Simpson Thacher

Insurance Law Alert

April 2025

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"Simpson Thacher's insurance practice group is among the best in the country. Their attorneys are supremely intelligent, hardworking, and regularly handle the most complex and high dollar insurance coverage claims in the nation."

– The Legal 500
(quoting a client)

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Illinois Court Addresses Scope Of Coverage For Losses Arising Out Of Cyber-Crime Incident Under Two Policies

An Illinois district court ruled that an exclusion in one policy barred coverage for wire transfers stemming from fraudulent emails, but that issues of fact precluded a ruling as to coverage under a computer fraud provision in another policy. *Office of the Special Deputy Receiver v. Hartford Fire Insurance Co.*, 2025 U.S. Dist. LEXIS 60484 (N.D. Ill. Mar. 31, 2025). (Click here for full article)

Illinois Court Rules That State Privacy Laws Do Not Apply To Life Insurance Applications

An Illinois district court dismissed a life insurance applicant's putative class action alleging violations of state privacy laws, ruling that such laws did not apply to life insurance underwriting. *Thompson v. Prudential Ins. Co. of Am.*, 2025 U.S. Dist. LEXIS 61405 (S.D. Ill. Mar. 31, 2025). (Click here for full article)

California Department of Insurance Issues Bulletin Regarding Coverage For Wildfire Smoke Damage

In the wake of the Los Angeles wildfires of January 2025, the California Insurance Commissioner issued a Bulletin last month seeking to clarify the regulations for insurance companies in evaluating wildfire-related damage claims. (Click here for full article)

Simpson Thacher News

Click here to read more about the Firm's insurance-related publications and speaking engagements.

Pennsylvania Court Rules That Insurer's Use Of Software In Appraisal Process Did Not Constitute A Breach Of Contract

HOLDING

A Pennsylvania district court granted a property insurer's summary judgment motion, ruling that its selection of a particular setting in an appraisal software program did not constitute a breach of contract. *Belotti v. State Farm Fire & Cas. Co.*, 2025 U.S. Dist. LEXIS 54471 (M.D. Pa. Mar. 25, 2025).

BACKGROUND

Homeowners notified State Farm of a fire that allegedly caused "catastrophic" damage to their home. The homeowners retained a public adjuster and State Farm hired a contractor to jointly inspect the loss. Both State Farm's and the homeowners' estimates were established using a software tool called Xactimate. State Farm's specialist selected a "new construction" labor efficiency in the software based on his understanding that the repair work would essentially be new construction and the homeowners would not occupy the property during reconstruction. The homeowners' public adjuster selected a "Restoration/Service/Remodel" labor efficiency setting in the software program. Because of the differently selected labor efficiencies, the homeowners' replacement cost estimate was approximately $200,000 higher than State Farm's estimate.

State Farm demanded appraisal, and the parties' respective appraisers ultimately reached an agreement as to the amount of loss. The appraisal award, which was higher than State Farm's estimate but lower than the homeowners' estimate, did not involve use of Xactimate software.

The homeowners brought suit, alleging breach of contract, breach of the implied covenant of good faith and fair dealing, declaratory relief, and violations of state statutory law. The court granted State Farm's summary judgment motion, dismissing all claims.

DECISION

The crux of the homeowners' breach of contract claim was that State Farm's use of the "new construction" setting on Xactimate violated a policy provision requiring State Farm to "pay the cost of repair or replacement" of the "damaged part of the property" with "similar construction." The homeowners asserted that use of State Farm's selected setting in Xactimate was "nowhere made a term of the policy nor disclosed in the Policy." Additionally, the homeowners argued that the phrase "damaged part of the property" requires "an estimation model that strictly covers costs to repair or replace, and thus not a 'new construction model.'"

Rejecting these assertions, the court ruled that State Farm had no contractual duty to use any "singular method of computation" when estimating losses. The court explained that the policy only requires use of "similar construction," stating: "We cannot identify any language that directly or indirectly concerns

any method of computation within the provision, much less any language that requires a singular method of computation. The language of an insurance policy should not be stretched beyond its plain meaning to create ambiguous terms."

Having determined that State Farm did not breach the contract, the court dismissed the bad faith and statutory claims relating to unfair practices and deceptive acts. The court noted that the bad faith claim also involved allegations relating to State Farm's conduct throughout the appraisal process (beyond use of the "new construction" Xactimate setting) but concluded that the record was devoid of evidence that substantiated those allegations.

COMMENTS

The decision not only sets a clear parameter relating to the interpretation of unambiguous policy language, but also reinforces an important principle relating to bad faith claims. The fact that the parties' appraisers ultimately assigned a higher value to the claim than State Farm's estimate does not mean that State Farm acted in bad faith. Similarly, an unusually lengthy appraisal process, as was the case here due to external, uncontrollable factors, does not in itself constitute an unreasonable delay for purposes of establishing bad faith.

Delaware Court Rules That Bodily Injury Claims Arising From Policyholder's Products Constitute A Single "Occurrence" Under The Policies

HOLDING

A Delaware trial court ruled that claims alleging bodily injury from the insured's products arose from a single "occurrence" and that loss must be allocated across multiple policies. *Mattel, Inc. v. XL Insurance America, Inc.*, 2025 Del. Super. LEXIS 145 (Del. Super. Ct. Mar. 28, 2025).

BACKGROUND

Mattel was named in various product liability suits alleging that design defects in a Rock n' Play Sleeper ("RNPS") resulted in bodily injury or death to infants. The first RNPS claim alleged bodily injury that occurred in 2013.

In 2023, Mattel sought a declaration regarding the defense and indemnity obligations of its primary, umbrella and excess insurers whose policies were in effect from 2011 through 2020. The parties filed summary judgment motions, asking the court to determine how Mattel's liability should be allocated across the nine years of insurance coverage towers.

Mattel and Chubb, its primary insurer, argued that the RNPS claims constituted a single occurrence that should be "batched" into a single policy year. In contrast, Great American, an excess insurer, argued that unresolved issues relating to policy interpretation preclude a summary judgment ruling as to the number of occurrences.

DECISION

The court ruled that the RNPS claims constitute a single "occurrence," defined by the primary policies as "an accident, including continuous or repeated exposure to substantially the same harmful conditions." The primary policies also include a Lot or Batch Clause Endorsement, which treats "as a single occurrence" any injury "included in the 'products-completed operations hazard' "and that "[a]rises out of any one 'lot' of 'your product.'" In addition, the policies contain a "Deemer Clause," which deems all injuries arising out of one "lot" of products to occur whenever the injury in the first-filed claim occurred.

The court reasoned that the RNPS products are the same or substantially similar, as they are all part of the same product line bearing the same alleged design defect, namely, the product's incline angle. The court rejected Great American's assertion that the court could not yet determine whether the RNPS claims arose out of the same defects and that a proximate causation finding is necessary in order to determine the number of occurrences.

Turning to the issue of allocation among the umbrella and excess policies in effect during the relevant time frame, the court ruled that the RNPS claims must be allocated to the policy year in which a given claimant's bodily injury actually occurred. The court noted that the claims could not be "batched" into the 2013 policy year because the umbrella policies did not contain a "Deemer Clause" allowing allocation of a multi-year occurrence into a particular policy year. While the umbrella policies did include an Occurrence Amendatory Endorsement, which allowed aggregation of claims arising from the same alleged hazard in substantially similar products into one occurrence, those policies lacked the type of Deemer Clause that was included in the primary policies.

Although the court had previously ruled that California law governs the dispute, it expressly rejected the application of California's "all-sums-with-stacking allocation rule," as set forth in *Montrose Chemical Corp. v. Admiral Ins. Co.*, 913 P.2d 878 (Cal. 1995) and *Montrose Chemical Corp. v. Superior Court of Los Angeles County*, 460 P.3d 1201 (Cal. 2012). The court explained that those cases involved long-tail, indivisible injuries caused by ongoing events, whereas the present case involved discrete injuries occurring at specific times. The court also rejected the notion that the claimants' mental anguish stemming from bodily injures was a long-tail injury, noting that under that theory, virtually any personal injury case could be categorized as long-tail based on emotional healing time. Such an application "exceeds the reasonable bounds of California's 'all-sums-with-stacking' caselaw." Therefore, the court endorsed an allocation for umbrella and excess policies based on "bodily injury which actually happened during a particular Policy's year."

COMMENTS

The ruling also addressed an issue of policy interpretation that arises when umbrella and excess policies "follow form" to underlying primary policies, but also contain provisions that change the scope of coverage from that provided by the primary policies. Great American's policy included a clause stating that it "will not be required to assume charge of the investigation of any claim or defense of any suit" against the insured. The policy also contained a Following Form Coverage Endorsement, which states that it follows form to the underlying umbrella policy, which includes a duty to defend.

The court ruled that Great American had a duty to defend, notwithstanding the provision disclaiming that obligation. The court reasoned that the Following Form Coverage Endorsement explicitly referenced nine items in its policy that supersede the terms of the underlying policy, and that the duty to defend disclaimer was not one of them.

Applying Washington Law, New York Court Rules That Ghost Gun Suits Do Not Allege An Occurrence Under Liability Policies

HOLDING

A New York district court ruled that an insurer was not required to defend or indemnify underlying lawsuits relating to the sale of ghost gun components. *Granite State Insurance Co. v. Rainer Arms LLC*, No. 2025 U.S. Dist. LEXIS 57651 (S.D.N.Y. Mar. 27, 2025).

BACKGROUND

Rainer, a Washington-based gun retailer, was a defendant in several suits for its alleged involvement in the sale of unfinished firearms, receivers, and frames that can be used to assemble "ghost guns" (guns that lack serial numbers, registration, or other means of tracing). The suits, filed by several municipalities in New York, all contain similar allegations relating to Rainer's marketing and sale of "unfinished" parts that are easily convertible into a ghost gun. The complaints further allege that Rainer evaded federal and state laws pertaining to the sale of firearms and that the target audience for such parts was consumers who otherwise could not legally purchase a firearm from a licensed retailer. Because of these and other actions, the suits alleged that New York faces a public health and safety crisis caused in part by violence involving ghost guns.

Rainer sought coverage from Granite, its general liability insurer. Granite disclaimed coverage on several bases, including that the suits did not allege a covered "occurrence." In ensuing litigation, Granite sought a declaration that it had no duty to defend Rainer in the underlying suits and moved for summary judgment on that issue. The court granted the motion.

DECISION

The policies defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Under Washington law, an "accident" (where, as here, undefined in the policy) means "an unusual, unexpected, and unforeseen happening." Further, a deliberate act can never constitute an "occurrence" unless "some additional unexpected, independent and unforeseen happening occurs which produces or brings about the result of injury or death."

Applying this legal standard, the court concluded that the ghost gun suits alleged only deliberate conduct. In particular, the court emphasized allegations relating to intentional, repeated, and longstanding actions involved in the marketing and sale of gun components in contravention of applicable laws. The court rejected Rainer's assertion that the suits nonetheless alleged an occurrence because the injuries were not intended by Rainer, explaining that "case law makes clear that the relevant inquiry . . . is whether the *conduct* was deliberate, not whether the injuries that resulted were intended" (emphasis in original).

The court also rejected Rainer's contention that claims for negligence in the underlying suits give rise to a possible "occurrence." Emphasizing that courts must look to the nature of the conduct rather than labels or causes of action, the court concluded that "the complaints are devoid of facts alleging non-deliberate conduct," even as to the negligence claims.

Additionally, the court held that the alleged conduct did not include any independent and unforeseen happening that could give rise to an "occurrence" notwithstanding Rainer's intentional conduct. The court stated that "no reasonably prudent person could find that

the harms alleged were unforeseeable—certainly not to an experienced firearms retailer like Rainer," adding that the various harms alleged by the municipalities were "the entirely predictable result" of Rainer's conduct.

Finally, the court rejected Rainer's assertion that coverage was available under a "products-completed operations hazard" ("PCOH") provision. Rainer argued that the PCOH clause specifically contemplated the intentional sale of products that ultimately caused injury or damage. The court rejected this argument as unsupported by both caselaw and the factual allegations at issue, including the absence of allegations of product defects in the underlying suits.

COMMENTS

As discussed in last month's Alert, a California federal district court employed similar reasoning relating to the "occurrence" analysis and ruled that injuries arising from a school shooting were not an "occurrence" and therefore that the insurer had no duty to defend a suit against the manufacturer of the gun used in the shooting.

Illinois Court Addresses Scope Of Coverage For Losses Arising Out Of Cyber-Crime Incident Under Two Policies

HOLDING

An Illinois district court ruled that an exclusion in one policy barred coverage for wire transfers stemming from fraudulent emails, but that issues of fact precluded a ruling as to coverage under a computer fraud provision in another policy. *Office of the Special Deputy Receiver v. Hartford Fire Insurance Co.*, 2025 U.S. Dist. LEXIS 60484 (N.D. Ill. Mar. 31, 2025).

BACKGROUND

Office of the Special Deputy Receiver ("OSD"), a non-profit corporation that administers estates of insolvent insurance companies, was the victim of a "spear phishing" attack. A hacker gained access to the Chief Financial Officer's Outlook account, and then posing as him, sent emails to various OSD employees requesting wire transfers to purportedly fund new investments. The employees carried out the instructions and eight transfers were sent totaling approximately $6.85 million. OSD was able to recover some, but not all the funds and turned to its insurers for coverage.

Hartford and HSB Specialty denied coverage. OSD filed suit and the insurers moved to dismiss. The court granted Hartford's motion but denied HSB Specialty's motion.

DECISION

The court ruled that Hartford's policy, a Financial Institution Bond, did not cover the losses as a matter of law. The court concluded that an Electronic Mail Initiated Transfer Fraud Coverage exclusion (Rider 17) unambiguously applied because it excluded from coverage "loss resulting directly or indirectly from the Insured having, in good faith, transferred or delivered Funds, Certificated Securities or Uncertificated Securities, in reliance upon a fraudulent instruction sent to the Insured through electronic mail . . . ."

OSD argued that notwithstanding the exclusionary language of Rider 17, coverage was available under a Computer Systems Fraud Coverage clause (Rider 13), which applied to "Loss resulting directly from a fraudulent (1) entry of Electronic Data or Computer Program into, or (2) change of Electronic Data or Computer Program within any Computer System operated by the Insured . . . ." OSD claimed that Rider 13 was "self-contained and not modified at all by the exclusions in any other riders" or alternatively, created ambiguity

when read in conjunction with Rider 17. Rejecting these assertions, the court ruled that both riders "modify the bond as a whole" and that Hartford need not "spell out, in every section of the Bond, that exclusions added to the bond apply" to the entire instrument.

However, the court denied HSB Specialty's motion to dismiss, finding issues of fact as to whether coverage was available under a Computer Fraud provision in the cyber policy. HSB Specialty acknowledged coverage under a Social Engineering provision, which was subject to a $250,000 sublimit, but denied coverage under a Computer Fraud provision. The Computer Fraud provision covered loss incurred "as a direct result of Computer Crimes," defining Computer Crimes as "the intentional, fraudulent or unauthorized input, destruction, or modification of electronic data or computer instructions into Computer Systems by any entity which is not an Insured Organization or person who is not an Insured Person."

HSB Specialty argued that OSD's loss did not "directly result" from a Computer Crime and instead resulted from human activity, such as the employees' conduct in transferring money. In support of its argument, HSB Specialty cited decisions from other jurisdictions involving similar factual scenarios. The court distinguished those cases based on differing policy language and factual circumstances. In particular, the court emphasized that here, the chain of causation between the initial hacking and the financial loss involved fewer "links" and a shorter time frame than the cases cited by HSB Specialty. Additionally, the court noted that the underlying Computer Crime need not be the sole cause of the loss and that court decisions requiring a strict "direct-cause analysis" (rather than proximate causation) involved fidelity bonds, not insurance policies.

In any event, even applying a stricter standard, the court concluded that OSD pled facts establishing a direct link between the loss and the Computer Crime. The court explained that each fraudulent email could constitute a Computer Crime because "[s]ending an email requires the input of 'electronic data or computer instructions'" and each wire transfer was "a direct response to those emails."

Finally, the court rejected two other arguments asserted by HSB Specialty: that the Social Engineering and Computer Fraud coverages were mutually exclusive and that OSD failed to allege facts that fall within the Computer Fraud coverage provision. The court noted that a policy amendment specified that one subsection of the Social Engineering provision was mutually exclusive with the Computer Fraud provision but emphasized that HSB Specialty issued payment under a different subsection of the Social Engineering provision which was silent on mutual exclusivity. The court also held that OSD sufficiently alleged facts giving rise to a Computer Crime even though the company's broader computer network was not breached, and no servers or hardware were altered. The court explained that the Computer Fraud provision did not include such requirements and that the hacker's alteration of the Chief Financial Officer's Outlook account was sufficient to allege the fraudulent or unauthorized "input, destruction, or modification of electronic data or computer instructions."

COMMENTS

As discussed in previous Alerts, several courts across jurisdictions have addressed whether losses stemming from fraudulently induced wire transfers "resulted directly" from computer fraud, or instead, were caused by the intervening actions of employees in effectuating those transfers. Decisions in this context turned on specific policy language, the factual record presented, and the causation standard (*e.g.*, but for or proximate) applied by the court.

Illinois Court Rules That State Privacy Laws Do Not Apply To Life Insurance Applications

HOLDING

An Illinois district court dismissed a life insurance applicant's putative class action alleging violations of state privacy laws, ruling that such laws did not apply to life insurance underwriting. *Thompson v. Prudential Ins. Co. of Am.*, 2025 U.S. Dist. LEXIS 61405 (S.D. Ill. Mar. 31, 2025).

BACKGROUND

Thompson applied for life insurance offered by Prudential. As part of the underwriting process, Prudential required Thompson to undergo a medical examination conducted by a third-party entity. The examination included questions about family medical history as well as a blood test.

In a putative class action suit, Thompson alleged that Prudential's use of her "sensitive genetic information" for underwriting purposes, including assessment of her eligibility for life insurance, violated the Illinois Genetic Information Privacy Act ("GIPA"). Prudential moved to dismiss the complaint and the court granted the motion.

DECISION

The relevant provision of GIPA, Section 20(b), provides that "[a]n insurer shall not use or disclose protected health information that is genetic information for underwriting purposes." The statute defines "underwriting purposes" to include, among other things, "rules for, or determination of, eligibility (including enrollment and continuing eligibility) for, or determination of, benefits under the plan, coverage, or policy (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program)."

The court concluded that Section 20(b) did not apply to life insurance underwriting. The court relied primarily on a recent decision in which another Illinois district court held that life insurers were not subject to GIPA. *See Thompson v. Banner Life Ins. Co.*, 2024 U.S. Dist. LEXIS 138655 (S.D. Ill. Aug. 5, 2024). The *Thompson* court reasoned that GIPA's regulation of genetic testing is aimed at accident and health insurance, and that both legislative history and statutory verbiage indicate an intent to exclude life insurers from its application.

COMMENTS

The decision provides important limits on the bounds of GIPA's protections. The court not only reaffirmed that GIPA does not apply to life insurance underwriting, but also clarified that a life insurance provider, such as Prudential, is not subject to GIPA merely because it offers both life insurance as well as health coverage (which is subject to GIPA). The court stated:

> Thompson is asking the undersigned to create an anomalous regulatory scheme where GIPA would exempt the use of genetic information for purposes of life insurance underwriting when the insurer offers only life insurance products but otherwise regulate the same use when the insurer happens to offer health insurance in addition to life insurance. Such a reading contravenes the basic principle of statutory construction that courts must "consider only those constructions of a statute that are 'fairly possible.'"

California Department of Insurance Issues Bulletin Regarding Coverage For Wildfire Smoke Damage

February's Insurance Law Alert reported on a California appellate court decision dismissing homeowners' complaint against a property insurer seeking coverage for alleged damage to their home from soot and ash brought by a nearby wildfire. *Gharibian v. Wawanesa General Ins. Co.*, 2025 Cal. App. LEXIS 64 (Cal. Ct. App. Feb. 7, 2025). The *Gharibian* court held that there was no coverage under the policy because fire debris was easily cleaned and thus did not cause a "distinct, demonstrable, physical alteration to property" as required by California law to establish a direct physical loss.

The *Gharibian* ruling extended the California Supreme Court's holding in *Another Planet Entertainment, LLC v. Vigilant Insurance Co.*, 15 Cal.5th 1106 (2024), which declined coverage for alleged physical loss caused by the COVID-19 virus. In reaching its decision, the *Gharibian* decision seized on the following facts: ash and soot can be "easily removed through normal cleaning"; "soot by itself does not physically damage a structure"; "wildfire debris gradually disappears over time on its own"; and "any ash and soot contamination could be cleaned with wiping, HEPA vacuuming, and pressure washing outside." The court reasoned that if fire debris-related contamination can be removed using the same types of cleaning methods needed to remove COVID-19 virus particles, then *Another Planet* applies to bar coverage.

In response to the *Gharibian* ruling and other decisions, and in the wake of the Los Angeles wildfires of January 2025, the California Insurance Commissioner issued Bulletin 2025-7 on March 7, seeking to "clarify[] regulations for insurance companies," and stating "that

insurance companies cannot summarily deny smoke damage claims without a thorough investigation."

The Bulletin states that *Gharibian* does "not support the position that smoke damage is never covered as a matter of law" and is "limited to the facts presented in that case." The Bulletin also argues that *Another Planet* supports the proposition that smoke damage may be covered as a "direct physical loss," based on the California Supreme Court's statement that "physical alteration need not be visible to the naked eye, nor must it be structural, but it must result in some injury to or impairment of the property as property."

The Bulletin also declares the Insurance Commissioner's intent to enforce specific guidelines for claims handling of smoke damage claims, including compliance with California Insurance Code Section 790.03(h) requiring "good faith efforts to effectuate prompt, fair, and equitable settlements of smoke damage claims where liability is reasonable clear" and Section 2695.7(d) of the Fair Claims Settlement Practices Regulations requiring "every insurer to conduct and diligently pursue a thorough, fair, and objective investigation of a claim."

The Bulletin makes note of potentially recoverable damage requiring "appropriate investigation," caused by contaminants present in fire debris and ash, including "asbestos, heavy metals, chemicals, and other hazardous substances," as well as "significant threats to public health through inhalation of dust particles and contamination of drinking water" and exposure of residents "to toxic materials" leading to the spread of "hazardous substances throughout the community."

We will continue to monitor the application of this Bulletin as well as court decisions relating to the scope of coverage for alleged wildfire-related damages.

Simpson Thacher News

Bryce Friedman, Head of the Firm's Insurance Litigation Practice, was quoted in a *Bloomberg Law* article, which explored how disputes over insurance coverage in opioid lawsuits are leading some courts to conclude that public nuisance claims are not covered accidents under commercial liability insurance policies. Addressing a recent California federal court decision in this context, Bryce explained: "If you market a product for use in a way you know is going to hurt people, that's not an accident. . . . It's really a line-drawing exercise." Bryce also noted that "[t]his will continue to come up in cases which focus on marketing and distribution of products that get used in a way, overused, or otherwise cause societal harm, whether it's guns, or opioids, or video games."

Summer Craig participated in the Practicing Law Institute's "Property and Casualty Insurance Law 2025" program on April 2 in New York. Summer spoke on a panel titled "PFAS: Insurance Coverage and Disputes," which included discussion of complex policy provisions addressing environmental pollution claims and PFAS claims. The panelists explained recent developments in PFAS-related regulation and underlying litigation, and explored exclusions and coverage gaps in traditional insurance policies, among other topics.

Bryce Friedman and Chet Kronenberg, along with associate Benjamin Malings, authored an article titled, "Don't Let an Anchor Drag Down the Defense at Trial," which was published by the *New York Law Journal*. The article discussed the practice of anchoring in litigation and its use by plaintiffs' counsel to obtain excessive non-economic damages awards. The article also described strategic responses to anchoring tactics, including exposing the anchor, proposing a counter-anchor, and attempting to overturn excessive verdicts stemming from anchoring through post-trial motions or appeals.

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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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** In April 2025, Simpson Thacher announced plans to expand its Bay Area presence with an office in San Francisco.*

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