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Insurance Law Alert

January 2026

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Shares Issued To Settle Shareholder Litigation May Constitute Covered "Losses" Under D&O Policy

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"The firm is right at the top of the pyramid in terms of ability."

– *Chambers USA* 2025
(quoting a client)

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New Jersey Appellate Court Holds No Duty To Defend Or Indemnify In Casino Assault Case

A homeowner's insurer owes no duty to defend or indemnify an insured in a suit arising out of a casino assault because an intentional punch is not an "accident" or "occurrence" triggering coverage. *De Chacon v. Caesars Ent. Corp.*, No. A-2376-23, 2025 N.J. Super. Unpub. LEXIS 2584 (Super. Ct. N.J. App. Div. Dec. 16, 2025) (per curiam). (Click here for full article)

Appellate Court Affirms Jury Verdict Awarding Auto-Accident Plaintiff A Fraction Of Alleged Medical Expenses

A Louisiana appellate court affirmed a jury decision to award a plaintiff a fraction of the medical expenses he claimed in an auto-accident case, affirming a medical award that was significantly below the amount sought at trial. *Agenor v. Suarez*, No. 25-CA-74, 2025 La. App. LEXIS 2608 (La. Ct. App. Dec. 30, 2025). (Click here for full article)

Delaware Court Rules That Policyholder Not Tied To Damages Valuation It Presented In Underlying Litigation

HOLDING

A policyholder is not bound, for insurance coverage purposes, by the damages valuation it pursued or recovered in the underlying litigation. *Hartree Nat. Gas Storage, LLC v. AIG Specialty Ins. Co.*, No. N22C-05-081, 2025 Del. Super. LEXIS 1291 (Del. Super. Ct. Dec. 9, 2025).

BACKGROUND

Hartree Natural Gas Storage acquired an energy center from PAA Natural Gas Storage and purchased representations and warranties insurance to cover seller breaches, including a second-layer excess policy from AIG that attached above approximately $56 million in losses. After closing, Hartree discovered that gas was missing and that it had overpaid for the transaction. Hartree notified its insurers that it was seeking coverage for (1) the costs of replacing the missing gas and (2) overpayment damages based on discounted cash flow analysis of the entire transaction. Coverage was denied.

In the underlying litigation against PAA, Hartree initially advanced two damages theories—one for the cost of replacing the missing gas valued at about $55 million, and the other for a "loss-of-sale-value" theory estimated at $90 million. At trial, Hartree abandoned the loss-of-sale-value theory and proceeded only on the missing-gas claim, ultimately recovering about $30 million.

Hartree then sued AIG for coverage under the excess policy. AIG moved for summary judgment, arguing that the excess layer was not triggered because Hartree recovered only $30 million in the underlying case and could not now claim damages exceeding $90 million.

DECISION

The court denied AIG's motion, rejecting each of the doctrines AIG relied on to bar Hartree's higher damages claim. Collateral estoppel did not apply because the loss-of-sale-value theory was never litigated or decided. Judicial and quasi-judicial estoppel failed because the underlying court did not adopt, rely on, or make findings about Hartree's withdrawal of that theory. Waiver and law-of-the-case theories were inapplicable because they operate only within the same litigation.

The court also held that unresolved factual issues precluded summary judgment, including whether Hartree complied with the policies' subrogation and mitigation provisions.

COMMENTS

This ruling underscores that excess insurers cannot assume they are off the risk simply because underlying litigation resolves below attachment points. A policyholder may pursue a narrower or lower-risk damages theory against a counterparty and later seek coverage on a higher valuation under its insurance program.

Shares Issued To Settle Shareholder Litigation May Constitute Covered "Losses" Under D&O Policy

HOLDING

Under Delaware law, settlements satisfied through the issuance of stock may qualify as covered "losses" under directors and officers liability policies. *AMC Ent. Holdings, Inc. v. XL Specialty Ins. Co.*, No. N23C-05-045, 2025 Del. Super. LEXIS 84 (Del. Super. Ct. Feb. 28, 2025) *aff'd, sub nom. Midvale Indem. Co. v. AMC Ent. Holdings, Inc.*, No. 206, 2025 (Del. Dec. 9, 2025).

BACKGROUND

AMC resolved a shareholder litigation by issuing shares of its common stock to the plaintiff-shareholders. AMC sought indemnity for the settlement from its primary directors and officers (D&O) insurer, which denied coverage on the ground that payment in stock did not constitute a covered loss under the policies. AMC then sued its D&O insurers, including excess insurer Midvale, seeking a declaratory judgment that the stock-based settlement was a covered "loss." The Delaware Superior Court granted summary judgment in AMC's favor on this issue. On appeal, the Delaware Supreme Court affirmed, relying on the trial court's reasoning discussed below.

DECISION

The trial court held that coverage was owed for AMC's settlement losses, notwithstanding that the settlement was satisfied through the issuance of stock rather than cash. The policies defined "Loss" to include "damages, judgments, settlements, pre-judgment and post-judgment interest, or other amounts (including punitive, exemplary or multiplied damages, where insurable by law) that any Insured is legally obligated to pay."

Midvale argued that the issuance of stock did not constitute a covered "Loss" because stock is not money and therefore cannot be "paid" within the meaning of the policies. AMC countered that the "Loss" definition contains no language limiting its application to cash payments.

The court agreed with AMC. It emphasized that the policy language does not restrict "Loss" to cash payments or monetary amounts and declined to read such a limitation into the contract. The court further explained that Delaware law treats stock as "a form of currency" that can be exchanged or used for a wide range of corporate purposes, including satisfying obligations and settling claims.

Applying the principle that words used in different provisions of the same agreement are presumed to have the same meaning, the court found additional support in the policy's "bump-up" exclusion, which used the term "paid" in a context that encompasses stock consideration. The court also rejected Midvale's argument that coverage should be unavailable because insurers cannot themselves "pay" stock on AMC's behalf. The court observed that the policies require the insurers to indemnify AMC for covered losses, not to directly fund the settlement. This case was remanded for further proceedings regarding the consent-to-settle requirements under the policy.

COMMENTS

The court found, under the specific policy language at issue, that covered "Loss" was not limited to cash payments. Policyholders may seek to rely on this ruling to argue that other non-traditional forms of consideration, such as cryptocurrency, fall within broadly worded loss definitions.

Second Circuit Affirms No-Coverage Ruling In Ghost Gun Case

HOLDING

Insurance companies have no duty to defend or indemnify underlying lawsuits related to harms from the sales and marketing of "ghost gun" parts because the underlying lawsuits do not allege an "accident" and therefore no occurrence under Texas law, to trigger coverage. *Granite State Ins. Co. v. Primary Arms, LLC*, 161 F.4th 160 (2d Cir. 2025).

BACKGROUND

Primary Arms is a manufacturer and retailer of gun part kits that can be used to assemble unregistered, untraceable guns known as "ghost guns." Because Primary Arms sells firearm parts and not the fully assembled firearm, the buyer does not receive a background or firearm license check prior to the sale. The later-assembled firearm also does not have a serial number like a finished firearm would. The State of New York and the cities of Buffalo and Rochester filed lawsuits against Primary Arms seeking to recover economic losses stemming from the increase in gun violence and crime linked to the company's products. The underlying lawsuits allege that Primary Arms marketed its products to consumers who otherwise would have been unable to legally obtain firearms, those wishing to skirt state-mandated background checks, and those wanting untraceable guns.

Primary Arms' insurers filed a declaratory judgment action seeking a ruling they had no duty to defend or indemnify the underlying suits. The policies provide coverage when there is an "occurrence" defined as an "accident." The district court ruled that the policies did not obligate the insurers to indemnify or defend Primary Arms because the underlying suits did not allege an "accident." The Second Circuit affirmed.

DECISION

The principal issue was whether the underlying suits allege harm caused by an "accident" as that term is used in the policies. The policy did not define the term "accident", so the court looked to Texas law to find the term's ordinary meaning. Under Texas law, an "accident" is defined as a "fortuitous, unexpected, and unintended event." Conversely, an act is not an accident if it: (1) is "intentional"; and (2) "results in injuries that ordinarily follow from or could be reasonably anticipated from the intentional act." The Second Circuit held that the underlying suits did not allege an "accident" because Primary Arms committed intentional acts (selling and marketing their products in New York to individuals who would otherwise be disqualified from purchasing finished firearms) that resulted in injuries that ordinarily follow from or could be reasonably anticipated from the intentional acts (*i.e.*, increased gun-related incidents and ensuing financial burdens). Primary Arms argued that coverage should apply because the underlying complaints alleged theories of negligence; the Second Circuit rejected this argument, concluding that the negligence allegations were mere "conclusory legal labels" inconsistent with the "basic facts underlying the claims."

COMMENTS

Policyholders often argue that an event should be deemed accidental based on the absence of subjective intent to cause harm or an underlying allegation of negligence. This decision reinforces the principle that for insurance coverage purposes, the determination of whether an "accident" exists turns primarily on whether the initial acts were intentional and whether the resulting harm could be reasonably anticipated—not whether the policyholder intended the specific consequences. This principle is significant in coverage cases involving public nuisance claims arising out of the opioid epidemic, environmental damage, social media cases, and other firearms cases.

Third Circuit Rules That Aggregate Limit Language In Excess Policy Is Ambiguous

HOLDING

The Third Circuit held that an excess insurer's definition of its aggregate limit was ambiguous when read in conjunction with the policy to which it follows form. *J.D. Eckman, Inc. v. Starr Indem. & Liab. Co.*, No. 23-2759, 2025 U.S. App. LEXIS 32545 (3d Cir. Dec. 12, 2025) (per curiam).

BACKGROUND

Construction company J.D. Eckman maintained a layered insurance program consisting of a primary policy issued by Arch, a first excess policy issued by Great American (GA), and a second excess policy issued by Starr. The Starr policy contained a follow-form provision stating that it followed the GA policy, which itself followed the Arch policy. Starr's policy provided a $4 million "Each Occurrence" limit and a $4 million "Other Aggregate Limit" defined as:

> the most we will pay for all 'Ultimate Net Loss' . . . that is subject to an aggregate limit provided by the [GA Policy]. The Other Aggregate Limit . . . applies separately and in the same manner as the aggregate limits provided by the [GA Policy]. (alterations in original).

Eckman experienced two accidents at two separate Eckman projects. After the second accident, Eckman sought confirmation that the Starr policy's aggregate limit applied on a "per-project basis"—*i.e.*, that a fresh $4 million aggregate was available for the second accident. Starr responded that all losses were subject to a single, overall $4 million aggregate limit under its policy.

Eckman sued, seeking a declaratory judgment that the Starr policy's aggregate limit applied on a per-project basis. The district court dismissed the action, concluding that the Starr policy unambiguously capped coverage at $4 million for "all Ultimate Net Loss" and that this interpretation is consistent with the policy's follow-form and limits provisions.

DECISION

The Third Circuit vacated the dismissal, holding that the Starr policy's aggregate limit language was ambiguous under Pennsylvania law. The court emphasized that Starr's coverage applied only to losses subject to an aggregate limit provided by the GA Policy, and that it was unclear whether the GA Policy makes project-specific losses subject to their own, per-project aggregate limit or one general aggregate limit.

Discussing the GA policy, the Third Circuit found two provisions in tension. On the one hand, the GA policy stated that it followed the Arch policy's form *except* as to the Arch policy's "Limits of Insurance," which include the $2 million Designated Construction Project General Aggregate Limit that applies on a per-project basis. On the other hand, the GA policy also provided that its $1 million aggregate limit "is the most we will pay for *all 'loss'* that is subject to an aggregate limit provided by" the Arch Policy, subject to certain exclusions.

Because the Third Circuit found that these provisions could reasonably be read different ways, the Third Circuit concluded that the GA policy's aggregate structure was ambiguous, and that ambiguity carried through to Starr's follow-form excess policy.

COMMENTS

The Third Circuit concluded that the GA policy could be interpreted in two ways: either to completely disregard the Arch policy's per project limits language or to partially reinstate it. In so holding, the Third Circuit was not persuaded that Starr's $4 million "Other Aggregate Limit" unambiguously capped Starr's coverage obligation at $4 million. To illustrate this, the court observed:

> [S]uppose Eckman operates two projects, A and B. If Eckman becomes liable for $6 million in qualifying damage on project A, it would be covered for the full $6 million on project A: $1 million from Arch, $1 million from GA, and $4 million from Starr. If Eckman then becomes liable for $6 million in qualifying damage on project B, that loss is still "subject to an aggregate limit" in the Arch Policy . . . because it is subject to the Arch Policy's per-project Designated Construction Project General Aggregate Limit. It would then be subject to a $1 million aggregate limit in the GA Policy.

Given the Court's conclusion of a reasonable divergence in interpretations, the court remanded the case for further proceedings, including discovery to obtain evidence that may assist the district court in interpreting the ambiguous language.

New Jersey Appellate Court Holds No Duty To Defend Or Indemnify In Casino Assault Case

HOLDING

A homeowner's insurer owes no duty to defend or indemnify an insured in a suit arising out of a casino assault because an intentional punch is not an "accident" or "occurrence" triggering coverage. *De Chacon v. Caesars Ent. Corp.*, No. A-2376-23, 2025 N.J. Super. Unpub. LEXIS 2584 (Super. Ct. N.J. App. Div. Dec. 16, 2025) (per curiam).

BACKGROUND

This case arose from a 2018 physical assault at Bally's Casino in Atlantic City, during which Nieves punched De Chacon. Nieves later pleaded guilty to third-degree aggravated assault. De Chacon sued Nieves civilly and sought a declaratory judgment that USAA, which issued a homeowners policy to Nieve's parents, owed a duty to defend and indemnify Nieves.

USAA moved for summary judgment arguing that the assault was intentional and therefore fell outside the policy's definition of "occurrence," and was independently barred by the policy's intentional acts exclusion. The trial court agreed. First, the court conducted a New Jersey choice-of-law analysis to decide what state's law controlled. It held that New York law governed the interpretation of the policy because New York had the most significant relationship to the transaction and the parties: the insureds resided in New York, the policy was issued in New York, and the insured property was located there.

Second, on the merits, the court concluded that the punch was intentional, and that coverage was precluded by the exclusion. The trial court rejected Nieves's argument that the "lawful reasonable force" exception applied, noting that the criminal sentencing court found no provocation or justification for the assault.

DECISION

The appellate court affirmed. Applying New York law, the court held that Nieves's guilty plea was dispositive. Even absent the plea, the court explained, New York courts routinely deny coverage for assault claims because assaults are intentional acts by definition, and bodily injuries arising from assault are "expected or intended" and not "accidental."

On appeal Nieves sought a ruling that New Jersey law should apply because the assault occurred in New Jersey—a distinction with potentially significant coverage consequences. Under New York law, an insured who pleads guilty to aggravated assault is collaterally estopped from asserting that the resulting bodily injury was unintended. By contrast, the court observed that New Jersey law may allow an insured to seek coverage for assault-related injuries notwithstanding a guilty plea. The court agreed with the trial court that New York law governed because New York had the most substantial relationship to the parties and the insurance contract, rendering the location of the assault insufficient to alter the choice-of-law analysis.

COMMENTS

Although it applied New York law, the court emphasized that the outcome would be the same under New Jersey law. The record established that Nieves "expected 'to cause some sort of injury;'" therefore, there was no "occurrence." The court declined to reach the applicability of the "defense of others" exception but noted that the record would not support it in any event.

Fighting Outsize Verdicts

Appellate Court Affirms Jury Verdict Awarding Auto-Accident Plaintiff A Fraction Of Alleged Medical Expenses

HOLDING

A Louisiana appellate court affirmed a jury decision to award a plaintiff a fraction of the medical expenses he claimed in an auto-accident case, affirming a medical award that was significantly below the amount sought at trial. *Agenor v. Suarez*, No. 25-CA-74, 2025 La. App. LEXIS 2608 (La. Ct. App. Dec. 30, 2025).

BACKGROUND

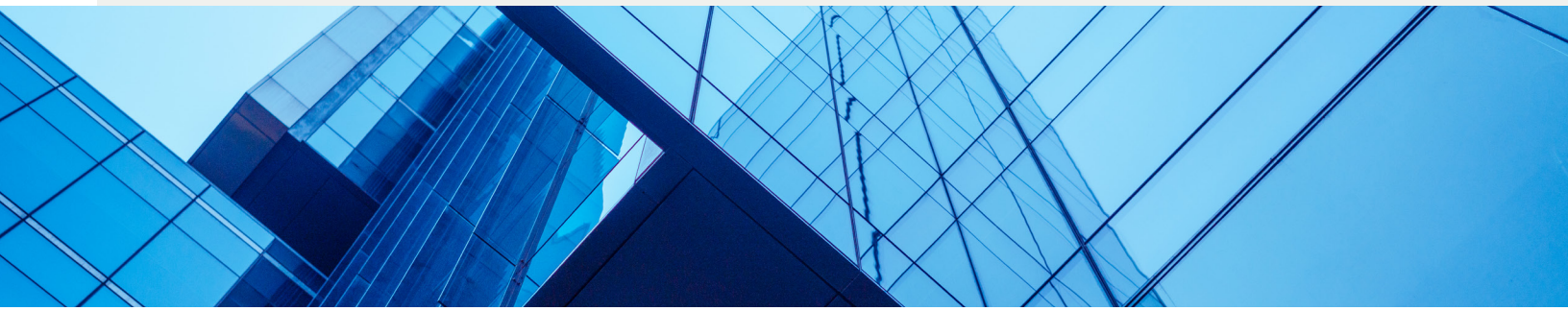
Agenor sued Suarez and her insurer seeking compensation for medical expenses and pain and suffering following a motor vehicle accident. At trial, Agenor claimed he incurred roughly $57,000 in medical expenses. The jury, however, awarded him only $5,000 for medical expenses and $7,500 for general damages. Agenor filed a motion for judgment notwithstanding the verdict, arguing that the jury's award was "abusively" low. The court denied the motion and Agenor appealed.

DECISION

The appellate court ruled that Agenor's appeal lacked merit, affirming the trial court's decision not to award him the full roughly $57,000 in medical expenses. On general damages, the appellate court concluded the jury did not commit a "manifest error" in crediting testimony that Agenor's injuries related to the accident had resolved by February 12, 2014, and awarding general damages accordingly.

The appellate court explained that special damages, such as medical expenses, are those that can be determined with "relative certainty." In its review, the appellate court outlined a two-step process for overturning the trial decision: First, there must be no reasonable factual basis for the trial court's conclusions. Second, the appellate court must find that the trial court's findings were "clearly wrong."

The appellate court concluded that the jury's award was supported by a reasonable factual basis and the jury did not err in determining its award. The court again noted that the jury credited physicians' testimony that Agenor's injuries related to the accident had resolved by February 12, 2014, such that it was not error to award Agenor for medical expenses incurred up to that date and to exclude those incurred afterward.



COMMENTS

This case stands out amid a broader trend of increasingly large jury verdicts. Notably, as discussed in our October 2025 Alert, a 2025 Behavioral Social Inflation Study by Swiss Re, based on a survey of 1,150 adults in the U.S., revealed that a significant percentage believe that large corporations should be responsible for medical expenses even if they aren't directly at fault. *Martin Boerlin & Surbhi Gupta, Verdicts on Trial: The Behavioral Science Behind America's Skyrocketing Legal Payouts (Sept. 24, 2025).* In contrast, the outcome in this case suggests that juries, when presented with persuasive and fact-based expert testimony can steer away from inflated awards, despite facing an insurer as one of the defendants. That said, the appellate court's decision leaves unclear what role the insurer played in the trial. Additionally, the fact that the tortfeasor, Suarez, was an individual rather than a corporation may have influenced the jury's decision.

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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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