment burdens companies largely

independent of their ability to pay. As a result, over 70 companies have filed bankruptcy due to asbestos-related expenditures.

(16) In response to these costs, the U.S. government considered the creation of a national trust. Those efforts culminated in the FAIR Act. The FAIR Act proposed a fixed schedule of payments for various medical conditions and sought $140 billion in funding. One of the downfalls of the trust was a lack of agreement over how it would be funded. Consistent with its earlier decisions, the U.S. government insisted that all the funding come from the private sector and none from the general taxpayer. Specifically, the FAIR Act allocated $46 billion to insurers, $90 billion to companies, and $4 billion to previously existing asbestos trust funds.

(17) Insurers were so far from agreement concerning the allocation of the $46 billion that the Act simply stated the industry's aggregate funding level and left the allocation of those funds unaddressed. In contrast, the FAIR Act provided explicit criteria for the funding obligations of companies. These criteria resulted in an allocation that was extremely different from the tort environment. Subsequently, companies that would have received a windfall under the FAIR Act were strong proponents of the bill. Conversely, companies whose obligations would have increased fought the bill.

(18) Companies and insurers in the EU will most likely act in the same way as their U.S. counterparts in response to a change in their funding allocations. Namely, once an initial baseline of financial obligations is established, each company will oppose reforms that increase its obligations. Those EU countries that prefer a national trust for asbestos liabilities therefore may have an easier time generating buy-in early in the process before tort positions have been established.

What procedures will be used for transnational claims?

(19) One option to resolve transnational claims is to let the tort system in each country run its course. Alternatively, EU countries may select a trust mechanism to cover asbestos liabilities. As with the FAIR Act, the trust will specify rules for claiming and mechanisms for funding. Where the FAIR Act analogy breaks down, however, is in the number of trusts to be created: a trust for each member country, one trust for the entire Union, or something in between.

(20) County-specific trusts have at least two major obstacles to resolve—double collection by claimants and funding. Consider an individual with mesothelioma who installed a product in the UK using asbestos-containing materials manufactured in France from asbestos mined in the former Soviet Republics. Is this individual entitled to collect from both the UK and French trusts? If so, is each respective award reduced to account for the compensation received from the other trust? If not, is the individual entitled to choose between the two trusts? If the individual is allowed to choose, the U.S. experience demonstrates that the individual typically will select the higher paying option. This situation is analogous to the U.S. tort experience where plaintiffs attempted to file in high-award jurisdictions. For example, the rush of cases into Madison County, Illinois was a direct result of its plaintiff-friendly environment. After recent changes to the legal environment in Madison County, many plaintiffs migrated from Madison County to Delaware and California.

(21) Turning to funding, one country cannot force another country to compensate claimants. In the above example, it is hard to see how the UK or France could compel the former Soviet Republics to compensate the claimant. Further, each country continues to face the same allocation of funding obligations discussed above. Additionally, each country needs to reconcile its workers compensation system with any proposed asbestos trust.

(22) The establishment of a single trust for all EU claimants eliminates the potential for double collection by claimants, but may prove politically difficult to establish. The time necessary to reach an agreement among all member states could produce a substantial delay in delivering compensation to claimants. In particular, individual member state norms on social programs differ, as do their legal standards for liability. Regardless of how compensation levels are set, there is also no clear way to apportion funding obligations across the member countries. Potential standards for apportioning funding obligations include each country's contribution to disease, generosity of compensation system, and ability to pay.

Conclusion

(23) The EU faces a large and growing wave of asbestos-related disease. As the EU grapples with this issue, it faces three fundamental questions: Who will receive compensation, how will that compensation be funded, and what mechanism will be used to resolve transnational claims? Now is the time for the EU member states to address these questions. As the U.S. experience illustrates, these issues only become more difficult with time.

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