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Claims Judicial and Legislative Affairs Quarterly Digest

June 2025

“Recognizing that today’s economic and litigation environments are top of mind for our customers, Zurich has devoted a team of subject matter professionals to address their concerns. The Claims Judicial and Legislative Affairs (CJLA) group studies social inflation and its drivers, providing insights and information to Zurich’s customers and brokers; our claims and risk engineering teams; and others who may influence our industry and the legislative environment. As a founding member and instrumental leader amongst a growing coalition of industry partners, we are proud to share this information in our *Quarterly Digest* and *Regional Recap*.”

Keith Daly
ZNA Chief Claims Office

Social inflation is increasingly responsible for rising claims costs. This may affect how companies do business, interact with their communities, and connect with their customers. Zurich remains dedicated to working collaboratively with our customers, brokers, and risk mitigation industry members to tackle these challenges.

The **CJLA *Quarterly Digest*** highlights issues which touch the industry on a global, national, and state level. Trending topics as well as successful trial tactics are also shared. The articles contain direct links for more in-depth information. The **CJLA *Quarterly Digest*** publishes once a quarter.

The **CJLA *Regional Recap*** captures the latest legislative enactments and judicial decisions that impact social inflation and the insurance industry. For ease of use, these are indexed by region and by state with direct links to the exact legislation or citation. The **CJLA *Regional Recap*** is now interactive, allowing for quick access to information, and is located on the CJLA Hub. Publishes four times a year.

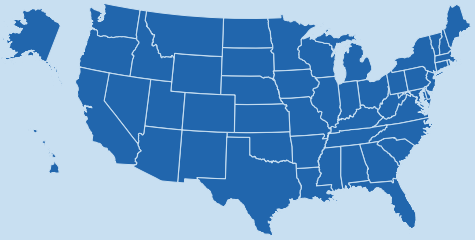
Education is only the beginning of the solution. Leveling the playing field requires that all be involved.

To join Zurich in combatting social inflation – or for questions or submission of topics for future issues – please contact lisa.bellino@zurichna.com

Table of contents

In this issue:

National news



Staged auto accidents:
A scheme that harms all

Fraudulent claims and plaintiffs exaggerating injuries are nothing new in the insurance industry. In fact, claims professionals, as well as special investigations units, scrutinize cases to uncover such things. However, staged accidents seem to be a national phenomenon, making headlines on a regular basis. They are not confined to one area of the country and their consequences can be extreme. As a result, Congress has proposed the Staged Accident Fraud Prevention Act of 2025 specifically making the intentional collision with a commercial vehicle a transportation offense. A person causing the collision or arranging for another to do so may be fined under the U.S. Crimes Code, imprisoned for up to 20 years, or both. Members of Congress have even asked the Department of Justice for a task force dedicated to this issue, noting how much insurance fraud costs each year, how it risks the lives of innocent motorists and how insurance fraud increases consumer costs.

These schemes employ varying techniques for causing an accident, leading the National Insurance Crime Bureau (NICB) to dub them "big business." Some of these techniques entail "swoop and squat," "drive down," "panic stop," and "side swipe." Regardless of the name, these schemes plague the nation's highways and have caused issues for residents in places like South Carolina, New York, and California. In fact, some states, like Massachusetts and California, have made such fraudulent schemes a crime. Others introduced legislation focusing on those same types of fraud.

Some recent headlines include incidents in Louisiana, Georgia, Washington, and New York:

Operation Sideswipe

In New Orleans, Louisiana, a group of 63 individuals, which included two attorneys, was indicted for allegedly staging vehicle accidents for over a decade. This group feigned or caused accidents by having cars crash into 18-wheelers, with the individual responsible for the crash ("slammer") leaving the scene in another vehicle ("spotter") so that those remaining passengers could submit fraudulent claims and create a narrative, all blaming the tractor trailer. To date, nearly 50 persons of those charged have pled guilty. Two of these participants also were recently indicted for allegedly murdering a third participant, who was working with the federal authorities after being indicted, rather than let him testify.

Rental truck scams

In some states, individuals used rental vehicles to stage accidents. The scheme behind the incidents was to rent a truck and purchase the insurance coverage. After driving to a pre-designated location where would-be plaintiffs were waiting with the car, the rental truck would crash into the car, and all would claim injuries and then treat at pre-arranged medical clinics.

In Georgia alone, approximately 50 of these incidents had taken place using one particular kind of rental truck. Over the course of years, over 26 individuals were convicted of participating in this scheme, which also spilled into Louisiana. The same scenario unfolded in New York, where the individuals were indicted and several were convicted or pled guilty. In California, an identical scheme played out, with plaintiff attorneys even highlighting what to do if involved in an incident with a rental truck.

Washington state scheme

In Spokane, Washington, a fraud ring involved automobiles as well as boats that were intentionally crashed to fabricate insurance claims there as well as in Nevada. The "ringleader" of the scheme was not only sentenced to 12 years in prison but also ordered to make restitution to those he harmed. The U.S. District Court for the Eastern District of Washington ordered that he pay over $6.6m to the carriers he defrauded as well as over $400,000 to the Internal Revenue Service for the taxes he failed to pay. His 22 co-conspirators even included his wife and children, all of whom pled guilty. While awaiting trial, he escaped to Florida where he was caught trying to sell a yacht and extradited.

Belt Parkway scam

A dashcam was key in identifying and apprehending the perpetrators of these staged accidents. Over a three-month period, the same silver vehicle pulled in front of the victim's car and backed into it on the Belt Parkway in New York City. It was reported that the driver of the offending car would leave the scene when another individual appeared, leaving the "passengers" to assert their claims. Those persons also were captured on dashcam footage feigning their injuries. Instances such as these prompted a statewide alert warning citizens to be wary of the possibility of these types of incidents.

Regardless of the state in which these fraud rings occur, their effect has garnered national attention. The federal legislation is one more attempt to stop these groups from causing harm to those whom they impact, literally, and those whom they defraud.

By: Lisa M. Bellino, Zurich CJLA

Discord at the top:
A piecemeal approach to tort reform

The 2025 Louisiana Regular Legislative Session ended on June 12, 2025, and saw reform bills passed and signed into law beyond those of the previous session. Unlike the 2023 comprehensive tort reform package passed in Florida or the recent tort reform package passed in Georgia, Louisiana process does not provide for such a comprehensive approach. Furthermore, although Governor Jeff Landry and Insurance Commissioner Tim Temple were aligned on several policy proposals, they also disagreed openly on insurance regulations to address costs. Louisiana's lawmakers therefore, proposed tort reform with a series of bills, and the result has been a more "piecemeal" approach to reform rather than a package. These include:

- **Overrule of *Housely* presumption (Act No. 18)** legislatively overrules the Louisiana Supreme Court decision in *Housley v. Cerise*, 579 So. 2d 973 (La. 1991). The Act became effective immediately upon the governor's signature and repealed the legal presumption that an injury diagnosed immediately after an accident is presumed to be related to the accident unless defendants can prove otherwise.
- **Increase of "No Pay/No Play" Limits (Act No. 16)** modified the "No Pay/No Play" law to bar uninsured motorists from recovering the first $100,000 of bodily injury and the first $100,000 of property damage in any cause of action arising from an automobile accident. Additionally, if an uninsured motorist sues to recover damages and is awarded $100,000 or less, they will be held liable for all court costs incurred by all parties involved in the action. This Act takes effect on August 1, 2025.
- **Bar to Recovery Based on Legal Status (Act No. 17)** prohibits unauthorized individuals from recovering general damages and past and future wages for injuries arising from an automobile accident. However, this restriction does not apply to claims made against uninsured or underinsured motorist policies that name the unauthorized alien as an insured. The Act is effective as of August 1, 2025.
- **Modified Comparative Fault (Act No. 15)** under this Act, claimants found to be 51% or more at fault for an accident are barred from recovering any damages. If a claimant's fault is less than 51%, their recoverable amount will be reduced by the percentage of their fault. This Act becomes effective on January 1, 2026, and repeals the current pure comparative fault regime.
- **Dashboard Camera (Act No. 19)** mandates an actuarially justified premium discount for commercial motor vehicle policyholders who have installed dashboard cameras and telematic systems, provided they meet other specified requirements. The Act aims to incentivize the use of technology to enhance road safety and becomes effective on January 1, 2026.

The group of passed bills above is expected to address lawsuit abuse in the state. However, the Governor also pushed for passage of Act No. 11, which allows the Insurance Commissioner to scrutinize insurance rates and premiums, beyond his "actuarial justification" review authority. It is unknown whether these passed reforms will be enough to make a lasting impact in Louisiana.

Important to note is that during the 2024 Louisiana Legislative Session, several significant bills were also passed, impacting various aspects of tort law, insurance policies, and litigation procedures. They include:

- **Extension of Statute of Limitations (Liberative Prescription) (Act No. 423)** was signed into law extending the liberative prescription period for torts from 1 year to 2 years. Injured parties now have two years to file suit in tort claims from the day the injury or damage is sustained, in an effort to resolve cases before filing. The change took effect on July 1, 2024, and applies to actions arising after that date.

- **Repeal of Direct Action (Act No. 275)** repealed Louisiana's Direct-Action statute and La. C.E. art. 411(D), effective August 1, 2024. As a result, injured parties no longer have the right to directly sue an insurer unless specific conditions are met: the insured files for bankruptcy, is insolvent, cannot be served, refuses to defend the action within 180 days, the cause of action involves family members, the insurer is a UM/UIM carrier, or the insurer denies coverage or defends under a reservation of rights.
- **Actions Against Insurers (Act No. 595)** removed the requirement that actions against foreign or alien insurers be brought in East Baton Rouge Parish (19th Judicial District Court). This change, effective August 1, 2024, combined with repeal of Direct Action, eliminated a forum shopping opportunity for injured parties to file actions in the 19th Judicial District Court regardless of where the accident or loss occurred.
- **"Opt-In" for Commercial UM/UIM (Act No. 770)** mandated insurers provide uninsured motorist (UM) liability coverage unless the insured explicitly rejects it or selects lower limits. However, this requirement does *not* apply to commercial automobile policies, making UM coverage for commercial vehicles an opt-in option. If the required form is signed but not properly completed, there will be no UM coverage if it is determined that the insured *intended* to reject or modify the UM coverage. The Act took effect on August 1, 2024.
- **Disclosure of "Foreign" Third-Party Financing Agreements (Act No. 765)** requires the disclosure of all foreign (out of state) third-party litigation financing agreements, making these agreements discoverable in litigation. The Act took effect on August 1, 2024.

These new laws are aimed to affect abusive issues within the legal system and follow in the footsteps of neighboring Florida and Georgia. However, whether these piecemeal measures over the last two sessions will be enough to make a lasting impact in Louisiana remains to be seen.

By: Skylar Comeaux, Zurich Staff Legal

Defense within limits policies:
The Silver State takes a step back

Nevada passed AB398 (codified as NRS 679.A210), which prohibits insurers domiciled in Nevada from issuing or renewing policies that offer "defense within limits" during its last legislative session in 2023. Unlike the majority of other states, Nevada holds session every two years instead of each year, so on June 3, 2025, it concluded its 83rd legislative session which addressed the unintended effects of this broadbrush prohibition.

A typical defense within limits policy includes both defense costs plus indemnification within the proffered limits of coverage. Thus, the costs of defense "erode" the policy limits, reducing the amount available to pay a settlement or judgment. "Defense outside limits" policies do not erode because of defense expenses and attorneys' fees. The former is often the policy of choice for professional liability policyholders while the latter for commercial liability policyholders. Further, the defense within limits is usually a fixed exposure while defense costs make defense outside limits policies more unwieldy.

While states such as Arkansas, Louisiana, Minnesota, New Jersey, New Mexico and New York have some prohibitions on defense within limits policies, the Nevada law was initially the broadest in the country. Faced with the unintended possibility of radical changes in available policies, the Nevada Division of Insurance issued regulation language clarifying restricted application of the law. The Department of Insurance's guidance has now been codified with the passage of AB 512, which will go into effect on October 1, 2025, and will bring the law in Nevada more in line with other states.

The 2023 passage of AB398 also prompted questions about the voice of the insurance industry in the state lawmaking process. Lawmakers seemed to be unfamiliar with the consequences of prohibiting defense within limits so expansively. Seeing the need for further education and advocacy on this issue, the insurance industry and the American Property & Casualty Insurance Association (APCIA) started the process of forming a Nevada civil justice organization. When asked directly about this, Mark Sektnan of APCIA remarked that the "need and interest in a Nevada organization dedicated to bringing a balanced approach to considering business and insurance voices has been overwhelming."

Currently, the Nevada Justice Association (NJA) represents consumer and trial lawyers' interests in the political space. There is no business-oriented equivalent, which leaves that voice unheard by lawmakers. The neighboring states of California (CJAC), Colorado (CCJL), and Texas (TCJL) each have their own business-led civil justice organization which work diligently to prevent the type of confusion that occurred in Nevada. The passage of AB398 served as an example of unintended consequences due to the lack of balanced opinions and information. Mark Sektnan further noted, "Our vision is to create a bipartisan discussion and provide businesses a voice in Nevada just like California's CJAC. Ultimately, a healthy economy requires that businesses, professionals, and corporations be able to provide goods and services to consumers and to afford insurance to provide them."

By: Mahima Raghav, Zurich CJLA

Staged accidents:
Legislation aimed at criminalizing fraud

The Coalition Against Insurance Fraud estimates insurance fraud costs American consumers at least $308.6 billion every year and occurs in about 10% of property-casualty insurance losses. New York, in particular, is struggling with a growing number of fraudulent insurance claims that arise from staged accidents. Staged accidents may involve an auto accident or take place at a construction site. Several pieces of legislation were introduced this session to address increased fraud in New York but did not get much traction during the 2025 legislative session.

New York drivers have seen an increase in staged auto collisions or "crash for cash" accidents. The New York Department of Motor Vehicles (DMV) notes that the Empire State had the second-highest number of such crashes in the nation during 2023. There were 1,729 staged crashes in New York state during 2023 – up 14% from 2022 and up 34% from 2021. In fact, the DMV's January 2025, press release includes a statement from Mark J.F. Schroeder, DMV Commissioner and Chair of the Governor's Traffic Safety Committee, cautioning New Yorkers to drive defensively and be aware that "[w]hen someone intentionally causes a crash to collect insurance money, it's called a staged crash or 'crash for cash,' which is a form of insurance fraud." This session, the "Staging a Motor Vehicle Accident" (A3851 / S5232) legislation was introduced. The bill would impose criminal penalties on anyone who directs, hires, or requests, another individual to cause a collision involving a motor vehicle.

Staged accidents may also occur at construction sites, as previously explained in a recent issue of the *Quarterly Digest*. New York Labor Law provisions include §240 of the Scaffold Law, protecting workers from any gravity-related incident on a work site, and §241(6) holding the owner and/or general contractor liable even if it provides the workers with appropriate safety devices. Both are susceptible to staged accidents which affect the construction industry as workers may feign injuries at sites in the hopes of receiving workers' compensation benefits and liability insurance payouts. Legislation addressing "Staging a Construction Site Accident" (A3800 / S5231) was introduced. The bill makes staging a construction accident for the purposes of insurance fraud a Class E Felony.

Both staged auto and construction accidents rely on "runners" to recruit others to perpetuate fraudulent schemes. Legislation criminalizing the act of being a runner or soliciting a runner was introduced during the 2025 legislative session (A7392/S4874). According to the proposed legislation, a "runner" is defined as someone who, for a pecuniary benefit, procures or attempts to procure a client, patient or customer at the direction of or request with a provider who is seeking to benefit from an insurance claim. The proposed legislation is patterned after the New Jersey runner law, N.J.S.A. 2C:21-22.1, and the federal Medicare-Medicaid Anti-Kickback Act, 42. U.S.C. §1320a-7b, which make it a crime to intentionally pay for patient referrals. The justification for the proposed New York legislation indicates that providers who commit insurance fraud have a rich incentive to use a runner to keep supplying patients to perpetuate fraud. The runner recruits patients who do not require treatment, were not involved in a motor vehicle accident, may exaggerate illness, or stage accidents. Without runners, "the patient supply for fraudulent clinics would dry up, and New York residents could save tens if not hundreds of millions of dollars."

At the conclusion of the 2025 legislative session, the three staged accident bills mentioned above remained in their respective committees. However, this legislation will carry over to the 2026 session although it is unclear whether this legislation will advance in the 2026 coming session.

By: Rebecca Fozo, Zurich CJLA

Trending topics

Navigating the new fraud frontier:
Top three commercial fraud trends in 2025

Fraud is a persistent and evolving threat that impacts all corners of the commercial insurance landscape. Schemes grow more sophisticated, driven by economic pressures, emerging technologies, and shifting regulations, which place customers and carriers on high alert. In 2025, three areas continue to show heightened fraud activity: transportation, medical, and cyber insurance. Understanding these trends assists in identifying risks early and applying effective strategies to prevent and mitigate losses.

Transportation fraud: the rise of staged and synthetic claims

The transportation sector continues to grapple with a surge in staged accidents, phantom cargo, and synthetic identity fraud. Fraudsters are exploiting supply chain vulnerabilities and the complexity of logistics networks to file inflated or entirely fictitious claims.

Fraudsters in the transportation sector are increasingly using double brokering scams, where they pose as legitimate freight brokers, reassign loads, and disappear with the cargo. Additionally, telematics tampering is becoming more common, with devices being manipulated to falsify vehicle location or speed data.

Key indicators include:

- Repeated claims from the same repair shops or medical providers.
- Inconsistent driver logs or GPS data that contradicts the claim narrative.
- Cargo theft claims with missing or unverifiable bills of lading.
- Use of newly registered LLCs with minimal operational history.

Medical fraud: AI-driven billing schemes and phantom networks

Medical fraud remains a persistent threat, especially in workers' compensation and auto injury claims. In 2025, a shift toward AI-generated billing fraud appeared, where bad actors are using automation to generate high volumes of fraudulent claims with realistic coding.

In the medical sector, fraud rings are creating phantom provider networks, establishing fake clinics with National Provider Identification (NPI) numbers, and billing insurers without ever seeing patients. Telehealth abuse is also on the rise, with fraudulent telemedicine consults being billed as in-person visits or specialist evaluations.

Key indicators in this area include:

- Excessive use of high-reimbursement CPT codes.
- Clusters of claims involving the same providers or diagnostic codes.
- Doctor shopping: Patients visiting multiple providers to obtain duplicate prescriptions or treatments, often to inflate claim values or conceal fraudulent intent.
- Medical records that fail to match the claimed injury: Discrepancies between reported injuries and documented medical evaluations can signal fabricated or exaggerated claims.

Cyber insurance fraud: exploiting digital claims and AI-generated evidence

As cyber insurance becomes a $16.3 billion market in 2025, fraudsters are targeting it with increasing sophistication. The most concerning trend is the use of AI-generated evidence to support fictitious ransomware attacks or data breaches.

Cyber insurance fraud is becoming more sophisticated, with fraudsters using deepfake ransom notes and fabricated system logs to simulate breaches. Business Email Compromise (BEC) claims are also being staged internally, and cybercrime-as-a-service platforms are offering fake breach kits.

Key indicators of this fraud type include:

- Claims involving obscure or unverifiable threat actors.
- Lack of forensic evidence or refusal to allow third-party investigation.
- Reuse of breach narratives across multiple insured entities.

Fraud in 2025 is faster, smarter, and more elusive than ever. Whether a staged truck collision, a phantom medical clinic, or a fabricated cyberattack, the common thread is the use of technology to obscure the truth. Knowing about these threats and understanding how they can occur should enable companies as well as carriers to be forewarned and therefore forearmed when dealing with the risks.

By: Delpha DiGiacomo, Zurich ZCIS

Trending topics

Validating Valisure:
The FDA attempts to break the cycle

Valisure identifies itself as an independent testing laboratory that performs quality assurance testing, addressing "a critical gap in the healthcare supply chain" by providing "transparency to quality and independent certification through chemical analysis." The company's website indicates that it offers independent certification, analytical studies and advocacy, vendor validation, consulting and other products that focus on science-based product quality. Specifically, the company touts that through its analytical studies and advocacy it gives its clients "unique insights into their own and competitive products" and that such insights "can lead to publications, reporting, filings." As discussed below, some of Valisure's analytical studies have led to reporting and filings, particularly in the consumer products and pharmaceutical forums.

The pattern that the following examples reveal appears to show that the results of Valisure's testing, which may have ties to the plaintiffs' bar, are routinely reported to the U.S. Food and Drug Administration (FDA) in the form of a Citizen Petition. A Citizen Petition filed with the FDA involves a formal process where individuals, organizations, or consumer groups can request the FDA issue, amend, or revoke regulation or take other administrative action with respect to drug approvals, food safety, medication regulation, etc. The process allows for public input in the FDA's regulatory decision-making process and can be made to change product labeling, challenge determinations of safe products or seek enforcement of existing regulations.

What is the concern with Valisure's testing and filing of Citizen Petitions? Not only has the FDA questioned the methodology and accuracy of Valisure's testing, Valisure's "independent" testing results shows signs of affiliation with the plaintiffs' bar and the generation of mass tort litigation. The filing of the Citizen Petition then leads to an explosion of class action and mass tort litigation. The pattern repeats and more litigation ensues.

Some examples:

Valisure reports that its testing of consumer products uncovered "widespread benzene contamination" in the following consumer products which resulted in various product recalls:

- Hand Sanitizers: In March 2021, Valisure announced 17% of the 260 hand sanitizer batches tested contained benzene.
- Sunscreens: In May 2021, Valisure reported 27% of 294 sunscreen batches tested resulted in recalls from Johnson & Johnson (Neutrogena & Aveeno) and Coppertone.
- Body Spray: In November 2021, Valisure claims its testing revealed 54% of 108 antiperspirant body spray batches contained benzene, leading to recalls of Procter & Gamble products, Old Spice, Secret, Aussie, Herbal Essences, and Waterless.
- Dry Shampoos: In November 2022, Valisure claimed that it found benzene in 60% of the 148 dry shampoo batches testing.

Valisure also reported "carcinogens in prescription drugs" with respect to:

- Valsartan: In June 2019, Valisure claimed that its testing revealed the presence of N,N-Dimethylformamide (DMF) – a probable human carcinogen.
- Metformin: In March 2020, Valisure claims to have detected N-Nitrosodimethylamine (NDMA) – a carcinogen.
- Zantac: Valisure claims to have determine that the medication could form N-Nitrosodimethylamine (NDMA) – a carcinogen during storage and digestion.

Following the pattern, Valisure's testing of dry shampoo products resulted in the filing of a Citizen Petition and then class action litigation. The class action matter captioned *Little v. Unilever United States, Inc.*, (3:22-cv-01189, U.S.D.C. Conn.) ensued just a few months after Valisure tested the company's dry shampoo product. Plaintiffs alleged that based on testing occurring from January to May 2022, Valisure revealed that Unilever's dry shampoo products "were contaminated, and have a material risk of being contaminated, with unsafe levels of benzene." The *Little* Complaint, filed in September 2022, alleged that Unilever should have known about the benzene contamination due to the Citizen Petition filed by Valisure. Thereafter, additional putative "copycat" class actions were filed in various districts and were later consolidated into the U.S. District Court for the District of Connecticut. The litigation dragged on for nearly three years.

Unilever questioned Valisure's testing arrangement, noting that Valisure was a consultant for plaintiffs even before Valisure filed a Citizen's Petition and further revealed that Valisure sent Unilever a proposed agreement to pay $1.25m up front, plus $250,000 a month over the term of the agreement for Valisure to keep Unilever's testing information confidential. Unilever declined to participate in Valisure's proposed agreement. A Notice of Settlement was filed with the Court in February 2025 and as of May 5, 2025, it appears the class action plaintiffs have asked the Court to approve a $3.6m settlement.

With respect to Zantac, Valisure's testing methods spurred thousands of mass tort lawsuits that culminated in multidistrict litigation (MDL). Valisure's testing claimed that Zantac could produce NDMA (N-nitrosodimethylamine), a carcinogen that may cause cancer. In a December 5, 2022, letter from the FDA to Valisure's CEO David Light, the FDA fired back with respect to the validity and accuracy of the company's testing citing "methodological deficiencies", including: failure to establish and document the accuracy, sensitivity, specificity, and reproducibility of its test methods; not adequately addressing out-of-specification test results; using instruments, apparatus, gauges, and/or recording devices that did not meet established specifications and failing to exercise appropriate controls over computer or related systems.

The next day, the MDL Court (Judge Robin Rosenberg) issued a 300 page opinion scrutinizing how Valisure's testing was flawed. The testing used an artificial stomach containing unnaturally high amounts of salt that humans could not safely ingest and heating the product to over 260 degrees (nearly double the average healthy person's body temperature), which did not pass muster – "there is no scientist outside this litigation who concluded ranitidine causes cancer." Judge Rosenburg's opinion resulted in dismissal of thousands of Zantac MDL claims.

Not only was Valisure's testing methodology called into question but there was a suggestion of coziness with the plaintiffs' bar. Emails produced during discovery indicated trial lawyers hired Valisure prior to the filing of the Citizen's Petition and that Valisure CEO's brother-in-law (a plaintiff's attorney) may have received testing information ahead of publication with lawsuits for Zantac being filed by him on the same day Valisure released the Citizen Petition.

Valisure has moved on to target acne medications. In March 2024, Valisure filed a Citizen Petition raising concerns about the active ingredient in the acne medications (benzoyl peroxide) possibly degrading into benzene. Following the filing of the Citizen Petition, 35 class actions were filed in 10 districts in the United States and litigation remains ongoing. The FDA initiated its own testing and recently announced that contrary to the data cited by Valisure in the Citizen Petition, more than 90% of the 95 products tested had undetectable or very low levels of benzene. The FDA further states that "use of unvalidated testing methods by third-party laboratories can produce inaccurate results leading to consumer confusion".

The acne medicine litigation appears to be following a pattern similar to that seen with other consumer and pharmaceutical products. Valisure conducts "independent" testing, a Citizen's Petition is filed with the FDA, mass tort litigation ensues. The FDA is pushing back on Valisure's testing in an attempt to validate Valisure's results, but it remains to be seen if this is enough.

By: Rebecca Fozo, Zurich CJLA

Trials & tribulations

Reasonableness and good faith:
Persuading the judge before persuading the jury

When an attorney loses control over a client who refuses to be reasonable, cases are forced to proceed to a jury trial. But when a *Plaintiff* refuses to engage in reasonable negotiations, showing the Court who actually is the reason for taking up the Court's time and resources can make the judge an ally in protecting the defendant's interests.

In a recent case, the client's tractor trailer made a sharp right turn out of a construction site, that due to the turn radius, placed it in the center lane of a city street, dedicated for traffic going straight, at a busy intersection where he needed to make another right turn. The right lane of traffic was for vehicles going straight or making right turns. The client's truck was the first vehicle at the light with its right turn signal on the entire time. Yet, Plaintiff approached the intersection with the intent of going straight, pulling into the right lane next to the trailer portion of the client's truck so he could sneak past him without having to wait for the slow truck.

When the traffic signal turned green, the truck began making its right turn while Plaintiff attempted to go straight. The truck driver was not able to see Plaintiff's vehicle and a minor impact occurred. As a result of the impact, Plaintiff claimed soft tissue injuries to his back, side, shoulder, and neck. At the time of the accident, Plaintiff had been operating within the course and scope of his employment as a driver for a local hospital.

Plaintiff inexplicably declined a very reasonable offer during the claim phase, requiring litigation. After discovery, the case was submitted to mandatory, non-binding arbitration before three attorneys which resulted in the Plaintiff receiving an award – significantly less that what had been offered prior to the litigation. Despite this commentary, Plaintiff appealed the arbitration award which allowed for a brief additional discovery period before attending a mandatory settlement conference. In that interim, a defense medical examination produced a narrative medical expert report thoroughly challenging any causal nexus between the accident and Plaintiff's alleged injuries.

More than two months after this second discovery deadline and immediately prior to the mandatory settlement conference, Plaintiff produced a very brief (less than two pages) expert medical report from a physician who did not examine Plaintiff and who based his report solely upon review of the medical records.

At the time of the mandatory settlement conference, once again the Plaintiff was not interested in the pre-litigation offer and further refused to provide any settlement demand. At this point, there would be no reasonable resolution of the case and trial was imminent.

Since there was clear fault on the part of the truck driver and always a concern of jury prejudice against a corporate defendant in a venue such as Philadelphia, a reasonable settlement was the preferrable resolution. So, trial tactics included demonstrating to the trial judge that Plaintiff's unreasonableness forced this case to the courthouse.

Two days prior to the start of the trial a judge was assigned. Despite the very late production of Plaintiff's medical expert and a motion *in limine* to preclude it, the judge expressed empathy but ultimately permitted the expert. The second motion *in limine*, however, sought to preclude evidence of Plaintiff's medical bills as he had treated with providers recommended by his attorney rather than through Workers' Compensation. These strategic pre-trial motions provided the judge's first glimpse into the flimsy and unreasonable nature of the case that Plaintiff had put together. The case proceeded to jury selection. (Philadelphia very recently changed its process from allowing the attorneys to essentially conduct the *voir dire* process on their own to having the judge involved. This new process served as a helpful reminder that the venue's reputation as being very plaintiff-friendly, existed for a reason. It also served as a reminder that no matter how strong of a case, it can be easily undermined by forces beyond counsel's control, making settlement an attractive alternative.)

Reasonableness and good faith: *Persuading the judge before persuading the jury*

The third strategic motion was based on objections to portions of the Plaintiff's expert physician's trial deposition testimony. Essentially, Plaintiff's counsel sought to have the doctor testify on matters that were beyond the scope of the very limited narrative report. This argument now forced the judge to review the expert report, revealing to her precisely how weak Plaintiff's case had been. The testimony subject to objection was precluded.

Calling the attorneys to her chambers, the judge told to Plaintiff's counsel that she had only just realized that her rulings effectively gutted Plaintiff's case, which then provided an invitation to the judge from Plaintiff's counsel to speak with his client. After this conversation, Plaintiff finally became willing to negotiate. While remaining stubborn, he ultimately agreed to settle the case for well below the limits of authority and for a number that made the defendant very happy.

Demonstrating reasonableness and good faith is imperative, regardless of the value of the case. This, along with strategic motions, made the judge an ally who reigned in those who sought to undermine the case and force it to a trial that was not in the best interest of the client. Here, persuading the judge, before needing to persuade the jury, made all the difference.

By: Christopher Morgan, Zurich Staff Legal

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Antitrust compliance is everyone's responsibility; however, ZNA's CJLA will monitor this publication and address any questions or concerns related to same.

For questions, submissions, or topics for discussion, contact lisa.bellino@zurichna.com.

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A1-P1045339-A (07/25) P1045339

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