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Key U.S. Insurance Decisions, Trends, & Developments: In These Times Of ESG, Social Inflation, COVID-19, Cyber/Privacy, Civil Unrest, Opioids & Other Perils

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Commentary

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Introduction

As 2022 rapidly approaches, we look back at some of the key decisions, trends, and developments impacting the U.S. insurance industry over the past couple of years and look ahead to what the new year promises. These are challenging times, indeed, for insurers, policyholders, and reinsurers having to confront ESG, social inflation, COVID-19, cyber/privacy, civil unrest, opioids, lead, construction defect, securities law, and many other challenges.

To be sure, 2020 featured fast-paced activities and unprecedented challenges for insurers and reinsurers in a year dominated by the COVID-19 Pandemic. Although COVID-19 continues to rage in 2021, ESG/sustainability has since taken the spotlight. This is due to a variety of reasons, including the Biden administration's all-of-government approach to ESG and the focus of state regulators. Some of the more significant trends, decisions, and developments are highlighted below.

ESG/Sustainability

Environmental, social, and governance criteria or standards ("ESG")—often referred to simply as sustainability—are having a significant impact on all sectors, including, and perhaps particularly, the insurance and financial sectors.

ESG encompasses a broad range of topics and implicates most corporate departments and business operations. 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; disposal practices; natural resource conservation; carbon and greenhouse gas blueprint; use of renewable energy and 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; unionization and labor practices; freedom of association; and charitable donations and support. Social criteria may extend beyond a company to the company's business relationships with suppliers, customers, regulators, unions, and others. Often, it involves an examination of the business practices of those entities.

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.

As businesses, insurers naturally are focused on their own ESG practices and operations, reviewing, establishing, revising, and implementing their goals regarding their own emissions, carbon blueprints, diversity, and governance.[1]

Insurance companies are being viewed with increasing frequency as agents for imposing affirmative ESG change on other entities, such as their policyholders and vendors. The underwriting, pricing, investment, claims, and business practices of insurance companies are under heightened scrutiny, both internally and externally. For example, insurers are altering their investment portfolio with ESG considerations in mind.[2] Insurers are reviewing their business and underwriting practices. Some insurers already are moving away from underwriting policyholders with unsatisfactory carbon blueprints and/or risks that deal with fossil fuels.[3]

The Federal Government's Focus On ESG

ESG has become a central component of many policies under the Biden Administration. Indeed, virtually all agencies and arms of the federal government are involved in reviewing ESG factors with a view toward increased regulation.[4]

Earlier this year, the U.S. Security and Exchange Commission ("SEC") announced the formation of the Climate and ESG Task Force with an initial focus on identifying any material gaps or misstatements in disclosures of climate risks under existing rules and proactively identifying related misconduct.[5] Treasury Secretary Janet Yellen charged the Financial Stability Oversight Council with assessing the financial risks associated with climate and shared that information with regulators and private investors.[6]

On August 6, 2021, the SEC approved the diversity disclosure rule proposed by the Nasdaq Stock Market (Rule 5605(f)). Nasdaq is the second largest exchange in the United States with over 3,700 public companies listed and market capital in excess of $19 trillion. SEC disclosure requirements may not be far behind. We appear to be heading toward a regulatory environment in which climate change-related disclosures—and disclosures of demographic composition of company boards and executives—will be required, with potential penalties and other consequences to follow. Such developments fuel claims and litigation against companies, their directors and officers, and others.

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.[7] The RFI and other developments strongly suggest that the FIO will be regulating the business of insurance in a significant manner.

State Regulators' Are Focused On ESG

Many state regulators also are laser focused on ESG. 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.[8] DFS also has taken action to promote diversity, equity, and inclusion in the insurance industry.

Rating Agencies Are Focused On ESG

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% 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 rating insurance companies and financial institutions. It identified 17 significant ESG factors—five environmental, seven social, and five governance—that now will be considered when rating companies.[9]

The United Nations' Principles For Sustainable Insurance

AM Best, like many insurers and others, is a signatory to the United Nations' Principles for Sustainable Insurance. The United Nations' Principles for Sustainable Insurance ("PSI") is a framework designed to embed ESG issues in decision-making that has been gaining traction over the past couple of years. The PSI is a voluntary sustainability framework launched by the United Nations Environment Programme 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.

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 realise 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.[10]

Traditional Practices Are Subject To Scrutiny

Many of the traditional tools and practices of insurers are under assault. 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 (by emergency order), and Utah. Several other states have introduced bills that would ban the use of credit-based scoring. Additionally, gender has been an element for auto insurance pricing for a long time. Some states do not allow gender to be a factor or require pricing to be gender neutral. As non-binary gender identification becomes more prevalent, insurers and regulators are revisiting the issue more broadly. 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 as pricing factors are considered by some to be discriminatory, as this practice can result in poor and minority communities experiencing higher insurance rates.

As insurers have turned to artificial intelligence and modeling with greater frequency to address the complex challenges confronting them, the use of algo-

rithms and predictive modeling is itself being subject to increased scrutiny. For example, the Colorado Insurance Commissioner is required to adopt rules to require insurers to test their algorithms, predictive models, and information sources to measure their performance and ensure that they do not unfairly discriminate against protected classes beginning in 2023.[11]

Successful Companies View ESG As Presenting Important Opportunities

Although often viewed as presenting challenges, ESG considerations also present numerous opportunities for insurers and other companies. Indeed, the ability to respond and lead effectively in these areas will likely be a major determinant of the success of corporations and insurance companies. This includes taking action where companies believe action is appropriate. Equally important, companies must be able to effectively resist action where they believe it to be unwarranted and, at the same time, minimize collateral damage associated with their decisions. Companies performing well in ESG tend to lower their probability of sustaining workforce-related accidents, reputation-damaging controversies, and fines and other adverse actions by regulators. Companies that are embracing and playing offense on ESG usually are winning and well-positioned. Indeed, successfully addressing ESG issues may be necessary for corporate survival.

ESG has moved away from being siloed within some aspects of corporate behavior and has become embedded in the DNA, strategy, and operations of the entire company.

Internal Pressures Are Causing Companies To Be Agents For Change

External stakeholders are using 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 are laudable, while others are not. With increasing frequency companies face reputational as well as financial consequences for alienating groups or not responding in a manner they deem to be acceptable. Cancel culture impacts companies as well as individuals.

It is important to understand, however, that ESG pressures are not only being applied by external forces, but increasingly by internal forces seeking 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, value, and demographic differences between generations are undoubtably having a large influence on internal decision-making. Not only have corporations adjusted to create a workplace that attracts and retains Millennial, Generation X, and Generation Z talent, but these workers are also increasingly becoming the corporate decision-makers. Thus, corporations are now becoming entities that will effect change, rather than resist change.

ESG Factors Are Driving Losses

ESG factors, of course, are driving losses and litigation with increasing frequency. Insurance claims professionals, risks managers, and company executives must understand these impacts and trends. ESG has a major impact on insured and uninsured losses. Apart from claims related to 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.[12] Both overall losses and insured losses were significantly higher than in 2019, which experienced a total loss of $166 billion, of which $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.

Social risk factors similarly may 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, people from poorer socio-economic backgrounds, and employees with disabilities in order to ensure equal pay are expected.

Social Inflation

Social inflation continues to be a major concern to insurers and their corporate policyholders.[13] The first aspect of social inflation involves abuses in the tort system, which impacts 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 costs of doing business. 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.

The second aspect of social inflation is aimed directly at insurers. This facet includes expansive reading of policy coverages and rulings by courts in coverage litigation, shifting of policyholder attorney's fees in coverage litigation, independent counsel fees, and some legislative and regulatory pronouncements. With respect to this component of social inflation, the interests of corporate policyholders and insurers often diverge. We previously discussed the sources of social inflation, some of which are endemic to the U.S. civil tort system and others of which are a function of legal and societal developments.[14]

In 2020, the impact of court closures and litigation delays associated with COVID-19 and governmental shut down orders appear to have been a short-term social inflation reduction or delaying factor, as progress in cases had been hampered and the number of verdicts had been reduced. At least some antidotal reports suggest the delay in cases moving forward has resulted in some plaintiffs' settlement demands being more reasonable. In such cases, justice delayed may actually be justice achieved.

In 2021, social inflation appears to have returned with a vengeance. The volume of coverage litigation related to COVID-19 itself fuels social inflation, particularly with respect to first-party property insurance claims. Fitch Ratings expected social inflation to accelerate again in 2021.[15] In fact, social inflation is widely considered to be the driving cost factor in the commercial liability market, with billions reported in business interruption and event cancellation claims. Many believe that significant pandemic-related liability claims have yet to be reported and additional lines of coverage are expected to be impacted. The evidence in 2021 suggests social inflation—as well as economic (price level) inflation—are significantly on the rise.

The activities of legislators in several states attempting to create business interruption insurance by abrogating applicable exclusions and requirements in first-party property policies by legislative fiat, if passed, would have spurred additional social inflation. Fortunately, so far, none of these proposed bills have become law. Pending federal legislation, as currently drafted, would not pose the same threat, as it is directed to prospective pandemics and insurer participation would be voluntary.[16]

COVID-19 Business Interruption And Other Pandemic Coverage Litigation

The issuance of various governmental orders requiring businesses to temporarily modify or close their operations led to an almost immediate avalanche of claims and lawsuits involving first-party commercial property policies. According to the University of Pennsylvania Carey School of Law Covid Coverage Litigation Tracker, by mid-November 2021, there had been approximately 2,088 COVID-19 coverage cases, with 1,870 involving business interruption, 1,687 extra expense, 1,608, civil authority, 207 other, 192 ingress/egress, 106 contamination, 87 event cancellation, 82 sue and labor, and 13 liability cases. Approximately 465 cases were filed as putative class actions and 717 cases include allegations of bad faith.[17]

At the trial court level, insurers have prevailed in over 75% of the 150 rulings on motions to dismiss in state courts and in over 95% of the 524 rulings by federal courts, mostly on the grounds that the virus claims do not involve "direct physical loss or damage" to property as required under most U.S. policy wordings, governmental orders do not constitute loss of property, and/or virus exclusions preclude coverage.[18] Insurers have prevailed in approximately 44 summary

judgment rulings, while policyholders have prevailed in 7. Insurers have prevailed in the first bench trial and in the first COVID-19 jury trial.[19]

At the appellate court level, insurers have prevailed in the first ten decisions from the U.S. Circuit Courts of Appeal, with the Sixth, Seventh, Eighth, Ninth, and Eleventh Circuits ruling for insurers under the laws of at least eleven states.[20] These courts have ruled in insurers' favor based on the lack of "direct physical loss or damage" as well as virus, microorganism, loss of use, and ordinance or law exclusions. Federal courts have dismissed over 40% of policyholders coverage actions for pandemic loss coverage, 17% of the pandemic insurance actions filed in federal courts have been voluntarily dismissed, and approximately 40% of the suits have yet to be fully decided according to Law360's COVID-19 Insurance Case Tracker. [21]

The first three state appellate court decisions, one in California and two Ohio rulings, also have been in favor of insurers.[22]

In the U.S., COVID-19 coverage litigation has proceeded mostly through individual cases. Efforts by some policyholders to consolidate COVID-19 business interruption coverage cases have been largely rejected. On August 14, 2020, the Judicial Panel on Multidistrict Litigation ("JPML") denied a request to consolidate all COVID-19 federal litigation.[23] The JPML later rejected a request to create multidistrict litigation ("MDL") involving four insurers, although it did agree to centralize more than 30 lawsuits against Society Insurance Company.[24]

While the pace of new filings on first-party policies has slowed, the activity level on other lines of policies—such as general liability, professional liability, director and officer liability ("D & O"), and workers' compensation—may increase.

With numerous outstanding motions to dismiss, many appeals yet to be decided, and new cases continuing to be filed, the COVID-19 coverage war is expected to rage on for some time. So far, it is fair to say that insurers have fared reasonably well.

Civil Unrest, Riots, And Strikes

Many commentators have predicted an increase in political risks in the United States. These risks include riots, civil commotion, and other activities that can produce substantial property losses as well as injuries and deaths. At one point, there were estimates of $1 to $2 billion in losses in 2020 from civil unrest. There were protests, demonstrations, or riots in approximately 140 U.S. cities in the wake of George Floyd's death.[25] It was reported previously that there was at least $500 million in damage to more than 1,500 locations in the Twin Cities in 2020.[26] During a 2-week period alone, the New York Police Department paid $115 million in overtime.[27] The Rodney King riots in 1992, for comparative purposes, resulted in $775 million in damage, or $1.42 billion in 2021 dollars.[28]

Although 2021 has not seen the degree of protest and civil unrest activity that was witnessed in 2020, civil commotion activities continued in 2021. Recent events suggest that it is becoming more common for civil commotion to follow results of elections and trials. Indeed, demonstrations over climate change, police brutality, criminal trials, and labor strikes continue to be on the radar for insurers and policyholders. Civil unrest, coupled with the "defund the police" movement, has produced a variety of losses for which coverage has been sought under first-party property, third-party liability, and strike, riot, and civil commotion policies ("SRCC"). Businesses often will look to their property coverage for potential coverage. First-party claims may include claims from property damage resulting from rioting, looting, or demonstration, damages regarding stolen property and merchandise, and lost revenue resulting from rioting, looting, or demonstration.

Physical damage caused by fire, riots, civil commotion, or vandalism may be covered under an all risk or business owners' policy. While loss of income may be covered under business income or business interruption coverage, this is typically implicated only if there is direct physical damage to the premises, and temporal and causational limitations may apply. Because governmental orders baring access to a specific area due to rioting have yet to be seen, civil authority coverage appears unlikely.

Although policyholder lawyers sometimes give the illusion that coverage is automatically available for riot-related damages, there often can be significant coverage issues. In first-party coverage claims, the issue of number of occurrences may present significant issues. Depending upon the particular facts and policy language, potential positions may include multiple

losses at a single location (such as when a store is vandalized or looted on successive days), losses at multiple locations in the same city, or losses at locations in different cities throughout the country (or some combination of the foregoing) constitute an occurrence. Additionally, vacancy provisions may limit coverage when buildings have been vacant for a designated period of time — 60 days is a common period. There may be issues concerning the actual cause of the loss where the specific loss may be unclear or subject to dispute—for example, whether the loss resulted from vandalism or from arson. Thus, the specific terms of the policy must be closely analyzed. Property insurance policies often contain exclusions that apply to various war risks, including insurrection. In the event that an insurrection is declared in connection with riots, losses arising therefrom may be excluded. Proving such damages will often present issues, particularly in light of COVID-19 related business closures.

There is the potential for third-party liability claims against governmental entities. These may include: businesses alleging property damage or lost revenue due to failure to prevent riots or to take adequate action to limit them; businesses alleging property damage or lost revenue as a result of law enforcement activities such as road closures, barricading business complexes; persons alleging bodily injury caused by law enforcement from pepper spraying, projectiles, tear gas, etc.; or persons alleging civil rights or claims for false arrest, malicious prosecution. There are numerous defenses and barriers to recovery, including governmental immunity. Governmental immunity may require claimants to show willful or intentional misconduct and some states immunize governmental entities and public officials from liability for claims "arising out of riot, civil commotion, or mob action or out of any act or omission in connection with the prevention of any of the foregoing."

There also may be claims against adjacent businesses or property owners for loss of use (*e.g.*, Business A was damaged during riot, thereby preventing adjacent Business B from operating); claims arising from businesses' use of force to protect property or persons (*e.g.*, business hires private security to protect property, and security causes injury to protestors, rioters, or bystanders); claims arising from businesses' failure to perform contractual obligations due to riot (*e.g.*, business cannot manufacture or deliver products because riots have shut down the business or prevented access to facilities or delivery routes). The most meritorious claims often would be claims against the rioters/looters for the injuries and property damage they caused, but generally, the individuals remain unidentified and/or are judgment-proof.

Depending upon the facts of the claim, there could be various other coverage issues including the absence of occurrence/fortuity, and some items may not constitute bodily injury or property damage within the meaning of the policy (*e.g.*, emotional distress/loss of revenue will be difficult to recover under most CGL policies). There may be a number of occurrence(s) issues presented, and several exclusions (such as those for expected or intended acts, criminal actions or exclusions for riot, civil commotion, or mob action) may apply.

Cyber Security And Privacy Insurance Claims

To date, the vast majority of cyber coverage decisions have involved traditional first-party, third-party, and crime/fraud policies. Claims under these policies are commonly referred to as silent cyber claims. Most insurers in the cyber-insurance market have now issued several iterations of cyber-specific policies. Rulings under these policies are expected to be rendered with increasing frequency over the next couple of years.

Indeed, cyber-insurers experienced a steep increase in claims over the past couple of years, driven primarily by ransomware, often coupled with data extraction, and business email compromise events. The costs associated with ransomware claims, in particular, have risen dramatically due to increased ransom demands, threats to disclose extracted data, and related business interruption costs. The pandemic-driven massive shift to remote work spurred additional cyber claims activity. As a result, industry leaders are anticipating a hardening of the cyber-insurance market, as well as increased premiums and underwriting scrutiny.

Zurich and Advisen's 11th Annual Information Security and Cyber Risk Management Survey was released in October 2021.[29] Among the interesting finding, 83% of respondents now buy cyber insurance, with 66% carrying stand-a-lone cyber policies.[30] The survey concluded that triple-digit premium increases, vanishing capacity, shrinking coverage, and shifted expectations around baseline controls have joined

long-term frustrations over inconsistent policy language to create a truly challenging renewal process for insurance buyers. Uncertainties around risk assessment and incident response are major concerns.[31]

According to the survey, ransomware has risen to the top of priority lists worldwide. For the first time, cyber extortion/ransomware has pulled even with data breach, with 95% of respondents selecting it as a coverage they expect to be included in their policies.[32] It was followed by data restoration at 90%; business interruption at 80%; and system failure coverage and bricking at 73%.[33] Results show that cyber risk management has significantly increased in priority to companies—86% say it is a significant concern and they have taken steps to assess their risk; 65 % have invested in cybersecurity solutions to mitigate risk; and 61% say risk managers and IT work together to monitor risk. The "unknowns" of ransomware may be the biggest issue for risk managers.[34]

Property Insurance

In January 2020, a federal district court in Maryland ruled that the first-party property coverage in a business owner's insurance policy (BOP) covered the replacement of the insured's computer system after a 2016 ransomware attack.[35] Following remediation, the system was still functional, but its performance was slowed by new protective software and it was likely that remnants of the virus remained on the system, increasing the risk of re-infection.[36] The court determined that the "loss of reliability, or impaired functionality demonstrate the required damage to a computer system, consistent with the 'physical loss or damage to' language in the policy."[37]

This decision does not materially advance efforts to secure cyber coverage under first-party property policies. While the *National Ink* policy was issued in 2016, it was primarily based on the 1999 ISO form. More recent forms, such as the 2012 ISO BOP form, exclude computer-related losses.

Business Email Compromise

A Mississippi federal district court ruled that Computer Fraud Transfer and Funds Transfer Fraud coverages were not applicable to losses resulting from an email phishing scam.[38] The insured, Mississippi Silicon Holdings ("MSH"), had fallen prey to spoofed emails and wired more than $1 million to fraudsters instead of a legitimate vendor.[39] Three MSH employees approved the wire transfers before MSH learned that hackers had infiltrated its computer system and impersonated an authentic vendor.[40]

MSH's insurer accepted coverage under the Social Engineering provision of its management liability policy, but not under the Computer Fraud Transfer and Funds Transfer Fraud coverage grants, which had much higher limits of liability.[41] MSH instituted coverage litigation, alleging the loss fell within all three coverages.[42]

The Computer Transfer Fraud provision covered losses resulting "directly from Computer Transfer Fraud that causes the transfer, payment, or delivery of Covered Property from the Premises or Transfer Account to a person, place, or account beyond the Insured Entity's control, without the Insured Entity's knowledge or consent."[43]

The Funds Transfer Fraud provision provided coverage for loss "resulting directly from the transfer of Money or Securities from a Transfer Account to a person, place, or account beyond the Insured Entity's control, by a Financial Institution that relied upon a written, electronic, telegraphic, cable, or teletype instruction that purported to be a Transfer Instruction but, in fact, was issued without the Insured Entity's knowledge or consent."[44]

The court declined to adopt a proximate cause standard advocated by MSH, agreeing with the insurer that Computer Transfer Fraud coverage was not implicated because "nothing 'entered' into or 'altered' within [MSH's] Computer System . . . directly caused the transfer of any Money."[45] Instead, the MSH employees caused the transfer, and thus, because the fraudulent emails did not themselves manipulate MSH's computer system, a "Computer Transfer Fraud" did not directly cause the transfers.[46]

The court further held that the requirement for the transfer to take place "without the Insured Entity's knowledge or consent" was not satisfied.[47] The court rejected MSH's assertion that a more logical reading of the requirement would be that MSH had to have actual knowledge of material facts, such as the transferee's true identity, stating that MSH provided no legitimate reason to impose a heightened requirement into the policy.[48] The court distinguished the

Social Engineering Fraud provision, which "clearly authorizes coverage when an employee relies on information that is later determined to be false or fraudulent.[49] In contrast, the Computer Transfer Fraud provision specifically states that coverage is only available when the loss occurs "without the insured entity's knowledge or consent."[50]

The court also held that the Funds Transfer Fraud coverage was not triggered because the MSH employees had knowledge of, and consented to, the transfers.[51] The court found no legitimate basis to accept MSH's argument that the policy required those MSH employees to know the spoofed emails were fraudulent at the time of the transfers.[52] The decision was affirmed by the Fifth Circuit in 2021.[53]

In *Midlothian Enters. v. Owners Ins. Co.*, a Virginia federal district court ruled a crime insurer had no obligation to cover losses resulting from an email phishing scam.[54] In that case, a Midlothian employee had complied with an email request from the company president and purportedly wired more than $400,000 from Midlothian's bank account to a bank account in Alabama.[55] Several days later, Midlothian discovered the email was fraudulent and tendered a claim to Owners Insurance Company, which denied coverage.[56]

The crime policy provided coverage for theft of money and securities, but excluded coverage for "[l]oss resulting from your, or anyone acting on your express or implied authority, being induced by a dishonest act to voluntarily part with title to or possession of any property."[57] The court had no trouble deciding that the exclusion unambiguously precluded coverage. The court rejected the insured's attempt to create ambiguities in the exclusion by highlighting terms with more than one meaning or interpretations that conclude in different results in the interpretation of the exclusion. The court stated: "The fact that a word or phrase has more than one dictionary definition . . . does not make a provision ambiguous."[58]

The court also rejected the insured's argument that a victim of fraud can never act voluntarily, and that the exclusion does not apply where the instruction to make payment is fraudulent: "The fact that another individual pretended to authorize the transaction does not negate the voluntariness of the transfer . . . ."[59] Consequently, "[a]llowing coverage of a fraudulently authorized transaction despite an exclusion based on '*any* dishonest act' would unreasonably limit the exclusion and render the provision meaningless."[60]

A New Jersey federal district court held that losses arising out of a phishing scam were not covered under a bank's Financial Institutions Bond.[61] *In Crown Bank JJR Holding Co. v. Great Am. Ins. Co.*, a fraudster impersonated Mrs. Jackie Rodrigues, the wife of a senior executive of Crown Bank.[62] In a series of 13 emails from a spoofed email address, the impersonator requested wire transfers from the Rodrigueses' Crown Bank accounts to accounts in Singapore.[63]

Pursuant to their Customer Agreement with Crown Bank, the Rodrigueses were permitted to request wire transfers by email, and Crown Bank was required to verify each request by calling the account holder at a designated phone number.[64] Upon receipt of each of the fraudulent email requests, Crown Bank employees requested information needed to complete the transfer and emailed a wire transfer authorization form back to the impersonator.[65] The impersonator would forge Mrs. Rodrigues's signature and then email a PDF of the completed form back to the bank.[66] Bank employees printed the PDF and then matched the forged signature on the form to the signature the bank had on file for Mrs. Rodrigues.[67] Bank employees never called the designated phone number to verify the requests, even though the wire transfer form indicated that the call had been made.[68] By the time the fraud was uncovered, over $2 million had been transferred from the Rodrigueses' accounts.[69] Crown Bank sought coverage for the loss under its Financial Institutions Bond and its Computer Crime Policy for Financial Institutions.[70] Its insurer denied coverage under both policies, and coverage litigation ensued.[71]

Crown Bank asserted that its claim was covered by Insuring Agreement D of the Financial Institutions Bond, which applied to: "Loss resulting directly from the Insured having, in good faith, paid or transferred any Property in reliance on any Written, Original . . . (4) Withdrawal Order . . . (6) Instruction or advice purportedly signed by a customer of the Insured or by a banking institution . . .which (a) bears a handwritten signature of any maker, drawer or endorser which is Forgery; or (b) is altered, but only to the extent the Forgery or [alteration] causes the loss. Actual physical possession of the items listed in (1) through (6) above by the Insured is a condition precedent to the Insured's having relied on the items."[72]

The term "Original" was defined as "the first rendering or archetype and does not include photocopies or electronic transmissions, even if received and printed" while "Written" was defined as "expressed through letters or marks placed upon paper and visible to the eye."[73]

The parties' central dispute was whether Crown Bank had actual physical possession of the "Written, Original" wire transfer forms, a condition precedent to coverage under Insuring Agreement D. The insurer argued that the bank failed to satisfy that condition because printouts of the electronically transferred PDFs from the impersonator did not fall within the Bond's definition of "Original".[74] Crown Bank contended that a PDF itself is not an electronic transmission, and each printout of a wire transfer authorization form from a PDF was a "first rendering" within the definition of "Original."[75]

The court rejected the Bank's arguments because "documents transmitted electronically are not originals, even if received and printed," according to the Bond.[76] The Bank's additional contention that the "first rendering or archetype" language in the definition of Original was ambiguous as applied to PDFs also missed the mark: "Regardless of any ambiguity concerning whether a PDF may qualify as an 'Original' without electronic transmission, where a PDF (or any electronic file format) is transmitted electronically, it cannot qualify as an 'Original' as defined in the [Bond]."[77]

In *G & G Oil Co. of Indiana v Continental Western Ins. Co*., the Indiana Supreme Court weighed in on cyber security in the context of a multi-peril policy's commercial crime and fidelity coverage. The court concluded the term "fraudulently cause a transfer" equates "to obtain by trick."[78] The court noted that every ransomware attack is not necessarily fraudulent. For example, if no safeguards were put in place, it is possible a hacker could enter a company's servers unhindered and hold them hostage. There would be no "trick." Thus, a question of fact exists precluding the entry of summary judgment in favor of the policyholder. The court found there is sufficient causal connection between the alleged fraud and the policyholder's use of the computer.[79] Its transfer of Bitcoin was nearly an immediate result of using a computer. Though the policyholder's transfer was voluntary, it was made only after consulting with the FBI and other computer tech services and was made under duress. Under those circumstances, the "voluntary" payment was not so remote that it broke the causal chain.[80]

Privacy Violations

In the absence of comprehensive federal laws, individual states continue to adopt their own privacy laws and regulations. For example, the ground-breaking California Consumer Privacy Act ("CCPA") went into effect in January 2020.[81] Similar to the European Union's General Data Protection Regulation, the CCPA created a number of privacy rights for California consumers and obligations for businesses that collect and process personal information. Although the California Attorney General has yet to commence a CCPA enforcement action, several class-action lawsuits have already been filed pursuant to the Act's limited private right of action. Despite the recent enactment of the CCPA, California residents voted in November to approve the California Consumer Privacy Rights Act ("CPRA"), which further expands consumer privacy rights.[82] The CPRA also creates a state-wide privacy agency that will be charged with enforcement of privacy laws. This likely will lead to increased enforcement actions for privacy violations in California.

In New York, a proposed amendment to the state's Civil Rights Law would create criminal liability for certain privacy violations, and the proposed It's Your Data Act would create CCPA-like consumer privacy rights with an even broader private right of action.[83] In July 2020, the New York Department of Financial Services, the state's powerful financial regulator, initiated its first enforcement action for alleged violations of its first-in-nation 2017 cybersecurity regulation.[84]

Increased regulatory enforcement and the further proliferation of privacy and cyber laws and regulations will likely drive increased cyber-insurance claims activity for both breach and information misuse events going forward.

Several decisions on the privacy front were issued in 2020. In *Brighton Collectibles, LLC v Certain Underwriters at Lloyd's London*, an insurer was required to defend a putative class action alleging that the insured retailer collected and sold customers' personal information in violation of California's Song-Beverly Credit Card Act.[85] The insured argued that the claim triggered its personal injury coverage, which applied

to personal injury caused by an offence arising out of the insured's business, which includes "oral or written publication of material that violates a person's right of privacy."[86]

Based on California Supreme Court precedent holding that the overriding purpose of the Credit Card Act is to protect the personal privacy of consumers, the Ninth Circuit found that the class action alleged an invasion of privacy sufficient to trigger the insurer's duty to defend. The court rejected the insurer's assertion that coverage was barred by the policies' exclusions for "advertising, publishing, broadcasting or telecasting done by or for" the insured.[87] The court stated: "The word 'publishing' in this coverage exclusion cannot be read to have the same meaning as the word 'publication' in the personal injury provision. Such a reading would exclude coverage for virtually any publication over which [the insured] might realistically be sued, rendering the policies' express coverage for publications that violate privacy rights practically meaningless."[88] The court also noted that the "grouping of 'publishing' with 'advertising . . ., broadcasting or telecasting in the coverage exclusion suggests that the exclusion applies only to broad, public-facing marketing activities."[89]

The Illinois Supreme Court found that a claimed violation of Illinois' Biometric Information Privacy Act ("BIPA") fell within (or potentially within) businessowners liability policies affording personal and advertising injury coverage.[90] In that case, the plaintiff in the underlying suit alleged she purchased a membership from the policyholder, a salon that granted her access to other salons.[91] Enrolling in the program purportedly required that the plaintiff have her fingerprint scanned in order to verify her identity.[92] The plaintiff alleged that the policyholder never provided her with, nor did she sign, a release allowing the policyholder to disclose her biometric data to any third party; nevertheless, the policyholder purportedly disclosed her fingerprint data to an out-of-state third-party vendor.[93] The plaintiff asserted claims for violation of BIPA, unjust enrichment, and negligence.

Because the policies did not define "publication," the court turned to the term's dictionary definition and applicable case law. Ultimately, the court held that "'publication' has at least two definitions and means both the communication of information to a single party and the communication of information to the public at large."[94] As such, the salon's disclosure of fingerprint data to another party constituted a "publication."[95] The court the held the violation of statutes exclusion did not bar coverage for the claim since BIPA was dissimilar from the statutes enumerated in the exclusion.[96]

In *Massachusetts Bay Insurance Co. v. Impact Fulfillment Services*, the district court found that the general liability insurers had no duty to defend their policyholder, Impact Fulfillment Services ("Impact"), in a proposed class action from Impact's Illinois employees.[97] The underlying suit alleged that Impact scanned workers' fingerprints to track work hours without their consent, in violation of BIPA.[98] Contrary to the Illinois Supreme Court's decision in *West Bend*, the North Carolina federal Court found the distribution of materials exclusion bars coverage for the exact type of illegal information collection regulated by BIPA.[99] Applying North Carolina law, the court noted the exclusion in the policies before it—which was revised in 2013 by ISO—was broader than the exclusion in *West Bend*.[100] Specifically, the exclusion included the terms "printing, dissemination, disposal, collecting and recording" of information and materials. The exclusion also bars coverage for violations of the Fair Credit Reporting Act, in addition to violations of the Telephone Consumer Protection Act and Can-Spam Act, which were also barred under the earlier version of the exclusion.[101] By contrast to the Illinois Supreme Court, the North Carolina federal court concluded that "BIPA is of the same kind, character and nature" as the Telephone Consumer Protection Act, the Fair Credit Reporting Act and other federal and state statutes for which coverage is barred by the exclusion.[102]

Lead Paint

Coverage issues relating to the $400 million-plus lead paint abatement fund involving three lead paint manufacturers are being addressed in three separate coverage actions. The courts have reached different conclusions in each on motions for summary judgment.

First, a California trial court ruled, in *Certain Underwriters at Lloyd's of London v. ConAgra Grocery Products Company*, that California's willful acts insurance law precluded coverage for public nuisance claims against the insured based on its predecessor's promotion of lead paint.[103] Evidence in the underlying liability litigation established that the predecessor had actual knowledge that lead paint on residential interior surfaces posed a public health hazard.

In the subsequent coverage litigation, the court rejected the insured's attempt to be "insulated from" that knowledge, as well as its argument that the scienter findings in the underlying litigation were insufficient to meet the willfulness standard of California Insurance Code §533, which provides that an "insurer is not liable for a loss caused by the willful act of an insured." According to the court, the fact that senior managers of the predecessor company were not proven to have knowledge of the relevant hazards made no difference, because under §533, an entity's employees' collective knowledge "is what matters." The case is on appeal.

Next, in *Sherwin-Williams v. Certain Underwriters at Lloyd's of London*, the court rejected the insurers' arguments that Sherwin-Williams either expected or intended the damages.[104] It nonetheless granted summary judgment to the insurers on the grounds that the abate fund does not constitute "damages" under the policies.[105] Finally, in *Certain Underwriters at Lloyd's, London v. NL Industries*, the court denied the insurers' motion for summary judgment based on similar grounds. [106]

Long-Tail Claims – Allocation

Allocation of losses among insurers and policyholders continues to be a driving issue in long-tail claims. *Pro rata* allocation continues to be the majority approach and is superior to the "all sums" allocation alternative.[107] Maryland's high court unanimously held that a commercial general liability ("CGL") insurer was responsible for only a *pro rata* share of a $2.7 million judgment against its insured based on a worker's bodily injury due to exposure to asbestos at the now defunct insured's property.[108] The worker, who developed mesothelioma decades after his asbestos exposure, argued that the policy's all sums language supported joint and several allocation, allowing him to collect the entire judgment against a single insurer.[109] Joining the majority of states that have considered the issue, the court held that damages for continuous injury must be allocated on a *pro rata* basis across all insured and insurable periods triggered by the worker's injuries.[110] The court stated that all sums allocation is inconsistent with the policy requirement for bodily injury to occur "during the policy period."[111]

The Ohio Supreme Court rejected the application of an all sums allocation for a product defect property damage claim where there was no evidence that the injury was over time.[112] Under the facts of that case, the court stated that "the operative contract language is not the reference to policy coverage for 'those sums' but rather to injury or damage 'that takes place during the Policy Period.'"[113] There was "no reason to allocate liability across multiple insurers and policy periods if the injury or damage for which liability coverage is sought occurred at a discernible time. In that circumstance, the insurer who provided coverage for that time period should be liable, to the extent of its coverage, for the claim." The court distinguished cases where it applied all sums allocation, noting that those cases involved progressive environmental pollution and asbestos bodily injury claims.

In the long-running Montrose environmental coverage litigation, the California Supreme Court adopted a vertical exhaustion requirement, allowing the policyholder to access coverage under any excess policy upon exhaustion of directly underlying excess policies for the same policy period.[114] Relying on the policies' "other insurance" clauses, the court rejected the horizontal exhaustion method advocated by the insurers, noting that none of those clauses clearly or explicitly states that Montrose must exhaust insurance with lower attachment points purchased for different policy periods.[115]

Traditionally, Florida courts did not allow contribution claims among liability insurers for defense costs; however, Fla. Stat. § 624.1055 was enacted to expressly provide that courts shall allocate defense costs among liability insurers that owe a duty to defend the policyholder against the same claim, suit, or other action "in accordance with the terms of the liability insurance policies."[116] The statute does not apply to motor vehicle liability insurance or medical professional liability insurance.[117]

On November 23, 2021, the Montana Supreme Court weighed in on long-tail claims in *National Indemnity Co. v. State of Montana*.[118] National Indemnity, which was the State of Montana's general liability insurer from 1973 to 1985, sought to resolve coverage issues arising from asbestos bodily injury and death claim which alleged the State failed to warn of asbestos dust conditions at vermiculite mining and milling operations in and around Libby, Montana Mine run by W.R. Grace & Company and its predecessors. The lower court entered a judgment against National Indemnity for nearly $98 million.[119]

On the duty to defend, the Montana Supreme Court ruled that National Indemnity did not breach its duty at the time the State initially tendered the Libby Mine claims because the State defended the claims through its self-insurance program, hired its own counsel, managed the litigation, made its own defense decisions, and took the position with the insurer that the matter was "under control" and nothing was left to be done.[120] The court ruled that, when the State subsequently requested a complete defense, National Indemnity breached its duty to defend by agreeing to pay only its *pro rata* share of defense costs.[121] The court reasoned that, under Montana's "mixed-action rule" an insurer is required to defend the entire action as long as one count is covered.[122] National Indemnity was not in breach when it later offered to pay 100% of the defense costs conditioned on a right of recoupment, because Montana law permits carriers to seek recoupment in certain circumstances. The court held that the insurer was estopped from asserting coverage defenses concerning claims for which it had not provided a full defense as of the date settlements of those claims were approved by the trial courts.[123] As to claims for which the insurer had offered to provide a full defense or that were not reduced to judgment before the insurer initiated the declaratory judgment action, the insurer was not in breach of the duty to defend and, therefore, not estopped from asserting the coverage defenses.[124]

The court held that the underlying injuries resulted from an "occurrence" because the State did not objectively intend or expect injuries to be sustained as a result of its actions.[125] Further, the known loss doctrine did not bar coverage because the doctrine applies only to a loss that the insured either knows of, planned, intended or is aware is substantially certain to occur. Additionally, the court determined the "sudden and accidental" pollution exclusion did not bar coverage as the exclusion applies only to discharges of pollutants by the insured and not to discharges by third parties such as the mine owner. [126]

Applying the "cause theory" to determine the number of "occurrences," the court found that the cause of the claimants' injuries was the State's separate failure to warn of the hazardous conditions at the Libby Mine and not its singular decision to withhold the results of its workplace inspections and not advise workers of the hazards.[127] The court rejected the notion that each claimant's individual injury constituted a separate occurrence and remanded the issue to the trial court to determine the exact number of occurrences.[128]

The court held that the State (which was self-insured for decades) was not required to share *pro rata* responsibility for settlement and defense costs that the insurer had paid under the policy. The court found it would be wrong to "giv[e] double effect" to the 'during the policy period' language as limiting both the trigger and the scope and extent of coverage."[129] The court held that "[a] Claimant exposed either during or prior to the Policy period may, despite a lack of manifestation of injury during the Policy period, be covered under the Policy as long as it can be determined, even retroactively, that some injury did occur during the policy period as a result of the State's failure to warn."[130] The court remanded the additional factual findings regarding injuries sustained during the policy period from exposure that occurred prior to the policy period.[131]

Construction Defect Coverage

Cases across the country have reached differing results as to whether defective construction is an "occurrence" or "accident" under general liability policies.

In a unanimous decision, the Michigan Supreme Court held that an "accident" could include faulty subcontractor work that was unintended by the insured, thereby constituting an occurrence under a CGL policy.[132] The court rejected the insurer's argument that covering faulty subcontractor work would convert the policy into a performance bond, noting that "the CGL policy covers what it covers" and there is no basis to eliminate coverage because similar protections may be available under another insurance product.[133]

Opioids Coverage

In the wake of the nationwide opioids epidemic, various state and local governments sued numerous entities involved in the manufacture, sale, distribution and prescription of opioid pharmaceutical products. Facing staggering potential liabilities, these entities have turned to their insurance companies for coverage under CGL and other policies.

There have been several significant settlements reached in the past several months. These include

pharmaceutical distributors' $215 million settlement with two Ohio counties, the distributors' $1.179 billion settlement with the State of New York and its participating subdivisions, Johnson & Johnson's $230 million settlement with the State of New York, and a $26 billion global settlement between drug distributors and a group of state attorneys general in the National Prescription Opioid MDL.

November 2021 was a key month in the litigation, as the Oklahoma Supreme Court overturned a $465 million judgment that Johnson & Johnson sustained in the nation's first opioid trial.[134] Also, a California judge handed a complete victory to drug manufacturers after the nation's second opioid trial.[135] The third trial did not go well for defendants, with pharmacy companies CVS Health, Walmart, and Walgreens being found liable for contributing to an opioid abuse epidemic in two Ohio counties.[136] This marked the first time a jury has weighed in on the controversial "public nuisance" legal theory at the heart of many similar suits nationwide in the context of opioids.

In terms of coverage decisions, in *Acuity v. Masters Pharm. Inc.*, the court reversed the trial court's ruling that the insurer had no duty to defend a pharmaceutical distributor against opioid lawsuits.[137] In finding a duty to defend, the court determined that, although the government entities were seeking their own economic losses, some of those losses, such as medical expenses and treatment costs, were arguably "because of" bodily injury.[138] It also rejected the insurer's argument based on the loss in progress or Montrose clause, ruling coverage for opioid claims would be barred only if the insured had knowledge of the specific injuries at issue.[139] The decision is currently on appeal before the Ohio Supreme Court, although other decisions have ruled in favor of insurers on this issue.

The lower Delaware court ruled, in *Rite Aid Corp. v. ACE American Insurance Co.*, that general liability insurers must defend their policyholders in litigation filed by government entities seeking to recover for amounts that they allegedly spent to provide health, emergency and other services to citizens addicted to prescription opioids.[140] That decision is now before the Delaware Supreme Court on appeal.

In October 2020, the Ninth Circuit held that a doctor's professional liability policy did not cover an opioid-related wrongful death claim.[141] The insured doctor had admitted that he willfully violated federal controlled substances laws, which resulted in the death of a Nevada woman. The court held that the policy's exclusion for any willful violations of law "clearly applied" to the claim.[142]

D & O: Disgorgement And Securities Law

Some key decisions impacting the D & O and securities law landscape were rendered as well. New York's highest court reversed an intermediate appellate court ruling and held that a $140 million settlement payment by J.P. Morgan Securities Inc.'s predecessor to the SEC was not an uninsurable penalty. The court concluded that the insurers failed to prove the disgorgement payment—"a component of the SEC settlement that serves compensatory purposes and was measured by the profits wrongfully obtained and losses caused by the alleged wrongdoing"—fell under the exclusion for "penalties imposed by law."[143]

On June 21, 2021, the U.S. Supreme Court issued its decision in *Goldman Sachs* holding that, at the class action certification stage, a court may consider whether a company's alleged misstatements were too generic to have impacted its stock price.[144] The decision is expected to make it more difficult to certify a class action in suits alleging securities fraud based on generic company statements.

In *Rsui Indemnity Co. v. Murdock*, the Delaware Supreme Court ruled Delaware law governed the excess D & O policy even though most contacts were in California, perhaps representing the court's desire to maintain Delaware's status as the home to more U.S. companies than any other state.[145] The court ruled that the profit/fraud exclusion did not apply on the narrow ground that one of the two underlying matters was resolved by settlement and, therefore, did not satisfy the requirement of the exclusion that the underlying matter be resolved by adjudication.[146] It also affirmed the trial court's application of the "larger loss" rule as opposed to the "relative exposure" rule to defense costs and costs of settling one of the two underlying matters.[147]

Although most special purpose acquisition company ("SPAC") securities class action lawsuits are filed after the de-SPAC transaction has been completed, more

suits are being filed before the merger becomes effective. In addition to merger objection lawsuits, more full-blown 10b-5 class actions are being filed. The trend of SPAC-related state court actions being asserting as state law causes of action rather than federal securities law violations likely will continue, with attorney's fees being a major consideration.

Approximately 28 SPAC-related securities suits were filed in 2021 compared to approximately 4 suits filed in 2020. SPAC-related suits are expected to increase, as over 590 SPACs have completed initial public offerings in 2021 compared to 248 in 2020. The SEC is signalling greater regulation of SPACs due to the perception that investors may not be getting the same protections as with traditional initial public offerings. This may take the form of increased disclosure requirements, greater focus on marketing practices, and liability for sponsors and others.

Cyber-attacks, data loss, regulatory risks, health and safety, COVID-19, EGS, climate and employment claims likely will remain among the leading D & O emerging risk areas.

Reinsurance

There have been relatively few reinsurance law decisions over the past couple of years outside of issues of arbitrability. For nearly 30 years, the majority rule has been that the "reinsurance stated" limits in a facultative reinsurance contract capped a reinsurer's total liability for indemnity and defense costs.[148] The New York Court of Appeals, in its 2017 *Global Re* decision, ruled that there is no blanket rule, and directed courts to look at the language of the particular reinsurance contract to determine the scope of the limits. Earlier in 2020, in *Global Reinsurance Corporation of America v. Century Indemnity Company*, the New York Southern District Court concluded on remand after conducting an evidentiary hearing that the stated limit capped losses and also capped expenses where there are no losses, but did not cap expenses where there are losses.[149]

In *Utica Mut. Ins. Co. v. Fireman's Fund Ins. Co*., the court ruled that a reinsurer was not obligated to pay the ceding company as a matter of law because the underlying asbestos-related bodily injury claims did not excess the attachment points of the reinsured umbrella policies.[150] In reversing, the Second Circuit held that the follow-the-settlements doctrine does not override the terms of the reinsurance contract.[151]

Finally, reinsurers continue to evaluate their exposures for COVID-19-related cessions.[152]

Endnotes

1. For example, press releases reflect that Zurich plans to be a net-zero emissions company by 2050 and Aon by 2030.

2. As of 2020, one-third (approximately $17 trillion) of all U.S. assets under management were invested following sustainability principles, a 42% increase from 2018. US SIF, *Report on US Sustainable and Impact Investing Trends* (2020), https://www.ussif.org/files/Trends%20Report%202020%20Executive%20Summary.pdf.

3. Zurich, for instance, has committed to terminating its relationship with companies that generate more than 30% of revenue from mining or generate more than 30% 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. R. Dalton, "Zurich cuts ties with over 90 companies over green issues," Insurance Insider (Mar. 12, 2021), https://www.insuranceinsider.com/article/289bc19d1z5abkxenls00/zurich-cuts-ties-with-over-90-companies-over-green-issues; Zurich Insurance Group, Exclusion policies (2021). 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% of revenues from thermal coal or unconventional fossil fuels by the end of 2021. Aviva, *Taking Climate Action: Sustainability* (2021). 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 appear to be jumping 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." Press Release, BP P.L.C., BP sets ambition for net zero by 2050, fundamentally changing organization to deliver (Feb. 12, 2020).

4. On May 20, 2021, President Biden signed an executive order on climate-related financial risk. The order directs federal agencies to analyze and mitigate the risks that climate change presents to homeowners, consumers, businesses, workers, and the U.S. financial system; develop a whole-of-government approach to mitigating climate-related financial risk; encourage financial regulators to assess climate-related financial risk, modernize federal lending, underwriting and procurement; incorporate climate-related financial risk in federal lending programs; consider new required disclosures of greenhouse gas emissions and climate-related financial risks for federal suppliers and seek to minimize such risks in federal procurements; and reduce the impact of climate change to the federal budget. Press Release, White House, FACT SHEET: President Biden Directs Agencies to Analyze and Mitigate the Risk Climate Change Poses to Homeowners and Consumers, Businesses and Workers, and the Financial System and Federal Government Itself (May 20, 2021).

5. Press Release, SEC, SEC Announces Enforcement Task Force Focused on Climate and ESG Issues (Mar. 4, 2021).

6. Press Release, U.S. Department of the Treasury, Remarks by Secretary of the Treasury Janet L. Yellen on the Executive Order on Climate-Related Financial Risks (May 20, 2021).

7. S.M., Seaman, "Comments Due to the Federal Insurance Office on its Wide-Ranging Work Relating to the Insurance Sector and Climate-Related Financial Risks," *JD Supra* (Oct. 13, 2021), https://www.jdsupra.com/legalnews/comments-due-to-the-federal-insurance-9466044/.

8. See "New York Issues Final Guidance to Insurers on Managing Risks of Climate Change," *Insurance Journal*, Nov. 15, 2021. 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. 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."

9. 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." B. Moorcraft, "Insurers facing greater pressure to manage ESG risk factors," *Insurance Business America*, Mar. 1, 2021.

10. UNEPFI, *The UNEP FI Principles for Sustainable Insurance* (June 2012), https://www.unepfi.org/insurance/psi/.

11. *See* S.B.169, 73rd Gen. Assemb., 2021 Reg. Sess. (Colo. 2021).

12. R. Nadeem, "Munich Re estimates overall 2020 nat cat losses at $210B," *S&P Global* (Jan. 7, 2021), https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/munich-re-estimates-overall-2020-nat-cat-losses-at-210b-62014389.

13. *See* S.M. Seaman & J.R., Schulze, *Allocation of Losses in Complex Insurance Coverage Claims*, Chapter 19 (Social Inflation And Sustainability/ESG) (Thomson Reuters, 10th ed. 2021-22).

14. *See* S.M. Seaman, et al.,"The Legal Trends Behind 'Social Inflation' in Insurance," *Law360*, (Feb. 21, 2020), https://www.law360.com/articles/1245725/the-legal-trends-behind-social-inflation-in-insurance.

15. *Social Inflation Will Be Accelerated by Pandemic*, Fitch Ratings (Dec. 14, 2020), https://www.fitchratings.com/research/insurance/social-inflation-will-be-accelerated-further-by-pandemic-14-12-2020.

16. *See* S.M. Seaman & J. Selby, "Tracking The Flurry Of COVID-19 Related Legislative & Regulatory Activity Impacting Insurers," *Mealey's Litig. Rep.: Catastrophic Loss*, Volume 15, No. 7 (April 2020).

17. *See Covid Coverage Litigation Tracker*, University of Pennsylvania Carey Law School, https://cclt.law.upenn.edu (last visited Dec. 7, 2021).

18. *Id.*

19. *Id.*

20. *See Bridal Expressions LLC v. Owners Ins. Co.,* No. 21-3381, 2021 U.S. App. LEXIS 35676 (6th Cir. Nov. 30, 2021); *Sandy Point Dental, P.C. v. Cin. Insurance Co.,* No. 21-1186, No. 21-1559, No. 21-1203, 2021 U.S. App. LEXIS 36399 (7th Cir. Dec. 9, 2021); *Bradley Hotel Corp. v. Aspen Specialty Ins. Co.,* No. 21-1173, 2021 U.S. App. LEXIS 36398 (7th Cir. Dec. 9, 2021); *Mashallah, Inc. v. W. Bend Mut. Ins. Co.,* No. 21-1507, 2021 U.S. App. LEXIS 36400 (7th Cir. Dec. 9, 2021); *Crescent Plaza Hotel Owner, L.P. v. Zurich Am. Ins. Co.,* No. 21-1316, 2021 U.S. App. LEXIS 36396 (7th Cir. Dec. 9, 2021); *Oral Surgeons, P.C. v. Cincinnati Ins. Co.,* No. 20-3211, 2021 U.S. App. LEXIS 19775 (8th Cir. July 2, 2021); *Mudpie, Inc. v. Travelers Cas. Ins. Co.,* No. 20-16858, 2021 U.S. App. LEXIS 29624 (9th Cir. Oct. 1, 2021); *Selane Prods. v. Cont'l Cas. Co.,* No. 21-55123, 2021 U.S. App. LEXIS 29633 (9th Cir. Oct. 1, 2021; *Chattanooga Prof'l Baseball LLC v. Nat'l Cas. Co.,* No. 20-17422, 2021 U.S. App. LEXIS 29632 (9th Cir. Oct. 1, 2021); *Gilreath Family & Cosmetic Dentistry, Inc. v. Cincinnati Insurance Co.,* No. 21-11046, 2021 U.S. App. LEXIS 26196 (11th Cir. Aug. 31, 2021).

21. Eli Flesch, "7th Circ. Deals Policyholders 'Body Blow' In Virus Ruling," *Law360*, (Dec. 7, 2021), https://www.law360.com/articles/1447503/7th-circ-deals-policyholders-body-blow-in-virus-ruling.

22. *See Inns-by-the-Sea v. Cal. Mut. Ins. Co.,* 71 Cal. App. 5th 688 (2021); *Sanzo Enters., LLC v. Erie Ins. Exch.,* 2021-Ohio-4268 (Ct. App.); *Nail Nook, Inc. v. Hiscox Ins. Co.,* 2021-Ohio-4211 (Ct. App.).

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24. *In re Soc'y Ins. Co. COVID-19 Bus. Interruption Protection Ins. Litigation,* 492 F. Supp. 3d 1359, 1361 (J.P.M.L. 2020).

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