

AMERICA 250

The History Of Insurance & Insurance Coverage Law & Litigation In The United States



1752

First Fire Insurance
Company



1759

First Life Insurance
Company



1898

First Automobile
Insurance Policy



1935

Social Security Act



1965

Medicare and
Medicaid Act



2010

Insurtech
Revolution

Scott M. Seaman
Pedro E. Hernandez
Peter J. Lewis

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Insurance Coverage Law And
Litigation In The United States

Scott M. Seaman
Pedro E. Hernandez
& Peter J. Lewis

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FOREWORD

CELEBRATING AMERICA 250 & THE ROLE OF INSURANCE & INSURERS IN THE UNITED STATES

The semi-quincentennial – commonly referred to as America 250 – is rapidly approaching. On July 4, 2026, America celebrates the country’s 250th birthday (as measured from the signing of the Declaration of Independence on July 4, 1776).² The year will be replete with celebrations, commemorations, acknowledgements, commentaries, tributes, and reflections reminiscent of the bicentennial celebration in 1976. America’s birthday is indeed worthy of celebration.

Although the greatness of America has been described by many, Frank Sinatra summed it up succinctly. In October 1974, at his Main Event concert at Madison Square Garden, the Chairman of the Board, in introducing his song “The House I Live In,” said:

It’s a song about this great, big, wonderful, imperfect country. I say imperfect because if it were perfect it wouldn’t be any fun trying to fix it, trying to make it work better, trying to make sure that everybody gets a fair shake and then some. My country is personal to me because my father, who wasn’t born here, rest his soul, he made sure that I was born here. And he used to tell me when I was a kid that America was a land of dreams and a dreamland, well I don’t know if our country fulfilled all of his dreams while he was alive, but tonight with all of us together for this hour, it sure fulfills my dreams. And to all of you in the country and all of you watching tonight, here’s a song about a

place we call home, probably the greatest nation ever put on this earth.

The lead-up to America's 250th birthday provides an appropriate occasion to examine the role America has played in the development of insurance and, more importantly, the role insurance has played in the development, growth, and grandeur of America. A close examination reveals that insurance, insurers, and insurance professionals – though popular scapegoats and common targets for criticism – have contributed mightily to the economic success, stability, and endurance of our country. Although the mass media may not acknowledge it, insurance has earned a prominent seat at America's birthday celebration table and should receive a big slice of America's birthday cake.

Part 1 of this book examines the role of insurance and insurers in the United States. It begins by providing an abbreviated history of insurance in the United States, tracing important developments with respect to some of the major lines of insurance. Next, it chronicles some significant technological advances and legal developments fueling underlying liabilities that, in turn, helped to shape insurance and liability insurance law. The book then provides an overview of the history of insurance regulation.

Part 2 of the book explores these “golden ages” of the insurance coverage wars, placing in context some key developments in insurance coverage litigation and highlighting America's unique contributions to insurance litigation, including the duty to defend, social inflation, and insurance bad faith and extracontractual liability. It includes the authors' nominations for the most significant court decisions in the history of American jurisprudence to start a dialogue among insurance practitioners, executives, and professionals about seminal insurance law decisions that shaped contemporary insurance law.

Part 3 discusses some important contemporary developments and issues in insurance coverage law and litigation. It is not intended to be a comprehensive examination of the contemporary insurance coverage landscape. Other insurance law resources and treatises, such as Scott M. Seaman and Jason R. Schulze *Allocation of Losses in Complex Insurance Coverage Claims* (13th Ed. Thomson Reuters 2025), adequately cover this terrain. Instead, it examines some select issues to provide readers with a general appreciation of the scope, depth, and vibrancy of insurance and insurance coverage issues in America today based upon recent writings of the authors and their colleagues.

Specifically, Part 3 begins by looking at some of the key insurance decisions, trends, and developments over the past year across various types of liability and property coverages. Next, it homes in on some of the coverage trends and decisions impacting directors' and officers' liability policies, representing a deeper dive into one particular line of insurance. It then addresses forever-chemical claims – already yielding substantial regulatory, litigation, and coverage developments – which have the potential to rival asbestos losses. Sustainability – otherwise known as ESG (Environmental, Social, and Governance Considerations) – has garnered considerable attention and action on the part of policyholders and insurers over the past several years and is addressed in Part 3. Finally, the book concludes that insurance will continue to play a vibrant role in the future of America.

We hope you will find this book to be informative and interesting. Happy Birthday, America!

Scott M. Seaman
Pedro E. Hernandez
Peter J. Lewis



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Scott is a prolific author and sought-after speaker on insurance and litigation issues. He has been recognized as a Top Insurance author for the last six consecutive years in the *JD Supra* Readers' Choice Awards and hosts Hinshaw Insurance Law Television. He

was named to the inaugural list of Midwest Trailblazers by *The American Lawyer* magazine. The list recognizes 50 professionals from 12 Midwestern states “who have moved the needle in the legal industry” and “are truly agents of change.” He was selected for his “high-profile, complex insurance coverage cases nationwide, which resulted in precedent-setting rulings that have altered insurance law.” Scott has received numerous distinctions and recognitions, including being named to *Crain’s Chicago Business* 2024 Notable Leaders in Accounting, Consulting & Law and to *Crain’s Chicago Business* 2025 Notable Litigators & Trial Lawyers, and garnering a Band 1 ranking in Insurance: Dispute Resolution by Chambers USA. He can be contacted at sseaman@hinshawlaw.com.



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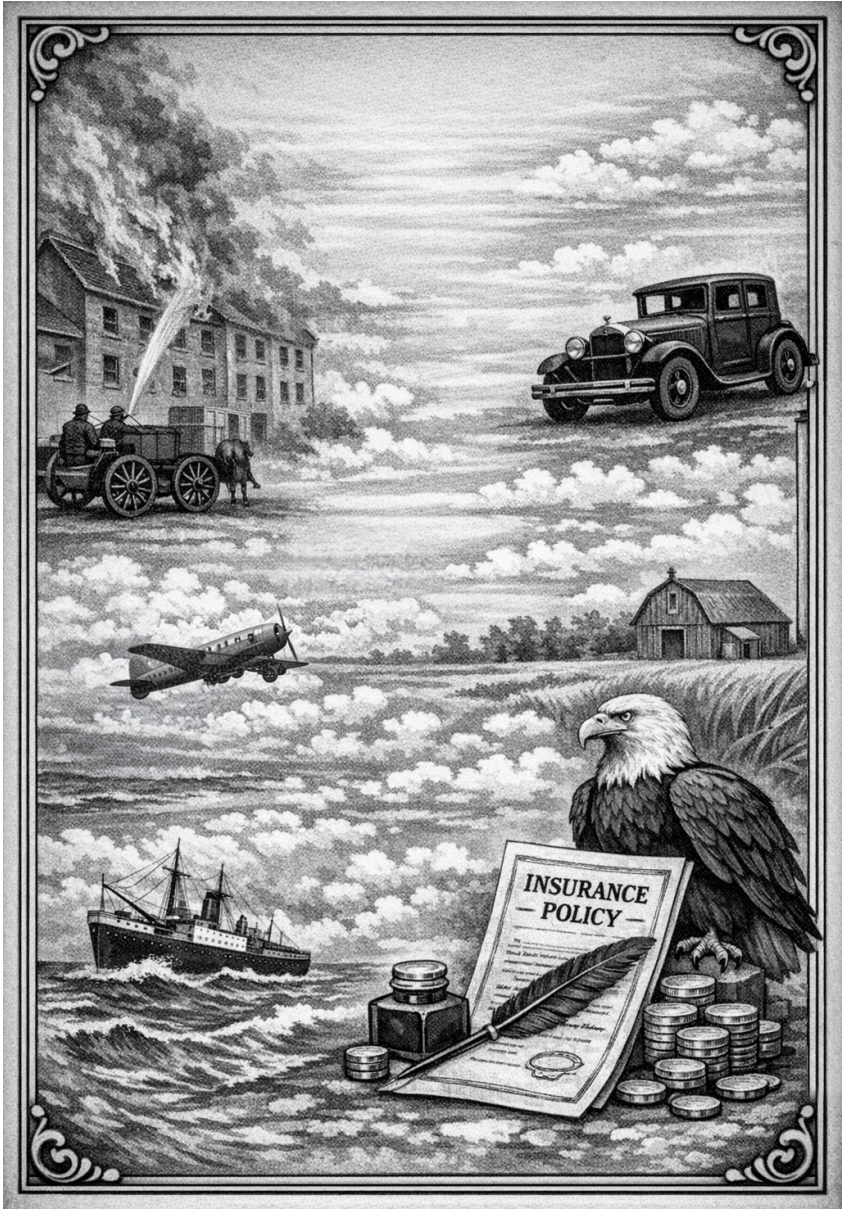
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Most importantly, we thank Charlene Seaman, Maria Hernandez, and Barbara Lewis for their inspiration, love, and support, and for encouraging us to devote time and energy to the activities in life that are truly meaningful and make for a balanced history.

PART 1
AN ABBREVIATED HISTORY OF
INSURANCE IN THE UNITED STATES



CHAPTER 1

INSURERS' CONTRIBUTIONS TO AMERICAN SOCIETY & THE AMERICAN ECONOMY

The list of American inventions is long and storied, encompassing such creations as the cotton gin, telegraphs, telephones, light bulbs, airplanes, air conditioning, televisions, microwave ovens, lasers, the internet, emails, the polio vaccine, 3D printing, and numerous medications and medical devices. Although America has played a prominent role in the development of various types of insurance, the conceptual roots of insurance predate the founding of our country. Simply stated, insurance was not invented in America and was not perfected in America. America, however, has made significant contributions to the evolution of insurance and has placed its unique imprimatur on insurance and, in particular, insurance coverage law and litigation.

Saying that insurance is just another industry would be akin to suggesting that Benjamin Franklin was just another man. Franklin's contributions to America extended far beyond founding an insurance company. Franklin was a critical founding father of the United States who signed the Declaration of Independence, the 1783 Treaty of Paris, and the United States Constitution. He was the oldest delegate at the 1787 Constitutional Convention. As a diplomat, he helped secure French support for the Revolutionary War. He invented bifocals, the lightning rod, and the urinary catheter, among other things. He founded the first volunteer fire department called the Union Fire Company, the American Philosophical Society, and a subscription library known as the Library Company of Philadelphia. Among his publications is *Poor Richard's Almanack*. Franklin was an extraordinary man.

Similarly, insurers have contributed to American society and the American economy in a variety of ways that extend far beyond issuing policies of insurance. The contributions began with the country's founding when marine insurers "underwrote the United States simply and straightforwardly by shouldering the financial risks of the war for American independence."³ Indeed, during the American Revolution, maritime insurers helped the new nation negotiate foreign loans, sell state debts, and establish early banking, acting as critical nation-builders. According to one author:

State-chartered insurance companies underwrote the United States, in the broader sense of the word, by lending it the sizable stores of capital that they accrued in a very short period of time. Far wealthier and more numerous than their place in historical memory would suggest, insurance corporations invested large portions of their capital in the securities issued by the United States. By purchasing so much American debt . . . insurance companies took on the state's risk, reaping both short- and long-term rewards. In the process, they reshaped the American financial landscape. They also bound themselves closely to American banks, bolstering the financial sector and allowing it to produce more wealth for the state. Meanwhile, they engaged in a cultural initiative to offset the political risk of popular antipathy toward their wealthy and exclusive corporations. Sending delegations to urban parades, bestowing expensive silver gifts on valiant sea captains, and commissioning portraits of themselves in culturally meaningful poses, insurers invested in their own future by weaving themselves into the fabric of American society. This strategy yielded significant profits to company leaders and shareholders, but American underwriters were not only out for themselves. They could not be, because

they were financially invested in the success of the new republic. It was therefore in their best interest to secure American prosperity by, say, publicly pronouncing the country successful, its institutions prosperous, and its trade secure. As insurers' wealth and influence grew, their expressed confidence in the nation's future helped summon that future into reality.⁴

Insurers use their expertise and data to proactively reduce the likelihood and impact of losses. In so doing, insurers save lives, prevent injuries, and preserve property. By providing loss control services, insurers assist their policyholders in identifying and managing vulnerabilities and risks before they result in losses and claims. Many insurers offer discounts or lower premiums to policyholders for implementing safety measures, such as telematics for safe driving, smart home sensors to detect leaks, and sprinkler systems to contain fires. Insurers are responsible for a variety of standards, including fire safety standards, stronger building codes, and forest management standards to reduce wildfire risks.⁵

Health and life insurers have supported proactive wellness measures rather than just paying for reactive care. Plans frequently feature incentives for healthy living, such as gym memberships, healthy food discounts, and monetary rewards for meeting health goals. By championing preventative health, insurers align their financial interests with policyholders' welfare, aiming to reduce the incidence of preventable diseases such as type 2 diabetes. Modern policies increasingly integrate consultations and wellness apps, for example, to treat mental health.⁶

Insurers have facilitated the rapid deployment of low-carbon technologies by providing specialized risk financing for renewable energy projects and through underwriting standards and actions. Insurers also drive global sustainability.⁷ Similarly, in the electronic

information age, insurer underwriting and loss control services assist policyholders in preventing and minimizing cyber losses.⁸

Insurers are major institutional investors, using their large investment portfolios to offset underwriting losses and provide reserves for future claim payments. The insurance industry's cash and invested assets reached over \$8.98 trillion at the end of 2024.⁹ This large investment portfolio plays an important role in the economy, supporting corporate issuers, capital markets, and the nation's infrastructure. Insurer capital can be found in the Hoover Dam, the Golden Gate Bridge, and the St. Lawrence Seaway, among so many other structures, projects, and landmarks.

Insurance fosters economic growth and serves as a backstop for invention and investment. Without insurance, airlines would be reluctant to bear the risk of flight, ships may not sail, people would drive less, builders would not break ground on many construction projects, doctors would not perform high-risk procedures, pharmaceutical and technology companies would not take the risks associated with developing drugs, vaccines, and medical devices. Simply stated, without insurance, the availability of products and services would be reduced greatly both in quantity and variety.¹⁰

Insurance contributions are well-mapped in America. Starting in the middle of the nineteenth century, some fire insurance companies began to make detailed maps of cities. Over time, these maps became more complex, reflecting building characteristics as well as streets and water supplies. Daniel Sanborn, first employed by Aetna, started out making maps of the Boston area. By the early twentieth century, the Sanborn Mapping Company published maps for more than five thousand cities and towns.¹¹

During times of crisis and catastrophe, many insurers provide direct relief, such as funding for frontline healthcare workers and essential supplies. Throughout its history, the United States has been impacted

by major storms, hurricanes, earthquakes, pandemics, fires, floods, and other catastrophic events. A few examples are set forth in Chart 1. Insurance has been critical for rebuilding after disasters and in helping people during disasters.

CHART 1

ILLUSTRATIVE UNITED STATES CATASTROPHES/CASUALTIES *

Event	Year	Comments
Selective Storms & Hurricanes		
Galveston Hurricane	1900	Deadliest natural disaster with an estimated death count between 8,000 and 12,000
Hurricane Katrina	2005	\$201 billion
Hurricane Harvey	2017	\$150 billion
Hurricane Ike	2008	\$43 billion
Hurricane Irma	2017	\$64 billion
Hurricane Ian	2022	\$113 billion
Hurricane Helene	2024	\$78 billion
Hurricane Andrew	1992	\$61 billion
Hurricane Sandy	2012	\$8 billion
Major Fires, Earthquakes, & Wildfires		
Peshtigo Fire	1871	Deadliest wildfire in U.S. history, burning over 1 million acres in Wisconsin
Great Chicago Fire	1871	\$5.7 billion
Camp Fire	2018	\$15 billion deadly California fire
Maui, Hawaii Wildfires	2023	\$6 billion
Oakland Fire	1991	\$7.6 billion

Event	Year	Comments
Palisades/Eaton	2025	\$60 billion
Nisqually, WA Earthquake	2001	\$2 billion
San Francisco Earthquake and Fire	1906	\$100 billion
Northridge Earthquake	1994	\$65 billion
Other		
Dust Bowl	1930s	Massive ecological and agricultural disaster in the Great Plains
Johnstown Flood	1889	Dam failure causing a 70-foot wave and massive casualties
Spanish Flu Pandemic	1918	Led to approximately 675,000 deaths
September 11 Terrorist Attacks	2001	Approximately \$40 billion in insured losses

* Estimates are provided in recent dollars.

CHAPTER 2

THE PRE-1776 ORIGINS OF INSURANCE & NINETEENTH CENTURY EXPANSION & INSTITUTIONALIZATION

The origins of insurance can be traced back long before the founding of America. Maritime insurance policies, for example, first became available in the fourteenth century, with the first formal insurance policy said to be issued in Genoa, Italy, in 1347. In these early days, maritime insurance generally was handled by merchants and financiers, rather than dedicated insurance companies. In 1492, when Christopher Columbus sailed the ocean blue, his vessels – the Niña, the Pinta, and the Santa Maria – reputedly were uninsured with the risks borne by Columbus’ royal sponsors, King Ferdinand and Queen Isabella of Spain, who financed the voyage, and by Columbus himself, who, to some extent, found himself to be uninsured. By the late seventeenth century, London’s Lloyd’s coffee house had become a marketplace for marine and other risks. Colonists imported many practices from the London market, and the London market continues to influence insurance in America today.

In 1752, Benjamin Franklin and fellow Philadelphians founded The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, a mutual insurer that deployed risk-based underwriting (including inspections and avoidance of fire-prone properties) and loss prevention. Some sources consider this to be the first United States insurance company.¹²

Colonial fire marks, subscription-based firefighting associations, and nascent mutuals reflected early American risk pooling. Coverage and claims were governed largely by English mercantile practice and

common law contract principles, setting the stage for the American blend of private ordering and public oversight that would come later. Swiss Re reports that “ten property companies were created within two decades following the Declaration of Independence in 1776 – including the first joint stock insurer, The Insurance Company of North America (INA), which was founded in 1792.”¹³ One of the first life insurance companies in the United States was the Pennsylvania Company for Insurance on Lives and Granting Annuities, which was founded in 1812.¹⁴

The nineteenth century brought industrialization, urbanization, and railroads, expanding the frequency, variety, and severity of losses. Fire and marine insurance grew, as did life insurance targeting family financial security. Regional centers – such as Hartford, New York, and Philadelphia – emerged as hubs for insurers, agents, and reinsurers. State supervision began to coalesce as legislatures created insurance departments to license insurers and collect taxes, with considerable early attention devoted to insurer solvency after periodic insurer failures. In the mid-1800s, during the period of Reconstruction after the Civil War, foreign insurers from the United Kingdom, Canada, Germany, and Switzerland were doing business in the United States.

Fire insurance grew substantially throughout the century, evolving from a modest local business into a sophisticated industry. Major urban fires, including the Great Fire of New York in 1835, which destroyed much of lower Manhattan and bankrupted numerous insurers, demonstrated the catastrophic potential of concentrated urban risks and the need for fire coverage. Marine insurance likewise expanded as American overseas trade flourished, protecting ships, cargo, and freight revenues on increasingly global commerce routes.

Life insurance emerged as a growing sector, particularly after mid-century, targeting middle-class families’ concerns about financial security in the event of a breadwinner’s death. Early life insurers adopted actuarial methods imported from Britain

and developed mortality tables based on American experience, gradually transforming life insurance from mutual aid societies and fraternal organizations into commercially viable enterprises offering standardized policies.

CHAPTER 3

THE TWENTIETH CENTURY & THE DEVELOPMENT & EVOLUTION OF MODERN INSURANCE POLICIES & LINES OF COVERAGE

Most modern insurance policies look considerably different in style, form, and length from the “slips” documenting the acceptance of risks dating back to the seventeenth century Lloyd’s Coffee House, where insurance agreements were actually written on paper “slips.” These documents were not figuratively handwritten as “back of the envelope” documents, but actually handwritten on napkins in pubs and bars, and outlined the essential terms, conditions, and premiums for coverage. An underwriter would signify his agreement by “scratching” his name or initials on the slip and, where applicable, indicate his “line” representing his share or participation. Although the slip bound coverage immediately, it was often followed by a more formal policy document.

To be sure, insurance policies in the United States evolved from colonial-era, handwritten “slips” covering maritime and fire risks into complex, digitized, and regulated modern policies. Key shifts included the rise of personal liability insurance in the 1920s, the introduction of package policies in the 1950s, and the twenty-first century shift to AI-driven insurtech, telematics, and personalized, on-demand coverage.

Many insurance policies are form policies written on standardized forms, facilitating standardization and regulatory approval. Others are manuscript or custom policies authored or adopted by individual insurers. Some for particular lines of insurance, others tailored for particular accounts. Even so-called “form” policies are commonly

modified by endorsement. There are numerous lines of insurance and types of policies, but we summarize some of the common policy types below.¹⁵

Personal Lines Policies: Personal lines insurance reflects social policy choices about mobility, homeownership, security, and consumer protection. The first auto liability policy purportedly was purchased in 1897 or 1898. Initial policies were rare, focusing on liability. By 1902, coverage expanded to include fire and theft, and by 1912, companies began bundling property and liability coverage. Connecticut implemented financial responsibility laws in 1925, and Massachusetts mandated auto insurance in 1927.¹⁶ As car ownership increased following World War II, more states began mandating liability insurance. By the 1970s, most states required some form of liability insurance and no-fault insurance was introduced.¹⁷

The fire insurance company founded by Benjamin Franklin and the Philadelphia Contributionship was discussed above. Mortgage lenders required coverage to protect their collateral in the 18th and 19th centuries. The modern homeowners policy was introduced in 1950 by the Insurance Company of North America and combined fire, theft, and liability into one policy. Over time, coverage expanded to include weather damage, structure, personal property, liability, and other perils. The integrated property and liability coverages became a widespread conduit for personal liability defense and indemnity, including personal and advertising injury coverage for defamation and privacy torts. Personal umbrella policies grew as a backstop for higher-net-worth households.

Commercial General Liability Policies: Comprehensive General Liability policies in the United States evolved from 19th century worker accident insurance into standardized, multi-line coverage, later more accurately rebranded as Commercial General Liability (“CGL”) policies. Originally, policies were unique to each insurer, but widespread confusion led to the first standardized forms in 1940,

followed by revisions in 1943, 1955, 1966, 1973, 1986, and later versions. Historically, revisions to policies were spurred by market changes and by court decisions that interpreted policy language in favor of policyholders, causing insurers to tighten coverage, especially with respect to environmental pollution.

Insurance policy drafting reflected economy-wide risk trends and the benefit of some standardization was realized. The commercial general liability policy is the backbone of third-party risk transfer for businesses. Its evolution from early manufacturers' and contractors' forms, to the 1966 accident-based form, to the 1973 occurrence-based policy, to the 1986 revisions reflects a century of tort growth and judicial interpretation. The 1970s and 1980s saw the introduction of claims-made policies beginning in professional liability policies and later expanding to some commercial general liability policies, driven by inflation, expanded tort liability, and "long-tail" exposures.

Product liability and completed operations coverage has been a component of commercial liability policies for some time under the "products-completed operations hazard" provision. It generally covers legal liability for accidents occurring away from the insured's premises, resulting from products manufactured, sold, or distributed. Commercial general liability policies began distinguishing "completed operations" from "premises/operations" coverage. The 1973 commercial general liability form broadened coverage to include continuous or repeated exposure to harmful conditions, potentially allowing for claims long after a project's completion. In the 1986 form, the Insurance Services Office, Inc. (ISO) introduced language addressing the subcontractor dilemma. The "your work" exclusion was added, which specifically did not apply if the damage arose from work performed on the insured's behalf by a subcontractor. Today, products-completed operations generally is a standard, often high-limit, component of commercial general liability policies, which is important for contractors and manufacturers due to rising litigation and costs.

Core insuring agreements cover bodily injury, property damage, and personal and advertising injury, subject to exclusions for expected or intended harm, contractual liability, workers' compensation, and professional services, among other exclusions. Products-completed operations hazards became central with the rise of mass manufacturing. Commercial general liability policies typically cover physical harm to persons or property, rather than pure economic loss arising from a defective product.

Commercial general liability policies generally refer to primary insurance policies usually written on standard form policies (often replete with endorsements or amendments that alter policy terms), which generally are subject to state regulatory approval. Although most discussions about defense focus on the duty to defend, primary general liability contracts generally provide that the insurer has the right as well as the duty to defend the insured. The right to defend is important because it typically affords the insurer the right to conduct the insured's defense in suits for which the insurance contract potentially provides coverage. The insurer's right to conduct the insured's defense generally includes the right to select defense counsel, to make strategic decisions concerning the defense of the suit pending against the insured, and to make decisions regarding settlement and disposition. Allowing the insurer to conduct the defense of the insured protects the insurer's financial interests and minimizes unwarranted liability.

Under many primary liability policies, the duty to defend (or to pay defense costs) is supplementary. In other words, it is in addition to – and does not reduce – the policy's limits of liability. Over the years and with increasing frequency, primary liability policies are issued on a “wasting limits” basis, meaning that payment of defense expenses reduces the policy's limits of liability. Wasting limits policies are permitted in most states.¹⁸

Excess and umbrella liability policies generally are not standard form policies, but rather drafted or issued by the various insurers. In contrast to the primary insurer, the excess insurer rarely undertakes to defend the insured. Although excess insurance contracts ordinarily do not contain a duty to defend, most provide the excess insurer with the right at its “option” to participate or “associate” in the defense of lawsuits pending against the insured. These provisions are intended to allow the excess insurer, if it chooses, to become involved in defending lawsuits that could involve its layer of coverage. The option to associate in the defense, for example, may be exercised by insurers in situations where there is significant exposure in excess of the underlying limits, and the insured and the underlying insurer are not mounting a strong defense. Another instance in which an excess insurer may wish to exercise its right to associate in the defense is where the insured or primary insurers are insolvent, and there is a risk of a default judgment impacting the excess insurer’s limits. Most courts recognize that the right to associate does not impose a duty to defend the insured.¹⁹

Some excess insurance contracts expressly exclude coverage for defense costs. Other excess contracts provide that, under certain circumstances, an excess insurer will reimburse the insured for defense costs. Many excess and umbrella insurance contracts expressly require the insured to obtain the insurer’s written consent prior to incurring defense costs for defense costs to be reimbursable under the excess insurance contract. There may be limited circumstances under which an excess or umbrella contract obligates the insurer to defend lawsuits. For example, umbrella policies often provide that the insurer will defend lawsuits that are covered under the umbrella contract but not under the primary contract. The broader coverage of an umbrella contract, including the umbrella insurer’s defense obligation, may apply to risks that are excluded by or are not within the scope of the underlying coverage or to those risks which fall within the more expansive coverage of the umbrella contract. Overwhelmingly, courts have rejected insureds’ arguments that the mere exhaustion of a

primary layer of coverage by the payment of claims gives rise to an umbrella insurer's defense obligation. Some excess policies are stand-alone policies, others "follow form" to underlying policies to the extent an excess policy does not contain its own language or terms addressing the issue. Historically, some excess policies were written by reinsurers or insurers that did not issue primary insurance and may be issued on an excess or surplus lines basis.²⁰

Although a detailed discussion of policy terms, conditions, and exclusions is beyond the scope of this book, it is worth pointing out that various versions of pollution or contamination exclusions were often included in earlier years by endorsement. The pollution exclusion – first the "sudden and accidental" or "qualified" in the 1970s, then "absolute" by 1986, and the "total" – evolved in reaction to environmental liabilities and uncertainty following the enactment of Superfund and court rulings in coverage litigation.²¹

The terms, conditions, and exclusions of general liability policies vary over time, by company, and by contract. Accordingly, it is important to consider the language of the subject insurance policy.

First-Party Property Policies & Business Interruption Coverage: Commercial property insurance traces its roots to fire and marine policies. Indeed, New York's 1943 Standard Fire Policy standardized first-party property coverage. Named peril policies began to give way to "all-risk" and "special form" coverages. The Insurance Services Office introduced the Businessowner's Policy (BOP) in 1976, bundling property and general liability for small and medium-sized, low-risk, non-manufacturing businesses. BOP policies expanded to include some cyber liability, electronic commerce, and customized options.

Business interruption (BI) and contingent time element coverages insure against lost profits and extra expense tied to physical loss or damage to insured or dependent properties. Boiler and machinery

transformed into equipment breakdown insurance as technology evolved. Contemporary disputes center on causation, exclusions and anti-concurrent causation wording, valuation and period-of-restoration principles, ordinance or law coverage, appraisals, and civil authority provisions. Major catastrophes – from the 1906 San Francisco earthquake and fires to Hurricanes Andrew, Katrina, and Sandy – have shaped drafting, underwriting, reinsurance, and claims practices. However, it was the COVID-19 business interruption insurance coverage that shone the greatest light on first-party policies.

Aviation Policies: Aviation insurance in the United States began in the early 20th century, heavily influenced by marine insurance, with the first policy written around 1911-1912 by Lloyd’s of London and then Travelers in 1919. Initially high-risk, the market stabilized with the 1928 formation of specialized pools like the United States Aircraft Insurance Group (USAIG) founded by World War II pilots. Policies evolved from “named perils” (e.g., fire, lightning) to “all-risks” coverage, separating hull (property) and liability coverage as commercial aviation matured. The 1929 Warsaw Convention resulted in a treaty establishing international liability standards for carriage by air, crucial for bringing stability to the industry.

The post–World War II era saw rapid growth as aircraft manufacturers such as Boeing, Douglas, McDonnell, and Lockheed positioned the United States as the dominant force in aviation. The jet age, beginning with the de Havilland Comet in 1952 and the Boeing 707 in 1958, created exposures far larger than any previously encountered, prompting the formation of entities like the Aircraft Builders Council, Inc. to address aircraft products liability. The introduction of the Boeing 747 in 1969, with two and a half times the seating capacity of the 707, inspired quota share arrangements among otherwise competing insurers. The Government Accountability Office (GAO) Aviation Insurance Program was established in 1951 to provide war-risk insurance when commercial markets could not. The 1980s through 2005 saw slower growth, punctuated by a severe

hard market in 1986 and the terrorist attacks of September 11, 2001, which is estimated to be the costliest disaster in aviation insurance history. Days after the attacks, all war risk coverage was cancelled, and the cost to repurchase such coverage increased by as much as 1500 percent, demonstrating the aviation world's absolute reliance upon the insurance industry for financial support.

The modern era has witnessed substantial growth in the number of aviation insurers. The abundance of worldwide capacity, combined with improved information and the reliability of modern airliners, has made placing coverage for both operators and manufacturers relatively straightforward. Commercial drone (unmanned aerial system, or UAS) operations have presented new challenges reminiscent of early aviation insurance—too few operators, little use data, accident data, and initially no uniform regulations—but following the FAA's 2016 rules permitting commercial UAS use, many major carriers now offer drone policies, and UAS has become an emerging coverage line.

Directors' & Officers' (D&O) Liability Policies: Directors' and officers' liability emerged mid-century but gained salience with federal securities laws of the 1930s, accelerating in the 1960s and again in the 1980s amid securities class actions, corporate mergers and acquisition activity, and corporate governance scrutiny.

D&O insurance protects individual directors and officers for non-indemnifiable losses (Side A), reimburses the corporation for indemnified losses (Side B), and in public-company policies often provides entity coverage for securities claims (Side C). Its modern trajectory mirrors federal securities enforcement and private litigation. The 1980s liability crisis introduced claims-made structures, higher retentions, and exclusions to address claims frequency and severity. Corporate governance reforms, such as the Sarbanes-Oxley Act and later Dodd-Frank, intensified compliance obligations. Modern risks – such as cybersecurity disclosures, environmental, social, and governance (ESG) scrutiny, event-driven litigation, and merger

objection suits – reshaped underwriting and retentions. Structures such as special purpose acquisition companies have produced disputes. Common contested issues include the definition of “loss” and insurability of fines and penalties, prior or pending litigation and related-claims provisions, severability, and allocation among insured persons and the entity.²²

Professional Liability (Errors & Omissions) Policies: Professional liability insurance in the United States emerged around the turn of the twentieth century, with MedPBro Group Malpractice Insurance offering the first medical malpractice policy in or about 1909. By 1915, policies expanded to include specialized coverage for physicians, surgeons, and druggists. Originally covering specific business risks, these policies evolved from “occurrence-based” to “claims-made” policies by the 1970s to address rising litigation and insurer losses, particularly in medical and corporate sectors. Professional liability burgeoned from physicians to encompass a broad range of professionals, including lawyers, accountants, architects and engineers, technologists, and others. Today the policies are mostly claims-made and reported, emphasizing timeliness and the scope of a professional service. The medical malpractice crises of the 1970s and later waves of E&O losses drove tort and legislative reforms, including caps on non-economic damages and procedural screens in some jurisdictions. Coverage issues frequently involve the interplay with professional services exclusions in commercial general liability policies, the boundary between intentional misconduct and negligence, prior knowledge and warranty statements at binding, claims-made and related claims issues and the application of retroactive dates.

Cyber Insurance: Cyber insurance emerged in the late 1990s from technology E&O and privacy liability coverages and matured in the 2000s and 2010s into hybrid products spanning third-party liability and first-party losses. Modern cyber policies address data breach response, notification and credit monitoring costs, regulatory investigations, network security and privacy liability, media liability,

business interruption from network outages, digital asset restoration, cyber extortion, and ransomware, and, increasingly, system failure without malicious cause. The application and scope of war and hostile acts exclusions have taken prominence in the wake of systemic cyber events. Ransomware frequency and severity reshaped retentions, sublimits, and security underwriting, with greater emphasis on controls such as multifactor authentication, privileged access management, backup resilience, and incident response planning. Coverage debates include attribution, contemporaneous fraud and social engineering perils, contingent business interruption tied to cloud and managed service providers, and the scope of regulatory “fines and penalties” as insurable loss. General liability policies, first-party policies, and crime fraud policies potentially contained some coverage for cybersecurity events and until recent years such so-called “silent cyber coverage” dominated coverage litigation. Over the past couple of years there has been an increase in claims and coverage litigation under cyber-specific policies. Coverage for cyber losses and artificial intelligence will loom large in the years to come.

Media Liability Policies: Media liability policies insure against claims such as defamation, invasion of privacy, infringement, and related torts arising from content creation and distribution. Although libel and slander risks predate the internet, key doctrinal developments, including *New York Times v. Sullivan’s* “actual malice” standard for public officials and later expansions to public figures, reshaped liability contours. The digital era expanded the class of publishers and platforms, and federal law limited certain platform liabilities while leaving content creators exposed. The advertising injury grants within commercial general liability policies provide partial coverage for some claims against smaller enterprises, but dedicated media E&O policies for publishers, broadcasters, and studios evolved broader coverage grants with specialized exclusions and clearance requirements. Disputes often center on knowing falsity, the scope of personal and advertising injury, the issue of publication, intellectual

property exclusions, immunity, and choice-of-law for multistate publication. Social media companies present novel exposures.

Health, Long-Term Care, & Disability Insurance: Today, health insurance covers medical expenses, including doctor visits, hospital stays, and prescription drugs. There are a variety of options, including private, employer-sponsored, and government coverages, namely Medicare, and Medicaid.

Before private health insurance there were efforts at government-sponsored coverage for workplace injury and industrial sickness funds. Hospitals and physicians led the implementation of forms of insurance as means to ensure payment for their services. Conventional insurance and managed care emerged at about the same time. In 1934, commercial insurers began offering hospital coverage but generally did not include coverage for physicians initially but they did offer surgical coverage. The start of World War II, the growth of the labor movement, and the federal tax code helped foster the growth of employer sponsored coverage. Private health insurance grew rapidly during the 1940s and 1950s. Commercial insurers experienced success in the market, in part, because they employed experience ratings, allowing them to offer lower-priced coverage to groups with lower expected claims experience. Prepaid group practice was the forerunner of managed care. Similar to Blue Cross, these plans began in 1929 in response to the Stock Market Crash and Great Depression. Some earlier plans existed in a couple of states dating back to the early 1900s.²³

At the time of the enactment of Social Security in 1935, the program did not make any provision for health insurance. President Truman laid the foundation, but Medicare was not introduced until 1965 to provide coverage to older citizens, who were attempting to track the private coverage available at the time. For a number of low-income populations, Medicaid was funded as a federal–state matching program.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 and led to the growth of self-insured employer health plans. The growth of managed care in the 1980s and 1990s was prompted by increasing healthcare costs and the emergence of self-insured employer plans. Medicaid and Medicare were expanded beginning in the 1980s and continuing through the 2000s.

In 2010, the Patient Protection and Affordable Care Act (ACA), commonly referred to as ObamaCare, was enacted. This effectuated a comprehensive health reform law in the United States that purportedly was aimed at increasing insurance coverage, capping out-of-pocket costs, and improving care quality. It established insurance marketplaces with subsidies, expanded Medicaid, mandated coverage for pre-existing conditions, and allowed young adults to stay on parental plans until age 26. The ACA has been highly controversial, with many believing it has failed to live up to its promises to reduce costs, increase the quality of care, and allow patients to retain their choice of plans and providers. Indeed, premiums have increased substantially, sparking an ongoing debate about controlling rising premiums and whether continuing insurer subsidies or making payments directly to individuals is the appropriate approach.

Life Insurance: Life insurance provides a financial payout to beneficiaries upon the death of the insured, with the main types being term (for a specific period) and permanent (whole or universal) life insurance. Life insurance in the United States traces its origins to the colonial era, with the Presbyterian Ministers' Fund, established in Philadelphia in 1759, widely recognized as the first life insurance company in America.

The industry remained relatively modest through the early nineteenth century, as cultural and religious skepticism about profiting from death initially hindered widespread adoption. During the 1840s, the number of mutual life insurance companies grew from 3 to about 20, with mutual companies being the prevailing form of corporate

organization for a period of time for life and fire insurers because, unlike stock companies, there were no initial capital requirements as funds were built from premiums paid by policyholders, which greatly assisted entry into a burgeoning industry.²⁴ Growth accelerated significantly after the Civil War, as industrialization, urbanization, and the war's devastating mortality rates heightened public awareness of the financial vulnerabilities faced by surviving families. More than one hundred new life companies, mostly stock, formed between 1865 and 1870 accounting for the New York Insurance Department reporting 747,000 policies in 1870 up from 56,000 policies in 1860. Although the Civil War spurred growth, it interjected significant disruption to the life insurance business. After Congress prohibited commerce with the South in 1861, it became virtually impossible to collect premiums from Southern policyholders. Companies attempted work-a-rounds such as permitting policies to be "surrendered for a cash value or reinstated at the end of the war."²⁵

By the late nineteenth century, major mutual life insurance companies had emerged as dominant financial institutions, and innovations such as industrial life insurance, which were sold door-to-door in small policies to working class families, expanded the market considerably. The early twentieth century brought increased state regulation following revelations of industry mismanagement and fraud, most notably in the Armstrong Investigation of 1905 in New York, which led to landmark reforms involving reserves, investments, and corporate governance. The Great Depression and subsequent New Deal era further shaped the regulatory landscape, solidifying the state-based system of insurance oversight that persists today. Throughout the twentieth century, life insurance evolved from simple death benefit protection to encompass a range of savings and investment products, reflecting broader changes in American economic life and financial planning.

Workers' Compensation & Employers' Liability: Travelers Insurance Company reportedly brought employers' liability

coverage to the United States in 1889. A year later, they broadened the coverage to create a general liability policy to protect employers from accidents to non-employees as well as employees. General liability premiums were based on payroll, with adjustments for the perceived hazardousness of the workplace. There was usually a limit for accidents that injured or killed one person and for those that injured or killed more than one person. Employers' liability premiums had risen from approximately \$150,000 in 1887 to \$4.7 million by 1897, but the business had become increasingly difficult in terms of assessing the hazards of different workplaces.

Between 1910 and 1915, approximately 32 states enacted workers' compensation insurance. Under these programs, employers accepted full liability for workplace injuries and could buy insurance coverage through their state. If employers purchased workers' compensation insurance, they retained three main legal defenses against negligence (*i.e.*, worker assumption of risk as part of the employment contract, the injury was caused by the negligent acts of a coworker rather than those of the employer, and the worker was at least partially at fault). However, if they did not purchase coverage, they were denied these defenses. Dating back to at least the time of the Civil War, "sickness funds" had been established by employers, unions, and fraternal organizations. Workers made weekly contributions of about one percent of their wages to the fund. When one of the fund members became too ill or injured to work, the fund would provide the worker with cash, often 60 percent of wages.²⁶

Concerns over social inflation were expressed in the context of employer liability insurance long before the phrase "social inflation" was coined. Specifically, concerns of unreasonable verdicts due to juries having sympathy with the working people and against corporations and lawyers were also thought to play a role in driving up costs: "Particularly since the advent of Employers' Liability Insurance, our court calendars have been filled with accident cases hunted up by a species of lawyer known as the ambulance runner."

These lawyers monitored reports about accidents and encouraged injured parties to sue, with the result that “a person who has suffered a trifling injury will be visited by several such lawyers.” Employers’ liability coverage created an attractive target for these lawsuits.²⁷

The Role Of Reinsurance & Types Of Reinsurance: Reinsurance is insurance for insurance companies, allowing insurers to manage risk, stabilize profits, and increase capacity for large-scale losses, such as natural catastrophes. Historically developing alongside maritime and fire insurance, it became a critical global industry, heavily reliant on both foreign and United States capacity. Treaty reinsurance covers a portfolio of risks, while facultative covers specific, individual risks or insureds. Proportional reinsurance involves sharing premiums and losses based on a percentage, while non-proportional covers losses exceeding a certain dollar threshold.²⁸

Reinsurance originated in Europe for marine risks in the 14th century. Dedicated reinsurance companies emerged in the mid-19th century. By the late 1800s, domestic insurers relied heavily on overseas companies to handle rising risks. The 1906 San Francisco Earthquake revealed the necessity of reinsurance for insurer solvency. Following the earthquake, major European insurers began establishing branches in the United States. The economic boom after World War II and increasing risks shifted the market toward “excess of loss” contracts, allowing insurers to cap their maximum losses. The NAIC adopted the Model Credit for Reinsurance Act in 1984. In 1992, Hurricane Andrew produced massive losses, exposing capacity constraints. This accelerated the development of alternative risk transfer methods such as catastrophe bonds and insurance-linked securities (ILS). Reinsurance is competing with other financial products, but remains crucial to the United States economy. Without it, insurance coverage would be more limited and costly. Reinsurance was a critical component of recent tort reform in Florida and even in connection with issues associated with getting ships to pass through the Straits of Hormuz.

An Excursion Into Insurance Contract Drafting, Policy Forms, & Policy Interpretation: Before embarking on a discussion of evolving risks and liabilities presented in the twentieth century, it is worth following the discussion of insurance lines with a brief excursion into policy forms and drafting.

Many people – even judges – are under the impression that insurance policies are drafted by insurance companies. Some policies are indeed drafted by insurance companies, but most are not. Most insurance policies are form policies drafted or created by insurance advisory organizations (or are derived in large measure from form policies). In many commercial transactions, sophisticated brokers draft or negotiate specific policy wording on behalf of their policyholder clients to obtain broader coverage. Many of these policyholder clients have considerable sophistication in matters of insurance and are armed with professional risk departments, managers, and counsel. Many have considerable bargaining power.

The various versions of the commercial general liability policy forms, for example, were primarily drafted by the Insurance Services Office (ISO) and its predecessor organizations. The Insurance Services Office or ISO was founded in 1971 as a non-profit association of insurers to standardize rates, provide actuarial services, and develop insurance policy language. ISO is not an insurance company. ISO was formed through the merger of several rating organizations, including the National Bureau of Casualty Underwriters (which later became the Insurance Rating Board (IRB) in 1968), the Mutual Insurance Rating Bureau, and the National Board of Fire Underwriters. The National Bureau of Casualty Underwriters drafted the first standard commercial general liability policy in 1941 and subsequent revisions in 1943, 1947, and 1955. Prior to 1971, commercial general liability policy forms were primarily drafted by the National Bureau of Casualty Underwriters and its successor ISO along with the American Mutual Insurance Alliance (AMIA) and Mutual Insurance Rating Bureau. Since then, ISO has been responsible for the major standard

CGL revisions, including revisions in 1986, 1993, 1998, 2001, 2004, and 2013.

ISO is not owned or controlled by insurance companies. By 1994, insurers had begun relinquishing control to a board that included non-insurer directors and, in 1997, ISO became a for-profit corporation. ISO is currently owned by public shareholders through its parent company, Verisk Analytics. Ownership is now primarily held by institutional investors.

Additionally, most insurance policy forms are subject to review and approval of the various state departments of insurance. Insurance department approval of policy forms is required primarily to ensure compliance with state laws and to protect consumers from unfair, deceptive, misleading, or ambiguous contract terms. These departments have the power, among other things, to disapprove or withhold approval of policy forms.

The realities of insurance policy drafting, the modern competitive insurance market, and insurance department review and insurance department approval of insurance policy forms undermine the tenets upon which a widely followed rule of policy interpretation is founded.

Contra proferentem, a Latin phrase meaning “against the offeror,” is a legal doctrine of contract interpretation providing that, where a term or provision of a contract is ambiguous, it should be interpreted against the interests of the party who drafted it. In the context of insurance coverage lawsuits, it means that, as a last resort, ambiguous insurance policy language may be interpreted against the insurer and in favor of coverage. The doctrine purportedly is used to protect the non-drafting party in cases of contracts of adhesion (contracts offered on a take-it-or-leave-it basis), where there was no opportunity to negotiate terms, and to encourage the party drafting the contract to use clear language. At least in the context of commercial insurance contract disputes, application of *contra proferentem* is not warranted,

justified, or fair. Most insurance policies are not drafted by insurers, are subject to regulatory review and approval, are issued to and negotiated by sophisticated entities with bargaining power, and some are even drafted by policyholders or their agents.²⁹

CHAPTER 4

THE TWENTIETH CENTURY PRODUCED A WORLD OF INCREASING RISKS, EXPOSURES, & LIABILITIES

Technology and the industrial revolution impacted exposures and risks worldwide. Twentieth-century tort and regulatory developments profoundly expanded the scope and stakes of liability insurance, particularly in the United States. Early workers' compensation statutes shifted workplace injury claims from fault-based litigation to an administrative insurance model. Henry Ford's invention ushered in the automobile era and resulted in a new creation – the automobile crash. Ultimately, the automobile era spurred the automobile policy and compulsory financial responsibility.

Consumers purchased radios, appliances, automobiles, and a variety of electronic and other devices. The roaring 1920s ended suddenly (in the abrupt sense of the term) with the crash of the stock market in 1929 and the Great Depression of the 1930s. Insurers were hit hard with massive losses from the stock market and exchange rates and suffered from falling revenues for a period of years. On the other side was the New Deal economy, replete with opportunities and the infusion of substantial regulation and capital.

The United States did not invent liability or claims, but elevated them to an entirely new level and gained separation from the rest of the world by creating mega liability. The United States civil justice system enabled the country to emerge as one of the world's most litigious countries.³⁰

Strict Liability In Tort: Then came the birth of product liability and strict liability in tort. Historically, manufacturers were largely protected from lawsuits by third parties (users who did not directly purchase the item) due to the requirement of privity. Courts began allowing exceptions to privity, such as in *MacPherson v. Buick Motor Co.* (1916), allowing negligence suits against manufacturers. The California Supreme Court’s *Greenman* decision in 1963 established that manufacturers are liable for defects regardless of fault under a theory known as “strict liability.” This was solidified by Section 402A of the Restatement (Second) of Torts in 1965. In the 1970s and 1980s, “mass tort” litigation resulted in insurance costs soaring.

The world is full of toxic substances – some naturally occurring and others made by man. War efforts also contributed toxins, such as Agent Orange. Chemicals and substances too numerous to mention have produced damages and injuries in large numbers.

The 1970s and 1980s saw an Explosion of Liability and gave rise to a liability insurance crisis, lead by asbestos and environmental.

CHART 2

SIGNIFICANT EVENTS IMPACTING LIABILITY

Year	Event
1950s	Significant rise in pain and suffering damage awards
1960s	Adoption of strict product liability
1963	The Clear Air Act was passed into law
1963	Amendment to Rule 23 of the Federal Rules of Civil Procedure to permit opt-out class actions in federal cases
1964	The Wilderness Act passed into law
1969	The National Environmental Policy Act was passed (requiring environmental impact statements)

Year	Event
1970	The Occupational Safety & Health Act passed
1972	The Clean Water Act, the Federal Insecticide, Fungicide, and Rodenticide Act, and the Marine Mammal Protection Act were passed
1973	The Endangered Species Act was passed
1974	The Safe Drinking Water Act was passed
1975	California adopts the Medical Injury Compensation Act limiting noneconomic damages (pain and suffering) to \$250,000 against health care providers based on professional negligence. More than half of states now place limits on damages for pain and suffering in medical liability cases or all personal injury lawsuits
1976	The Resource Conservation & Recovery Act and the Toxic Substances Control Act was passed
1970s	Partial no-fault insurance laws adopted for auto accidents in several states and onset of asbestos-related litigation
1977	United States Supreme Court invalidated a state's blanket ban on attorney advertising paving the way for attorney television, radio, and print ads
Early 1980s	Plaintiffs' lawyers began to use Alien Tort Statute to assert claims against corporations for conduct taking place outside the United States
Mid-1980s	Several states enact tort reform that includes items such as statutes of repose establishing outer time limits on bringing product liability claims, abolishing, or limiting joint and several liability, providing relief to innocent product sellers, and establishing punitive damages reforms
1982	Johns-Manville filed for bankruptcy protection due to asbestos liabilities
1980	The Comprehensive Environmental Response, Compensation, and Liability Act
1986	National Childhood Vaccine Injury Act enacted to reduce liability of vaccine makers and creates a federal no-fault system for compensating vaccine-related injuries and deaths

Year	Event
1989'	The EPA issued a final rule banning most asbestos products that was partially overturned repealed in 1991
1990s	First wave of cases in which the United States Supreme Court addresses punitive damages. In various decisions, it: expressed concern over punitive damages running wild; warned that unlimited jury/judicial discretion in awarding punitive damages presents constitutional issues; required judicial review of the size of a punitive damage award; and established guideposts for courts to evaluate whether a punitive damage award is unconstitutionally excessive
1993	United States Supreme Court raised the standard for admitting expert testimony by directing federal district court judges to serve as gatekeepers to ensure the reliability of expert evidence and exclude “junk science” expert testimony, which subsequently has been followed by most states
1994	State attorneys general partnered with plaintiff contingency fee lawyers on tobacco suits. Years later, such partnering was eliminated by an executive order signed by President George W. Bush that remains in effect
1994	Congress enacted the General Aviation Revitalization Act establishing an 18-year statute of repose for lawsuits against manufacturers of noncommercial general aviation aircraft and component parts, which is credited for reviving the industry
1994	Congress enacted section 524(g) of the Bankruptcy Code, which established a statutory procedure for dealing with future personal- injury asbestos claims against a bankrupt company
1995	Congress enacted the Private Securities Litigation Reform Act of 1995 (PSLRA) to limit abusive securities lawsuits, which was later strengthened
Late 1990s	Asbestos litigation reaches “crisis” level

Year	Event
Late 1990s–early 2000s	Alaska, Florida, Mississippi, Texas, Alabama, Tennessee, Wisconsin, South Carolina, and Oklahoma were among states to enact comprehensive legal reforms. Tort reform was struck down in states such as Illinois and Ohio
2005	Class Action Fairness Act enacted by Congress expanding federal jurisdiction over multistate class and mass actions seeking over \$5 million and limiting lawyer fees for token/coupon settlements
2005	United States District Court Judge Janis Graham Jack for the Southern District of Texas, who presided over federal silica multidistrict litigation, found that all but one of 10,000 silica cases aggregated for pretrial purposes were based on “fatally unreliable” diagnoses. Judge Jack stated that the claims “were driven by neither health nor justice: they were manufactured for money.” This brought greater scrutiny to abuses in mass tort litigation
2007-2009	The United States Supreme Court tightened liberal pleading standards somewhat, allowing courts to dismiss a complaint if it does not set out a “plausible” claim
2011	The United States Supreme Court enforced class action waiver in consumer arbitration agreement, relying upon the primacy of federal arbitration law to compel arbitration
2012	Ohio enacted asbestos trust transparency law requiring asbestos plaintiffs to file bankruptcy trust claims before trial and allowing defendants to demonstrate alternative causation for plaintiffs’ injuries. Similar laws have been enacted in other states such as Georgia, Texas, Alabama, Michigan, Kansas, Mississippi, Iowa, North Carolina, Texas, Tennessee, Michigan, North Dakota, and South Dakota

Year	Event
2013	The United States Supreme Court rendered multiple decisions holding that the Alien Tort Statute does not apply extraterritorially except in limited circumstances, strengthened class certification standards by rejecting a proposed class action that featured an improper damages model, and reaffirmed the right of contracting parties to pursue resolution through arbitration including for claims alleging violations of federal law
2015	Amendments to the Federal Rules of Civil Procedure required discovery to be “proportional to the needs of the case” and authorize courts to enter orders shifting the cost of discovery to the requesting party and many states have since followed
2016	The United States Supreme Court ruled that plaintiffs must allege a concrete injury to have standing to bring a lawsuit. A bare allegation of a statutory violation is inadequate to show injury-in-fact
2017	The United States Supreme Court restricted the ability of plaintiffs to file cases in courts they view to be most favorable by generally limiting court jurisdiction over a business defendant to its state of incorporation or principal place of business unless there is a connection between the specific claim and another location (such as place of injury)
2017-18	Several groups renew a proposal to amend the Federal Rules of Civil Procedure to require the disclosure of third-party litigation funding arrangements in any civil action filed in federal court. Wisconsin required disclosure of litigation funding. These efforts are ongoing in other states and proposed federal legislation
2024	EPA bans use of chrysotile asbestos

Asbestos & Environmental: One substance – asbestos – stands head and shoulders above the rest because it is ubiquitous, capable of causing disease and death and responsible for hundreds of thousands

of injuries and deaths – though not as many as it has been accused of by the plaintiff’s bar. Asbestos produced large losses, led to numerous insurer insolvencies, and contributed greatly to the development of modern insurance coverage law. Asbestos represents one of the best case studies for the perfect liability storm.

Asbestos is a group of six main types of naturally occurring fibrous silicate minerals known for heat resistance, strength, and durability, widely used in construction, insulation, and automotive parts such as brakes. Asbestos was used in over 3,000 products due to its fireproof, durable, and insulating properties. It was used in a wide-range of building materials, such as roofing shingles, ceiling tiles, floor tiles, insulation (including asbestos cement), and siding. Older homes, factories, and ships often have asbestos in insulation, patching compounds, and textured paints. Asbestos was widely used in automotive parts and industrial equipment such as brake pads, clutches, and transmission components. Many other products, including fireproof clothing, contained asbestos. The fiber has so much utility that it seemed to be everywhere before being identified (or at least acknowledged) as highly toxic and carcinogenic. Inhaled or ingested fibers cause severe diseases, including asbestosis and lung and other cancers – often developing over decades after exposure. It even has what many consider to be its own disease – mesothelioma, which is cancer of the lining of the lungs or abdomen – that can take four decades to develop. Today, it is allegations of asbestos that is driving the talc litigation.

Environmental liabilities also played an outsized role in supercharging liabilities. In prior times, state law focused on common law theories, and early federal laws focused on resource management and some pollution control, such as the Rivers and Harbors Act of 1899, which regulated dumping into navigable waters, and the Lacey Act of 1900, which addressed illegal wildlife trade. In the mid-20th century, laws began to shift toward conservation, including the Antiquities Act of 1935, the Wilderness Act of 1964, and the Wild and Scenic

Rivers Act of 1968. The National Environmental Policy Act of 1969 required federal agencies to consider the environmental impacts of their actions.

In the 1970s and 1980s, environmental laws exploded in number and scope, setting the stage for large environmental liabilities. The United States Environmental Protection Agency was established in 1970 and sweeping liability-creating legislation followed with the Clean Air Act in 1970, the Clean Water Act in 1972, the Endangered Species Act in 1973, the Safe Drinking Water Act in 1974, the Resource Conservation and Recovery Act in 1976 (RCRA), and the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or Superfund) in 1980. Other laws include the Coastal Zone Management Act of 1972, The Marine Protection, Research and Sanctuaries Act of 1972, the Toxic Substances Control Act of 1976, and the Oil Pollution Act of 1990. It seems that much of the land, water, and air of our beautiful country is laden with pollutants from sea to shining sea.

The stage was set for the United States tort system to explode. The number of lawsuits increased, as did the size of jury awards. Strict liability and the need to only establish a degree of culpability made companies targets for creative plaintiff attorneys. During the second half of the twentieth century United States tort costs rose from 0.6 percent of GDP to 2.2 percent. The expanded concept of liability resulted in casualty insurers facing volumes of claims in the 1980s under policies written in the 1960s and 1970s that they did not anticipate and for which they did not adequately factor into premiums or reserves for defense and claim payment. In the early 1980s, some insurers were spending as much as 25 percent of their premiums on legal expenses. The largest losses were for environmental pollution and health hazards, with asbestos-related claims leading the way. The liability insurance crisis of the 1980s resulted in the insolvency of several insurers and the unwillingness of other insurers to continue writing casualty insurance. The cost

of insurance rose exponentially, impacting professional liability insurance for medical malpractice claims, product liability losses under general liability policies, workers' compensation losses, and directors' and officers' liability, and other lines of insurance felt this as well. Some politicians sided with consumers seeking to promote large jury awards for the plaintiff's bar funding them and others sided with companies seeking to enact tort reform.

Asbestos and environmental claims gave rise to many insurance coverage disputes and court decisions, but a variety of other underlying claim types produced insurance coverage activity. Chart 2 highlights some of the significant events impacting the United States civil justice system dating back to the 1950s.³¹

PFAS: Many candidates have been proposed as the “next asbestos” over the past several decades. Benzene, electromagnetic fields, Y2K, and many others were suggested but fell far short. Cyber and AI are likely to produce significant litigation regarding liability and coverage, but these claims transcend industries. PFAS, which can be viewed as simply a subtype of environmental claim, has already produced substantial liabilities and several coverage actions and may prove to present losses to the insurance industry that rival asbestos losses. Commentators have offered predictions about the extent of losses insurers may sustain from PFAS-related claims. Some predict that PFAS-related losses could rival or exceed insurer asbestos-related losses. Praedicat, for example, estimates that the United States' cleanup costs for PFAS-contaminated water alone could exceed \$400 billion for insurers.³² This amount does not include potential losses in product liability, personal injury, and director and officer lawsuits. Forecasts of PFAS-related exposures, however, vary considerably and will evolve. The exposures will play out over an extended period of time. The ultimate cost to the insurance industry will depend upon a variety of factors, many of which remain unknown or incapable of accurate assessment at this time.³³

In reality, PFAS litigation and exposures will follow their own course. On one hand, factors such as social inflation, the devotion of substantial resources by the plaintiffs' bar, and the use of reptilian tactics – which were not present at the beginning of the asbestos litigation explosion, at least to the same extent as they are now – will fuel PFAS litigation. On the other hand, the science and proof of PFAS-related bodily injuries and damages are still developing, identifying the parties and products responsible for particular PFAS-related injury or damage may present difficulties in many cases, substantial causation issues exist, and no specific disease tied exclusively to PFAS has yet to emerge that is similar to mesothelioma from exposure to asbestos.³⁴

The insurance dynamics are different as well. Many legacy policies are lost, settled, released, exhausted, or impaired. Coverage under more recent policies is likely to be more restrictive, contain applicable exclusions, be written on a claims-made basis, and present coverage defenses not available to the same extent with respect to asbestos-related liabilities. Many insurers are employing sound underwriting practices, loss control services, education of staff and policyholders, and outstanding claims professionals and attorneys to contain PFAS-related exposures. More globally, insurers and their policyholders would be well-served by taking many of the steps to confront and contain social inflation that are applicable to PFAS-related claims. There is no question but that insurers and their policyholders will continue to face large losses from PFAS. The developments over the past couple of years do not suggest that a downward projection in PFAS-related losses is warranted.

PFAS regulation, liability, and coverage issues are discussed in more detail in Chapter 12.

CHAPTER 5

THE EVOLUTION OF INSURANCE REGULATION

Regulation of the business of insurance in the United States has generally been left to the states. The business of insurance is highly regulated, but that was not always the situation. Insurance regulation has a long and storied history in the United States, dating back to a 1799 Massachusetts law. During the early nineteenth century, most states saw their role as primarily promoting the growth of the industry by approving corporate charters. Solvency soon became an issue and, in 1807, Massachusetts required some financial reporting by insurers.³⁵ A 1820 Massachusetts law provided that no fire risk could be written that exceeded ten percent of a company's capital stock. Subsequent laws created a standardized form. New York established its first general insurance laws in 1849.³⁶ State insurance regulation was primarily focused on insurer solvency. State supervision of insurance began to coalesce during this period as state legislatures recognized the public interest in insurer financial stability.

New Hampshire established the first dedicated insurance regulatory office in 1851, appointing an insurance commissioner with authority to examine insurer finances and report to the legislature. Other states followed this model, creating insurance departments charged with licensing insurers, collecting premium taxes as significant sources of state revenue, and monitoring insurer solvency. These early regulatory efforts reflected considerable anxiety about insurer failures, which occurred with troubling frequency during economic panics and after major conflagrations that exceeded insurers' capacity to pay claims. The comprehensive regulatory reforms enacted after the Armstrong Investigation of 1905³⁷ would later demonstrate the ongoing tensions

between insurance industry practices and public expectations of regulatory oversight.

In 1869, the United States Supreme Court held, in *Paul v. Virginia*, that insurance was not interstate commerce for purposes of the Commerce Clause, leaving regulation of insurance to the states.³⁸ A couple of years later, in 1871, state regulators formed the National Association of Insurance Commissioners (NAIC) to coordinate model laws and standards. Standardized policy wording began to be used, culminating later in the New York Standard Fire Policy, which would become a bedrock template for property insurance.

Conflicts of interest among supervisors were also commonplace with superintendents often serving as officers or directors of insurers before taking office and returning to insurers after leaving office. At various times, insurers sought to have regulation be a matter of state law, and sometimes, regulation was used to the advantage of bigger insurers.

In February 1871, New York insurance superintendent George W. Miller invited all state commissioners, directors, and superintendents to a meeting in New York City dubbed the “National Insurance Convention.” Twenty-nine states joined to form the NIC, now known as the National Association of Insurance Commissioners.

In 1944, the United States Supreme Court reversed course and held in *United States v. South-Eastern Underwriters*³⁹ that insurance was interstate commerce, subjecting it to federal antitrust laws. Before federal regulation could take hold, however, Congress responded with the McCarran-Ferguson Act of 1945, reaffirming state primacy in insurance regulation while exempting certain collaborative activities from federal antitrust scrutiny. Accordingly, state rate regulation, solvency oversight, and form approval have been within the jurisdiction of the various state departments of insurance. The

systems matured and provided sufficient consistency through NAIC coordination.

American insurance regulation remains fundamentally state-based. State insurance codes govern solvency, rates, forms, market conduct, producer licensing, and claims practices, with the NAIC playing a vital role in maintaining a level of consistency and coordination among the several states. State guaranty associations protect policyholders against insurer insolvency. Several insurers became insolvent in the late 1970s and 1980s, largely due to unanticipated and daunting asbestos and environmental liabilities, giving birth to litigation regarding whether other insurers had an obligation to “drop down” to fill gaps of insolvent insurers.⁴⁰ Although several insurers were liquidated or placed in receivership, the insurance industry survived. Reinsurance collateral reforms, group capital initiatives, and Own Risk and Solvency Assessment (ORSA) requirements modernized solvency regulation. Risk-based capital frameworks in the 1990s aligned capital charges with risks. Model Unfair Claims Settlement Practices Act served as a goalpost for state legislation.

Climate change, as a phenomenon, continues to drive insurance instability, particularly in California, Florida, and Louisiana, where extreme weather events such as wildfires, hurricanes, and flooding have led to rising premiums, large insurer withdrawals, and insolvencies. Between 2018 and 2023, insurers canceled or non-renewed nearly 2 million policies in these states. In the wake of several insurer insolvencies, Florida enacted two statutes interposing litigation reform impacting first-party claims, particularly with respect to claims involving roof damage, and creating a \$2 billion reinsurance program. Louisiana also passed meaningful tort reform. California regulators have been working to afford insurers greater latitude in setting premiums after multiple major insurers announced they would stop or limit writing homeowner’s policies in California.⁴¹

Though state-based regulation remains the norm, occasionally and to some extent, increasingly federal action has intruded on state regulation and sometimes altered the regulatory landscape. The Liability Risk Retention Act of 1981, amended in 1986, authorized risk retention groups to write liability coverage for their members across state lines, subject to a single state's domicile regulation. The Non-Admitted and Reinsurance Reform Act of 2010 streamlined surplus lines tax allocation and affirmed home-state regulation. The Financial Stability Oversight Council (FSOC) is empowered to designate certain large, non-bank financial companies (including some insurers) as Systemically Important Financial Institutions (SIFIs), which subjects them to heightened oversight by the Federal Reserve. The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 created the Federal Insurance Office (FIO), facilitating federal coordination and international engagement without displacing state authority. The FIO monitors aspects of the insurance industry, identifies gaps in regulation that could lead to a systemic crisis, and advises the Treasury Secretary on national and international insurance matters. The FIO, however, does not have direct supervisory authority over individual insurance companies. Under the Biden administration, it appeared that the FIO was poised to exert additional authority and perhaps usurp state regulation, but that threat appears to have subsided under the Trump administration.

The Terrorism Risk Insurance Act of 2002, with subsequent reauthorizations, established a federal backstop for certified terrorism risks to stabilize capacity post-September 11. Sanctions, anti-money laundering rules, and international standard-setting by bodies such as the International Association of Insurance Supervisors influence United States practice, even as United States statutory accounting principles remain distinct from international regimes.

Federal laws like the Affordable Care Act (ACA) and the Employee Retirement Income Security Act (ERISA) establish significant federal requirements for private health insurance and employer-sponsored

plans. The federal government runs specific programs such as the National Flood Insurance Program and the Terrorism Risk Insurance Program. Although insurers are largely exempt from some federal antitrust laws when regulated by states, insurance companies are subject to federal antitrust legislation concerning acts of boycott, coercion, or intimidation.

Cyber and artificial intelligence (AI) have impacted society and businesses in ways that are both transformative and disruptive, and present major opportunities and exposures for companies and their insurers. Insurers are using AI in connection with underwriting, risk management, fraud detection, and claims handling. AI is also being used to proliferate fraudulent claims. A working group of the NAIC issued a request for information in May 2025 to explore drafting a model law governing insurers' use of AI. Policyholder lawyers are targeting insurer use of AI in coverage and bad faith litigation. Regulators in New York, Colorado, California, and other states have expanded oversight, emphasizing fairness, accountability, and transparency in the use of AI by insurers.

PART 2
THESE GOLDEN AGES OF THE
INSURANCE COVERAGE WARS



CHAPTER 6

LONG-TAIL ASBESTOS & ENVIRONMENTAL CLAIMS FUELED MODERN INSURANCE COVERAGE LITIGATION

The potential for coverage litigation exists whenever an insurer denies a policyholder's claim for coverage. Yet, for most of recorded world history – and even the history of the United States – coverage litigation was not especially common.⁴² Rarely did individual policyholders have the financial means to engage in protracted coverage litigation, and most individual and corporate policyholder disputes were resolved amicably. When coverage was litigated, the disputes generally were not particularly complex, did not involve many issues or parties, and rarely warranted high-priced legal talent.

However, legal developments and increasing liabilities beginning in the 1970s ushered in the “golden ages” of the insurance coverage wars that began in earnest in the second half of the 1980s and continue to the present day. Large environmental, product, professional liability, directors' and officers' liability, corporate/securities, and toxic tort liabilities and claims fueled waves of coverage litigation. Insurance practitioners, particularly coverage geeks, are fortunate to be engaged in the insurance coverage arena during these challenging and exciting “golden ages” of the insurance coverage wars.

In tandem, large asbestos and environmental liabilities gave birth to “long-tail” claims. Long-tail claims, in turn, set into motion the age of high-stakes insurance coverage litigation. Long-tail claims involve claims of continuous or progressive injury or damages – claims not limited in time, place, and space.⁴³ The underlying claims and resulting coverage litigation were sufficiently large, complex,

and interesting to attract large law firms and highly skilled lawyers to represent insurance companies and policyholders alike. The involvement of elite legal minds further increased the stakes, the sophistication, and the costs of coverage litigation.

In modern coverage battles, it is common for corporate policyholders to embroil a large number of their insurers in coverage litigation, often seeking to hold insurers hostage for settlement, to avoid any gaps in coverage, to hedge against the range of potential court rulings, and to help ensure a maximum insurance recovery.

THRESHOLD ISSUES OF CHOICE OF LAW, FORUM, & CASE MANAGEMENT

Choice of law looms large in many insurance coverage disputes and often is an important threshold consideration. Insurance coverage law is primarily a creature of state law; there is considerable variance in court decisions from state to state (and sometimes within a state) on the full panoply of coverage issues, and courts have taken different approaches in making choice of law decisions.

Policyholders often are in a better position to evaluate choice of law in advance of coverage litigation. It can be difficult for individual insurers to predict what law will be applied by a court in multi-party coverage litigation (particularly in the absence of an express choice of law provision in their policies), not knowing the entire roster of insurers on the policyholder's historical coverage profile and the salient contacts involving other insurers and given the propensity of courts to avoid applying different state's laws to different parties, policies, and issues.

Policyholders generally institute coverage litigation and, as such, often enjoy the initial advantage of selecting the forum. On occasion,

insurers institute declaratory judgment actions to obtain a proper forum. Where the choice of forum is critical or the choice of forum may impact the results, the parties may engage in protracted forum battles to secure the venue they believe will provide them with the best results.

Insurers sometimes are disadvantaged in litigation. For example, *Brillhart* and *Wilton* abstention has been used to deny insurers the same access to federal courts based on diversity jurisdiction afforded to all other parties.⁴⁴ Over the years, some bad law for insurers has resulted from insurers litigating contribution claims or taking positions that may be advantageous on a particular claim but contrary to their larger portfolio interests.⁴⁵ Generally, policyholders are not burdened by insurance portfolio concerns and are free to take whatever positions maximize coverage in a particular coverage action.

Most general liability policies were occurrence-based through the 1980s and beyond, with claims-made policies beginning to appear to some extent in the mid to late 1980s. The presence of multiple insurers creates case management challenges and requires coordination among insurers with some common and some competing interests. Long-tail claims present many opportunities for diverging interests among: (1) insurers issuing policies in different years; (2) insurers issuing policies with various limits and different attachment points; (3) primary and excess insurers; (4) insurers issuing occurrence-based contracts and those issuing claims-made contracts; (5) insurers issuing policies with different terms, conditions, and exclusions; and (6) insurers with different portfolio interests and litigation mixes. Although there are opportunities to work together and share costs, insurers often are presented with challenges in their dealings with each other as well as in their dealings with the policyholder. Often, insurers wisely attempt to defer litigating potential claims with other insurers pending resolution of the claims of the policyholder and seek to minimize differences and avoid shooting at each other

unnecessarily. Policyholders are adept at exploiting differences among insurers, and judges sometimes do not appreciate insurers' differing interests. Simply stated, conducting a joint defense in a coverage action can be challenging.⁴⁶

Mega coverage actions often engender disputes at every phase, in addition to the forum, venue, and choice of law disputes described above. First, at the pleadings stage, policyholders are often over-inclusive in the insurers included, the claims asserted, and the relief sought. Insurers often spare no trees in asserting affirmative defenses.

Second, the parties often shift into high gear when it comes to motions directed at the pleadings, filing motions to dismiss, motions for more definite statements, and motions to strike affirmative defenses, which they litigate with the zest common in commercial disputes.

Third, case management and scheduling are hardly treated as perfunctory matters. They may be subject to briefing, complex case management and scheduling orders, discovery and trial phasing orders, appointment of magistrates and special discovery masters, and their recommendations often are appealed to the trial judge. Parties may fight over which claims (or sites in environmental coverage actions) should go first and whether and how to prioritize forms of discovery and phase discovery and trial, and when summary judgment motions may be filed.

Fourth, discovery can be expensive and protracted. The parties seek to obtain favorable documents and testimony for their case, information harmful to the other side, and, regrettably, sometimes seek to impose costs and burden on their adversaries. Some of the discovery is aimed at the claims, policies, and matters at issue, but often discovery may be directed to extraneous matters such as policyholder quests for reserves, reinsurance, other claims, and so-called drafting history and interpretive materials. Disputes regarding document productions, document reviews, third-party discovery, and

privilege logs inevitably arise, and motions to compel and motions for protective orders often are filed to obtain probative evidence and protect privilege and overreaching.

Usually, at some point, formal or informal settlement discussions or mediations are pursued. The discussions may involve the policyholder and a single insurer, a group of insurers, all parties, or rarely involve only the insurers. Often, information and documents are exchanged on a separate track from discovery in the case, so the parties may obtain the information needed to evaluate and value the case that they have been deprived through discovery. Absent a settlement, the parties will eventually engage in the substantive motion practice. In some instances, summary judgment motions resolve the case entirely. More often, some issues are narrowed, resolved, or the parties at least learn what standards the court may apply at trial. Often, trials are phased by sites, claims, or issues. In summary, complex, multi-party coverage actions may be burdensome, protracted, and expensive. Most of the cases ultimately are resolved by settlement, often after issues are narrowed through motion practice, and claims are more fully evaluated once sufficient facts are developed in discovery.

Fortunately, most coverage claims and disputes are resolved without resort to litigation. Although some mega coverage actions continue to be filed, more coverage actions today involve fewer issues and parties and are resolved more quickly. This is a function of a variety of factors, including: (1) the parties and their counsel having developed working relationships; (2) the increased number of claims-made policies limiting the tail and the number of parties and coverage towers involved; (3) increased use of forum, choice of law, and arbitration provisions in policies; (4) a better appreciation of the propensities of various courts with respect to policyholders, insurers, and issues; (5) a more developed body of law and precedent in jurisdictions with appreciable coverage litigation; (6) release and settlement of many legacy policies in prior coverage matters; (7) more and tighter policy conditions and exclusions drafted with the

benefit of prior coverage litigation experience; (8) rocket dockets and judges imposing and enforcing aggressive schedules; and (9) a greater willingness on the part of parties to resolve matters amicably where possible, to mediate early, to submit cases to arbitration, or to agree to limit the parameters of the litigation.

Various forms of claims have been subject to coverage litigation over the years and have produced numerous legal rulings, but long-tail claims in general – and asbestos and environmental coverage claims in particular – have made numerous contributions to substantive insurance law and have fundamentally shaped modern insurance law and practice. We highlight some of the issues below.

SUBSTANTIVE COVERAGE ISSUES IN LONG-TAIL AND OTHER COVERAGE CLAIMS

Trigger Of Coverage: Asbestos and environmental claims have been key in addressing issues concerning which insurance policies are required to respond to long-tail claims. Various trigger theories have emerged, including: exposure, manifestation (date of discovery), continuous trigger, and injury-in-fact trigger (the last two potentially implicated multiple policies in effect from the initial exposure through the manifestation of injury or damage or date of claim). Some insurers made missteps early on with broad pronouncements about the trigger theory they advocate. Later, insurers understood the benefit of taking more limited and nuanced positions closely tied to specific policy language, controlling law, and claim-specific facts. Ultimately, the issue boils down to when the injury and damage took place, and the facts developed through fact and expert discovery may actually drive the result.⁴⁷

Allocation Of Losses: Allocation involves apportioning defense and indemnity costs between and among triggered insurance policies and

the policyholder (for periods of self-insurance, underinsurance, and periods in which insurance was unavailable for any reason). In the absence of being able to determine precisely what injury or damage took place at particular times, policyholders generally advocate for an “all sums” allocation to increase their recoveries and maintain flexibility by avoiding multiple self-insured retentions or deductibles, insurance insolvencies, and policy exclusions. Insurers generally seek a *pro rata* allocation, prorating losses by time-on-the risk, policy limits, a combination of both time-on-the-risk and limits, or some other methodology.⁴⁸

For a variety of reasons, *pro rata* allocation has emerged as the majority rule and the preferred approach. An “all sums” ruling does not guarantee a policyholder a full recovery, and often they seek to “stack” years of coverage to increase their recovery. Although a *pro rata* allocation and the policyholder bearing responsibility for periods in which it is uninsured or where insurance is unavailable for any reason “go together like peanut butter and jelly,” policyholders sometimes seek to avoid this result by arguing that they should not be responsible for post-1986 periods because insurance was unavailable without asbestos and pollution exclusions. Except in New Jersey and Connecticut, these arguments rarely prevail. Where an “all sums” allocation is applied, the potential for contribution claims among insurers and elongated litigation or separate actions is presented. This does not promote fairness or judicial economy. Moreover, the policyholders’ “all sums” argument involves a selective reading of that language while ignoring the “to which this insurance applies” and “during the policy period” limitations. Further, the “all sums” language relied upon by policyholders was eliminated in the 1986 commercial general liability form and was never present in most excess policies.⁴⁹

Coordination and priority of coverage issues may be presented involving the interplay of various policy types, such as claims-made and occurrence-based policies, the interplay of general liability

policies with environmental impairment insurance, contractor pollution liability, or the interplay among general liability, directors' and officers' liability, property, and professional liability policies depending upon the type of claim.⁵⁰

In construction-related coverage litigation an additional dynamic is presented by the parties' allocation of risks among themselves in the construction documents. Some courts resolve issues by reference to these documents, while others look to the insurance contract and "other insurance" clauses.

The observation of the New Jersey Supreme Court regarding environmental coverage law remains particularly apt with respect to environmental coverage actions generally and allocation issues in particular: "[I]t sometimes appears that just as soon as one issue of importance is resolved, like Hydra, the many-headed serpent in Greek mythology, at least two new issues arise to replace it."⁵¹ The allocation "Hyra" diagram (Chart 3) illustrates the point, by identifying some of the allocation-related issues presented once the fundamental issues of trigger and allocation methodology are decided.

CHART 3

THE ALLOCATION HYDRA



Exhaustion: Methods for attaching and eroding insurance policies such as vertical exhaustion (spiking), horizontal exhaustion, and functional exhaustion are subject to a host of legal arguments and rulings by courts. Factual issues regarding exhaustion are often presented and working through them can be time consuming.⁵² Exhaustion is an issue that transcends claims type (longtail and traditional) where the amount of the loss exceeds the first layer of coverage.

Occurrence Issues & Knowledge-Based Defenses: Several occurrence-related issues may be presented in long-tail and traditional claims, spanning such matters as: whether and what constitutes an “accident,” whether multiple, long-term exposures or claims constitute one or many occurrences, and the legal standards for determining these issues.⁵³ Knowledge-based defenses encompass several issues, including: whether the damages or injuries were expected or intended or otherwise non-fortuitous; whether claims are barred by public policy such as California Insurance Code Section

533; and whether fraud, misrepresentation, or non-disclosure voids coverage. When misrepresentation or non-disclosure is involved, an action for rescission may be instituted. In general, insurers have been more successful in prevailing on these issues in environmental claims than in asbestos claims.

Scope & Applications Of Various Exclusions: Rulings on various forms of pollution exclusions, asbestos exclusions, silica exclusions, dust exclusions, owned property exclusions, and a variety of other exclusions have given rise to a proliferating volume of decisions that sometimes conflict across the country and even within a given jurisdiction. The “sudden and accidental” pollution exclusion, generally included in commercial general liability from approximately 1970 to 1985, has been subject to an inordinate number of decisions. Indeed, “sudden and accidental” is one of the most litigated phrases in insurance coverage history. The clause excluded coverage for pollution damages unless the release was “sudden and accidental,” leading to decades of disputes. Insurers generally argue that “sudden” has a temporal requirement, meaning the release must occur abruptly or within a short time span to be excepted from the ambit of the exclusion. Policyholders typically argue that “sudden” is synonymous with “unexpected and unintended,” and even gradual releases should be covered if they were not intended by the insured. Numerous decision support each of these views. Some courts have placed the burden on the policyholder to prove that the release of pollutants was “sudden and accidental” for this exception to the exclusion to apply. The New Jersey Supreme Court put its own imprimatur on the issue using a “regulatory estoppel theory” to resolve the issue, finding that the insurance industry misrepresented the scope of the exclusion to regulators.⁵⁴

The large volume of litigation and inconsistent court decisions on the “sudden and accidental” pollution exclusion resulted in insurers replacing it with “absolute” and “total” pollution exclusions, mostly in and after 1986. These exclusions are plain and undeniably broad

and would bar most disputed pollution claims by their express terms. Some courts, however, have interposed a limitation found nowhere in the language of the exclusions by judicial fiat, ruling that the exclusions bar only “traditional environmental pollution.” Litigation over pollution exclusions has not died out. Indeed, the Illinois Supreme Court was called upon earlier this year to address the issue of whether pollution exclusions apply where the policyholder’s discharges were within the limits of state-issued permits or regulations authorizing emissions. The court held that emission standards are not mentioned in or relevant to the exclusions and compliance with emission requirements does not preclude the application of pollution exclusions.⁵⁵

Owned property exclusions have been a common subject of litigation in environmental coverage actions. The exclusion bars coverage for damage to property owned, occupied, or used by the insured. Some decisions have limited application of the exclusion by ruling groundwater is not owned by the insured or by ruling onsite cleanup of the policyholder’s property is not barred by the exclusion where on-site remediation is performed to prevent imminent off-site damage or migration.

Competing Coverage Claims: Corporate sales, mergers and acquisitions, and assignments of policies and policy rights by companies sometimes produce disputes between a putative insured and an insurer or among entities claiming to be named or additional insured that must be resolved. These issues may arise and be resolved by the corporate documents, in disputes between the companies, or they may spill over into coverage litigation.

“Property Damages” & “Bodily Injury:” Issues concerning whether claims involve “Property Damage” or “Bodily Injury” within the meaning of insurance policies are presented in a wide range of decisions beginning with environmental coverage disputes and continuing to other disputes such as coverage for opioids, lead

paint, and firearms. In environmental coverage actions, a commonly presented issue was whether environmental remedial investigation costs and feasibility study costs constitute “damages.” Other issues, such as whether emotional injuries constitute covered “Bodily Injury,” have been presented. The issue may arise with respect to exclusions. For example, cyber policies commonly exclude claims for “Bodily Injury.”

Insurer Insolvencies & Policyholder Bankruptcies: Issues associated with insurer insolvencies, such as whether or when insurance policies must “drop down” to cover gaps presented by the insolvency of other insurers, have been litigated in various coverage matters. Policyholder bankruptcies involving companies facing mass tort liabilities have added a host of issues that impact rights and obligations of the parties under insurance policies, including issues of acceleration, assignment of insurance rights or policy proceeds, insurance neutrality, and impact on retentions. Asbestos liabilities gave birth to a specific section of the United States Bankruptcy Code (Section 524(g)) and bankruptcy trusts controlled by plaintiffs’ asbestos lawyers managing billions of dollars of what once were policyholder assets and insurance proceeds. Such bankruptcies sometimes present circumstances involving fraud through bankruptcy and the judicial process in asbestos and silicosis claims.⁵⁶ Access to insurance policies by officers and directors is a recurring issue under D&O policies.

Bankruptcy also affords insurers with opportunities to obtain finality through settlements involving channeling injunction protection and policy buybacks free and clear of any rights or interests under Section 363(f) of the Bankruptcy Code. Overall, bankruptcies have separated insurers from billions of dollars. Recently the United States Supreme Court has issued rulings in the context of policyholder bankruptcies that directly and indirectly impact insurers.⁵⁷

Claims-Made Issues: The introduction of “claims-made” and “claims-made and reported” policies has been somewhat successful in limiting insurer exposure to long-tail claims. Claims-made issues include determining what constitutes a “claim,” when a claim is made, how many claims are involved, and “related claims” issues.⁵⁸ Claims-made issues are commonly presented in the context of directors’ and officers’ liability and professional liability coverage disputes, as virtually all of these policies are claims-made policies.

Applicable Limits Of Liability: Numerous decisions have addressed what limits are applicable to claims, including “per occurrence” and “aggregate” limits. For example, after litigation involving asbestos “products” limits spanning decades and billions of dollars, another round of litigation involving coverage for asbestos installation claims proceeded, involving the issue of whether these claims implicated aggregates for products/completed operations. Insurers have added sub-limits applicable to various types of coverages to control risks in recent years.

CHAPTER 7

THE WIDER WORLD OF CONTEMPORARY COVERAGE DISPUTES

There is a wide range of contemporary coverage disputes, including construction defect, traditional property coverage disputes, weather-related and disaster coverage disputes, COVID-19 business interruption litigation, silica, cyber, privacy, and AI, various drugs, chemicals, and toxic torts, and the list goes on. We provide a quick review of a few of these areas involving coverage litigation.

Property Coverage & COVID-19 Business Interruption Litigation: Property insurance coverage suits have addressed such issues as concurrent causation and “anti-concurrent causation” clauses, especially in the context of catastrophe losses. Business interruption coverage has been tested by natural catastrophes and, more recently, pandemic-related shutdowns, with courts largely requiring direct physical loss or damage to support coverage unless policy language provides otherwise.

Comparing the litigation experience of insurers and policyholders in asbestos coverage litigation to their experience in the recent wave of COVID-19 business interruption insurance coverage litigation is instructive. Policyholders enjoyed overwhelming success in asbestos coverage litigation. Insurers’ asbestos-related paid losses have totaled over \$1.8 billion in 2024 alone. Asbestos losses rendered many insurers insolvent, particularly in the 1980s. Asbestos coverage litigation has proceeded in several waves spanning decades. Many of the policies did not contain asbestos-specific exclusions or contained limited exclusions such as “asbestosis exclusions” and prevailing

upon knowledge-based defenses proved elusive. Overall, it is fair to say that insurers have not fared well in asbestos coverage litigation.

By contrast, insurers have experienced overwhelming success in the COVID-19 business interruption coverage litigation. Approximately 2,400 cases were filed in the United States, most of which have been resolved already. No new actions are being filed as the suit limitations period in most first-party “all-risk” and BOP policies usually is one or two years. At one point, insurers prevailed in nearly 70 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 obtained on the grounds that the claims do not involve “direct physical loss or damage” to property as required by the language contained in most first-party policies or based upon the application of virus or other exclusions. Insurers have prevailed in most summary judgment rulings and in most of the few trials held. Insurers have prevailed before every United States Circuit Court of Appeals and in the vast majority of state supreme court and intermediate appellate court decisions. Although policyholders prevailed in a small number of cases and states, it is fair to state that insurers have won the COVID-19 business interruption coverage battle.

There are several distinctions to be drawn between asbestos and COVID-19 coverage litigation. The COVID-19 business interruption litigation involved first-party policies, many of which required “direct physical loss” and contained virus or other applicable exclusions. Insurers did an outstanding job of conveying effectively, early, and often that such claims are not within the intended scope of coverage and in sounding the alarm that improvident rulings to the contrary could threaten the solvency of the industry. Insurers were able to prevail based upon the merits of their coverage positions, even though many courts expressed sympathy for the business policyholders who sustained large losses through no fault of their own. Also, in some

of the early cases, policyholders were not represented by seasoned policyholder counsel.

Privacy, Cyber, & AI Coverage Litigation: Cyber and privacy coverage litigation has emerged in recent years. Most of the litigation and decisions to date involved so-called “silent cyber” claims, claims under traditional liability, property, and crime/fraud policies. Over the past couple of years, coverage disputes under cyber-specific policies have increased, and cyber, privacy, and AI-related coverage cases are expected to increase.

Many exclusions may apply in particular cases. Recording and distribution/statutory violation, access or disclosure (data breach), unlawful collection, and employment-related practices exclusions have sometimes been applied in the context of privacy claims, such as claims under the Illinois Biometric Information Privacy Act. Bodily injury/physical damage, prior acts/known circumstances, wrongful collections, electronic data liability, generative AI (GenAI) output, absolute AI, hallucinations, data poisoning and algorithmic bias, fraud and social engineering, regulatory non-compliance, systemic and catastrophic events, state-sponsored cyber-attack, war, failure to patch, unpatched vulnerability, and other exclusions may apply to bar cyber and AI claims.⁵⁹ The number and variety of underlying AI claims are increasing and are expected to result in more AI coverage actions and decisions.

Climate Change Related Claims: The greatest impact that climate change has had on insurance claims to date has been its impact on the frequency and severity of weather events. Hurricanes, flooding, fires, and other weather events have produced coverage claims and have presented issues of insurer solvency, insurance rates, and availability of insurance.

The first wave of climate change litigation involved decisions on jurisdiction, political question, and regulatory compliance issues that

did not produce significant coverage litigation. Climate change-related claims alleging injury and damage are a subset of environmental claims. Despite all the media attention, climate change activities, and underlying litigation, there have only been two significant reported coverage decisions on insurance coverage for climate change claims.

First, the Virginia Supreme Court held that an insurer had no duty to defend a lawsuit against an energy company that allegedly damaged a village by causing global warming through the emission of greenhouse gases. In *AES*, the court concluded that AES' actions were not an "accident" because climate change was the "natural or probable consequence" of AES' emissions.⁶⁰

Second, the Hawaii Supreme Court determined that insurers had no duty to defend Aloha Petroleum in two climate-change-related cases. The court ruled in favor of the policyholder on the occurrence issue, determining that an "accident" includes a policyholder's reckless conduct. The court distinguished the *AES* case as reflecting a difference in legal standards between Virginia's "natural or probable consequences" standard and Hawaii's "practically certain" test for determining whether there was an "occurrence."⁶¹ The Hawaii Supreme Court ruled in favor of the insurers on the pollution exclusion issue, determining greenhouse gases are "pollutants" as defined in the policies' pollution exclusions, even while applying pro-policyholder positions such as holding pollution exclusions only apply to "traditional" environmental pollution.

Tobacco Coverage Litigation: Tobacco litigation gave rise to large liabilities, but did not impact the insurance industry as drastically as other mass liabilities and only produced one major coverage action. In large measure, this is because most general liability policies issued to tobacco companies contained tobacco exclusions, tobacco companies did not want insurers involved in defending them, and most tobacco companies did not vigorously pursue coverage. Coverage was hard-fought, however, in *Liggett Group Inc. v. Ace Prop. & Cas. Ins. Co.*⁶²

The Delaware Supreme Court determined there was no coverage under more than 100 liability policies issued by thirty-three insurers from 1970 through 2000.⁶³ The Delaware Supreme Court ruled that coverage was barred by tobacco exclusions contained in the policies.

The Return Of Silica Coverage Litigation: Silica-related claims actually preceded asbestos claims in some instances and have continued over time. Silica-related coverage claims have resurged in recent years due to a variety of factors, including the popularity of engineered stone (a man-made material composed primarily of crushed natural stone combined with a polymer resin binder and pigments) for kitchen and bath countertops over the last two decades. This engineered stone contains a higher content of respirable crystalline silica (which can cause silicosis) compared to natural stone. Following a \$52 million verdict awarded to a stone fabricator by a Los Angeles jury in the *Reyes-Gonzalez* case, hundreds of cases were filed in California.

Multiple silica-related coverage actions have been filed recently. These coverage claims may implicate several issues, including: trigger, allocation, number of occurrences, absence of an occurrence, fortuity, other knowledge-based defenses, and the application of several exclusions, including silica or silica-related dust exclusions, other dust exclusions, silicosis exclusions, and pollution exclusions. In *Hanover Am. Ins. Co. v. Francini, Inc.*,⁶⁴ insurers filed a declaratory judgment action against their insured, a stone importer and distributor, seeking a determination that they had no duty to defend or indemnify Francini in connection with 17 state lawsuits filed against them and others between 2021 and 2023. The underlying plaintiffs allegedly suffered from silicosis and other conditions due to their exposure to silica and silica-related dust while working with the defendants' products. The court determined that the claims fell squarely within the scope of the silica exclusion. The exclusion provides that the policies do not apply to bodily injuries arising "in whole or in part, out of the actual, alleged, threatened or suspected inhalation of, or

ingestion of, ‘silica’ or ‘silica-related dust.’” The court did not have occasion to consider the application of the pollution exclusion. The court granted the insurers’ judgment on the pleadings. Although the court stated it was skeptical that Francini could amend its answer to cure the deficiencies, it nonetheless granted leave to amend. In *Sompo Am. Ins. Co. v. LX Hausys Am. Inc.*,⁶⁵ however, the court denied an insurer’s motion to dismiss based on silica dust exclusion. The court reasoned that an insurer cannot avoid its duty to defend where an insured risk and excluded risk are alleged to constitute concurrent proximate causes of the underlying bodily injuries.

This litigation can perhaps best be described by the phrase everything old is new again.

Construction Defect Litigation: Coverage for construction defect and water intrusion claims continues apace. Whether defective construction constitutes an “occurrence,” the scope of “insured contract,” “your work,” and “your product” exclusions, and “additional insureds” issues remain commonly litigated issues in construction defect and water intrusion matters. Allocation and priority of coverage issues are also commonly presented.

Both federal and state courts issued significant rulings regarding construction defect claims. The Oregon Supreme Court in *Twiggs v. Admiral Ins. Co.*, for example, reversed lower court rulings that had denied coverage for construction defect claims under a CGL policy.⁶⁶ The insurer denied coverage for defective garage floor construction, arguing the claims arose solely from breach-of-contract obligations. The court held that coverage may exist even when framed as contract claims if the underlying facts support tort liability and property damage caused by negligent workmanship.

The United States Court of Appeals for the Eighth Circuit addressed builder’s risk coverage in *Bob Robison Commercial Flooring Inc. v. RLI Ins. Co.*,⁶⁷ where the insured subcontractor installed a gym floor

with painted lines that were defective. The insurer denied coverage, citing the defective workmanship exclusion. The policyholder argued that the “ensuing loss” provision restored coverage. The court disagreed, holding that the ensuing loss clause did not apply because no separate covered peril caused the damage, underscoring the concept that builder’s risk policies will not cover costs of correcting faulty workmanship absent a distinct covered peril.

A couple of years ago, in *Acuity v. M/I Homes of Chicago, LLC*,⁶⁸ the Illinois Supreme Court ruled that inadvertent construction defects causing property damage can constitute an “occurrence” and “property damage” under commercial general liability policies. The court held that negligent or faulty work that is not intended, anticipated, or expected constitutes an “accident,” which qualifies as an “occurrence,” and that water damage to the interior of units caused by faulty construction qualifies as “property damage,” even where the damage is limited to the project itself. The court remanded the case to determine whether any business risk exclusion, such as the “your work” exclusion, barred coverage. An Illinois Appellate Court affirmed a trial court’s grant of summary judgment in favor of a general contractor’s insurer and against the subcontractor’s insurer, holding that a worker’s injury potentially “arose out of” the subcontractor’s ongoing operations and noted that it is a low threshold to implicate an insurer’s duty to defend. The court rejected the late-notice argument of the subcontractor’s insurer, finding it had early knowledge of the worker’s injury and had already denied coverage before suit was even filed. The court noted that the underlying complaint inherently implied negligence by the subcontractor, creating a potential for coverage.⁶⁹

A decision of the United States Court of Appeals for the Eighth Circuit stands as a reminder that coverage for an “additional insured” is not necessarily coextensive with the coverage afforded to a “named insured.” The court affirmed the grant of summary judgment to the insurer, holding that the additional insured contractor was not

covered for its alleged losses of rental income and soft costs from damages and delays resulting from the failure of a retaining wall. The court noted that an additional named insured does not necessarily have the same rights and responsibilities as the named insured, and the coverage sought here only extended to the named insured.⁷⁰

These are a small sampling of a wide-range of decisions rendered in construction defect coverage cases. The rising costs of construction and replacement have imposed challenges in claims handling and underwriting.

CHAPTER 8

AMERICA'S CONTRIBUTIONS TO INSURANCE LAW

Apart from litigation American style, there are a couple of major contributions to the world of insurance coverage that are uniquely (or at least mostly) American. The first is the duty to defend. The second is insurer bad faith and extracontractual liability. The third is social inflation, which has only recently impacted a few other countries, and only to a far lesser extent than in America.

THE DUTY TO DEFEND

Although the duty to defend also exists under Canadian law, it is most robustly established and closely associated with the United States. Outside of the United States and Canada, liability insurers in other countries generally do not recognize a duty to defend. It is common in other countries for insurers to indemnify policyholders for defense costs under some circumstances, as it is in the United States. The duty to defend presents numerous issues, which have been extensively litigated in the United States in traditional and long-tail claims alike.

Many primary policies – commercial general liability policies – provide the insurer with the right and duty to defend. By contrast, most excess insurers do not have a duty to defend. In most states, absent an express undertaking to defend, an excess insurer has no duty to defend, though it usually has the right to associate in the defense. In a minority of jurisdictions, a duty to defend exists unless the insurance contract expressly negates a duty to defend. Accordingly, many excess policies provide that the insurer does not assume charge of the defense.

The standard for determining whether an insurer has a duty to defend has been presented in cases pre-dating long-tail coverage litigation. Generally, the duty to defend is deemed to be broader than the duty to indemnify under the “potential” for coverage standard. Most jurisdictions make the determination as to whether there is a duty to defend under the “four corners” or “eight corners” rule, in which the allegations of the underlying complaint are compared against the insurance policy to determine whether there is a “potential” for coverage. The circumstances under which information not contained in the policy or underlying complaint may or must be considered in determining whether an insurer has a duty to defend (extrinsic evidence) vary considerably from state to state.

The duty to defend generally is limited to defending “suits.” The determination of what constitutes a “suit,” and whether insurers are required to defend something other than a lawsuit, such as an administrative hearing, a demand letter, or potentially responsible party letter from the United States Environmental Protection Agency or a state environmental authority, has been considered by multiple decisions in many states. In pre-1986 commercial general liability policies, the term “suit” is not defined, leading to extensive litigation. The commercial general liability form was revised in 1986 to define “suit” as a formal “civil proceeding” (a lawsuit), or specific arbitration or other alternative dispute resolution proceedings to which the insurer consents.” This change was aimed at eliminating disputes over the meaning of “suit” and emphasizing that the duty to defend generally is limited to defending lawsuits.

When the duty to defend begins and ends varies considerably from state to state. In some states, the duty to defend begins when the underlying complaint is tendered by the policyholder to the insurer for defense. In other states, it may be when the insurer receives notice or tender by another party. Depending upon the state and policy language, the duty to defend ends upon exhaustion of limits, resolution of all potentially covered claims, obtaining a declaratory judgment, or

the resolution of all appeals. Policies usually specify that the duty to defend ends when the applicable policy limits have been used up in the payment of judgments or settlements. Absent specific language authorizing the practice, most courts have prevented insurers from escaping their defense obligation by unilaterally tendering the policy limits into court without the policyholder's consent. The majority of decisions to consider the issue have disapproved the practice of "cutting and running" and have found that the duty to defend continues until the case is fully resolved by settlement or judgment. Some policies, however, expressly provide for terminating the duty to defend by posting or interpleading limits or otherwise.

An insurer's obligation to defend generally extends to defending the entire lawsuit, even where only some of the facts alleged, the counts asserted, or relief sought in the underlying complaint are potentially covered (mixed claims), and is well-established under the "complete defense" rule.

The issue of whether and when an insured may select its own defense counsel to be paid by the insurer (independent counsel) has been widely litigated. Under some circumstances and in some states, where the interests of the insurer and the policyholder are "conflicting," the right and duty to defend may be transformed into an obligation of the insurer to pay defense costs of counsel selected by the insured, sometimes referred to as "independent," "*Cumis*," or "*Peppers*" counsel. Numerous decisions across the country reached varying decisions on when and whether an insurer is entitled to independent counsel, who may select such counsel, the rates paid to such counsel, and the rights retained by insurers under such circumstances. Some states have enacted legislation governing some of these issues.

Another issue subject to extensive litigation is whether an insurer may recoup from the insured the costs of defense attributable to claims that are not potentially covered in the absence of an express contract provision providing for recoupment by unilaterally reserving

the right to reimbursement. The issue has been subject to conflicting decisions throughout the country, with a slight majority favoring insurers' rights of reimbursement. The issue is largely historical as many contemporary policies contain provisions or endorsements expressly providing for recoupment.

An additional issue commonly presented is whether an insurer has an obligation to reimburse its policyholder for defense costs incurred by the policyholder prior to the time that it placed the insurer on notice of the claim. Many decisions have held that there is no coverage for "pre-tender" costs.

The consequences of a breach of the duty to defend vary considerably from state to state and depend upon the circumstances. These consequences may include: breach of contract damages (the costs of defense), liability for the amount of the underlying judgment up to the amount of policy limits, insurers being estopped from asserting some or all coverage defenses, the loss of the ability of insurers to enforce some policy conditions, insurers being bound to the underlying litigation results or having the ability to challenge settlements limited.

Many environmental coverage actions have presented the issue of whether environmental investigation and feasibility costs constitute defense or indemnity costs. There are decisions applying different standards, and some states have statutes or regulations addressing the issue.

INSURER BAD FAITH & EXTRACTIONAL LIABILITY

Another of America's unique contributions to insurance law is bad faith and extracontractual liability. Legislatures in many states have entered the picture with consumer fraud laws and unfair settlement practices statutes. Bad faith is a misnomer and actually refers to

a breach of the implied covenant of good faith and fair dealing. Extracontractual liability is a broader umbrella term that refers to liability that falls outside the terms and limits of the insurance contract. It may include statutory penalties, attorney's fees, and damages from violation of consumer fraud statutes, consumer protection statutes, or insurance codes that impose penalties for "unreasonable and vexatious" conduct (in many states, violations of insurance code provisions do not give rise to a private cause of action), breach of fiduciary duty, fraud, conspiracy, or market conduct.

The existence, basis, and remedies for bad faith vary considerably from state to state as do the standards and available defenses. In some states, insurers do not face substantial exposure to bad faith liability. In other states, bad faith exposures and damages can be substantial. Tort law, insurance coverage law, and bad faith law are not static. Accordingly, it is important to keep apprised of changes in law and trends and to consider the claim-specific facts and governing law.

The doctrine of insurance bad faith emerged in American jurisprudence during the mid-twentieth century as some courts recognized that the traditional contract remedy of expectation damages was inadequate to address the unique nature of the insurer-insured relationship. Prior to this development, policyholders who were wrongfully denied coverage were limited to recovering only the policy benefits owed, which some courts believed provided little incentive for insurers to handle claims fairly and promptly. The seminal case of *Comunale v. Traders & General Ins. Co.*, decided by the California Supreme Court in 1958⁷¹ marked a turning point by recognizing that every insurance contract contains an implied covenant of good faith and fair dealing, the breach of which could give rise to tort liability. This decision acknowledged the inherent imbalance of power between insurers and policyholders and the quasi-fiduciary nature of the insurance relationship, setting the stage for the widespread development of bad faith jurisprudence across American jurisdictions. Following

Comunale, the doctrine expanded in some states throughout the 1960s and 1970s.

Courts distinguish between first-party and third-party bad faith claims. Third-party bad faith – which arises in the liability insurance context where an insurer fails to reasonably settle claims against its insured within policy limits – was the initial focus of judicial development. The original concern was that an insurer could roll the dice in a “heads the insurer wins, tails the policyholder loses” scenario. In other words, if the insurer refuses to settle and the judgment turns out to be for less than policy limits, the insurer saves part of its limits. If, on the other hand, the judgment is greater than the applicable limits, the insurer would not be responsible for the amount of the judgment in excess of policy limits. Some courts held that insurers owe a duty to give equal consideration to the interests of their policyholders when evaluating settlement opportunities, and failure to do so could expose insurers to liability for excess judgments. In some states, an insurer is required to make the settlement determination based upon an evaluation of the policyholder’s liability and the amount of damages likely to be awarded without taking coverage defense into account.⁷²

First-party bad faith, involving an insurer’s unreasonable denial or delay of benefits owed directly to its policyholder, gained traction shortly thereafter, with the California Supreme Court’s 1979 decision in *Gruenberg v. Aetna Ins. Co.*⁷³ holding that insurers could be held liable in tort for the unreasonable handling of first-party claims.

The coin, however, has flipped. The high costs of defense make it much more unlikely that an insurer will benefit from refusing to settle on reasonable terms. Given the way that the law has devolved, too often claimants receive windfalls and recover more than the inherent value of their claims or the damages actually sustained. Further, a wedge between the insurer and policyholder often is created by obliterating the cooperation of the policyholder in defending claims and creating

competing interests between the insurer and the policyholder, which is in contravention of a major predicate of liability insurance – that the policyholder and insurer have a common interest and will work together to defeat liability and minimize the amount paid on claims. The availability of enhanced damages in some instances actually incentivizes policyholders to assert bad faith claims (many of which utterly lack merit), which increases the cost of insurance, complicates and lengthens litigation, increases litigation costs, and fuels social inflation.

Bad faith law expanded further in the 1980s and 1990s, when courts in some jurisdictions permitted the recovery of consequential damages, emotional distress damages, and punitive damages against insurers found to have acted in bad faith. Additional theories of bad faith have emerged, such as “institutional bad faith,” in which policyholders seek broad-ranging discovery fishing for insurers’ pattern and practice in matters other than the specific claim in dispute. Bad faith failure to defend has been recognized in a small minority of jurisdictions. Although a finding of bad faith generally implicates issues of fact, a couple of decisions have ruled that an insurer committed bad faith as a matter of law.

There are a number of defenses to bad faith claims generally available to insurers. In some states, the policyholder must provide notice of alleged grounds for bad faith or violations of statutory requirements, and insurers are afforded a period to cure or re-evaluate their decisions. In most jurisdictions and for most cases, an insurer cannot be subject to bad faith liability where the policyholder has failed to establish the existence of coverage. However, some jurisdictions have permitted policyholders to pursue bad faith claims in the absence of coverage under some theories, such as failure to properly investigate the claim or violation of some statutory requirements.

Generally, merely being wrong or losing on coverage alone should not subject an insurer to bad faith damages. The standard is articulated

differently, such as the issue being “fairly debatable,” or the insurer’s position being “reasonable.” Under the genuine dispute doctrine, an insurer cannot be held liable when it adopts an objectively reasonable, albeit erroneous, interpretation of its policy or a statutory provision.⁷⁴

Punitive damages are potentially recoverable in some jurisdictions. Generally, mere unreasonableness or negligence is not enough to impose punitive damages. There must be proof of aggravated conduct such as malice (despicable conduct, willful and conscious disregard of the policyholder’s rights), oppression, or fraud. A policyholder must have sustained actual damages to recover punitive damages. Punitive awards generally are discretionary, not automatic or a matter of entitlement.

Many states interpose statutory and constitutional limits or caps on punitive awards. Punitive damages implicate United States constitutional protections and limitations. Proof by clear and convincing evidence and *de novo* review by the appellate court are required. *Cooper Industries v Leatherman Tool*, 532 U.S. 424 (2001). As a matter of United States Constitutional law, in reviewing a punitive award, a court must consider three “guideposts:” “the degree of reprehensibility of the defendant’s misconduct;” the “disparity between the ... harm suffered by plaintiff and the punitive damages award;” and “the difference between the punitive damages awarded [and any applicable civil penalties] imposed in comparable cases.” *State Farm Mut. Auto. Ins. Co. v Campbell*, 538 U.S. 408 (2003); *BMW of North America, Inc. v Gore* (1996) *BMW of North American, Inc. v Gore*, 517 U.S. 559 (1996). See also *Philip Morris USA v Williams*, 549 U.S. 346 (2007) (holding that the jury may not punish a defendant for harm caused to individuals other than the plaintiff); *Safeco Ins. Co. of Am. v Burr*, 551 U.S. 47 (2007) (recklessness is “conduct violating an objective standard: action entailing ‘an unjustifiably high risk of harm that is either known or so obvious that it should be known’ where defendant’s analysis of its legal duties, albeit erroneous, was not objectively unreasonable.”).

In some states, a policyholder may be awarded attorneys' fees for seeking insurance policy benefits.

The use and integration of AI in claims handling presents a burgeoning area for bad faith claims by policyholders. Insurers may also face claims for failing to use AI. Balancing claims handling efficiency and accuracy with the need for individualized claim attention will prove important. Accuracy in evaluation and monitoring algorithms will prove beneficial to insurers in connection with avoiding bad faith liabilities and with respect to regulatory compliance in the areas of pricing, underwriting, fraud detection, and claims handling. A primer on the use of AI, AI regulatory compliance, and AI best practices is beyond the scope of this book; however, the following directives will likely serve insurers well:

- transparency in the use of AI;
- accuracy in marketing materials and communications with policyholders;
- adopting internal procedures for review and approval of AI-generated reports and customer messaging;
- avoiding unfairness and bias in decisions; making sure hallucinations are locked out;
- ensuring AI complies with insurance policy terms and regulatory requirements;
- implementing, monitoring, and updating controls and safeguards;
- educating and training personnel;
- reviewing any decisions made by automated processes;
- ensuring that sufficient flexibility exists to consider and respond to facts, circumstances, and developments and to allow claims and underwriting professionals to exercise professional judgment;
- having procedures in place for customers to challenge decisions; and

- ensuring that AI is encompassed within the insurers' culture of excellence.

Insurers are likely to retain responsibility for the actions or inactions of contractors, consultants, and vendors they use, so selection and monitoring of these entities will be important considerations.

Tort reform legislation enacted in various states over the past couple of years has provided insurers with opportunities to limit their exposure to bad faith liabilities.

In Florida, for example, Section 624.1551, enacted in December 2022, will likely reduce specious bad faith claims against property insurers by requiring an adverse adjudication by a court confirming that the insurer breached the insurance contract, followed by a final judgment or decree against the insurer before any extracontractual damages claim may be filed. A bad faith finding is precluded where an insurer tenders the policy limits or the amount demanded within 90 days of receiving notice and supporting evidence and makes clear that negligence does not constitute a basis to impose bad faith liability. Section 624.155(6), enacted in March 2023, allows insurers to interplead insurance funds when faced with competing liability claims that collectively exceed policy limits, providing a mechanism for insurers to reduce the risk of being held liable beyond the available policy limits. In December 2025, Florida Insurance Commissioner Michael Yaworsky reported that overall litigation is down about 30 percent since lawmakers approved the property insurance reforms in late 2022 and 2023, though still higher than in other states.

In Louisiana, La. R.S. Section 22.1892(I) provides that an insured may seek to hold an insurer liable for "any proven economic damages sustained as a result of the breach" or for immovable property claims, penalties in an amount not to exceed fifty percent of the damages sustained or \$5,000, whichever is greater. Such penalties are in addition to any amounts actually incurred due to the breach and the

resulting attorneys' fees and costs. Penalties from an insurer's failure to pay in a timely manner will be awarded where it is found to be arbitrary, capricious, or without probable cause. An insured may seek up to 50 percent damages on the amount found to be due from the insurer, plus any proven economic damages sustained as a result of the breach or \$1,000, whichever is greater. Where partial payment or tender was made previously, an insured may only be entitled to 50 percent of the difference between the amount paid and the amount found due, plus reasonable attorneys' fees and costs, and any proven economic damages sustained as a result of the breach.

The Louisiana amendments create a "reverse bad faith" provision, imposing a requirement on insureds and their representatives to exercise the duty of good faith and fair dealing in submitting coverage claims. Although an independent cause of action is not created, insurers may use this as an affirmative defense that may be considered by a jury when considering whether to impose penalties on the insurer for breaching its duty to the insured. Failure to comply with affirmative contractual duties, misrepresenting pertinent facts or policy provisions, and submitting estimates or claims for damages that lack a basis for coverage or evidentiary support constitute grounds for a "reverse bad faith" claim. The Act creates a new 60-day "Cure Period Notice" for insurers, which applies to catastrophic loss claims involving immovable property. Claimants are precluded from filing bad faith claims arising out of catastrophic losses without first complying with a Cure Period Notice.

In 2024, Georgia amended its "Bad Faith Failure-to-Settle" statute, clarifying the structure of time-limited settlement demands: what "material terms" mean, how insurers should respond, and when they can avoid bad faith. In Montana, S.B. 236 (2023) requires that time-limited settlement demand letters reasonably describe the claim, allow 60 days for acceptance by the insurer, and also requires claimants to provide reasonable records and information to insurers; emphasizing the need for timely, reasonable claims settlement. S.B.

165 restricts certain third-party (common law) bad faith causes of action.

California added a statutory framework (CA Civ. Pro. Code Section 999) for time-limited demands. It requires demands to be in writing, remain open for a minimum time period of 30 or 33 days, depending on how the demand was delivered, include material terms, including the release to be provided, information about the injuries sustained, and the amount demanded, along with reasonable proof. If a demand fails to substantially comply with these requirements, it generally will not constitute a “reasonable” offer for a bad faith lawsuit.

Numerous decisions have been rendered on bad-faith claims in 2025. For example, the Indiana Supreme Court held that an insurer did not breach the duty of good faith and fair dealing when it rejected a time-limited settlement demand by one claimant and filed an interpleader of policy funds naming all claimants.⁷⁵ A Montana federal court denied a professional liability insurer’s motion for summary judgment, finding that questions of fact existed for the jury to decide a bad faith claim seeking punitive damages brought by a doctor alleging the insurer allowed a malpractice case to proceed even though it estimated less than a 10 percent chance of defeating the claim. The malpractice case ultimately settled at mediation.⁷⁶ The U.S. Court of Appeals for the Fifth Circuit affirmed the dismissal of a bad faith claim without leave to appeal where the complaint contained conclusory allegations that the insurer failed to “thoroughly investigate” the property damage and pay the requested amounts without containing specific factual allegations to support the claim.⁷⁷

A breach of fiduciary duty claim based on allegations that the insurer undervalued the loss was dismissed on the grounds that it was duplicative of the bad faith claim, and Washington courts have not yet recognized a breach of fiduciary duty as an independent claim in the context of insurance.⁷⁸ A Pennsylvania court granted an insurer’s motion to dismiss parts of a complaint, relying on the

insurer's litigation conduct by allegedly violating discovery and making a misrepresentation in a discovery report narrative. An insurer's litigation conduct can be evidence of bad faith only where "the insurer is intentionally avoiding its obligation under a policy or is undermining the truth-finding process and where the conduct involves the insurer in its capacity as an insurance company, not as a legal adversary."⁷⁹ An insurer was entitled to summary judgment, determining the insurer's election to proceed with appraisal did not constitute grounds for a bad-faith claim because the policy expressly provided for appraisal, which the insured agreed to contractually.⁸⁰

In California, an insurer was granted summary judgment on a bad faith claim alleging the insurer failed to conduct a reasonable investigation by not contacting any of the insured's major customers to discuss projected sales when determining the amount of covered business income loss. The court determined the insurer's reliance on a forensic accounting expert's opinion provided the insurer with a reasonable basis for its determination of the amount of loss.⁸¹ The U.S. Court of Appeals for the Ninth Circuit affirmed summary judgment awarded to an insurer on a bad faith claim for failure to settle within policy limits due to the claimants' failure to provide medical records in response to ten requests from the insurer.⁸²

A California intermediate appellate court held that the trial court erred in finding a title insurer was not liable for bad faith breach of its duty to defend an easement claim because the complexity of the underlying factual and legal issues did not excuse breach of the duty to assess the possibility of coverage fairly and in good faith based on the available facts. The appellate court found that the genuine dispute doctrine, which generally holds that an insurer does not act in bad faith when it mistakenly withholds policy benefits if there is a reasonable basis for the withholding or legitimate dispute regarding the insurer's liability, was incompatible with the principles governing third-party duty to defend where the mere possibility of coverage triggers the duty. It may be that this decision is incompatible with

long-standing California law on the genuine dispute doctrine. The court correctly found the evidence failed to establish the heightened culpability necessary to support an award of punitive damages as a matter of law.⁸³

The U.S. Court of Appeals for the Eleventh Circuit affirmed the district court's order granting summary judgment for an insurer, holding that under the totality of the circumstances, the insurer did not act in bad faith in its handling of an auto accident claim with multiple claimants as a matter of Florida law. A two-week delay in reviewing the police report was not bad faith. Further, the insurer was entitled to conduct a reasonable evaluation before making a settlement offer in light of conflicting opinions on liability. By withholding distribution of the policy limits until a global settlement conference, the insurer acted in its policyholder's best interests by minimizing the magnitude of possible excess judgments against the policyholder.⁸⁴ A Florida Court of Appeal reversed a jury verdict in favor of the insured, holding that the trial court improperly admitted irrelevant and unduly prejudicial evidence of claims handling in an action that only alleged breach of contract. The evidence included a public adjuster's remarks that the insurer "dropped the ball" and "did not take [the claim] seriously" and repeated arguments by the insured's counsel that "there was no investigation." Because this theme permeated the trial, the court concluded that the admission of such evidence and arguments constituted reversible error rather than harmless error.⁸⁵

Insurer bad faith has been an area presenting numerous challenges to insurers and will continue to evolve, presenting insurers with challenges and opportunities to reduce exposures. Overall, increasing bad faith exposures impact insurer claims handling costs and practices, increase the costs of claims handling, which are passed on to policyholders and consumers, and adversely impact the availability and costs of insurance. Increasing extra-contractual exposures fuel social inflation.

SOCIAL INFLATION

The phrase “social inflation” has been re-trending in the insurance industry in recent years. The phrase generally refers to the increasing costs of insurance claims (defense and indemnity) resulting from societal trends such as litigious proclivities, large defense costs, nuclear and thermonuclear jury awards, broad insurance policy interpretation, and a plaintiff-friendly and policyholder-friendly environment. *The Wall Street Journal* described social inflation in insurance industry parlance as referring to: an upward creep in perceptions by an injured party of what they are owed, their willingness to pursue that via the legal system, and what that means for insurance policies covering companies’ liabilities.⁸⁶ Another way to define social inflation is the amount by which claim costs are rising above the rate of general economic inflation.⁸⁷

Social inflation is a concept that dates back to at least the late 1970s (although, as mentioned above, in some instances, long before). It has been the dynamic driving tort reform efforts by the defense bar and insurers spanning decades. In 1977, Warren Buffet referred to social inflation as “a broadening definition by society and juries of what is covered by insurance.” Yet, many aspects of social inflation are new and evolving, fueled by more recent developments such as litigation funding, social media, and modern attitudes.

The Causes & Costs Of Social Inflation: The first aspect of social inflation involves abuses in the tort system, which impact both corporate policyholders and insurers. Corporate policyholders feel the effects insofar as they are subjected to large verdicts and defense costs for which they are self-insured, and to some extent in the form of higher insurance premiums and costs of doing business. Insofar as insurers are required to provide a defense and/or indemnify under policies issued to businesses and other entities, the impact of social inflation directed to their policyholders is also visited upon insurers. Accordingly, as to this component of social inflation, the interests

of corporate policyholders and insurers generally are aligned. Many of the means to controlling this aspect of social inflation—such as damage limitations, tort reform, requiring full disclosure with respect to litigation funding, and dialing down the abuses in the tort system—may be best achieved through cooperative efforts of the defense bar, businesses, and insurers.

There are a myriad of underpinnings in the United States civil justice system that foster social inflation, including: an organized, well-funded plaintiffs' bar; the availability of punitive/exemplary damage awards; class action and multidistrict litigation; securities and shareholder derivative litigation; the availability of juries in civil actions; a system of state and federal law with differing procedural rules, substantive laws, standards, and available damages and other relief; extensive pretrial discovery and disclosures (including interrogatories, document requests, requests for admission, physical and medical examinations, depositions of fact witnesses, corporate representative witnesses, and experts witnesses); the use of contingent fees in bodily injury cases; the American Rule on attorney fees (which generally works against corporate defendants); fee-shifting statutes that, where applicable, usually benefit policyholders and some underlying claimants; junk science and lax evidentiary standards; forum shopping and carpetbagger claims; the disparate impact of *res judicata* and collateral estoppel against corporate defendants; increased regulatory requirements that either provide for private causes of action or create litigation generating publicity or evidence; and plaintiffs acting as private attorneys general.

Modern trends impacting liability and social inflation include: litigation funding; hamstrung defense – giving up traditional defense advantages; defendants have surrendered their traditional budgetary/leverage advantage; attorney advertising; lawyering up; increasing anti-corporate/anti-insurer sentiment; political discourse and views impacting mindset of jurors; beliefs over facts; reptilian strategy has been effectively employed by plaintiffs' bar; impact of informational

age and jury nullification; increased number and amount of nuclear verdicts and normalization of large awards; expanded liability and disappearing defenses (*e.g.*, disappearing statutes of limitations on sexual misconduct claims, emergence of public nuisance super tort); aggressive governmental action (*e.g.*, acting in concert with plaintiffs' bar in civil litigation); technology, social media, internet have an impact on many levels; ability to pay merging into liability; punishment invading compensatory damages; ESG/Sustainability; younger jurors favoring social justice and redistribution of wealth; jurors not following jury instructions.

Insurers face a double whammy from social inflation. The second aspect of social inflation is aimed directly at insurers. This facet includes expansive reading of policy coverage and pro-policyholder rulings by courts in coverage litigation, shifting of policyholder attorney fees to insurers in coverage litigation, rising independent counsel fees, policyholder aggressiveness in seeking independent counsel, increased bad faith and extra-contractual damage awards, use of time-limited demands, efforts to hold adjusters personally liable, and consumer protection and unfair claims handling statutes. With respect to this component of social inflation, the interests of corporate policyholders and insurers usually diverge.

The impact of social inflation has undoubtedly been felt most heavily in the United States due to our civil justice system. Other countries, such as Australia, Canada, and the United Kingdom, have experienced social inflation, but to a much lesser extent. In February 2024, Morgan Stanley estimated that social inflation caused \$13.3 to \$24.5 billion of excess losses on commercial auto liability from 2013-2022, accounting for 7 to 14 percent of total commercial auto losses and \$27 to \$44.1 billion in general liability losses from 2014 to 2023, accounting for 6.5 to 10.6 percent of industry general liability losses.⁸⁸

We have previously discussed the scourge of social inflation in depth.⁸⁹ Social inflation continues largely unabated, with nuclear

and thermonuclear verdicts raining down. A 2025 behavioral social inflation study by Swiss Re amply summarizes the state of social inflation in the U.S.⁹⁰ The study confirms that juror sentiment has shifted decisively toward plaintiffs, adversely impacting insurers and companies. For example, only 56 percent of respondents indicated that there are too many lawsuits in the U.S. (as compared to 90 percent in 2016), 76 percent of respondents stated that damages awarded in lawsuits are either too low or just right (up from 58 percent in 2016), and 85 percent of respondents agreed that large corporations prioritize profit over safety, demonstrating the success of plaintiffs' reptilian tactics, the susceptibility of jurors to these tactics, or both. Only about half of the respondents expressed the profit over safety sentiment regarding small and medium-sized enterprises. Support for punitive damage awards appeared strong, with 79 percent agreeing punitive damages are the best way to deter misconduct by large corporations and 67 percent supporting punitive damage awards against smaller companies. Other studies have shown that punishment has bled into compensatory damage awards. Injury severity was said to be a stronger driver of verdict behavior than company size. Reptilian tactics are designed to make jurors focus on broad safety concerns rather than on whether the defendant is actually at fault.

In the Swiss Re study, self-identified Democrat respondents selected award amounts that were 25 percent to 65 percent higher than those proposed by Republicans, with the gap widening at higher plaintiff anchors. Independent respondents fell between the two groups in terms of award size, but showed less enthusiasm than Democrat respondents for aggressive legal action and large punitive awards. Younger respondents (particularly those under 40) were more plaintiff-oriented than older respondents (*e.g.*, 83 percent of participants under 40 stated that current damages are too low or just right, compared to just 41 percent of those over 60). As younger people make up a larger share of jury pools, this generational divide may contribute to a sustained increase in large awards. Lower-income respondents favored broader corporate accountability and were more likely to

support legal action. Though not addressed in the study, it may be posited that a younger judiciary could also potentially fuel social inflation as improvident legal and evidentiary rulings contribute to nuclear verdicts and increase litigation costs.

Insurers and corporate policyholders are being outspent substantially by the plaintiffs' bar, which has averaged about \$1.5 billion a year in advertising. Plaintiff trial lawyers spent approximately \$6.8 billion on advertising from 2017 to 2021.⁹¹ The plaintiffs' bar is doing a much stronger job in messaging as well. Insurers, companies, and the defense bar must do a far better and more sustained job in educating the public on how these litigation dynamics impact the availability and affordability of coverage and products. In the courtroom, addressing damages and counter-anchoring by defendants is essential. Ambulance chasing has become more pronounced and sophisticated, with Sedgwick reporting that 64 percent of general liability and 75 percent of auto liability claimants have legal representation within two weeks of claim assignment.

It is difficult to monetize the costs of social inflation with precision as there are various reports. Tort costs have increased at an annual increase of 7.1 percent, more than twice the inflation rate from 2016 to 2022. The United States Chamber of Commerce reported tort costs in 2020 in the United States were \$445 billion or 2.1 percent of gross domestic product. From 1916 to 2020 the direct costs of the tort system grew at 6 percent per year exceeding inflation which averaged 1.9 percent per year. Some estimates suggest tort costs equate to more than \$3,621 per household (with considerable variation among states). The Consumer Price Index rose 10.5 percent from 2017-2021, while property and casualty incurred losses increased more than 57 percent during the same period. A recent article in the *Boston Globe* reports that "excessive litigation" retracts the U.S. economy by up to \$500 billion a year. It is clear that social inflation exacts a high cost.

According to a 2025 Marathon Strategies report, nuclear verdicts rose by 52 percent and thermonuclear verdicts increased 81.4 percent in 2024, with the median mega verdict amount increasing by 15.9 percent, pushing the average to \$51 million. Texas, California, Pennsylvania, Florida, New York, and Delaware lead the way with an increasing percentage of nuclear verdicts taking place in federal courts.⁹² The costs of defense have risen as well. A Thomson Reuters survey showed that defense firm rates rose by 6 percent in 2023 and 6.5 percent in 2024.⁹³

Meanwhile, the troubling practice of policyholders seeking to hold adjusters personally liable continues. Whether done to destroy diversity jurisdiction, intimidate adjusters, sow division between insurers and their employees, gain litigation leverage, or expand recovery, these tactics are improper and should be vigorously opposed by insurers. In one case, insureds sued their homeowners insurer and an individual adjuster in state court for breach of contract, fraud, and bad faith, and the insurers removed the case to federal court, contending the adjuster was fraudulently joined to defeat diversity. The court disagreed, ruling that plaintiffs alleged a colorable claim of fraud and stating the fraudulent joinder standard is higher than the Rule 12(b)(6) dismissal standard and remanded the case to state court.⁹⁴

There are a couple of small rays of light in combating social inflation. First, as detailed above, recent tort reform legislation in states such as Florida, Georgia, and Louisiana has shown early signs of effectiveness.⁹⁵ Sustained tort reform efforts are required. Second, Bloomberg reports that the litigation finance industry is facing challenges as funds and other sources of capital are pulling back, causing some litigation finance firms to suspend fundraising rounds and explore alternatives for generating cash. They cite regulatory changes, lower payouts, and longer trial times. Litigation disclosure efforts may be helpful, but efforts to revive legislation that would levy a 41 percent tax on the industry's profits seem to be sending chills

through the litigation funding industry. The commercial litigation finance industry retracted by 16 percent in 2024 according to this report, resulting in a market that was nearly 30 percent smaller than levels reached in 2022.⁹⁶ Time will tell if this report is accurate and whether the level of litigation funding will continue to change. Finally, ISO has approved an endorsement requiring disclosure of litigation funding for inclusion as a policy condition.⁹⁷

The use and surge of third-party litigation funding in recent years has been a boon for plaintiffs' counsel. Litigation funding has increased the volume of cases that are being pursued. It has enhanced the ability of plaintiffs to take cases further and pursue larger recoveries – extending the litigation timeline, increasing the costs of defense, and increasing the potential for larger verdicts and settlements. It has enabled plaintiffs to invest in experts, research, studies, and other weapons to deploy against defendants. Litigation funding presents numerous challenges to defendants and courts, including compromising lawyers' ethical duties, contributing to mass filings of speculative or unsupported tort claims, making settlements more difficult and costly to achieve, undermining companies, and creating a possible path for theft of trade secrets and disclosure of sensitive information.

Because of the larger awards associated with compelling cases, litigation funders can justify a greater investment of funds, thus allowing creative plaintiffs' lawyers to run wild in civil litigation. According to the CEO of one litigation funder, “[o]n an average basis, we’ll largely double our money . . . [w]e’re right about 90% of the time”⁹⁸ Not only are compelling cases likely to result in larger awards, but the disposition costs of mediocre cases have also increased as plaintiffs' lawyers invoke cost-intensive discovery. With the proliferation of nuclear verdicts discussed below, funders view litigation funding as a good investment, providing a high rate of return. Although litigation funding generally covers attorneys' fees

and costs, it has broader uses, including providing operating capital for business parties during litigation.

The American Tort Reform Foundation, in its 2024-25 “Judicial Hellholes” report, notes that outside money flowing into U.S. litigation is growing exponentially, with more than \$15 billion invested in United States litigation in 2023 from 39 active funders.⁹⁹ In the mass tort context, the “funding provided to individual law firms now regularly exceeds \$50 million,” and at least one plaintiffs’ law firm has received “\$250 million in funding.”¹⁰⁰ Litigation funding has transformed lawsuits into investment vehicles.

Litigation funding was once widely prohibited by the legal doctrine of “champerty” or “maintenance,” which generally barred strangers to a lawsuit from funding litigation fees and costs in exchange for a financial interest in the outcome of the case. Litigation funding has gained traction as most states have abandoned or substantially limited their anti-champerty laws over the past couple of decades.

The main focus of the defense bar has been to seek mandatory disclosure of third-party funding. Disclosure of litigation funding is necessary for a variety of reasons. The presence of a litigation funder can prejudice defendants by changing a two-party negotiation into a multi-party settlement with an unknown, undisclosed funding constituent. Disclosure is necessary for defendants to challenge, and judges to assess, potential conflicts of interests, to ensure compliance with ethical rules, to protect the legitimate interests of all litigants, and to prevent or limit mass tort cases that are filed without proper vetting and support (*i.e.*, cases where the claimant did not use the product at issue, did not suffer from the injury that is the focus of the litigation, or the claim is time-barred). Reform directed at litigation funding must be sought on a comprehensive basis. Some advocate for the return of anti-champerty laws, but that ship is unlikely to return to harbor.

While plaintiffs are investing in achieving bigger verdicts and settlements, many corporate defendants and insurers have relinquished to plaintiffs the large budgetary and leverage advantages that defendants historically enjoyed by what appears, at times, to be a myopic focus on limiting defense expenditures. The need to control costs and ensure expenses are reasonable is undeniable. But at times it seems that the pendulum has swung too far, and too much attention has been focused on attorney hourly rates, legal bills, fee audits, and appeals. This focus, at times, has come at the expense of devoting the money and efforts needed to contain swelling indemnity numbers and discourage future litigation.

Apart from contributing to nuclear verdicts, the long-term impact is that defendants and insurers are losing quality legal talent to deploy in personal injury and wrongful death cases. Concerns have been expressed about the ability of defense firms to compete against plaintiff firms and other corporate practice areas for top legal talent. Millennial and Generation Z attorneys appear to be less receptive to being tied to tracking billable hours, complying with litigation and billing guidelines, responding to audits, and “paying their dues” for advancement in law firms than prior generations of attorneys. Rate limitations further limit the ability of law firms to acquire and retain top-quality legal talent in this arena.

According to one commentator, the excessive focus by some claim departments on legal spending, combined with a “dose of complacency,” has helped the plaintiffs’ bar forge ahead and left defense counsel scrambling to play catch-up.¹⁰¹ Corporate policyholders and their insurers must ensure that adequate resources are committed to defending cases and protecting their litigation interests.

The plaintiffs’ bar has adapted to the changing demographics of jurors and judges. Key among the changing juror demographics is the increasing number of Millennials and Generation Z jurors in the jury

pool. “Reptilian tactics or theory” employed by plaintiffs, discussed further below, has particular appeal to the values, approach, and mindset of these younger jurors—though studies are mixed as to whether they are more likely to actually render nuclear verdicts. It appears younger jurors do not value money in the same way as baby boomers. Younger jurors also tend to be more plaintiff-oriented and distrustful of corporations, according to many commentators.¹⁰² Illinois State University researchers concluded that younger jurors (Millennials and Generation Z) are somewhat more likely to favor a plaintiff and to favor awarding higher damages.

Though defendants and their counsel appear to be doing a better job, sometimes they simply have not adequately defended against reptilian tactics and have failed to mount a compelling defense. Magna Legal Services reported that 84 percent of over 3,500 prospective jurors surveyed around the country over the 18 months prior to its report agreed that juries needed “to be ‘guardians of the community’ by forcing companies to change bad behavior with large damage awards.”¹⁰³ In addition, 37.6 percent of juror respondents strongly agreed that the primary purpose of damages was to punish defendants rather than compensate plaintiffs, while 44.5 percent somewhat agreed.¹⁰⁴ This report is troubling. Although punishment may be a consideration in appropriate punitive damages claims, it should play no role whatsoever in our civil justice system with respect to liability or compensatory damages.

Lawyering up and the proliferation of attorney advertising – elements that have been around for some time – serve as potent recruiting tools for plaintiff’s counsel, which they have employed masterfully. This has generated more, and sometimes better, plaintiffs. Advertising has also created great expectations for recovery. Plaintiffs enter the courtroom with the considerable advantage of having the jury pool conditioned favorably to them as a result of advertising. Insurers, corporate policyholders, and trade organizations must devote more resources to counter this concerted messaging effort.

Hostility toward and distrust of large companies is hardly a new development – it has been something plaintiffs’ counsel have exploited for a long time. But anti-corporate sentiment has increased markedly in recent years due to, among other things, residuals from the Great Recession, the Occupy Wall Street movement, and the #MeToo movement. Distrust and negative views of corporations have increased and become more of a bipartisan phenomenon in the wake of the COVID-19 pandemic. A survey of potential jurors conducted in 2023 by Orrick Herrington & Sutcliffe LLP shows that 77 percent of respondents had either a neutral or negative impression of lawyers who represent corporate defendants, compared to a clear majority of 58 percent of respondents who had a positive view of lawyers representing injured plaintiffs. Areas with higher income inequality, higher layoff rates, a greater proportion of low-wage workers, or a general lack of opportunity are likely to produce higher rates of nuclear verdicts.¹⁰⁵

Jurors – especially Millennials and Generation Z jurors – are more inclined to render awards with less emphasis on fault, greater emphasis on company reputation and safety practices, and based upon the perceived ability of corporate defendants and their insurers to absorb losses. A national survey conducted by Sound Jury Consulting in 2019¹⁰⁶ found that three-quarters of respondents eligible for jury service stated they would decide a case based on their personal beliefs of right or wrong if those beliefs conflicted with the law as instructed by the judge. The civil justice system places great importance on jury instructions, and the rule of law depends, in large part, upon jurors following the judge’s instructions. Although “limiting instructions” have been known to be of questionable utility, the inclination to ignore court instructions on the law is very troubling and threatens the fair administration of justice.

According to the Sound Jury Consulting survey, 57 percent of respondents say they would ignore a judge’s instructions to avoid internet research on the case if they believe they could obtain important

information. 52 percent say they would not take the time to look at the jury instructions during deliberations if they believed they understood the issues in the case. Additionally, 75 percent of respondents said they would disregard the judge's instruction to ignore inadmissible testimony if they believed the testimony was important.¹⁰⁷ In some states, such as New York, Washington, California, Massachusetts, and Minnesota, efforts are underway or being considered to update pattern jury instructions. Given jurors' increasing proclivity to ignore jury instructions, it is far from clear whether additional, better, or more specific instructions will be followed. In any event, defendants and their insurers must address concerns about jurors not following instructions—the plaintiffs' bar will not.

The influence of social media, the information age, and immediate access to high-powered computers known as cell phones makes it much more likely that jurors receive information outside of the courtroom. Limiting jurors' access to evidence only admitted at trial has always been a challenge. However, absent complete sequestration and cellphone confiscation, it is virtually an impossible undertaking in the information age with instant access to the internet and social media. The Sound Jury Consulting Study shows that jurors are not above the lack of self-discipline permeating our society today—they often refer to outside materials.

Judicial Hellholes: Many cases have the potential to produce nuclear verdicts, but some jurisdictions are worse than others for defendants. The most dangerous jurisdictions have earned the reputation of being “judicial hellholes.” Corporate policyholders and their insurers seek to avoid judicial hellholes wherever possible, but one characteristic of a judicial hellhole is that it allows carpet-bagging plaintiffs in and does not let defendants out.

The American Tort Reform Foundation (ATRF) most recent report on “judicial hellholes” (2025-26) identifies Los Angeles, CA; New York City; South Carolina asbestos litigation; Louisiana coastal litigation;

Philadelphia Court of Common Pleas; St. Louis; Cook, St. Clair and Madison Counties in Illinois; King County and the Washington Supreme Court as judicial hellholes. On its watch list are: Gwinnett, Fulton, and Cobb Counties in Georgia and Texas. In a broader sense, the United States bankruptcy court system has been converted into a judicial hellhole with respect to debtors with large asbestos and other mass tort liabilities.

Factors associated with problematic jurisdictions include: bad judges; defendants targeted based on deep pockets rather than culpability; extraordinary verdicts being upheld, even when unsupported by evidence and violate constitutional standards; cases proceed even where parties/events have no connection to the jurisdiction (*i.e.*, forum shopping allowed); judges allowing suits not supported by existing law to go forward and admitting junk science and questionable experts; discovery abuse (*i.e.*, judges allow unnecessarily broad, invasive and expensive discovery requests to increase the burden of litigation on defendants or deny defendants the right to learn about the plaintiff's case; consolidation and joinder of claims that do not have common facts and circumstances; improper class action certification; unfair case scheduling; uneven application of evidentiary rules; improper or slanted jury instructions; judges facilitate and sustain excessive damage awards; expansion of damages such as "hedonic" damages in personal injury claims, loss of companionship damages in animal injury cases, or emotional harm damages in wrongful death suits; private lawsuits under loosely-worded consumer protection statutes; logically-stretched public nuisance claims; governmental overreach, such as alliances between state attorneys general and personal injury lawyers; cozy relationships between plaintiffs' attorneys and judges.

Containing Social Inflation: The impact of social inflation has been felt across multiple lines of coverage, including commercial auto, medical malpractice and professional liability coverages, primary, umbrella and excess general liability coverage, and directors and officers liability coverage.¹⁰⁸

Insurers recognize that social inflation is a multifaceted problem that requires the expertise of claims, legal, underwriting, actuarial, data analytics, loss control, and marketing to understand and formulate appropriate responses. Fortunately, insurers endeavor to employ bright and talented people who have always found ways to meet the challenges presented. Insurers have several tools to address social inflation.

On the underwriting side, insurers may assess and better quantify the risks; raise premiums to account for the risks; lower limits, including sub-limits (where appropriate); draft policies with appropriate terms, conditions, and exclusions to contain the risks; exercise underwriting discipline; employ artificial intelligence and technology; identify macro-factors that can influence underwriting strategy; and explore new and non-traditional data sources such as economic, public, and proprietary data.

On the claims side, artificial intelligence, data, and technology can also be employed. Earlier and better use of mock juries and jury research can help in valuing cases, evaluating potential outcomes, selecting jurors, and formulating arguments and strategies to counter or neutralize applicable social inflation factors in the courtroom. When employing mock juries, it is important to consider appropriate variables and make sure that the realities of the jurisdiction are taken into account, as well as fairly portraying the evidence and arguments likely to be adduced by plaintiffs. Care must be used to ensure that the views and beliefs of defense counsel do not undermine or bias the results. There are several options that can be used in addition to or in lieu of full mock jury trials, such as focus groups, shadow juries, surveys, and polls to test themes, arguments, and evidence, and to create successful narratives and counternarratives for trial.

Insurers are relying upon an expanding scope of data to include current and historical activity by examining internet activity and social media trends that shed light on behavioral activity. Insurers

are often well-served by involving coverage counsel to address social inflation drivers such as policy limit demands and bad faith risks, evaluate the impact of covered versus non-covered claims, and identify issues and protect the interests of the insurer throughout the pendency of the litigation.

Prompt and accurate claims and case evaluation by claims examiners and counsel is critical. The practice of some attorneys to maintain that a claim is lacking in merit or fully defensible for months or years, only to advocate paying large settlement amounts or caving late in a case, was always troubling. It is particularly dangerous in times of social inflation. It is important to encourage a culture of no surprises and candid evaluation and to avoid adopting a kill-the-messenger mentality.

On both the claims and underwriting sides, training personnel and retaining skilled counsel and experts remain important. Internal communication plays a pivotal role in quickly identifying social inflation factors and formulating strategies to address them. Policyholders similarly employ bright and talented people to evaluate their exposures, limit or eliminate them, and work on strategies to minimize exposures. Insurers will continue to work with policyholders to employ cogent loss control, safety, and best practices to avoid and limit liability even in an environment supercharged with social inflation.

Educating policyholders and seeking ways for insurers and policyholders to work together in identifying and responding to social inflation is more important than ever. Understandably, insurers are emphasizing active safety and quality control programs and loss control.

Insurers and defense organizations have created and participated in seminars and training programs to promote awareness of social inflation and to develop ways to combat it. For example, DRI's Center

for Law and Public Policy recently created a social inflation task force. Many insurers have assigned specific individuals to identify and respond to issues associated with social inflation.

The factors endemic to the American civil justice system and changes in the legal landscape and society have been the targets of the protracted battle for sensible tort reform. Although some meaningful tort reform measures have improved affairs in some jurisdictions and for some types of cases, they have not had a significant impact in others. Still, other jurisdictions have dialed back tort reform or have seen provisions struck down by courts. Suffice it to say, tort reform has been helpful, but it has not been a panacea. At least from the perspectives of defendants and insurers, the civil justice system remains highly flawed.¹⁰⁹ Companies and insurers have been engaged in efforts to improve the civil justice system for decades. The results have been mixed and countered by a well-funded, well-incentivized, resourceful plaintiffs' bar. Fighting for fairness in the civil justice system is a continuing battle that must be waged wherever and whatever unfairness exists. As significant as social inflation has been, the situation would be considerably worse in the absence of these efforts and the positive changes they have achieved.

Nuclear verdicts continue to be rendered in record amounts and numbers. Product liability, intellectual property, motor vehicle, wrongful death, and workplace safety lawsuits produce the most nuclear verdicts.

In a world of nuclear verdicts, defendants can ill afford to ignore damages. Deemphasizing damages out of concern that it will make jurors more likely to find liability can be a risky strategy. Defendants must be aggressive in conducting discovery on damages and in challenging plaintiffs' damage proofs. Plaintiffs have been inclined to set higher damage anchors recently, even at the risk of seeming unreasonable, based on studies showing that jury awards are increased by higher damages requests and decreased by lower

damages requests. In many cases, defendants are well-served by setting out their lower damage anchors earlier and more often at trial. Defendants should remember to present fact witnesses and experts to address damages issues.

Plaintiffs' use of reptilian tactics initially caught defendants and judges off guard, but defendants have begun to catch up and have been more effective in countering these tactics. Among other things, defendants have exposed reptilian tactics to judge and jury, identified cases with high nuclear verdict potential, reached early settlements of such cases on terms acceptable to defendants and their insurers, where achievable, strived to put a dollar value on a case or claim early and revisit it as the matter evolves, conducted proper "post-mortem" analysis of cases involving nuclear verdicts; prevented reptilian tactics from being used by motions to dismiss, strike, *in limine*, and motions for protective orders; adduced evidence to activate the reptile in jurors in ways favorable to defendants; emphasized the importance of following the law and evidence; humanized the defendant and placed jurors in defendant's shoes; explained the reasoning, safety, and utility of actions taken and dangers of doing what the plaintiff is advocating; put the proper resources and preparation into defending, including witness preparation; prevented the creation of harmful documents through education; employed traditional evidentiary rules; and started conditioning the jury during *voir dire*.

CHAPTER 9

SOME OF THE MOST SIGNIFICANT INSURANCE LAW DECISIONS IN THE HISTORY OF THE UNITED STATES

We recognize that it is not possible to describe or even list the most important insurance law decisions rendered over the 250 year history of the United States. Chart 4 contains a listing of our nominations for the most significant insurance law cases in the United States. By including a decision in this list, we are not implying that we agree with the decision's reasoning or outcome. There are too many factors that could reasonably be applied to measure the importance of a decision. Further, the importance of a decision depends upon the focus, perspectives, and areas of interests of the insurance lawyers and professionals evaluating the decision. We propose the following decisions to demonstrate the wide range of insurance cases to begin a dialogue among insurance lawyers, executives, and professionals regarding the history and vibrancy of insurance law.

CHART 4

NOMINEES FOR SOME OF THE MOST
SIGNIFICANT INSURANCE LAW
CASES IN UNITED STATES HISTORY

Citation	Significance	Main Issue
<p><i>Foster-Gardner, Inc. v. National Union Fire Ins. Co.</i>, 18 Cal. 4th 857 (Cal. 1998) and <i>Certain Underwriters at Lloyd's of London v. Superior Court</i>, 24 Cal. 4th 945 (Cal. 2001)</p>	<p><i>Foster-Gardner</i> held that, in policies that did not define “suit,” the duty to defend was limited to civil suits prosecuted in court.</p> <p><i>Certain Underwriters</i> held that damages in a commercial general liability policy are limited to money ordered by a court. Together, they constitute the “Foster-Gardner Syllogism,” which limits coverage to the defense of civil lawsuits (although this has been chipped away to include “lawsuit-type” proceedings) that seek money ordered by a court (although this has also been diluted by cases involving EPA fines). This is significant as this can be relied upon in determining the duty to defend, <i>i.e.</i>, that no defense is owed under a commercial general liability policy for things such as demand letters or suits seeking injunctive relief for otherwise covered events. Courts across the country have reached differing conclusions. Most post-1986 policies define “suit.”</p>	<p>Defense</p>
<p><i>Garvey v. State Farm Fire & Cas. Co.</i>, 48 Cal. 3d 395 (1989)</p>	<p>Establishes “efficient proximate cause” doctrine for first-party claims.</p>	<p>Property</p>

Citation	Significance	Main Issue
<i>Borel v. Fibreboard Paper Products Corp.</i> 493 F.2d 1076 (5 th Cir. 1973)	Although not an insurance coverage decision, it established strict liability for asbestos manufacturers, initiating decades of coverage litigation.	General
<i>First Solar, Inc v. National Union</i> , 274 A.3d 1006 (Del. 2022)	Refined the standard for “related claims” in securities litigation, emphasizing policy-specific language over general similarity	Claims made
<i>Brillhart v. Excess Ins. Co.</i> , 316 U.S. 491 (1942) and <i>Wilton v. Seven Falls Co.</i> , 515 U.S.277 (1995)	<p>Establishes that federal courts have broad discretion to stay or dismiss insurance-related declaratory judgment actions when a parallel state court proceeding is pending, purportedly to prevent uneconomical and vexatious duplication when the same issues and parties are involved in state court. The “Brillhart” factors federal courts should consider when deciding whether to hear a case are whether the state court can fully adjudicate the issues, the scope of the state proceeding, and the nature of the defenses.</p> <p>In <i>Wilton</i>, the United States Supreme Court held that the discretionary standard from <i>Brillhart</i> governs a district court’s decision to stay a declaratory judgment action, that district court decisions are reviewed for abuse of discretion, not de novo, and clarified that the more stringent “exceptional circumstances” test from <i>Colorado River</i> and <i>Moses H. Cone</i> does not apply.</p> <p>The impact of this abstention has been to deny insurers the same access to federal courts in diversity cases afforded to other parties.</p>	Jurisdiction

Citation	Significance	Main Issue
<i>National Federation of Ind. Bus. v. Sebelius</i> , 567 U.S. 519 (2012)	The United States Supreme Court upheld the Affordable Care Act's individual mandate to purchase health insurance as a valid exercise of Congress's taxing power. However, it ruled that the federal government could not coerce states into expanding Medicaid by threatening to withhold all Medicaid funding.	Health
<i>Pilot Life Ins. Co. v. Dedeaux</i> , 481 US 41 (1987)	Established that ERISA preempts state common law tort and contract actions (such as "bad faith" claims) arising from the improper processing of benefit claims under an insured employee benefit plan.	ERISA
<i>San Diego Navy Fed. Credit Union v. Cumis Ins. Co.</i> , 162 Cal. App. 3d 358 (Cal. App. 1984) and <i>Maryland Casualty Co. v. Peppers</i> , 64 Ill. 2d 187 (1976)	These decisions established the "Cumis counsel" doctrine or "Pepper's counsel," holding that, when certain conflicts of interest arises between an insurer and its insured, the insurer must pay for independent counsel chosen by the insured. The <i>Cumis</i> decision has been codified into statute. Courts in tri-partite jurisdictions differ on whether and when policyholders are entitled to independent counsel.	Defense
<i>Buss v. Superior Court</i> , 939 P. 2d 766 (1997) and <i>General Agents Ins. Co. of Am., Inc. v. Midwest Sporting Goods Co.</i> , 828 N.E.2d 1092 (Ill. 2005)	Buss is representative of cases permitting an insurer with a duty to defend a "mixed" action (one containing both covered and non-covered claims) to seek reimbursement from the insured for defense costs solely attributable to the non-covered claims unilaterally by reservation of rights letter. <i>General Agents</i> is representative of decisions rejecting the right of insurers to obtain reimbursement unilaterally by issuing a reservation of rights letter absent a provision allowing reimbursement. Many	Defense

Citation	Significance	Main Issue
	contemporary policies now have express provisions allowing reimbursement.	
<i>Great Lakes Ins. SE v. Raiders Retreat Realty Co.</i> 601 US 65 (2024)	The United States Supreme Court held that choice of law provisions in maritime insurance contracts are presumptively enforceable under federal law, providing greater certainty for international and maritime insurers.	Choice of law
<i>AIU Ins. Co. v. Superior Court</i> , 799 P. 2d 1253 (Cal. 1990)	California Supreme Court held that environmental cleanup costs mandated by the government are “damages” covered under commercial general liability policies. Courts across the country have rendered conflicting decisions.	Interpretation
<i>Eljer Mfg., Inc. v. Liberty Mut. Ins. Co.</i> , 972 F. 2d 805 (7 th Cir. 1992)	The court ruled that “property damage” can occur at the time a defective product is installed, even if it has not failed yet.	Property damage
<i>Aloha Petroleum, Ltd. v. National Union Fire. Ins. Co. of Pittsburgh, PA</i> , 557 P.3d 837 (Haw. 2024) and <i>AES Corp. v. Steadfast Ins. Co.</i> , 283 Va. 609, 725 S.E.2d 532 (2012).	The Hawaii Supreme Court ruled climate change-related harms (greenhouse gas emissions) could be considered an “occurrence,” but are excluded by pollution exclusions. The Virginia Supreme Court ruled there was no “occurrence” in a climate change coverage case. These are the only two published decisions ruling on the merits of coverage for climate change claims.	Climate change
<i>Keene Corp. v. Ins. Co. of North Am.</i> , 667 F. 2d 1034 (D.C. Cir. 1981)	<i>Keene</i> is the decision credited with originating the “all sums” allocation approach. The court ruled that, because asbestos injury is continuous, <i>any</i> policy triggered during the exposure period is liable for the <i>entire</i> loss up to its limits.	Allocation Trigger

Citation	Significance	Main Issue
	The policyholder can select which policy responds, and that insurer may then seek contribution from others. Many other courts have since followed the “all sums” approach, but the <i>pro rata</i> approach to allocation has emerged as the majority and preferred approach.	
<i>Zurich Ins. Co. v. Raymark Ind. Inc.</i> , 514 N.E.2d 150 (Ill. 1987)	A policy is triggered where bodily injury, sickness, or disease takes place during the policy period, known as the triple trigger.	Trigger
<i>Montrose Chem. Corp. v. Admiral Ins. Co.</i> , 913 P.2d 878 (Cal. 1995)	Held that coverage was not precluded for damage that the policyholder knew existed at the time policy was purchased as long as the policyholder’s liability for that property damage was still contingent. As a result ISO adopted an endorsement in 1999 that became part of the 2001 CGL form known as the Montrose exclusion.	Trigger
<i>Ray Ind., Inc. v. Liberty Mut. Ins. Co.</i> , 974 F.2d 754 (6 th 1992)	Representative of decisions applying an exposure trigger under which policies on the risk during the period of exposure to harmful conditions are triggered.	Trigger
<i>Mraz v. Canadian Universal Ins. Co., Ltd.</i> , 804 F.2d 1325 (4 th 1986)	Representative of decisions applying a manifestation trigger under which the policies on the risk on the date that property damage or bodily injury is discovered are triggered.	Trigger
<i>Northern States Power Co. v. Fid. & Cas. Co.</i> , 517 N.W.2d (Minn. 1994)	Representative of decisions applying an injury-in-fact trigger.	Trigger
<i>In the Matter of Viking Pump</i> , 52 N.E.3d 1144 (N.Y. Ct. App. 20216).	Although New York is presumably a <i>pro rata</i> allocation state, this case carved out a major exception ruling that, where a policy contains a “non-cumulation clause,” an	Allocation

Citation	Significance	Main Issue
	<p>“all sums” allocation must apply to avoid rendering that clause illogical. Other courts have reached different results regarding the impact of “non-cumulation” clauses.</p>	
<p><i>Ins. Co. of North Am. v. Forty-Eight Insulations, Inc.</i>, 633 F.2d 1212 (6th 1980)</p>	<p>This is the seminal case for the <i>pro rata</i> allocation approach. The court reasoned that, because the injury occurred over time, defense and indemnity costs should be allocated among all years the policyholder was insured and self-insured. <i>Pro rata</i> allocation has emerged as the majority approach to allocation.</p>	<p>Allocation</p>
<p><i>Owens-Illinois, Inc. v. United Ins. Co.</i> 650 A. 2d 974, (N.J. 1994) and <i>Carter-Wallace, Inc. v. Admiral Ins. Co.</i>, 712 A.2d 1116 (N.J. 1998)</p>	<p><i>Owens-Illinois</i> adopted a <i>pro rata</i> allocation based upon equities rather than policy language and held a policyholder is responsible for self-insured periods where insurance is available.</p> <p><i>Carter-Wallace</i> followed <i>Owens-Illinois</i> and created a <i>pro rata</i> formula allocating losses based on both time-on-the-risk and policy limits.</p>	<p>Allocation</p>
<p><i>Boston Gas Co. v. Century Ind. Co.</i>, 910 N.E. 2d 290 (Mass. 2009)</p>	<p>The Massachusetts Supreme Judicial Court rejected the “all sums” allocation and firmly adopted a <i>pro rata</i> allocation by time-on-the-risk.</p>	<p>Allocation</p>
<p><i>KeySpan Gas East Corp. v. Munich Reins. Am. Inc.</i>, 96 N.E. 3d 209 (NY 2018)</p>	<p>The New York High Court ruled that, under a <i>pro rata</i> allocation, the policyholder is responsible for years where they had no insurance, even if insurance was unavailable in the marketplace (<i>e.g.</i>, pollution coverage after 1986). <i>Pro rata</i> jurisdictions other than Connecticut (<i>R.T. Vanderbilt</i>) and New Jersey (<i>Owens Illinois</i> and <i>Honeywell</i>) do not have an “unavailability exception,”</p>	<p>Allocation</p>

Citation	Significance	Main Issue
	where insurers must pick up the tab for years when coverage was not available in the market.	
<i>Gray v. Zurich Ins. Co.</i> , 65 Cal. 2d 263 (Cal. 1966)	This decision established that the duty to defend is broader than the duty to indemnify, and an insurer must defend its policyholder if the lawsuit alleges facts that create even a <i>potential</i> for coverage, regardless of the precise legal theories pleaded. It also introduced the doctrine of “reasonable expectations,” ruling that ambiguous policy language must be interpreted in favor of what a reasonable policyholder would expect.	Defense
<i>Stonewall Ins. Co. v. Asbestos Claims Management Corp.</i> , 73 F. 3d 1178 (2d Cir. 1995)	This decision required policyholders to pay a separate deductible for each individual asbestos claim (as opposed to one deductible for a “single occurrence” of manufacturing asbestos), which can effectively wipe out coverage for companies with high deductibles.	Occurrence
<i>Appalachian Ins. Co. v. Liberty Mut. Ins. Co.</i> , 676 F. 2d 56 (3 rd Cir. 1982)	The Third Circuit employed the “cause” test for determining the number of occurrences. The court ruled there was only one occurrence: Liberty Mutua’s adoption of the discriminatory employment policy. The multiple injuries (claims) were just the result of that single cause. The cause test, rather than the “effects” test or “unfortunate event” test is the majority rule for determining the number of occurrences but does not dictate the result as courts have applied it in different ways with respect to various claims.	Occurrence

Citation	Significance	Main Issue
<i>Koikos v. Travelers Ins. Co.</i> , 849 So. 2d 263 (Fla. 2003)	Concurrent cause shooting case. The Florida Supreme Court ruled that each shot was a separate occurrence because each required a separate volitional act by the shooter. This allowed the victims to access two separate policy limits.	Occurrence
<i>Appalachian Ins. Co. v. General Electric Co.</i> , 863 NE 2d 994 (N.Y. 2007)	The New York high court applied the “unfortunate events” test to determine the number of occurrences in a mass tort context. It rejected GE’s argument that 400,000 asbestos-related claims should be treated as a single occurrence based on a common “cause” (GE’s failure to warn). Instead, the court ruled that the number of occurrences is determined by the last link in the causal chain leading to liability in this case, each individual’s exposure to asbestos. Each individual plaintiff’s exposure was a separate occurrence. Because GE’s excess insurance policies only triggered for claims exceeding \$5 million per occurrence, and the average claim was only \$1,500, this ruling prevented GE from accessing its excess coverage.	Occurrence
<i>Shell Oil Co. v. Winterthur Swiss Ins. Co.</i> , 12 Cal. App. 4th 715 (Cal. App. 1993)	The decision addresses several issues arising out of a 1988 trial in which the jury found no coverage under more than 30 years of coverage with respect to coverage for property damage including damage at an arsenal. The decision addresses insurance policy interpretation; the scope of California Insurance Code section 533; whether “expected” as used in the policies and exclusions, implies an objective, reasonable person standard or a subjective	Interpretation Occurrence

Citation	Significance	Main Issue
	<p>test that examines the insured's state of mind; whether for purposes of the qualified pollution exclusion "sudden" means only "unexpected" or instead refers to events that are abrupt; whether exclusions for property in the insured's care, custody, or control were properly submitted to the jury; and whether the insurers showed substantial actual prejudice caused by untimely notice from Shell. The decision was selected because it identifies many common issues in environmental coverage actions on which courts have reached various decisions and have applied varying standards. It is known as the "dead duck" case because evidence included pesticide residues found in dead ducks.</p>	
<p><i>In Re Alexion Pharmaceuticals, Inc. Ins. Appeals</i>, 339 A. 3d. 694 (Del. 2025)</p>	<p>Adopted a "meaningful linkage" standard for "related-claims" exclusions. It held that multiple legal actions (like an SEC subpoena and a later class action) are only "related" if materially connected by the same wrongful acts, which can limit coverage to a single policy period.</p>	<p>Claims-Made</p>
<p><i>C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.</i>, 227, N.W.2d 169 (Iowa 1975)</p>	<p>A burglary policy required "visible marks of force" on the <i>exterior</i> of the building. The burglars picked the lock but left marks on the <i>interior</i>. The insurer denied the claim based on the plain text. The Iowa Supreme Court ruled for the policyholder, famously stating that even unambiguous policy language will be ignored if it is "bizarre or oppressive," "eviscerates the non-standard terms explicitly agreed to," or eliminates the "dominant purpose" of the</p>	<p>Property</p>

Citation	Significance	Main Issue
	<p>transaction. Many consider this the high-water mark of the reasonable expectations doctrine, allowing courts to override clear policy text to prevent unfairness.</p>	
<p><i>Cummins, Inc. v. Atlantic Mutual Ins. Co.</i>, 867 NYS 2d 81 (N.Y. App. Div. 2008)</p>	<p>Ruled that the rule of <i>contra proferentem</i> does not apply if the policyholder is sophisticated and instrumental in crafting the agreement.</p>	<p>Interpretation</p>
<p><i>Yeaton v. Fry</i>, 9 U.S. 335 (1809)</p>	<p>Chief Justice John Marshall wrote that, if an insurance policy is “susceptible of two constructions,” the one that is most favorable to the insured (the party who did not draft the contract) should be adopted. This is one of the earliest high-court applications of the <i>contra proferentem</i> rule for insurance.</p> <p>The Court famously stated: “The company cannot complain if that construction is adopted which is most favorable to the insured. This rule is a just one... because the company itself prepared the contract.”</p>	<p>Interpretation</p>
<p><i>Communale v. Traders & General Co.</i>, 328 P.2d 1958 (Cal. 1958)</p>	<p>Established the implied covenant of good faith and fair dealing in insurance. An insurer’s refusal to defend or settle within policy limits when it is reasonable to do so constitutes a breach of the implied covenant of good faith.</p>	<p>Bad faith</p>
<p><i>Crisci v. Security Ins. Co.</i>, 66 Cal. 2d 425 (Cal. 1967)</p>	<p>Widely cited case explaining an insurer can be held liable in contract and tort for an entire judgment exceeding policy limits if it unreasonably refuses to settle a claim within policy limits.</p>	<p>Bad faith</p>

Citation	Significance	Main Issue
<i>Johansen v. Cal. State Auto. Assoc. Inter-Ins. Bureau</i> , 15 Cal.3d 9 (Cal 1975)	An insurer is liable for an entire judgment against its insured—even if it exceeds policy limits—if it wrongfully refuses to accept a reasonable settlement offer. Consideration as to reasonableness of settlement demand is “whether, in light of the victim’s injuries and the probably liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer.”	Bad Faith
<i>Gruenberg v. Aetna Ins. Co.</i> , 510 P. 2d 1032 (Cal. 1973)	Created the “tort” of bad faith, allowing punitive damages for unreasonable claim denials.	Bad faith
<i>Stowers Furniture Co. v. Am. Ind. Co.</i> , 15 S.W.2d 544 (Tex. Comm’n App. 1929)	The <i>Stowers</i> doctrine requires an insurers to act in good faith by settling claims within policy limits when liability is reasonably clear and an insurer that unreasonably rejects a settlement offer may be liable for the entire judgment even above policy limits. A valid <i>Stowers</i> demand must be a demand within policy limits, offers a full release of liability for the insured, and the insurer has to be afforded a reasonable time to respond.	Bad faith
<i>State Farm Mut. Auto. Ins. Co., v. Campbell</i> , 538 U.S. 408 (2003)	The court promulgated guideposts for determining the constitutional limits on punitive awards including the degree of reprehensibility (whether the harm was physical rather than purely economic, whether conduct showed a reckless disregard for the health or safety of others, the financial vulnerability of the victim, whether the conduct was a repeated pattern or an isolated incident, whether the harm resulted from intentional malice, trickery, or deceit); the ratio between the punitive	Damages

Citation	Significance	Main Issue
	<p>damages and the actual or potential harm (compensatory damages) suffered by the plaintiff (noting few awards exceeding a single-digit ratio will satisfy due process and a 4-to-1 ratio is often “close to the line of constitutional impropriety”); and the difference between the punitive award and the civil penalties authorized or imposed in similar cases.</p>	
<p><i>Hawkins v. Allstate Ins. Co.</i>, 733 P.2d 1073 (Ariz. 1987)</p>	<p>Considered by some to establish institutional bad faith. The case focused on an insurer’s systemic, company-wide practice of unfairly deducting small amounts from thousands of claims, rather than a single isolated incident, to generate large profits.</p>	<p>Bad faith</p>
<p><i>Boston Old Colony Ins. Co. v. Gutierrez</i>, 386 So.2d 783 (Fla. 1980)</p>	<p>Establishing that an insurer has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of their own business, setting the foundational standard for bad faith.</p>	<p>Bad faith</p>
<p><i>Truck Ins. Exchange v. Kaiser Gypsum Co.</i>, 602 U.S. 268 (U.S. 2024)</p>	<p>Affording insurers “party in interest” status in mass tort bankruptcies.</p>	<p>Bankruptcy</p>
<p><i>UNR Indust., Inc. v. Continental Cas. Co.</i>, 942 F.2d 1101 (7th Cir. 1991)</p>	<p>The Seventh Circuit held that a claims estimation in bankruptcy results in a judgment that is binding on excess insurers allowing plan proponents to seek immediate payment from insurers, giving rise to a result known as acceleration.</p>	<p>Bankruptcy</p>

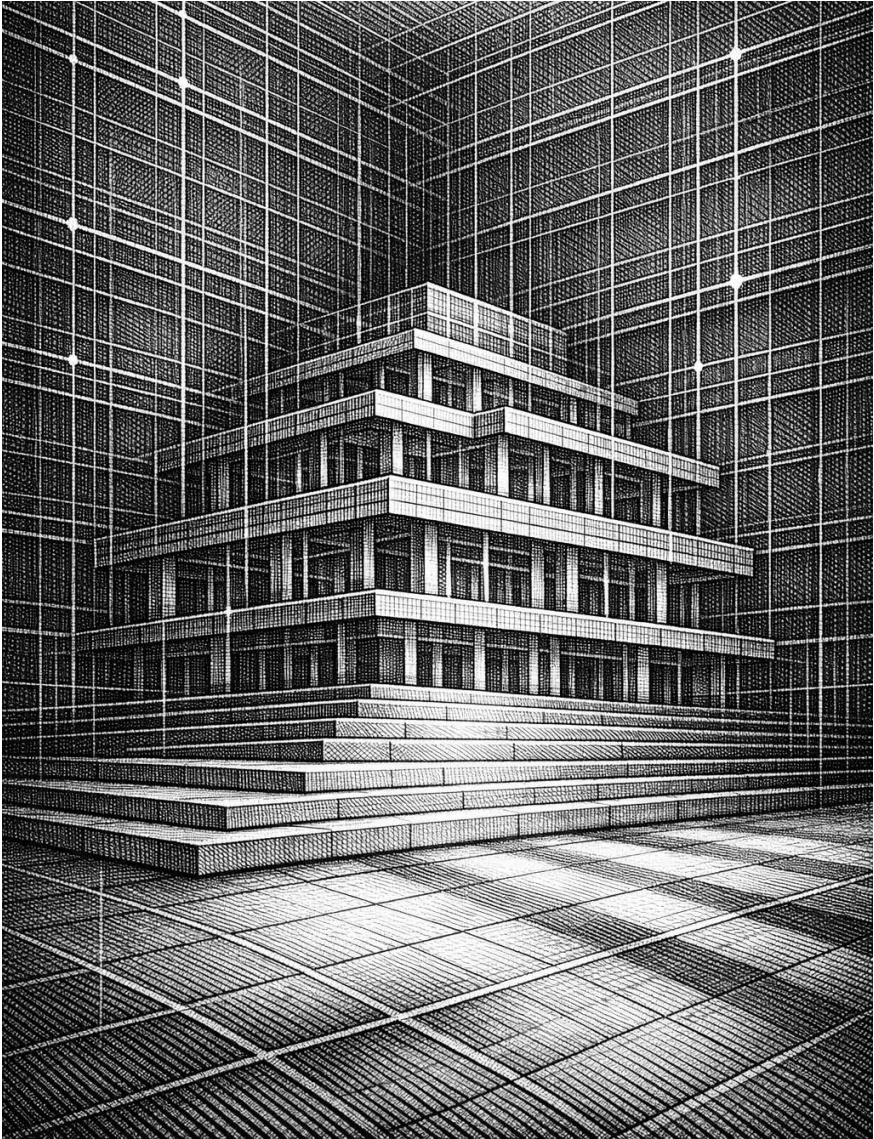
Citation	Significance	Main Issue
<i>Fuller-Austin Insulation Co. v. Highlands Ins. Co.</i> , 135 Cal.App.4 th 958 (Cal. App. 2006)	The California Court of Appeal in <i>Fuller Austin</i> ruled that the bankruptcy reorganization plan did not constitute a trial of liability, nor did it allow the insurers' obligations to be determined by estimated future claims rather than actual, paid claims. This ruling established that insurers are not bound by the "initial payment percentage" of a bankruptcy trust and can challenge the reasonableness of settlements.	Bankruptcy
<i>In re: Silica Products Liability Litigation</i> , 398 F. Supp. 2d 563 (S.D. Tex. 2005) and <i>In re: Garlock Sealing Tech., LLC</i> , 504 B.R. 71 (Bankr. W.D. N. C. 2014)	Judge Janis Jack and Judge George R. Hodges outline and expose the billions of dollars of fraud and abuses in silica and asbestos litigation being challenged through bankruptcy proceedings.	Bankruptcy
<i>Harrington v. Purdue Pharma L.P.</i> , 603 U.S. 204 (U.S. 2024)	Bankruptcy code does not authorize a release and injunction that would discharge non-debtors without the consent of affected claimants.	Bankruptcy
<i>Zeig v. Mass. Bonding & Ins. Co.</i> , 23 F.2d 665 (2d Cir. 1928)	Permitting functional exhaustion of underlying insurance rather than requiring full exhaustion of underlying limits by payment of claims.	Allocation
<i>Comerica Inc. v. Zurich Am. Ins. Co.</i> , 498 F. Supp. 2d 1019 (E.D. Mich. 2007)	Rejected the "functional exhaustion" doctrine, ruling that an insured cannot settle with a primary insurer for less than policy limits and immediately claim coverage from an excess insurer. The court held that unambiguous policy language requiring "actual payment" by the primary insurer meant the excess policy was not	Allocation

Citation	Significance	Main Issue
	triggered until the primary limits were fully exhausted. Several cases have followed this decision.	
<i>Insurance Co. v. Colt</i> , 87 U.S. 560 (1874)	Establishing that the place where an insurance contract is delivered and the premium paid (the place of contracting) determines the law governing the policy.	Choice of law
<i>Auten v. Auten</i> , 124 N.E.2d 99 (N.Y. 1954)	This is a “grouping of contacts” or “center of gravity” case that rejected the rigid rule that the law of the place of contracting governed, instead looking for the jurisdiction with the most significant contacts. This case directly influenced the drafting of Section 188 of the Restatement.	Choice of law
<i>Warnock v. Davis</i> , 104 U.S. 775 (1881)	The United States Supreme Court required a valid insurable interest for life insurance policies. Justice Oliver Wendell Holmes Jr. noted that, while policies should be assignable as property, the requirement prevents “mischievous gaming” or wagering on human lives is not arbitrarily applied.	Life
<i>Allstate Ins. Co. v. Hague</i> , 449 U.S. 302 (1981)	The United States Supreme Court established constitutional minimum that, for a state’s substantive law to be applied in an insurance case, that state must have a “significant contact or significant aggregation of contacts” creating a state interest in the application of its law.	Choice of law
<i>Bi-Economy Market, Inc. v. Harleysville Ins. Co. of New York</i> , 10 N.Y.3d 187 (N.Y. 2008) and <i>Panasia Estates, Inc. v. Hudson Ins. Co.</i> , 10 N.Y.3d 200 (2008)	Holding that insurers can be liable for consequential damages—including the total destruction of a business—if their failure to pay claims in good faith causes such losses. These cases ruled these damages are recoverable if they were foreseeable at the time of contracting.	Damages

Citation	Significance	Main Issue
<i>Royal Globe Ins. Co. v. Superior Court</i> , 592 P.2d 329 (Cal. 1979)	Establishing that a third party (an injured person) could directly sue a tortfeasor's insurer for unfair claim settlement practices.	Bad faith
<i>McAnarney v. Newark Fire Ins.Co.</i> , 247 N.Y. 176 (N.Y. 1928)	Establishes the "actual cash value" principle and how to measure loss, emphasizing that indemnity should not exceed the actual loss.	Damages
<i>Montrose Chemical Corp. v. Superior Court</i> , 6 Cal. 4th 287 (Cal. 1993)	Adopting a "continuous trigger" for environmental liabilities.	Trigger
<i>Egan v. Mut. of Omaha Ins. Co.</i> , 24 Cal. 3d 809 (1979)	An insurer's failure to properly investigate a claim can constitute bad faith.	Bad faith
<i>United States v. South-Eastern Underwriters Ass'n.</i> , 322 U.S. 533 (U.S. 1944)	The United States Supreme Court held that insurance is "interstate commerce" and thus subject to federal regulation under the Sherman Antitrust Act. This prompted Congress to pass the McCarran-Ferguson Act, which preserves the states' primary role in regulating insurance.	Regulation
<i>Bellefonte Reinsurance Co. v. Aetna Cas. & Sur. Co.</i> , 903 F.2d 910 (2d Cir. 1990); <i>Excess Ins. Co. v. Factory Mut. Ins. Co.</i> , 3 N.Y.3d 577 (N.Y. 2004) (N.Y. 2004); and <i>Global Reinsurance Corp. of Am. v. Century Indem. Co.</i> , 91 N. E .3d 1186, 69 N.Y.S.3d 207 (N.Y. 2017)	<i>Bellefonte</i> capped a reinsurer's liability to the amount specified in the facultative reinsurance certificate, encompassing both loss and expense and provided the majority rule for nearly 30 years. In <i>Excess Ins.</i> the New York Court of Appeals followed the <i>Bellefonte</i> cap. In <i>Global Re</i> , the New York Court of Appeals refined the treatment of expenses under facultative certificates, effectively moving away from the strict presumption of the <i>Bellefonte</i> cap.	Reinsurance

Citation	Significance	Main Issue
<i>Unigard Security Ins. Co. v. North River Ins. Co.</i> 4 F.3d 1049 (2d Cir. 1993)	Discusses the duty of utmost good faith (<i>uberrimae fidei</i>) and when a cedant's failure to notify a reinsurer of a loss relieves the reinsurer of liability and ruling that a reinsurer must show prejudice to avoid liability due to late notice.	Reinsurance
<i>Aetna Cas. and Sur. Co. v. Home Ins. Co.</i> , 882 F. Supp. 1328 (S.D. N.Y. 1995)	The court held that it is an established industry custom for reinsurers to follow the good-faith claim settlement decisions of the ceding company, even if the reinsurance contract lacks an explicit follow the settlements or loss clause. The court found that Aetna's decision to settle with A.H. Robins with respect to the massive underlying Dalkon Shield intrauterine device – which included covering defense costs beyond policy limits – was reasonable and not made in bad faith. The court examined whether the Home Ins. Co. reinsurance policies were concurrent (coextensive) with Aetna's underlying excess policies regarding “cost-supplemental” defense benefits. Various courts have addressed these issues and reached various results. The decision was selected for identifying the issues not for its rulings on them.	Reinsurance
<i>Morton Intern., Inc. v. General Acc. Ins. Co. of Am.</i> , 629 A.2d 831 (N.J. 1993)	Applying regulatory estoppel.	Pollution Exclusion

PART 3
SOME CONTEMPORARY ISSUES
IMPACTING INSURANCE & INSURERS



CHAPTER 10

SOME KEY INSURANCE DECISIONS, TRENDS & DEVELOPMENTS

The past year was action-packed for insurers and insurance coverage. In this Chapter, we examine some of the key trends, developments, and decisions impacting the U.S. insurance industry in 2025 and forecast potential trends and developments for “America 250” – the semi-quincentennial – in 2026. Civil lawsuits and claims in the U.S. remain fueled by social inflation with nuclear and thermonuclear awards and large settlements continuing largely unabated, while economic inflation continues at a reduced level. The change in public policy from the Biden administration to the second Trump administration (Trump 2.0) is perhaps the most impactful development of the year, with Environmental, Social, and Governance considerations (ESG) and Diversity, Inclusion, and Equity (DEI) being scaled back at the federal level.

Artificial intelligence (AI) and cybersecurity continue to loom large for insurers and their policyholders. For insurers, the challenges presented by technological developments are multifold as they continue to integrate AI into their businesses across their operational, underwriting, pricing, fraud control, claims handling, and other functions. On the compliance side, insurers are contending with local, state, federal, and international regulations as businesses in general, as well as specific regulations aimed at the business of insurance. The impacts of AI and cybersecurity on policyholders are visited upon insurers in their loss control, risk management, and underwriting functions. Increasingly, AI is reverberating on the claims side, impacting claim types and activities directly and indirectly. The lightning pace of developments places a premium on skillsets. All of this is taking place against a backdrop of challenges

faced by insurers in attracting and retaining employees with the requisite skillsets and potential reductions in force associated with AI. For example, one insurer announced in December that it plans to cut its workforce by as much as 20 percent over the next three to four years as part of a digital transformation to automate key insurance functions.¹¹⁰

Insurers and their policyholders continue to be challenged by a wide range of claims and coverage actions, including climate and weather-related claims, mass tort claims, PFAS claims, traditional asbestos and environmental claims, sexual misconduct claims, and D&O/securities claims, which dominated claims activities and court decisions in 2025. Cyber and privacy claims continue to proliferate with more coverage claims and decisions involving cyber-specific coverages in addition to the silent cyber coverage claims under traditional first-party, liability, and crime/fraud policies that have dominated in the past. Silica claims have reemerged in recent years, while lead paint and COVID-19 business interruption coverage claims have waned. Insurers failed to retain the unprecedented level of attention from the United States Supreme Court that they garnered in 2024.

Among the numerous trends and developments in 2025, a few stood out above all others. These include the impact of Trump 2.0, the downgrading of ESG and DEI at the federal level, the stubborn continuation of social inflation, and the supersized role of AI.

Impact Of Trump 2.0: The most impactful development of 2025 relates to the policies under Trump 2.0 and the vast departure many of those policies represent from the policies of the Biden administration. The impact on claim frequency and severity varies by insurance line, but on balance, deregulation is expected to result in an overall decrease in enforcement actions by federal agencies. Commentators' predictions regarding the overall impact on litigation-related liabilities are more variable, but the appointment of more conservative federal judges figures to reduce litigation-related liabilities slightly. The One,

Big, Beautiful Bill ¹¹¹ – which permanently increases the maximum deduction for certain business property, allows full expensing of domestic research and experimentation expenditures, and makes permanent most of the 2017 tax cuts – generally affords more favorable treatment to companies than either pre-existing law.

Tariffs have injected some uncertainty as well as additional revenues, but many of the concerns expressed by some economists have not materialized to the extent feared so far. Credit, trade, and political risks historically have not presented significant losses domestically, but in recent years they are seen as presenting greater risks along with social unrest.

ESG Is Down But Not Out: As predicted, there has been a substantial rollback of ESG regulation from the “all of government” approach of the Biden administration. Trump 2.0 has adopted a responsible “drill baby drill” approach that is friendlier to fossil fuels in an effort to decrease energy costs and increase supplies needed to quench the energy demands of artificial intelligence data centers. Automobile emissions standards are likely to be reduced, and the push for electric vehicles and fuel efficiency will be decelerated under Trump 2.0, and due to practical considerations such as costs and technological limitations. ¹¹²

Even before Trump 2.0, the Biden administration failed to push a final, enforceable climate disclosure rule across the finish line. The U.S. Supreme Court somewhat limited the unbridled authority of administrative agencies generally and specifically in the areas of ESG and DEI, ¹¹³ and ESG backlash became a well-developed resistance movement. The Trump administration – through tabling climate disclosure rules, executive orders, regulatory retraction, and budgetary priorities – has taken much of the bite out of ESG, at least for now.

Several states led by California have picked up the ESG baton. In November, the Ninth Circuit granted an injunction staying the enforcement of California SB 261 that requires companies to publish climate risk reports in January 2026 identifying their financial risks associated with climate change and their efforts to mitigate these risks.¹¹⁴ The court, however, did not stay another law, SB 253, that requires companies to disclose their Scope 1 and Scope 2 greenhouse gas emissions by an unspecified date in 2026. Though California is taking the lead, pro-ESG measures and legislation have been enacted in other states including Colorado, Florida, Illinois, Maine, Maryland, New Hampshire, Oregon, and Utah, demonstrating that Newton's Third Law of Motion is bipartisan.

U.S. companies doing business internationally are subject to international laws and regulations that remain in place, although the European Union announced earlier this year that it was dialing back some of its ESG initiatives. On November 20, the European Commission published a proposal to amend the Sustainable Finance Regulation that has been in effect since 2021 in response to market comments that the program is overly complex. For a detailed analysis of ESG, *see generally*, Scott M. Seaman and Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 21 Sustainability/ ESG (Environmental, Social, and Governance Considerations) & PFAS.¹¹⁵

It is important to recognize that companies must still comply with traditional environmental laws, and environmental liabilities remain large.

Employment Practices & An End To “Illegal” Diversity, Equity, & Inclusion: The Biden administration also applied its “all of government” approach to advance its DEI initiatives throughout the U.S. government and sought to impose DEI on private companies and actors. The U.S. Supreme Court and some initiatives in so-called red

states took aim at DEI during the Biden administration. In *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College* and the companion case *Students for Fair Admissions, Inc. v. University of North Carolina*, the Court issued its seminal decision striking down affirmative action admissions policies used by both Harvard and UNC, effectively barring the consideration of race as an independent factor in university admissions.¹¹⁶ The decision raised questions regarding efforts aimed at increasing diversity in the application and hiring processes for other public institutions and for private sector entities as well. Many companies changed their employment practices as a result.

Trump 2.0 has targeted “illegal DEI.” On inauguration day, President Trump issued Executive Order 14151 “Ending Radical and Wasteful Government DEI Programs and Preferencing.”¹¹⁷ The next day, Executive Order 14173 “Ending Illegal Discrimination and Restoring Merit-Based Opportunity” was issued.¹¹⁸ Attorney General Pam Bondi subsequently issued a memorandum directing the Civil Rights Division of the U.S. Department of Justice (DOJ) to investigate, eliminate, and penalize “illegal DEI and DEIA preferences, mandates, policies, programs, and activities in the private sector and in educational institutions that receive federal funds.” In March 2025, the DOJ and the U.S. Equal Employment Opportunity Commission began educating the public on unlawful discrimination related to DEI practices. The DOJ issued a final rule on Dec. 9, 2025, removing regulations issued under Title VI of the Civil Rights Act of 1964 that precluded recipients of federal funding from engaging in disparate impact discrimination on the basis of race, color, or national origin. This final rule does not address other federal laws prohibiting disparate impact discrimination, including Title VII, which prohibits unintentional disparate impact and authorizes private rights of action, nor does it directly impact state disparate impact laws.

Both the pro-ESG and DEI policies of the Biden administration and the counter policies of Trump 2.0 present challenges and opportunities

that can both limit and increase exposures. Companies believing DEI and ESG policies are harmful or unhelpful to their missions have an easier time scaling back or eliminating these programs and activities. Companies wishing to continue their ESG and DEI programming, in large measure, are continuing them with relabeling and other adjustments. For example, some companies have revised statements and disclosures, renamed or eliminated programs, and revised policies in an effort to avoid unwanted scrutiny from both regulatory authorities and corporate activists. Underwriters continue to evaluate companies' practices and capabilities in employment, environmental, sustainability, governance, and supply chain areas, as the ability to manage these matters remains key to their success and to controlling their exposures.

Although compliance remains a fundamental concern, other factors impacting employment, governance, and DEI programming and practices include: attracting and retaining talent (Generation Z and Millennials are reportedly more likely to seek out and remain with employers with visible commitment to DEI and ESG); traditional discrimination and harassment litigation; reputational risks; and other business and financial risks. Not only are younger Americans dominating the workforce, but they are also playing a larger role in managing companies. The impact of younger workers and managers in corporate America was a significant factor in many companies shifting from supporting tradition and resisting change to becoming agents of change, helping to usher in ESG practices with notable speed and depth.

Living In An Artificial Intelligence World: AI has impacted society and businesses in ways that are both transformative and disruptive, and presents major opportunities and exposures for companies and their insurers. Insurers are using AI in connection with underwriting, risk management, fraud detection, and claims handling. A working group of the National Association of Insurance Commissioners (NAIC) issued a request for information in May 2025 to explore

drafting a model law governing insurers' use of AI. Policyholder lawyers are targeting insurer use of AI in coverage and bad faith litigation.¹¹⁹ Regulators in New York, Colorado, California, and other states have expanded oversight, emphasizing fairness, accountability, and transparency in the use of AI by insurers.¹²⁰ California's Privacy Protection Agency advanced draft rules requiring cybersecurity audits, risk assessments, and governance standards for automated decision-making systems.¹²¹

At the federal level, a proposed 10-year moratorium on state AI regulation was rejected 99-1 by the U.S. Senate due to concerns about the impact on federalism and about limiting the ability of states to protect their residents from fraud, deepfakes, and child sexual abuse material. On December 11, 2025, President Trump signed an Executive Order "Ensuring a National Framework for Artificial Intelligence." The order directs the Attorney General to establish an AI Litigation Task Force to identify and challenge state AI laws inconsistent with national policy of global dominance over AI within 30 days, directs the Secretary of Commerce to publish an evaluation of existing state AI laws that conflict with national policy within 90 days, provides for potential withholding of federal funds under the Broadband Equity Access and Deployment Program and discretionary grants, and directs the Chairman of the Federal Communications Commission to determine whether to adopt a reporting and disclosure standard for AI models that preempts conflicting state laws. The order also directs the preparation of a legislative recommendation establishing a uniform national policy framework for AI that preempts state AI laws that conflict with the policy set forth in the order.

A report from the Financial Services Institute sensibly recommends that regulators apply existing cyber and other rules and standards to artificial intelligence and enact new rules only where AI brings genuinely new issues or significantly alters existing risks.¹²²

Although much attention has focused on generative AI, agentic AI (systems capable of operating and developing autonomously with little or no human oversight) presents significant risks when integrated into systems through application programming interfaces. Deepfakes are being adapted to foster identity fraud and to bypass security systems.

Insurers are including AI exclusions, sub-limits, and endorsements to control AI-related risks in a variety of policy types and are providing affirmative AI coverages.¹²³ Notwithstanding the amount of attention given to AI over the past year, the AI story is only just beginning to unfold.

It is hardly surprising that the frequency and severity of claims and the high stakes and costs of coverage litigation continue to escalate in the world's most litigious country. The nature of complex coverage litigation has changed with large losses often being litigated with fewer parties than decades earlier, due to a variety of factors, including broader use of claims-made contracts. There is much to report regarding claims and coverage activities in 2025.

Cyber & Cybersecurity: Underlying cyber claim frequency remained stable while severity dropped by 50 percent year-over-year, according to one report, reflecting improved incident response, widespread adoption of multi-factor authentication, and the increased use of real-time monitoring tools.¹²⁴ A 2025 Cyber Claims Report by Coalition highlighted that business email compromise and funds transfer fraud accounted for 60 percent of cyber claims, with ransomware continuing to represent the most costly and disruptive attack type.

Regulatory oversight also intensified as the transition period for the SEC 2023 cybersecurity disclosure rules ended and those rules became effective in 2025, requiring registrants to report material cyber incidents within four business days and disclose governance practices annually.¹²⁵ Enforcement actions expanded, targeting

failures in board-level cyber risk oversight.¹²⁶ There has also been an increase in shareholder lawsuits over delayed or incomplete disclosures. Congress has temporarily extended the Cybersecurity Information Sharing Act of 2015 through the end of January 2026. The future of the law, which provides a critical underpinning for information sharing and collaboration across government and industry, remains in doubt.¹²⁷

In 2025, the number of coverage disputes under cyber-specific policies has increased as courts continue to grapple with “silent cyber” claims under traditional liability, property, and crime/fraud policies. In January 2025, the U.S. Court of Appeals for the Sixth Circuit issued an important decision in *Home Depot Inc. v. Steadfast Ins. Co.*¹²⁸ The case arose from Home Depot’s massive data breach, which triggered lawsuits by financial institutions seeking reimbursement for losses. Home Depot argued that its commercial general liability (CGL) policies should respond, but the Sixth Circuit held that electronic data does not constitute “tangible property” under traditional liability coverage and that insurers therefore had no duty to defend or indemnify.

Late in 2025, the Illinois Appellate Court rendered a decision on “extra expense” coverage in *Villa Financial Services, LLC v. Underwriters at Lloyd’s of London*.¹²⁹ The case arose after Villa Financial made ‘reasonable,’ but contractually unnecessary payments in response to a cyberattack and sought reimbursement under its cyber policy. The court held that “extra expense” coverage applies only to costs that are strictly necessary. Although unpublished, the ruling may reflect a broader trend signaling that insureds cannot recover for nonessential measures taken during breach response.

Privacy Claims: In 2025, state-level activity surged with over 800 consumer privacy bills introduced and at least eight new state laws enacted in Delaware, Iowa, Nebraska, New Hampshire, New Jersey, Tennessee, Minnesota, and Maryland.¹³⁰ At the federal level, the

Trump administration has reduced oversight and enforcement by the Federal Trade Commission (FTC) and the Consumer Financial Protection Bureau. Early in the year, the administration issued a regulatory freeze on some Biden-era initiatives, including proposed updates to the Children's Online Privacy Protection Act and broader FTC rulemakings on commercial surveillance and data security.¹³¹

In Illinois, insurers have prevailed in several appellate rulings applying "violation of law" exclusions to bar coverage under cyber and general liability policies. Although statutory damages under privacy laws like BIPA remain a major exposure for businesses, in some cases insurers are prevailing based upon exclusions that limit coverage for alleged violations of law.¹³² Illinois also has a Genetic Information Privacy Act. Section 20(b) of that Act prohibits insurers from using or disclosing "protected health information" that is "genetic information" for underwriting purposes. The Act adopts HIPAA's definitions of both terms. "Genetic information" means information about: (i) an individual's genetic tests; (ii) the genetic tests of family members, the manifestation of a disease or disorder in family members, or any request for, or receipt of, genetic services, or participation in clinical research, which includes genetic services, by the individual or any family member. A decision of the Illinois Appellate Court held that Section 20(b), which applies to health care providers, health plans, employers, and clearinghouses, does not apply to life insurers.¹³³

There was a wave of consumer privacy cases filed under various enacted state laws, such as the California Invasion of Privacy Act (CIPA), and in New York under the SHIELD Act. These disputes often targeted policyholders for using website tracking tools and collecting personal information.¹³⁴ In 2025, several trial court decisions dismissed such claims, concluding that the alleged conduct did not rise to the level of a statutory violation.¹³⁵

Drugs, Guns, & Insurrections: In January 2025, a \$7.4 billion settlement involving thousands of claimants against Purdue Pharma and the Sackler family was approved in the U.S. Bankruptcy Court for the Southern District of New York.¹³⁶ Settlements involving opioids have totaled more than \$57.7 billion as of November 2025.¹³⁷

We previously reported on several decisions favoring insurers in the context of opioids. This trend continued in 2025. A Delaware Superior Court, *In re CVS Opioid Insurance Litigation*, ruled that CVS Health was not entitled to insurance coverage for thousands of separate opioid-related lawsuits. The court held that the claims brought by governments, hospitals, and benefit plans sought damages for economic losses, not individualized “bodily injury” or “property damage” covered under the general liability policies.¹³⁸ Insurers of Bloodworth were granted summary judgment with respect to underlying lawsuits claiming the distribution, marketing, and placing of opioids into the stream of commerce without fulfilling the duty to prevent diversions and reporting suspicious orders constituted a public nuisance and was otherwise unlawful. The Georgia federal court held this did not constitute an “occurrence,” and the underlying plaintiffs (health care provider and governmental entities) were seeking recovery for economic losses and costs of abating the opioid epidemic, which are not “damages because of bodily injury.”¹³⁹

The U.S. Court of Appeals for the Second Circuit affirmed a lower court’s ruling that insurers had no duty to defend or indemnify a firearms retailer in three underlying lawsuits alleging public nuisance and other claims relating to their intentional marketing and sales of “ghost gun” kits to individuals who could not buy firearms through legitimate channels. Governmental entities claimed that the activities led to increased gun violence and imposed increased costs and financial burdens on them in a variety of ways, including investigating and responding to crimes and gun-related injuries. The Second Circuit held that the claims did not arise from an “accident” or “occurrence” under Texas law. The court focused on the gravamen of

the complaints alleging intentional activity and ignored the inclusion of conclusory legal labels of negligence in analyzing coverage.¹⁴⁰ These coverage victories are important considering the unwelcome development of public nuisance claims emerging as a super-tort.

From drugs and guns to insurrection. The Second Circuit determined that a New York federal court did not err in finding that Venezuelan President Nicolás Maduro's actions against the American-recognized government of Juan Guaidó constituted an "insurrection" within the meaning of Citgo's marine cargo reinsurance policy, as the Maduro regime's actions were violent and constituted an uprising to overthrow the recognized government. The court affirmed a \$54 million judgment in favor of Citgo.¹⁴¹

Health Insurance: Health insurance continues to present concerns in terms of scope and costs of coverage, with the Affordable Care Act of 2010 not living up to its name. Premium subsidies were funded during the pandemic, but are scheduled to expire at year-end. Congress recessed for 2025 without passing legislation to address the issue. Legislative action is required, but may prove difficult in view of the sharp divides between the political parties. The upcoming year promises to present changes in the health insurance landscape.

Weather-Related Claims: Climate change continued to drive insurance instability in 2025, particularly in California, Florida, and Louisiana, where extreme weather events such as wildfires, hurricanes, and flooding led to rising premiums and large insurer withdrawals and insolvencies. Between 2018 and 2023, insurers canceled or non-renewed nearly 2 million policies in these states. In response, California regulators began allowing insurers greater flexibility in setting premiums after multiple insurers announced they would stop or limit writing homeowners' policies. Tort reform in Florida included steps to address insurer insolvencies.

Property insurers processed 28 percent fewer claims in the third quarter of 2025 compared to the third quarter of 2024, according to Verisk's Q3 2025 Quarterly Property Report. The industry is on track to have the lowest claim volume in five years. The drop appears to be attributable to a mild 2025 hurricane season in North America. Catastrophe claims declined 32.7 percent while non-catastrophe claims decreased 26.1 percent year-over-year. Wind and hail-related perils dominated, accounting for 51 percent of all combined claims in the third quarter. Texas maintained its position as the state with the highest claim volume at 136,870 claims, though this represented a 53 percent decline from third quarter of 2024. Wyoming experienced the most dramatic shift with a 6,479 percent increase in catastrophe claims due to a major hail event near Cheyenne. Alaska saw a 429 percent increase driven by fire claims, while Vermont posted the largest decrease at 87 percent.

Individual claim costs are projected to reach between \$17,258 and \$18,431, once fully matured, potentially making it one of the most expensive quarters on record. In the second quarter of 2025, average replacement cost value increased 8.5 percent from \$16,944 to \$18,384. The gap between declining volumes and increasing costs per claim suggests that favorable weather patterns may provide only temporary relief.¹⁴²

In January 2025, the Palisades Fire and Eaton Fire in Los Angeles destroyed over 16,000 structures and caused industry-wide insured losses of an estimated \$45 billion. With respect to claims arising out of wildfire losses, a California appellate court decision ruled that minor infiltration of wildfire debris and smoke into a home that does not alter the property in any lasting or persistent manner and that is easily cleaned is not considered covered property damage within the meaning of the homeowners' policy.¹⁴³ A federal court decision likened smoke to asbestos while differentiating smoke from viruses for insurance coverage purposes.¹⁴⁴ The U.S. Court of Appeals for the Eighth Circuit determined that soot damage – like asbestos

damage and unlike a virus – is both “directly material, perceptible, or tangible” and “permanent, absent some intervention.”¹⁴⁵

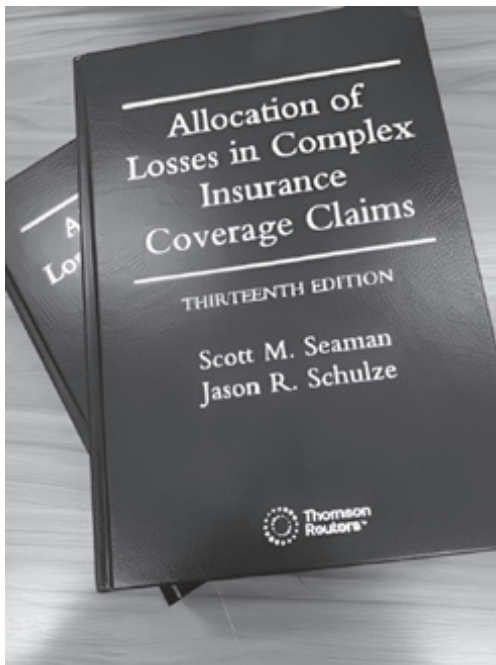
What To Look For In 2026: Insurance, as a fundamental economic engine of growth and stability, will play a central role in addressing the full range of challenges that ricochet throughout the economy. In 2026, these are expected to include supply chain vulnerabilities, mental and physical health, workforce shifts, climate change, affordability, and technological advances. With a divided federal government, insurers may play an outsized role in addressing health care coverage and premium challenges.

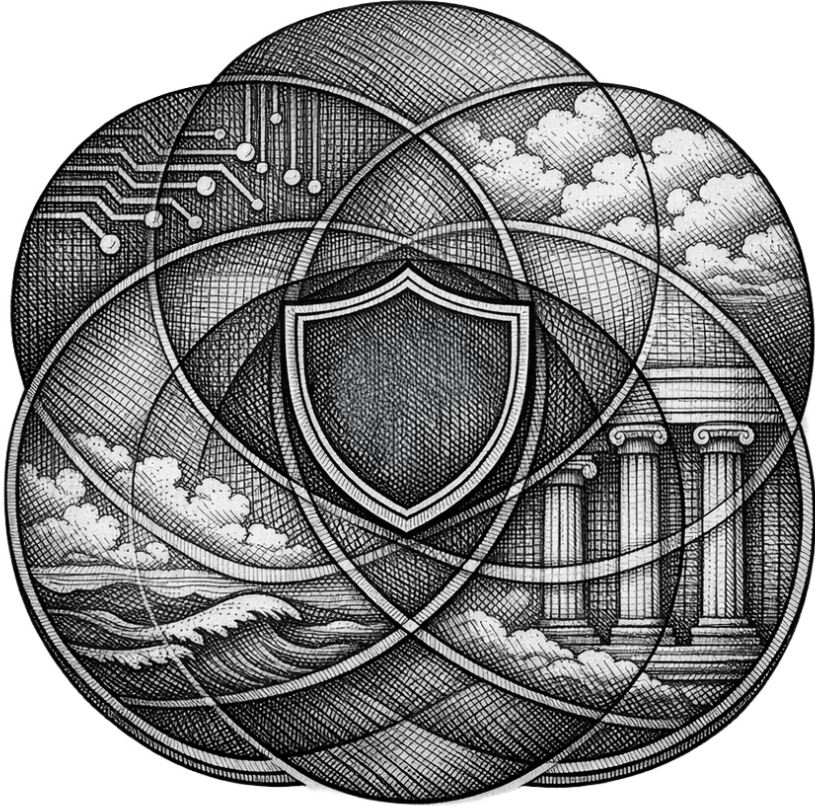
Cybersecurity and AI will continue to provide an overriding backdrop for insurers and policyholders. AI is transforming risk profiles of companies across industries, and the insurance market is only beginning to adapt. The limited loss activity and historical data complicates underwriting and pricing. The pace of technology and application of AI presents evolving challenges as policyholders and insurers adopt AI protocols, practices, and loss controls. Policyholders will continue to examine their traditional coverages, such as professional liability, general liability, workers’ compensation, intellectual property, products liability, media liability, D&O, crime/fraud, employment practices, and property insurance, in connection with insurance renewals to identify and fill potential gaps in coverage for AI-related losses. After an AI-related loss is experienced, policyholders will search for “silent AI coverage” in their traditional policies. In many ways, coverage litigation involving “silent AI coverage” may mirror the “silent cyber” coverage experience. Insurers are adding exclusions and endorsements with sub-limits on traditional policies to expressly address AI to extend and to limit coverage. New AI-specific coverages are emerging and constitute a multi-billion dollar market. There may be some initiatives for mandated AI coverage and government backstops for major AI events. Although AI will pose unique challenges, for many issues cyber and AI risks may best be addressed in tandem.

A host of new data privacy laws took effect on January 1, 2026, including the Indiana Consumer Data Protection Act, the Kentucky Consumer Data Protection Act, and the Rhode Island Data Transparency and Privacy Protection Act. The right to cure periods under the existing Delaware and Oregon privacy acts expired on January 1, 2026. The revised California CCPA regulations became effective on January 1, 2026, along with the California Delete Act regulations.

Insurers will continue to address social inflation through tort reform and education in 2026. They will push for third-party litigation funding disclosure and limitations and track third-party funding bills (one requiring disclosure of litigation funding in federal court cases and another precluding litigation funding by foreign entities) that are currently before the House Judiciary Committee.

All of the claim types discussed above are expected to be subject to additional rulings in 2026, particularly in areas of cyber-specific policies, AI, and PFAS. Emerging claims areas include IT outages, glyphosate-related claims (Roundup), formaldehyde (chemical hair straighteners), and processed-food claims.





CHAPTER 11

D&O LIABILITY & COVERAGE TRENDS & DECISIONS

The past year has been an interesting and action-packed year in the world of Directors & Officers (D&O) liability and coverage. We begin by examining some of the key trends and developments impacting directors, officers, and their insurers. Significant trends include the impact of the Trump administration on D&O liability, artificial intelligence (AI), environmental, social, and governance considerations (ESG), employment practices and diversity, equity, and inclusion (DEI); the potential of moving from quarterly mandatory reporting to bi-annual reporting; allowing corporate bylaws to provide for arbitration of securities actions; DExits (the movement of company places of incorporation away from Delaware to other states such as Nevada and Texas); and pig butchering.

Overall, insofar as the federal government elevates economic concerns over environmental and social considerations, the frequency and severity of D&O claims may be reduced. In general, the expected appointment of more conservative federal judges is viewed as favorable in terms of reducing litigation-related liabilities.¹⁴⁶

Companies and their managers still face an environment rife with risks, exposures, and uncertainty. Cyber and AI continue to present substantial risks as well as opportunities. Tariffs have injected some uncertainty, but so far, the fears expressed by some economists have not been fully realized. Credit risks, trade risks, and political risks historically have not been viewed as presenting significant concern domestically, but in recent years, these risks have presented greater concerns along with social unrest and have caused many companies to seek insurance coverage for these risks.

Global business insolvencies also present risks for D&O liability. For private companies, insolvencies appear to be rising by 6 percent in 2025 and are predicted to rise another 5 percent in 2026. Reportedly, there were 17 bankruptcies of companies with over \$1 billion in assets during the first half of 2025, the highest number since the COVID-19 pandemic. Accordingly, directors and officers must concern themselves with the solvency of their companies as well as the financial condition of customers and companies in the supply chain.¹⁴⁷

Health and safety risks remain ever-present for companies and their officers and directors.

SEC Enforcement Activity Has Declined Overall: The United States Security Exchange Commission's (SEC) enforcement action reached its lowest level in ten years overall, though insider trading and market manipulation enforcement activities have increased. The SEC appears to be focusing greater scrutiny on foreign companies listed on U.S. stock exchanges. This has been attributed to a shift in enforcement priorities under Trump 2.0 and a decline in the size of the SEC's workforce.

Artificial Intelligence; AI has impacted society and businesses in ways that are both transformative and disruptive. AI presents major opportunities and exposures for companies and their directors, officers, and insurers. AI-washing claims have been brought against companies for publicly overstating their AI capabilities or making material misstatements or omissions regarding the reliability and oversight of complex technological systems. The \$65 million pending settlement between Snapchat Inc. (SNAP) and its investors to resolve a putative securities class action served as an eye-opener for D&O underwriters where companies adopt AI into their core infrastructure.

¹⁴⁸ The case was brought on behalf of investors who purchased SNAP securities under Sections 10(b) and 20(a) of the Securities Exchange Act and Rule 10b-5. Companies and executives touting themselves as

safe, transparent, or containing best practices without maintaining a robust compliance infrastructure may face such claims.

There has been a rise in AI-related securities class action litigation. There have been at least 53 AI-related lawsuits filed since 2020. According to the *Stanford Law School Securities Class Action Clearinghouse*, during the first six months of 2025, 12 AI-related securities class action lawsuits were filed on top of the 15 filed in 2024.¹⁴⁹ AI-related securities suits have included lawsuits against companies that are providing AI products or services. Many have been AI-washing claims that contain allegations similar to those that have been the subject of SEC enforcement actions. AI-related securities class action lawsuits also may involve companies that, rather than allegedly overstating their AI capabilities or prospects, allegedly understated their AI-related risks and misled investors by downplaying them. Other AI-related actions may involve the use or misuse of AI by companies and their managers, defamation, intellectual property claims, and shareholder derivative suits.

President Trump has paused an alleged draft executive order that would seek to preempt state laws on AI through lawsuits and by withholding federal funds. Earlier this year, the Senate voted 99-1 against an effort to block states from enacting AI laws through the \$42 billion Broadband Equity, Access, and Deployment program. Many expressed concerns about the impact on federalism and limiting the ability of states to protect their residents from fraud, deepfakes, and child abuse or pornographic imagery.¹⁵⁰

Much of the media coverage has been directed toward degenerative AI. But agentic AI – artificial intelligence systems that are capable of operating and developing autonomously and independently with little or no human oversight – presents significant risks as well when integrated into systems through application programming interfaces. Deepfakes – hyper-realistic media created through AI that can mimic someone’s appearance, voice, and behavior – are increasingly being

adapted for malicious purposes, particularly with respect to identity fraud. Synthetic identity could be used to bypass security systems, such as voice-activated banking systems, facial recognition used for mobile authentication, and online verification processes employed by financial institutions and others. Overall, the expectations have increased for officers and directors to play a greater role in monitoring and providing for cybersecurity. Insurers are using AI in connection with underwriting, risk management, fraud detection, and claims handling. AI is presenting opportunities and challenges for insurers.

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Another concern is AI's displacement of humans in the job market. Although some of these displacements may be offset by the creation of different jobs, several companies have announced reductions in workforce attributable to AI. A new Senate Bill S. 3108 – the AI-Related Job Impacts Clarity Act – would create a federal reporting framework to track how AI is impacting employment in the United States.¹⁵²

These AI risks require insurers, insureds, and brokers to review and negotiate policy terms. Although many D&O policies do not contain cyber exclusions or AI exclusions, there is an increased focus on whether to include such exclusions, whether to interpose sub-limits on such claims, or to otherwise channel such claims to AI- or cyber-specific covers.

Cybersecurity and privacy claims continue to loom large for companies and their officers and directors. Cyber incidents, such as ransomware attacks and outages, continue to be major drivers of D&O claims frequency, and many losses are severe, presenting risks of first-party claims (for property damage and lost business and profits), third-party claims, and governmental enforcement actions. Accordingly, an increasing number of companies are purchasing cyber specific coverage.¹⁵³

Potential For Bi-Annual Reporting: SEC Chair Paul Atkins has indicated that the agency is prepared to move forward with President Trump’s proposal for changing the mandatory periodic reporting requirements for public companies from quarterly to bi-annually. Some support the proposal believing it would reduce reporting costs, cause managers to think longer term, and reduce exposure for companies associated with reporting by virtue of fewer public statements and more time to contemplate the accuracy of disclosures. Others believe that the reduction in costs associated with quarterly reporting may come at the expense of a larger time period for information to be exploited by insiders (*e.g.*, insider trading), increased market uncertainty or adverse impact, or increased volatility of share prices, and potentially reduce the overall quality of reporting.

At the other end of the reporting spectrum is the issue of when intra-quarter reporting is required. The Ninth Circuit recently adopted the “materiality” test for determining when intra-quarter reporting is required in the context of initial public offering under the Securities Act of 1933.¹⁵⁴ The court rejected the “extreme departure” test applied by the lower court and long followed in the First Circuit. The Ninth Circuit now joins the Second Circuit in following the “materiality” test.

Bylaws Requiring Arbitration: The notion of companies avoiding securities class action litigation by adopting bylaws requiring securities law claims to be submitted to arbitration has been flouted for years. The SEC historically has opposed such provisions, but in September the SEC issued a new policy statement (approved by a 3-1 party line vote) that the decision of whether to accelerate the effectiveness of a registration statement will not be impacted by the presence of provisions requiring the arbitration of investor claims arising under the federal securities laws. This issue will be closely watched. The plaintiff’s security bar can be expected to oppose these efforts and, if passed, to seek to infiltrate the arbitration arena with pro-plaintiff arbitrators.

DExits – The Movement Away From Delaware: Delaware has been the leading corporate home for U.S. companies, sporting more corporate incorporations by far than any other state.¹⁵⁵ The desire of Delaware courts to maintain this status more than anything else explains the Delaware judiciary’s reputation for being pro-policyholder in D&O liability insurance coverage matters. However, in recent years, Delaware courts have been seen as less supportive in limiting corporate liability and more inclined to challenge corporate board decisions. As a result, companies have been electing to incorporate in other states such as Nevada and Texas in greater frequency in a movement known as “DExits”. Texas and Nevada are coxing companies by enacting laws making it harder for claimants to sue and prevail against companies. In an attempt to stem the tide of corporate departures, the Delaware legislature enacted S.B. 21 effecting numerous changes to the Delaware Corporations Code.

Among other things, the legislation: (1) limits “controlling stockholders” to individuals who own at least half of a company’s stock or who own a third of stock plus have a managerial role; (2) installs safe harbors controlling stockholder transaction where approved or recommended by a committee consisting of a majority of disinterested directors or approved or ratified by a majority of votes cast by disinterested stockholders; (3) provides that controlling stockholders and control groups, in their respective capacities, may not be held liable for monetary damages for purported breaches of the duty of care; and (4) narrows the scope of “books and records” that shareholders can obtain under Delaware law to include core materials, effectively eliminating rights to obtain emails, texts, and other documents.

Delaware corporations may face lesser exposures with respect to direct and derivative suits filed in Delaware under Delaware law, such as claims for breach of duties. S.B. 21 does not, however, alter federal securities laws or claims under the laws of other states. D&O insurers may benefit in terms of the reduced exposure faced by their

insureds, including under Side A, but S.B. 21 does not purport to directly impact the terms of policies or coverage determinations. S.B. 21 is being challenged on constitutional grounds.

“Pig Butchering”: The term “pig butchering” traditionally referred to the agricultural practice of fattening pigs before slaughter. In today’s world of crypto, it refers to an investment scam where fraudsters gain the trust of victims over time (*e.g.*, grooming them through on-line romance) and coaxing them to invest in fake crypto assets or another fraudulent investment opportunities. For companies and their directors and officers, this presents risks of *Caremark*-type and other claims relating to adequate corporate oversight or ignoring suspicious transactions when crypto tokens are integrated into business operations. Regulators appear locked and loaded with the United States Department of Justice moving in October to seize \$15 billion in Bitcoin tied to “pig-butchering” fraud and two banks being sued in July for allegedly ignoring red flags related to a \$20 million loss resulting from a NFT-related “pig butchering” scam.

The Fine Line Between Notice Compliance & Time-Bar: In *General Cable Corp. v. Scottsdale Indem. Co.*,¹⁵⁶ the court dismissed a lawsuit against a manufacturer’s excess D&O insurers because its claims were either not ripe for adjudication or untimely filed. The court’s ruling on the policyholder’s anticipatory breach of contract claim turned on when the excess policy attached and required the insurer to cover the claims. A contract is not breached, the court explained, until the time for performance has expired. The excess policy provided that “[i]t is expressly agreed that liability shall attach to the Company only after the full amount of the Underlying Limits is paid in accordance with the terms of the Underlying Policies by any or all of the following” The court found that this provision meant the excess insurer was entitled to wait out “good-faith coverage disputes” between the manufacturer and its other insurers without breaching its performance obligations. Accordingly, the manufacturer’s anticipatory breach of contract claim was not yet

ripe for adjudication until the underlying policies were paid, and consequently, the statute of limitations had not yet begun to run. The court dismissed the claim without prejudice.

As for the declaratory judgment claim, the court noted that, under Delaware law, insurance claims become ripe when an insured establishes that there is a “reasonable likelihood” that coverage under the disputed policies will be triggered. Because Scottsdale insured the manufacturer for losses over \$25 million, and because the manufacturer had incurred defense costs far above the policy’s attachment point, the claim became ripe, the court concluded, the day that the underlying accounting investigations and FCPA lawsuits against the manufacturer were resolved in 2019. It was from that date that Delaware’s three-year statute of limitations for the declaratory judgment claim began to run. Unfortunately for the manufacturer, it waited over five years to bring the declaratory judgment action against the recalcitrant excess insurer. Accordingly, that cause of action was time-barred and dismissed with prejudice.

Insurers scored a notable win in *Evanston Ins. Co. v. Frederick*.¹⁵⁷ The policy required the insured to give written notice “as soon as practicable, or within ninety (90) days after expiration” of the policy. As the initial notice only named the entity and not the individuals, the individual insureds failed to comply with the reporting requirement of the policy. The difficulty for the individuals stemmed from the fact that they were named in the suit nearly 2 years after the original notice. Nonetheless, the court held firm to the policy requirements, noting that allowing the insureds to modify or apply constructive notice concepts would be “tantamount to an extension of coverage to the insured *gratis*.”

Non-Application Of New York Law To Foreign Companies: New York’s high court rendered two decisions concerning the application of New York law to disputes between stockholders and companies incorporated in foreign countries. In *Ezrasons, Inc. v. Rudd*,¹⁵⁸ the

New York Court of Appeals held that English law applied to the dispute and affirmed the dismissal of the case. The court determined that the internal affairs doctrine, providing for the application of the substantive law of the place of incorporation to disputes relating to the rights and relationships of corporate shareholders and directors and officers, required the application of English law as Barclays was incorporated in England. The court rejected the stockholder's argument that Sections 626(a) and 1319(a)(2) of the New York Business Corporations Law displaced the internal affairs doctrine and mandated application of New York substantive law to standing questions in shareholder derivative litigation, finding these sections provided New York courts with jurisdiction to hear derivative lawsuits brought on behalf of foreign corporations, but the substantive law of the place of incorporation still determines which stockholders have standing to bring derivative actions.

In *Hausman v. Baumann*,¹⁵⁹ the New York Court of Appeals affirmed the appellate division's decision dismissing a shareholder derivative action filed against a company incorporated in Germany on *forum non conveniens* grounds. Once again, under the internal affairs doctrine, German law controlled and the plaintiff lacked standing to bring a stockholder derivative action.

Enforcement Of Forum Selection Clauses: In *Epicentrx, Inc. v. Superior Court*,¹⁶⁰ the California Supreme Court reversed the Court of Appeals' decision that held the forum selection provision in the company's certificate of incorporation providing the Delaware Court of Chancery as the exclusive forum for most stockholder lawsuits was unenforceable on the basis of there being no right to jury trial in the Delaware Court of Chancery. The California Supreme Court followed the modern trend favoring the enforcement of voluntarily adopted forum selection clauses. The court noted that courts generally should not decline enforcement of contractual forum selection provisions on public policy grounds, especially where no statute or constitutional provision directly addresses the issue. Although California public

policy supports the right to a jury trial, the right may be waived and “concern[s] the right to a jury trial in California courts, not elsewhere.”

Related/Inter-Related Claims: Similar to the issue of the number of occurrences under occurrence-based policies, the subject of related claims made under D&O insurance policies is subject to varying decisions that sometimes may be difficult to reconcile. The different results may be driven by the facts associated with the claims, the language of the policy definitions of “claims” or provisions regarding “related claims,” the test applied by the court in determining whether the claims are related, and whether the insured or insurer is benefited by the determination. Indeed, D&O insurers and policyholders may take different positions regarding relatedness depending on the circumstances. For example, in some cases, an insured may argue in favor of relatedness to avoid multiple retentions. In other cases, an insured may argue against relatedness to recover under greater policy limits across multiple policy years.¹⁶¹

Earlier this year, the Delaware Supreme Court provided its “relatedness” analysis under D&O policies with its decision in *In Re Alexion Pharms., Inc. Ins. Appeals*.¹⁶² The Delaware Supreme Court adopted the “meaningful linkage” standard for relatedness analysis. In this case, the 2014-2015 D&O policy tower included a related claim provision that stated, “any Claim which arises out of such Wrongful Act shall be deemed to have been first made at the time such written notice was received by the Insurer.” The related claim provision in the 2015-2017 D&O tower contained similar language. The insured reported “a notice of circumstances,” based upon an SEC subpoena served on the insured in 2015. At that time, the primary insurer did not consider the company’s communication to be a claim and stated it needed additional information. The company later provided notice in January 2017 of a securities class action filed against the company in 2016. The primary insurer ultimately decided that the SEC subpoena and the securities class action were related, and thus

took the position that “the Securities Action, among other actions, was a single ‘Claim’ first made in the 2014-2015 policy period.” Some of the excess insurers took different positions on relatedness.

The Delaware Supreme Court examined the language of the related claims provisions in the policies. Because terms used in those provisions were undefined, and there was no other textual evidence of the parties’ intent about those terms, the court interpreted the “arises out of” language in the related claim provisions as requiring a “meaningful linkage” between two conditions for them to be related. The court emphasized that the linkage must be meaningful, not merely tangential. The court held that the SEC subpoena and the securities class action were related claims because they involved the same underlying wrongful acts. The common underlying wrongful acts were the company’s alleged improper sales tactics worldwide, including its grantmaking activities. The insurance coverage for both was limited to the earlier of two D&O towers, and the insured could recover only up to the one policy limit. It is important to note that the Delaware Supreme Court adopted the “meaningful linkage” test based upon the language of the policies at issue and different language may warrant a different test or compel a different result.

In *Nat’l Amusements Inc. v. Endurance Am. Specialty Ins. Co.*,¹⁶³ the insurers argued that the 2019 and 2016 lawsuits arising out of the merger of Viacom and CBS were interrelated, making the settlement covered under policies in effect in 2016, rather than 2019. The Delaware Superior Court granted the insured’s motion for summary judgment, holding the 2019 lawsuit was not interrelated with the 2016 lawsuits and, thus, the costs associated with the 2019 suit were covered under the 2019 Policy. The court concluded that the two sets of litigation were not “meaningfully linked.” It found the primary relatedness factor – the conduct underlying the lawsuits – weighed in favor of finding that the claims are not meaningfully linked. Although both sets of lawsuits involved alleged breaches of fiduciary duty, the suits challenge distinct wrongful acts and involve different legal theories.

Additionally, the plaintiffs in the two suits were slightly different, the time periods involved differed somewhat, while there was some overlap in proofs, some evidence was distinct, and one suit sought monetary damages for inadequate merger consideration, while the other sought declaratory and judgment relief.

In *AmTrust Fin. Servs. v. Liberty Ins. Underwriters Inc.*,¹⁶⁴ the insured sought to recover costs it incurred in connection with two shareholder lawsuits filed in 2017. The insurer participated in a tower of coverage effective September 30, 2016 to September 30, 2017. The insurer argued that an earlier tower provided the proper source of coverage because the 2017 lawsuits “arise out of” circumstances noticed by AmTrust during the earlier period. The policy language provides that claims are not covered if they “aris[e] out of any circumstances of which notice has been given” under any prior policy. Applying *Alexion* here, the court concluded that there is a meaningful link between the 2015 Notice of Circumstance and the 2017 Securities and Derivative Lawsuits. Most important, they involve the same alleged conduct (specific accounting improprieties and material misrepresentations in financial statements regarding those specific improprieties), they rely on the same evidence (financial statements and public statements by officers regarding AmTrust’s accounting), the relevant time periods overlap, and the theories of liability are similar (alleging AmTrust committed specific violations of accounting rules causing its financial statements to be materially misleading and/or false). Accordingly, the court determined AmTrust’s costs incurred with respect to the Securities and Derivative Lawsuits are excluded under the 2016/2017 policy period and are properly attributed to the 2014–2015 policy period.

In *Navigators Specialty Ins. Co. v. Avertest, LLC*,¹⁶⁵ the court ruled that two claims were not related. Avertest operates a laboratory that conducts drug testing of biological samples. In 2021 (during a period it was insured by Continental), the *Gonzalez* suit was filed, alleging that Avertest prioritized speed over accuracy in its testing

procedures, resulting in false positives that caused plaintiffs to lose custody or visitation rights with their children. In 2022 (during the policy period Averhealth was insured by Navigators Specialty), Averhealth was sued in the *Foulger* case. Plaintiffs in the two cases were represented by the same lawyers, the suits were filed in the same federal district, and the allegations concerned the same core misconduct of prioritizing speed over accuracy and using improper testing methods, and the harms alleged involved frustrating child visitation rights of parents. The court nonetheless ruled in favor of the insured concluding that the allegations in the lawsuits were not sufficiently similar to constitute related claims under the Navigators and Continental policies.

In *Boyne USA, Inc. v. Fed. Ins. Co.*,¹⁶⁶ the court ruled against the insured finding the Montana and Michigan actions were related claims because the actions assert causes of action against Boyne based on the same general business practice and course of conduct concerning a mandatory rental management program. Although the suits were brought by different plaintiffs, in different forums, and concerned different properties, Boyne's mandatory rental management program is at the center of both lawsuits. The main distinction in outcomes in these cases was that, in *Avertest*, the court applied the more restrictive "common nexus" test, whereas here, in *Boyne*, the court emphasized that "the relevant inquiry was whether there is a "single course of conduct" that serves as the basis for the various causes of action. This "single course of conduct" test was previously endorsed by a Delaware bankruptcy court and district courts in California and Illinois. That standard differs from what courts have applied in Delaware ("meaningful linkage") and most recently in Virginia ("common nexus of facts" that "arose from the same occurrence of wrongful acts" to make claims "sufficiently similar"). Issues of what constitutes a claim, when claims are made, and whether claims are related will continue to be among the most litigated issues under D&O liability policies.

California Insurance Code Section 533: The United States Court of Appeals for the Ninth Circuit held that coverage for settlement amounts and defense costs incurred in an underlying employee and client poaching lawsuit was barred by California Insurance Code Section 533. Section 533 bars insurance coverage for losses caused by the willful act of the insured. In *United Talent Agency, LLC v. Markel Am. Ins. Co.*,¹⁶⁷ one of United Talent Agency's (UTA) competitors, Creative Artists Agency (CAA), sued UTA for allegedly stealing CAA's clients and employees. CAA asserted claims against UTA for inducing breach of contract, intentional interference with prospective economic advantage, conspiracy to breach a fiduciary duty, intentional interference with contractual relations, and aiding and abetting a breach of fiduciary duty. Markel, which issued a management liability insurance policy, denied coverage for a variety of reasons, including that the claim was precluded by the operation of California Insurance Code Section 533. UTA sued the insurer for breach of contract and bad faith. The district court granted the insurer's motion for summary judgment, agreeing coverage was precluded by the application of Section 533. UTA appealed. The Ninth Circuit affirmed, concluding that "there is no genuine dispute that the CAA litigation alleged willful acts by UTA, thereby triggering Section 533's exclusionary clause." The Ninth Circuit pointed out the gravamen of the underlying complaint is that UTA conspired to steal and deliberately stole CAA's clients and employees and any alleged non-willful acts were so closely related to UTA's conspiracy to harm CAA as to constitute the same course of conduct for purposes of Section 533." California courts have broadly applied Section 533 to bar coverage claims under D&O liability policies as well as general liability policies.

Payment By Non-Insured Does Not Satisfy An SIR: The Delaware Supreme Court in *In re Aearo Techs. LLC Ins. Appeals*,¹⁶⁸ affirmed the lower court's ruling that payment of defense costs by a non-insured did not count toward the insured's self-insured retention, and that the insured's payment of the self-insured retention was a

condition precedent to the insurer's obligation to cover losses under the policy. The coverage dispute arose out of the insurers' denial of coverage to 3M Company and Aearo Technologies for coverage, including reimbursement of their defense costs, incurred with respect to thousands of bodily injury claims resulting from allegedly defective earplugs. The relevant policies each included self-insured retention obligations of the insured Aearo for \$250,000 per occurrence, subject to an aggregate maximum of \$1.5 million.

The court rejected the argument of 3M and Aearo that the payment of defense costs by 3M, an entity not insured under the policies, on behalf of Aearo satisfied Aearo's self-insured retention obligations under the policies. The court found that the self-insured retention clauses unambiguously obligated the insured alone to satisfy the self-insured retention. The court also rejected the argument, based upon the policies' maintenance clause, that the amount of the SIR may be used by the insurers as an offset from the amount of coverage owed rather than as a basis to forfeit coverage. The court held that an insurance policy maintenance clause serves the dual purposes of not relieving an insurer of its coverage obligations if an insured is bankrupt or insolvent and not requiring an insurer's coverage obligations to drop down if an insured fails to pay its self-insured retention. Accordingly, the court determined the maintenance clauses were inapplicable. The court noted the fundamental purpose of a self-insured retention is to obligate the insured to share in the risk and assume the first layer of coverage. The court analogized the situation to a primary and excess insurance relationship, such that failure of the primary coverage to be exhausted means the excess coverage is not triggered.

No Action Clauses: *Origis USA LLC v. Great Am. Ins. Co.*,¹⁶⁹ involved two towers of insurance. In a coverage action filed by Origis, the 2021 insurers filed a motion to dismiss, arguing that, because the underlying matter was still pending, the coverage lawsuit violates the policy's "no action" clause. The insureds argued the "no action"

clause precludes suits against the insurer while the underlying action is pending *only* for suits brought by third-party claimants, but *not* for claims for coverage brought by insured persons. The 2023 insurers moved to dismiss, arguing that the Prior Acts Exclusions preclude coverage because all of the allegedly wrongful acts occurred prior to the past acts date. The insureds argued that three paragraphs in the underlying complaint constituted a separate claim involving alleged wrongful acts occurring after the past acts date. The Superior Court granted both motions to dismiss.

In a unanimous decision, the Delaware Supreme Court affirmed the Superior Court's ruling with respect to the separate claim/past acts date issue. On the "no action" clause issue, the Supreme Court remanded the issue to the Superior Court for further proceedings. The court found that there were various policy provisions, particularly with respect to the advancement and allocation of defense expenses, that potentially could be relevant to the determination of the meaning and application of the "no action" clause. The insureds argued that the insurers' defense cost obligations are present obligations, and the provisions requiring advancement and allocation of defense costs required the insurer to make present payments of allocated expense amounts, making the "no action" clause inapplicable to these issues. The court did not reject to the lower court's analysis but believed a "more in-depth analysis that considers the combination of these provisions and how they function together" was required.

What A Difference A "The" Makes: In *Paloma Res., v. Axis Ins. Co.*,¹⁷⁰ the United States Court of Appeals for the Fifth Circuit reversed the grant of summary judgment in favor of the insurers based upon the Intellectual Property exclusion. The insured, Paloma, argued that the placement of the determiner "the" immediately preceding the phrase "misappropriation of ideas or trade secrets" in the exclusion suggests no carryover modification by the phrase "actual or alleged" to the clause – the result being *actual*, as opposed to *alleged*, misappropriation of trade secrets is required to trigger

application of the exclusion. Further, Paloma argued it is nonsensical to read the exclusion as applying to “any actual or alleged ... the misappropriation of trade secrets” and that the inclusion of the determiner “the” before “misappropriation” signals a break from the series of infringement actions modified by the phrase “actual or alleged.” The decision and its acceptance of the insured’s linguistic gymnastics is subject to criticism as the underlying claim was the type of IP claim the exclusion was designed to exclude from coverage.

Bump-Up Exclusion: In *Towers Watson & Co. v. Nat’l Union Fire Ins. Co.*,¹⁷¹ the United States Court of Appeals for the Fourth Circuit, applying Virginia law, held that the bump-up exclusion applied to bar coverage for a \$90 million settlement of litigation related to Towers Watson’s January 2016 merger with Willis Group Holdings. In a prior decision, the Fourth Circuit reversed the district court ruling that the merger agreement did not involve an “acquisition” within the meaning of the bump-up exclusion. It remanded the case without reaching an ultimate determination of whether the exclusion barred indemnity coverage. In this decision, the Fourth Circuit resolved the applicability of the exclusion. It determined that the district court correctly granted summary judgment on the “bump-up” exclusion because the two remaining elements for the exclusion to apply were satisfied. First, there was a claim alleging that the consideration paid for the acquisition was inadequate. Second, the settlement represented an effective increase in the price or consideration shareholders received. The term “represented” and the phrase “effectively increase” were not defined in the policies. Accordingly, the court properly turned to dictionary definitions for the plain meaning of these words.

The Fourth Circuit shot down the major arguments advanced by Tower as to why the exclusion should not apply. It may be true that allegations of violations of Section 14(a) of the Securities Exchange Act involve disclosures rather than adequacy of consideration. Nonetheless, the reality here is that the settlement represented an increase in consideration. The court also rejected Tower’s illusory

coverage argument. In this case, the insurers actually paid millions of dollars in defense costs in this matter. Further, most security claims do not involve corporate acquisitions, so coverage may be afforded in many instances and under many circumstances, notwithstanding the presence of a “bump-up” exclusion. Finally, the court rejected Tower’s more narrow argument that \$17 million of the \$90 million settlement was not excluded because it ended up going toward attorneys’ fees. The Fourth Circuit recognized that the full \$90 million actually was paid into a common fund entirely for the benefit of shareholders. Once paid to the beneficiaries, the ultimate distribution of the funds had no consequences in terms of the application of the exclusion. Money ultimately going toward attorneys’ fees does not mean that this sum did not represent part of the amount of increased consideration.

This case represents a favorable decision for insurers seeking to apply similarly worded “bump-up” exclusions. The decision pumps up the bump-up exclusion.

Insurers have not fared as well with bump-up exclusions in Delaware. In January 2025, a Delaware Superior Court decision held in *Harman Int’l Indust., Inc. v. Illinois Nat’l Ins. Co.*,¹⁷² that a D&O insurance policy’s bump-up exclusion did not preclude coverage for amounts paid in settlement of claims arising out of Harman International’s reverse triangular merger with Samsung Electronics America. In that case, Judge Wallace accepted one of the arguments rejected by the Fourth Circuit in the *Towers Watson* case. He ruled that, because the underlying claim involved only allegations under Section 14(a), for which an increase in consideration is not a remedy, the settlement could not have involved an increase in the deal consideration. Previously, Judge Wallace ruled in *Northrop Grumman Innovation Sys., Inc. v. Zurich Am. Ins. Co.*,¹⁷³ that a bump-up exclusion did not apply to preclude coverage for a settlement of a Section 14(a) merger objection lawsuit. In *Viacom Inc. v. U.S. Specialty Ins. Co.*,¹⁷⁴ the court granted summary judgment to the insured, finding the exclusion to be ambiguous as to whether it encompassed mergers

in addition to pure acquisitions. The court noted that a reverse-triangular merger might be a covered merger rather than an excluded acquisition.

Parties must review the language of the particular bump-up exclusion, as there are different wordings.

Capacity Exclusion; In *Mist Pharms, LLC v. Berkley Ins. Co.*,¹⁷⁵ the New Jersey intermediate appellate court reversed the decision of the trial court and determined that the claims were barred by the capacity exclusion in a D&O policy. The lower court avoided application of the capacity exclusion by finding that the insurer breached its duties under the policy by unreasonably withholding the insured officer/director's request to consent to a settlement.

Many liability policies require the insurer's written consent to settle without containing any requirement that the insurer not unreasonably withhold consent. Where the policy does not impose any reasonableness requirement, the insurer generally has the absolute right to grant or withhold consent in accordance with its own interests, particularly in the context of general liability policies. After all, the requirement of consent is for the protection of the insurer. Many courts recognize this, but some courts do interpose an obligation to act reasonably as a matter of contract law or based upon the requirement of good faith and fair dealing.

Under policies that expressly provide that the insurer may not withhold consent unreasonably, the refusal to withhold consent, of course, must be reasonable. Here, the appellate court determined that the insurer's refusal to provide consent to settle was reasonable under the circumstances. First, the global settlement at issue represented the separate interests of multiple entities not insured under the D&O policy. Second, the insurer reserved its rights under the capacity exclusion. Third, the circumstances put in play the issue of whether the capacity exclusion applied to bar coverage. The insured director/

officer is alleged to have engaged in wrongful corporate acts in dual capacities – first acting in an official capacity as a director/officer of the insured business and second in an official capacity as a director/officer of an uninsured business.

The capacity exclusion provides “T]he Insurer shall not be liable to make any payment for Loss in connection with a claim made against any Insured . . . based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving any Wrongful Act of an Insured Person serving in their capacity as director, officer, trustee, employee, member or governor of *any other entity other than an Insured Entity* or an Outside Entity, or by reason of their status as director, officer, trustee, employee, member or governor of such other entity. The appellate court seized upon the expansive interpretation by New Jersey courts of the phrase “arising out of” whether it appears in a coverage grant or in an exclusion. The court relied upon an Eleventh Circuit decision under Georgia law enforcing a similar capacity exclusion.¹⁷⁶ The New Jersey Supreme Court granted review, and the case remains pending.

Allocation: In *Flextronics Int’l. Ltd. v. Allianz Glob. Corp.*,¹⁷⁷ the court upheld a \$11 million arbitration award in favor of an international supply and manufacturing company. Under the terms of the subject third-layer excess D&O policy, where a claim involved both covered and uncovered claims or entities, the parties “shall use their best efforts to determine a fair and proper allocation of loss covered under this policy.” The policies applied New York law, except as to “insurability of damages,” where “any applicable” law favoring the insured on that issue would apply. The matter arose out of a trade secrets lawsuit against the company and four executives, which settled for over \$42 million. The insured sought to recover \$10,963,951 from Allianz (plus pre-award interest), representing the loss that remained after subtracting the \$45 million in underlying limits. The insurer argued that Flex’s recoverable loss did not exceed \$45 million—and therefore could not reach Allianz’s layer—because

some percentage of the total loss should be allocated to the two non-covered corporate defendants.

The arbitration panel, however, ruled for Flex, holding that the parties' insurance policy entitled it to receive the entirety of its \$10,963,951 claim against Allianz. Flex argued for Delaware law's "larger settlement" rule, under which a loss is fully recoverable unless the insurer can show that the non-covered conduct increased its liability. Allianz countered that New York's "relative exposure" rule governs, under which the insurer and insured allocate settlement costs between covered and non-covered parties, with the insurer bearing the burden to prove the amount that should be excluded from coverage. The panel agreed with Allianz, finding New York's relative exposure rule to apply. Applying the relative exposure rule, however, the panel concluded that Allianz should bear the entire covered loss. It determined that the liability of the two uninsured corporate entities was "concurrent and conterminous" with that of the four insured directors and officers, such that those four insured parties had exposure for acts and omissions of the noninsured corporate entities. The panel concluded that Allianz had not met its burden of proving that any part of the settlement should be excluded from coverage. The only evidence that Allianz had offered was an expert's testimony and report that the panel found to be unpersuasive and of little probative value. The panel noted that the expert had never read the policy at issue, did not consider any correspondence among the parties as to allocation, and premised his opinions on the assumption given to him by Allianz, that "the liability of the defendants on any claim should be allocated on a "per capita basis" without any effort to analyze and evaluate the relative exposure of the defendants. The court confirmed the award and denied Allianz's cross-motion to vacate, demonstrating the limited grounds and high showing required to vacate an arbitration award.

The decision speaks more to the power of an arbitration panel than to the substance of allocation. For a detailed discussion of allocation

issues under D&O policies, *see generally*, Scott M. Seaman and Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 14 (Allocation Issues and Satisfaction of Claims-Made Requirements Under Directors and Officers Liability Contracts).

Cash Is No Longer King In Delaware: Growing up many of us were told “cash was king.” The concept has eroded as reflected by some restaurants and retailers refusing or unable to take cash. The concept of cash being king took another hit with the Delaware Superior Court decision in *AMC Ent. Holdings, Inc. v. XL Specialty Ins. Co.*¹⁷⁸ In this case, the court found that the insured movie theater’s settlement payment made in the form of its stock valued at \$99.3 million qualified as a covered “Loss” under its D&O policy.

The court rejected the insurer’s argument that there was no coverage for the settlement payment because it was not a “Loss” under the terms of the policy. The policy defined “Loss,” in relevant part, as “damages . . . settlements . . . or other amounts . . . that any Insured is legally obligated to pay.” Further, the policy provides that the insurer will “pay ‘Loss’ on behalf of AMC.” The insurer contended that, because the settlement involved the issuance of stock, not cash, and because the insurer could not pay the settlement on AMC’s behalf, it was not a covered “Loss.” The court disagreed, finding that “Loss” was not limited to cash payments. It emphasized that, under Delaware law, stock is a form of currency that can be used for a variety of corporate purposes, including settling debts. Thus, AMC’s issuance of stock was deemed a covered “Loss,” which the court refused to limit in a way not explicitly provided for in the D&O policy. Further, the court looked to the policy’s bump-up exclusion, which uses the word “paid” twice. The court stated, “[t]his exclusion is not applicable to the issue presented, but its use of the word ‘paid’ is relevant” because words used in different parts of a policy are presumed “to bear the same meaning throughout[.]” The court reasoned that because under Delaware Law the bump-up exclusion, and its use of the word “paid,”

can apply to stock transfers, it is “necessarily implie[d] that stock can be an amount AMC ‘pays’ which creates a covered ‘Loss’.”

The court also rejected the insurer’s argument that AMC did not suffer economic harm, noting the policy did not condition coverage on the existence of such harm. The court refused to “insert a restricting clause into the Policy.”

Finally, the court ruled that whether AMC sought the insurer’s consent to settle or waiver of consent on a phone call presented a factual issue to be decided by a jury. However, the court noted that Delaware law allows a policyholder that does not comply with consent requirements to obtain coverage by rebutting the presumption that the insurer was prejudiced by the breach and showing that the settlement was reasonable.

Perhaps more than anything this case illustrates the accuracy of the “pro-insured” approach commentators often ascribe to Delaware courts when addressing D&O coverage issues. Apart from bending the “Loss” provision beyond recognition and ignoring the consent to settle requirement, the court’s look to the “bump up” exclusion (which Delaware courts have avoided applying) to justify its ruling on “Loss” was a stretch. Decisions such as this may cause insurers to revise policies to prevent or limit the forms or methods of payments that satisfy “Loss” or “exhaustion” requirements. Insureds on the other hand may seek endorsements to accommodate cryptocurrency or other forms of payments.

Although the foregoing discussion is focused on trends and decisions over the past year, it provides a solid overview of directors’ and officers’ liability coverage and litigation.

CHAPTER 12

PFAS/FOREVER CHEMICAL REGULATION, LITIGATION & INSURANCE COVERAGE ISSUES

Per and polyfluoroalkyl substances (“PFAS”) represent major exposures to insurers and their policyholders. Thousands of lawsuits are pending nationwide, and numerous large settlements have already been reached. Insurers are facing claims, tenders, and coverage actions from policyholders seeking defense and indemnity for PFAS-related claims. The plaintiffs’ bar is focused on PFAS and views these so-called “forever chemicals” as a fertile source of lawsuits and large recoveries. Though late to the game, federal and state regulators are now locked and loaded on regulating these substances in significant ways. Whether or not PFAS-related liabilities present losses to the insurance industry that will rival asbestos-related liabilities remains to be seen. Nonetheless, insurers are preparing for numerous claims and large losses.

THE WIDE-SPREAD USE OF PFAS

PFAS is an umbrella term encompassing human-made chemicals to make products stain- and grease-resistant and otherwise useful.¹⁷⁹ There are over 12,000 substances identified as PFAS on the United States Environmental Protection Agency’s (“EPA’s”) PFAS Datasets.¹⁸⁰ PFAS have been patented since the 1940s and have been used in a wide range of consumer and industrial products since at least the 1950s. Similar to asbestos, which garnered widespread use due to its incredible insulation and fire-resistant abilities, PFAS quickly gained traction because of their ability to overcome the natural limitations of fire, oil, and water. PFAS have been included in so many products

and applied in a vast array of contexts that they are described by many as being ubiquitous—even more so than asbestos.¹⁸¹ They are commonly referred to as “forever chemicals” because they are thought to not degrade over time.

Products containing PFAS include food contact surfaces such as cookware, pizza boxes, fast food wrappers, and popcorn bags; stain-resistant and waterproofing treatments on carpets, textiles, furniture, and other products; packaging; additives in polishes, waxes, paints, and cleaning products; protective coatings and sealants; additives to hydraulic fluids and lubricants; aqueous fire-fighting foams; pesticides; and more. Scientists from the Centers for Disease Control found four common PFAS in the blood serum of nearly everyone tested. Though more than 95 percent of Americans may have PFAS in their blood, finding a measurable amount of PFAS in the bloodstream does not establish that the presence of PFAS will cause negative health effects.¹⁸² Forty-five percent of the nation’s tap water purportedly contains one or more PFAS.¹⁸³ PFAS disperse through indoor and outdoor air and are often consumed in food.¹⁸⁴

Researchers and activists cite three primary reasons for PFAS being potentially harmful to human health and the environment: (1) their chemical structures prevent them from breaking down in the environment and in human bodies; (2) they are especially effective contaminants because they move quickly through the environment; and (3) even extremely low levels of exposure *may* negatively impact human health.¹⁸⁵

The name “forever chemicals” actually may turn out to be a misnomer, as researchers at Northwestern University recently published a study showing that PFAS can be destroyed using two relatively harmless chemicals: sodium hydroxide or lye.¹⁸⁶ Previously, the only operational way to break down PFAS was to expose the particles to extremely high temperatures—sometimes above 1,800 degrees Fahrenheit—in

an incinerator. That energy-intensive process can still release harmful chemicals into the environment.

Studies have shown PFAS may contribute to several adverse health impacts, including higher cholesterol, thyroid disease, ulcerative colitis, breast, testicular, and kidney cancers, changes to the immune system, liver disease, low birth weight, decreased sperm quality, pregnancy-induced hypertension, and delayed mammary gland development.

Industry exposures have been difficult to quantify due to evolving science, the ever-present nature of PFAS compounds, and difficulties in identifying and isolating sources and timing of contamination. However, recent modeling by risk experts estimates \$65 billion in corporate losses from PFAS water contamination and another \$15 billion from bodily injury litigation.¹⁸⁷ PFAS-related litigation plainly represents a significant exposure to insurers and their policyholders as well as reinsurers in view of the ubiquity of the substances, their widespread use, rising claim frequency, large settlements, and additional defendants and legal theories subject to litigation.

GOVERNMENT REGULATION OF PFAS

Governmental regulators appear to have arrived on the PFAS regulation scene late, allowing for extensive exposures. But regulators are now focused heavily on PFAS regulation. In 2006, the U.S. Environmental Protection Agency (“EPA”) and several PFAS manufacturers entered into a voluntary agreement to study and phase out some PFAS, with subsequent findings suggesting that a common PFAS was carcinogenic.¹⁸⁸ Over the past couple of years, a flurry of regulatory activity has followed.

In June 2021, the EPA issued its first-ever PFAS chemicals reporting proposal, which would require all manufacturers and importers to gather and report the categories and use of PFAS chemicals, volumes

manufactured and processed, byproducts, environmental and health effects, worker exposure, and disposal for every year since 2011.¹⁸⁹

In October 2021, the EPA released its “PFAS Strategic Roadmap,” setting timelines by which it plans to take specific actions safeguarding public health, protecting the environment, and holding companies accountable. The “PFAS Strategic Roadmap” embodies a four-year plan to research, restrict, and remediate PFAS use.¹⁹⁰ Over the past six months, the EPA issued significant regulations that will further increase the resources and funds that companies will be required to devote to tracking and remediating PFAS use.

On October 11, 2023, the EPA issued its final rule regarding PFAS under the Toxic Substances Control Act.¹⁹¹ The rule requires every company that manufactured or imported PFAS for a commercial purpose in and after 2011 to report PFAS data to the EPA within 18 months of the rule’s November 13, 2023, effective date. The EPA has subsequently issued multiple rules delaying the reporting period, which is currently set to begin April 13, 2026, with submission due by October 13, 2026, for most manufacturers and by April 13, 2027, for small manufacturers reporting exclusively as article importers.¹⁹² The reportable data under the rule includes chemical identity and molecular structure, quantities, how the reporting entity and consumers used the chemical, health and environmental impact, disposal methods, and more. The rule covers over 1,462 chemicals. The EPA requires companies to obtain information from the reporting entities’ entire organization, not merely management and supervisory personnel. Compliance may also require inquiries outside the organization. Understandably, many companies, trade associations, and professional advisors are concerned about the costs of reporting and the ability to comply with these onerous reporting requirements for these ubiquitous substances. Many are skeptical about the utility of the reporting requirements and concerned that the reporting scheme will mostly accrue to the benefit of the plaintiffs’ bar.

In January 2024, the EPA added seven more PFAS to the chemicals covered by the Toxics Release Inventory, expanding the types of PFAS that are subject to data tracking and collection obligations for some industries.¹⁹³ It also finalized a new use rule that prevents companies from starting or resuming the manufacture, processing, or importing of PFAS that they had previously discontinued.¹⁹⁴ Under the rule, companies that wish to restart manufacturing, production, or importing of 329 PFAS that are designated as inactive on the Toxic Substances Control Act's Chemical Substance Inventory must notify the EPA at least 90 days before starting to process those chemicals for significant new use. The EPA, in turn, will conduct a review that "assesses whether the new use may present unreasonable risk to the health or the environment" and take appropriate action "as required to protect health or the environment."

On April 10, 2024, the EPA announced the National Primary Drinking Water Regulation ("NPDWR").¹⁹⁵ The final rule establishes legally enforceable Maximum Contaminant Levels specific to five types of PFAS, ranging from 4 to 10 parts per trillion, and sets some PFAS reduction benchmarks that must be achieved over the next three to five years. Although this rule targets public water systems, it is expected to have downstream effects on wastewater treatment facilities and other companies that are permitted to discharge wastewater containing forever chemicals. The 2021 Infrastructure Law made \$9 billion available to help communities affected by forever chemicals in drinking water and \$12 billion available for general drinking water improvements, but the costs for some municipalities to remediate water systems are expected to dwarf those sums. Utilities are expected to expand their efforts to seek additional money through litigation against PFAS manufacturers and others to fund the remediation obligations. Indeed, only two days after the NPDWR was issued, some municipal corporations and special districts that own and operate public water systems sued several chemical companies, alleging that they knew their products

would contaminate water supplies and could cause health issues, and citing the NPDWR.¹⁹⁶

On April 19, 2024, the EPA designated two types of PFAS, perfluorooctanoic acid (“PFOA”) and perfluorooctanesulfonic acid (“PFOS”), as “hazardous substances” under the Comprehensive Environmental Response, Compensation, and Liability Act (“CERCLA”).¹⁹⁷ This designation could subject current and former owners and operators of facilities contaminated with PFAS, as well as persons who “arranged for [their] disposal” or treatment and certain transporters, to CERCLA’s retroactive, strict, and joint-and-several liability regime for cleaning up contaminated sites. As a result, entities that manufacture and process PFOA or PFOS, as well as those that manufacture products containing PFOA or PFOS, use products containing PFOA or PFOS, and operate waste management or treatment facilities, may be liable for PFAS contamination at Superfund sites. This designation creates the potential for the listing of new Superfund sites and permits the EPA to reopen settlements for former Superfund sites on which cleanup has been completed due to PFOA and PFOS contamination. Further, this designation now requires facilities working with PFOA and PFOS to report releases of one pound or more within 24 hours.

In conjunction with this designation, the EPA issued its PFAS Enforcement Discretion and Settlement Policy under CERCLA, in which it states that it intends to only target “those parties that have played a significant role in releasing and exacerbating the spread of PFAS in the environment.”¹⁹⁸ The policy statement indicates that “equitable factors” support not seeking liability against the following categories of entities: community water systems and publicly owned treatment works; municipal separate storm sewer systems; publicly owned/operated municipal solid waste landfills; publicly owned airports and local fire departments; and farms where biosolids are applied to the land. These entities reportedly will not be subjected to EPA CERCLA enforcement actions so long as they provide their “full

cooperation [to the] EPA, including providing access and information when requested and not interfering with activities that EPA is taking.” This designation survived the recent change in administrations with the EPA announcing on September 17, 2025, that it would retain this Biden-era designation and seek to “hold[] polluters accountable” for cleanup costs.¹⁹⁹ Indeed, in litigation brought by industry groups challenging the rule, the EPA recently filed an unopposed motion to lift an abeyance that was entered to permit the new administration to determine its position, now indicating that it intends to defend the rule.²⁰⁰

The Environmental Protection Agency (EPA) finalized drinking water standards for six PFAS compounds and expanded reporting requirements under the Toxic Substances Control Act in 2025, while proposing broader disclosure rules.²⁰¹ At the state level, over 350 PFAS-related bills were introduced across 39 states, with 17 new regulations adopted in nine states by mid-year.²⁰² States such as New Mexico and Illinois enacted bans on PFAS in consumer products and packaging, while others focused on water quality and industrial discharge limits.²⁰³

Other federal agencies are also responding to the prevalence and concerns of PFAS. The Food and Drug Administration has moved to remove PFAS from food packaging, first announcing in early 2024 that all grease-proofing agents containing PFAS, used in paper wrappers, pizza boxes and similar products, will cease due to industry phaseout and FDA’s withdrawal of approvals.²⁰⁴ In January 2025, the agency withdrew existing food-contact approvals for those PFAS, effectively banning PFAS-based food wrappers and bags.²⁰⁵ The U.S. Department of Agriculture has likewise adjusted its programs to help farmers manage PFAS impacts: the Dairy Indemnity Payment Program now compensates producers for cows lost to PFAS contamination, and the Natural Resources Conservation Service provides cost-share assistance for PFAS testing of soil and water. Together, these measures reflect federal recognition of the

risks PFAS pose to agricultural land, crops, and livestock. Thus, at this stage, it appears that Trump 2.0 will continue regulating PFAS.

In addition to federal regulations, companies must be cognizant of additional state regulations that, in some cases, may be more stringent than federal regulations. In recent years, multiple states, including Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin, have established enforceable drinking water standards for certain PFAS.²⁰⁶ Delaware and Virginia are considering instituting enforceable standards, and other states have established non-enforceable guidelines.

Several states are also working to adopt more sweeping restrictions on PFAS across major consumer product categories. In 2025, California passed SB 682 to phase out intentionally added PFAS in items such as food packaging, children's products, dental floss, cleaning products, and ski wax by 2028, with cookware following in 2031.²⁰⁷ However, California Governor Gavin Newsom vetoed the measure, citing concerns about cost and availability of cooking products. Illinois has successfully enacted a similarly broad ban covering cookware, cosmetics, children's products, personal care items, intimate apparel, and food packaging beginning in 2026.²⁰⁸ Colorado, through laws passed in 2022 and 2024, has implemented phased product bans and labeling requirements across a wide array of goods, including cookware, cleaning supplies and ski wax.²⁰⁹

States are also expanding disclosure and reporting mandates. Illinois now requires manufacturers of firefighting gear to identify and label PFAS-containing components, with a complete PFAS ban taking effect in 2027, and Minnesota has enacted similar reporting obligations.²¹⁰

Compliance with both state and federal standards will require careful monitoring of an evolving patchwork of requirements and limits.

THE PFAS UNDERLYING LITIGATION LANDSCAPE

Despite the long and widespread use and presence of PFAS, forever chemicals only recently became one of the most fervent areas for civil litigation. However, the litigation floodgates are now wide open with thousands of PFAS-related cases pending across the U.S. and numerous eye-opening settlements already reached.

PFAS cases pending in courts throughout the U.S. have been targeting manufacturers, distributors, and even downstream users of PFAS-containing products.²¹¹ As of November 2025, approximately 19,600 cases were pending in a South Carolina federal court, consolidated into a multidistrict litigation (MDL) proceeding regarding exposure to firefighting foams.²¹² Beyond the MDL cases, states and municipalities have filed lawsuits against chemical manufacturers, seeking compensation for the costs of water treatment, environmental remediation, and public health monitoring.²¹³

More than 6,400 PFAS-related lawsuits were filed in federal court between July 2005 and March 2022, and thousands more have been filed since. At last report, there are more than 15,000 lawsuits in the federal PFAS litigation. These cases have resulted in some eye-opening settlements, such as a 3M settlement of \$850 million,²¹⁴ a \$69.5 million settlement involving Wolverine Worldwide,²¹⁵ a \$23.5 million settlement involving Taconic Plastics,²¹⁶ and a \$17 million settlement involving Johnson Controls.²¹⁷ In 2025, New Jersey obtained a \$2 billion settlement from DuPont to clean up environmental damages. In 2021, Dupont de Nemours Inc., its affiliate Corteva, Inc., and a spin-off entity, Chemours Co. (collectively, “Dupont”), agreed to set aside \$4 billion for future PFAS liabilities.²¹⁸ That same year, Dupont settled a multidistrict litigation in Ohio alleging personal injury for \$83 million.²¹⁹

Dupont is also a defendant in ongoing multidistrict litigation over PFAS-laden fire suppressant foams, *In Re: Aqueous Film-Forming Foams Products Liability Litigation*, MDL No. 2:18-mn-2873 (D.S.C.) (the “AFFF Multidistrict Litigation”), which continues to produce large PFAS settlements. In June 2023, Dupont agreed to pay \$1.18 billion to settle a class action involving public water systems serving large portions of the United States population.²²⁰ And in March 2024, Judge Richard Gergel, the federal judge overseeing the AFFF Multidistrict Litigation approved an agreement between 3M and public water utilities to settle thousands of lawsuits involving alleged PFAS water contamination that will require 3M pay more than \$10 billion over 13 years to more than 11,000 public water systems.²²¹

The following month, and shortly after the EPA finalized national drinking water standards, Tyco Fire Products LP, another defendant in the AFFF Multidistrict Litigation, reached a \$750 million agreement to settle class action claims by water suppliers across the country that Tyco’s firefighting products contaminated drinking water with PFAS.²²² Judge Gergel has considered objections from defendants Deepwater Chemicals and Chemicals Incorporated, referred to as the “Tollers.” They argued that they are “released parties” under the terms of the settlement because, while they provided services under Tyco’s direction, they did not market or sell and PFAS-contaminated products.²²³ Judge Gergel, however, rejected this argument, determining that neither the settlement agreement’s terms nor its underlying intent supported the Tollers’ release and has preliminarily approved the settlement. A final fairness hearing on the settlement was held on November 1, 2024.²²⁴ The parties continue to wait for a ruling as of the date of this update.

In May 2024, defendant BASF Corp. reached an agreement to settle with a nationwide class of public water systems in the AFFF Multidistrict Litigation for \$316.5 million (\$312.5 million to resolve the PFAS claims, plus \$4 million toward settlement administration costs).²²⁵ Judge Gergel granted final approval for the class settlement

on November 22, 2024, determining that the payouts were fair, reasonable, and adequate.²²⁶ In August 2025, Chemours, DuPont, and Corteva announced that they reached a settlement agreement with the state of New Jersey to pay \$875 million over 25 years to resolve environmental claims for pollution that included PFAS.²²⁷

To date, most PFAS litigation has fallen within several broad categories. First, firefighters and others have brought PFAS exposure claims against companies that allegedly manufactured, designed, marketed, and sold aqueous film forming foam (“AFFF”), a fire suppressant, with knowledge that it contained PFAS and that exposure can lead to adverse health outcomes.²²⁸

Second, public and private water utilities have sued companies that utilize PFAS, including AFFF manufacturers, alleging that they have contaminated water supplies and seeking damages for purchasing water from alternate sources, investigating and remediating contamination, and monitoring water for PFAS.²²⁹ In 2023 alone, lawsuits accusing companies of polluting drinking water with PFAS led to over \$11 billion in settlements. Considering the EPA’s new regulatory tools and a patchwork of developing state regulations, liabilities relating to drinking water are likely to increase substantially.

Third, states’ attorneys general have sued manufacturers, distributors, and suppliers for contamination in their states’ waterways, alleging violations of environmental statutes.²³⁰ These cases present substantial exposure for companies because they allege statewide contamination and not merely contamination of discrete areas. As of April 2024, approximately thirty states have sued manufacturers and others for contaminating water and damaging natural resources.²³¹

Fourth, individual plaintiffs have sued manufacturers and sellers of products containing PFAS for alleged illness and injury from drinking PFAS-contaminated water.²³²

Fifth, plaintiffs have brought actions against companies for violations of environmental statutes based on their use and discharge of PFAS.²³³ At the outset of this era of PFAS litigation, cases focused on PFAS manufacturers. Recent cases demonstrate that merely using wrappers and packaging that contain PFAS can subject a company to suit, as demonstrated by class actions filed against McDonald's and Burger King.²³⁴

Finally, plaintiffs have brought consumer protection claims against companies alleging that, despite marketing touting health benefits, their consumer products contain PFAS. For instance, a putative consumer class action was filed in early 2024 in the Southern District of New York, in which the lead plaintiff has asserted New York General Business Law and unjust enrichment claims on behalf of nationwide and New York putative classes against Health-Ade.²³⁵ The complaint alleges that Health-Ade falsely markets its kombucha "health" products, including product labels that boast that the products are "organic" and facilitate a "happy gut," when they in fact contain PFAS. The lead plaintiff further alleges that her claims are based on "independent laboratory testing" of five different Health-Ade products that demonstrate the presence of PFAS, which poses a health risk. Considering a motion to dismiss in another similar case, the Southern District of New York explained that plaintiffs seeking to establish standing under a price-premium theory of injury must allege facts making it at least plausible that one of them purchased a product that was misbranded (*i.e.*, that contained PFAS).²³⁶ Plaintiffs may either take the more direct approach of alleging that they tested and detected PFAS in the very products that they purchased or the more indirect approach of alleging that they tested products within the same product line as the items that they purchased. With the latter approach, plaintiffs must "'meaningfully link' the results of their independent testing 'to Plaintiffs' actual Purchased Products.'" The court dismissed plaintiffs' claims because they did not make such a link, failing to allege that they tested the products from the same products line as the products that they purchased near in time to

plaintiffs' purchases, facts from which the court could extrapolate that their isolated testing should apply broadly to defendants' products, or facts regarding the frequency of their purchases.

Greenwashing claims have also been asserted. For example, two putative class actions were filed in 2020 in California against both the manufacturer (Kroger) and retailer (Amazon) of compostable dinnerware.²³⁷ Rather than relying on representations about health risks, plaintiffs alleged that they relied on the defendants' marketing statements, namely that their products were disposable and would degrade over time.

The spectrum of defendants has continued to expand. Primary manufacturers of PFAS were initially and continue to be popular targets. The second tier of manufacturers with exposure to PFAS liabilities includes companies that use PFAS chemicals to treat the products they produce. The third tier encompasses companies that have supply chain exposures. These companies often assemble products out of components treated with PFAS, but do not use the chemicals. The number and types of defendants will likely continue to expand, potentially implicating sellers of the chemicals, businesses using PFAS, professionals calling for or recommending the use of PFAS or materials containing PFAS, officers and directors, and others.

There is little doubt that manufacturers and others who process, sell, transport, or otherwise utilize PFAS and their insurers will encounter significantly more litigation for years to come. Several manufacturers have stopped producing PFAS-containing products, and several large retailers have decided to stop selling PFAS-containing products to mitigate future liability.

Companies scored an important victory last year that may at least temper the size of litigation they must defend. Specifically, in *Hardwick v. 3M Co. (In re E.I. du Pont de Nemours)*, the United

States Court of Appeals for the Sixth Circuit vacated a district court order certifying a class of eleven million Ohio residents in a case involving ten defendants.²³⁸ 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 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. The decision sets forth a burden for establishing standing that plaintiffs must satisfy to bring PFAS class claims against multiple defendants. Specifically, they must establish how each defendant manufactured or provided

a “plausible pathway” that delivered PFAS to the plaintiff’s body. Nonetheless, it will take time to know whether other courts will impose a “traceability” requirement. No doubt plaintiffs’ counsel will adjust their pleadings and continue to pound on the doors of PFAS manufacturers, distributors, and other prospective defendants.

PFAS COVERAGE ISSUES

More than sixteen PFAS-related coverage actions have already been instituted in at least eleven states nationwide. Numerous additional demands for coverage and tenders have and will be made, and numerous additional coverage actions will be filed. Depending upon the facts, parties, and claims, coverage may be sought under general liability, property, environmental, professional liability, directors’ and officers’ transactions/representations and warranty, and other policies. Although insurance coverage may be widely sought, insurance recovery often will not be secured due to numerous available coverage issues and defenses. Parties involved in PFAS-related coverage actions should consider the numerous potential issues presented.²³⁹

Forum Selection & Choice Of Law: 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 policyholders (who institute most coverage actions) often will have notions about which state’s substantive law will be most favorable to their positions and the forums in which they prefer to litigate.

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 Ins. Co. v. Fire-Dex, LLC*.²⁴⁰ 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. The insurer 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 acceptance of the case would encroach on state court 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.²⁴¹ 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.²⁴² Some believe the Sixth Circuit decision improvidently denied the insurer an appropriate forum.

In July 2023, Fire-Dex filed a complaint in state court, seeking declaratory judgment. Admiral removed to federal court, and Fire-Dex moved to remand back to state court, arguing that two doctrines of *Thibodaux* abstention and *Burford* abstention militated against the court exercising its jurisdiction over the case.²⁴³ First, *Thibodaux* abstention applies where there are uncertain questions of state law and an important state interest that is intimately involved with the government's prerogative beyond the mere fact of invoking a specific area of law. With respect to the first *Thibodaux* question, the court held that it could not reasonably predict how Ohio state courts would apply policy exclusions, noting that an understanding of "occupational disease" had been developed in the context of worker's compensation but not insurance policy exclusions under Ohio law. Regarding the second *Thibodaux* question, the court recognized the Sixth Circuit's understanding that insurance rules and regulations are by and large reserved for states to craft, making clear that issues of insurance contract interpretation are best left to state courts.

Burford abstention applies when there is a difficult question of state law that bears on policy problems of substantial public import that “transcends the case at hand” and “when conflicting state and federal rulings on the question would be disruptive of state efforts to establish a coherent policy. The court again noted the Sixth Circuit’s references to issues in this case as “untouched legal terrain” and explained that actions taken by Ohio to regulate insurance, including its creation of a dedicated state agency, evidenced a concern and desire for a uniform application of Ohio’s insurance policy, favored abstention. Ultimately, the court remanded the parties’ competing declaratory judgment claims to state court and stayed Fire-Dex’s breach of contract and bad faith claims.

Lost Policies, Prior Settlements, Releases, & Dismissals: As PFAS have been produced and used dating back to the 1930s and 1940s, many claims potentially implicate legacy as well as current insurance policies. Accordingly, many policyholders are looking for legacy insurance policies and engaging insurance archeologists to identify potential coverage. In some instances, policyholders may be unable to establish that alleged policies were actually issued or adduce sufficient proof of the terms of alleged policies. 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 PFAS-related claims have been released or are barred in whole or in part by prior settlements and dismissals of prior coverage cases. It was not uncommon, particularly years ago, for toxic tort or environmental coverage litigation to result in settlement agreements providing full site releases, full policy releases, or releases beyond the specific claims litigated.

Trigger Of Coverage: Trigger of coverage may present issues in some PFAS-related coverage cases. In *Crum & Forster Specialty Ins. Co. v. Chemicals, Inc.*, 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*.²⁴⁴

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. In some PFAS-related actions, the issue of trigger may preclude or limit the policies implicated by some PFAS-related claims.

Allocation And Coordination Of Coverage Issues: 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. Courts apply to PFAS claims the same allocation rules as they apply to other long tail claims.²⁴⁵ 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.²⁴⁶

Non-Covered Items: 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, economic loss, or medical monitoring may not be covered under liability policies. Additionally, characterization of particular items such as remedial investigation/ feasibility studies (RI/FS costs) as defense costs or indemnity may be an issue in some cases.

Pollution Exclusions: 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.*, the intermediate New York appellate court addressed the application of both the “total” pollution exclusion and the “sudden and accidental” pollution exclusion.²⁴⁷ Tonoga settled an action with the New York State Department of Environmental Conservation, which accused Tonoga of polluting

soil, air, and water supplies in Petersburg, 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 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 both the "sudden and accidental" and "total" pollution exclusions. The "total" pollution exclusion plainly applied. The appellate court affirmed the trial court's ruling that allegations in the complaint that PFAS were improperly dumped and spilled over a period of many years, prohibited 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.*, 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 that 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.*, 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.²⁴⁸ 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 ambit of the “total” pollution exclusion under North Carolina law. Many courts in other contexts have not limited the application of the “total” pollution exclusion to “traditional environmental pollution,” and many PFAS cases involve “traditional environmental pollution.”

In *Grange Ins. Co. v. Cycle-Tex Inc.*, the court issued a declaratory judgment in favor of the insurer, concluding the underlying lawsuit fell squarely within the policy’s “total” pollution exclusion.²⁴⁹ 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 thermoplastic recycling facility and was sued for allegedly discharging harmful PFAS into the North Georgia waterways. Plaintiffs alleged they suffered damage 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 that the plaintiffs's claims that they 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 that the claims for water costs were barred by the second clause in the pollution exclusion.

The applicability of pollution exclusions remained a focus in PFAS coverage litigation in 2025. In *Nat'l Foam, Inc. v. Zurich Am. Ins. Co.*, the Northern District of California issued a mixed summary-judgment ruling addressing insurance coverage for PFAS-related claims brought against National Foam, a manufacturer of aqueous film-forming foam (AFFF).²⁵⁰ The court held that the "total" pollution exclusion barred coverage for claims based on indirect environmental exposure to PFAS, but did not apply to a claim alleging direct exposure from use of the company's products. It also concluded that the insurers had no duty to defend more than 180 other purported direct-exposure claims because National Foam failed to show that those claims involved injuries occurring after it began operations, though the insurers did owe a defense in one exemplar case where such timing was clear.

The decision arose in a coverage action brought by National Foam while facing thousands of PFAS lawsuits—many consolidated in the AFFF multidistrict litigation—alleging both direct and indirect exposure to PFAS. National Foam sought a ruling that its liability insurers were obligated to defend all direct-exposure claims, while the insurers argued that the pollution exclusion eliminated any duty to defend three exemplar suits. Applying a strict construction of the exclusion, the court found that harms alleged from direct use of the company’s AFFF products did not arise from “pollution” in the conventional sense because they were tied to product use rather than environmental contamination. In so holding, the court rejected the insurers’ argument that the exclusion applied because PFAS are a chemical and chemicals are specifically enumerated as a type of pollutant, explaining that “‘pollution’ is not just a class of substances (*i.e.*, ‘smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste’), but also a mechanism of harm.” Relying on the California Supreme Court’s decision in *MacKinnon v. Truck Ins. Exch.*,²⁵¹ as well as the *Buckeye Fire Equip. Co.* decision detailed above, the court explained that the alleged “harms did not arise from ‘pollution’ in any recognizable sense”; instead, the underlying “plaintiffs allege that they were exposed to PFAS through their ordinary use of National Foam’s products, not via general environmental pollution (*i.e.*, a contaminated water supply).” As such, the court concluded that “the pollution provision, which is strictly construed to injuries resulting from ‘discharge, dispersal, seepage, migration, release or escape of ‘pollutants’ does not clearly remove coverage for the alleged injuries.”

By contrast, the court held that the exclusion clearly barred coverage for suits alleging environmental contamination and indirect exposure, such as those involving polluted water supplies. As a result, the insurers had no duty to defend the two indirect-exposure exemplar cases, but were obligated to defend the single direct-exposure exemplar. Nonetheless, the court rejected National Foam’s attempt to extend this duty across all other identified direct-exposure claims, emphasizing that the company had not established that those claims

fell within the coverage period and that a duty to defend one MDL action does not automatically extend to all consolidated claims.

In *Town of Harrietstown v. Westchester Fire Ins. Co.*, the Northern District of New York held that liability insurers owed a duty to defend the Town of Harrietstown against a PFAS-related environmental contamination claim arising at the Adirondack Regional Airport.²⁵² The insurers relied on a “noise and pollution and other perils” exclusion that excludes from coverage “claims directly or indirectly occasioned by, happening through or in consequence of: . . . (b) pollution and contamination of any kind whatsoever . . .,” subject to the “combined claims” exception. The court found that the claim potentially fell within an exception preserving coverage for pollution “caused by or resulting in a crash fire explosion or collision.” Because at least one alleged source of contamination involved AFFF used in response to aircraft crashes, the exception was triggered, requiring the insurers to defend unless they could later show with certainty that the New York State Department of Environmental Conservation (“NYSDEC”) claim fell outside the exclusion.

The Town had been targeted by the NYSDEC, which issued a Superfund Site Classification Notice deeming the airport a significant threat to public health and the environment due to PFAS contamination. The insurers argued that the pollution exclusion barred coverage and that, even if part of the claim arguably fell within an exception, the “Combined Claims” provision relieved them of a defense obligation. That provision states that insurers need not defend claims covered under the policy when combined with claims that are excluded, though they may need to reimburse defense costs attributable to covered components.

The court rejected that argument, concluding that the NYSDEC matter constituted a single claim rather than a “combined claim” involving separate covered and uncovered components. Because the insurers could not demonstrate that the contamination claim was

“solely and entirely” excluded, and because an alleged crash-related source of PFAS was enough to invoke the exception to the pollution exclusion, the court ruled that the insurers had a present duty to defend the Town in the underlying environmental proceeding.

PFAS-Specific Exclusions: There are various forms of specific PFAS or forever chemical exclusions that may be included in policies of more recent vintage. For instance, Lloyd’s Market Association unrolled a couple of model exclusions in 2022 and the Insurance Service Office, Inc. recently released its own PFAS exclusions for various policy forms.²⁵³

Other Exclusions: Other exclusions, such as owned property, intentional act, and occupational disease exclusions, may bar or limit coverage for particular claims. For example, *James River Ins. Co. v. Dalton-Whitfield Regional Solid Waste Management Authority* involved a different insurance policy and different types of exclusion but concerned the same underlying action as *Cycle-Tex*.²⁵⁴ 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.

Knowledge-Based Defenses: 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.

Non-Compliance With Policy Terms & Conditions; 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.²⁵⁵ 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.²⁵⁶ These types of issues may be presented with PFAS claims as well.

Issues Arising From Policyholder Bankruptcies: Other considerations arise where policyholders become embroiled in bankruptcy proceedings on account of mounting PFAS-related liabilities or for other reasons. These policyholders 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.²⁵⁷

Having PFAS-related liabilities embroiled in bankruptcy is more than an abstract possibility. Kidde-Fenwal, Inc., a fire suppression company, filed a bankruptcy petition in May 2023, citing over \$1 billion in PFAS-related liabilities.²⁵⁸ In November, 2023, Kidde-Fenwal initiated an adversary proceeding seeking insurance coverage from approximately thirty insurers.²⁵⁹ Lexington Insurance Co. and National Union Fire Insurance Co. of Pittsburgh, Pa. filed a motion to

stay claims in favor of arbitration based upon an arbitration provision contained in its policies. Kidde-Fenwal responded by arguing the policies contain “only a narrow arbitration provision” that merely delegates “interpretation” of the pollution exclusion – not its “applicability” – to arbitration. Century Indemnity, another insurer sued in the adversary proceeding, moved to dismiss or for a more definite statement of claims, arguing that Kidde-Fenwal’s complaint fails to allege that Kidde-Fenwal started manufacturing AFFF within the period of the Century Indemnity policy. The motions remain pending as of the time this commentary was prepared.

Policyholders and insurers undoubtedly will continue to draw upon their experiences with asbestos and other environmental coverage litigation. Often, the lessons learned will prove to be instructive. Indeed, some of the case law will be instructive or even controlling. Nonetheless, the parties and their counsel should keep in mind that the science associated with PFAS chemicals is developing, and different arguments may be presented in the context of particular PFAS-related coverage claims. A premium remains on creativity, as neither policyholder nor insurer representatives are likely to be well-served by rote application of arguments, strategies, or tactics employed in traditional environmental claims and cases.

It will be important for insurers and policyholders to have a stable of solid experts and capable defense and coverage counsel retained for PFAS and coverage litigation and to get ahead of the junk science funded by the plaintiffs’ bar.²⁶⁰ An insurer’s approach must be flexible to account for the policies at issue, the particular policyholder and its coverage program, claim-specific facts, application of controlling law, and other factors related to the insurer’s portfolio interests.

CHAPTER 13

WHAT INSURERS AND POLICYHOLDERS SHOULD KNOW ABOUT ESG (ENVIRONMENTAL, SOCIAL, AND GOVERNANCE CONSIDERATIONS)

Environmental, social, and governance (ESG) considerations or standards – also known as sustainability – have been impacting all sectors of society, including corporate and professional entity policyholders and insurers, for a long time. Under the Biden administration’s “all of government” approach to ESG, ESG considerations played an oversized role – dominating corporate activity and impacting virtually all aspects of corporate strategy, positioning, and operations. The second Trump administration has signaled that it will dial back significantly the excesses of ESG in favor of an environmentally responsible “drill baby drill” energy approach and replace the focus on Diversity, Equity, and Inclusion (DEI) with merits-based hiring.

Chapter 10 contains a brief update on the status of ESG and DEI in the aftermath of the first year of the Trump administration. In this chapter, we take a deeper dive and provide background into ESG. The authors do not intend to make any political statements and are not expressing any normative views on the political or social aspects or on the propriety of any specific ESG measure. ESG has become laden with political considerations, and we merely attempt to outline the realities confronting insurers and corporate policyholders and the corresponding challenges and opportunities presented.

The reality is that environmental, social, and governmental considerations existed long before the Biden administration and will continue long after the second Trump administration, but the focus and emphases will change substantially. Although the approach and policy of these administrations differ sharply, federal law applicable to environmental, social, and governance considerations will remain. Further, the existence of state and international law and the demands of various corporate stakeholders ensures that ESG will neither die nor disappear, though it likely will be approached with more moderation at least at the federal level. In these early days of the second Trump administration, it is clear that insurers and other companies will be afforded greater latitude to act in their own interests on ESG-related issues with a rolling back of regulatory demands. The particulars and durability of the ESG policies of the Trump administration are subject to change as policies are adopted and subjected to judicial scrutiny. The sustainability of the Trump approach to ESG will depend, at least in part, on what policies are enacted into law by Congress as many policies made through Executive Orders and regulations can be readily changed by the next administration. The landscape surrounding ESG is evolving and presents numerous regulatory and business opportunities and challenges to insurers and corporate policyholders. The current environment affords companies greater flexibility to act in accordance with their own interests as compared to the recent past.

The Importance Of Sustainability/ESG: ESG criteria or standards or sustainability issues have impacted all sectors of society, including corporate and professional policyholders, their risk managers, insurance underwriters, and claims personnel. Many of the same societal factors driving social inflation are also involved in driving ESG. ²⁶¹

It is hardly surprising that insurance companies have had a leading role with respect to ESG. ESG considerations have been in play for many years. Most companies value social responsibility and take

their role as responsible corporate citizens seriously. The legacy of corporate generosity, philanthropy, and volunteerism has been very impactful. In the past, attention to environmental, social, and governance considerations above and beyond legal and regulatory compliance was largely voluntary. Historically, it was done for altruistic reasons or simply because it was considered “good business” to be responsible corporate citizens. Companies have always faced pressure from various stakeholders, but these pressures ramped up considerably in recent years.

In the contemporary corporate world, as insurers and policyholders were tackling ESG, they were increasingly told that components of ESG were mandatory or “essential business.” European companies and regulators have, in large measure, been ahead of U.S. companies and regulators with respect to ESG. The focus, intensity, and pace of ESG increased substantially in the U.S. under the Biden Administration. However, a marked rollback at the federal level now appears at hand.

Fueled in part by events in 2020, activist groups, investors, regulators, customers, suppliers, rating entities, and others called upon companies to act in what these external “stakeholders” deem to be “socially responsible” or “fair and just” with greater frequency, more intensity, and at a higher volume. They sought to have corporate policies and practices align with their standards or criteria (which sometimes differ or conflict among stakeholders and within members of the same stakeholder) and to impose consequences for conformance or non-conformance with their ESG standards. It seems fair to say that ESG topped the list of matters that received attention from many executives and boards of directors of insurance companies and corporate policyholders, at least for a period of several years.

The deep and widespread momentum of the ESG movement triggered Newton’s Third Law of Motion – which posits that “[f]or every action, there is an equal and opposite reaction – gave rise to a strong

anti-ESG movement. This emerged with some state legislatures, along with stockholder demands targeting ESG policies and practices. Decisions of the U.S. Supreme Court have imposed some limitations on administrative agencies – the unelected arms used by the federal government to impose its regulatory will. The second Trump Administration is poised to rollback ESG regulations and target ESG for budget cuts. Competing pressures further complicate the substance and approach to ESG taken by companies.

Although often viewed as presenting challenges, ESG considerations also present numerous opportunities for insurers and policyholders. Indeed, the ability to respond and lead effectively in these areas was seen as a major determinant of the success of corporations and insurance companies. This includes taking action where companies believe action is appropriate. Equally important is the ability of companies to effectively resist action where they believe it to be unwarranted. Either way, it is important for companies to minimize collateral damage associated with their decisions. Companies performing well in ESG tended to have a lower probability of sustaining workforce-related accidents, reputation-damaging controversies, fines, and other adverse actions by regulators. Companies at both ends of the ESG spectrum – those inattentive to ESG and those crossing the line into ESG advocacy at the expense of their core missions – face risks.

ESG considerations remain important to legal, corporate, and financial risk assessment. Under the Biden administration, ESG moved from being siloed within some aspects of corporate behavior and appeared to become embedded in the DNA, strategy, identity, and operations of entire companies. Stakeholders have used the full panoply of vehicles to achieve their goals, including traditional media, social media, investment decisions, purchase decisions, boycotts, threats, pressure, intimidation, lobbying, legislation, regulation, and cancel culture. Some of the goals and tactics were laudable, while others were not.

It is important to understand that ESG pressures were not only being applied by external forces, but increasingly internal forces sought to exact change. The reality is that Millennials, Generation X, and Generation Z are now, by the numbers, dominant members of the workforce and management, as they replace Baby Boomers. The educational, experiential, methodological, values, and demographic differences between generations are undoubtedly having a large influence on internal decision-making within risk management and insurers alike.

Not only have corporations adjusted to create a workplace that attracts and retains Millennial, Generation X, and Generation Z talent, but these workers are increasingly becoming the corporate decision-makers. Thus, corporations are now becoming entities that will effect change, rather than resist change. In recent years, this has added to the momentum of ESG. With President Trump having received increased support from younger voters, it will be interesting to see what the impact of younger workers and managers will have on ESG over time.

The great resignation and great attrition following the pandemic have impacted the insurance industry workforce, making companies more responsive to employee values and providing employees with greater leverage. A McKinsey & Company study found that 65 percent of those who resigned from a job in insurance or finance between April 2020 and April 2022 left the industry entirely. These departures from the insurance industry come as the industry is experiencing and will continue to experience a high level of retirements of baby boomers.²⁶² There is also a skill gap that younger workers seem to present.

Some commentators have argued that, to attract and retain a younger workforce, the insurance industry must expand upon its conservative image and show the breadth of opportunities and the diversity of people who drive the industry forward.²⁶³ This commentator suggests that “Gen Z talent are drawn to businesses that uphold and promote

values that reflect a greater effort to create an equitable future and push society and the environment in the right direction.” Work/life balance is critical for these younger workers. The insurance industry faces at least the same level of challenges as many industries in attracting and retaining employees.

According to a 2021 study, 70 percent of employees now demand purposeful work.²⁶⁴ Additionally, 86 percent of employees say they would prefer to support or work for companies that care about the same issues they do.²⁶⁵

The Component Parts Of ESG: ESG considerations are not static. ESG encompasses a broad range of topics and implicates most corporate departments and business operations. Below is a general overview of the components. The first component – environmental considerations – concerns how a company performs as a steward of nature and the environment. These considerations may include a company’s: energy use; waste and pollution streams and volumes, as well as disposal practices; natural resource conservation; carbon and greenhouse gas blueprint; use of renewable energy; use of raw materials; ownership of contaminated land; environmentally compatible production; compliance with environmental regulators and laws; and treatment of animals.

The second component – social criteria – concerns how a company manages relationships with employees, suppliers, customers, and the communities in which it operates. Social factors include occupational safety practices and loss history; inclusion and diversity; equity in hiring, pay, opportunity, and advancement; compliance with labor laws; community engagement; employee engagement; training and development; respect for employee rights; working environment and conditions; unionization and labor practices; and freedom of association. This may include an examination of aspects such as whether, to whom, and how much the company is donating to nonprofit organizations; whether the company encourages and

supports employee volunteer work; whether the company's working conditions show high regard for its employees' health and safety; whether there are allegations of trafficking, human rights violations, or child labor; and whether the interests of various other stakeholders are taken into account. Social criteria may extend beyond a company to the company's business relationships with suppliers, customers, regulators, unions, and others, and involve an examination of the business practices of those entities. It will be interesting to see the extent to which stakeholders focus on the human rights and other practices of countries in which a company does business. DEI primarily falls under this area of ESG, although it also spills into governance concerning the composition of management and boards of directors.

The third component – governance – includes practices and policies regarding anti-bribery; corruption; money laundering; executive pay; transparency in financial and public reporting; gender pay gaps; composition of management and the board; risk management and oversight; board actions and obligations; cyber and data security; regulatory compliance; allowing shareholders to vote on significant issues; and avoiding conflicts of interests. It must be acknowledged that the core components of ESG have been subject to longstanding state and federal law and regulation. For example, compliance with environmental and labor laws and regulators has been a focus for decades.

THE IMPACT OF ESG ON INSURERS

Insurers Qua Businesses: First and foremost, insurers (and insurance brokers) – like all companies – focus on their own practices and operations. Many insurers made commitments regarding their own operations. In the recent past, Zurich, for example, planned to be a net-zero emissions company by 2050 and developed science-based targets for underwriting.²⁶⁶ Aon committed to becoming a net-zero carbon emissions producer by the end of the decade.²⁶⁷ It committed

to setting science-based targets and adopting achievable objectives by setting out plans focused on sustainable sourcing, energy efficiency, business travel, and renewable energy. Aon established an internal ESG committee to play a central role in reaching the 2030 target. Aon stated it was also committed to the “social” element of ESG, by building diverse and thriving teams with the brightest talent. In August 2022, thirteen major UK insurers and brokers vowed to cut their supply chain emissions as part of the Sustainable Markets Initiative’s sustainable supply chain pledge. The initiative was established by King Charles (then Prince Charles) to accelerate the “transition of a sustainable future.”

The shift in focus is evidenced in part by insurer panel counsel calls. Traditionally, these calls focused on billing practices, compliance with litigation management guidelines, and legal trends implicating liability and coverage claims and lawsuits. More recently, however, ESG dominated the agenda of these calls with insurers spelling out their ESG and DEI targets and letting their counsel and vendors know what will be expected of them. Over the past year or so, these calls appeared to focus more on the traditional agenda items. As a result of the pandemic, many companies and court’s reduced travel, and remote hearings and meetings became prevalent. Corporate travel has returned, and remote working has been scaled back. It will be interesting to see the extent to which insurers, companies, and courts may continue to have less of an appetite for travel, and whether remote hearings, discovery, meetings, and work will continue. Reducing carbon emissions, as well as cost savings and worker expectations, may continue to motivate reduced travel in the future and impact the use and demands for commercial real estate space.

The Net-Zero Insurance Alliance, which was launched in 2021 as part of the Glasgow Financial Alliance for Net-Zero set up by United Nations climate envoy Mark Carney, required members to commit to reducing their greenhouse gas emissions. This and similar alliances have come under fire as of late. In May 2023, 23 state attorneys

general advised members that the Net-Zero Insurance Alliance's targets and requirements appeared to violate both federal and state antitrust laws. Several members of the alliance have since withdrawn. Munich Re, Zurich, Hanover Re, and Swiss Re have been joined by Allianz SE, Axa SA, and Scor SE in withdrawing from the alliance. This does not mean that the former members are not adjusting their own policies, programs, practices or proceeding as planned with regard to their individual net zero commitments.

Additionally, national security concerns may have influenced major insurance companies to leave the Net-Zero Insurance Alliance.²⁶⁸ A concern is that, without the insurance industry underwriting the risks in the gas and oil industry, the costs of energy and availability of petroleum products for the populace and/or national defense could significantly increase.²⁶⁹

Six major banks, including Goldman Sachs, Wells Fargo, Citi, Bank of America, and Morgan Stanley, reportedly left the Net-Zero Banking Alliance between the U.S. 2024 election and the presidential inauguration in 2025.²⁷⁰ Of note, Ken Paxton, the Attorney General of Texas opened a review of Bank of America, Morgan Stanley, J.P. Morgan, and other entities in October 2023 under a Texas law (Texas Senate Bill 13) that prohibits governmental entities from entering into contracts with companies that boycott the oil and gas industries.²⁷¹ Further, in March of 2024, the Texas Permanent School Fund withdrew \$8.5 billion in state money from BlackRock, terminating its contract to manage those funds with accusations that BlackRock was boycotting Oil and Gas energy producers, which are a large part of Texas' industry.²⁷² While insurance companies are not banks, they are no less vulnerable to such policies.

Insurance companies were being viewed – with increasing frequency and severity – as agents for imposing affirmative ESG change on others, such as their policyholders and vendors, as well as implementing change in their own operations. In essence, the insurance industry

was targeted because many stakeholders believe it can effect change by not insuring companies that harm the environment, engaging in anti-competitive practices, or lacking sufficient diversity in the management ranks (or company-wide), or by increasing costs of insurance on these companies. “Globally, the insurance industry is in a unique position when it comes to climate risk as insurers are exposed on both sides of the balance sheet: Their investments face climate risk on the asset side of the balance sheet, and they face underwriting risk, particularly in the property and casualty line, on the liability side.”²⁷³

Insurers Qua Investors: Property and casualty insurers are also large institutional investors. Accordingly, their investment practices are subject to scrutiny. Insurers and reinsurers were facing damage to their reputations by reason of insuring or investing in companies whose ESG considerations are questionable or perceived to be subpar. Indeed, many trace the origins of ESG to investment strategy – not investing in industries or companies with poor environmental performance. Zurich, for instance, in the past committed to fully decarbonizing its \$200 billion asset portfolio.²⁷⁴ It committed to using its influence as an investor and insurer to pressure companies to take action on climate change. According to the Forum for Sustainable and Responsible Investment (US SIF), as of 2020, one-third (approximately \$17 trillion) of all U.S. assets under management were invested following sustainability principles, with money managers paying closest attention to climate change/carbon emissions, natural resources/agriculture sustainability, and board governance issues. This figure represents a 42 percent increase over 2018.²⁷⁵ According to a KPMG survey of 200 U.S. ESG investors, over 60 percent reported a willingness to pay a premium for opportunities aligning with their ESG priorities and more than half indicated that ESG concerns could be a deal killer.²⁷⁶

In November 2021, The Hartford announced it would invest \$2.5 billion in companies and technologies supporting a transition to

renewable energy over the next five years. It stated the investments will come in addition to existing plans to withdraw coal holdings by 2023. Hartford also said it signed onto the United Nations Global Compact. The Hartford's CEO Christopher Swift stated, "[w]e view the transition to a greener society as a business imperative."²⁷⁷

AM Best, in a November 2020 report, emphasized that insurers and reinsurers who ignore ESG in their underwriting and investment decisions confront serious reputational risk. These risks may cause buyers and investors to flee to competitors, affecting the companies' creditworthiness and ratings. By contrast, insurers that invest in and underwrite companies and technologies that will help tackle climate change stand to gain reputationally and with respect to earnings.²⁷⁸

Insurers Qua Underwriters: Some insurers moved away from underwriting risks that deal with fossil fuels. Zurich, for instance, is committed to terminating its relationship with companies that generate more than 30 percent of revenue from mining or generate more than 30 percent of their electricity from thermal coal, oil sands, and oil shale, extract more than 20 million tons of thermal coal or continue to invest in coal mining and infrastructure.²⁷⁹ For those that exceed the thresholds, Zurich stated it would engage in a dialogue on transition plans, but if companies fail to demonstrate meaningful improvement, it will cease to underwrite or invest in them. Aviva stated it will stop insuring companies generating more than 5 percent of revenues from thermal coal or unconventional fossil fuels by the end of 2021.²⁸⁰ Aviva added it would make exceptions for companies serious about their transition out of high-carbon fuels that have already "committed to clear science-based targets aligned to the Paris Agreement target of limiting temperature rises to 1.5 degrees." Even oil companies appeared to jump on the ESG bandwagon. BP's Chief Executive, Bernard Looney, stated in February 2020 that it was BPs "new ambition to become a net zero company by 2050 or sooner, and to help the world to get to net zero."²⁸¹

Changes in underwriting have taken place. The analysis of risks expanded from traditional components such as the types of operation or geographical characteristics to qualitative analyses in relation to ESG criteria. This sometimes included examination of employee rights and audits of supplier companies, as set out in the proposed Supply Chain Acts in Germany and the EU. Policyholders that actively address sustainability issues sometimes benefit from this change in the underwriting process with respect to pricing, policy terms, program structuring, and lower deductibles. It is clear that most insurers have embedded ESG into their risk models, particularly in property, casualty, and cyber lines.²⁸²

Insurers began taking into account the consequences of disclosure requirements imposed on companies. Increased use of artificial intelligence and scoring systems has been formulated and deployed as part of an integrated underwriting process. Underwriting applications and questionnaires have been updated, and early dialogue regarding ESG risks has been incorporated into the underwriting process.

Insurers Qua Claims Handlers: Finally, insofar as ESG impacts claims types and claims frequency and severity, insurers are impacted appreciably on the claims side. As discussed in part 2 of this commentary, policyholders and insurers must consider the impact of risk profiles and claims resulting from ESG and ESG regulation. Unquestionably, insurers have to be cognizant of the ESG practices and risks of policyholders, as ESG issues impact claims and loss activities. ESG issues are rife for litigation and claims. The commentary does not specifically address climate change insofar as it may account for an increase in the frequency or severity of weather-related claims.

The Impact Of ESG On Policyholders: Corporate policyholders have fully felt the impact of ESG in all aspects of their businesses. Corporate risk managers have had to address the impact of ESG on their companies' risk profiles, in providing input into company

strategies and activities, in purchasing insurance, in connection with their insurance coverage profiles, in the content of their self-insurance and insurance policies, and in responding to insurer information requests in connection with placing insurance.

The “All Of Government” Approach Of The Biden Administration:

The ESG movement began long before the Biden administration. ESG became a central component of most policies and departments under the Biden Administration, however, and it increased the pace and focus on ESG in the U.S. substantially. On May 20, 2021, President Biden signed an Executive Order on climate-related financial risk. The order directed federal agencies to analyze and mitigate the risks that climate change presents to homeowners, consumers, businesses, and workers, and the U.S. financial system. A fact sheet distributed during a White House briefing indicated that the executive order will:

- Develop a whole-of-government approach to mitigating climate-related financial risk. The order directs the White House national climate advisor and the director of the National Economic Council to develop and identify, within 120 days, public and private financing needed to realize economy-wide net-zero emissions by 2050, while also advancing economic opportunity, worker empowerment, and environmental mitigation, particularly in disadvantaged communities and communities of color.
- Encourage financial regulators to assess climate-related financial risk. The order urges the Secretary of the Department of the Treasury to work with Financial Stability Oversight Council (FSOC) members to assess climate-related financial risk as it pertains to the stability of the federal government and of the U.S. financial system within a 180-day period. The order also requests a report on plans of member agencies to improve climate-related disclosures and other sources of data and to incorporate climate-related financial risk into regulatory and supervisory practices.

- Bolster the resilience of life savings and pensions. The order directs the Secretary of the Department of Labor to consider suspending, revising or rescinding any rules from the prior administration that would have barred investment firms from considering environmental, social or governance (ESG) factors, including climate-related risks, in investment decisions involving workers' pensions. The order also requests a report on other potential measures to protect the life savings and pensions of U.S. workers and families from climate risk and an assessment of how the Federal Retirement Thrift Investment Board will incorporate ESG risk factors.
- Modernize federal lending, underwriting, and procurement. The order requests recommendations for how federal financial management and reporting can incorporate climate-related financial risk, in particular in federal lending programs. The order also directs consideration of new required disclosures of greenhouse gas emissions and climate-related financial risks for federal suppliers and seeks to minimize such risks in federal procurements.
- Reduce the impact of climate change on the federal budget. The order mandates fiscally responsible action to respond to the risk of increased costs and lost revenue resulting from climate change. It also directs the federal government to develop and publish annual assessments of climate-related fiscal risk exposure.²⁸³

The extent of activity of the federal government with respect to environmental considerations is illustrated by the actions of the Federal Department of Insurance, the Security Exchange Commission, and the Federal Trade Commission.

The Federal Insurance Office of the U.S. Department of the Treasury (FIO) issued a Request for Information (RFI), following the May 20, 2021, Executive Order on Climate-Related Financial Risk, that solicits “public input on FIO’s future work relating to the insurance

sector and climate-related financial risks.” FIO expressed the intent for its climate-related work to respond to the Executive Orders and the Treasury Department’s broader climate work, including working with Treasury’s Climate Hub. Public comments were due on November 15, 2021.

FIO indicated that it intended *initially* to focus on three climate-related priorities. The first is insurance supervision and regulation, which encompasses assessing climate-related issues or gaps in the supervision and regulation of insurers, including their potential impacts on U.S. financial stability. This will include monitoring the integration of climate-related financial risks into insurance supervisory practices and regulatory frameworks, as well as assessing whether sufficient data, methodologies, and tools exist to manage the solvency of insurers and to protect them against the long-term risk of climate change. FIO states it “will consult with individual state insurance regulators and the NAIC” during its assessment of such supervisory practices and resources. Generally speaking, state regulators have been fairly effective in ensuring the solvency of insurers facing a variety of risks, including environmental liabilities, for the past 30 years.

The second stated priority concerned insurance markets and mitigation/resilience. This involves assessing the potential for major disruptions of private insurance coverage in U.S. markets that are particularly vulnerable to climate change impacts and facilitating mitigation and resilience for disasters. The final stated initial priority concerns insurance sector engagement. FIO planned to increase its engagement on climate-related issues and take a leadership role in analyzing how the insurance sector may help mitigate climate-related risks. FIO appears ready to address the insurance sector’s transition of its operational activities attributable to greenhouse gas (GHG) emissions. It also stated its intent to look into the underwriting activities, investment holdings, and business operations to influence policyholders and markets to support or interpose a low- emissions

economy. In some respects, it may be that the FIO will seek to have insurers serve as private regulators (similar to private attorneys general).

Throughout 2023 and 2024, the FIO continued its efforts to collect insurance data to better understand the impacts of climate-related financial risks on the insurance sector. In March 2024, the FIO announced a collaboration with the National Association of Insurance Commissioners (NAIC) and with state insurance regulators. Under this collaboration, the NAIC would be collecting data on the zip code level from the largest homeowner's insurers to be used for a nationwide assessment of climate-related financial risks to consumers in the United States. The data collection was anticipated to be completed and provided by the NAIC to the FIO by September 2024.²⁸⁴

The Federal Insurance Office (FIO) was established by the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. The FIO is part of the U.S. Department of the Treasury and is headed by a director who is appointed by the Secretary of the Treasury. The office provides expertise on insurance matters to the Treasury Department and other federal agencies and engages in international discussions relating to insurance. However, it is not a regulatory agency, and its authorities do not displace the time-tested, robust state insurance regulatory regime. The FIO is charged with monitoring all aspects of the insurance sector, including identifying activities within the sector that could potentially contribute to a systemic crisis in the broader financial system, the extent to which underserved communities have access to affordable insurance products, and the sector's regulation.

The FIO is authorized to receive and collect data and information on the insurance industry and can enter into information-sharing agreements with state regulators. The FIO can also require an insurer or its affiliate to submit data to the office where it determines the information is not available from any public or regulatory sources.

Traditionally, the regulation of the insurance business has been left to the states. The McCarran-Ferguson Act of 1945²⁸⁵ reaffirmed the rights of states to tax and regulate the business of insurance within their respective borders, absent specific congressional intent to the contrary, and generally excepts insurers from federal antitrust laws. However, since the terrorist attacks of September 11, 2001, and increasing with the financial crisis of 2008, insurers have been subject to increasing federal legislation and regulation.

Many commentators expressed concerns about the FIO expanding its role and perhaps even displacing the state regulation of the business of insurance. These concerns have been allayed as the second Trump Administration is not interested in expanding the role or activities of the FIO. Although under the Biden Administration, the SEC issued a final climate disclosure rule. Several lawsuits were instituted challenging the rule. The SEC issued an order staying its climate rule, effective April 4, 2024.²⁸⁶ The rule never went into effect as the second Trump administration ended the litigation and prevented the disclosure rule from taking effect.

U.S. Supreme Court Decisions Directly Impacting The “E” Of “ESG”: Recent decisions of the U.S. Supreme Court also have limited ESG and administrative agency authority more generally. First, the court employed the “major issues doctrine” to strike down ESG and DEI initiatives.

On June 30, 2022, the U.S. Supreme Court issued its decision in *West Virginia v. Environmental Protection Agency*.²⁸⁷ In this case, the Supreme Court addressed the Clean Power Plan, a rule promulgated by the EPA to address carbon dioxide emissions from existing coal and natural gas-fired power plants. The Clean Power Plan set forth three important measures: (1) “heat rate improvements,” which were practices that power plants could use to burn coal more cleanly; (2) a shift in electricity production from coal-fired power plants to natural gas-fired power plants; and (3) a shift from coal and gas plants to

more renewable energy production, such as wind and solar power. The EPA also set forth “final emission guidelines for states to follow in developing plans” to regulate existing power plants. At issue was whether the EPA had the authority to regulate these emissions via the “best system of emission” identified in the Clean Power Plan. The Supreme Court found that the EPA, which purported to derive its authority from Section 111(d) of the Clean Air Act, did not have the broad authority to do so.

The case resulted in a 6-3 ruling from the Supreme Court, with the majority opinion written by Chief Justice Roberts. The Court began by addressing threshold issues of justiciability. The majority held that the State petitioners had standing as they were injured because the EPA rule would require them to more stringently regulate power plant emissions within their borders. As to mootness, the Court rejected the government’s argument that the case is moot based upon its representation that the EPA does not intend to enforce the Clean Power Plan prior to promulgating a new Section 111(d) rule.

The Court stated that “voluntary cessation does not moot a case” unless it is “absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.” The Court noted that the government did not suggest that, if this litigation was resolved in its favor, it would not reimpose emissions limits predicated on generation shifting. Although this aspect of the ruling is hardly groundbreaking, it will support the standing of states to challenge future agency action. The Court reversed the D.C. Circuit Court of Appeal’s ruling that had struck down the Trump administration’s Affordable Clean Energy rule, which had repealed the Obama-era Clean Power Plan and replaced it with more limited regulations of carbon dioxide emissions from existing power plants. The Supreme Court’s ruling, instead, restricted the EPA’s “power to regulate greenhouse gas emissions from power plants, finding that the Obama Administration exceeded its authority under the Clean Air Act by allowing states to issue regulations aimed at increasing the use of

cleaner sources of electricity generation.” The majority determined that the EPA exceeded the congressionally mandated authority by using the Clean Power Plan to give states the option to promulgate regulations that would encourage “generation shifting” or moving away from power sources like coal to cleaner ones, like natural gas or renewables. According to Chief Justice Roberts: “Capping carbon dioxide emissions at a level that will force a nationwide transition away from the use of coal to generate electricity may be a sensible “solution to the crisis of the day” But it is not plausible that Congress gave EPA the authority to adopt on its own such a regulatory scheme in Section 111(d). A decision of such magnitude and consequence rests with Congress itself, or an agency acting pursuant to a clear delegation from that representative body.”

Chief Justice Roberts stated the government – under the major questions doctrine – could not point to “clear congressional authorization” for its manner of regulations but instead pointed to the EPA’s authority to establish emissions caps at a level reflecting “the application of the best system of emission reduction ... adequately demonstrated.” According to the majority, “[s]uch a vague statutory” was “not close to the sort of clear authorization required” by the Court’s precedent.

In her dissent, Justice Kagan stated Section 111 of the Clean Air Act did, in fact, broadly authorize the EPA to devise the “best system of emission reduction” for power plants and that the parties did not dispute that the “best system” was generation shifting. Accordingly, Justice Kagan’s dissent viewed the majority’s decision as depriving the agency of “the power needed – and the power granted – to curb greenhouse gases.” Justice Kagan added that a key reason Congress makes broad delegations like Section 111 was so an agency could respond appropriately and commensurately to new and big problems. She accused the majority of substituting its own policymaking ideas for those of Congress and stated that the majority’s decision was “really an advisory opinion on the proper scope of the new rule EPA

is considering,” as the Biden administration stated it would not revive the 2015 Clean Power Plan.

The Supreme Court recognized that the EPA does have the power to regulate greenhouse gas emissions, and the ruling does not prevent the EPA from regulating power plant greenhouse gas emissions outright under Section 111(d) or under the Clean Air Act. The EPA could look to other sources of authority or rely on traditional tools such as those used to regulate other air pollutants, but at a minimum, it will be required to exercise greater care in regulating greenhouse gas emissions. Of course, the limitations will apply regardless of whether the administration is Democrat or Republican. The decision may potentially give states a greater role to play with respect to clean energy requirements, which likely will play out differently in red and blue states. Principles of federal law preemption must be considered. Also, many states tether their air quality standards to federal standards by specifically incorporating references to parts of Section 111 into their own statutes and regulations. Others choose to implement the EPA’s determinations as a baseline or guide for minimum air quality standards. As such, the Supreme Court’s decision will directly impact state law.

The Supreme Court’s reliance upon “the major questions doctrine” is significant. In his concurrence, Justice Gorsuch described the doctrine as a tool to ensure that the government does “not inadvertently cross constitutional lines.” The major questions doctrine has previously been used to guard against unintentional, oblique, or otherwise unlikely delegations of the legislative power. Both liberal and conservative justices have relied upon the major question doctrine in the past. The related “non-delegation” doctrine prevents Congress from intentionally giving away its own power. Application of the major questions doctrine often results in requiring Congress – the people’s elected representatives – to weigh in legislatively to solve more contemporary problems or issues. In the majority’s decision in *West Virginia v. EPA*, the doctrine was used to prevent the EPA’s

authority from being based upon “vague” statutory grants and require the EPA to point to clear congressional authorization.

The decision – particularly its reliance upon “the major questions doctrine” – likely had implications beyond the EPA and greenhouse gas emissions. It signals the view of the current majority of justices that the “administrative state” may be out of control and that it may be sympathetic to efforts to limit the broad and growing power of unelected government bureaucrats in federal administrative agencies. Stated differently, rather than treating such assertions of power as standard statutory interpretations, as to which judges are highly deferential to agency actions, courts may approach extraordinary, novel actions of administrative agencies with far-reaching consequences with a greater degree of skepticism. As Justice Roberts stated “[i]f Congress wishes to effect a sweeping overhaul of the nation’s economic activity, it must now do so explicitly—with ‘clear congressional authorization’ Agencies may not, on their own initiative, transform a statutory scheme used for one thing to perform some other ambitious work, even if the law’s language makes their statutory interpretation ‘colorable.’” The decision may have implications beyond the context of ESG as well. Another important takeaway from the Supreme Court’s decision is a lesson learned by most Presidential administrations: namely, in a democracy, courts and judicial challenges can delay and derail an administration’s policies, no matter the number of resources or the amount of political capital devoted to them. The bigger and more sweeping the policy, the more subject to challenge the policy may be.

On May 25, 2023, the U.S. Supreme Court issued a ruling in *Sackett v. Environmental Protection Agency*,²⁸⁸ narrowing the federal government’s authority to regulate bodies of water and effectively upending a Biden Administration rule that had recently gone into effect. The EPA classified the wetlands on the Sacketts’ property as “waters of the United States” because they were near a ditch that fed into a creek, which fed into Priest Lake, a navigable, intrastate lake.

The EPA ordered the Sacketts to restore the site, threatening penalties of over \$40,000 per day. 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. The decision was unanimous on the merits, but the court split 5-4 on determining how the federal government should go about defining water sources. According to the majority opinion authored by Justice Alito, understanding the Clean Water Act to apply to wetlands that are distinguishable from otherwise covered waters of the United States would substantially broaden the statute to define navigable waters as waters of the United States and adjacent wetlands.

On December 30, 2022, the EPA and the U.S. Army Corps of Engineers announced that they had approved a water of the United States regulation to be implemented in March 2023. After announcing this, EPA Administrator Michael Regan stated that the rule “safeguards our nation’s waters.” The rule opened the door for the federal government to regulate wetlands, lakes, ponds, streams, and “relatively permanent” waterways, largely mimicking a pre-2015 environmental rule set during the Obama Administration, which implemented the changes to curb water pollution. The regulation was the broadest interpretation to date of which water sources require protection under the Clean Water Act. Industry groups and some lawmakers criticized the regulation as an example of federal overreach. In April, a federal judge granted a request from 24 states and several trade groups to pause the implementation of the regulation. The Supreme Court’s decision was hailed for protecting farmers, ranchers, and landowners from overreach under the Clean Water Act. The foregoing decisions are consistent with the trend of decisions of the Court – including the Court’s decision in *Department of Education v. Brown*,²⁸⁹ striking down the Biden Administration’s effort to forgive student loan debt – insisting that administrative agency actions, particularly major actions, be grounded in specific legislative authority to act.

On balance, these decisions slowed down the pace of agency-designed environmental regulation as well as any regulation specific to ESG under the Biden Administration, but these decisions did not alter the direction or goals of the Biden Administration or lessen the pressures companies faced from stakeholders to undertake ESG efforts. Certainly, the 2024 election had a more significant impact.

A trilogy of cases decided by the United States Supreme Court in 2024 limits the power of administrative agencies in a manner that extends well beyond ESG and DEI. The regulatory or administrative state wields enormous power and influence in the United States. These agencies reside in the Executive Branch and are delegated authority by Congress to issue rules, regulations, licenses, and establish rates. Reportedly, there are now over 400 federal departments and agencies. The number of regulations, the size of the Code of Federal Regulations (which contains all finalized rules and regulations), the scope of regulations, and the costs of compliance with these regulations have all increased significantly over the decades. The Federal Register totaled 61,308 pages in 2017 (which was down from the all-time high of 95,894 pages in 1993) and swelled back up to 86,356 pages in 2020.

In 2021, the Biden Administration promulgated over 3,250 regulations in contrast to 81 laws passed by Congress, meaning agencies accounted for over 97 percent of new laws adopted in the United States. It has been estimated that regulatory compliance and the economic impact of regulation exceed \$1.9 trillion annually.

Perhaps more problematic than the number and costs of regulations is the power of agencies to promulgate laws that lack majority support by the general public. Agencies pass regulations that would not withstand media scrutiny, would not garner sufficient public support to survive the legislative process, and could have adverse consequences for the reelection of United States Representatives, Senators, and the President.

Indeed, Chief Justice Roberts' dissent in the *City of Arlington v. FCC*,²⁹⁰ compared administrative agencies to tyranny: "One of the principal authors of the Constitution famously wrote that the "accumulation of all powers, legislative, executive, and judiciary, in the same hands, . . . may justly be pronounced the very definition of tyranny." The Federalist No. 47, p. 324 (J. Cooke ed. 1961) (J. Madison). Although modern administrative agencies fit most comfortably within the Executive Branch, as a practical matter they exercise legislative power, by promulgating regulations with the force of law; executive power, by policing compliance with those regulations; and judicial power, by adjudicating enforcement actions and imposing sanctions on those found to have violated their rules. The accumulation of these powers in the same hands is not an occasional or isolated exception to the constitutional plan; it is a central feature of modern American government" ²⁹¹

As the Chief Justice aptly noted, "hundreds of federal agencies [are] poking into every nook and cranny of daily life."

Government bureaucrats who run these agencies and promulgate these regulations having the force and effect of law are not elected by voters. Many are not even appointed by the President and confirmed by the Senate. Many believe that bureaucrats are sometimes unaccountable to elected officials and may even frustrate the efforts and agendas of elected officials.

The U.S. Supreme Court decision in *Loper Bright Enters v. Raimondo*²⁹², does not abolish agencies or substantially limit their general rule-making power when properly delegated to them by Congress. It does, however, provide a meaningful check on agencies by ending court deference to agencies in interpreting ambiguous law. Writing the 6-3 majority opinion, Chief Justice Roberts put an end to the *Chevron* deference sometimes afforded to administrative agencies by courts in interpreting ambiguous law. Justice Roberts set the stage by noting that, since the Court's decision in *Chevron*

*U.S.A. Inc. v. Natural Resources Defense Council, Inc.*²⁹³, the Court sometimes required courts to defer to agency interpretations of the statutes those agencies administer – even when a reviewing court reads the statute differently.

Where *Chevron* applied, a court would first determine whether Congress expressed its intent clearly concerning the question at issue. If so, Congressional intent would be effectuated. Where the statute is silent or ambiguous with respect to the subject issue, under *Chevron*, the reviewing court was required to defer to the agency's interpretation, provided it was based on a "permissible construction" of the statute.

The reviewing courts in each case applied *Chevron* to resolve challenges to the same agency rule in favor of the government. The National Marine Fisheries Service (NMFS) administers the Magnuson-Stevens Fishery Conservation and Management Act (MSA) pursuant to delegation from the Secretary of Commerce (SEC). Pursuant to this scheme, councils developed fishery management plans, which NMFS approves and promulgates as final regulations. A plan may require that one or more observers be on board domestic vessels to collect data necessary for the conservation and management of the fishery. The MSA specifies three groups that must cover the costs associated with observers: foreign fishing vessels operating within the exclusive economic zone; vessels participating in certain limited access privilege programs; and vessels within the jurisdiction of the North Pacific Council.

The MSA expressly caps the relevant fees at two or three percent of the value of fish harvested on the vessels for the latter two categories. The MSA does not address whether Atlantic herring fishermen may be required to bear costs associated with any observers that a plan may mandate. The NMFS fully funded the observer coverage that the New England Fishery Management Council required in its plan for the Atlantic herring fishery. In 2013, the council proposed amending

its fishery management plans to empower it to require fishermen to pay for observers if federal funding became unavailable.

Several years later, the NMFS promulgated a rule approving the amendment. Petitioners are family businesses that operate in the Atlantic herring fishery. In February 2020, they challenged the Rule under the MSA, which incorporates the Administrative Procedure Act (APA).²⁹⁴ They argued that the MSA does not authorize NMFS to mandate that they pay for observers required by a fishery management plan. In one case, the district court granted summary judgment to the government.

It concluded that the MSA authorized the Rule but noted that even if these petitioners' "arguments were enough to raise an ambiguity in the statutory text," deference to the agency's interpretation would be warranted under *Chevron*. A divided panel of the D. C. Circuit affirmed. The majority addressed various provisions of the MSA and concluded that it was not "wholly unambiguous" whether NMFS may require Atlantic herring fishermen to pay for observers and deferred to the agency's interpretation as a "reasonable" construction of the MSA.

In the companion case, petitioners Relentless Inc., Huntress Inc., and Seafreeze Fleet LLC, owners of two vessels that operate in the Atlantic herring fishery, filed a suit challenging the Rule as unauthorized by the MSA. The First Circuit affirmed the ruling of the district court in favor of the government. The First Circuit concluded that the agency's interpretation of its authority to require at-sea monitors that owners of regulated vessels pay for does not exceed the bounds of the permissible. It purported to apply *Chevron* but did not explain which aspects of its analysis were relevant to which of *Chevron's* two steps. The United States Supreme Court granted certiorari in both cases, limited to the question of whether *Chevron* should be overruled or clarified.

In ending *Chevron* deference, Chief Justice Roberts mainly relied upon the fundamental principle of judicial review to support the Court's decision that interpretation of the law is within the province of courts, not administrative agencies. He pointed out that the framers of the Constitution envisioned that the final interpretation of the laws would rest within the province of the courts.

The United States Supreme Court initially embraced this understanding in *Marbury v. Madison*, one of the first cases law students will study in constitutional law class. In *Marbury*, Chief Justice Marshall declared that “[i]t is emphatically the province and duty of the judicial department to say what the law is.”²⁹⁵ Precedent teaches that whatever respect an executive branch interpretation was due, a judge is not bound to adopt the construction given by the head of a department.

Next, Chief Justice Roberts turned to the Administrative Procedures Act (“APA”) enacted in 1946. He noted the APA serves “as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices.”²⁹⁶ According to Chief Justice Roberts, the APA itself addresses the issue before the Court: “In addition to prescribing procedures for agency action, the APA delineates the basic contours of judicial review of such action. Section 706 directs that “[t]o the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action.”²⁹⁷

The APA requires courts to hold unlawful and set aside agency actions, findings, and conclusions that are not in accordance with the law. Chief Justice Roberts concluded: “The APA thus codifies for agency cases the unremarkable, yet elemental proposition reflected by judicial practice dating back to *Marbury*: that courts decide legal questions by applying their own judgment. It specifies that courts, not

agencies, will decide “all relevant questions of law” arising on review of agency action, §706 (emphasis added)—even those involving ambiguous laws—and set aside any such action inconsistent with the law as they interpret it. And it prescribes no deferential standard for courts to employ in answering those legal questions. That omission is telling, because Section 706 does mandate that judicial review of agency policymaking and factfinding be deferential. See §706(2)(A) (agency action to be set aside if ‘arbitrary, capricious, [or] an abuse of discretion’); §706(2)(E) (agency fact-finding in formal proceedings to be set aside if ‘unsupported by substantial evidence’).”

The Chief Justice acknowledged that courts may seek aid from the interpretations of those responsible for implementing particular statutes. Such interpretations “constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance,” consistent with the APA.²⁹⁸

According to the Chief Justice, the deference *Chevron* required of courts cannot be squared with the APA. *Chevron* defies the command of the APA that the reviewing court – not the agency whose action it reviews – is to decide all relevant questions of law and interpret statutory provisions. He rejected the arguments offered for deferring to agencies to resolve statutory ambiguities, including that agencies have subject matter expertise regarding the statutes they administer, deferring to agencies promotes the uniform construction of federal law, and resolving statutory ambiguities may involve policymaking best left to political actors, rather than courts.

He pointed out that Congress expects courts to handle technical statutory questions and that courts have the expertise in interpreting law.²⁹⁹ Justice Thomas concurred, writing separately to underscore his view that *Chevron* deference also violates our Constitution’s separation of powers. Justice Gorsuch wrote a separate concurring opinion regarding *stare decisis*.

Justice Kagan dissented and was joined by Justice Sotomayor and Justice Brown-Jackson. According to Justice Kagan, Congress would usually prefer that the responsible agency, not a court, resolve ambiguities: “Some interpretive issues arising in the regulatory context involve scientific or technical subject matter. Agencies have expertise in those areas; courts do not. Some demand a detailed understanding of complex and interdependent regulatory programs. Agencies know those programs inside-out; again, courts do not. And some present policy choices, including trade-offs between competing goods. Agencies report to a President, who in turn answers to the public for his policy calls; courts have no such accountability and no proper basis for making policy. And of course, Congress has conferred on that expert, experienced, and politically accountable agency the authority to administer—to make rules about and otherwise implement—the statute giving rise to the ambiguity or gap. Put all that together and deference to the agency is the almost obvious choice, based on an implicit congressional delegation of interpretive authority. We defer, the Court has explained, ‘because of a presumption that Congress ‘would have ‘desired’ the agency (rather than the courts)’ to exercise ‘whatever degree of discretion’ the statute allows. The pendulum has been swinging away from *Chevron* deference for some time. The 2013 dissent of Chief Justice Roberts, joined by Justice Kennedy and Justice Alito, in *City of Arlington* foreshadowed the elimination of *Chevron* deference. Over the past two terms, the nation’s high court stepped up its efforts to address agency overreach. As previously discussed, the court has been using the “major issues doctrine” to erode *Chevron* deference. The U.S. Supreme Court itself had not employed *Chevron* deference since 2016, and Chief Justice Roberts thought it made sense to free lower courts from its restraints.

In 2023, Congress took a stab at ending *Chevron* deference. Specifically, on June 15, 2023, the House of Representatives passed the Separation of Powers Restoration Act of 2023 (SOPRA). The bill, which was never enacted into law, would have eliminated *Chevron*

deference about a year before the U.S. Supreme Court overruled *Chevron*. Though not a basis for the result in *Loper Bright*, SOPRA at least evinced the intent of the current House of Representatives not to continue *Chevron* deference.

The day before deciding *Loper Bright*, the Supreme Court issued its ruling in *Securities and Exchange Commission v. Jarkesy*.³⁰⁰ The decision did not involve *Chevron* deference but rather interposed restrictions on the agencies' ability to adjudicate disputes before their courts. Shortly after the passage of the Dodd-Frank Act, the SEC initiated an enforcement action for civil penalties against investment adviser George Jarkesy, Jr. and his firm, Patriot28, LLC, for alleged violations of the antifraud provisions contained in federal securities laws. The SEC decided to adjudicate the matter in-house and determined that Jarkesy and Patriot28 violated securities law and levied a civil penalty of \$300,000. Jarkesy and Patriot28 petitioned for judicial review. The Fifth Circuit vacated the SEC's order on the ground that adjudicating the matter in-house violated the defendants' Seventh Amendment right to a jury trial. The Supreme Court granted *Certiorari*.

In a 6-3 decision written by Chief Justice Roberts, the Supreme Court affirmed, holding that, when the SEC seeks civil penalties against a defendant for securities fraud, the Seventh Amendment entitles the defendant to a jury trial, and the agency must bring proceedings in federal court. The Court held that the "public rights" exception to Article III jurisdiction – which allows Congress to assign certain matters for decision to any agency without a jury (*e.g.*, certain customs and immigration laws) – does not apply because the present action does not fall within any of the distinctive areas involving governmental prerogatives where the Court has concluded that a matter may be resolved outside of an Article III court, without a jury. In the case *sub judice*, the SEC targeted the same basic conduct as common law fraud, which is a private as opposed to a public right.

Justice Sotomayor filed a dissent, joined by Justice Kagan and Justice Brown-Jackson. According to Justice Sotomayor's dissent, "the Constitutionality of hundreds of statutes may now be in peril, and dozens of agencies could be stripped of their power to enforce laws enacted by Congress."

On the last day of that term, the Supreme Court issued its decision in *Corner Post, Inc. v. Bd. of Governors of the Fed. Rsrv. Sys.*³⁰¹ In this final case of the trilogy increasing the ability of regulated entities and individuals to challenge agency action, the Court held that the default six-year statute of limitations for challenging federal agency actions begins to run when the plaintiff is injured by a final agency action, not when the final agency action is published. The 6-3 decision authored by Justice Coney-Barrett allows decades-old regulations to be challenged.

In this case, Corner Post, a truck stop that opened in 2018, challenged Regulation II of the Federal Reserve Board, which was introduced in 2011. Regulation II capped debit card interchange fees at \$0.21 per transaction and 0.05 percent of the transaction's value. The district court dismissed the suit as time-barred, and the Eighth Circuit affirmed, holding that the statute of limitations begins to run when a regulation is published, the rule followed by the majority of the U.S. Courts of Appeal. As the Federal Reserve Board published Regulation II in 2011, the lower courts held that the time to challenge the regulation expired in 2017, a year before Corner Post existed and processed its first debit card transaction.

Justice Brown-Jackson dissented along with Justice Sonia Sotomayor and Justice Kagan. Justice Jackson believed that the majority's reasoning was fundamentally flawed and inconsistent with the Court's prior decisions. According to Justice Jackson, the decision "means that there is effectively no longer any limitations period for lawsuits that challenge agency regulations on their face" and that

litigants could “game the system by creating new entities or finding new plaintiffs whenever they blow past the statutory deadline.”

Justice Jackson predicted that this decision, coupled with *Loper Bright*, will “wreak havoc on Government agencies, businesses, and society at large” and lead to a “tsunami of lawsuits” challenging agency regulations. Justice Jackson is likely correct that the number of lawsuits challenging administrative agency regulations will increase significantly, at least in the short term. The Supreme Court recognized that it is the role of courts and not administrative agencies to interpret statutes. In so doing, it has provided an avenue for regulated persons and entities to limit agency authority and abuses through litigation. It also imposed a measure of checks and balances on agencies consistent with the type of government envisioned by the framers.

Loper Bright’s ending of *Chevron* deference unquestionably is a significant development. The decision will empower regulated entities and provide greater incentive for them to litigate by improving their chances of prevailing where the issue involves regulation in areas in which the agency does not have expressly delegated authority.

There has been some research suggesting that courts have frequently invoked *Chevron* deference and that, in such cases, agencies have prevailed over 77 percent of the time, which is an increase in the agency win rate of more than 23 percent in cases in which *Chevron* deference was applied as compared to cases in which *Chevron* deference was not applied. In addition, regulated entities may experience some upstream advantage by achieving greater influence as part of the rulemaking process insofar as agencies afford greater weight to their comments.

In the wake of *Loper Bright*, doubt may be cast on the validity of some existing agency interpretations and regulations that rely on broad or ambiguous statutory language. However, the Supreme Court

majority made clear that its decision does not invalidate prior cases decided under *Chevron*. Many believe that some of the broader, more far-reaching regulations may be at risk without *Chevron* deference, but many long-settled regulations will survive. Many federal agencies have been preparing for the elimination of *Chevron* deference since the Supreme Court granted review in *Loper Bright*. They had been honing their reasons to support newly promulgated regulations and others they believe to be at risk.

It remains to be seen whether *Loper Bright* will effectuate a sea-level change or merely result in a modest decrease in agency power. Congress retains the ability to delegate authority to federal agencies but must make such intent to delegate clear. Many times, the delegation of authority or the expression of congressional intent to allow agencies to “gap fill” will be expressed and clear. In such instances, *Loper Bright* does nothing to invalidate such a delegation. Many cases before *Loper Bright* did not apply *Chevron* deference. Also, in several instances, parties impacted by regulations may not have the funds or time to litigate against agencies with seemingly unlimited resources.

Although *Loper Bright* rejects mandatory deference under *Chevron*, the Court observed that federal courts may still “seek aid” from the executive branch, giving careful attention to what the agencies have to say on interpretive matters, particularly where the agency’s construction rests on “factual premises” within its expertise. Some courts may see this language as providing an opening to effectively defer to agency interpretation without expressly applying *Chevron* deference.

The ruling emphasizes the importance of clear and explicit delegation of authority from Congress to agencies. This may lead to more detailed and specific statutory language in future legislation and perhaps require Congress to revisit existing legislation. Ideally, Congress would improve its legislative actions by passing legislation

that is shorter and more succinct, and that addresses issues with greater precision, leaving less room for agencies to legislate under the guise of rulemaking. There is the potential that Congress could begin inserting broad, *pro forma* delegation language in legislation.

Many commentators have complained that *Loper Bright* reflects the Court's usurpation of power by the judiciary through judicial review at the expense of Congress. Others believe the real shift of power among the three branches of government is Congress's abdication of its legislative function in favor of the executive branch and the assumption of power by administrative agencies that was unimaginable at the time of the Constitution's drafting. Agencies and the bureaucrats that run them remain vested with broad powers. Many of their activities are not subject to the same sunlight as legislation passed by Congress. Actions and regulations that would not pass muster if subjected to the scrutiny of the legislative process are commonplace in the administrative state.

Also, Congress does not enforce or adjudicate the legislation it passes. Administrative agencies enforce and adjudicate the regulations they promulgate. There are many ways in which agencies can influence the nation's policy agenda and legislation through the President and the President's bully pulpit, and through the speeches and activities of agency heads and subheads.

Loper Bright is a significant decision, but agencies will continue to wield enormous power over Americans. The other two decisions also may benefit those challenging agency activities. Many litigants will benefit by litigating in federal court as opposed to in an agency-controlled forum. Many litigants whose challenges would be barred before the entity existed or were injured by regulations promulgated years or decades before will welcome the opportunity to assert claims that would be time-barred if the statute of limitations began to run once a regulation is published. *Loper Bright* will impact insurers as businesses and regulated entities in the same manner as other

businesses and regulated entities. Regulatory actions impact insurers' underwriting, investment, and claims-handling activities, which may impact losses.

Regulatory enforcement actions are a concern for every corporate policyholder, and policyholder lawyers are reminding their clients to review the regulatory environment for risks related to the business and to ensure their insurance programs proactively provide coverage for the related regulatory risk. Policyholders and insurers are keeping their eyes on civil penalties. Many expect an uptick in securities cases that could impact professional liability and D&O policies and increase defense costs. The trilogy of cases decided by the Supreme Court in the 2024 term will significantly impact agency power, rulemaking, and adjudication. However, the extent of the impact will depend, in part, on the actions of agencies, Congress, the President, and the courts. At least in the short term, the level of judicial challenges to agency regulation can be expected to increase.

It is important to note that the Supreme Court's reliance on the "major questions doctrine" does not necessarily favor one party or the other. On February 20, 2026, the Supreme Court ruled 6–3 in *Learning Resources, Inc. v. Trump*³⁰² that the President does not have the authority to impose sweeping, open-ended tariffs under the International Emergency Economic Powers Act. Chief Justice John Roberts wrote that the Act's authority to "regulate... importation" does not include the power to tax or impose tariffs, as the word "regulate" is distinct from "taxation" in federal law. Three conservative justices endorsed the application of the "major questions doctrine," ruling the President cannot use vague or old statutes to exert vast economic and political power without clear congressional authorization.

In *Federal Communications Commission v. Consumers' Research*³⁰³, decided on June 27, 2025, the U.S. Supreme Court ruled 6-3 that the FCC's Universal Service Fund (USF) is constitutional. The Court reversed a lower court ruling, holding that Congress did not violate the

nondelegation doctrine and that the FCC maintains sufficient control over the fund's administration. Many commentators predicated that case would provide the Court with the opportunity to reinvigorate the nondelegation doctrine. However, the Court did not take the invitation and upheld the congressional action.

The nondelegation doctrine is rooted in Article I of the Constitution and its grant of legislative authority to Congress. The nondelegation doctrine was last used in a significant way to strike down laws in the 1930s. Since then, courts generally have applied the "intelligible principle" test to uphold exercises of agency discretion where Congress provided at least some minimal level of guidance as to how that discretion should be exercised. The nondelegation doctrine was raised in a 2019 case, *Gundy v. United States*.³⁰⁴ In that case, all four conservative justices participating in the case signaled support for strengthening the nondelegation doctrine. With a majority of conservative justices, it is possible that the Court could have strengthened the nondelegation doctrine. The nondelegation doctrine is more sweeping than the "major issues" doctrine as it could be employed where an administrative agency exercises any amount of policy discretion as opposed to where it exercises discretion on major policy issues. Also, the remedy for violating the nondelegation doctrine potentially is broader as well in that a statute granting the policy discretion may be struck down as being unconstitutional, removing the ability of the agency at hand to regulate in that area entirely and potentially affecting more rules than only the challenged rule. The application of the nondelegation doctrine could have rip roared across the country and invalidate many laws, but the court declined to go that route.

Countervailing Forces Impacting ESG: Federal law and policy are critically important with respect to ESG requirements imposed on companies. Insurers and policyholders also have to comply with applicable state and international law. Of course, insurance regulators at the state level and political subdivisions also impact ESG. During

the Biden administration, Republican-controlled states enacted anti-ESG legislation and policies.

Now, during the second Trump administration, several states led by California have picked up the ESG baton. In November, the Ninth Circuit granted an injunction staying the enforcement of California SB 261 that requires companies to publish climate risk reports in January 2026, identifying their financial risks associated with climate change and their efforts to mitigate these risks.³⁰⁵ The court, however, did not stay another law, SB 253, that requires companies to disclose their Scope 1 and Scope 2 greenhouse gas emissions by an unspecified date in 2026. Though California is taking the lead, pro-ESG measures and legislation have been enacted in other states including Colorado, Florida, Illinois, Maine, Maryland, New Hampshire, Oregon, and Utah, demonstrating that Newton's Third Law of Motion is bipartisan.

U.S. companies doing business internationally are subject to international laws and regulations that remain in place, although the European Union announced earlier this year that it was dialing back some of its ESG initiatives. On November 20, the European Commission published a proposal to amend the Sustainable Finance Regulation that has been in effect since 2021 in response to market comments that the program is overly complex. For a detailed analysis of ESG, *see generally*, Scott M. Seaman and Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 21 Sustainability/ESG (Environmental, Social, and Governance Considerations) & PFAS.³⁰⁶ In any event, it is important to recognize that companies must still comply with traditional environmental laws and environmental liabilities remain large.

DEI: Diversity, equity, and inclusion programs have been subject to both considerable praise and criticism. They have been hailed for promoting fairness and opportunity and eliminating discrimination

in the employment arena. Concerns were expressed about DEI itself being discriminatory and that demographics were often displacing merits and skill in hiring and retention decisions, which could adversely impact the performance of companies and the health, safety, and welfare of consumers.

It was not political events, but rather a U.S. Supreme Court decision that started a major rollback on corporate DEI initiatives and programming. In *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*³⁰⁷ and the companion case *Students for Fair Admissions, Inc. v. University of North Carolina*,³⁰⁸ the Court issued its seminal decision on DEI. 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. The decision raises questions regarding efforts aimed at increasing diversity in the application and hiring processes for other public and private institutions alike.

Plaintiff in both cases, the Students for Fair Admissions, Inc., filed the cases against Harvard and UNC in 2014, challenging both universities' use of race as a factor in admissions decisions. The case against Harvard asserted that the policy in place discriminated against Asian Americans, and the case against UNC asserted that the policy in place discriminated against white and Asian Americans. Lower courts upheld the policies, and the matter was taken up on *certiorari*.

Per Title VI of the 1964 Civil Rights Act, "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Both Harvard and UNC receive forms of federal funding. The Equal Protection Clause, in turn, forbids

discrimination on the basis of race by state and federal governments. As a state university, UNC comes within the Equal Protection Clause.

Chief Justice Roberts authored the 40-page majority opinion concluding that, while “commendable,” Harvard’s and UNC’s goals, as stated with respect to their policies, are not “sufficiently coherent” to clear the “strict scrutiny” threshold required for any exception to the Equal Protection Clause. As outlined by Justice Roberts, [t]hose interests include training future leaders, acquiring new knowledge based on diverse outlooks, promoting a robust marketplace of ideas, and preparing engaged and productive citizens.” However, in the majority’s estimate, “[i]t is unclear how courts are supposed to measure any of those goals, or if they could, to know when they have been reached so that racial preferences can end.”

The Chief Justice further concluded both universities’ policies “unavoidably employ race in a negative manner” and “involve racial stereotyping.” As he put it, “[c]ollege admissions are zero-sum, and a benefit provided to some applicants but not to others necessarily advantages the former at the expense of the latter.” Finally, his opinion pointed out that the admissions programs’ lack a “logical end point.” On both of these additional points, Chief Justice Roberts concluded that Harvard’s and UNC’s admissions policies “cannot be reconciled with the guarantees of the Equal Protection Clause.”

Chief Justice Roberts was joined in the opinion by Justices Clarence Thomas, Samuel Alito, Neil Gorsuch, Brett Kavanaugh, and Amy Coney Barrett. Notably, the opinion stated that nothing therein “should be construed as prohibiting universities from considering an applicant’s discussion of how race affected his or her life” leaving a possible opening in what would otherwise appear to be a wholesale prohibition. The decision further left open the possibility that military academies might continue their affirmative action programs given “distinct interests” at issue in those circumstances.

Justice Thomas issued a concurring opinion expressing his own criticism of the actual impact of admissions policies like those at issue, contending that “[f]ar from advancing the cause of improved race relations in our Nation, affirmative action highlights racial differences with pernicious effect.” Justice Gorsuch also issued a concurring opinion, in which Justice Thomas joined, concluding that the admissions policies at issue violate Title VI’s prohibitions against discrimination on the basis of race. And lastly, Justice Kavanaugh concurred, emphasizing the need for a sunset provision on any admissions policies like Harvard’s and UNC’s.

Justice Sonia Sotomayor dissented from the court’s holding, issuing a 69-page opinion, joined by Justices Elena Kagan and Ketanji Brown-Jackson – the latter as to UNC only, as she had recused herself from the matter as to Harvard. Justice Jackson issued her own dissenting opinion on the UNC matter, in which Justice Sotomayor and Justice Kagan joined. Justice Sotomayor’s dissent celebrated admissions policies like those at issue as advancing “the constitutional guarantee of racial equality.” In her view, the majority’s decision “stands in the way and rolls back decades of precedent and momentous progress” on that guarantee. That said, Justice Sotomayor’s dissent anticipates that “[a]lthough the Court has stripped out almost all uses of race in college admissions, universities can and should continue to use all available tools to meet society’s need for diversity in education.” Likewise, Justice Jackson criticized the majority’s decision as “arrest[ing] the noble generational project that American universities are attempting,”

The decision on affirmative action has had a significant impact on private employer diversity initiatives, even though private companies generally are not subject to the Equal Protection Clause. Instead, companies are generally governed by Title VII of the Civil Rights Act (as opposed to Title VI), but the language of Title VII is very similar. Courts have been confronted with arguments by private claimants and advocacy groups that the decision applies in other contexts where race is a factor in decision-making, including employment,

vendor and supplier contracting, and investment. Courts may, in turn, analogize to the decision and its rationale in those contexts.

Numerous lawsuits have challenged supplier diversity programs and state-funded programs that take race into account. Companies have been reviewing their ESG and DEI programs, assessing potential challenges, reviewing internal and external communications and policies, and revising practices and messaging as appropriate. Companies recognized they were subject to reverse discrimination claims. Yet, curtailing or eliminating DEI programs and practices could increase traditional discrimination lawsuits and even shareholder suits challenging these decisions, and could present reputational and operational risks.

Many companies have ended DEI programs, scaled back DEI programs, and downsized or eliminated employees focused on DEI. Indeed, since the Supreme Court decision, several companies have announced that they are eliminating or cutting back on DEI programs. These companies include: JP Morgan Chase (rolling back DEI commitments); Goldman Sachs (dropping requirement that a company it takes public must have at least two diverse members on its board of directors based on Fifth Circuit ruling in December that Nasdaq could not impose rules designed to increase diversity in corporate America by requiring companies listed on the exchange to have women and minority directors on their boards or explain why they do not); Disney (shifting from DEI to talent strategy); Deloitte (telling U.S. employees working with government clients to remove pronouns from their email signatures and rolling back its DEI goals and ceasing issuing diversity reports); PBS (closing DEI office and those in DEI roles have left the company, to make sure it complies with Trump's anti-DEI executive orders); Google (cutting DEI hiring goals and no longer marking the start of cultural observances like Pride Month and Black History Month); Pepsi, GM, Google, Disney, GE, Intel, PayPal, Chipotle and Comcast paring back or removing references to DEI in their 2024 annual reports to investors); Accenture

(no longer using diversity targets in hiring and promoting); Amazon's (annual report omitted a section included in prior annual reports indicating it has a focus on inclusion and diversity in hiring); and Amtrak (rolling back DEI programs and policies).

Other companies and entities moving away from DEI programs and efforts include: the Smithsonian Institution (closing its diversity office); Target (curbing LGBTQ Pride merchandise line and pulling back on racial hiring targets); FBI (closing its DEI office); Meta (ending several programs intended to increase its hiring of diverse candidates); McDonalds (abandoning specific diversity targets and ceasing participation in external surveys that measure company demographics); Walmart (abandoning its DEI commitments, including winding down a Center for Racial Equity nonprofit it had founded); Boeing (dismantling its global DEI department); Molson Coors (abandoning supplier diversity quotas and shifting DEI training sessions to focus on business objectives); Loews (ceasing participating in HRC surveys and participating in external events like Pride parades); Ford Motor Co. (ending participation in external diversity surveys); Brown-Forman (no longer linking executive compensation to DEI progress, removing workforce and supplier diversity goals, and ending participating in the HRC index); Harley Davidson (abandoning its DEI function and use of diversity quotas for hiring or suppliers); and John Deere (no longer supporting cultural awareness events and removing "socially-motivated messages").

Not all companies have abandoned their DEI programming. Some companies have publicly announced that they are standing behind their DEI policies, including: Costco, Apple, Delta Airlines, Cisco, and Deutsche Bank. The ultimate impact of this decision will continue to play out over time, but the U.S. Supreme Court decision has been impactful.

The election of President Trump in 2024 was another major DEI-limiting event. President Trump, during the presidential campaign,

made it clear that a second Trump administration would move away from DEI and return to a merit-based hiring and retention system. In the early days of the administration, President Trump has been delivering on that campaign promise. On his first day in office in his second term, President Trump signed two executive orders taking aim at DEI. The first, entitled “Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,” provides:

Section 1. Purpose. Across the country, ideologues who deny the biological reality of sex have increasingly used legal and other socially coercive means to permit men to self-identify as women and gain access to intimate single-sex spaces and activities designed for women, from women’s domestic abuse shelters to women’s workplace showers. This is wrong. Efforts to eradicate the biological reality of sex fundamentally attack women by depriving them of their dignity, safety, and well-being. The erasure of sex in language and policy has a corrosive impact not just on women but on the validity of the entire American system. Basing Federal policy on truth is critical to scientific inquiry, public safety, morale, and trust in government itself.

This unhealthy road is paved by an ongoing and purposeful attack against the ordinary and longstanding use and understanding of biological and scientific terms, replacing the immutable biological reality of sex with an internal, fluid, and subjective sense of self unmoored from biological facts. Invalidating the true and biological category of “woman” improperly transforms laws and policies designed to protect sex-based opportunities into laws and policies that undermine them, replacing

longstanding, cherished legal rights and values with an identity-based, inchoate social concept.

Accordingly, my Administration will defend women's rights and protect freedom of conscience by using clear and accurate language and policies that recognize women are biologically female, and men are biologically male.

Sec. 2. Policy and Definitions. It is the policy of the United States to recognize two sexes, male and female. These sexes are not changeable and are grounded in fundamental and incontrovertible reality. Under my direction, the Executive Branch will enforce all sex-protective laws to promote this reality, and the following definitions shall govern all Executive interpretation of and application of Federal law and administration policy:

(a) "Sex" shall refer to an individual's immutable biological classification as either male or female. "Sex" is not a synonym for and does not include the concept of "gender identity."

(b) "Women" or "woman" and "girls" or "girl" shall mean adult and juvenile human females, respectively.

(c) "Men" or "man" and "boys" or "boy" shall mean adult and juvenile human males, respectively.

(d) "Female" means a person belonging, at conception, to the sex that produces the large reproductive cell.

(e) "Male" means a person belonging, at conception, to the sex that produces the small reproductive cell.

(f) “Gender ideology” replaces the biological category of sex with an ever-shifting concept of self-assessed gender identity, permitting the false claim that males can identify as and thus become women and vice versa, and requiring all institutions of society to regard this false claim as true. Gender ideology includes the idea that there is a vast spectrum of genders that are disconnected from one’s sex. Gender ideology is internally inconsistent, in that it diminishes sex as an identifiable or useful category but nevertheless maintains that it is possible for a person to be born in the wrong sexed body.

(g) “Gender identity” reflects a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Sec. 3. Recognizing Women Are Biologically Distinct From Men. (a) Within 30 days of the date of this order, the Secretary of Health and Human Services shall provide to the U.S. Government, external partners, and the public clear guidance expanding on the sex-based definitions set forth in this order.

(b) Each agency and all Federal employees shall enforce laws governing sex-based rights, protections, opportunities, and accommodations to protect men and women as biologically distinct sexes. Each agency should therefore give the terms “sex”, “male”, “female”, “men”, “women”, “boys” and “girls” the meanings set forth in section 2 of this order when interpreting or applying statutes, regulations, or

guidance and in all other official agency business, documents, and communications.

(c) When administering or enforcing sex-based distinctions, every agency and all Federal employees acting in an official capacity on behalf of their agency shall use the term “sex” and not “gender” in all applicable Federal policies and documents.

(d) The Secretaries of State and Homeland Security, and the Director of the Office of Personnel Management, shall implement changes to require that government-issued identification documents, including passports, visas, and Global Entry cards, accurately reflect the holder’s sex, as defined under section 2 of this order; and the Director of the Office of Personnel Management shall ensure that applicable personnel records accurately report Federal employees’ sex, as defined by section 2 of this order.

(e) Agencies shall remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology, and shall cease issuing such statements, policies, regulations, forms, communications or other messages. Agency forms that require an individual’s sex shall list male or female, and shall not request gender identity. Agencies shall take all necessary steps, as permitted by law, to end the Federal funding of gender ideology.

(f) The prior Administration argued that the Supreme Court’s decision in *Bostock v. Clayton County* (2020), which addressed Title VII of the Civil Rights Act of 1964, requires gender identity-based access to

single-sex spaces under, for example, Title IX of the Educational Amendments Act. This position is legally untenable and has harmed women. The Attorney General shall therefore immediately issue guidance to agencies to correct the misapplication of the Supreme Court's decision in *Bostock v. Clayton County* (2020) to sex-based distinctions in agency activities. In addition, the Attorney General shall issue guidance and assist agencies in protecting sex-based distinctions, which are explicitly permitted under Constitutional and statutory precedent.

(g) Federal funds shall not be used to promote gender ideology. Each agency shall assess grant conditions and grantee preferences and ensure grant funds do not promote gender ideology.

Sec. 4. Privacy in Intimate Spaces. (a) The Attorney General and Secretary of Homeland Security shall ensure that males are not detained in women's prisons or housed in women's detention centers, including through amendment, as necessary, of Part 115.41 of title 28, Code of Federal Regulations and interpretation guidance regarding the Americans with Disabilities Act.

(b) The Secretary of Housing and Urban Development shall prepare and submit for notice and comment rulemaking a policy to rescind the final rule entitled "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs" of September 21, 2016, 81 FR 64763, and shall submit for public comment a policy protecting women seeking single-sex rape shelters.

(c) The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

(d) Agencies shall effectuate this policy by taking appropriate action to ensure that intimate spaces designated for women, girls, or females (or for men, boys, or males) are designated by sex and not identity.

Sec. 5. Protecting Rights. The Attorney General shall issue guidance to ensure the freedom to express the binary nature of sex and the right to single-sex spaces in workplaces and federally funded entities covered by the Civil Rights Act of 1964. In accordance with that guidance, the Attorney General, the Secretary of Labor, the General Counsel and Chair of the Equal Employment Opportunity Commission, and each other agency head with enforcement responsibilities under the Civil Rights Act shall prioritize investigations and litigation to enforce the rights and freedoms identified.

Sec. 6. Bill Text. Within 30 days of the date of this order, the Assistant to the President for Legislative Affairs shall present to the President proposed bill text to codify the definitions in this order.

Sec. 7. Agency Implementation and Reporting. (a) Within 120 days of the date of this order, each agency head shall submit an update on implementation of this order to the President, through the Director of

the Office of Management and Budget. That update shall address:

(i) changes to agency documents, including regulations, guidance, forms, and communications, made to comply with this order; and

(ii) agency-imposed requirements on federally funded entities, including contractors, to achieve the policy of this order.

(b) The requirements of this order supersede conflicting provisions in any previous Executive Orders or Presidential Memoranda, including but not limited to Executive Orders 13988 of January 20, 2021, 14004 of January 25, 2021, 14020 and 14021 of March 8, 2021, and 14075 of June 15, 2022. These Executive Orders are hereby rescinded, and the White House Gender Policy Council established by Executive Order 14020 is dissolved.

(c) Each agency head shall promptly rescind all guidance documents inconsistent with the requirements of this order or the Attorney General's guidance issued pursuant to this order, or rescind such parts of such documents that are inconsistent in such manner. Such documents include, but are not limited to:

(i) "The White House Toolkit on Transgender Equality";

(ii) the Department of Education's guidance documents including:

(A) “2024 Title IX Regulations: Pointers for Implementation” (July 2024);

(B) “U.S. Department of Education Toolkit: Creating Inclusive and Nondiscriminatory School Environments for LGBTQI+ Students”;

(C) “U.S. Department of Education Supporting LGBTQI+ Youth and Families in School” (June 21, 2023);

(D) “Departamento de Educación de EE.UU. Apoyar a los jóvenes y familias LGBTQI+ en la escuela” (June 21, 2023);

(E) “Supporting Intersex Students: A Resource for Students, Families, and Educators” (October 2021);

(F) “Supporting Transgender Youth in School” (June 2021);

(G) “Letter to Educators on Title IX’s 49th Anniversary” (June 23, 2021);

(H) “Confronting Anti-LGBTQI+ Harassment in Schools: A Resource for Students and Families” (June 2021);

(I) “Enforcement of Title IX of the Education Amendments of 1972 With Respect to Discrimination Based on Sexual Orientation and Gender Identity in Light of *Bostock v. Clayton County*” (June 22, 2021);

(J) “Education in a Pandemic: The Disparate Impacts of COVID-19 on America’s Students” (June 9, 2021);
and

(K) “Back-to-School Message for Transgender Students from the U.S. Depts of Justice, Education, and HHS” (Aug. 17, 2021);

(iii) the Attorney General’s Memorandum of March 26, 2021 entitled “Application of *Bostock v. Clayton County* to Title IX of the Education Amendments of 1972”; and

(iv) the Equal Employment Opportunity Commission’s “Enforcement Guidance on Harassment in the Workplace” (April 29, 2024).

Sec. 8. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the

application of its provisions to any other persons or circumstances shall not be affected thereby.

The second executive order, entitled “Ending Radical and Wasteful Government DEI Programs and Preferencing,” also dated January 20, 2025, provides:

Section 1. Purpose and Policy. The Biden Administration forced illegal and immoral discrimination programs, going by the name “diversity, equity, and inclusion” (DEI), into virtually all aspects of the Federal Government, in areas ranging from airline safety to the military. This was a concerted effort stemming from President Biden’s first day in office, when he issued Executive Order 13985, “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.”

Pursuant to Executive Order 13985 and follow-on orders, nearly every Federal agency and entity submitted “Equity Action Plans” to detail the ways that they have furthered DEIs infiltration of the Federal Government. The public release of these plans demonstrated immense public waste and shameful discrimination. That ends today. Americans deserve a government committed to serving every person with equal dignity and respect, and to expending precious taxpayer resources only on making America great.

Sec. 2. Implementation. (a) The Director of the Office of Management and Budget (OMB), assisted by the Attorney General and the Director of the Office of Personnel Management (OPM), shall coordinate the termination of all discriminatory programs, including illegal DEI and “diversity, equity, inclusion,

and accessibility” (DEIA) mandates, policies, programs, preferences, and activities in the Federal Government, under whatever name they appear. To carry out this directive, the Director of OPM, with the assistance of the Attorney General as requested, shall review and revise, as appropriate, all existing Federal employment practices, union contracts, and training policies or programs to comply with this order. Federal employment practices, including Federal employee performance reviews, shall reward individual initiative, skills, performance, and hard work and shall not under any circumstances consider DEI or DEIA factors, goals, policies, mandates, or requirements.

(b) Each agency, department, or commission head, in consultation with the Attorney General, the Director of OMB, and the Director of OPM, as appropriate, shall take the following actions within sixty days of this order:

(i) terminate, to the maximum extent allowed by law, all DEI, DEIA, and “environmental justice” offices and positions (including but not limited to “Chief Diversity Officer” positions); all “equity action plans,” “equity” actions, initiatives, or programs, “equity-related” grants or contracts; and all DEI or DEIA performance requirements for employees, contractors, or grantees.

(ii) provide the Director of the OMB with a list of all:

(A) agency or department DEI, DEIA, or “environmental justice” positions, committees, programs, services, activities, budgets, and expenditures in existence on

November 4, 2024, and an assessment of whether these positions, committees, programs, services, activities, budgets, and expenditures have been misleadingly relabeled in an attempt to preserve their pre-November 4, 2024 function;

(B) Federal contractors who have provided DEI training or DEI training materials to agency or department employees; and

(C) Federal grantees who received Federal funding to provide or advance DEI, DEIA, or “environmental justice” programs, services, or activities since January 20, 2021.

(iii) direct the deputy agency or department head to:

(A) assess the operational impact (*e.g.*, the number of new DEI hires) and cost of the prior administration’s DEI, DEIA, and “environmental justice” programs and policies; and

(B) recommend actions, such as Congressional notifications under 28 U.S.C. 530D, to align agency or department programs, activities, policies, regulations, guidance, employment practices, enforcement activities, contracts (including set-asides), grants, consent orders, and litigating positions with the policy of equal dignity and respect identified in section 1 of this order. The agency or department head and the Director of OMB shall jointly ensure that the deputy agency or department head has the authority and resources needed to carry out this directive.

(C) To inform and advise the President, so that he may formulate appropriate and effective civil-rights policies for the Executive Branch, the Assistant to the President for Domestic Policy shall convene a monthly meeting attended by the Director of OMB, the Director of OPM, and each deputy agency or department head to:

(i) hear reports on the prevalence and the economic and social costs of DEI, DEIA, and “environmental justice” in agency or department programs, activities, policies, regulations, guidance, employment practices, enforcement activities, contracts (including set-asides), grants, consent orders, and litigating positions;

(ii) discuss any barriers to measures to comply with this order; and

(iii) monitor and track agency and department progress and identify potential areas for additional Presidential or legislative action to advance the policy of equal dignity and respect.

Sec. 3. Severability. If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected.

Sec. 46. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

The foregoing demonstrates that the second Trump administration will move away from DEI and toward merit-based employment decisions. Time will tell the extent to which states and courts may push back in favor of DEI.

The Impact Of ESG & ESG Regulations On Risk Profiles & Claims: Risk managers and insurers alike must consider the impact of ESG on corporate risk profiles and claims. Indeed, ESG has given rise to new claims. For example, insurers and policyholders must be aware of the potential for greenwashing claims. As reporter Shane Dilworth pointed out: “Increased scrutiny of companies accused of engaging in so-called greenwashing – or falsely conveying that their products are more environmentally friendly than they really are – will likely lead to insurance coverage disputes as federal regulators zero in on environmental, social and governance issues this year. Companies such as Exxon Mobil Corp., Suncor Energy, and Chevron Corp. came under fire for greenwashing in lawsuits brought by local governments that claim they suffered increased infrastructure costs as a result of rising sea levels and severe weather events. The plaintiffs in those cases accuse the energy giants of intentionally misrepresenting their knowledge about the association between burning fossil fuels

and climate change. Another theory on greenwashing, experts say, involves whether companies are being properly managed or clearly representing to investors information about their societal governance and efforts to operate in an environmentally friendly manner.”³⁰⁹ Indeed, Greenwashing may have severe reputational, financial, and legal consequences for companies.

The SEC and other regulators have been reviewing public statements and disclosures surrounding ESG issues, as have investors and securities lawyers. In *Commonwealth v. Exxon Mobil Corp.*³¹⁰ Massachusetts initiated an enforcement action alleging that Exxon’s communications with investors and consumers related to climate change by representing that its motor oil products were clean, greenhouse-gas reducing, and beneficial to the environment. The action alleges greenwashing and unfair and deceptive practices. Previously in 2019, two consumer nonprofit groups sued Tyson Foods, Inc., alleging it misled consumers with false statements claiming their chicken products are produced in an environmentally responsible way. *Organic Consumers Ass’n v. Tyson Foods, Inc.*³¹¹ The plaintiffs assert that Tyson Foods marketed its company as “stewards of the environment” while it actually contaminated the environment and treated animals cruelly. The trial court denied a motion to dismiss filed by Tyson Foods, ruling that its statements that its products were a humane choice and that it was committed to excellence in animal welfare were detailed and concrete enough to be actionable under the D.C. Consumer Protection Procedures Act.

Cases like these testing whether ESG representations are sufficiently detailed and supported – or whether they are mere “greenwashing” – were on the rise. Accusations include ones that firms are making unsubstantiated or misleading claims about the environmentally friendly credentials of their products or services, that they are making highly selective disclosures about the environmental impacts of their business practices, and that they are making misleading and/or

overstated claims about their performance in the context of halting climate change (sometimes referred to as “climate-washing”).

Another outcome of the rise in accusations of greenwashing or climate-washing is the related phenomenon of “green hushing,” where companies seek to hide their climate strategies from wider scrutiny. A report by consultancy firm South Pole found that nearly a quarter (23 percent) of 1200 “sustainability-minded organisations” surveyed about their “science-aligned climate targets” had decided not to publish details of their plans.³¹² This highlights the sense of nervousness felt by some business leaders around the potential downside of climate change commitments.

There has been an increase in greenwashing cases, including in shareholder derivative suits and securities cases. Some of those have also included actions against officers and directors for breach of fiduciary duty. The cases generally claim that statements by senior executives are materially false and misleading and, in turn, resulted in inflated share prices. Issues have covered a broad range, including the biodegradability of plastics, recycling processes, and the demand and production capabilities of electric trucks, to name a few.³¹³

There has also been an increase in consumer litigation in ESG representations. Consumer-based cases center around misstatements about products and processes, ranging from labor conditions of workers who produce cocoa beans, to the environmental sustainability of shoes, to whether juice is organic, to whether tuna is “dolphin safe,” to the labeling of products as recyclable, biodegradable, and eco-friendly. The cases point to representations about products or processes in product labels, websites, social media, marketing materials, and environmental reports. The overall theory of the cases is that the consumer would not have purchased the product “but for” the representation. These cases can be costly. For example, Keurig Green Mountain agreed to settle a class action lawsuit against it regarding the recyclability of its coffee pods for \$10 million.³¹⁴

Recently, cases have extended to claims about overall sustainability and carbon neutrality, albeit with mixed outcomes.³¹⁵

In November 2021, the New York State Department of Financial Services (DFS) announced that it formed a climate division. Later that month, DFS issued final guidance to insurers subject to the department's regulation regarding their management of the financial risks from climate change. DFS claims to be the first U.S. financial regulator to issue a holistic set of expectations on managing the financial risks from climate change. As described in the guidance, DFS expects insurers to take a strategic approach to managing climate risks that considers both current and forward-looking risks and identifies actions required to manage those risks in a manner proportionate to the nature, scale, and complexity of insurers' businesses.³¹⁶

DFS states that insurers should: integrate the consideration of climate risks into its governance structure at the group or insurer entity level; when making business decisions, consider the current and forward-looking impact of climate-related factors on its business using time horizons that are appropriately tailored to the insurer, its activities and the decisions being made; incorporate climate risks into the insurer's existing financial risk management, including by embedding climate risks in its risk management framework and analyzing the impact of climate risks on existing risk factors; use scenario analysis to inform business strategies and risk assessment and identification; and disclose its climate risks and engage with the Task Force on Climate-related Financial Disclosures and other initiatives when developing its disclosure approaches.³¹⁷ Acting Superintendent of Financial Services Adrienne A. Harris stated, "[c]limate change is an urgent issue that poses wide-ranging and material risks to the financial system. Insurers, which are uniquely impacted as climate change affects both sides of their balance sheets, also play a critical role in managing climate risks."

On August 6, 2021, the SEC approved the diversity rule proposed by the Nasdaq Stock Market (Rule 5605(f)). Nasdaq is the second largest exchange in the United States, with over 3700 public companies listed and with a market capitalization in excess of \$19 trillion. Nasdaq-listed companies will generally be required to either have (or explain why they do not have) at least one director who self-identifies as female and at least one director who self-identifies as an underrepresented minority or LGBTQ+ as those terms are defined in the rule.³¹⁸ On December 11, 2024, in *Alliance for Fair Board Retirement v. SEC*³¹⁹, the United States Court of Appeals for the Fifth Circuit struck down the rule proposed by Nasdaq and approved by the U.S. SEC that would have required most Nasdaq-listed companies to disclose statistical information relating to board diversity and to have, or explain why they do not have, at least two diverse directors. By a 9-8 vote, the majority of the Circuit court held that the disclosure requirements were not related to the goals of protecting investors from speculative, manipulative and fraudulent practices and promoting competition in the market for securities transactions—which the majority considered the primary purposes of the Securities Exchange Act of 1934 (the “Exchange Act”)—and that the SEC’s determination that the proposed rule was consistent with the requirements of the Exchange Act was “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”

There have been diversity-related lawsuits filed, including cases against businesses such as Facebook, Oracle, and Monster Beverages. One common charge against the directors and officers of the sued companies is that they breached their fiduciary duties and violated Section 14(a) of the Securities Exchange Act by failing to include diverse directors on their boards and in their senior executive ranks, while touting their commitment to diversity, equity, and inclusion in the company’s proxy statements/other publications. Suits are seeking a wide range of relief, including disgorgement of compensation, attorney fees, forced resignations, termination of auditors, vendors,

diversity training programs, and establishment of hiring committees focused on diverse hiring.

On June 28, 2022, a plaintiff shareholder filed a securities class action in the Northern District of California against Wells Fargo and certain of its directors and officers, alleging defendants made false or misleading statements regarding its commitment to diversity in the workplace and conducted fake job interviews to meet its Diverse Search Requirement, thereby subjecting the company to an increased risk of regulatory enforcement and negatively impacting the company's reputation.³²⁰

On May 13, 2022, a Los Angeles County Superior Court ruled in *Robin Crest, et al., v. Alex Padilla*³²¹ that California's statute (S.B. 826) requiring California-based public companies to have one to three women on their boards of directors, depending on their board size, violated the equal protection clause of the state constitution. Although the decision, which followed a bench trial, does not specifically address the related requirement in S.B. 826 that companies disclose board member information to the secretary of state, the court's decision enjoins enforcement of the entire law. This decision follows the decision of another Los Angeles County Superior Court in April 2022, striking down a similar law requiring companies to include at least one member of an "underrepresented community" on their boards, concluding the law violated the equal protection clause in California's constitution.

Many insurers believe that policyholders with ESG awareness have a better risk profile than those not focused on ESG or policyholders with poorly conceived ESG policies or strategies. Understandably, insurers are reviewing policyholder ESG policies and performance with increasing frequency and in greater depth. Insurers also should recognize that, when a policyholder's ESG awareness becomes ESG activism, it could result in additional risks, resulting in claims against the policyholder. ESG activism could present similar risks to insurers

in their own business strategies and policies. This applies to the components of ESG.

Ben & Jerry's ice cream provides an example in the context of D&O Claims. On June 15, 2022, U.K. consumer products company Unilever was sued by a shareholder alleging that the company mishandled the decision by its Ben & Jerry's unit to stop selling ice cream in Israeli-occupied Palestinian territories. Unilever acquired Ben & Jerry's ice cream in 2000, but Ben & Jerry's retained an independent board. In July 2020, the independent Ben & Jerry's board passed a resolution to end Ben & Jerry's sales of its products in areas the board considered to be Palestinian territories illegally occupied by Israel. The newly filed securities class action complaint in the Southern District of New York against Unilever and some of its executives alleges that the defendants made "false and misleading representations" as "Unilever acknowledged the importance of maintaining successful customer relationships with existing customers but omitted discussing that the B&J board had already decided to end sales to existing Israeli customers, which risked reduced sales and a customer backlash." According to the complaint, Unilever acknowledged that its brands and reputation are "valuable assets that could be impacted by unethical conduct but omitted discussing Ben & Jerry's boycott decision, which risked damage to Unilever's brands, reputation, and business results." The complaint also states that "Unilever acknowledged that complying with all applicable laws and regulations was important but omitted discussing Ben & Jerry's boycott decision, which risked adverse governmental actions for violations of Anti-BDS Legislation." As seen above, it was Ben & Jerry's social activism that gave rise to the lawsuit.³²²

Another example is Disney's handling of The Parental Rights in Education Act, dubbed by some as the "Don't Say Gay" legislation, in Florida. The company's handling of the issue seemed to anger people on both sides of the issue and had adverse consequences for the company in terms of legislative action and stock price.³²³

The National Basketball Association's stand or failure to take a stand with respect to policies in China also may present issues. Simply stated, different people view many policies differently, and individuals may be impacted differently by the policies even within the same constituency. The foregoing illustrates the importance of not mishandling ESG issues as well as the difficulties ESG issues can present to companies. Taking a position – or not taking a position – can impact a company. Another example is the consumer backlash faced by Bud Light as a result of its affiliation with transgender actor and social media influencer Dylan Mulvaney.

The outcome in the matter regarding Disney in Florida is of particular consequence. Although taking a position on Florida legislation had business consequences that were not positive for Disney in terms of political reprisal, stock price, and market positioning, Disney officers and directors prevailed in a stockholder action seeking books and records based upon an alleged breach of fiduciary duty. On June 27, 2023, *Simeone v. Walt Disney Co.*³²⁴, held that the determination by Disney directors and officers to publicly oppose Florida's HB 1557 – the bill limiting instruction on sexual orientation or gender identity in Florida classrooms – did not constitute a breach of fiduciary duty.

Initially, Disney was silent on the bill. After receiving criticism from employees and collaboration partners, however, the Disney board convened a special meeting at which it decided to publicly criticize the bill. The court denied the stockholder's records demand, concluding he failed to establish a proper purpose and that the demand was overly broad. First, the court determined the purposes described in the records demand were not the plaintiff's own purposes but were those of his counsel. 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 investigating potential wrongdoing, mismanagement, and breaches of fiduciary duties certainly may be a proper purpose. Yet, second--and perhaps more notably--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 plaintiff wanted to know the persons responsible for making the decision to oppose the bill.

At its core, plaintiff’s theory was that Disney’s board and officers had breached their fiduciary duties when they decided to publicly oppose 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 on 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 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 went one step further, noting 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 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.”

Governmental entities and regulators are weighing in with various pieces of legislation and regulations to implement their policy agendas. One recent example aimed directly at insurers is the State of Washington’s removal of insurers’ right to use credit scores in pricing despite their close correlation with risk. More broadly, property and casualty insurance is being pressed to alter its premium pricing structures.

Insurance rating agencies across the globe have become increasingly aware of ESG risk factors and their potential impacts on their investment portfolios and lending policies. Since March 2020, when AM Best began disclosing whether ESG factors were key rating drivers, roughly 10 percent of rating movements have been a result of ESG factors. Environmental and governance factors have been the most frequent drivers of these rating movements. DBRS Morningstar reports that large institutions are facing greater pressure from external

shareholders to better manage their exposures to environmental risks. This has become more important than ever for property and casualty insurers after several years of heightened natural catastrophe losses. DBRS Morningstar announced it is taking a more formal approach to incorporating ESG factors into its rating process across all rating groups worldwide, including in rating insurance companies and financial institutions. It identified 17 significant ESG factors - five environmental, seven social, and five governance--that will now be considered when rating companies.³²⁵

AM Best is a signatory to the United Nations' Principles for Sustainable Insurance (PSI), a framework designed to embed ESG issues in decision-making. The PSI is a voluntary sustainability framework launched by the United Nations Environment Programmed Finance Initiative in 2012. It requires insurers to demonstrate their adoption of sustainable insurance practices and make transparent disclosures to the public around ESG issues. AM Best Rating Services CEO Matthew Mosher said the move forms part of the agency's focus on insurance and its continued belief that ESG elements play an important role in the financial strength of an insurance company. According to PSI: "ESG issues are increasingly influencing traditional risk factors and can have a significant impact on the industry's viability. Therefore, a resilient insurance industry depends on holistic and far-sighted risk management in which ESG issues are considered. As risk managers, risk carriers, and investors, the insurance industry has a vital interest and plays an important role in fostering sustainable economic and social development. We believe that better management of ESG issues will strengthen the insurance industry's contribution to building a resilient, inclusive and sustainable society. However, many ESG issues are too big and complex and need widespread action across society, innovation and long-term solutions. Therefore, it is our aspiration to build on the foundation the insurance industry has laid in supporting a sustainable society. The future we want is a society in which people are aligned and incentivised to adopt sustainable practices. To realize this aim,

we will use our intellectual, operational and capital capacities to implement the Principles for Sustainable Insurance (the ‘Principles’) across our spheres of influence, subject to applicable laws, rules and regulations and duties owed to shareholders and policyholders.”³²⁶

ESG has a major impact on insured and uninsured losses. Apart from claims based upon climate change, the environmental component of ESG has substantially impacted what were traditionally called losses from natural disasters. Global losses from natural disasters in 2020 were \$210 billion, according to Munich Re, of which only \$82 billion was insured.³²⁷ Both overall losses and insured losses were significantly higher than in 2019, which experienced a total loss of \$166 billion, of which US \$57 billion was insured.

Climate change will play an increasing role in all of these hazards, requiring property and casualty insurers to manage their environmental exposures appropriately. The assessment of environmental risks is a major component of DBRS Morningstar’s analysis for the property and casualty insurance business. It explained, “[t]his includes the impact of insured catastrophes on an insurance company’s financial strength, as well as considerations regarding claims predictability, frequency, and severity.”³²⁸

The London School of Economics and Political Science reports that the global number of climate change-related cases has more than doubled since 2015, with over 800 cases filed between 1986 and 2014 and over 1,000 cases filed between 2015 and 2021. Not surprisingly, 1,387 of the 1,841 ongoing or concluded cases of climate change litigation from around the globe were filed in the U.S. It notes that the number of cases challenging government inaction in climate goals continues to grow. Cases are targeting a wider variety of private sector and financial actors and there is more diversity in the arguments being employed. It warns three areas to look out for are “value chain litigation, cases of government support to the fossil fuel industry (e.g., through subsidies or tax relief), and cases focused

on the distribution of the burdens associated with action, which may be classed as ‘just transition’ cases.’³²⁹

According to the report, (1) cases against private parties continue to be brought and the arguments and strategies continue to develop (2) some seek to establish corporate liability and seek billions of dollars in damages to pay for infrastructure investments for climate adaptation; and (3) An increasing number of claims focus on financial risks, fiduciary duties, and corporate due diligence, which directly affect not only fossil fuel and cement companies, but also banks, pension funds, asset managers, insurers and major retailers, among others. Examples include claims raising issues around deliberate disinformation (*e.g.*, “greenwashing” cases), failure to disclose and manage climate change risk, cases seeking the recognition of corporate human rights responsibilities (*e.g.*, corporate duty of care and the alignment of major emitters’ activities with climate change targets), and cases that challenge specific projects or developments (*e.g.*, carbon-intensive projects or technologies).³³⁰ Although the momentum is overwhelming on the side of advancing ESG, there is some pushback.

McKinsey & Company pointed to the four major objections associated with ESG: (1) ESG is a distraction from what businesses are supposed to do; (2) ESG is not feasible because it is too difficult to strike the balance needed to implement in a way that resonates among multiple stakeholders; (3) ESG is not measurable, at least to any practicable degree; and (4) even when ESG can be measured, there is no meaningful relationship with financial performance.³³¹ According to McKinsey: “The fundamental issue that underlies each of the four ESG critiques is a failure to take adequate account of social license—that is, the perception by stakeholders that a business or industry is acting in a way that is fair, appropriate, and deserving of trust ... But what some critics overlook is that a precondition for sustaining long-term value is to manage, and address, massive, paradigm-shifting externalities. Companies can conduct their operations in a

seemingly rational way, aspire to deliver returns quarter to quarter, and determine their strategy over a span of five or more years. But if they assume that the base case does not include externalities or the erosion of social license by failing to take externalities into account, their forecasts--and indeed, their core strategies--may not be achievable at all. Amid a thicket of metrics, estimates, targets, and benchmarks, managers can miss the very point of why they are measuring in the first place: to ensure that their business endures, with societal support, in a sustainable, environmentally viable way. "Accordingly, the responses to ESG critics coalesce on three critical points: the acute reality of externalities, the early success of some organizations, and the improvement of ESG measurements over time. And the case for ESG cannot be dismissed by connections between ESG scores and financial performance and changes in ESG scores over time."³³²

Social risk factors may similarly have a significant impact on an insurance organization's customer and employee base, as well as its financial strength. Weak corporate governance and unethical conduct may have a detrimental impact on financial performance and reputation, and could result in fines, damages, or loss of operating licenses. Increases in costs associated with recruitment and retention of women and workers from ethnic minorities, poorer socio-economic backgrounds, and employees with disabilities, and ensuring equal pay are expected.

Insurers have insurance and risk management products that are useful to corporate policyholders in managing risks and addressing ESG issues. Insurers have expertise and capabilities in risk assessment, management, response, and loss control that could benefit corporate policyholders. Sustainable insurance products are already being marketed. For example, in a sustainable household insurance policy, policyholders can expect compensation for additional costs if appliances need to be replaced with new ones that meet the highest energy efficiency class. In the automotive sector, better differentiation

can be achieved through the use of telematics, or discounts could be considered for the purchase of an electric car.

Various insurers have and are developing methodologies, applications, and platforms for their use and the use of their policyholders. Some insurers have been providing readiness questionnaires, guidance, and best practices based on objective criteria for environmental compliance, assessments, and readiness.

Notwithstanding the foregoing, it is generally expected that regulatory risks and administrative action related to ESG will be sharply reduced under the second Trump administration.

The Role Of Shareholders, Rating Agencies, & Others: As previously suggested, numerous internal and external stakeholders factor into a company's ESG policies and practices. In addition to employees and management, customers, vendors, distribution chain partners, markets, and communities in which companies are located and do business are among the various stakeholders that can impact the ESG policies of insurers and policyholders. Shareholders can have a profound impact on ESG policy and practices. This can take place through shareholder resolutions, the institution of shareholder derivative actions, and voting on management.

Insurance rating agencies across the globe have become increasingly aware of ESG risk factors and their potential impacts on their investment portfolios and lending and underwriting policies. Since March 2020, when AM Best began disclosing whether ESG factors were key rating drivers, roughly 10 percent of rating movements have been a result of ESG factors. Indeed, environmental and governance factors have been the most frequent drivers of these rating movements. DBRS Morningstar announced it was taking a more formal approach to incorporating ESG factors into its rating process across all rating groups worldwide, including rating insurance companies and financial institutions. It identified 17 significant ESG factors – five

environmental, seven social, and five governance – that it considers when rating companies.

Many of the traditional tools and practices of insurers have been under assault due to ESG-related considerations. Insurance scoring, which is a type of credit-based analysis used by insurers for a long time, is now prohibited in several states, including California, Hawaii, Maryland, Massachusetts, Michigan, Oregon, Washington, and Utah. Several other states have introduced bills that would ban the use of credit-based scoring. Additionally, gender has been an element of automobile insurance pricing for a long time. Some states do not allow gender to be a factor or require pricing to be gender-neutral. The use of zip codes and educational levels in underwriting and pricing is also under attack. Insurers' use of zip code and level of education in underwriting and pricing is considered by some to be discriminatory, as this practice may result in impoverished and minority communities experiencing higher insurance rates or less insurance availability.

Insurers and corporate risk managers will continue to confront and be confronted by the challenges and opportunities associated with environmental, social, and governance issues. It appears that the next few years will afford them an increased opportunity and more latitude to manage these issues with greater autonomy, in the interests of their businesses, and with less federal regulation.

CHAPTER 14

THE BRIGHT AND VIBRANT FUTURE OF INSURANCE IN AMERICA

As demonstrated above, insurance is critical in the United States, acting as a foundational risk management tool for individuals and businesses, while driving economic growth and stability. It provides essential protection against financial catastrophe from illness, accidents, and disasters, fostering investment, innovation, and consumer confidence.

According to some sources, there are over 26,000 insurance companies operating in the United States, but this number includes all types and sizes of insurers, including small-scale, regional, and niche entities as well as captive insurers, fraternal insurers, and other entities not necessarily actively offering insurance policies. The number of active, operating, regulated insurance companies, however, is approximately 6,000 as derived from formal regulatory filings. We believe this number presents a more accurate picture of the number of insurers. The important role of insurance brokers, agents, intermediaries, managing general agents, and third-party claims administrators should not be overlooked.

The United States insurance industry reached a total of \$1.7 trillion in net premiums written in 2024, with significant profitability as net income rose to \$169 billion (up from \$89 billion in 2023). The Property/Casualty sector accounts for 53.1 percent (\$932.5 billion) of premiums, while life/annuity represents 46.9 percent (\$822.6 billion). Life insurance benefits and claims paid reached \$965.6 billion in 2024, up from \$831.8 billion in 2023.

As of late 2024, the United States insurance industry employed over three million people across insurers, agencies, and brokerages. The workforce has grown from around 2.7 million in 2020.

The United States insurance industry has been a major philanthropic force, contributing over \$1.3 billion in charitable donations in 2023 and \$1.53 billion in 2024, and contributing tens of thousands of professionals participating in millions of hours of volunteer work to over 137,300 nonprofits and causes. Coordinated by organizations like the Insurance Industry Charitable Foundation (IICF), these efforts focus on education, disaster relief, health/social services, and food insecurity, totaling over 7.5 million volunteer hours in 2022.

The financial health of insurers is critical to the economy. There are some events such as pandemics, terrorist attacks, state-sponsored cyber-attacks, or traditional wars that are beyond the ability of any insurer or even a collective group of insurers to sustain. Such areas are appropriate for government pools or backstops.

Insurance has played a critical role in the formation, growth, and success of America during the nation's first 250 years. It will contribute mightily to America's future. The future of the United States insurance industry is bright because the future of America is bright. Insurers have been blessed to have a deep bench of talented, visionary people who have enabled insurers to meet the challenges and take advantage of the opportunities presented over the years, including the challenges presented by technology, litigation, social inflation, underlying liabilities, coverage issues, and bad faith exposures. One of the critical challenges confronting insurers in the coming years is to attract, recruit, train, and retain the talent needed for the next 250 years, in view of the large number of people expected to leave the industry over the next few years due to retirement and relocation to other industries.

Artificial intelligence (AI) has impacted society and businesses in ways that are both transformative and disruptive. AI presents major opportunities and exposures for insurers and their policyholders. Insurers are using AI in connection with underwriting, risk management, fraud detection, and claims handling. A working group of the NAIC issued a request for information in May 2025 to explore drafting a model law governing insurers' use of AI. Policyholder lawyers are targeting insurer use of AI in coverage and bad faith litigation. Regulators are expanding oversight, emphasizing fairness, accountability, and transparency in the use of AI by insurers.

Although much attention has focused on generative AI, agentic AI (systems capable of operating and developing autonomously with little or no human oversight) presents significant risks when integrated into systems through application programming interfaces. Deepfakes are being adapted to foster identity fraud and to bypass security systems. AI-washing claims have been brought against companies for publicly overstating their AI capabilities or making material misstatements or omissions regarding the reliability and oversight of complex technological systems. AI-related securities class action lawsuits also may involve companies that, rather than allegedly overstating their AI capabilities or prospects, allegedly understated their AI-related risks and misled investors by downplaying them. Other AI-related actions involve the use or misuse of AI by companies and their managers, defamation, intellectual property claims, and shareholder derivative suits. Such claims are likely to continue to proliferate, and AI could prove to be disruptive in the litigation arena. Insurers are including AI exclusions, sub-limits, and endorsements to control AI-related risks in a variety of policy types and are providing affirmative AI coverages. Notwithstanding the amount of attention given to AI over the past year, the AI story is only just beginning to unfold. Policyholders are challenging insurer AI in coverage and bad faith actions. Insurers' ability to address the challenges associated with AI will be a key determinant of their future success.

As we celebrate America 250, we should celebrate insurance and focus on sending realistic and hopeful messages about the important role played by insurance and insurers in America. Happy birthday, America!

APPENDIX OF CITATIONS TO AUTHORITIES



- ¹ A version of this work was initially published as a two-part commentary, Scott M. Seaman, Pedro E. Hernandez, & Peter J. Lewis, “America 250: A History Of Insurance And Insurance Coverage Law And Litigation In The United States, Part 1” *Mealey’s Emerging Toxi Torts*, Vol. 34, #24 (March 17, 2026) and Scott M. Seaman, Pedro E. Hernandez, & Peter J. Lewis, “America 250: A History Of Insurance And Insurance Coverage Law And Litigation In The United States, Part 2” *Mealey’s Litigation Reports: Insurance*, Vol. 40, # 20 (March 25, 2026).

- ² One of the authors was alive for the bicentennial, but lacked sufficient perspective to comment on the impact of insurance. To hedge against the potential that the authors may not be around to write about the tricentennial, *America 250* provides an appropriate occasion to provide an abbreviated history and perspective on the role of insurance in the United States.
- ³ Hannah Farber, *Underwriters of the United States – How Insurance Shaped the American Founding* (2021).
- ⁴ Hannah Farber, *Underwriters of the United States – How Insurance Shaped the American Founding* (2021). Insurers also had their hands in the French Revolutionary War in 1793 helping the American economy grow due to the demand for its fleet of merchant vessels.
- ⁵ Leigh Wolfrom, *The Crucial Role of Insurance in Managing Wildfire Risks*, OECD (Jan. 20, 2025), available at: [https://www.oecd.org/en/blogs/2025/01/the-crucial-role-of-insurance-in-managing-wildfirerisks.html#:~:text=Insurers%20are%20integral%20to%20climate,reduce%20the%20impacts%20of%20disaster](https://www.oecd.org/en/blogs/2025/01/the-crucial-role-of-insurance-in-managing-wildfirerisks.html#:~:text=Insurers%20are%20integral%20to%20climate,reduce%20the%20impacts%20of%20disaster;); Lance Malcolm, *Building Fortification and the Role of the Insurance Industry*, Claims J. (Feb. 20, 2026), available at <https://www.claimsjournal.com/news/national/2026/02/20/335692.htm>.
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- ⁷ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses In Complex Insurance Coverage Claims*, (13th Ed. Thomson Reuters 2025) at Vol. I, Chapter 21 (Sustainability/ESG (Environmental, Social, and Governance Considerations & PFAS)); Scott M. Seaman, “Sustainability Recalibration: What Insurers And Policyholders Should Know About ESG (Environmental, Social, and Governance Considerations) Under Trump 2.0, Part 1,” *Mealey’s Litigation Report: Insurance* March 5, 2025; and Scott M. Seaman, “Sustainability

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- ⁸ Stacie Lilien, *Viewpoint: Loss Control Services Are Underused Tools to Reduce Identity Security Risk*, *Ins. J.* (May 22, 2025), available at: <https://www.insurancejournal.com/news/national/2025/05/22/824706.htm>.
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- ¹¹ Walter W. Ristow, *United States Fire Insurance and Underwriters Maps: 1852-1968*, 25 *Q.J. Libr. Cong.* 194, 195–96 (1968).
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- ¹⁵ There are numerous types of policies and lines of coverage, but we provide a summary of only some for illustrative purposes.

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- ¹⁸ Scott M. Seaman, Pedro E. Hernandez, Paulette S. Sarp, *et al Duty To Defend: A Fifty-State Survey* (3rd Ed. Hinshaw & Culbertson LLP 2025).
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- ²⁰ For more detailed treatment of excess insurance issues, see generally, Scott M. Seaman & Jason R. Schulze, “Chapter 17 Excess Insurance Coverage,” *Environmental Liability & Insurance Recovery* (ABA 2012); Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (13th Ed. Thomson Reuters 2025) at Vol. 1, Chapter 12 Defense Costs, Attorney’s Fees, and Legal Audits).
- ²¹ Randy Manifoff, Margo Meta, and Jeffrey Stemple, *General Liability Insurance Coverage: Key Issues In Every State* (6th Ed. Mathew Bender & Company, Inc.) at Chapters 14 and 15.
- ²² For a discussion of some recent trends and decisions under directors’ and officers’ liability policies, see Scott M. Seaman & Pedro E. Hernandez “D&O Liability & Coverage: 2025 Trends, Developments & Decisions,” *Mealey’s Litigation Report: Artificial Intelligence*, Vol. 3, #4, December 2025.
- ²³ Thomas C. Buchmueller & Alan C. Monheit, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform 2–3* (Nat’l Bureau of Econ. Rsch., Working Paper No. 14839, 2009). .

- ²⁴ Katherine Hempstead, *Uncovered: The Story of Insurance in American* (Oxford Press 2024) at 7.
- ²⁵ *Id.* at 8.
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- ²⁷ *Id.* at 152.
- ²⁸ *See generally*, Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 11 (Reinsurance Allocation Methodologies); *A Primer On Reinsurance Law & Principles* (Hinshaw & Culbertson LLP 2016).
- ²⁹ Numerous court decisions have declined to apply *contra proferentem* to ambiguous policy language where the policy is issued to sophisticated policyholder was actually negotiated between the parties, or was prepared by the policyholder or its agent. A couple of decisions have suggested in *dicta* that *contra proferentem* could be used to construe language against a policyholder where it or its agent drafted the language. *See, e.g., Fireman's Fund Ins. Co. v. Fibreboard Corp.*, 182 Cal. App. 3d 462 (Cal. App. 1986); *Metpath Inc. v. Birmingham Fire Ins. Co. of PA*, 86 A.D.2d 407 (N.Y. App. Div. 1982); *Cummins Inc. v. Atlantic Mut. Ins. Co.*, 56 A.D.3d 288 (N.Y. App. Div. 2008). Readers would be hard-pressed to identify a decision actually applying *contra proferentem* to construe an insurance contract against a policyholder.
- ³⁰ Many consider the United States to be the most litigious country in the world. At least one source, however, ranks the United States fifth for lawsuits *per capita*, behind Germany, Sweden, Israel, and Austria. The United States has the most lawyers *per capita*, with approximately one lawyer for every 300 people. The United States ranks first in total litigation costs and the impact of the tort system on the economy. In 2022, United States tort costs were estimated at \$443 billion, roughly 2.3 percent of the nation's GDP. Another sources note that it boasts the highest total number of lawsuits filed annually, estimated at roughly 40 million cases. The United States Supreme Court receives 7,000 to

8,000 petitions for *certiorari* annually, but grants review and issues opinions on less than 100 cases per term. Only 2 percent to 3 percent of federal cases go to trial, down from approximately 20 percent in the 1940s. See Marc Galanter, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts*, 1 J. EMPIRICAL LEGAL STUD. 459, 464.

³¹ The information in the chart is derived, in part, from a time line on the United States Chamber Institute for Legal Reform website, available at: <https://www.instituteforlegalreform.com/pages/tort-reform-timeline> and is provided for illustrative purposes.

³² See Gary Booth, “PFAS – the mother of all toxic torts?,” *Insider Engage* (Aug. 2, 2021), available at: <https://www.insiderengage.com/article/28tq7id3b65wxgwia04qo/legal-and-regulatory/pfas-the-mother-of-all-toxic-torts>.

³³ Scott M, Seaman & Gar Lauerma, “2025 Updated Primer on PFAS/ Forever Chemical Claims Regulation, Litigation & Insurance Coverage Issues,” *Mealey’s Emerging Toxic Torts*, Vol. 34, #18, December 16, 2025.

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³⁶ Hempstead, *supra* note 25, at 26.

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³⁸ *Paul v. Virginia*, 75 U.S. 168, 182-83 (1869).

- ³⁹ *United States v. South Eastern Underwriters Ass'n*, 322 U.S. 533 (1944).
- ⁴⁰ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 9 (Insolvency of Underlying Insurers – The Issue of “Drop Down” and the Impact of Policyholder’s Bankruptcy On Insurers).
- ⁴¹ Scott M. Seaman & Pedro E. Hernandez, “2025 Key Insurance Decisions, Trends, & Developments & A Look Ahead To 2026,” *Mealey’s Emerging Insurance Disputes*, Vol. 31, #1, January 9, 2026; Scott M. Seaman & Pedro E. Hernandez “2024 Key Insurance Decisions, Trends, & Developments & A Look Ahead To 2025,” *Mealey’s Litigation Report: Insurance* December 4, 2024.
- ⁴² Although claim denials and coverage disputes receive much attention, the vast majority of insurance claims are paid. Information about the percentage of claims denied and paid is conflicting and claim denial rates vary significantly across different insurance lines, with healthcare generally experiencing higher denial rates. The bases for denial vary widely from missing or incomplete documentation, duplicative submissions, failure to submit claims on time, non-compliance with policy terms and conditions, losses and not falling within the scope of coverage or being bared by exclusions. For general liability, denial rates have been reported as high as 24.5% in 2024, but many of those claims (more than half) are ultimately paid after additional information is provided and the claim adjustment process is complete. In 2023, for example, it has been reported that United States insurers wrote \$777 billion in net premium (after reinsurance) and paid \$571 billion in losses and loss adjustment expenses. It had over \$200 billion of other expenses (such as agent commissions, salaries and overhead) resulting in net underwriting losses of \$23 billion. Factoring in investment income of \$71 billion a net operating gain of \$43 billion was realized (4.9 percent of direct written premium).
- ⁴³ *See generally*, Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters

13th Ed. 2025) at Vol. 1, Chapter 2 (Policies Required to Respond to A Loss – The Issue of Trigger of Coverage).

⁴⁴ For example, some states such as Ohio had allowed mere allegations of bad faith to abrogate an insurer’s right to protect documents from disclosure under certain circumstances based upon the attorney-client privilege and attorney work produce. The decision of the Supreme Court of Ohio in *Boone v. Vanliner Ins. Co.*, 744 N.E. 3d 154 (Ohio 2001) established a broad common-law exception to the attorney-client privilege in insurance bad-faith cases that was expanded by other cases. Fortunately, the Supreme Court of Ohio recently made a pivotal ruling in *Eddy v. Farmers Prop. Cas. Ins. Co.*, 2026-Ohio-606 (Ohio Feb. 26, 2026) reinforcing the attorney-client privilege and the work-product doctrine for insurers involved in bad faith disputes. The court held its 2001 decision in *Boone* has been completely superseded by the enactment of R.C. 2317.02(A)(2). Under *Eddy*, mere allegations of bad faith will no longer automatically negate privilege or expose insurer claim files to discovery. Other courts have scrutinized the actions of outside counsel representing insurers seeking to invalidate privilege claims on the grounds that they were performing business functions rather than rendering legal advice.

⁴⁵ *See, e.g., Institute of London Underwriters v. Hartford Fire Ins. Co.*, 599 N.E.2d 1311 (Ill. App. 1993) (giving rise to the selective or targeted tender rule which, when applicable, renders “other insurers” clauses inapplicable and destroys a selected insurers’ rights of contribution).

⁴⁶ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 7 (The Issue Of Number Of Occurrences).

⁴⁷ *Id.*

⁴⁸ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 13 (Conducting a Joint Defense in Complex Coverage Litigation).

- ⁴⁹ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 3 (Allocation Methodologies).
- ⁵⁰ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 6 (Coordination of Coverage Between Claims-Made CGL Contracts and Prior Occurrence Contracts).
- ⁵¹ *General Accident Ins. Co. v. State of New Jersey*, 627 A.2d 1154 (N.J. 1996).
- ⁵² Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 10 (Allocation Start And Stop Dates, Coverage Discounts, Proper Exhaustion, And Cost Issues).
- ⁵³ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 7 (The Issue Of Number Of Occurrences).
- ⁵⁴ *Morton Intern., Inc. v. General Acc. Ins. Co. of Am.*, 629 A.2d 831 (N.J. 1993).
- ⁵⁵ *Griffith Foods International, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2026 IL 131710 (Ill. 2026).
- ⁵⁶ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 9 (Insolvency of Underlying Insurers (The Issue of “Drop Down”) And The Impact Of The Policyholder’s Bankruptcy On Insurers).
- ⁵⁷ *See Truck Ins. Exch. v. Kaiser Gypsum Co. Inc.* 602 U.S. 268 (2024) (holding insurer with financial responsibility for claims is a “party in interest” and “may raise and may appear and be heard on any issue.” *See also Harrington v. Purdue Pharma, L.P.* 603 U.S. 204 (2024)

(holding the bankruptcy code does not authorize non-consensual third party releases).

⁵⁸ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 2 (Policies Required to Respond to A Loss – The Issue of Trigger of Coverage) and Chapter 14 (Allocation Issues And Satisfaction Of Claims-Made Requirements Under Directors And Officers Liability Contracts).

⁵⁹ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 17 (Cybersecurity, Privacy, and Artificial Intelligence Claims).

⁶⁰ *AES Corp. v. Steadfast Ins. Co.*, 725 S.E. 2d 532 (Va. 2012).

⁶¹ *Aloha Petro., Ltd. v. Nat’l Union Fire Ins. Co. of Pitt., PA*, 155 Haw. 108, 123 (Haw. 2024).

⁶² 798 A.2d 1024 (Del. 2001).

⁶³ *Id* at 1028.

⁶⁴ *Hanover Am. Ins. Co. v. Francini, Inc.*, 2025 U.S. Dist. LEXIS 70996 (C.D. Cal. March 2025).

⁶⁵ No. CV 25-2832-JFW(MAAx) (C.D. Cal. Dec. 22, 2025).

⁶⁶ *Twigg v. Admiral Ins. Co.*, 568 P.3d 156 (Or. 2025).

⁶⁷ *Bob Robison Commercial Flooring, Inc. v. RLI Ins. Co.*, 131 F.4th 832 (8th Cir. 2025).

⁶⁸ 2023 IL 129087 (IL. 2023).

⁶⁹ *Navigators Spec. Ins. Co. v. TBR Construction, LLC*, 2025 IL. App. (1st) 242052-U (Dec. 3, 2025).

- 70 *CC Partners, LLC v. Travelers Prop. Cas. Co. of Am.*, 140 F.4th 465 (8th Cir. 2025).
- 71 *Comunale v. Traders & Gen. Ins. Co.*, 50 Cal. 2d 654, 658-59 (1958).
- 72 *Johansen v. Cal. State Auto. Assoc. Inter-Ins. Bureau*, 15 Cal.3d 9 (Cal 1975).
- 73 *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 575 (1973).
- 74 *See, e.g., Morris v Paul Revere Life Ins. Co.*, 109 Cal. App. 4th 966 (2003); *Chateau Chamberay Homeowners Assn. v Associated Internal. Ins. Co.*, 90 Cal. App. 4th 335 (2001); *Griffin Dewatering Corp. v Northern Ins. Co. of N.Y.*, 176 Cal. App. 4th 172 (2009) (objective reasonableness).
- 75 *Baldwin v. Standard Fire Ins. Co.*, 269 N.E.3d 1197 (Ind. 2025).
- 76 *UMIA Ins., Inc. v. Arguelles*, 2025 U.S. Dist. LEXIS 10537 (D. Mont. Jan. 21, 2025).
- 77 *Spinosa v. Foremost Ins. Co. Grand Rapids Mich.*, 2025 U.S. App. LEXIS 1746 (5th Cir. Jan. 27, 2025).
- 78 *Bowles v. Allstate Veh. & Prop. Ins. Co.*, 2025 U.S. Dist. LEXIS 21742 (W.D. Wash. Feb. 6, 2025).
- 79 *Rocco v. Farmers Ins. Exch.*, 2025 U.S. Dist. LEXIS 22116 (E.D. Pa. Feb. 7, 2025).
- 80 *Belotti v. State Farm Fire & Cas. Co.*, 2025 U.S. Dist. LEXIS 54471 (M.D. Pa. Mar. 25, 2025).
- 81 *Raison D’Etre Bakery LLC v. Mass. Bay. Ins. Co.*, 2025 U.S. Dist. LEXIS 22920 (N.D. Cal. Feb. 9, 2025).
- 82 *McGranahan v. GEICO Indem. Co.*, 2025 U.S. App. LEXIS 6515 (9th Cir. Mar. 20, 2025).

- ⁸³ *Bartel v. Chicago Title Ins. Co.*, 111 Cal. App. 5th 655, 333 Cal. Rptr. 3d 38 (Cal. App. May 2025).
- ⁸⁴ *Martinez v. GEICO Cas. Ins. Co.*, 152 F.4th 1323 (11th Cir. Sept. 23, 2025).
- ⁸⁵ *Universal Prop. & Cas. Ins. Co. v. Naze*, 417 So. 3d 313 (Fla. 4th DCA June 4, 2025).
- ⁸⁶ Demos, *The Specter of Social Inflation Haunts Insurers*, Wall St. J. (Dec. 27, 2019).
- ⁸⁷ Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 19 (The Impact Of Social Inflation On Insurers And Policyholders); Scott M. Seaman, “The Ultimate Social Inflation Survival Guide: Containing Rising Claims Costs In A World Rife With Economic Inflation, Litigation Funding, Nuclear Verdicts, And Anti-Corporate Sentiment,” *Mealey’s Asbestos Report: Vol. 40*, # 6, April 23, 2025.
- ⁸⁸ See “Social inflation driving billions of dollars of excess losses in commercial auto: Morgan Stanley” *Reinsurance News* (Feb. 28, 2024), available at <https://www.reinsurancene.ws/social-inflation-driving-billions-of-dollars-of-excess-losses-in-commercial-auto-morgan-stanley/>.
- ⁸⁹ See generally, Scott M. Seaman & Jason R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (Thomson Reuters 13th Ed. 2025) at Vol. 1, Chapter 19 (The Impact of Social Inflation on Insurers and Policyholders).
- ⁹⁰ Martin Boerlin & Surbhi Gupta, *Verdicts on Trial: The Behavioral Science Behind America’s Skyrocketing Legal Payouts*, Swiss Re (Sept. 24, 2025), available at <https://www.swissre.com/reinsurance/insights/verdicts-on-trial.html>.

- ⁹¹ Press Release, “Study: Trial Lawyers Spent \$1.4 Billion on Advertising in 2021,” *American Tort Reform Association*, February 22, 2022, available at <https://www.atra.org/2022/02/22/study-trial-lawyers-spent-1-4-billion-on-advertising-in-2021/>.
- ⁹² See <https://marathonstrategies.com/wp-content/uploads/2025/05/Nuclear-Verdicts-Report-2025.pdf>.
- ⁹³ See <https://www.thomsonreuters.com/en-us/posts/legal/law-firm-rates-bull-bear-base-case/>.
- ⁹⁴ *Hersh v. State Farm Fire & Cas. Co.*, 2025 U.S. Dist. LEXIS 4451 (D.N.J. Jan. 9, 2025).
- ⁹⁵ Milliman, “How Tort Reforms Are Shaping Insurance Claims in Florida and Georgia,” *Milliman Insight*, 2025, available at <https://www.milliman.com/en/insight/how-tort-reforms-shaping-insurance-claims-florida-georgia>.
- ⁹⁶ Gautam Naik, “Litigation Finance Hits a Wall as Bets on Huge Gains Falter,” *Bloomberg*, November 30, 2025, updated December 1, 2025, available at <https://www.bloomberg.com/news/articles/2025-11-30/litigation-finance-hits-a-wall-after-bets-on-huge-gains-falter>.
- ⁹⁷ The endorsement reads:

Litigation Funding Mutual Disclosure

If we and an insured do not agree whether or to what extent a claim or “suit” is covered by this Policy, either party may make a written demand for mutual disclosure of any “third-party litigation funding agreement(s)” regarding that claim or “suit”.

When this demand is made, each party must disclose in writing within 30 days whether they or their attorney(s) have executed any “third-party litigation funding agreement(s)”. If a party or their attorney(s) have executed any “third-party litigation funding agreement(s)”, the written disclosure must include:

- a. A copy of such “third-party litigation funding agreement(s)”;
- b. The names of each person or organization who has entered into such “third-party litigation funding agreement(s)”;
- c. Whether such person or organization is required to approve of or be consulted on litigation or settlement decisions, and if so, the nature of the terms and conditions relating to that approval or consultation; and a brief description of the financial interest of any person or organization who provided such funding.

Each party must provide to the other party a copy of any update of their written disclosure within 30 days of:

- a. Any change in the above information in Paragraphs through d.; or
- b. When the parties or their attorney(s) have executed any “third-party litigation funding agreement(s)” after the initial demand.

The endorsement contains a definition of “Third-party litigation funding agreement” that includes any agreement to provide litigation funding to a party or its attorneys.

⁹⁸ Lesley Stahl, *Litigation Funding: A Multibillion-dollar Industry for Investments in Lawsuits with Little Oversight*, CBS News: 60 Minutes (Dec. 18, 2022), available at <https://www.cbsnews.com/news/litigation-funding-60-minutestranscript-2023-07-23/> [<https://perma.cc/U8VB-QCBZ>] (interview of Christopher Bogart, CEO, Burford Capital LLC).

⁹⁹ *Judicial Hellholes 2024-2025: Pennsylvanians Stuck In Nation’s Worst Judicial Hellhole*, American Tort Reform Foundation, at 85, available at https://www.judicialhellholes.org/wp-content/uploads/2025/01/ATRA_JH24_text_04b_smaller.pdf.

¹⁰⁰ Tom Baker, *Where’s the Insurance in Mass Tort Litigation*, 101 Tex. L. Rev. 1569, 1586 (2023); see also Emily R. Siegel, *Fortress’ Billions Quietly Power America’s Biggest Legal Fights*, Bloomberg L. (Oct.

16, 2024), available at <https://news.bloomberglaw.com/business-and-practice/fortress-billions-quietly-power-americas-biggest-legal-fights> (“What started as \$5 million to \$10 million investments in single commercial cases has grown into loans exceeding \$100 million to law firms for their entire caseloads. It’s a built-in diversified portfolio that hedges risk.”).

¹⁰¹ J. Theodorou, “The Scourge of Social Inflation” (Dec. 2021), available at <https://www.rstreet.org/wp-content/uploads/2021/12/RSTREET247.pdf>.

¹⁰² *See generally* “Gen Z and Millennials are Less Trusting of the Average Brand,” *Morning Consult*, 2020, available at <https://morningconsult.com/form/gen-z-millennials-trust/>; “Striving for balance, advocating for change: The Deloitte Global 2022 Gen Z & Millennial Survey, available at: <https://www.deloitte.com/content/dam/assets-shared/legacy/docs/about/2022/deloitte-2022-genz-millennial-survey.pdf>.

¹⁰³ “Online Jury Research: COVID’s Effect on Juror Perspectives & Damages”, *Magna Legal Services* (Apr. 8, 2021), available at <https://magnals.com/covid-effect-on-damages/>.

¹⁰⁴ “Impact of COVID-19 on Juror Perceptions,” *Magna Legal Services* at p. 14, full survey results available at <https://magnals.com/wp-content/uploads/2021/03/Magna-COVID-19-Survey-Results.pdf>.

¹⁰⁵ *See* “6 Factors That Can Make For A ‘Nuclear’ Juror” *Law360* (August 13, 2024).

¹⁰⁶ Thomas O’Toole, *The Causes of Social Inflation and “Nuclear” Jury Verdicts*, *Sound Jury Consulting* (Feb. 12, 2020), available at <https://soundjuryconsulting.com/the-causes-of-social-inflation-and-nuclear-jury-verdicts/>.

¹⁰⁷ *Id.*

¹⁰⁸ *See* Bethan Moorcraft, What is social inflation, and why is it hurting insurance?, *Insurance Business America* (Jan. 3, 2020), available at

<https://www.insurancebusinessmag.com/us/news/breaking-news/what-is-social-inflation-and-why-is-it-hurting-insurance-195626.aspx>.

- ¹⁰⁹ Many commentators believe that further tort reform efforts would materially benefit state economies. For example, in California, it is estimated that aggressive and/or abusive lawsuits cost the state \$23.6 billion in annual output in 2019, further leading to an estimated loss of 242,761 jobs and a “tort tax” of \$594.71 per person. *See* “Tort Reform will give California a better chance to recover,” *Valley News* (May 21, 2020), available at <https://myvalleynews.com/tort-reform-will-give-california-a-better-chance-to-recover/>. Similar research shows that such litigation costs Missouri \$2 billion and a loss of 32,205 jobs with a “tort tax” of \$505.21 per person. *See* “Missouri Tort Reform, Abusive Lawsuits won’t keep rolling along,” *Lexology* (May 20, 2020), available at <https://www.lexology.com/library/detail.aspx?g=159021fe-ba2f-49dc-88a8-46529b8a6eb7>. In Chicago, it is estimated that the “tort tax” costs residents \$811 per year, and the city \$3.8 billion in direct costs annually. *See* “Hidden ‘tort tax’ from heavy lawsuit activity costing Chicago area residents \$800 each, every year, new report says,” available at <https://cookcountyrecord.com/stories/513240758-hidden-tort-tax-from-heavy-lawsuit-activity-costing-chicago-area-residents-800-each-every-year-new-report-says>.
- ¹¹⁰ “Chubb to cut up to 20% of workforce in ‘radical’ AI drive” *Business Insurance* (Dec. 12, 2025), available at [insurancebusinessmag.com/us/news/breaking-news/chubb-to-cut-up-to-20-of-workforce-in-radical-ai-drive-559950.aspx](https://www.insurancebusinessmag.com/us/news/breaking-news/chubb-to-cut-up-to-20-of-workforce-in-radical-ai-drive-559950.aspx).
- ¹¹¹ “One Big Beautiful Bill Act” H.R. 1, 119th Cong. (2025), available at: <https://www.govtrack.us/congress/bills/119/hr1/text>.
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and Governance Considerations) Under Trump 2.0, Part 2 Mealey’s Litigation Report: Insurance, Vol. 39, #18 March 12, 2025.

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- ¹¹⁴ *See United States Chamber of Commerce v. Randolph*, No. 25-5327 D.C. (Nov. 18, 2025), available at <https://www.uschamber.com/assets/documents/Order-re-Motion-for-Injunction-Pending-Appeal-Chamber-v.-Sanchez-C.D.-Cal.pdf>.
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- ¹¹⁶ *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*, 600 U.S. 181, 143 S. Ct. 2141, 216 L. Ed. 2d 857 (2023).
- ¹¹⁷ Exec. Order No. 14151, *Ending Radical and Wasteful Government DEI Programs and Preferencing* (Jan. 2025), available at <https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-and-wasteful-government-dei-programs-and-preferencing/>.
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- ¹²⁴ Allianz, *Commercial Cyber Security Resilience 2025*, available at <https://commercial.allianz.com/content/dam/onemarketing/commercial/commercial/reports/cyber-security-trends-2025.pdf>.
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- ¹²⁷ The Cybersecurity Information Sharing Act of 2015: Expiring Provisions, Cong. Rsch. Serv., IF12959 (Apr. 8, 2025), available at <https://www.congress.gov/crs-product/IF12959>.
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- ¹³² *Thermoflex Waukegan, LLC v. Mitsui Sumitomo Ins. USA, Inc.*, 102 F.4th 438 (6th Cir. 2024).
- ¹³³ *Reynolds v. State Farm Life Ins. Co.*, 2025 IL App (2d) 240399 (Dec. 10, 2025).
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- ¹³⁵ *See Rodriguez v. Autotrader.com, Inc.*, 2025 U.S. Dist. LEXIS 70074 (C.D. Cal. Apr. 4, 2025); *Wright v. TrueCare Prop. Holdings, LLC*, 2025 U.S. Dist. LEXIS 229707 (S.D. Cal. Nov. 21, 2025); *Sanchez v. Cars.com, Inc.*, 2025 Cal. Super. LEXIS 710 (L.A. Cnty. Super. Ct. 2025).

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- ¹³⁸ *In re CVS Opioid Ins. Litig.*, 2024 Del. Super. LEXIS 595 (Del. Super. Ct. Aug. 20, 2024).
- ¹³⁹ *Allied Prop. Cas. Ins. Co. v. Bloodworth Wholesale Drugs, Inc.*, 727 F. Supp. 3d 1404 (M.D. Ga. Mar. 2024), *appeal pending*.
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- ¹⁴¹ *CITGO Petro. Corp. v. Ascot Underwriting Ltd.*, 158 F.4th 368 (2d. Cir. 2025).
- ¹⁴² Verisk, “Property Insurance Faces Claims Volume vs. Severity Paradox in Q3 2025” (Dec. 5, 2025), available at https://riskandinsurance.com/property-insurance-faces-claims-volume-vs-severity-paradox-in-q3-2025/?rid=1319136&utm_campaign=RiskandInsurance.
- ¹⁴³ *Gharibian v. Wawanesa General Ins. Co.*, 108 Cal. App. 5th 730, 329 Cal. Rptr. 3d 574 (Cal. App. 2025).
- ¹⁴⁴ *Bottega, LLC v. Nat’l Sur. Corp.*, 2025 U.S. Dist. LEXIS 5666 (N.D. Cal. Jan. 2025) (finding questions of fact regarding whether closure at one business was caused by smoke damage precluded summary judgment for either party and finding no evidence of closure or suspicion of operations as to two other businesses warranted summary judgment in favor of insurer).

- ¹⁴⁵ *Maxus Metro., LLC v. Travelers Prop. Cas. Co. of Am.*, 2025 U.S. App. LEXIS 29921 (8th Cir. Nov. 17, 2025).
- ¹⁴⁶ See Russ Banham, “Mixed Bag: What Trump 2.0 Tariffs, DOGE Activities Mean for Insurers” *Carrier Management* (Dec. 11, 2024), quoting Scott Seaman and others.
- ¹⁴⁷ Claire Wilkinson, “Geopolitical tension, AI among emerging D&O risk sources” *Business Insurance* (Dec. 4, 2025).
- ¹⁴⁸ Gillian R. Brassil, “Snap Inks \$65 Million Deal to End Investors’ Ad Revenue Suit (2)” Bloomberg (Oct. 29, 2025), available at <https://news.bloomberglaw.com/securities-law/snap-inks-65-million-deal-to-end-investors-ad-revenue-suit>.
- ¹⁴⁹ See “Cornerstone Research Discusses Securities Class-Action Filings So Far in 2025” *Cornerstone Research* (July 31, 2025), available at <https://clsbluesky.law.columbia.edu/2025/07/31/cornerstone-research-discusses-securities-class-action-filings-so-far-in-2025/>. The report also notes that plaintiffs filed 114 securities class actions in federal and state courts in the first half of 2025 which nearly equaled the number (115) of class actions filed in the second half of 2024. Although the number of AI-related filings and cryptocurrency-related filings are trending up, COVID-19-related filings are on pace to decline significantly.
- ¹⁵⁰ Senate Strikes AI Moratorium from Budget Reconciliation Bill in Overwhelming 99-1 Vote (July 1, 2025), available at <https://www.commerce.senate.gov/2025/7/senate-strikes-ai-moratorium-from-budget-reconciliation-bill-in-overwhelming-99-1-vote/8415a728-fd1d-4269-98ac-101d1d0c71e0>.
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