Simpson Thacher

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– *Chambers USA* 2025 (quoting a client)

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A Texas district court granted a property insurer's motion for judgment as a matter of law following a jury verdict awarding the policyholder $4.8 million in actual damages and $35 million in punitive damages, finding a lack of evidence to support the awards. *Green Acres Baptist Church, Inc. v. Bhd. Mut. Ins. Co.*, 2025 U.S. Dist. LEXIS 126690 (E.D. Tex. July 3, 2025). (Click here for full article)

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A Nebraska district court denied an insurer's motion to dismiss a coverage claim, finding that a "loss" provision in the policy was ambiguous and that exclusions did not bar coverage as a matter of law. *Panorama Point Partners, LLC v. Everest Nat'l Ins. Co.*, No. 8:24CV393 (D. Neb. June 20, 2025). (Click here for full article)

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A California district court granted an insured's summary judgment motion, ruling that a Dilution Claims Exception in an Insured v. Insured Exclusion restored D&O coverage. *Scottsdale Ins. Co. v. Hamerslag*, 2025 U.S. Dist. LEXIS 118805 (S.D. Cal. June 23, 2025). (Click here for full article)

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The Fifth Circuit ruled that an Intellectual Property Exclusion in a liability policy was ambiguous, and separately, that the insured did not establish that one of its employees was "legally obligated to pay" a third party for purposes of triggering the insurer's defense obligations. *Paloma Res., L.L.C. v. Axis Ins. Co.*, 2025 U.S. App. LEXIS 16588 (5th Cir. July 7, 2025). (Click here for full article)

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First Circuit Rules That Jury Verdict Awarding Business Interruption Damages In Excess Of Policyholder's Loss Lacked Evidentiary Basis

HOLDING

The First Circuit ruled that a district court abused its discretion in denying an insurer's post-trial motion to reduce a jury's damages award, finding that the award, which exceeded the policyholder's claimed loss, lacked evidentiary support and thus must be reduced. *Coco Rico, LLC v. Universal Ins. Co.*, 141 F.4th 321 (1st Cir. 2025).

BACKGROUND

Coco Rico, a manufacturer of beverage concentrate, suffered damage to its facility when a hurricane hit Puerto Rico in 2017. It sought coverage under a property policy issued by Universal, which provided coverage for "business interruption" losses and certain "extra expenses." When the parties could not agree on the amount of covered loss, Coco Rico sued, alleging breach of contract and bad faith. The suit sought payment for business interruption loss as well as compensatory and consequential damages, attorneys' fees, and interest.

The case proceeded to trial, after which Universal moved for judgment as a matter of law on Coco Rico's request for consequential damages. The court denied the motion and the jury ultimately found in Coco Rico's favor on the breach of contract and bad faith claims. The jury awarded Coco Rico $873,000 for business interruption and extra expense loss, and $250,000 in consequential damages resulting from Universal's bad faith.

The district court denied Universal's renewed motion relating to consequential damages. The court also denied Coco Rico's post-trial motion to amend the judgment to include attorneys' fees and pre- and post-judgment interest. The court granted Universal's motion to reduce the contractual damages award from $873,000 to $750,000, the policy limit for business interruption and extra expense coverage. But it rejected Universal's argument that the award should be further reduced to $686,000, the amount of loss calculated by Coco Rico's own expert.

DECISION

The First Circuit ruled that the trial court abused its discretion in refusing to reduce the contractual damages award to $686,000. The court noted the deferential standard given to district courts as to such rulings, but concluded that the $750,000 award exceeded "any rational appraisal or estimate of the damages that could be based upon the evidence before the jury." In particular, the First Circuit emphasized that the record lacked information about Coco Rico's sales, projected earnings, or restoration efforts. Further, the court noted that while Coco Rico originally sought $900,000 in business interruption loss, its counsel and witnesses "expressly and repeatedly" stated its contractual damages were not more than $686,000 during trial.

With respect to consequential damages, the First Circuit applied a de novo standard of review. The court concluded that there was no reasonable basis for the district court to deny Universal's motion for judgment as a matter of law. The First Circuit cited the lack of any testimonial evidence supporting consequential damages, noting that a statement by Coco Rico's owner that "[e]very year we operate and don't operate in Puerto Rico is . . . hundreds of thousands of dollars that it costs us not to be down here" was too general and conclusory to support a specific consequential damages dollar amount.

Finally, the First Circuit upheld the denial of attorneys' fees and interest pursuant to Puerto Rico statutory law. Under the applicable Rules of Civil Procedure, such costs may be awarded only if Universal behaved "obstinately" during litigation. The court held that the factual record lacked evidence of such conduct and therefore that the district court's refusal to award such costs was not an abuse of discretion.

COMMENTS

The First Circuit's denial of attorneys' fees and interest highlights certain noteworthy principles. First, the First Circuit rejected the assertion that the jury's finding of bad faith amounted to a finding of obstinate conduct. The court explained that the relevant statute expressly limits obstinate conduct to a party's conduct during litigation, whereas the jury's bad faith finding was based on Universal's delay in fulfilling its contractual obligations—conduct that preceded litigation.

Second, the decision reaffirms the well-established principle that an insurer is not obstinate merely because its argument was ultimately unsuccessful. The First Circuit rejected the notion that Universal acted with obstinance in asserting various denials and affirmative defenses, noting that Universal provided reasoned explanations for its denials, even if those arguments ultimately proved unsuccessful.

Deeming Cyber Policy Ambiguous, New Mexico Appellate Court Rules That Policyholder Is Entitled To Coverage For Third-Party Losses Stemming From Security Breach

HOLDING

Affirming a trial court decision, a New Mexico appellate court ruled that a cyber policy was ambiguous and therefore construed it in favor of coverage. *Kane v. Beazley USA Servs., Inc.*, 2025 N.M. App. LEXIS 38 (N.M. Ct. App. June 16, 2025).

BACKGROUND

The coverage dispute arose out of a security breach in which a hacker posed as an account manager for OptumRX, a vendor of New Mexico Health Connections, Inc. ("NMHC"). The hacker sent a fake invoice to NMHC, after which NMHC wired approximately $4.4 million to the hacker's bank account. When amounts due to OptumRX were not paid, OptumRX sued. NMHC sought defense and indemnity from Beazley, which denied coverage. Beazley argued that OptumRX's claims did not trigger third-party coverage under the cyber policy, and even if they did, that two exclusions applied.

In ensuing litigation between NMHC and Beazley, a trial court granted NMHC's summary judgment motion. The court ruled that a policy provision covering damages to third parties "for a security breach" was ambiguous and should be construed in NMHC's favor. The trial court further found that the exclusions did not clearly apply to the loss at issue. The appellate court affirmed.

DECISION

The parties did not dispute that the incident constituted a "security breach," defined by the policy as "a failure of computer security to prevent . . . unauthorized access or use of [the insured's] computer systems." Rather, the dispute centered on whether OptumRX's claim was a claim "for" a security breach.

Beazley argued that the term "for" limits coverage to claims directly for a security breach itself, such as a suit seeking damages for a policyholder's loss of a third-party's private data. Beazley therefore claimed that the policy did not extend to a breach of contract claim based on NMHC's failure to pay OptumRX's invoices, even where the breach of contract originated with a security breach. In contrast, NMHC argued that the phrase "for a security breach" included all third-party claims where the loss was causally related to a security breach.

The appellate court agreed with the trial court that the provision was ambiguous. The court determined that the dictionary did not resolve any ambiguity because there were multiple competing dictionary definitions of "for." Additionally, the court found that decisions from other jurisdictions construing the meaning of "for" were inapposite because those cases concerned commercial general liability coverage (*e.g.*, for bodily injury) rather than cyber insurance coverage and, according to the appellate court, lacked an "interpretive consensus."

The appellate court also ruled that two exclusions did not apply. One exclusion applied to loss arising out of a diminution of monetary value during the transfer of funds between accounts. The court deemed this provision inapplicable because the factual record lacked evidence of a loss in value during a monetary transfer. The second exclusion barred coverage for loss of funds "in the care, custody or control of the insured organization." The court ruled that the lost funds were not within the care, custody, or control of NMHC because the funds were held at a Wells Fargo bank. Applying New York law in accordance

with a choice of law policy provision, the court ruled that money deposited with a bank "belongs to the bank and is not the property of the depositor."

COMMENTS

The nature of the policy at issue—a cyber breach response policy—was relevant to the court's finding of ambiguity. The court noted that cybersecurity insurance is a relatively new product and posited that purchasers of such coverage "often have little knowledge about the breadth and sophistication of cybersecurity risks they face" whereas insurers "are far more knowledgeable." The court further reasoned that the "imbalance is exacerbated by the lack of standard policy language among insurers to define or limit coverage."

Texas Court Grants Insurer's Motion For Judgment As A Matter Of Law Following Jury's Nuclear Verdict In Property Damage Coverage Suit

HOLDING

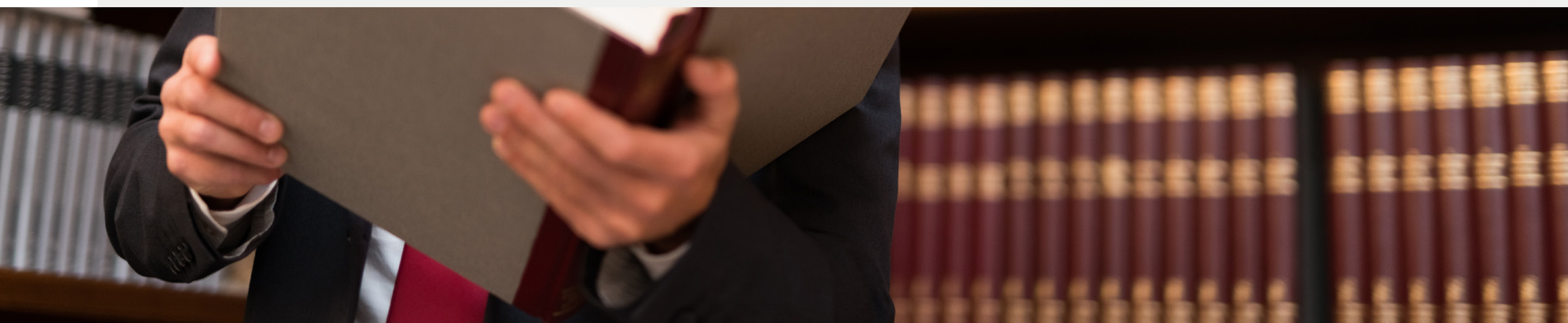
A Texas district court granted a property insurer's motion for judgment as a matter of law following a jury verdict awarding the policyholder $4.8 million in actual damages and $35 million in punitive damages, finding a lack of evidence to support the awards. *Green Acres Baptist Church, Inc. v. Bhd. Mut. Ins. Co.*, 2025 U.S. Dist. LEXIS 126690 (E.D. Tex. July 3, 2025).

BACKGROUND

Property owned by Green Acres Baptist Church incurred damage during a hailstorm. Brotherhood Mutual paid more than $3.1 million to repair or replace the property according to the policy and the parties' agreed upon scope of work. However, the parties disputed whether certain other property was covered by the policy. Green Acres filed suit, alleging breach of contract, bad faith, and violations of the Texas Insurance Code.

The case went to trial and a jury returned a verdict awarding Green Acres approximately $4.8 million on the breach of contract claim and $35 million in punitive damages. Although the jury found that Brotherhood engaged in unfair or deceptive acts, it awarded no damages on that claim. It also found that Brotherhood did not violate the Texas Insurance Code.

Post-trial, Brotherhood sought a take-nothing judgment as a matter of law. It argued that it complied with the policy by paying Green Acres the replacement costs of all property that had been repaired or replaced. With respect to property that had not yet been repaired or replaced, Brotherhood argued that it owed only actual cash value, which Green Acres failed to prove at trial. The court agreed and granted Brotherhood's motion for judgment as a matter of law.



DECISION

The policy provides that Brotherhood must pay the lesser of the amount determined under the "Valuation of Property" clause or the cost to repair, replace, or rebuild the property with material of like kind and quality. The Valuation of Property clause states that Brotherhood must pay the replacement cost up to the amount Green Acres spends to repair or replace with similar materials. Thus, if Green Acres does not repair or replace damaged property, Brotherhood does not owe replacement costs. Rather, in that case, Green Acres may make a claim for the actual cash value.

The court held that Green Acres was not entitled to any additional replacement costs because it had not repaired or replaced any property for which Brotherhood had not already paid. The court further held that Green Acres was not entitled to actual cash value because it failed to submit evidence supporting such claims. In this context, the court held that estimates of replacement costs were insufficient to establish actual cash value. Along similar lines, the court held although Green Acres was not satisfied with some of the repairs, it failed to present evidence that the materials used were not "of like kind and quality."

Having reached these conclusions, the court held that Brotherhood did not breach the policy and that Green Acres did not suffer any damages, let alone the $4.8 million awarded by the jury.

As to the common law and statutory bad faith claims, the court held that Green Acres failed to prove the actual damages required to substantiate the common law claims. Rather, the only source of actual damages raised at trial were the allegedly unpaid policy benefits. The statutory claims likewise failed to substantiate actual damages given that the jury had found that Brotherhood did not violate any statutory provisions. As such, the court ruled that Brotherhood was entitled to judgment as a matter of law on the bad faith claims as well.

COMMENTS

The decision is important not only in its substantive findings, but also in its clear pronouncement as to the burden of proof for actual cash value claims. Green Acres argued that the actual cash value clause in the "Valuation of Property" provision constituted a limitation on liability for which Brotherhood bears the burden of proof. The court rejected this assertion, explaining that the clause provides a way to measure damages, not a limitation on liability.

Nebraska Court Declines To Dismiss Coverage Suit Stemming From Cyber Theft

HOLDING

A Nebraska district court denied an insurer's motion to dismiss a coverage claim, finding that a "loss" provision in the policy was ambiguous and that exclusions did not bar coverage as a matter of law. *Panorama Point Partners, LLC v. Everest Nat'l Ins. Co.*, No. 8:24CV393 (D. Neb. June 20, 2025).

BACKGROUND

Panorama, a private equity investment fund management company, entered into negotiations with an entity that it believed to be a Swiss-based investment group. The investors pledged a $50 million investment, contingent upon Panorama creating a "good faith reserve" of $2.83 million. To fund the reserve, Panorama borrowed $3 million from Access Bank.

Panorama also obtained a private equity insurance policy from Everest. The policy covered losses for both "Wrongful Acts" and "Security Wrongful Acts." "Wrongful Act" was defined as any "actual or alleged act, failure to act, error, omission, misstatement, misleading statement, neglect or breach of duty by an Insured Person," as well as any "Security Wrongful Act." Separately, a "Security Wrongful Act," was defined as "any actual or alleged act, error, omission, neglect or breach of duty by an Insured that results in a System Breach, Denial of Service Attack or Privacy Event."

Panorama initially put the loan funds in a secure cryptocurrency account, but at the urging of the investors, moved the funds to an unsecured blockchain account. Within seconds of the transfer to the unsecured account, the purported Swiss investors hacked the account and stole the $2.83 million.

When Access Bank learned of the incident, it demanded that Panorama recover the lost funds. Thereafter, Panorama filed a claim with Everest, which denied coverage. Panorama filed suit and Everest moved to dismiss. The court denied the motion.

DECISION

The policy defined "loss" to exclude "any amount that represents . . . any actual or alleged funding obligations . . . or monies paid . . . as a result of any actual or proposed equity purchase, equity investment or equity contribution, acquisition, or loan or extension of credit." Everest contended that the loss at issue was a loan and therefore excluded from coverage. The court concluded that this provision was ambiguous, reasoning that the language was unclear as to whether it excluded only equity-related funding obligations (as contended by Panorama) or all loans.

Everest also argued that the bank's letter did not constitute a covered "loss" for a "Wrongful Act" or "Wrongful Security Act" as required by the policy, but instead merely sought repayment of a loan. Rejecting Everest's construction, the court reasoned that the bank's letter was more expansive than a simple loan repayment request and included references to the cyber theft and alleged misrepresentations by Panorama in obtaining the loan. The court stated: "While its primary purpose was seeking for Panorama to recover the lost funds, it also explains the potential wrongful acts which necessitated the recovery of funds. It would be myopic to read the Bank's letter as merely seeking loan repayment when the theft of the funds was the precipitating event." The court therefore concluded that the demand letter triggered coverage for a Wrongful Act and/or a Wrongful Security Act under the relevant policy provisions.

The court also rejected Everest's assertion that coverage was barred by a cyber theft exclusion, which applied to claims "based upon, arising out of, or is attributable to the loss, transfer [or] theft of monies, securities or tangible property in the care, custody or control of the Insured," among other things. The court explained that the heading to this exclusion stated that it applied exclusively with respect to coverage for a Security Wrongful Act. Therefore, even if the exclusion applied, Panorama could obtain coverage for a Wrongful Act.

COMMENTS

Because the court was ruling on a motion to dismiss, the availability of coverage under Everest's policy remains unsettled. The court noted that the factfinder must consider extrinsic evidence relating to the ambiguity of the "loss" provision. Such evidence may result in a finding of no coverage. Similarly, development of the factual record may lead to a ruling that coverage is barred by the exclusionary clauses.

Delaware Court Rules That Tolling Agreement Is Not A Securities Claim For Purposes Of Triggering D&O Coverage

HOLDING

A Delaware trial court denied a policyholder's summary judgment motion, ruling that a tolling agreement with the Securities and Exchange Commission ("SEC") was not a "Securities Claim" alleging a "Wrongful Act" as required by the policy. *Clear Channel Outdoor Holdings, Inc. v. Ill. Nat'l Ins. Co.*, Del. Super. LEXIS 328 (Del. Super. Ct. June 30, 2025).

BACKGROUND

When Clear Channel discovered that an employee had misappropriated funds, it initiated an internal investigation and notified the SEC. The SEC then initiated its own investigation and requested that Clear Channel toll the statute of limitations for any enforcement action. Clear Channel agreed and the parties entered into a tolling agreement.

Clear Channel notified AIG of the tolling agreement and sought coverage under the D&O policy for all response costs incurred after and as a result of the SEC's tolling request. AIG denied coverage, arguing that the matter was "only an investigation," not a covered "Securities Claim." The court agreed with AIG.

DECISION

The policy provided two types of coverage: coverage for individual insureds and coverage for Clear Channel, as an organization. The organizational coverage provisions applied to loss arising out of any "Securities Claim" made against the organization for any "Wrongful Act." The policy further stated that a "Securities Claim" is "a Claim, other than an investigation of an Organization . . . alleging a violation of any federal, state, local or foreign regulation, rule, regulating securities." A "Claim" was defined to include any written request to toll or waive the applicable statute of limitations.

Based on this language, the court concluded that the SEC's tolling request was not a Securities Claim. The court reasoned that the tolling request was part of an investigation of Clear Channel, an organization, which is expressly excluded from coverage.

In so ruling, the court rejected Clear Channel's assertion that this interpretation of "Securities Claim" rendered coverage for tolling requests "meaningless or illusory." The court explained that coverage for tolling requests was provided for individual insureds because the applicable policy language provided coverage for "Claims." However, as to the organization, the policy provided coverage only for "Securities Claims."

The court further held that coverage was unavailable for the following independent reasons: (1) the tolling request did not allege any violation of law regulating securities, as required by the "Securities Claim" definition; and (2) the tolling request did not seek relief for any "Wrongful Act."

COMMENTS

The decision highlights an important concept relating to "Claims" versus "Securities Claims" for purposes of organizational coverage under a D&O policy. Here, the policy defined "Securities Claim" to include a "Claim." Further, the policy defined "Claim" to include any written request to toll or waive an applicable statute of limitations. Notwithstanding those definitions, the policy stated that a "Securities Claim" does not include an investigation of an organization.

In light of this language, the court observed: "[A]lthough an insured must have a Claim . . . to have a Securities Claim, not every Claim qualifies as a Securities Claim . . . This means, Securities Claims are limited to a subset of Claims—ones that are not investigations."

Fifth Circuit Rules That Insurer Waived Right To Cancel Life Insurance Policy By Continuing To Accept Premium Payments

HOLDING

The Fifth Circuit ruled that ERISA applied to a life insurance policy and that the insurer waived the right to cancel the policy by accepting premium payments for more than two years after its right to cancel vested. *Edwards v. Guardian Life Ins. of Am.*, 140 F.4th 729 (5th Cir. 2025).

BACKGROUND

When a salon owner died, her husband sought payment on a life insurance policy she obtained in 2007. Guardian denied the claim, arguing that the policy had been cancelled in January 2022, before her death. The policy was a group policy that covered multiple salon employees, but by November 2019, coverage had dropped to a single individual (the salon owner), triggering Guardian's contractual right to cancel it. Nevertheless, Guardian accepted the salon owner's premiums for these twenty-six months, including throughout September 2020 to October 2021, when (due to Covid-19) Guardian suspended its standard policy of canceling one-member plans. The salon owner's husband sued Guardian, alleging common law claims and alternatively, that he was entitled to benefits under ERISA.

In the Mississippi district court, the salon owner's husband submitted an affidavit from the salon owner's insurance agent, claiming that the agent never received the customary cancellation notice and therefore, neither did the salon owner. The district court found, however, that the cancellation notice was *sent* to the salon owner—both on October 28, 2021 and January 5, 2022—despite her husband's assertions that notice was never *received*. The district court found the agent's affidavit alone did not create a genuine dispute of material fact as to whether notice was sent.

The district court granted Guardian's partial summary judgment motion. The Fifth Circuit reversed.

DECISION

As a preliminary matter, the Fifth Circuit ruled that ERISA applied to the life insurance policy, finding that it constituted an "employee benefit plan" "established or maintained by any employer engaged in commerce." The parties disputed whether the salon owner had "employees," a requirement under ERISA. Concluding that the other salon workers were employees, rather than independent contractors, the court emphasized that the owner controlled their hours, owned the building and equipment they used, and paid their premiums out of the salon's business account.

Having deemed ERISA applicable, the court turned to the question of benefits under the policy. The policy allowed Guardian to cancel coverage when less than two employees are insured. That right vested in November 2019, when the owner became the sole participating employee. The Fifth Circuit ruled that Guardian waived its discretionary right to cancel under ERISA by accepting premiums for twenty-six months after its right to cancel vested. The court did not address the dispute over whether notice was sent or received but instead rested its ruling on the ten-month period between when Guardian's cancellation right vested (November 2019) and when it instituted its policy against canceling one-member plans (September 2020) and the fact that Guardian accepted premiums from November 2019 to January 2022. The court found that the delay in cancellation prejudiced the salon owner because by the time of the purported January 2022 cancellation, the owner was mentally and physically deteriorated such that she could not conduct business.

COMMENTS

Guardian argued that any delay in cancelling the plan was at least partially due to a temporary change in its cancellation policies in September 2020, due to the pandemic. During the pandemic, Guardian temporarily suspended its practice of terminating plans that had dropped to one participant, but later reinstated its normal cancellation policies and terminated the salon owner's coverage in January 2022, a few months before her death. The court deemed this temporary suspension of Guardian's standard cancellation policy irrelevant to the finding of waiver.

The Fifth Circuit's waiver ruling focused largely on Guardian's acceptance of premiums for more than two years after its right to cancel vested, rather than the agent's alleged failure to receive notice.

California Court Rules That "Dilution Claims Exception" To Insured v. Insured Exclusion Restores D&O Coverage

HOLDING

A California district court granted an insured's summary judgment motion, ruling that a Dilution Claims Exception in an Insured v. Insured Exclusion restored D&O coverage. *Scottsdale Ins. Co. v. Hamerslag*, 2025 U.S. Dist. LEXIS 118805 (S.D. Cal. June 23, 2025).

BACKGROUND

David Loo was the founder and CEO of Perspectium, a data analytics company. Steven Hamerslag, through his venture capital firm, TVC Capital, invested $16 million in Perspectium and became a director alongside Loo.

In the underlying litigation, David Loo, his wife Sarah Loo, and the Loo Family Trust (collectively, the "Loo Plaintiffs") sued Hamerslag, alleging that he exploited his position in Perspectium for his own personal profit and to the detriment of the Loo Plaintiffs. More

specifically, the complaint alleged that Hamerslag negotiated a contractual arrangement with BitTitan, another company in which he served as director, to position himself to financially benefit at the expense of the Loo Plaintiffs in an all-cash sale that immediately followed the transaction. The complaint further alleged that Hamerslag artificially inflated the value of BitTitan. The suit, which included breach of fiduciary duty claims and negligent misrepresentation, was ultimately resolved.

Hamerslag sought coverage, which Scottsdale denied pursuant to an Insured v. Insured Exclusion that applied to claims "brought or maintained by, on behalf of, in the right of, or at the direction of any Insured in any capacity . . ." Scottsdale then filed suit, seeking a declaration of no coverage. Scottsdale moved for judgment on the pleadings and Hamerslag moved for summary judgment. The court denied Scottsdale's motion and granted Hamerslag's motion.

DECISION

The court ruled that judgment as a matter of law as to application of the Insured v. Insured Exclusion was not warranted because issues of fact existed as to the identity of the trustees in the Loo Family Trust.

However, the court held that even if the exclusion applied, coverage would be restored by the Dilution Claims Exception, which applied to claims brought by a director or officer "solely in their capacity as a securities holder of the Company and where such Claim is solely based upon and arising out of any actual or alleged unfair dilution of such securities holder's securities interest . . ." For the exception to apply, the court held that the following elements must be satisfied: (1) the Loo Plaintiffs filed the underlying suit "solely" in their capacity as Perspectium securities holders; and (2) the underlying suit was "solely" based upon and arising out of alleged unfair dilution of the Perspectium shares.

The court found that both prongs were met, rejecting Scottsdale's assertion that the Loo Plaintiffs were also suing in their capacity as BitTitan employees and shareholders. The court stated:

> The Loo Complaint sets forth one continuous chain of events allegedly resulting in harm to the Loo Plaintiffs, all of which emanated directly from the Loos' stake in Perspectium shares . . . The mere fact that Hamerslag's alleged scheme persisted beyond the closing of the Perspectium-BitTitan merger, thereby incidentally implicating David Loo's newfound status as a BitTitan equities holder . . . does not negate the reality that the underlying suit is all about one thing: how the Loos retained less money from their Perspectium shares than the shares were otherwise worth absent Hamerslag's alleged wrongdoing.

COMMENTS

The ruling rejects what it termed an overly "strict" reading of the term "solely" to mean exclusively or entirely. The court noted that while the allegations in the underlying complaint "may incidentally bump up against David Loo's dual status as a BitTitan shareholder," Loo's dual status arose exclusively because of Hamerslag's alleged wrongdoing—which allegedly resulted in the diminution of share value.

On July 21, 2025, Scottsdale noticed its appeal to the Ninth Circuit Court of Appeals, where it remains pending.

Fifth Circuit Addresses Interpretation Of Intellectual Property Exclusion And "Legally Obligated To Pay" Requirement In Liability Policy

HOLDING

The Fifth Circuit ruled that an Intellectual Property Exclusion in a liability policy was ambiguous, and separately, that the insured did not establish that one of its employees was "legally obligated to pay" a third party for purposes of triggering the insurer's defense obligations. *Paloma Res., L.L.C. v. Axis Ins. Co.*, 2025 U.S. App. LEXIS 16588 (5th Cir. July 7, 2025).

BACKGROUND

Paloma and one of its employees were sued by Continental Resources, a business competitor. The suit alleged that the Paloma employee colluded with two Continental Resources employees to steal confidential information from Continental Resources. The parties ultimately settled, with Paloma stipulating that the suit involved the unauthorized disclosure of and access to Continental Resource's confidential information. Additionally, under the settlement, Continental Resources agreed to release the employee from liability and the claims against him were dismissed.

Thereafter, Paloma sought to recover its defense and indemnity expenses from Axis. Axis denied coverage, arguing that an Intellectual Property Exclusion applied. In ensuing litigation, a Texas district court granted summary judgment in favor of Axis on two issues: (1) that the Intellectual Property Exclusion barred coverage; and (2) that Axis had no duty to reimburse Paloma for any expenses the company incurred in defending the employee in the underlying litigation.

The Fifth Circuit reversed in part and affirmed in part.

DECISION

Reversing the district court's ruling as to the Intellectual Property Exclusion, the Fifth Circuit concluded that the provision was ambiguous. It barred coverage for loss arising out of "any actual or alleged infringement of copyright, patent, trademark, trade name, trade dress, or service mark or the misappropriation of ideas or trade secrets, or the unauthorized disclosure of or access to confidential information."

Paloma argued that use of the term "the" immediately before the phrase "misappropriation of ideas or trade secrets" indicates that the phrase "actual or alleged" modifies only the first list of propriety information. Paloma further claimed that with respect to the list of misconduct that follows the disjunctive term "or," the actual conduct (not merely alleged conduct) is required for the exclusion to apply. Finding this construction reasonable, the court deemed the exclusion ambiguous. In so ruling, the court also noted that the exclusion would be grammatically incorrect if the phrase "actual or alleged" was intended to precede/modify the phrase "the misappropriation of ideas or trade secrets."

However, the Fifth Circuit affirmed the grant of summary judgment in favor of Axis with respect to its

coverage obligations to Paloma's employee. The Fifth Circuit reasoned that the employee was not "legally obligated to pay" under the settlement, a prerequisite to coverage under the policy. Paloma put forth two arguments in support of its assertion that the employee was "legally obligated to pay." First, it argued that as a Delaware limited liability company, Paloma had the power to indemnify its employee and therefore that any expenses incurred by the employee could be considered legally owed to Paloma as an indemnitor. Second, Paloma argued that it incurred vicarious liability for the employee's actions, which constituted a legal obligation to pay on the part of the employee. The Fifth Circuit rejected both assertions, finding them to be without merit and unsupported by Texas law.

COMMENTS

The decision highlights the general principle that the phrase "legally obligated to pay" in insurance policies typically relates to a legal obligation to pay a third party, based on an underlying settlement or judgment. Where, as here, the alleged insured has no obligation to pay the third party, indemnity coverage is generally unavailable.

Simpson Thacher News

The *New York Law Journal* has named Simpson Thacher a finalist for "Litigation Department of the Year" in the "Insurance" category as part of its 2025 New York Legal Awards. Simpson Thacher was previously named Insurance Litigation Department of the Year in 2018, 2020, 2023 and 2024.

Lynn Neuner has been named among *Bloomberg Law*'s inaugural list of "Unrivaled Litigators," an elite group of litigation attorneys who "lead the industry in high-stakes trials and settlements on impactful matters for clients." Lynn was recognized for her work delivering successful outcomes for clients in multiple big-ticket litigations, including guiding TD Bank to a favorable settlement in $13 billion litigation related to Allen Stanford's Ponzi scheme.

Laura Lin was quoted in an article by *The Register* titled, "U.S. Budget Bill Passes Without Controversial Block on States Regulating AI." The article discusses the recent passing of the budget reconciliation bill without a provision blocking state-level AI regulation. Noting the significance of this development, Lin noted: "There's been growing frustration with the current patchwork of state-level rules, which tech companies that operate across multiple states see as creating bureaucratic hurdles and demanding significant compliance investments . . . The tech industry will likely keep pushing for federal AI legislation."

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 Thacher

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

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