United States Insurance Trends and Decisions 2023

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As 2024 rapidly approaches, we look back at some of the key decisions, trends, and developments impacting the U.S. insurance industry in 2023 and look ahead at some trends and cases to watch in 2024. Insurers continue to confront social inflation, economic inflation, ESG/sustainability, and artificial intelligence.

The universe of challenging claims includes COVID-19 business interruption claims, cyber, privacy, PFAS, opioids, lead paint, construction defect, weather-related claims, representations and warranty, D&O/securities, marine, and sexual molestation, asbestos, and talc claims in the context of policyholder bankruptcies as well as traditional environmental and other claims.

Part 1: Insurers Are Operating in Dynamic, Complex, and Challenging Times

These are dynamic and challenging times for insurers. They are doing business in times of substantial social inflation, continuing economic inflation, and rapidly developing requirements for meeting the challenges and opportunities of ESG as businesses as well as in their underwriting and claims handling functions. Many of their traditional business practices, ranging from pricing to claims determinations, are garnering increased scrutiny from regulators and policyholders alike.

Insurers are confronting the systemic challenges associated with artificial intelligence and cyberattacks, as are their policyholders. Recruiting and retaining a workforce sufficient in size and with requisite skill sets present additional challenges for the industry as it confronts baby boomer retirement and the different approach of a younger workforce.

All of the shortcomings in the United States civil justice system are visited upon insurers as well. More than ever, insurers are required to call upon their talented executives, managers, line personal, and skilled vendors (such as outside counsel) to meet these challenges. As insurance remains the bedrock of economic stability and growth, it is important that insurers meet these challenges now as they have in the past.

I. Social Inflation

Although economic inflation has dropped from a 40-year-high of 9.1% in 2022 to approximately 3.5%, it remains almost three times the rate of 2020.[ii] Social inflation remains unabated in the U.S., where a world-leading 40 million lawsuits a year are filed.[iii] One report shows that tort system costs per household range from $2,000 to $5,500, depending upon the state. The same report shows that, for every dollar paid in compensation to claimants, 88 cents were paid in legal and other costs.[iv]

Combating social inflation is difficult in an environment fraught with improvident legal and evidentiary rulings by judges, giving rise to large liabilities, coupled with nuclear and thermonuclear verdicts rendered by juries. Traditional rules of evidence and jury instructions have been ineffective in tapering the opinions and proclivities of younger jurors or in addressing the challenges presented in this age of instant information.

The 'plaintiffs' bar is rolling in cash, armed with litigation funding, employing reptilian tactics, and spending nearly $1.5 billion annually in advertising to recruit plaintiffs and pre-condition future jurors to render large verdicts. Meanwhile, defendants and insurers appear to have relinquished the traditional leverage and financial advantages they enjoyed in favor of what, at times, seems to be a myopic focus on containing their litigation spend.

Little meaningful tort reform has been enacted across the U.S. in recent years. One notable exception is Florida, which enacted substantial tort reform in 2022 and 2023. The short-term impact has been the infusion of 280,000 new cases filed in advance of the effective date of the legislation. By contrast, state legislators have contributed to social inflation by passing privacy statutes such as the Illinois Biometric Information Privacy Act, 740 ILCS 14 *et seq*. (BIPA) (which allows for recoveries in the absence of plaintiffs sustaining

any actual damages), enacting extensions of (or eliminating) statutes of limitation for sexual abuse cases, expanding causes of action permitting an award of punitive damages (*e.g.*, Illinois now allows awards in some wrongful death actions),[v] and the public nuisance tort theory has gained traction in some states.[vi]

For a comprehensive review of the current state of social inflation, including the factors endemic in the U.S. civil justice system making it susceptible to social inflation, the societal trends fueling social inflation, the costs of social inflation, the impact of judicial hellholes, and countering and combating social inflation, *see* S. Seaman, "Updated Social Inflation Survival Guide: The Dangerous Triple Barrel Threat of Social Inflation, Economic Inflation, and Greenflation in a Judicial Environment Swarming With Reptiles and Raining Nuclear Verdicts, " May 2, 2023, available at JD Supra. *See also* Scott M. Seaman & Jason R. Schulze, Allocation Of Losses In Complex Insurance Coverage Claims (11th Ed. Thomson Reuters 2023) in Chapter 19.

II. ESG/Sustainability

The Biden administration and many states continue to advance environmental, social, and governance (ESG) criteria or standards – often referred to simply as sustainability – on a "whole of government" approach, whereby ESG dominates most decisions and actions of agencies and departments.

The U.S. Securities and Exchange Commission has proposed an onerous climate-related disclosure rule that has not been finalized and is stepping up enforcement activity concerning ESG, as are many arms of government, including the U.S. Department of Labor, the U.S. Environmental Protection Agency (EPA), state departments of insurance, and other arms of government.

These activities have profoundly impacted all sectors of society and industries, including corporate, entity, and professional policyholders. Insurance companies, with increasing frequency and at greater depth, are being impacted by ESG and are playing a leading role in implementing policies to address ESG standards.[vii]

The momentum remains on the side of ESG, but ESG is not exempt from Einstein's theory of relative. The pace and depth of ESG have resulted in backlash and spawned anti-ESG activity. Indeed, the anti-ESG movement has gained momentum on the heels of last year's U.S. Supreme Court decision in the *West Virginia v EPA* case,[viii] which struck down a rule promulgated by the EPA to address carbon dioxide emissions from existing coal and natural gas-fired power plants, ruling the agency exceeded its authority under the Clean Air Act.

On May 25, 2023, the U.S. Supreme Court issued a ruling in *Sackett v. EPA*,[ix] narrowing the federal 'government's authority to regulate bodies of water and effectively upending a Biden administration rule that recently went into effect. The Supreme Court ruled that the federal 'government's definition of the term " waters of the United States" must be restricted to a water source with a "continuous surface connection" to major bodies of water. These decisions will not stop the Biden 'administration's ESG push but may slow the pace down and require it to act with greater care moving forward.

The U.S. Supreme Court decision in *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College* [x] and the attendant case *Students for Fair Admissions, Inc. v. University of North Carolina*,[xi] have taken a bite out of diversity, inclusion, and equity (DEI) initiatives in terms of college admissions. In a 6-3 decision issued on June 29, 2023, the Court struck down affirmative action admissions policies used by both Harvard and UNC, effectively barring the consideration of race as an independent factor in university admissions and, in the decisions, raising questions for efforts aimed at increasing diversity in the application and hiring processes for other public and private institutions alike.

Both Harvard and UNC receive federal funding and are subject to the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution and Title VI of the Civil Rights Act of 1964, which bar discrimination based on race. Private companies generally are not subject to the Equal Protection Clause but are subject to Title VII of the Civil Rights Act of 1964, which has language very similar to Title VI. Many companies are at least reevaluating their DEI initiatives. The ultimate impact on private employer diversity initiatives will play out over time.

As the ESG debate roils, some state legislative bodies have enacted or proposed anti-ESG legislation, and much of this legislation is directed at investment issues. This past legislative season saw roughly 99 bills nationwide to restrict the use of ESG factors, a marked increase from the 39 bills in 2022.[xii]

III. Artificial Intelligence

Insurers are using artificial intelligence (AI) in a variety of ways with respect to underwriting, pricing, fraud investigation, claims evaluation and handling, and other activities. Artificial intelligence and algorithms may create or amplify biases, resulting in discrimination toward members of protected classes and infringement on intellectual property rights.

Artificial intelligence systems may malfunction and create or magnify errors resulting in financial losses, property damage, bodily injury, personal injury, and advertising injury (including appropriation of 'another's name or likeness, unreasonable publicity, portrayal in a false light, defamation, violation of privacy rights, etc.). AI claims may implicate a variety of insurance coverages, including general liability (particularly Coverage B), cyber, errors and omissions, directors and officers, crime, intellectual property, product liability, employment practices, and media liability policies.

There are no insurance industry-wide AI standards or regulations, but state insurance regulators, the National Association of Insurance Commissioners [xiii], and various organizations are formulating regulations, guidelines, and best practices for the use of artificial intelligence and algorithms by insurers, and artificial intelligence may be subject to otherwise applicable existing regulatory requirements. In September and October, the Colorado Division of Insurance began implementing a regulatory scheme to govern the use of artificial intelligence by life insurers.

In November, the U.S. Cybersecurity and Infrastructure Security Agency (CISA) and the UK National Cyber Security Centre (NCSC) released their Guidelines for Secure A.I. System Development.[xiv] The use of AI and algorithms by insurers is drawing increased scrutiny from regulators and policyholders alike.

Effective use of AI will be an important determinant of insurer success going forward. AI has already produced claims, and it is expected to produce and amplify a large volume of claims activity in the future.

Part 2: Claims Activity, Cases, and Developments

I. COVID-19 Business Interruption Litigation

More than 2,388 COVID-19 business interruption coverage cases have been filed in state and federal courts across the U.S. since the pandemic. The coverage claims are broken down as follows: 2,154 involve business interruption; 1,964 involve extra expense; 1,858 involve civil authority; 263 involve ingress/egress; 128 involve contamination; 103 involve event cancellation; 92 involve sue and labor; 41 involve premium relief; 23 involve liability; and 249 are characterized as "other."

Approximately 476 cases have been filed as putative class actions, and 856 cases include allegations of bad faith. The top industries involved in the litigation by case number are food and drink, ambulatory health care, accommodation, personal and laundry services, amusement, gambling and recreation, real estate, professional, scientific, and technical services, clothing and accessories, performing arts and spectator sports, educational services, and hospitals.[xv]

At the trial court level, as of September 1, 2023, insurers have prevailed in approximately 69 percent of the 236 rulings on motions to dismiss in state courts across the country and in more than 86 percent of the 740 rulings in federal courts. These victories have been predominately obtained on the following grounds:

- the virus claims do not involve "direct physical loss or damage" to property as required by the language contained in most U.S. first-party policies;

- governmental orders do not constitute loss of property and
- virus or other exclusions preclude coverage.

Insurers have prevailed in most summary judgment rulings, approximately 83 (with partial summary judgment granted to insurers in another 19 cases), while policyholders have prevailed in whole or in part in 15 cases. Insurers prevailed in the country's first COVID-19 coverage bench trial and in at least six jury trials. Policyholders scored their only jury win to date with a $48.5 million verdict in favor of Baylor College of Medicine in a COVID-19 business interruption case against 'Lloyd's of London following a three-day trial in Harris County, Texas.[xvi]

Insurers have run the deck in COVID-19 decisions before the U.S. Courts of Appeals, prevailing in the First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth, and Eleventh Circuits. Only the D.C. Circuit has yet to rule. Insurers have also prevailed in appeals before State Supreme Courts in Delaware, Connecticut, Iowa, Louisiana, Massachusetts, Nevada, New Hampshire, Ohio, Oklahoma, South Carolina, Washington, and Wisconsin. Policyholders were handed a victory in the Vermont Supreme Court, allowing a lawsuit to go forward. Insurers have prevailed in the majority of state intermediate appellate court decisions to date as well.[xvii]

Given the number of pending cases and appeals, litigation likely will continue in earnest over the next couple of years before beginning to wind down. However, few new case filings are expected as the two-year contractual limitations period under many first-party policies has passed. So far, insurers have done exceedingly well in the litigation overall.

II. Cyber

For the past 13 years, the U.S. has had the highest average costs in the world for data breaches at $9.48 million. Since 2020, the costs of healthcare data breaches have increased by 53.3%. Phishing accounts for 16% of data breaches, followed by stolen or lost credentials at 15%. Breaches resulting from the use of stolen or lost credentials had the longest lifecycle at nearly 11 months to detect and contain the breach. Organizations with high levels of incident response planning and testing reduce average data breach costs by $1.49 million, and extensive security, artificial intelligence, and automation, on average, lower data breach costs by $1.76 million.[xviii]

According to a recent MIT study commissioned by Apple, the total number of data breaches more than tripled between 2013 and 2022, exposing 2.6 billion personal records in the past two years. The study concludes that the findings demonstrate the need for strong data breach protections in the cloud, such as end-to-end encryption. [xix] This underscores the important role insurers will play in assessing, underwriting, and providing loss control services with respect to policyholder cyber systems, controls, and practices and the large market for cyber insurance.

To date, most reported coverage decisions involving cyber issues have been so-called silent cyber decisions – decisions under traditional general liability policies, first-party policies, and crime/fraud policies. However, more reported decisions are expected under cyber-specific policies.

One of the most watched cases involves the application of the war exclusion. In *Merck & Co. v. Ace Am. Ins. Co.*,[xx] an insured pharmaceutical company, sought coverage under 26 insurance policies for damages it sustained in a 2017 cyberattack from malware known as NotPetya. Infected or exploited accounting software from a Ukrainian company that the policyholder used for accounting and transmitting tax and financial information to the Ukrainian government allowed malicious actors to install and run NotPetya on the 'policyholder's systems as well as the systems of other companies across sixty-four countries. The attack was carried out by hackers acting on 'Russia's behalf.

After the policyholder provided notice of the loss, the insurer reserved its rights based on the 'policy's hostile/warlike action exclusion. The trial court granted the policyholder's motion for summary judgment, holding that the hostile/warlike action exclusion did not apply based on the reasoning that the language of exclusion had been the same for many years and had never applied to similar facts. Therefore, it was a

reasonable expectation for the exclusion language to apply to traditional warfare rather than some new definition of warfare that included cyberattacks.

On appeal, the New Jersey appellate court agreed with the trial court "that the plain language of the exclusion did not include a cyberattack on a non-military company that provided accounting software for commercial purposes to non-military consumers, regardless of whether the attack was instigated by a private actor or a 'government or sovereign power.'"[xxi] The appellate court did not give weight to the fact that the attacker reportedly was an agent or actor for the Russian Federation. Although it is commonly referred to as a war exclusion, it is a hostile/warlike action exclusion.

Of course, in war, collateral damage commonly impacts non-combatants. In the information age, a state-sponsored cyberattack targeting or exploiting Ukrainian software that affects a non-Ukrainian company may be similar enough to conventional collateral damage to be considered warlike or a use of force. The New Jersey Supreme Court agreed to review the decision.

The decision will be important for legacy cyber insurance contracts, but insurers are moving forward with a new generation of war exclusions. For example, Lloyd's of London issued a bulletin directing its syndicates to include one of four exclusions in all standalone cyber policies for state-backed cyberattacks that significantly impair a target nation's infrastructure.

Cyberattacks on critical infrastructure may affect entire systems and result in catastrophic financial loss beyond what can be covered by private insurance.[xxii] Reportedly, the U.S. Department of Treasury has reached a tentative conclusion that a federal cyber insurance backstop is required for catastrophic cyber risk. At this point, however, no such backstop exists.

On July 26, 2023, the U.S. Securities and Exchange Commission adopted rules requiring registrants to disclose material cybersecurity incidents they experience. Additionally, they must disclose annually material information regarding their cybersecurity risk management, strategy, and governance.[xxiii] The New York Department of Financial Services announced amendments to its cybersecurity rules. Most major insurers with operations in New York will continue to be subject to enhanced compliance obligations, including independent audits of their cybersecurity program and implementation of sophisticated privileged access management and password solutions, endpoint detection, and event logging and alerting systems. [xxiv]

III. Privacy

The U.S. lacks an encompassing federal law comparable to the European Union's General Data Protection Regulations. Data breach notification laws, however, are in place in all 50 states (which have varying rules and definitions, including the definition of breach, the extent of any exemptions, and the timelines for providing notice to affected individuals). There are now nine different comprehensive state privacy laws along with at least 25 other state data security laws in the U.S. At least 16 states introduced privacy bills in the 2022-2023 legislative cycle.

Privacy acts in Connecticut and Colorado became effective in 2023, and the comprehensive California Privacy Rights Act of 2020 (CPRA) became fully effective. Beyond the CPRA, California Governor Gavin Newsom signed the Delete Act into law, which will enable residents to request that their personal information be deleted from the coffers of all the data brokers in the state. The law requires filing a request with each company and will be implemented by 2026.

Numerous rulings have been rendered under BIPA. The Illinois Supreme Court held that actions under section 15(a)-(e) of BIPA are governed by a five-year statute of limitations[xxv] and that a violation[xxvi] occurs each time an entity captures or transmits a person's biometric information without prior, informed consent. The court stated that, under the act, damages were discretionary rather than mandatory and that there is no language in the act suggesting a legislative intent authorizing damage awards that would financially destroy a business.

Based on that decision, a $228 million damage award was vacated in *Rogers v. BNSF Ry. Co.* [xxvii] In *Rogers*, a truck driver brought a class action lawsuit when he was required to register and scan his fingerprint to enter a railway company's railyards. The action went to trial, and the jury found that the railway recklessly or

intentionally committed 45,600 violations of BIPA.

Because the court had previously ruled that the monetary award under BIPA was a liquidated amount, the court multiplied the number of violations by the statutory damages of $5,000 per violation, leading to a $228 million judgment. On post-trial motions, the court vacated the damage judgment after recognizing that determining statutory damages under BIPA was discretionary and an issue for a jury to decide.

In the wake of the 2021 Illinois Supreme Court decision in *West Bend Mut. Ins. Co., v. Krishna Schaumburg Tan, Inc.*,[xxviii] there have been several subsequent BIPA coverage decisions on policy exclusions. Most notable is *Citizens Ins. Co. of Am. v. Wynndalco Enterprises, LLC.* [xxix] In this case, the insured, Wynndalco, was sued in two class action lawsuits for violations of BIPA for its alleged role between Clearview AI and the Chicago Police Department. Clearview had accumulated over three billion facial images from social media websites, converted those images into biometric facial recognition identifiers, and created a facial recognition application allowing the user to upload a picture of a stranger and potentially find and identify that person. Clearview marketed the application to law enforcement.

The Chicago police allegedly obtained Clearview's product through Wynndalco as an intermediary or as an alleged agent of Clearview, which violated BIPA in either case. The two class action lawsuits, among other claims, alleged that Wyndalco had intentionally or recklessly violated the BIPA by profiting from the named plaintiffs' and putative class members' biometric identifiers or biometric information in the Clearview AI app database, *see* 740 ILCS 14/15(c), as well as capturing, collecting, and storing biometric identifiers without notice and permission in violation of 740 ILCS 14/15(b).

Citizens Insurance sought a declaratory judgment that it had no obligation under the terms of the business owner's insurance contract to indemnify Wynndalco for the BIPA violations or to provide Wynndalco with a defense, and the policyholder asserted counterclaims. The court entered judgment on the pleadings in favor of Wynndalco, holding that a literal reading of the expansive wording of the catchall provision would preclude not only privacy-related statutes (like BIPA) but also statutory causes of action that the insurance was supposed to cover including slander, libel, trademark violations, and copyright violations, rendering the provision ambiguous.

Further, it held that applying interpretive canons, *ejusdem generis,* and *noscitur a sociis* did not resolve the ambiguity that the court considered "intractable." The court held that the insurer had not affirmatively established that the claims against Wynndalco were excluded from coverage and that Citizens had a duty to defend Wynndalco in the class action lawsuits. Citizens appealed.

The Seventh Circuit affirmed the judgment of the district court and agreed that a plain reading of the catchall provision was ambiguous. According to the court, the exclusion, as written, would potentially "swallow a substantial portion of the coverage" that the policy explicitly purported to cover in defining a covered "personal or advertising injury," and arguably all of the coverage for categories of statutory claims such as copyright infringement.

The court rejected the insurer's argument that the application of the cannons of construction resolved the ambiguity and construed the exclusion against the insurer, holding the class action lawsuits potentially fell within the coverage for personal and advertising injury.

Late in the year, the Illinois Appellate Court issued an important decision that expressly disagreed with the Seventh Circuit decision *Wynndalco* and held the "violation of law" exclusion applied to bar a defense for BIPA claims. In *National Fire Ins. Co. of Hartford and Continental Ins. Co. v. Visual Pak Co*., [xxx] the Illinois Appellate Court determined that the insurer had no duty to defend a BIPA class action that resulted in a $19.5 million settlement ($3.5 of which the policyholder Visual Pak apparently agreed to pay via confession of judgment and assigned of its claims against CNA in favor of class plaintiffs). The First District determined that the trial court correctly reconsidered its initial, erroneous ruling applying the Illinois estoppel doctrine and properly reversed course as the insurers owed no duty to defend because the "violation of law" exclusion barred coverage. Given the exclusion barred coverage, the issue of estoppel was rendered moot.

The First District held that a violation of BIPA falls within the "catchall exclusion of subsection (4)" for any

other statute not previously identified in the exclusion, which governs the dissemination, disposal, collecting, recording, sending, transmitting, communicating, or distribution of material or information."

The court noted that the catchall provision in the subject exclusion is broader than the provision that the Illinois Supreme Court held in the West Bend case does not bar coverage for BIPA claims. In particular, the exclusion's inclusion of the words "disposal, collecting, [and] recording" undoubtedly broadens the exclusion at issue here. According to the First District, it is impossible to deny that this catchall language describes BIPA as regulating the collection, dissemination, and disposal of biometric identifiers and information. The court expressly disagreed with the Seventh Circuit decision in Wynndalco as wrongly decided. It described in detail its disagreements with Wynndalco, noting, among other things:

"First, under Illinois law, the fact that an exclusion has a 'broad sweep' is not, in and of itself, a reason to deem the coverage 'illusory' It is only when the exclusion has the effect of 'swallowing' the coverage entirely that the exclusion can be deemed illusory—and this is plainly not the case here. And second, the fact that the exclusion might 'conflict' or 'clash' with other provisions of the coverage that are not presently at issue in this case is not a basis to invalidate the exclusion as applied to this case; our job is not to seek out other problems and solve them, but rather to adjudicate the controversy presently before us. [citations omitted]."

The First District agreed with the trial court's decision to reconsider its initial ruling on estoppel, as the trial court initially "put the cart before the horse," by considering the claim of estoppel first and ruling against the CNA on that basis. The question of duty to defend came first. After determining that CNA owed no duty to defend the underlying BIPA lawsuit, the trial court correctly deemed the question of estoppel moot.

IV. PFAS/Forever Chemicals

Per- and polyfluoroalkyl substances (PFAS), often referred to as "forever chemicals," have been around since at least the 1940s and have been used in so many products they are said to be ubiquitous. Yet, forever chemicals only recently became one of the most fervent areas for civil litigation. Thousands of cases are pending across the U.S., with numerous eye-opening settlements reached.

Governmental regulators in the U.S. arrived late to the scene but are now locked and loaded in regulating PFAS chemicals. Over a dozen states are suing manufacturers and others for contaminating drinking water and damaging natural resources. In an important victory for PFAS defendants and their insurers, the United States Court of Appeals for the Sixth Circuit vacated a district court order certifying a class of 11 million Ohio residents in a case involving ten defendants. The opening two paragraphs of the opinion tell much of the story:

> Seldom is so ambitious a case filed on so slight a basis. The gravamen of Kevin Hardwick's complaint is that his bloodstream contains trace quantities of five chemicals—which are themselves part of a family of thousands of chemicals whose usage is nearly ubiquitous in modern life. Hardwick does not know what companies manufactured the particular chemicals in his bloodstream; nor does he know, or indeed have much idea, whether those chemicals might someday make him sick; nor, as a result of those chemicals, does he have any sickness or symptoms now. Yet, of the thousands of companies that have manufactured chemicals of this general type over the past half-century, Hardwick has chosen to sue the ten defendants present here. His allegations regarding those defendants are both collective—rarely does he allege an action by a specific defendant—and conclusory. Yet Hardwick sought to represent a class comprising nearly every person "residing in the United States"—a class from which, under Civil Rule 23(c), nobody could choose to opt out. And as relief for his claims, Hardwick asked the district court to appoint a "Science Panel"—whose conclusions, he said, "shall be deemed definitive and binding on all the parties[.]
>
> The district court, for its part, certified a class comprising every person residing in the State of Ohio—some 11.8 million people. The defendants now appeal that order,

> arguing (among many other things) that Hardwick lacks standing to bring this case. We agree with that argument and remand with instructions to dismiss the case.

The Sixth Circuit determined that the 40-year firefighter failed to establish standing based upon his failure to establish "traceability." The opinion represents an important victory for defendants and highlights the challenges confronting plaintiffs. Nonetheless, plaintiffs' counsel will adjust their pleadings and continue to pound on the doors of PFAS manufacturers, distributors, and other prospective defendants.

On October 11, 2023, the EPA issued its final rule under the Toxic Substances Control Act (TSCA).xxxi The rule requires every company that manufactured or imported PFAS for a commercial purpose in 2011 or after to report PFAS data to the EPA within 18 months of the effective date of November 13, 2023.

The reporting requirements, among other things, call for the chemical identity and molecular structure, quantities, how the reporting entity and consumers used it, health and environmental effects, disposal, and more. The rule encompasses more than 1,462 chemicals. The EPA notes that inquiry may be required from "the full scope of [the reporting entities'] organization[,]" not merely management and supervisory personnel. It may also require inquiries outside the organization. Understandably, many companies and their professional advisors are raising concerns about the costs of reporting, questioning the ability to comply with these onerous reporting requirements for these ubiquitous substances and remaining skeptical about the utility and benefits of the reporting requirements. The reporting scheme will likely accrue to the benefit of the plaintiffs' bar.

PFAS claims present numerous coverage issues. A fairly well-developed body of insurance coverage law exists in the context of toxic and mass tort claims in general and asbestos and environmental claims in particular. From this starting point, insurers and policyholder representatives (who institute most coverage actions) often will have notions about which state's substantive law is the most favorable to their positions, which necessarily leads to preferences concerning the forum to litigate.

Recently, in an unpublished decision, the U.S. Court of Appeals for the Sixth Circuit affirmed the dismissal of an insurer's coverage action involving firefighters' personal injury claims in Admiral Insurance Co. v. Fire-Dex, LLC.xxxii Fire-Dex, a manufacturer of clothing worn by firefighters, was sued by the firefighters and their spouses, alleging they had incurred injury from the PFAS in clothing worn while fighting fires. Admiral denied coverage based on the occupational disease exclusion in its policy and sought a declaratory judgment that it had no duty to defend Fire-Dex against the suits.

The district court declined jurisdiction over the declaratory judgment action, concluding its acceptance of the case would encroach on state jurisdiction because Ohio state courts had yet to address the question of insurance liability for PFAS manufacturing. The Sixth Circuit affirmed the district court's abstention, noting that novel issues of state law are best decided by state courts. This decision is contrary to lessons learned from COVID-19 business interruption insurance coverage litigation, where federal courts regularly and properly decided state law coverage issues in the context of a unique pandemic.xxxiii

As PFAS have been produced and used dating back to the 1930s and 1940s, many claims potentially implicate legacy and current insurance policies. Accordingly, many policyholders are looking for legacy insurance policies and engaging insurance archeologists. Insurers are well-served by identifying settlement agreements and dismissal orders involving companies presenting forever chemical claims (as well as their predecessors and related companies) to see whether such claims have been released or are barred in whole or in part.

Trigger of coverage may present issues in some PFAS-related coverage cases. In *Crum & Forster Specialty Ins. Co. v. Chemicals, Inc*.,xxxiv for example, the insurer sought a declaration for the duty to defend in connection with several hundred personal injury lawsuits consolidated in the multidistrict litigation case, *In re Aqueous Fire-fighting Foams Prods*. *Liability Litigation*.

The complaints in the underlying cases did not allege either the date when the firefighters were first exposed to the products or when they first manifested symptoms of injury from the products. The subject policies require bodily injury "first occurs during the' policy period.'" The policies contain another provision stating that if the date of the injury could not be determined, then it would be deemed to have occurred before the policy period.

The district court denied the insurer's motion for summary judgment, noting the insurer had the burden to demonstrate that the dates of injury could not be determined or that the claims were outside the scope of coverage provided by the policies. So long as the date of injury "could" potentially be determined in future proceedings and "could" fall within the terms of the policies' coverage, the insurer was obligated to defend. As plaintiffs in the underlying cases alleged dates of employment during the periods of the insurance policies at issue, the district court ruled that a defense was owed.

Depending on the types of policies involved in a coverage action and the claim facts, several allocation-related issues may be presented. There may be issues concerning which, if any, lines of coverage respond to a claim, and coordination or priority of coverage issues may be presented. Allocation of loss issues may also be significant in many cases. In addition to allocation methodology, other issues may be presented and limit (or increase) the insurance contracts impacted and the extent of potential coverage, including treatment of multi-year policies, stub policies, policy extensions, exhaustion, impact of insurance unavailability, and number of occurrence(s) issues.

PFAS-related claims may also seek damages or other relief not covered under the particular policy at issue. For example, claims involving matters such as regulatory compliance costs, punitive damages, costs of doing business, or medical monitoring may not be covered under liability policies.

Various forms of pollution exclusions have been included in insurance policies going back to the 1970s and before. Many PFAS-related claims – depending upon the facts and controlling law – may be barred in whole or in part by the "sudden and accidental" pollution exclusion, the "absolute" pollution exclusion, the "total" pollution exclusion, or other forms of pollution exclusions. Issues concerning the application of pollution exclusions will be familiar to veterans of the environmental coverage wars. These may include whether PFAS are "pollutants," whether there was a discharge or release, whether the discharge was "sudden and accidental," whether the matter involves "traditional" environmental pollution, and whether a hostile fire exception applies.

Some early decisions have held that pollution exclusions bar coverage for PFAS claims. Courts have differed in their application of such exclusions in the context of PFAS-related claims as they have in the broader context of environmental coverage claims.

In *Tonoga, Inc. v. New Hampshire Ins. Co.,*[xxxv] the intermediate New York appellate court addressed the application of both the "sudden and accidental" and the "total" pollution exclusions. Tonoga settled an action with the New York State Department of Environmental Conservation, which accused Tonoga of polluting soil, air, and water supplies in Petersburgh, New York. Multiple lawsuits were filed against Tonga subsequently, for which it also sought defense and indemnity. The policyholder's manufacturing process from 1961 to 2013 generated PFOA and PFOS (one group of PFAS) byproducts and waste materials that were, in turn, discharged into the environment as part of the plaintiff's routine processes.

The appellate court affirmed the trial court's ruling that the insurers had no duty to defend or indemnify, concluding coverage was barred by the "sudden and accidental" and "total" pollution exclusions. The court found allegations in the complaint that PFAS were improperly dumped and spilled over a period of many years, prohibiting the conclusion that the pollution was abrupt or unintentional. The court rejected Tonoga's argument that the suggestion there may be other ways the PFAS were discharged into the environment was sufficient to raise the possibility the "sudden and accidental" exception applied "given that the gravamen of each suit [was] decidedly plaintiff's knowing discharge of PFOA and/or PFOS as part of its routine manufacturing processes."

By contrast, in *Wolverine World Wide, Inc. v. The American Ins. Co*.,[xxxvi] the court found the "sudden and accidental" pollution exclusion did not preclude the insurer from being required to provide a defense. Wolverine, a footwear manufacturer, was the subject of hundreds of individual tort actions, three consolidated class actions, an individual landowner suit, and two governmental enforcement actions alleging it was responsible for PFAS in the groundwater as a result of its use of the product Scotchgard in its manufacture of footwear from 1958 through 2002. The court ruled the insurers were required to defend Wolverine in these matters "until it is determined that every claim in the lawsuit involving pollution is conclusively determined to be intentionally discharged by Wolverine."

In *Colony Ins. Co. v. Buckeye Fire Equipment Co*.,[xxxvii] the court held the insurer did not have a duty to defend most toxic tort claims relating to fire equipment containing fire-suppressing foam that included PFAS. The court concluded that the "total" pollution exclusion barred the majority of cases that alleged injury or damage solely from environmental exposure to PFAS. However, some cases (approximately one-third) also alleged harm from direct exposure to the products. The court ruled the insurer had a duty to defend the direct exposure cases because those cases did not involve "traditional environmental pollution" and were not within the gambit of the "total" pollution exclusion under North Carolina law.

Finally, in *Grange Ins. Co. v. Cycle-Tex Inc*.,[xxxviii] the court issued a declaratory judgment in favor of the insurer, concluding the underlying lawsuit fell squarely within the policy's "total" pollution exclusion. The "total" pollution exclusion excluded coverage for:

1. bodily injury or property damage which would not have occurred in whole or in part but for the actual, alleged, or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants at any time; and
2. any loss arising out of a request, demand, order, or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify, neutralize, or in any way respond to or assess the effects of pollutants.

Cycle-Tex operated a thermoplastics recycling facility and was sued for allegedly discharging harmful PFAS into the North Georgia waterways. The plaintiffs alleged they suffered damages to their health by ingesting contaminated water, causing property damage resulting from contamination of the water supply, and paying surcharges and heightened water rates due to the contamination. Grange agreed to defend Cycle-Tex in the litigation under a full reservation of rights and sought a declaratory judgment that it had no duty to indemnify or defend based on the policy's "total" pollution exclusion.

The court easily found PFAS were "pollutants" under the policy both because the definition of "pollutant" included chemicals and because Georgia courts have emphasized the broad reach of the term "pollutant." The court concluded claims that the plaintiffs suffered bodily injury and property damage plainly fell within the first clause of the exclusions.

Although the plaintiffs' claim for an increase in water costs did not fit within the first clause of the pollution exclusion, the court concluded it was reasonable to infer the increased water costs resulted from the city's compliance with environmental laws and its response to a demand or request that the city protect its citizens from a dangerous nuisance. Accordingly, the court held the claims for water costs were barred by the second clause in the pollution exclusion.

There are various forms of specific PFAS or forever chemical exclusions that may be included in policies of more recent vintage. These exclusions are likely to become more common going forward. Lloyd's Market Association unrolled a couple of model exclusions last year, and an ISO exclusion is in the works.

Other exclusions such as owned property, intentional act, and occupational disease exclusions may bar or limit coverage for particular claims. Some coverage actions may implicate knowledge-based defenses such as the absence of an accident or occurrence, expected or intended damages, known loss, loss in progress, lack of fortuity, or improper disclosure (misrepresentations or failure to disclose material facts) in connection with obtaining or renewing coverage.

James River Ins. Co. v. Dalton-Whitfield Regional Solid Waste Management Authority[xxxix] involved a different insurance policy and different types of exclusion but the same underlying action as Cycle-Tex. The policyholder, a public solid waste authority, allegedly operated landfills and discharged PFAS-contaminated substances to a treatment works area.

The exclusion at issue was not a pollution exclusion but rather an exclusion for bodily injury or property damage that was "expected or intended from the standpoint of the insured." The court held that because one or more claims in the underlying complaint asserted negligence and nuisance, the policy did not unambiguously exclude coverage. The court dismissed with prejudice the insurer's declaratory relief action with respect to the duty to defend and dismissed without prejudice the insurer's declaratory relief action with

respect to the duty to indemnify as being not ripe, pending judgment in the underlying action.

Non-compliance with notice, cooperation, and other policy terms, definitions, and conditions may bar or limit coverage in some instances. Past voluntary payments or defense fees incurred prior to proper notice or tender may not be covered.

Environmental impairment or pollution policies often have additional requirements that must be satisfied as well. Many such policies (and some general liability policies) are written on a claims-made basis. The policyholder must satisfy any claims-made and reporting requirements. In a case involving EtO emissions from Medline's medical instruments sterilization facility in Waukegan, Illinois, for example, the Illinois appellate court ruled there was no coverage under a pollution liability policy because the discharges had been occurring since 1994, long before the policy's September 2018 retroactive date[xl]. These types of issues may be present with PFAS claims as well.

Other considerations arise where policyholders with PFAS-related liabilities become embroiled in bankruptcy proceedings for PFAS-related liabilities (or for other reasons). These policyholders (and claimants) may attempt to use bankruptcy law to limit or shed their liabilities. In such cases, some of the bankruptcy issues insurers have addressed in asbestos, talc, and sexual molestation claims may be presented in connection with PFAS-related claims.

V. Climate and Weather-related Claims

The greatest impact climate change has had on insurance claims to date has been as a phenomenon impacting the frequency and severity of weather events. Despite all of the activity surrounding climate change, only one substantive climate change coverage decision has been reported. This is the Virginia Court of Appeals decision in *AES Corp. v. Steadfast Ins. Co.*,[xli] in which the court affirmed the grant of summary judgment in favor of the insurer on the basis that the underlying complaint did not allege an "occurrence" covered by the policies. The court did not address the pollution exclusion or trigger issues.

There are market developments relating to climate change warranting discussion. California, Florida, Louisiana, and other Gulf Coast locations remain reliable bases for weather-related claims. Florida property insurers have been impacted heavily. Several insurers have been rendered insolvent in recent years. Florida enacted two statutes interposing litigation reform affecting first-party claims, particularly concerning claims involving roof damage and creating a $2 billion reinsurance program.

This year, two major insurers announced that they would stop writing homeowner's policies in California, and another announced that it would limit the number of homeowner's policies it would issue in California. The problem, at least in part, in California is that insurers have not been able to charge adequate premiums due to the requirements imposed by Proposition 102, adopted in 1988, which requires insurers to obtain prior approval from the California Department of Insurance before changing rates.

VI. Traditional Environmental and Asbestos Claims

Notwithstanding the various emerging claim types, traditional asbestos and environmental claims continue to dominate. Over the past 20 years, American taxpayers have spent over $21 billion in cleanup and oversight costs for Superfund sites. There are over 1300 current Superfund sites.

Approximately 21 million people (6 percent of U.S. population) live within 1 mile of a Superfund site, and 73 million people (22 percent of U.S. population) live within 3 miles of a Superfund site. Approximately $1 billion from the Infrastructure Investment and Jobs Act was allocated to the cleanup of 49 Superfund sites. Claims-made policies and issues are more dominant in environmental claims today than decades ago.

VII. Opioids

A 2022 bipartisan congressional report found that the opioid epidemic costs the U.S. approximately $1 trillion

annually. Approximately 3,000 state and local governmental entities have been seeking to recover the costs of public services associated with opioids from drug manufacturers and distributors. In 2022, the Delaware Supreme Court ruled that distributor Rite Aid was not entitled to a defense because recovery was sought for economic damages, not personal injury.[xlii]

Similarly, the Ohio Supreme Court ruled that Masters Pharmaceutical was not entitled to coverage because the local governmental entities were attempting to recover economic losses as opposed to damages because of bodily injury.[xliii] A California federal court ruled insurers had no duty to defend a drug distributor as the policyholder's over-distribution of opioids led to the foreseeable diversion of prescription painkillers, which did not arise out of an accident or occurrence.[xliv] The Ninth Circuit will hear oral arguments on the appeal in January 2024.

This year, in *Westfield Ins. Co. v. Quest Pharmaceuticals Inc.* and *Motorists Mutual Ins. Co. v. Quest Pharmaceuticals Inc*.,[xlv] the United States Court of Appeals for the Sixth Circuit, applying Kentucky law, held insurers are not required to defend a drug wholesaler in 77 suits brought by governments over the opioid epidemic, finding the underlying suits do not seek damages because of bodily injuries.

Although policyholders have not fared well-seeking coverage under general liability policies, a policyholder recently scored a victory under a D&O policy. In *North Carolina Mutual Wholesale Drug*,[xlvi] the district court granted summary judgment to the policyholder, finding the insurer had a duty to indemnify the policyholder for defense costs and liabilities arising out of several dozen lawsuits concerning opioid prescriptions in which various municipalities, hospitals, and individuals asserted tort and statutory claims against it.

The suits generally allege Mutual Drug is liable for failure to monitor, detect, investigate, and refuse to fill suspicious orders by pharmacies for prescription opioids, in violation of federal and state law and regulations, and in breach of common law duties. No breach of contract claim was asserted. The court determined that neither the contract exclusion nor the professional services exclusion barred coverage.

VIII. Lead Paint

Coverage issues relating to the $400 million plus lead paint abatement fund resulting from a long-pending case in California against three lead paint manufacturers have been subject to three separate coverage actions. Insurers prevailed at the trial court and on appeal in California in the *ConAgra* case based upon the insured's predecessor having actual knowledge of the harms associated with lead paint when it promoted lead paint for interior residential use.[xlvii] In the *NL Industries* case, policyholders prevailed last year in the intermediate appellate court in New York.[xlviii]

In the *Sherwin-Williams* case in Ohio,[xlix] the trial court granted summary judgment in favor of the insurers. Although it rejected the insurers' expected/intended argument, the trial court ruled there were no recoverable "damages." On appeal, the intermediate appellate court reversed, holding the abatement fund qualified as "damages." The Ohio Supreme Court heard oral argument in October.

IX. Construction Defect

There has been no slow-down in activity in construction defect coverage litigation. Courts across the country have differed on the issue of whether faulty workmanship constitutes an "occurrence" in the context of construction claims. Some courts have held that general liability policies are not performance bonds and do not cover defects to the insured's work unless the defective workmanship causes "property damage" to something other than the insured's work. Other courts have said defective work can be an "occurrence" where property damage was not planned, expected, or intended.

The Illinois Supreme Court weighs in on the issue in *Acuity v. M/I Homes*[l]. The decision warrants mention because the court took a more liberal approach for policyholders than appellate decisions had taken on the issues of "occurrence" and "property damage." The Illinois Supreme Court determined water damage to the interior of the completed units alleged in the complaints, if proven, constitutes physical injury to tangible property and would satisfy the definition of "property damage."

Further, as alleged, neither the cause of the harm (the defect) nor the harm (the resulting water damage to the walls of the interior of the units) was intended, anticipated, or expected; thus, the "occurrence" requirement was satisfied for purposes of the duty to defend.

It is important to emphasize that the Illinois Supreme Court's decision addressed only the duty to defend, which is a broader duty than the duty to indemnify. It is based upon the *potential* for coverage and requires reading the allegations of the complaint liberally in favor of the policyholder. The proofs may not support the allegations, and ultimately, there may be no duty to indemnify. Further, the Illinois Supreme Court did not even conclude there was a duty to defend, only that the allegations were sufficient to establish the first step of the analysis that the claim potentially fell within the policy's coverage grant.

The court recognized that the duty to defend may be precluded by an exclusion such as business risk exclusions (j) and (l). Exclusion (j) provides the insurance does not apply to property damage to property that must be restored, repaired, or replaced because your work was incorrectly performed on it. This exclusion does not apply to property damage in the products/completed operations hazard.

Exclusion (l) excludes property damage to "'your work' arising out of it or any part of it and included in the 'products-completed operations-hazard,'" but does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

Accordingly, the Illinois Supreme Court never concluded the duty to defend. Instead, it remanded the case to the trial court to address whether the exclusions apply to preclude a duty to defend. Part of that determination may depend on how the parties' statuses as named insured and additional insured impact the analysis.

In 5 Walworth, LLC v. Engerman Contracting, Inc.,[i] the Wisconsin Supreme Court used a coverage action arising out of damages allegedly caused by the deficient construction of an inground pool, resulting in a cracked pool and a leak of water into the surrounding soil, to alter its analysis of coverage. The homeowner was required to demolish the entire pool structure and construct a new one. Two of the insurers, in this case, issued commercial general liability policies to the general contractor, and the other issued a CGL policy to the supplier of the shotcrete pump mix used to construct the pool.

The Wisconsin Supreme Court changed the way it analyzed whether there has been "property damage" caused by an "occurrence" under the policies. It overruled its prior decision in Wisconsin Pharmacal Co., LLC v. Nebraska Cultures of California, Inc., wherein the court held that "property damage" under a CGL policy requires damage to "other property." It used the "integrated systems analysis" – a test derived from tort law – to assess whether other property was damaged.[ii]

The integrated systems analysis asks whether the product is part of an integrated whole such that any damage can be ascribed only to the product itself rather than to other property. With the benefit of hindsight, the Wisconsin Supreme Court concluded the Pharmacal approach was an unwarranted departure from well-established law. The court returned to a "contract-focused" analysis. The court reiterated the basic principle "that while faulty workmanship is not an 'occurrence,' faulty workmanship may cause an 'occurrence.'"

According to the court,

The lesson from our case law examining similar policy language is this: faulty workmanship is not an occurrence, but faulty workmanship can lead to an occurrence that causes property damage. Turning to the summary judgment record, the WJE report concluded that cracks in the main pool occurred, and therefore water leaked into the surrounding soil. This was the result, according to the report, of suboptimal installation of the shotcrete and poor placement of steel reinforcing bars, among other reasons. The improper installation of the shotcrete and the incorrect placement of the steel reinforcing bars are not enough on their own to constitute an occurrence; if proven, that is faulty workmanship. But the record can support a conclusion that this faulty work caused the pool to crack and leak, and those cracks became worse as the pool leaked and destabilized the surrounding soil. The cracks, leakage, and soil damage could constitute accidents – unexpected and unforeseen events – caused by improper installation. And these cracks and the damage to the surrounding soil also could constitute physical injuries to the homeowner's tangible property *i.e.*, property damage as defined by the policy. In the end, 5 Walworth claims the whole pool complex was compromised

and needed to be rebuilt. Therefore, a trier of fact could conclude that General Casualty's policy provides an initial grant of coverage because there is "property damage" caused by an "occurrence" as those terms are defined in the policy.

The Fifth Circuit recently had occasion to consider the distinction between allocation in the first instance between the policyholders and insurers under an "all sums" allocation and the apportionment among insurers in the equitable contribution or subrogation context. *The inter insurer dispute in Colony Ins. Co. v. First Mercury Ins. Co*.,[liii]arose from an underlying construction defect matter in which First Mercury and Colony contributed to a settlement of an underlying negligence claim. Both companies provided consecutive coverage under commercial general liability insurance policies. After the settlement, Colony sued First Mercury, arguing First Mercury was required to reimburse Colony, under either a contribution or subrogation theory, for the full amount of its settlement contribution because the First Mercury policies covered all damages at issue. The trial court granted summary judgment in favor of First Mercury, and the Fifth Circuit affirmed. The Fifth Circuit determined, under Texas law, that First Mercury is not responsible for damages that arose after its policies ended. Colony would be entitled to reimbursement from First Mercury for its settlement contributions only if Colony paid more than its fair share, meaning it paid for damages covered by First Mercury's policies. Because the Colony did not prove or even create a genuine dispute that it paid for damages that First Mercury should have covered, its contribution and subrogation claims failed.

X. Representations and Warranty/Transactions Insurance

Representation and warranty insurance and other forms of transaction insurance remain popular in many transactions. The universe of coverage opinions remains small at this time but is likely to grow in view of the number of claims. For a discussion of the nature, history, and various forms of transaction insurance, focusing on the placement and underwriting of transaction insurance, key coverages, policy provisions, and claims issues, *see* Scott Seaman, "Hinshaw Insurance Law TV – Transaction Insurance Solutions," September 11, 2023, available at JD Supra.

XI. D&O and Securities Law

There has been an uptick in litigation involving greenwashing claims, including shareholder derivative actions against officers and directors for breach of fiduciary duty and securities cases. Many cases allege statements by senior executives are materially false and misleading and, in turn, result in inflated share prices.

There also has been consumer litigation around ESG representations involving alleged misstatements about products and processes, ranging from labor conditions of workers who produce cocoa beans to the environmental sustainability of shoes, to whether the juice is organic, to whether tuna is "dolphin-safe" to claims about overall sustainability and carbon neutrality, with mixed outcomes. In an attempt to minimize exposure to greenwashing, some companies have turned to "green hushing" – where companies seek to hide their climate strategies from broader scrutiny.

Although companies with cogent ESG practices may reduce some exposures, corporate activism on ESG issues can harm stock prices and create litigation exposures. Disney has found itself embroiled in controversy and sustained a significant loss in stock value as a result of ESG issues.

Initially, Disney was silent on Florida's HB 1557 – the bill limiting instruction on sexual orientation or gender identity in Florida classrooms. After receiving criticism from employees and collaboration partners, however, the Disney board convened a special meeting at which it decided to criticize the bill publicly. This criticism had business consequences that were not positive for Disney in terms of political reprisal, stock price, and market positioning.

Disney officers and directors were also subject to a stockholder action seeking books and records based upon an alleged breach of fiduciary duty. On June 27, 2023, the Delaware Chancery Court, in *Simeone v. Walt Disney Co.*,[liv] held that the determination by Disney directors and officers to publicly oppose the bill did not

constitute a breach of fiduciary duty.

The court denied the stockholder's records demand, concluding he failed to establish a proper purpose and that the demand was overly broad.

1. First, the court determined the purposes described in the records demand were not the plaintiff's own purposes but were those of his counsel. The plaintiff had been solicited to submit the demand by an attorney from a public interest law firm noted to be advancing the litigation costs of the case. The court recognized that the law firm was the party investigating potential wrongdoing.
2. Second, the court found the plaintiff had failed to show "evidence to suggest a credible basis for wrongdoing" in the case.

Also, the court noted that Disney had, in fact, provided some records to the stockholder, which the court deemed to be sufficient insofar as the plaintiff wanted to know the persons responsible for making the decision to oppose the bill.

At its core, "the plaintiff's theory was that Disney's board and officers had breached their fiduciary duties when they publicly opposed HB 1557. According to the court, deciding whether or not to speak publicly on policy issues is an ordinary business decision. Vice Chancellor Will stated:

Delaware law vests directors with significant discretion to guide corporate strategy, including social and political issues. Given the diversity of viewpoints held by directors, management, stockholders, and other stakeholders, corporate speech on external policy matters brings both risks and opportunities. The board is empowered to weigh these competing considerations and decide whether it is in the corporation's best interest to act (or not act).

This suit concerns such a business decision by the Disney board—a decision that cannot provide a credible basis to suspect potential mismanagement irrespective of its outcome. There is no indication that the directors suffered from disabling conflicts. Nor is there any evidence that the directors were grossly negligent or acted in bad faith. Rather, the board held a special meeting to discuss Disney's approach to the legislation and the employees' negative response. Disney's public rebuke of HB 1557 followed.

The court noted that a board's:

> consideration of employee concerns was not, as the plaintiff suggests, at the expense of stockholders. A board may conclude in the exercise of its business judgment that addressing the interests of corporate stakeholders—such as the workforce that drives a company's profits—is 'rationally related' to building long-term value. Indeed, the plaintiff acknowledges that maintaining a positive relationship with employees and creative partners is crucial to Disney's success. It is not for this court to 'question rational judgments about how promoting non-stockholder interests—be it through making a charitable contribution, paying employees higher salaries and benefits, or more general norms like promoting a particular corporate culture—ultimately promote stockholder value.

The court further noted that, even if a board's defiance of a political threat could provide a credible basis to suspect wrongdoing, there was no factual support for that conclusion here as the plaintiff failed to demonstrate that Disney was warned of financial repercussions or dissolution of Florida's Reedy Creek Improvement Act (which granted self-governance to Disney) before its public opposition of the bill.

As the court recognized, this case exemplifies:

> the challenges a corporation faces when addressing divisive topics—particularly ones external to its business. Individual investors have diverse interests—beyond their shared goal of corporate profitability—and viewpoints that may not align with the company's position on political, religious, or social matters. Yet stockholders invest with the understanding that the board is empowered to direct the corporation's affairs.

On September 14, 2023, the Delaware Supreme Court ruled that a management liability insurance policy's

professional services exclusion did not apply to preclude coverage for the underlying claim.[lv] In 2017, a former GRI employee brought a *qui tam* action against GRI, alleging that GRI violated the False Claims Act (FCA) by falsely certifying to the government that certain loans were eligible for a federally insured mortgage loan program.

The claimant also alleged that GRI falsely claimed that it complied with all lending requirements. On June 22, 2019, the U.S. Department of Justice issued a civil investigative demand to GRI, in which the DOJ notified GRI that it was investigating allegations relating to violations of the loan program. In February 2020, GRI settled the FCA claims with the government and with the claimant for $15.06 million.

GRI filed an action in Delaware Superior Court seeking coverage under the management liability insurance policy for the settlement amount and for defense costs incurred in connection with the government investigation. GRI asserted claims for breach of contract and for bad faith. The insurer filed a motion to dismiss GRI's action, arguing, among other things, that the professional services exclusion precluded coverage for the underlying investigation and claims.

The insurer contended that the underlying investigation and settlement were based on GRI's underwriting services. The Superior Court denied the insurer's motion to dismiss and subsequent motion for summary judgment, although the Court granted summary judgment to the insurer on the bad faith claims. The parties filed cross-appeals.

The Delaware Supreme Court affirmed the Superior Court, ruling that the Superior Court correctly concluded that the management liability insurance policy's professional services exclusion did not preclude coverage for the underlying investigation and claim. The court concluded that the FCA claims against GRI "were not caused by the professional services provided to borrowers." Although without GRI's underwriting conduct, some of the certifications would not have been false, a meaningful linkage is lacking given "the difference between the subject of the FCA claims – false certifications – and the underwriting conduct used to demonstrate the falsity of the claims – underwriting loans."

The U.S. Supreme Court granted review in *Macquarie Infrastructure Corp. v. Moab Partners, L.P.*, to determine whether the failure to make the disclosure required by Item 303 of Reg. S-K (requiring disclosure of known trends or uncertainties that have or will have a materially favorable or unfavorable impact on the company) constitutes an actionable omission under Section 10(b) and Rule 10b-5. The Second Circuit has held that Item 303 creates an actionable duty of disclosure, while the Third, Ninth, and Eleventh Circuits have held that it does not.

XII. Marine Insurance

This is a rare time when two cases directly impacting insurers are pending before the U.S. Supreme Court. On October 10, 2023, the justices heard arguments in *Great Lakes Ins. SE v. Raiders Retreat Realty Co. LLC*,[lvi] which involves the issue of choice of law under a marine insurance policy. Great Lakes and yacht owner Raiders Retreat Realty Co. are arguing over a choice of law provision contained in a marine insurance policy. Great Lakes is challenging the decision by the United States Court of Appeals for the Third Circuit ruling that a separate Pennsylvania insurance law favoring policyholders could trump a federal maritime choice of law provision.

The U.S. Supreme Court appears poised to promulgate a test for determining when choice of law provisions should be given effect as a matter of federal law. Depending upon the court's ruling and language, this decision could impact federal choice of law jurisprudence beyond maritime insurance. As a matter of federal law, choice of law provisions are presumed to be valid and enforceable. Courts will refuse to apply a choice of law clause only where the parties have no substantial relationship to the chosen law (which is not the situation here) or where the chosen law violates public policy.

The Third Circuit decision subject to the appeal marked the first time a United States Court of Appeals held that a maritime choice of law clause was potentially unenforceable as a matter of state public policy. In this case, the issue is whether the public policy to be referenced in enforcing a choice of law provision is federal

public policy, as the insurer argues and as traditionally applied, or is state public policy, as the policyholder advocates.

Many commercial contracts – insurance and other contracts – contain a choice of law provisions. Choice of law clauses became more common in maritime contracts after the U.S. Supreme Court's 1955 decision in *Wilburn Boat Co. v. Fireman's Fund Ins. Co*.[lvii] This case allowed state law to play a substantive role in maritime cases in situations lacking a federal statute or controlling, entrenched federal common law.

Parties to maritime contracts seeking consistency and predictability of well-established law often include a choice of law provisions that provide for the application of the law of a state – such as New York – with a well-developed body of maritime law. The presumption of enforceability is a uniform federal rule, and the public-policy exception should relate only to federal public policy. This has been the case for over 200 years, both before and after *Wilborn Boat*, until the Third Circuit decision in this case.

Allowing the determination to come from public policy of one of fifty states – which may be determined after the time of contract, which may be difficult to ascertain, which may involve conflicting policies, and which may turn on the selection of the location of the lawsuit – threatens to interject uncertainty and frustrate the intent of sophisticated parties. It would take away parties' ability to manage their contractual obligations and could impact the price and availability of insurance coverage. It also would needlessly complicate things by inviting challenges based on a panoply of state law matters.[lviii]

XIII. Asbestos, Sexual Molestation, and Talc Bankruptcies

The second case before the U.S. Supreme Court – *Truck Ins. Exchange v. Kaiser Gypsum Co. Inc.* case [lix] raises the issue of whether an insurer has standing to object to a plan of reorganization. One of Kaiser Gypsum's insurers, Truck Insurance Exchange, objected to Kaiser Gypsum's Chapter 11 plan of reorganization. Facing substantial liability for asbestos personal injury claims under general liability policies issued over several years, the insurer objected to the plan on several grounds, mainly that insufficient protections against fraudulent and excessive claim payments were made for insured claims.

The United States Court of Appeals for the Fourth Circuit found in February 2023 that the North Carolina federal judge correctly determined that Truck Insurance lacked standing under the U.S. Bankruptcy Code since it determined that the reorganization had no adverse impact on the insurer and that the insurer lacked standing under Article 3 of the U.S. Constitution. The primary basis for the court's determination is the presence of an "insurance neutrality" provision in the Chapter 11 plan of reorganization.

By way of background, as a matter of state contract law, an insurance contract generally cannot be modified without all parties' consent, and bankruptcy law generally does not authorize a debtor to unilaterally modify its contracts. Nonetheless, debtors and creditors (particularly claimant committees) often propose plans of reorganization that alter or adversely impact insurers' rights or interests in various ways.

In bankruptcy reorganizations involving companies with large asbestos or mass tort liabilities, often a trust is established to resolve and pay claims against the debtor. Channeling injunctions are issued to protect parties other than the debtor, including settling insurers, co-insureds, and debtor-affiliates. Generally, the trust is responsible for administering a court-approved procedure for resolving claims, commonly called trust distribution procedures or TDPs. The TDPs generally include medical and other criteria (such as requirements regarding exposure to the debtor's products), categories and levels of injury or impairment that will be compensated, and claim values or ranges.

The procedures typically include requirements that claimants submit claim forms to the trust that contain specified information and that are reviewed by personnel retained by the trustee to determine whether or not the claim will be allowed and how much will be paid. The TDPs generally provide for mediation, arbitration, or litigation for claims not resolved by the matrix criteria. Often, insurers – particularly those not agreeing to fund the trust – are not involved in negotiating or approving the TDPs.

The payment of claims through a trust alters the dynamics substantially because the policyholder is not aligned with its insurers in defending against claims as it had been in the tort system. Instead, the policyholder

effectively turns the keys to the store over to the claimants' representatives. The claims are paid in accordance with the TDPs, and the trust, effectively compelled by plaintiffs' asbestos lawyers, is making determinations and overseeing the process.

A bankruptcy plan of reorganization that sets out an alternative procedure for determining and liquidating a debtor's liability through TDPs directly affects the insurer's monetary and contractual interests.

In an attempt to avoid contested plan confirmation and litigation about impairment of insurer contractual rights, debtors often include so-called "insurance neutrality" provisions in their plans. These provisions purport to neither increase the insurers' pre-petition obligations nor impair their pre-petition contractual rights under the insurance policies. Even well-intended insurance neutrality provisions are no panacea for insurers. These provisions generally are included in an attempt to limit the insurers' standing to object to the plan (or related events), but they may instead be required to challenge the adequacy of the insurance neutrality language.

These provisions can protect insurers depending on the plan, the bankruptcy, and the issue. In some instances, if the language of the neutrality provision is acceptable and the plan is otherwise acceptable to the insurers, the insurers may not object to the plan. Still, even where the insurance neutrality language is acceptable in many instances, other plan provisions adversely impact insurers' rights. They often fail to provide adequate protections to insurers, leaving them adversely impacted by the realities that a plan will visit upon them, particularly in asbestos or mass tort-driven bankruptcies with trust distribution procedures that do not provide adequate protections against unsubstantiated, excessive, or fraudulent claims.

Fraud is no stranger to mass tort claims and greatly contributes to social inflation. For years, the plaintiffs' bar has used Section 524(g) of the Bankruptcy Code as a superhighway to drain resources from insurers and their policyholders. Courts have been called to impose anti-fraud and related measures to limit these abuses.

There is a split among the circuits as to standing in this context of challenging plans of reorganization, which likely accounts for the Court's decision to hear the case. It seems reasonable that the party who must pay an insurer should stand and be considered a "party in interest" and be afforded a meaningful opportunity to be heard, at least where it can articulate specific ways its interests are impaired. Indeed, depriving the parties of the financial incentive to raise issues under these circumstances may undermine the integrity of the bankruptcy process.

The *Boy Scouts of America* case addresses many of the bankruptcy issues potentially impacting insurers in the context of sexual abuse claims. U.S. District Court Judge Richard G. Andrews of the District of Delaware affirmed the September 2022 order of U.S. Bankruptcy Judge Laurie Selber Silverstein confirming the Boy Scouts of America (BSA) bankruptcy plan in *Nat'l Union Fire Ins. v. BSA* (In re BSA).[lx]

The plan in this matter involves a global resolution of scouting-related sexual abuse claims. The cornerstone of the plan is a series of settlements, resolving a complex array of overlapping liabilities and insurance rights, that establishes a settlement trust consisting of $2.46 billion in cash and property in addition to unliquidated assets, including insurance rights worth up to another $4 billion or more.

The plan channels to the settlement trust all sexual abuse claims against BSA, the Related Non-Debtor Entities, the Local Councils, certain Chartered Organizations, and those covered by insurance policies issued by the settling insurers. It provides for coextensive, nonconsensual releases of the channeled sexual abuse claims. The channeled abuse claims will be processed, liquidated, and paid for by the trustee under the Settlement Trust Agreement and TDPs. Settling insurers received releases, channeling injunction protection, and "free and clear" buybacks under Section 363 of the Bankruptcy Code.

Aided by the substantial recruitment and advertising efforts of the plaintiff's bar and legislation enacted in approximately seventeen states since 2002 allowing victims of sexual abuse to assert claims that previously would have been barred by statutes of limitation, more than 82,200 claims of childhood sexual abuse were filed. *See* Scott M. Seaman & Jason R. Schulze, Allocation Of Losses In Complex Insurance Coverage Claims (11th Ed. Thomson Reuters 2023) in Chapter 19.

Fifteen sets of non-settling insurers and two sets of claimants appealed the confirmation order. BSA, the *Ad Hoc* Committee of Local Councils, the Future Claimants' Representative, the Coalition of Abused Scouts for

Justice, and the settling insurers filed briefs supporting the Confirmation Order.

On appeal, the court determined that the holders of direct claims would likely be paid in full under the plan, affirming the finding of the bankruptcy court based largely upon the valuation of BSA's economic expert, Dr. Charles Bates. The court rejected the claimants' contentions that the estimated value of the claims should have been higher based on their failure to offer expert witness testimony. The court also affirmed the bankruptcy court's determination that it had jurisdiction to confirm the plan and to approve channeling injunction protection and nonconsensual releases.

The court rejected arguments by the non-settling insurers that the bankruptcy court lacked authority to authorize a plan that assigns insurance policy proceeds. It further rejected the insurers' claims that the plan abrogated their contractual rights, noting that the plan protects insurer contract rights by containing a provision stating:

> [n]othing in these TDP shall modify, amend, or supplant the terms of any Insurance Policy or rights and obligations under an Insurance Policy assigned to the Settlement Trust to the extent such rights or obligations are otherwise available under applicable law . . . .

The court rejected complaints relating to judgment reduction provisions, found the plan was proposed in good faith under Section 1129 (a) (3), rejected claims of inflated claims and improper leverage being exercised against insurers, and collusion, among other things. The matter is on appeal before the Third Circuit. On December 14, 2023, the Third Circuit denied a motion by the Boy Scouts and several insurers that supported the Chapter 11 Plan seeking to dismiss two appeals on equitable or statutory mootness grounds on the basis that the Chapter 11 plan became effective in April. The order referred the matter to the panel assigned to address the appeals on the merits. [lxi]

In November, Arrowood Indemnity Co., the runoff U.S. insurance operation of Royal & Sun Alliance, was placed into liquidation by the Chancery Court of Delaware. A claim bar date of January 15, 2025, has been established. Arrowood attributed its adverse financial condition in part to the enactment of child victim act statutes and the continued emergence of claims related to legacy insurance policies.

Johnson & Johnson (J&J) talc claims involved a new strategy being employed in some bankruptcies known as the Texas two-step. The Texas two-step strategy involves converting a business entity into a Texas organization (if it is not already) and subsequently splitting it into one or more separate entities, with the bulk of tort or other liabilities allocated to one entity.

Subsequently, the entity holding such liability files a Chapter 11 petition for reorganization in an effort to achieve a global resolution of the claims. The maneuver seeks to avoid putting the assets of the original company into play. Tort claimants have been complaining that the entities holding such liabilities are insufficiently funded to pay them, and the company initially responsible for the liabilities can continue its business operations asset-rich without having contributed sufficient sums to cover the liabilities.

Johnson & Johnson Consumer Inc. (the subsidiary of J&J that produced baby power) was spun off into a separate entity known as Old Consumer. Facing mounting liabilities, Old Consumer, through a series of intercompany transactions, was split into two new entities: LTL Management LLC ("LTL"), holding principally Old Consumer's liabilities relating to talc litigation and a funding support agreement from LTL's corporate parents; and Johnson & Johnson Consumer Inc. ("New Consumer"), holding virtually all the productive business assets previously held by Old Consumer. J&J's goal was to isolate the talc liabilities in a new subsidiary so that the entity could file for Chapter 11 without subjecting Old Consumer's entire operating enterprise to bankruptcy proceedings.

LTL petitioned for Chapter 11 relief in the Bankruptcy Court for the Western District of North Carolina. That court transferred the case to the Bankruptcy Court for the District of New Jersey. Talc claimants moved to dismiss LTL's bankruptcy case as not being filed in "good faith." The bankruptcy court, in two opinions, denied those motions and extended the automatic stay of actions against LTL to hundreds of non-debtors, including J&J and New Consumer, and to the New Jersey coverage action.

The Third Circuit reversed the bankruptcy court's order denying the motions to dismiss. The Third Circuit remanded the case to the bankruptcy court with instruction to dismiss LTL's Chapter 11 petition. The Third Circuit determined that the bankruptcy petition was not filed in good faith. According to the court, "[g]ood intentions—such as to protect the J&J brand or comprehensively resolve litigation—do not suffice alone. What counts to access the Bankruptcy Code's safe harbor is to meet its intended purposes. Only a putative debtor in financial distress can do so. LTL was not. Thus, we dismiss its petition."

The Third Circuit in *In re LTL Mgmt., LLC*,[lxii] stated its focus was on the financial state of LTL "on its assets, liabilities, and, critically, the funding backstop it has in place to pay those liabilities" and Old Consumer's status was relevant only insofar as it informed LTL's status. The Third Circuit determined that LTL was not in financial distress when it filed its Chapter 11 petition. The value and quality of its assets include a roughly $61.5 billion payment right against J&J and New Consumer.

According to the court, "LTL did not have any likely need in the present or the near-term, or even in the long-term, to exhaust its funding rights to pay talc liabilities. In the five years of tort litigation to date, the aggregate costs had reached $4.5 billion (less than 7.5% of the $61.5 billion value on the petition date), with about half of these costs attributable to one ovarian cancer verdict, *Ingham*." The Third Circuit believed that the bankruptcy court failed to consider the company's success in the talc litigation.

After the dismissal of the bankruptcy, LTL filed another Chapter 11 action and reached a $8.9 billion proposed settlement with certain talc claimants. Ten motions to dismiss were filed by various claimant factions seeking to dismiss the second bankruptcy. After briefing and a hearing, the bankruptcy court issued a memorandum opinion dismissing LTL's second bankruptcy.[lxiii] The court concluded that the evidentiary record does not establish sufficient "imminent" or "immediate" financial distress to satisfy the criteria enunciated by the Third Circuit in *In re LTL Mgmt*.

According to the court, "the Debtor does not meet the more exacting gateway requirement implemented by the Circuit with respect to 'good faith' under 11 U.S.C. §1112(b), which would allow LTL to take advantage of the tools available under the Bankruptcy Code to resolve its present and future talc liabilities." The court granted the motions seeking dismissal of the bankruptcy proceeding as having been filed in bad faith. J&J has indicated that it intends to appeal the ruling. At least one other pending bankruptcy involves the Texas two-step, but to date, it has not been challenged on that basis.

Finally, the competing demands of directors' and officers' liability policies often result in the insurers facing demands for defense or indemnity of individual officers and directors while a bankruptcy involving the company is pending. When an insured entity files for bankruptcy, D&O insurers often file a motion to lift the automatic stay before advancing defense costs to individual insureds.

"[I]t is well-settled that a debtor's liability insurance is considered property of the estate. However, the courts are in disagreement over whether the proceeds of a liability insurance policy are property of the estate." Courts that have addressed whether the proceeds of a liability insurance policy are property of the estate are guided by the language and scope of the specific policies at issue.[lxiv] When an insurance policy only provides direct coverage to a debtor, courts generally rule that the proceeds are property of the estate.[lxv]

However, when an insurance policy provides exclusive coverage to directors and officers, courts have generally held that the proceeds are not the property of the estate.[lxvi] In cases where liability insurance policies provide direct coverage to both directors and officers and debtors, courts have held that "the proceeds will be the property of the estate if depletion of the proceeds would harm the estate to the extent the policy actually protects the estate's other assets from diminution."[lxvii]

To facilitate the funding of a defense of officers and directors where those actions are not subject to the stay, several decisions have lifted the automatic stay to allow directors and officers access to D&O Policy proceeds to fund their defenses.[lxviii]

XIV. Wasting Limits Policies, Reimbursement Of Defense Costs, & Duty To Defend

Traditionally, most liability policies that contain a duty to defend pay defense costs on a supplementary basis. With increasing frequency, policies have covered defense on a wasting limits basis. Effective October 1, 2023, Nevada became the first state in the country to preclude the issuance or renewal of insurance policies on a wasting limits basis. Under Nevada law, insurers are prohibited from issuing insurance contracts providing defense within limits (*i.e.*, wasting limits policies).[lxix]

The enactment of this legislation generated considerable concern that the abolition of wasting limits policies would result in insurers leaving the Nevada market or liability insurance becoming prohibitively expensive. In response to these concerns, on November 6, 2023, the Nevada Commissioner of Insurance adopted a regulation limiting the application of the law.

Regulation R029-23 clarifies that a "policy of liability insurance" includes only a policy of casualty insurance that:

1. provides insurance against legal liability arising from the ownership or operation of a motor vehicle;
2. provides insurance against legal liability arising from the ownership of housing occupied by the owner of the housing;
3. is a policy of general commercial liability insurance;
4. is a policy of commercial automobile insurance or
5. provides insurance covering the professional liability of certain health care providers.

The regulation also clarifies that the law does not apply to risk retention groups, to captive insurance that does not cover third-party liability, or to insurers that are not authorized to engage in the business of insurance in Nevada but who are authorized by existing law to provide certain insurance coverages in Nevada that cannot be procured from authorized insurers.

Courts across the country are split over the issue of whether insurers may obtain reimbursement for defense costs incurred on non-covered claims by asserting the right to reimbursement in a reservation of rights letter in the absence of a policy provision expressly providing for reimbursement.[lxx]

Policyholders have prevailed on this issue in a couple of recent cases. In answering a certified question from the U.S. District Court for the District of Hawaii, the Hawaii Supreme Court determined that an insurer may not recoup defense costs for defended claims pursuant to a reservation of rights letter unless the insurance policy contains an express reimbursement provision.

It reasoned that the insurance contract governs, permitting reimbursement in the absence of an express contract provision erodes the duty to defend, and the policyholder is not unjustly enriched. *St. Paul Fire and Marine Ins. Co. v. Bodell Construction Co*. [lxxi]

Reimbursement is one of eleven issues associated with the duty to defend addressed in the Second Edition of Volume III of Hinshaw & Culbertson's "On The Law Series" *Duty to Defend: A Fifty-State* Survey released earlier this fall. The eBook is available at https://www.jdsupra.com/legalnews/hinshaw-releases-second-edition-of-duty-43872/.

XV. Reinsurance

There have been several decisions on arbitration and panel-related issues but few substantive reinsurance decisions in 2023. The Second Circuit considered allocation under English law in *The Ins. Co. of the State of PA. v. Equitas Ins. Ltd*. [lxxii] There, the cedent settled environmental claims with its insured, applying an "all sums" allocation pursuant to California law.

The reinsurer challenged the cession, contending that an "all sums" allocation was improper under English

law, which governed the facultative certificate. The Second Circuit determined the issue was not whether English law would have allocated the cedent's liability based on an "all sums" allocation.

Instead, the issue was, once the decedent's liability was properly allocated as the parties agreed was the case, whether English law would interpret the reinsurance policy as providing coextensive coverage. The Second Circuit concluded English law would interpret the reinsurance policy as providing coextensive coverage.

The Second Circuit also rejected the reinsurer's late notice defense. The United States District Court for the Middle District of Alabama avoided ruling on the number of retentions and claims in *Alabama Municipal Ins. Corp. v. Munich Reinsurance America, Inc.*[lxxiii] finding genuine issues of fact precluded entry of summary judgment.

A Look Ahead to 2024

Social inflation, ESG, and artificial intelligence will continue to impact insurers for several years to come. All of the claim types discussed above will likely be subject to additional decisions in 2024. Few new COVID-19 business interruption cases are expected to be filed, but pending cases will continue to be litigated and generate decisions for the next couple of years before dropping off.

Among the significant pending COVID-19 coverage appeals are *Another Planet Entertainment* case before the California Supreme Court on certified question from the Ninth Circuit and *Consolidated Restaurant Operations Inc.* before the New York Court of Appeals.

Coverage decisions will be rendered under cyber-specific policies with greater frequency. PFAS claims will present major losses to insurers and their policyholders with the potential to rival asbestos-related losses.

The two cases pending before the U.S. Supreme Court discussed above will result in decisions in 2024. Pending before the California Supreme Court is a case involving equitable contribution.[lxxiv] The court has limited review to the issue of whether a primary insurer may seek equitable contribution from an excess insurer after the primary policy underlying the excess policy has been exhausted (vertical exhaustion) or only after all primary policies have been exhausted (horizontal exhaustion).

In addition, the U.S. Supreme Court is expected to issue its decision in *Harrington v. Purdue Pharma LP* concerning the power of courts to issue nonconsensual third-party releases. Finally, the U.S. Supreme Court set oral argument in February in cases raising issues as to whether the U.S. EPA can implement a plan to reduce cross-state pollution over objections its "Good Neighbor Plan" usurps the authority of states to develop their own plans for controlling emissions. [lxxv]

The first-party bad faith section of the American Law Institute's *Third Restatement of Torts*, which is secluded as Section 20-A of the Miscellaneous Provisions volume, is expected to be presented for approval at the institute's Spring 2024 meeting.

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ii For a discussion on the impact of economic inflation on insurers, see Scott M. Seaman, "Updated Social Inflation Survival Guide: The Dangerous Triple Barrel Threat of Social Inflation, Economic Inflation, and Greenflation in a Judicial Environment Swarming With Reptiles and Raining Nuclear Verdicts," May 2, 2023, available at https://www.jdsupra.com/legalnews/updated-social-inflation-survival-guide-2705745/.

iii See "Global Trends and Politics Legal system abuse is rampant what insurers can do and how reinsurers can help" Munich Re (November 16, 2022), available at https://www.munichre.com/en/insights/economy/legal-system-abuse-is-rampant-what-insurers-can-do-and-how-reinsurers-can-help.html.

iv U.S. Chamber of Commerce Institute for Legal Reform, Tort Costs in America: An Empirical Analysis of Costs and Compensation of the U.S. Tort System (Nov. 22, 2022), available at https://instituteforlegalreform.com/research/tort-costs-in-america-an-empirical-analysis-of-costs-and-compensation-of-the-u-s-tort-system/.

v Scott M. Seaman, "Punitive Damages Are Now Available in Wrongful Death and Survival Claims in Illinois," August 15, 2023, available at https://www.jdsupra.com/legalnews/punitive-damages-are-now-available-in-8866247/.

vi For a comprehensive review of social inflation, including the factors endemic in the U.S. Civil Justice system making it susceptible to social inflation, the societal trends fueling social inflation, the costs of social inflation, the impact of judicial hellholes, and countering and combating social inflation, see Scott M. Seaman, "Updated Social Inflation Survival Guide: The Dangerous Triple Barrel Threat of Social Inflation, Economic Inflation, and Greenflation in a Judicial Environment Swarming With Reptiles and Raining Nuclear Verdicts," May 2, 2023, available at https://www.jdsupra.com/legalnews/updated-social-inflation-survival-guide-2705745/. See also Scott M. Seaman & Jason R. Schulze, Allocation Of Losses In Complex Insurance Coverage Claims (11th Ed. Thomson Reuters 2023) at Chapter 19.

vii We have been tracking these developments. For a discussion of ESG and the impact on insurers, see "Key U.S. Insurance Decisions, Trends, & Developments: In These Times Of ESG, Social Inflation, COVID-19, Cyber/Privacy, Civil Unrest, Opioids & Other Perils" MEALEY'S LITIGATION REPORT: Reinsurance, Vol. 32, #16 Dec. 17, 2021. See also Scott M. Seaman & Jason R. Schulze, Allocation Of Losses In Complex Insurance Coverage Claims (11th Ed. Thomson Reuters 2023) at Chapter 19.

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ix 143 S. Ct. 1322, 1344 (2023).

x 143 S. Ct. 2141, 2176 (2023).

xi 143 S. Ct. 2141, 2176 (2023).

xii Scott Seaman and Bessie Daschbach, "What The ESG Divide Means For Insurers And Beyond" Law360 (July 13, 2023), available at https://www.law360.com/articles/1697393/what-the-esg-divide-means-for-insurers-and-beyond.

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xxvi Cothron v. White Castle Sys., Inc., 2023 IL 128004, as modified on denial of reh'g (July 18, 2023) (on certified question from the Seventh Circuit).

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xxviii 2021 IL 125978, 451 Ill. Dec. 1.

xxix 70 F.4th 987 (7th Cir. 2023).

xxx 2023 IL App (1st) 221160 (Dec. 19. 2023).

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xxxii 2023 U.S. App. LEXIS 14822 (6th Cir. June 13, 2023).

xxxiii See, e.g., Dianoia's Eatery, LLC v. Motorists Mut. Ins. Co., 10 F.4th 192, 208-211 (3d Cir. 2021).

xxxiv 2021 U.S. Dist. LEXIS 146702 (S.D. Tex. Aug. 5, 2021).

xxxv 2022 NY Slip Op 00094, 201 A.D.3d 1091, 159 N.Y.S.3d 252 (App. Div. 3rd Dept.)

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lxv See In re Allied Digital Techs. Corp., 306 B.R. 505, 512 (Bankr. D. Del. 2010).

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