Simpson Thacher

Insurance Law Alert

December 2025

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New York Appellate Court Affirms Order Requiring Production Of Reinsurance Agreements In Coverage Dispute Arising Out Of Sexual Abuse Claims Against Church

Insurers that issued primary and excess policies allegedly covering sexual abuse claims against church officials and organizations must produce reinsurance agreements to the insured entities. *Archdiocese of N.Y. v. Century Indem. Co.,* 2025 N.Y. App. Div. LEXIS 6519 (N.Y. App. Div. 1st Dep't Nov. 20, 2025). (Click here for full article)

Delaware Court Establishes Deferential Framework For Handling Objections To Insurance Commissioner's Proposed Procedures In Liquidation Proceedings

In an insolvent reinsurer's liquidation proceedings, a deferential standard applies under which the state Insurance Commissioner's proposed procedures must comply with state law and must not constitute an abuse of discretion, and objectors must establish that the plan violates law or lacks evidentiary support. *In the Matter of the Rehab. of Scottish Re (U.S.) Inc.,* 2025 Del. Ch. LEXIS 2045 (Del. Chanc. Ct. Nov. 28, 2025). (Click here for full article)

Second Circuit Allows Negligence Actions To Proceed Against Broker Based On Failure To Deliver Notice To Insurer

A New York district court erred in dismissing a negligence claim against a broker based on lack of ripeness and failure to state a claim. *Paro Mgmt. Co., Inc. v. Willis of N.J.,* 2025 U.S. App. LEXIS 29289 (2d Cir. Nov. 5, 2025). (Click here for full article)

Eleventh Circuit Rules That Parkland Mass Shooting Constitutes A Single "Occurrence" Subject To One SIR

HOLDING

The Broward County Sheriff's Office is obligated to pay only one self-insured retention under an excess policy because a shooting spree at a Florida high school constitutes a single occurrence for coverage purposes. *Sheriff of Broward Cnty. v. Evanston Ins. Co.,* 2025 U.S. App. LEXIS 29494 (11th Cir. Nov. 10, 2025).

BACKGROUND

A tragic mass shooting at a Parkland High School resulted in the death of 17 students and injuries to several others. The families of the victims sued the Sheriff of Broward County, alleging negligence in failing to secure the school once the incident began. The Sheriff, in turn, sought a declaration that the shooting constitutes a single occurrence under Evanston's policy and therefore Evanston is required to pay excess judgments following payment of a single SIR. In contrast, Evanston argued that each injury-causing gunshot constitutes a separate "occurrence" as a matter of law under *Koikos v. Travelers Ins. Co.,* 849 So.2d 263 (Fla. 2003), in which the Florida Supreme Court held that a perpetrator's shooting of two victims at a restaurant constituted two separate occurrences under the applicable policy.

A Florida federal district court granted the Sheriff's summary judgment motion and awarded attorneys' fees and costs under Florida statutory law. The district court reasoned that *Koikos* does not stand for the proposition that each victim of a shooting constitutes a separate occurrence, but rather that the term "occurrence" is ambiguous and should be interpreted in favor of the insured.

DECISION

The Eleventh Circuit affirmed. The court noted that the *Koikos* decision is "no model of clarity," but concluded it should be interpreted as holding that the term "occurrence" defined as "an accident, including continuous or repeated

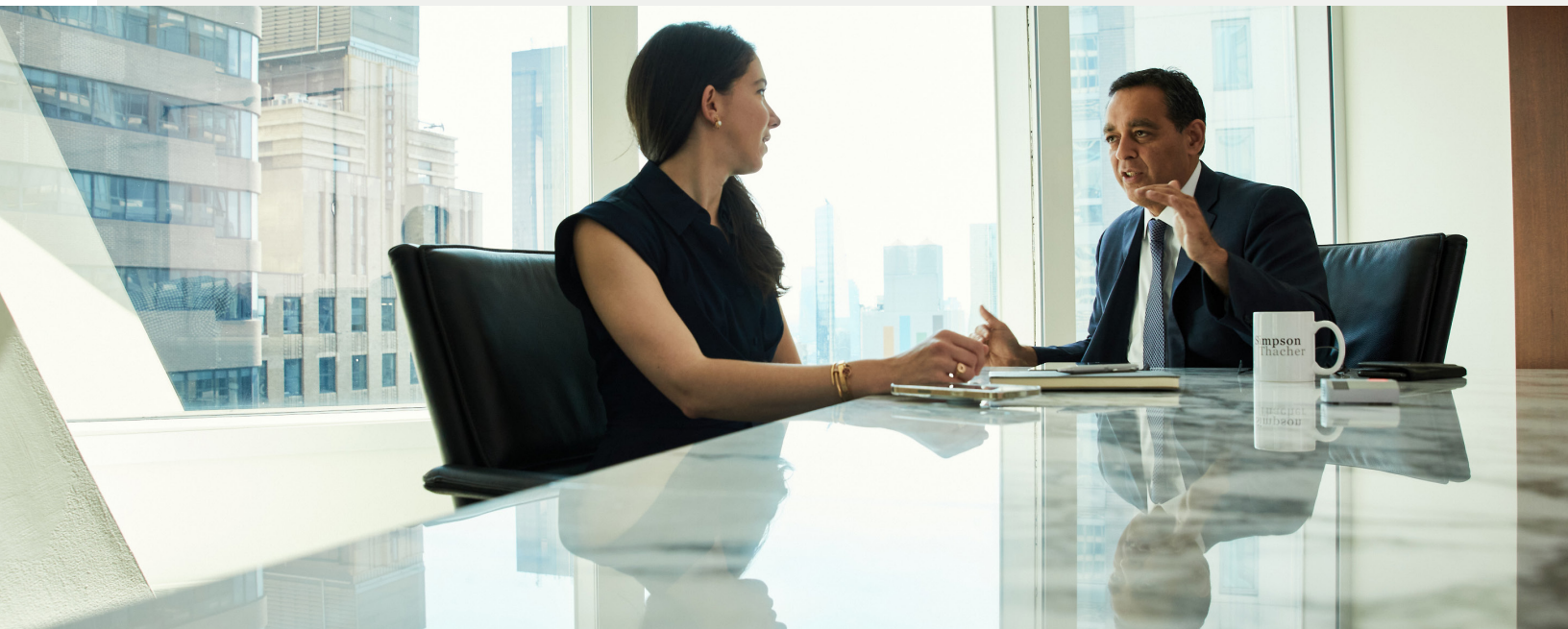
exposure to substantially the same general harmful conditions" is ambiguous in the context of the particular shooting incident involving multiple victims. More specifically, the Eleventh Circuit explained that under *Koikos*, "occurrence" could mean the negligence of the insured entity in connection with the incident or the intervening acts by the gunman.

Having found ambiguity, the court ruled in the Sheriff's favor. The court rejected Evanston's assertion that the Florida rule of contract interpretation requiring ambiguities to be construed in favor of coverage does not apply because the Sheriff is a sophisticated insured. The court similarly refused to consider evidence of the parties' negotiations, emphasizing that "Florida law is clear that . . . ambiguity is resolved in favor of coverage and against the insurer, without regard to extrinsic evidence or the parties' supposed intentions or expectations."

Additionally, the Eleventh Circuit affirmed the award of attorneys' fees and costs. Fees and costs are allowable under Florida statutory law when an insurer wrongfully denies coverage. Evanston argued that while it had raised the number-of-occurrences issue in two reservation of rights letters and a subsequent communication, it had never officially denied coverage. Rejecting this assertion, the Eleventh Circuit upheld the district court's finding that a letter from Evanston "maintain[ing] its position that each gunshot that resulted in injury or death to a victim of the shooting constitutes a separate 'occurrence'" constituted a denial of coverage, or at a minimum, a threat of a denial, which has been held to meet the requirements of Florida statutory law regarding attorneys' fees and costs.

COMMENTS

In other coverage disputes arising out of gun-related injuries, courts have reached various conclusions as to the number of occurrences, even when employing the same "cause-based" test and/or interpreting similar policy language. Outcomes turn primarily on the factual record presented, including the length of time and particular circumstances separating the injury-causing shots and the existence of intervening events.



Illinois Appellate Court Rules That Accidental Overpayments By Policyholder To Its Employees Following Cyberattack Are Not Covered "Extra Expenses"

HOLDING

An Illinois trial court properly dismissed a coverage suit against a cyber insurer because the insured's inadvertent overpayment to employees following a cyberattack on the company's payroll vendor was not covered under the policy. *Villa Fin. Serv's, LLC v. Underwriters at Lloyd's of London,* 2025 Ill. App. Unpub. LEXIS 2116 (Ill. App. Ct. Nov. 24, 2025).

BACKGROUND

Villa Financial Services contracted with a third-party vendor for its payroll operations. In 2021, the vendor notified Villa that it was the victim of a ransomware attack and was unable to initiate its payroll processes. Therefore, to meet its payroll obligations, Villa paid its employees based on data from prior payroll periods. This method resulted in an overpayment of more than $1.2 million.

Villa sought coverage from Underwriters under a Cyber Private Enterprise Policy. When the insurer denied coverage, Villa sued, seeking a declaration that the overpayments constituted an "extra expense," defined by the policy as "reasonable sums necessarily incurred to mitigate an interruption to business operations." The trial court granted Underwriters' motion for judgment on the pleadings and the appellate court affirmed.

DECISION

The appellate court's ruling centered on its finding that the inadvertent overpayments to Villa's employees were not "necessary." As a threshold matter, the court held that the undefined term "necessary" was not ambiguous and means "essential, indispensable, or requisite." The court further acknowledged that Villa may have been unable to access reliable payroll records due to the cyberattack on its vendor but emphasized that the overpayments were not amounts that Villa was contractually obligated to pay and were therefore not "necessary." Rather, only amounts actually earned by Villa's employees could be deemed "necessary" for the continued operation of the business.

COMMENTS

The decision highlights an important distinction between consequential expenses and necessary expenses. The court explained: "while the overpayments made by plaintiff were a consequence of the ransomware attack, they were not covered by the insurance contract . . . . Incurring those additional expenses might have made good business sense to plaintiff, but they were not necessarily incurred for purposes of the extra expense provision."

Nebraska Supreme Court Rules That Dispossession Of Aircraft Due To Payment Dispute Constitutes A "Direct Physical Loss" Under Policy

HOLDING

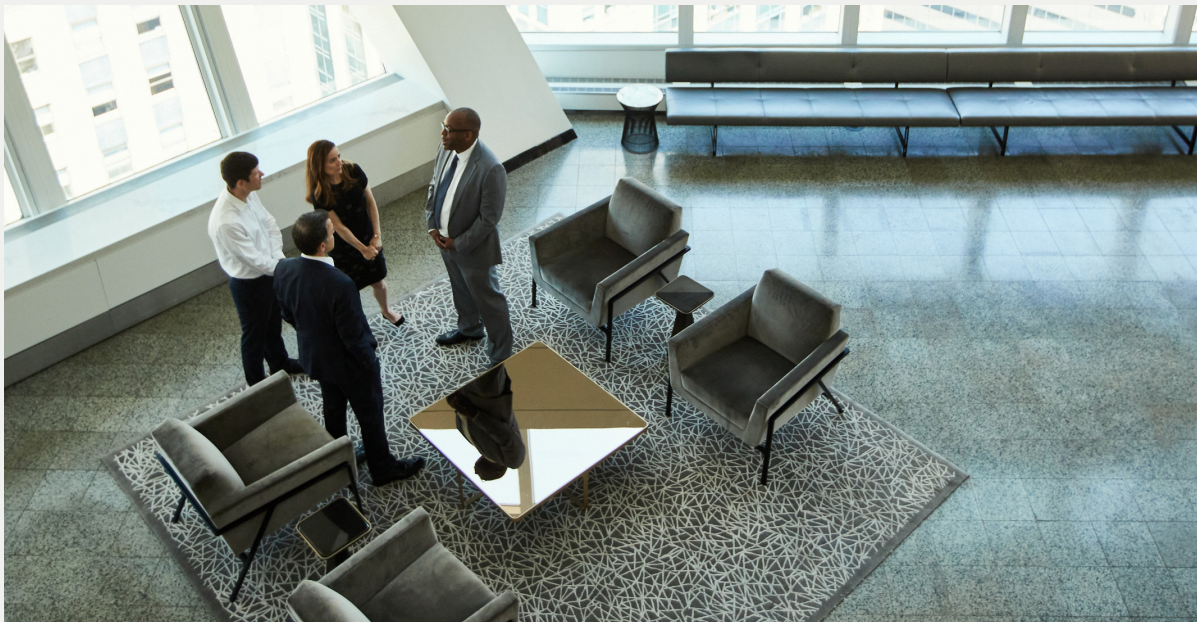
A trial court erred in dismissing a coverage suit stemming from an owner's temporary dispossession of an aircraft because this incident constitutes a direct physical loss under the terms of the policy. *U.S. Specialty Ins. Co. v. D S Avionics Unlimited LLC,* 2025 Neb. LEXIS 105 (Neb. Sup. Ct. Nov. 7, 2025).

BACKGROUND

DSA owned a Piper PA-30 aircraft which was covered by a policy issued by U.S. Specialty. DSA delivered the aircraft to a mechanic for maintenance, but the mechanic was unable to access the hangar due to a dispute with the airport owner over allegedly overdue rent. The mechanic was ultimately able to access the hangar and move the aircraft to an outdoor location, but when DSA arrived to retrieve it, a truck was parked in front of it, preventing its removal. The airport owner refused to move the truck, citing the overdue rent payment from the mechanic.

DSA submitted a statement of loss to U.S. Specialty, which denied the claim on several bases, including that there was no "direct physical loss" or "accident" as required by the policy. Thereafter, U.S. Specialty sued, seeking a declaration of no coverage and DSA counterclaimed, alleging breach of contract and bad faith.

Ruling on cross-motions for summary judgment, the trial court held that DSA's claim was not within the scope of coverage. DSA appealed and while the appeal was pending, the aircraft was released to DSA by court order in a separate proceeding more than 3 years after the truck had blocked it from moving. On appeal, the Nebraska Supreme Court reversed the trial court decision, finding that dismissal of the case was premature and remanding the matter.



After a hearing, the trial court ruled in favor of U.S. Specialty again, finding there was no covered "loss" or "accident" under the policy. The Nebraska Supreme Court reversed.

DECISION

The Nebraska Supreme Court held that DSA's claim was within the scope of coverage because an "accident" caused the direct physical loss of the aircraft. The court reasoned that the blocking of the aircraft by a truck was an "accident," defined by the policy as "a sudden event during the policy period, neither expected nor intended by [the insured]." The court emphasized that the incident was not gradual and was neither expected nor intended from the standpoint of DSA.

While the court acknowledged that intentional acts are typically excluded from coverage and not within the scope of the term "accident," the policy at issue expressly defined "accident" to be interpreted from the perspective of the insured, *i.e.*, whether the insured, itself, expected or intended the event(s). The court likewise rejected the assertion that public policy precludes coverage for the intentional act at issue, noting that DSA, the insured, did not intend or expect the incident to occur.

Finally, the court rejected U.S. Specialty's contention that there was no "direct physical loss" because DSA ultimately recovered the aircraft. In so ruling, the court distinguished cases involving COVID-19-related business losses, noting that such scenarios did not involve the physical dispossession of property.

COMMENTS

The ruling is driven largely by the language of the policy, namely, the express requirement that "accidents" are to be interpreted from the expectations and intentions of the insured. Thus, for policies without such qualifying language, intentional acts are often deemed outside the scope of coverage.

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New York Appellate Court Affirms Order Requiring Production Of Reinsurance Agreements In Coverage Dispute Arising Out Of Sexual Abuse Claims Against Church

HOLDING

Insurers that issued primary and excess policies allegedly covering sexual abuse claims against church officials and organizations must produce reinsurance agreements to the insured entities. *Archdiocese of N.Y. v. Century Indem. Co.,* 2025 N.Y. App. Div. LEXIS 6519 (N.Y. App. Div. 1st Dep't Nov. 20, 2025).

BACKGROUND

Thousands of sexual abuse lawsuits were filed against the Archdiocese of New York. In the coverage disputes that ensued, several insurers initially agreed to defend the suits under a reservation of rights, but subsequently denied coverage based on the "expected and/or intended" injuries alleged in the suits.

The insurers sought a declaration of no coverage. During discovery, the insured entities sought to compel production of reinsurance agreements between their primary and excess insurers and reinsurers. A Special Discovery Master granted the motion. *See* Referee Decision & Order, *Century Indem. Co. v. Archdiocese of N.Y., et al.,* No.652825/2023 (N.Y. Sup. Ct. N.Y. Cnty. Mar. 11, 2025).

DECISION

Affirming the ruling, the Appellate Division held that reinsurance agreements are subject to automatic disclosure under CPLR 3101(f). The court explained that "any insurance agreement" in that provision includes reinsurance agreements, stating "[i]f the legislature wished to exclude reinsurance agreements from CPLR 3010(f), it could have done so explicitly." Further, "the legislature's failure to add a straightforward exclusion when it amended CPLR 3101(f) . . . is strong evidence that it did not disagree with the conclusion of those courts that reinsurance agreements were included within the scope of CPLR 3101(f)."

COMMENTS

An important distinction exists between reinsurance agreements and other reinsurance-related material, such as reserve information or communications between a reinsurer and its cedent. The discoverability of the latter category may be subject to more scrutiny in the context of motions to compel.

Indeed, the Special Discovery Master in this case denied the Archdiocese's motion to compel production of material in the reinsurance claim files and communications with the reinsurers on the basis that the discovery requests were overbroad, and that the material was arguably protected work product and/or irrelevant to the coverage dispute.

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Delaware Court Establishes Deferential Framework For Handling Objections To Insurance Commissioner's Proposed Procedures In Liquidation Proceedings

HOLDING

In an insolvent reinsurer's liquidation proceedings, a deferential standard applies under which the state Insurance Commissioner's proposed procedures must comply with state law and must not constitute an abuse of discretion, and objectors must establish that the plan violates law or lacks evidentiary support. *In the Matter of the Rehab. of Scottish Re (U.S.) Inc.,* 2025 Del. Ch. LEXIS 2045 (Del. Chanc. Ct. Nov. 28, 2025).

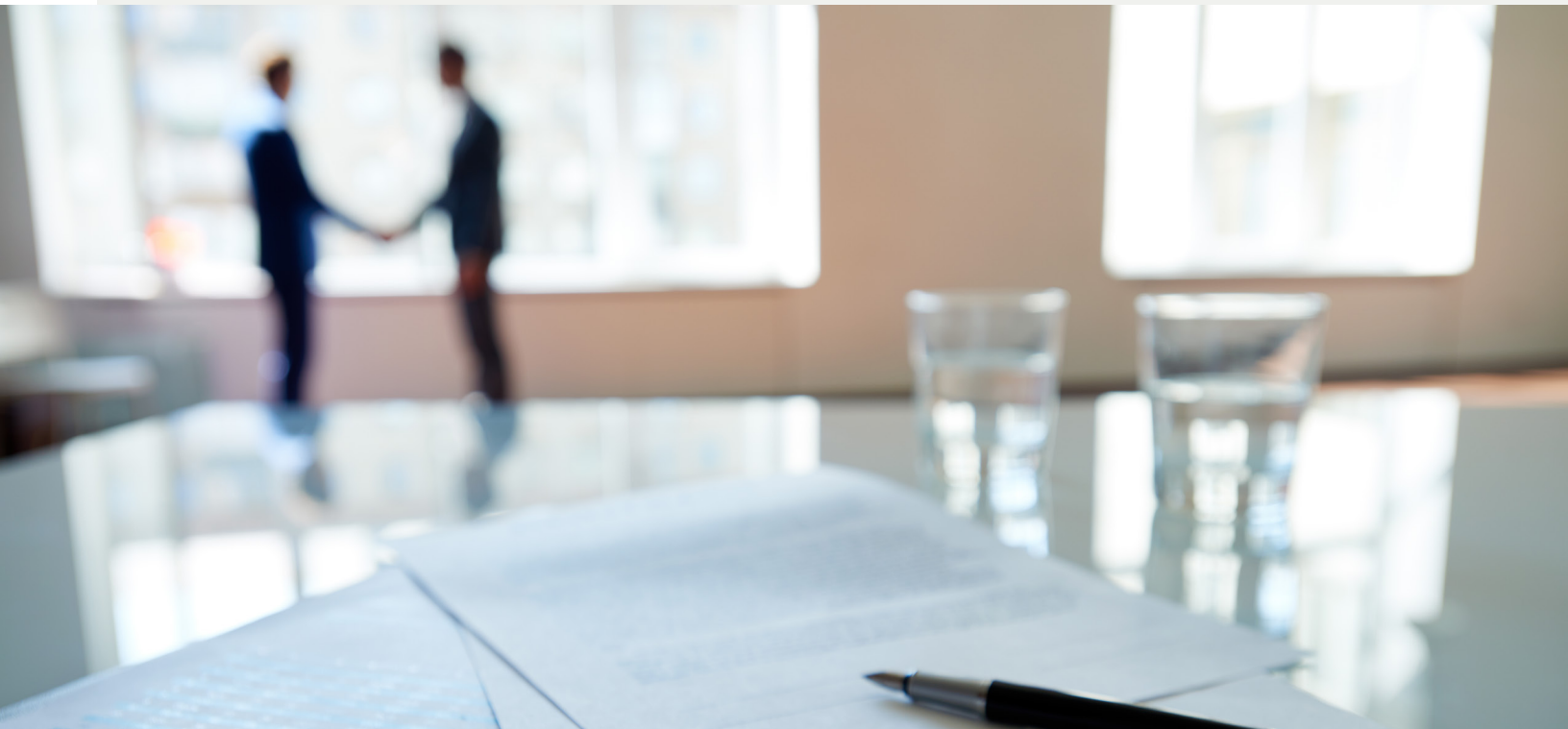
BACKGROUND

Scottish Re, a reinsurer, entered insolvency proceedings and the Delaware Insurance Commissioner obtained a rehabilitation order. After attempts to salvage the business failed, the court converted the case to a liquidation, fixing Scottish Re's financial obligations and imposing antisuit injunctions and requiring all claims to be handled through the receivership.

The Insurance Commissioner filed a series of motions seeking approval of various procedures including the following: reinsurance claims procedures, "other claims" procedures, dispute resolution rules, and "final determination" procedures for adjudicating and paying claims. Numerous parties objected and raised the question of the appropriate standard of review for the Commissioner's decisions and various elements of the claims process.

DECISION

The court ruled that in determining whether to adopt the procedures proposed by the Commissioner, the appropriate standard of review is whether "the procedures comply with [state] law . . . and otherwise do not constitute an abuse of discretion." The court set forth a two-step procedure: First, the

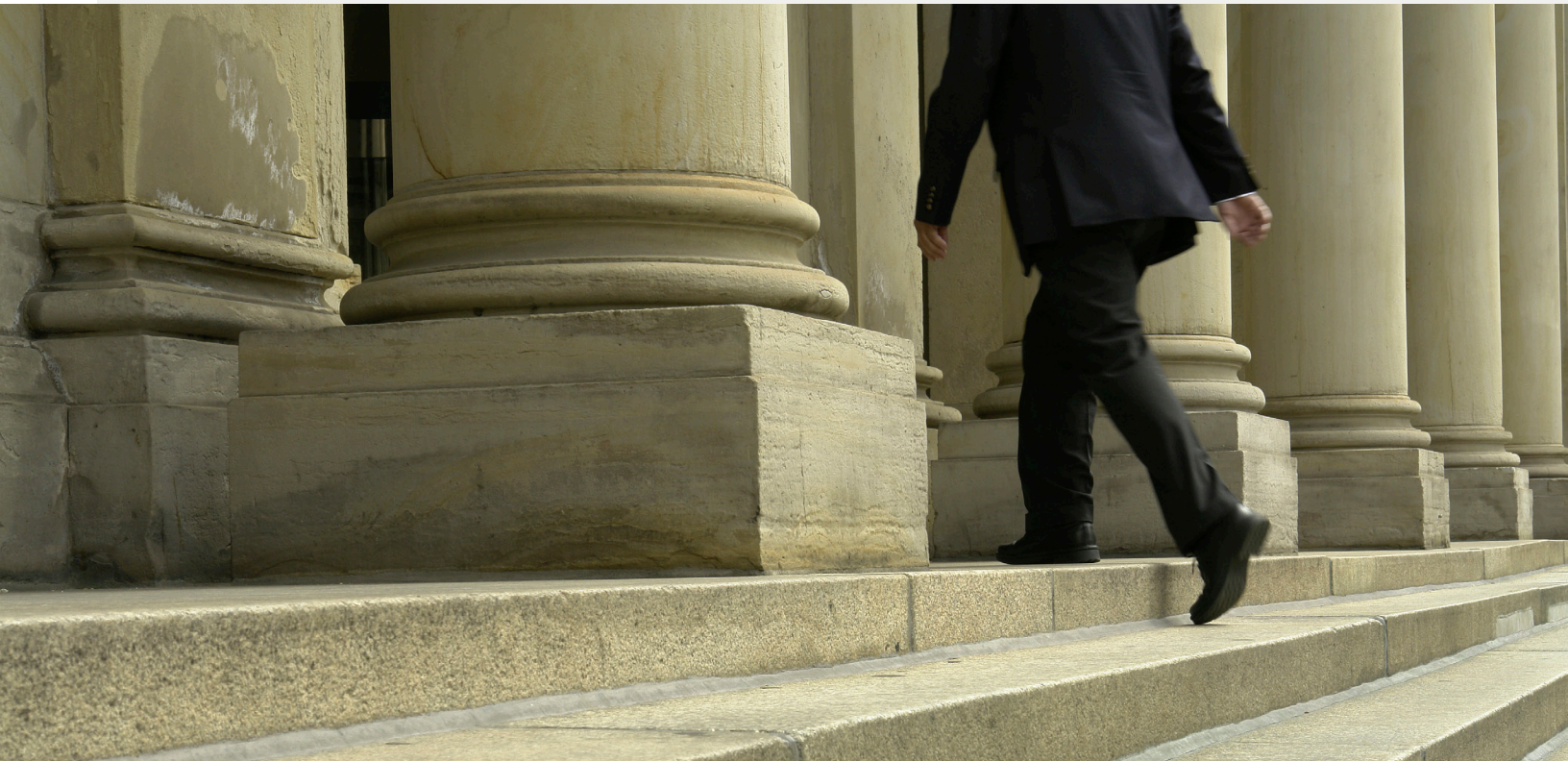


Commissioner must establish a *prima facie* case for deference by "identify[ing] a source of authority, articulat[ing] a rationale for the relief and creat[ing] a factual record that supports the proffered rationale." If such a showing is made, the burden shifts to the objecting party to demonstrate "that (i) the Commissioner lacked authority to make the decision or that the decision does not comply with applicable law, (ii) the Commissioner's rationale does not have substantial evidentiary support, or (iii) the decision constitutes an abuse of discretion."

With respect to the Commissioner's claim recommendations, the court held that for any issues relating to legal compliance, a *de novo* standard applies. However, for any issues requiring the exercise of judgment or the weighing of evidence, an abuse of discretion standard applies.

Applying this framework, the court concluded that the Commissioner's proposal under which the Commission solicits information from each claimant and then sends each claimant an initial assessment of the claim value which may be accepted or rejected by the claimant did not violate Delaware's Uniform Insurance Liquidation Act ("DUILA") and was not an abuse of discretion. The objectors argued that under DUILA, claimants must first file a claim prior to any evaluation by the Commissioner. Rejecting this contention, the court concluded that the approach did not constitute an abuse of discretion, particularly given the absence of a particular order set forth in DUILA.

Additionally, the court rejected the objectors' contention that the Commissioner's valuation methodology in making assessments constitutes an abuse of discretion. The court declined to endorse or invalidate any specific valuation formulas, but rather reasoned that the proposed methodologies were within the Commissioner's discretion.



Finally, the court ruled that, contrary to the objectors' assertion, the proposed claim procedures (which do not contemplate arbitration notwithstanding the inclusion of arbitration provisions in certain contracts) did not violate the DUILA. The court explained: "A claimant who believes a claim should be arbitrated may ask the court to lift the antisuit injunctions barring litigation or arbitration outside of the liquidation process. The court will do so only when resolving a claim outside the liquidation process comports with DUILA and its policy goals."

COMMENTS

The court rejected a host of other objections related to access to information, the reinsurers' contractual rights to receive notice of and investigate claims, and the appropriate retrocession termination date, finding that none of the Commissioner's proposed procedures constituted an abuse of discretion or violation of law and/or that the Commissioner was not bound by contractual provisions in his capacity as receiver.

The decision highlights two important principles: the Commissioner's broad discretion in making decisions in the context of a receivership (and other insolvency-based proceedings) and the inefficiency and unpredictability of insurance receivership proceedings in Delaware.

As to the latter point, the court emphasized the need for statutory reform in this context, stating:

> It is hard to understand why Delaware would hold fast to a statutory scheme that became obsolete four decades ago, but that is the choice that the General Assembly has made . . . . The Commissioner would be the natural champion for a new statute, but an obsolete statute that says little imposes few constraints, giving the Commissioner wide latitude. Insurance companies would benefit from greater clarity, but operating companies would have to see value in lobbying for an updated insolvency statute. The statutory improvements would only benefit insurers who became insolvent or regularly participated in insolvencies. For a solvent company to devote resources to improving Delaware's insolvency regime could send mixed signals about its own viability or exposure, and solvent companies have better places to invest their resources.

As the court noted, more than thirty states have adopted a "second-generation" statute containing components of the Insurers Rehabilitation and Liquidation Model Act of 1968, and several states have adopted in whole or in part a "third-generation" statute, the Insurer Receivership Model Act promulgated in 2005. Delaware has adopted neither.

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Second Circuit Allows Negligence Actions To Proceed Against Broker Based On Failure To Deliver Notice To Insurer

HOLDING

A New York district court erred in dismissing a negligence claim against a broker based on lack of ripeness and failure to state a claim. *Paro Mgmt. Co., Inc. v. Willis of N.J.,* 2025 U.S. App. LEXIS 29289 (2d Cir. Nov. 5, 2025).

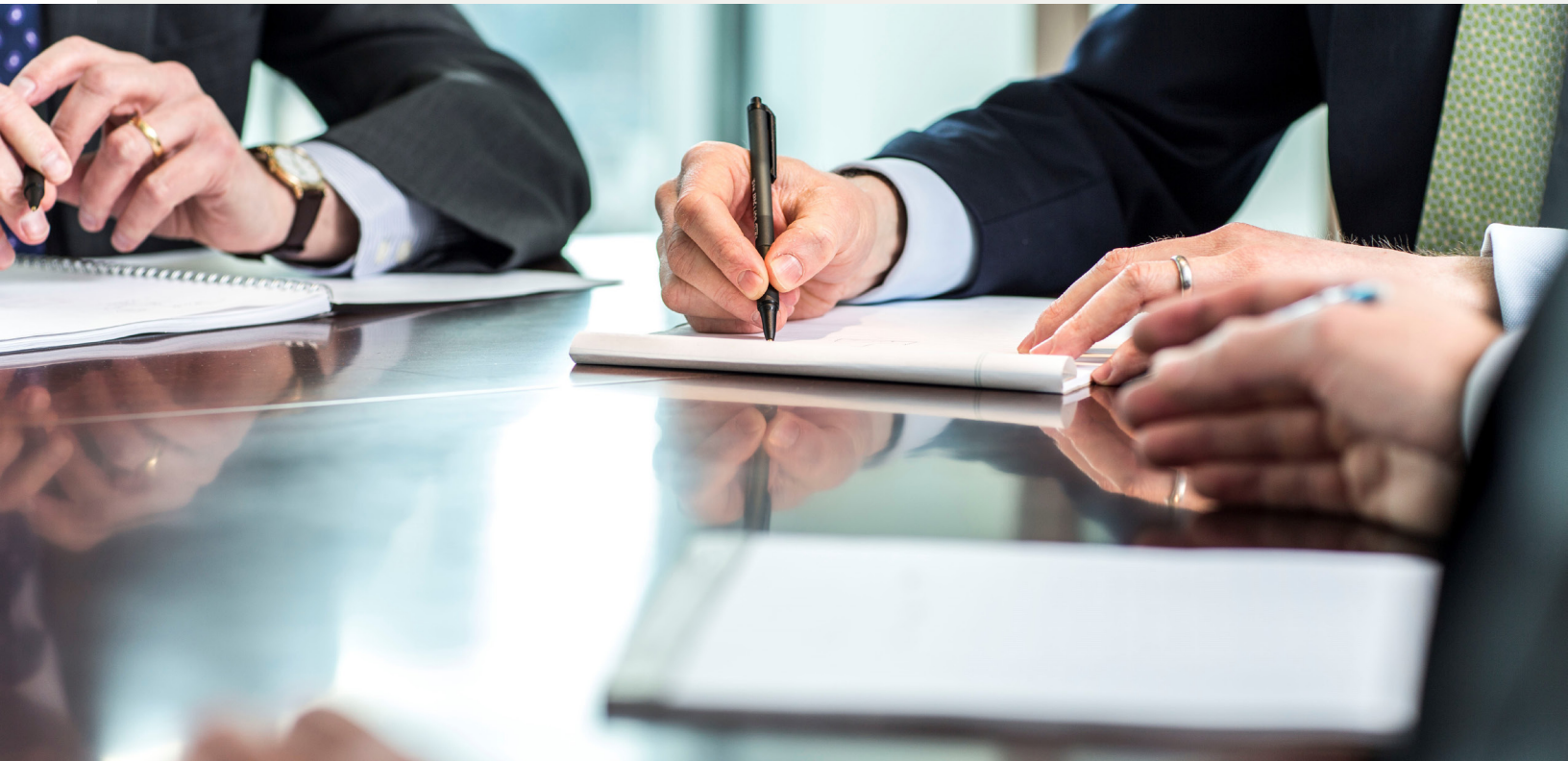
BACKGROUND

Paro Management alleged that Willis, its insurance broker, failed to convey notice of the presence of lead paint on its property to Paro's insurer, despite Paro's request to do so. When Paro was later sued by tenants, the insurer denied coverage based on untimely notice.

Paro sued Willis, alleging negligence and negligent misrepresentation. The district court dismissed the complaint as unripe based on the tenants' pending suit against Paro and another pending suit between Paro and its insurer. The district court ruled that dismissal was also warranted based on Paro's failure to state a claim for relief.

DECISION

The Second Circuit reversed the district court's ruling as to ripeness. The Second Circuit explained that Paro's claims against Willis presented a "real, substantial controversy" notwithstanding the absence of rulings as to Paro's liability to the tenants or the insurer's liability to Paro. The court reasoned that Willis's failure to convey notice to the insurer led to the coverage denial, which led to the instant lawsuit, prompting Paro to incur litigation costs in bringing a declaratory judgment action against its insurer. Thus, the court concluded, Paro's injury is "actual," not "conjectural or hypothetical."



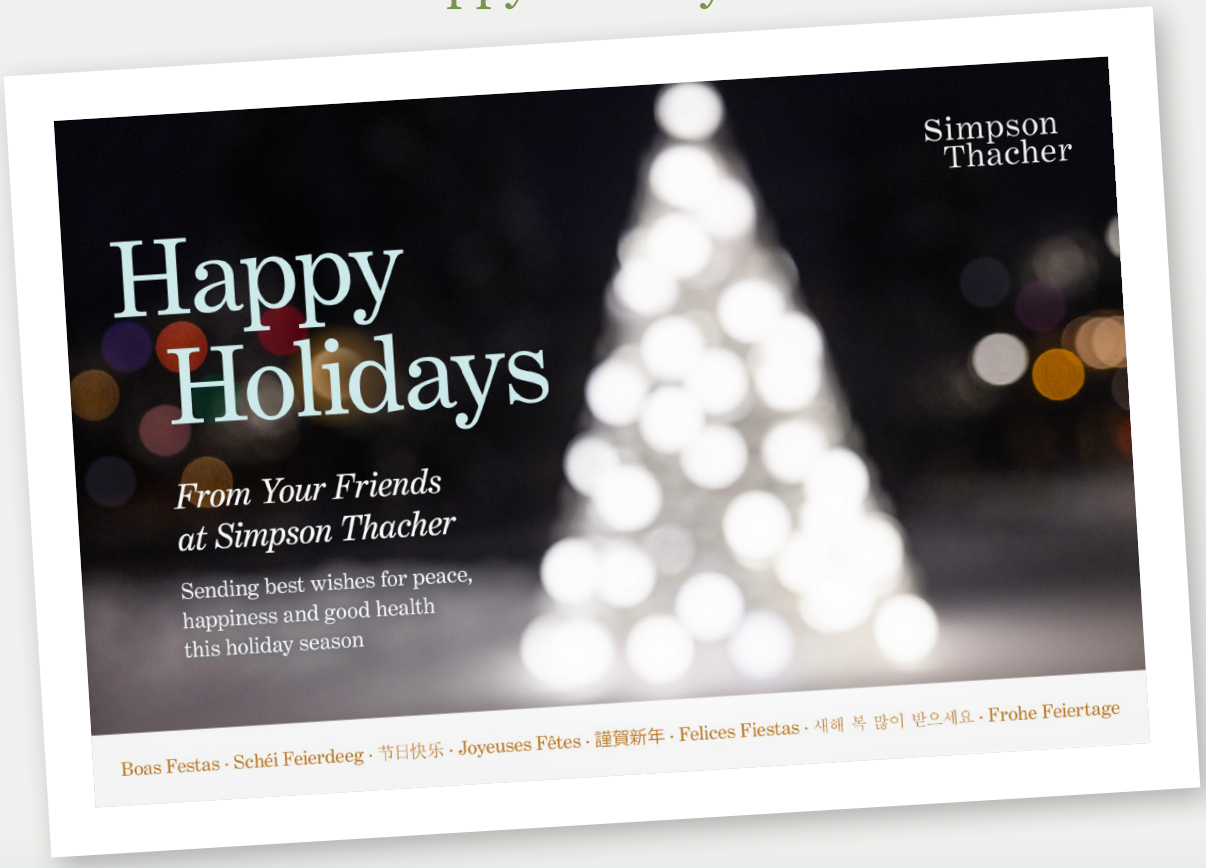
Turning to the merits of Paro's suit against Willis, the court ruled that the complaint stated a claim for negligence. Under New York law, a broker's obligation to an insured is generally limited to the procurement of coverage requested by the insured, but liability may arise where, as here, the insured asks the broker to take on additional responsibilities, such as providing notice to the insurer.

However, the Second Circuit affirmed the dismissal of Paro's negligent misrepresentation claim. Such claims require representations that are "factual in nature, and not promissory or relating to future events that might never come to fruition."

COMMENTS

A question may arise as to whether negligence claims and negligent misrepresentation claims against a broker are duplicative. The district court had concluded that the two causes of action were duplicative, but since the Second Circuit dismissed the negligent misrepresentation claim based on the failure to allege the requisite elements, it declined to consider whether the two claims were duplicative. Notably, both causes of action require the policyholder to establish that the broker owed a duty of care and breached that duty.

Happy Holidays!



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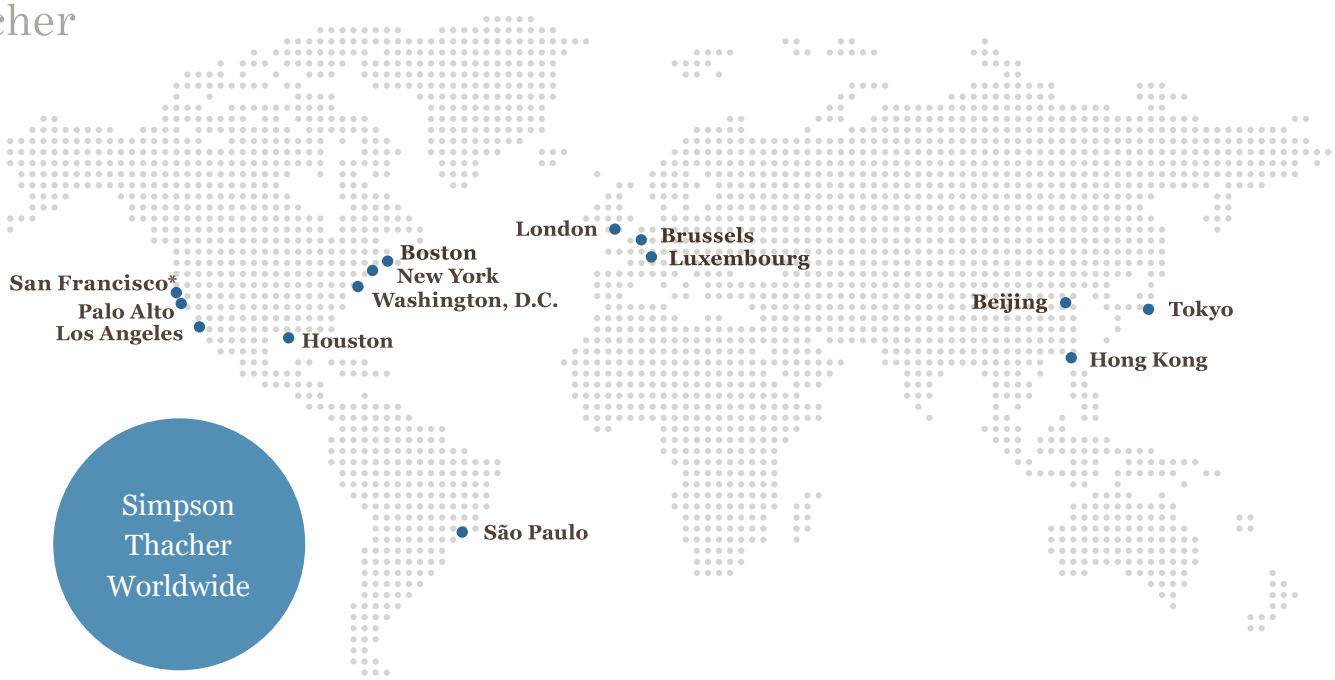

** In April 2025, Simpson Thacher announced plans to expand its Bay Area presence with an office in San Francisco.*

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