Simpson Thacher

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A Florida appellate court held that a judgment in an insured's favor in an underlying property insurance breach of contract action does not preclude an insured from pursuing a subsequent first-party bad faith action seeking extra-contractual damages allegedly resulting from insurer's claims handling. *Healthy Food Experts, LLC v. AmGUARD Ins. Co.*, No. 4D2025-0181, 2026 Fla. App. LEXIS 4456 (Fla. Dist. Ct. App. June 10, 2026). (Click here for full article)

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Colorado Supreme Court Holds That Statutory Notice-And-Cure Requirements Do Not Apply To Conditions Precedent And Clarifies Exhaustion Standard For Excess UIM Coverage

HOLDING

The Colorado Supreme Court held that a Colorado statute requiring insurers to provide written notice and an opportunity to cure before asserting a failure-to-cooperate defense does not apply when an insurer relies on an insured's failure to satisfy enumerated conditions precedent to coverage. The court further held that excess underinsured motorist coverage is triggered when an insured's undisputed damages exceed the limits of underlying coverage, rejecting a rule requiring payment of the underlying policy limits before excess coverage may apply. *United Servs. Auto. Ass'n v. Wenzell*, 588 P.3d 711 (Colo. 2026).

BACKGROUND

In 2017, Anthony Wenzell was injured in an automobile accident and subsequently sought underinsured motorist ("UIM") benefits under policies issued by State Farm and United Services Automobile Association ("USAA"). The USAA policy, which was issued to Wenzell's brother and covered family members, contained an excess "other insurance" clause. Both insurers sought medical records and authorizations to determine which of Wenzell's claimed injuries were attributable to the 2017 accident and which stemmed from an earlier 2014 accident. The policies required Wenzell to provide information and authorizations reasonably necessary to evaluate his claims, and the insurers contended that these requirements were conditions precedents to coverage. According to the insurers, Wenzell failed to provide adequate medical releases and therefore failed to satisfy those conditions precedent.

In 2021, Wenzell sued State Farm and USAA for breach of contract and for bad-faith delay or denial of insurance benefits. The trial court granted summary judgment in favor of the insurers, concluding that there was no genuine dispute that Wenzell failed to comply with policy provisions requiring him to provide the requested medical information. The trial court also granted summary judgment to USAA on Wenzell's bad faith claim, holding that USAA's obligations as an excess insurer had not been triggered because Wenzell had not exhausted the underlying State Farm coverage.

The trial court did not address section 10-3-1118, C.R.S. (2025) ("section 1118"), a statute enacted in 2020 that limits an insurer's ability to assert a failure-to-cooperate defense. Under the statute, before relying on such a defense, an insurer must have sent a written request for information to insured and requested a response within 60 days, if no response has been received within the 60 days, insurer has 60 days from the expired deadline to provide written notice identifying the alleged failure to cooperate and afford the policyholder 60 days to cure the deficiency. On appeal the intermediate appellate court reversed, concluding that "section 1118's procedural requirements apply to all defenses when an insurer asserts that a policyholder failed to comply with a policy provision, not just those based in the general cooperation clause." The appellate court also concluded that USAA could not rely on the lack of underlying policy-limits payment to deny or delay coverage and held that any requirement that an insured receive payment of underlying policy limits before accessing excess UIM coverage was void as against public policy.

DECISION

The Colorado Supreme Court reversed in part and affirmed in part.

Addressing section 1118, the court considered whether the statute's notice-and-cure requirements apply only when an insurer invokes a common law failure-to-cooperate defense or whether they also apply when an insurer contends that the insured failed to satisfy an express condition precedent to coverage. The insurers argued that the policies' requirement that Wenzell provide medical records and authorizations necessary to evaluate his claim constituted such a condition precedent.

The court concluded that section 1118 did not abrogate the longstanding distinction between an insured's general duty to cooperate and an insured's contractual obligation to satisfy specific conditions precedent. Noting that the statute does not define the term "cooperate" and finding that term ambiguous, the court found no clear indication in either statutory text or legislative history that the General Assembly intended to eliminate that distinction. Accordingly, the court held that section 1118 applies only to common law failure to cooperate defenses and does not apply when an insurer relies on an insured's failure to satisfy a specifically enumerated condition precedent to coverage. The court further concluded that the policies' requirement that Wenzell provide medical records and authorizations constituted such a condition precedent. Because Wenzell failed to provide adequate medical releases, the insurers were entitled to rely on that defense without complying with section 1118's notice-and-cure procedures.

The court also addressed what it means for underlying insurance to be "exhausted" in the context of excess UIM coverage. Observing that Colorado had not previously adopted a definitive exhaustion standard in that setting, the court rejected a strict payment-limits approach under which excess coverage could not be implicated until the underlying insurer actually paid its policy limits. Instead, the court adopted an "undisputed-damages" approach, under which excess UIM coverage may be triggered when an insured's undisputed damages exceed the limits of the underlying policy.

Applying that standard, however, the court concluded that Wenzell could not establish exhaustion on the record before it because the extent of his accident-related damages remained disputed because the medical records needed to apportion costs from the 2017 accident had not been provided. Because Wenzell could not establish entitlement to benefits under the undisputed-damages approach, the court held that his claims for bad faith delay or denial of benefits against USAA failed as a matter of law.

Justice Berkenkotter dissented from that portion of the opinion addressing section 1118. She argued that the majority's interpretation was inconsistent with both the statute's text and legislative purpose. According to the dissent, distinguishing between general cooperation obligations and specific conditions precedent would allow insurers to avoid the statute's notice-and-cure requirements simply by drafting increasingly detailed policy conditions.

COMMENTS

The significance of the decision lies in the court's reaffirmation of the common law distinction between cooperation obligations and conditions precedent. By holding that section 1118 applies only to common law failure to cooperate defenses, the court avoided an interpretation that would have extended the statute's notice-and-cure requirements to defenses based on the insured's failure to satisfy express conditions precedent to coverage.

Texas Supreme Court Reaffirms Broad Right To Appraisal Despite Coverage, Causation, and Bad Faith Disputes

HOLDING

The Texas Supreme Court held that a trial court abused its discretion by denying insurers' motion to compel appraisal where the parties' dispute concerned, at least in part, the amount of loss. The court reaffirmed that potential disputes regarding coverage, causation, or alleged bad-faith claims handling generally do not defeat a contractual right to appraisal. *In re Ace Am. Ins. Co.*, No. 25-0461, 2026 Tex. LEXIS 411 (Tex. May 8, 2026).

BACKGROUND

The dispute arose from property damage sustained by a food-distribution warehouse following a ruptured water line. After repairing the property, the insured submitted a claim under its property insurance policy. The insurers paid portions of the claim but disputed the full amount sought by the insured.

The policy contained an appraisal provision allowing either party to demand appraisal if the parties "disagree on the amount of loss." The insurers invoked appraisal, asserting the parties had reached an impasse regarding the scope of damage and associated repair costs. The insured refused to participate, contending the appraisal was premature and unwarranted. Although the parties subsequently entered into a standstill agreement and engaged in further negotiations, they were unable to resolve their differences.

The insurers then filed suit to compel appraisal. The insured counterclaimed for breach of contract, violations of the Texas Insurance Code, bad faith, and declaratory relief, alleging that the insurers had failed to conduct a reasonable investigation, wrongfully refused to pay covered amounts, and invoked appraisal as leverage to force acceptance of an inadequate settlement. The trial court denied the motion to compel appraisal, and the court of appeals denied mandamus relief.

DECISION

The Texas Supreme Court granted the insurers' petition for mandamus relief and directed the trial court to compel appraisal.

The court began by reaffirming that appraisal clauses are "generally enforceable, absent illegality or waiver." Citing *State Farm Lloyds v. Johnson*, 290 S.W.3d 886 (Tex. 2009), the court emphasized that appraisal is designed to resolve disputes concerning the amount of loss, while courts remain responsible for resolving questions of coverage and liability. At the same time, the court reiterated *Johnson's* recognition that "any appraisal necessarily includes some causation element, because setting the amount of loss requires appraisers to decide between damages for which coverage is claimed from damages caused by everything else." The court further noted *Johnson's* admonition that "the fact that an appraisal may turn out to involve not just damage but also liability does not mean appraisal should be prohibited as an initial matter." According to the court, *Johnson* establishes a "significant hurdle" for a party seeking to avoid appraisal. Unless the "'amount

of loss' will never be needed" to resolve the parties' dispute, appraisals should proceed without preemptive judicial intervention.

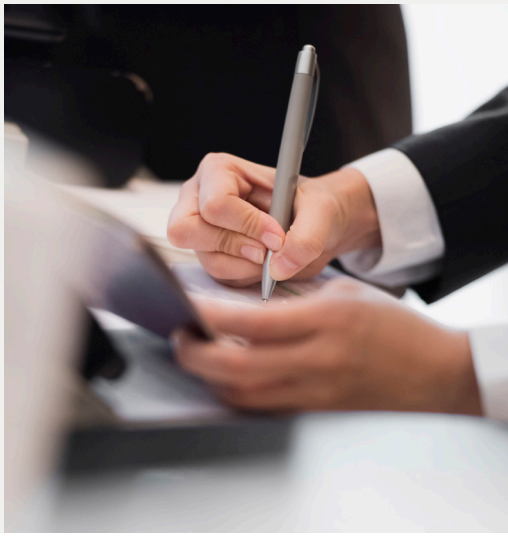
Applying these principles, the court concluded that the parties' dispute involved, at least in part, the amount of loss. Although the insured attempted to characterize the dispute as one involving coverage and claims handling, the court found that the parties' disagreement concerning mold remediation, building-code compliance expense, and replacement cost valuation all implicated the amount of loss and therefore fell within the scope of appraisal.

With respect to mold remediation, the court concluded that disputes regarding allocation of mold-related losses among insurers and whether remediation should have been priced on a time-and-materials basis or a fixed-price basis were disputes over the cost of loss, not the existence of coverage. Similarly, insurers' contention that certain repairs were more extensive than necessary presented a disagreement regarding the proper scope and cost of repairs—an appraisal issue rather than a coverage issue. The court likewise concluded that disagreements concerning the replacement cost measure of loss implicated valuation questions appropriately raised through appraisal.

Finally, the court also rejected the insured's contention that the insurers' alleged bad faith claims handling and prior material breach excused compliance with the appraisal provision. The court emphasized that Texas law recognizes only "two specific, limited exceptions" to the enforcement of an appraisal clauses—illegality and waiver. Neither exception was present. The court further observed that the court of appeals had already rejected the insured's prior breach theory because it effectively "puts the cart before the horse." Determining whether the insurers materially breached the insurance policy would require a court to adjudicate the merits of the parties' dispute before appraisal occurs, contrary to the role appraisal is intended to play in the claims adjustment process. As *Johnson* recognized, appraisal is designed to occur before suit is filed and before courts are asked to resolve the parties' substantive disputes. Accordingly, the court held that allegations of bad faith or other purported breaches by the insurer do not create an independent exception to an otherwise enforceable appraisal clause.

COMMENTS

The decision strengthens insurers' ability to compel appraisal in Texas by reaffirming that appraisal should proceed whenever the parties' disagreement concerns, at least in part, the amount of loss. The ruling also provides guidance on the proper sequencing of first-party property disputes. Even where the insured asserts coverage defenses, bad faith allegations, or other extra-contractual claims, those issues generally do not prevent appraisal from going forward. Instead, appraisal remains the mechanism for determining the amount of loss, with any remaining coverage and liability issues to be resolved afterward.



California Appellate Panel Holds FTC Civil Investigative Demand Does Not Constitute A Covered "Claim" Under Excess E&O Policy

HOLDING

In an unpublished decision, the California Court of Appeal affirmed summary judgment in favor of an excess errors and omissions ("E&O") insurer, holding that a Federal Trade Commission ("FTC") civil investigative demand ("CID") was neither a demand for "non-monetary relief" nor a covered "Regulatory Proceeding," and therefore did not constitute a covered "Claim" under the policy. *Zoom Video Commc'ns Inc. v. Underwriters at Lloyd's, London,* No. H052221, 2026 LX 297743 (Cal. Dist. Ct. App. May 27, 2026).

BACKGROUND

In 2019, the FTC issued a CID to Zoom Video Communications, Inc. ("Zoom") to investigate whether Zoom had engaged in unfair or deceptive practices in violation of Section 5 of the FTC Act. The CID included interrogatories and document requests concerning Zoom's privacy and security practices. Zoom ultimately incurred more than $6.6 million in costs and fees responding to the CID and the ensuing FTC investigation, which culminated in a consent agreement and order requiring Zoom to implement and maintain a comprehensive information security program and related compliance measures.

While the FTC investigation was ongoing, Zoom also faced multiple lawsuits alleging that it had misrepresented its data security practices and improperly disclosed users' personal identifying information to third parties. Zoom ultimately settled at least one class-action lawsuit for $85 million.

Zoom sought coverage from multiple primary and excess E&O policies for costs associated with the CID, the FTC investigation, and the related litigation. After settling with its primary insurers and all excess insurers except for Underwriters at Lloyd's, London ("Underwriters"), Zoom pursued coverage litigation against Underwriters.

The parties disputed whether the FTC CID constituted a "Claim" under the policy. The policy defines "Claim" in relevant part to include a written demand for "non-monetary or injunctive relief" and a "Regulatory Proceeding" as "a suit, civil investigation or civil proceeding by or on behalf of a government agency . . . commenced by the service of a complaint, or similar pleading based on an alleged or potential violation of Privacy or Cyber Laws[.]" The policy further defines "Privacy or Cyber Laws" as "identity theft and privacy protection laws . . . or regulations that require commercial entities that collect Protected Information to . . . adopt specific privacy or security controls."

The trial court held that the CID was not a "Claim" because it was neither a demand for non-monetary relief nor a "Regulatory Proceeding," and entered judgment for Underwriters.

DECISION

The California Court of Appeal affirmed.

First, the court held that the CID was not a covered "Claim" because it was not a demand for "non-monetary relief." Looking to the ordinary meaning of the term, the court concluded that "non-monetary relief" refers to legal redress akin to what a party would seek from a court, distinct from monetary damages or injunctive relief. The CID sought only documents, information, and responses to interrogatories in connection with the FTC's investigation and did not allege any wrongdoing or seek any form of legal redress. The court also emphasized that interpreting "non-monetary relief" broadly enough to encompass mere demands for documents or information would render the policy's separate definition of "Regulatory Proceeding" largely superfluous, contrary to established principles of contract interpretation.

Second, the court held that the CID did not qualify as a covered "Regulatory Proceeding." The policy limited that term to proceedings based on alleged or potential violations of "Privacy or Cyber Laws," defined as identity theft protection laws or regulations requiring entities that collected protected information to adopt specific privacy or security controls. The court concluded that Section 5 of the FTC Act did not satisfy that definition. The court reasoned that although Section 5 broadly prohibits unfair or deceptive acts or practices and authorizes the FTC to police privacy- and cybersecurity-related conduct, it does not adopt specific privacy or security controls. Because Section 5 imposes no such affirmative obligations on regulated entities, the court concluded it was not a "Privacy or Cyber Law." Accordingly, the CID was not a covered "Regulatory Proceeding" and therefore could not constitute a covered Claim.

Because the CID did not constitute a covered "Claim," the court held that coverage under the excess policy was not triggered and affirmed judgment for Underwriters. Zoom's coverage theory depended on treating the CID as the initial Claim to which the subsequent FTC proceedings and related consumer litigation could be tied through the policy's interrelated claims provisions. Having concluded that the CID was not a covered Claim, the court found it unnecessary to address whether those later matters were interrelated claims.

COMMENTS

Although unpublished and therefore generally not citable as precedent under California Rules of Court, the *Zoom* decision provides support for insurers facing claims for regulatory investigation costs under policies that do not expressly cover subpoenas, civil investigative demands, or similar information-gathering requests. The court rejected authority treating investigative subpoenas as demands for "non-monetary relief" and instead held that the term refers to legal redress akin to what is sought from a court. Courts across the country continue to take diverging approaches on this issue, with the majority finding a subpoena or CID seeking the production of documents or testimony is a demand for "non-monetary relief."

The decision also underscores the importance of policy-specific definitions. Rather than broadly characterizing the FTC Act as a privacy or cybersecurity law, the court focused on the particular policy's definition of "Privacy or Cyber Laws" and concluded that Section 5 of the FTC Act did not qualify because it does not require entities to adopt specific privacy or security controls. The opinion therefore illustrates how investigation-coverage provisions may limit coverage for regulatory inquiries even where the underlying investigation concerns privacy or cybersecurity practices.

California Federal Court Holds Umbrella Insurer Must "Drop Down" And Defend Sexual Abuse Actions

HOLDING

A California federal court held that an umbrella insurer owes a duty to defend underlying sexual abuse lawsuits pursuant to a "Defense Settlement" provision requiring it to defend suits involving occurrences "not covered" by underlying insurance. The court concluded that, in the context of the policies at issue, the phrase "not covered" refers to the scope of indemnity coverage provided by the underlying policies, rather than whether the underlying insurer would have owed a duty to defend. *Westchester Fire Ins. Co. v. Roman Cath. Bishop of Orange*, No. 8:24-cv-01539 (C.D. Cal. June 1, 2026).

BACKGROUND

More than 200 lawsuits were brought against the Roman Catholic Bishop of Orange ("RCBO") under California's Childhood Victims Act ("CCVA"), which revived or extended the statute of limitations for childhood sexual abuse claims. RCBO was insured under primary commercial general liability policies issued by Centennial and under umbrella policies issued by a predecessor to Westchester.

Centennial was later placed into liquidation and did not provide defense or indemnity for any of the CCVA actions. The Westchester umbrella policies contain a "Defense Settlement" provision requiring Westchester to defend suits involving "any occurrence not covered, as warranted, by the underlying policies . . . but covered by the terms and conditions of this policy[.]" The underlying Centennial policies define "occurrence" as an "accident" and cover "bodily injury." By contrast, the Westchester umbrella policies define "occurrence" more broadly as "an accident or happening or event," and extend coverage to "shock, mental anguish and mental injury."

Westchester commenced a declaratory judgment action seeking a determination that it had no duty to defend or indemnify unless the underlying Centennial limits were exhausted. RCBO counterclaimed, arguing that the Defense Settlement provision affords primary "drop down" coverage for occurrences covered by the umbrella policies but not by the underlying insurance. The parties filed cross-motions for partial summary judgment on the drop-down duty to defend issue.

DECISION

The court granted summary judgment to RCBO, holding that Westchester owed a duty to defend the CCVA actions under the Defense Settlement provision.

The principal dispute concerned the meaning of the phrase "any occurrence not covered" in the Defense Settlement provision of the umbrella policies. Westchester argued that an occurrence is "covered" whenever the underlying insurer would owe a duty to defend. Under that interpretation, because the CCVA complaints alleged claims at least potentially within the Centennial policies, Centennial's duty to defend would be triggered, and, therefore, Westchester would have no independent defense obligation. RCBO argued that "any occurrence not covered" refers to the scope of indemnity coverage provided by the underlying policies. The court agreed with RCBO.

The court emphasized that the distinction was "significant" because the duty to defend is broader than duty to indemnify. The court noted that, under California law, an insurer that owes a duty to defend a single potentially covered claim must defend the entire action, including claims that ultimately may fall outside the policy's indemnity coverage. Accordingly, the fact that Centennial would have owed a defense did not establish that all of the occurrences and injuries alleged in the CCVA complaints were actually covered by the underlying policies. The court therefore concluded that the phrase "occurrence not covered" refers to the scope of indemnity coverage afforded by the underlying insurance rather than existence of a defense obligation.

Applying that interpretation, the court concluded that the CCVA complaints alleged occurrences and injuries potentially covered by the umbrella policies but not by the underlying Centennial policies. Westchester argued that the relevant "occurrence" was RCBO's alleged negligent supervision, retention, and hiring of clergy, which it contended constituted an "accident" under the Centennial policies. According to Westchester, the alleged abuse and resulting injuries were merely effects of that occurrence, and therefore Centennial's duty to defend precluded any drop-down obligation.

The court rejected that argument. It reasoned that even if the negligence allegations were sufficient to trigger Centennial's duty to defend the entire action, that fact did not resolve whether the underlying policies actually provided indemnity coverage for all of the conduct and injuries alleged in the CCVA complaints. Nor did it answer whether the complaints alleged occurrences falling within the umbrella policies' broader definition of "occurrence." The court therefore declined to treat RCBO's alleged negligence as the sole relevant occurrence and instead examined the full range of conduct and injuries alleged in the underlying actions.

The court pointed to allegations of intentional infliction of emotional distress, sexual harassment, sexual battery, and human trafficking, as well as non-physical injuries involving grooming, exploitation, humiliation, loss of dignity, and invasion of privacy. It concluded that such allegations potentially constitute a "happening or event" causing "shock, mental anguish and mental injury" within the meaning of the umbrella policies, while not necessarily constituting an "accident" resulting in "bodily injury" under the underlying Centennial policies. Because the complaints alleged occurrences potentially covered by the umbrella policies but not by the underlying policies, the court held that Westchester's drop-down defense obligation was triggered.

COMMENTS

The court addressed a novel question concerning the interaction between California's duty to defend rules and an umbrella insurer's drop-down obligations. Despite the fact that the underlying insurer would have owed a duty to defend the entire action based on potentially covered negligence claims, the court focused on the scope of the underlying insurer's indemnity coverage and the broader coverage afforded by the umbrella policies. The decision underscores the significance of differences in policy language between primary and umbrella coverage.

Florida Appellate Court Holds Underlying Coverage Judgment Does Not Bar Insured's First-Party Bad Faith Claim

HOLDING

A Florida appellate court held that a judgment in an insured's favor in an underlying property insurance breach of contract action does not preclude an insured from pursuing a subsequent first-party bad faith action seeking extra-contractual damages allegedly resulting from insurer's claims handling. *Healthy Food Experts, LLC v. AmGUARD Ins. Co.*, No. 4D2025-0181, 2026 Fla. App. LEXIS 4456 (Fla. Dist. Ct. App. June 10, 2026).

BACKGROUND

AmGUARD issued a commercial insurance policy to a restaurant that included coverage for business personal property (up to $30,000), business income (up to $1,000,000), and food spoilage (up to $10,000). According to the insured, after the restaurant's ceiling collapsed and the fire department deemed the premises unsafe, the insurer hired an engineer who concluded that the collapse resulted from a "sudden and accidental occurrence," and its field adjuster estimated recoverable losses of $60,000. The insured further alleged that the insurer denied coverage for business personal property and business income losses, paying only for food spoilage, and did not disclose the engineer's or the field adjuster's conclusions to the insured.

The insured sued the insurer for breach of contract. Following a 2022 trial, the jury found that defective construction and hidden decay had caused the collapse and awarded the insured $31,330 in damages. While the insurer's appeal of that judgment was pending, the insured filed a civil remedy notice ("CRN") alleging that the insurer had wrongfully denied the claim and concealed information supporting coverage. The insurer did not pay the amount demanded in the CRN during the statutory sixty-day cure period. After the judgment was affirmed on appeal, the insurer paid the judgment in full.

In 2023, the insured commenced a first-party bad faith action seeking extra-contractual damages. The insurer moved to dismiss, arguing that, under *Fridman v. Safeco Insurance Co. of Illinois*, 185 So. 3d 1214 (Fla. 2016), the breach of contract judgment fixed the insured's damages, and that the insured could not maintain a bad faith claim because the judgment did not exceed policy limits. The trial court agreed and dismissed the complaint.

DECISION

The appellate court reversed, concluding that the trial court misapplied *Fridman*. The court explained that *Fridman* arose in the uninsured/underinsured motorist ("UM/UIM") context, where Florida law permits an insured to recover the full extent of his or her damages, including damages exceeding policy limits, in a subsequent bad faith action. In that setting, a determination of the insured's damages in the underlying action is binding in the later bad faith proceeding to avoid relitigating of the same issue. According to the court, those principles do not apply in the same manner to first-party property insurance claims. Unlike UM/

UIM claims, first party property bad faith actions do not provide a mechanism for recovering actual property damages in excess of policy limits. Rather, the insured may seek extra-contractual damages, resulting from the insurer's alleged bad faith conduct, including damages that are the "natural, proximate, probable, or direct consequence of the insurer's bad faith."

The Court emphasized that such extra-contractual damages are distinct from contractual policy benefits at issue in breach of contract action and could not have been litigated in that proceeding. The court further noted that evidence related to claims handling and allegations of bad faith generally are not admissible in a coverage trial, reinforcing the conclusion that those issues were neither litigated nor resolved by the underlying judgment.

COMMENTS

The decision narrows insurers' ability to rely on *Fridman* to argue that an underlying coverage judgment fixes the damages recoverable in a subsequent first-party bad faith action. The court distinguished the UM/UIM context addressed in *Fridman* and held that an insured may pursue extra-contractual damages that could not have been recovered in the underlying coverage action. At the same time, the opinion does not address the scope of recoverable extra-contractual damages or the causation required to recover them. Rather, insurers are likely to argue that any claimed extra-contractual damages must be separate from the policy benefits awarded in the coverage action and must have been caused by the insurer's alleged bad faith claims handling.

English Commercial Court Dismisses Contingent Insurers' Contribution Claims Worth Over US$340 Million In Russian Aircraft Litigation

HOLDING

The English Commercial Court struck out and granted summary judgment dismissing contribution claims brought by two contingent war risk insurers against primary war risk reinsurers, holding that the contingent reinsurers' claims were for subrogation, not contribution. *The Russian Aircraft Litig. – Operator Policy Claims* [2026] EWHC 1134 (Comm) (13 May 2026).

BACKGROUND

This dispute arose following Butcher J's judgment in *Re Russian Aircraft Policy Claims* [2025] EWHC 1430 (Comm), which concerned claims by AerCap and Merx, aircraft leasing companies that owned aircraft and engines leased to Russian airlines. Following Russia's invasion of Ukraine in February 2022, AerCap and Merx sought coverage under insurance policies taken out to protect their interests as lessors (the "Lessor Policies"). Pursuant to the Butcher J judgment, two Lessor Policy insurers together paid over US$340 million to AerCap and Merx.

Having paid their share of the judgment, those two Lessor Policy insurers then brought contribution claims against the war risk reinsurers of insurance policies taken out by the lessees, or operators, of the aircraft (the "Operator Policies"), contending that those Operator Policy reinsurers bore primary responsibility for the loss. The claims rested on: (i) indemnity principles applicable where a secondary obligor discharges a primary obligor's liability; (ii) double insurance; and (iii) the Civil Liability and Contribution Act 1978. The Operator Policy reinsurers applied to strike out the claims, or for summary judgment.

DECISION

The court struck out the contribution claims on all three bases.

On indemnity and reimbursement, the Court held that payments made by the Lessor Policy insurers did not discharge any liability owed by the Operator Policy reinsurers under the Operator Policies. Applying the fundamental principle that a payment by an insurer to its insured is a matter between those two parties alone and does not discharge any third-party liability, the Court held that the paying insurer's remedy must lie in subrogation rather than a direct claim.

The Court next rejected the attempt by the Lessor Policy insurers to characterize the case as one approximating double insurance, or in the alternative, as something similar to a guarantee as "both novel and wrong in principle." Double insurance requires co-ordinate liability between insurers, *i.e.,* where each insurer is independently liable to the same insured for the same loss, with the insured free to choose which to claim against. The Court found that the Lessor Policies were contingent, not co-ordinate: they only responded because the Operator Policies had failed to pay, the lessors had no free choice of insurer, and there was no mutuality because the Operator Policy reinsurers could never have claimed contribution from the Lessor Policy insurers.

The Court further held that the Civil Liability and Contribution Act 1978 did not apply because the Operator Policy reinsurers' alleged liability was based in debt under Russian law and they were therefore not "liable in respect of any damage" as required by the Act. The Court held that the claims would fail in any event because the payments had not discharged the Operator Policy reinsurers' liability, a necessary precondition for a claim under the Act. The Court also noted that it was inclined to agree with the "bold" submission that the Act would not apply between insurers but declined to decide this given unresolved conflict in Supreme Court decisions on this point.

COMMENTS

The judgment provides clarity on when subrogation, rather than a contribution or indemnity claim, is the appropriate recovery route for a paying insurer against a party it alleges is primarily liable. The practical consequences of that distinction were significant in this case.

Simpson Thacher's Insurance Practice Honored By *Chambers USA*, *Legal 500*, And *Benchmark Litigation*

Chambers USA 2026: Insurance: Dispute Resolution: Insurer (Band 1)

- **Bryce Friedman:** *Insurance: Dispute Resolution: Insurer (Band 1 ranked both in NY and Nationwide)*
- **Lynn Neuner:** *Insurance: Dispute Resolution: Insurer (Band 2 ranked in NY)*

Legal 500 2026: Insurance: Advice to Insurers (Tier 1)

- **Bryce Friedman:** *Insurance: Advice to Insurers (Hall of Fame); Leading Trial Lawyer*
- **Lynn Neuner:** *Insurance: Advice to Insurers (Hall of Fame)*
- **Joshua Polster:** *Insurance: Advice to Insurers (Next Generation Partner)*

Benchmark Litigation 2026: Insurance Firm of The Year (12th time)

- **Bryce Friedman:** *shortlisted for "Insurance Litigator of the Year"*
- **Joshua Polster:** *named "Future Star"*

Simpson Thacher

Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

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Simpson
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** In February 2026, Simpson Thacher announced plans to expand its presence in Texas with an office in Dallas.*

*** In April 2026, Simpson Thacher announced plans to expand its presence in Asia with an office in Singapore.*

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