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Insurance Disputes

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In-Depth: Insurance Disputes (formerly The Insurance Disputes Law Review) provides a practical overview of recent developments in insurance disputes across major jurisdictions worldwide. It examines the key features of the legal framework governing insurance-related disputes in each jurisdiction, covering substantive and procedural issues, recent litigation trends and much more.

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Introduction

US courts have recently addressed a number of significant insurance-related issues, including the definition of damages in a general liability insurance policy, the exhaustion of primary and first-level excess coverage, the application of a 'bump-up' exclusion in a directors' and officers' (D&O) liability insurance, policy and coverage for business losses during the covid-19 pandemic. Going forward, courts undoubtedly will continue to address the parameters of cyber-related coverage, as well as coverage disputes arising out of the use of artificial intelligence (AI) technology, PFAS 'forever chemicals,' and climate change events. Insurance-related issues will also continue to be litigated in bankruptcy cases commenced by policyholders as a means to resolve mass tort claims.

Year in review

General liability

Definition of damages

In *Sherwin-Williams Co v. Certain Underwriters at Lloyd's, London*,^[1] the Ohio Supreme Court clarified that, under the language of the liability policies at issue, payments made by a policyholder to fund lead paint abatement do not constitute 'damages'. The court held that because Sherwin-Williams's contributions to the abatement fund were intended to prevent future harm – not to compensate for past harm – they fell outside the scope of coverage.

The underlying litigation, brought by Santa Clara County, California, and other government entities, sought to hold paint manufacturers liable for public nuisance. The trial court found that Sherwin-Williams and two other paint companies had caused a public nuisance and ordered them contribute to an abatement fund for home paint testing, remediation of lead paint hazards, and lead paint poisoning education, among other things.

Sherwin-Williams then sought indemnification under its liability policies, arguing that such payments constituted 'damages.' The company contended that the fund addressed past harms, pointing out that lead paint had been present in California homes for decades and that the purpose of the abatement fund was to compensate for past property damage. The Ohio Supreme Court rejected this argument, holding that because the payments to the abatement fund were intended to prevent future harm rather than compensate for past harm, they did not constitute 'damages' under the policies.

Notably, the court distinguished a prior decision under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), noting that it involved 'response costs' aimed at remediating past harm done to property, even where a public nuisance claim was alleged.

Exhaustion

InTruck Insurance Exchange v. Kaiser Cement and Gypsum Corp.,^[2] the California Supreme Court held that a policyholder may access excess insurance policies once primary policies covering the same policy period and directly underlying the excess policies are exhausted. The case involved Kaiser Cement, a manufacturer of asbestos-containing products, and the allocation of insurance coverage among primary and first-level excess insurers. Truck Insurance, Kaiser Cement's primary insurer, sought equitable contribution from first-level excess insurers, arguing that their indemnity obligations attached upon exhaustion of the directly underlying primary policies, an approach known as 'vertical exhaustion.'

Both the trial court and intermediate appellate court had rejected this argument, interpreting the excess policies' 'other insurance' provisions to require horizontal exhaustion; that is, exhaustion of all primary policies in effect during the period of continuous injury. Relying on its earlier decision in *Montrose Chemical Corp of California v. Superior Court*,^[3] the California Supreme Court explained that 'other insurance' provisions in excess policies have been typically construed to govern allocation questions with respect to overlapping, concurrent policies, not exhaustion of policies from different periods. The court emphasised that the excess policy language, including references to specific underlying policies and attachment points, indicated that exhaustion requirements apply only to direct underlying insurance.

While the decision clarified the appropriate method for exhaustion of the first-level excess policies, it did not resolve whether Truck Insurance was entitled to contribution from the excess insurers. The court underscored that contribution claims among insurers implicate 'equitable principles designed to accomplish ultimate justice in the bearing of a specific burden,' and remanded the matter, noting that qualitative distinctions between primary and excess insurance 'might have more salience in the context of equitable contribution'.

Directors and officers

'Bump-up' exclusion

In *Towers Watson & Co v. National Union Fire Ins Co of Pittsburgh, PA*,^[4] the Fourth Circuit affirmed that a US\$90 million settlement with former shareholders fell within a 'bump-up' exclusion, which barred claims alleging that 'the price or consideration paid or proposed to be paid for the acquisition . . . of all or substantially all the ownership interest in or assets of an entity is inadequate'. Towers Watson sought coverage for a settlement with shareholders who alleged that the merger of Towers Watson and Willis Group Holdings had resulted in a below-market valuation of their shares due to conflicts of interest on Towers Watson's board. The D&O insurers funded Towers Watson's defence but denied indemnity based on the exclusion. The Fourth Circuit held that the settlement effectively increased the consideration paid to shareholders, regardless of whether the underlying suits alleged violations of Section 14(a) of the Securities Exchange Act concerning inadequate disclosures.

The Fourth Circuit's decision aligns with the emerging majority view, at least outside of Delaware, that bump-up exclusions bar coverage in shareholder suits challenging the price in a merger or acquisition. See *Komatsu Mining Corp v. Columbia Gas Co.*,^[5] *Onyx Pharms, Inc v. Old Republic Ins Co.*^[6] Like the latest Fourth Circuit holding, these decisions have broadly construed different shareholder claims – including disclosure claims – as

effectively seeking an increase in per-share valuation. By contrast, the Delaware Superior Court has taken a narrower approach: in *Harman International Industries Inc v. Illinois National Insurance Co*,^[7] which is currently on appeal, the court held that a bump-up exclusion did not bar coverage because the underlying action alleged Sections 14(a) and 20 violations, which do not provide for an increase in the transaction price as a remedy.

Business interruption

Covid-19

In *North State Deli, LLC v. Cincinnati Ins Co*,^[8] the North Carolina Supreme Court held that commercial property policies covered business losses during covid-19 shutdowns. The court ruled that a 'reasonable policyholder' could interpret 'direct physical loss' to include loss of use or access to property caused by government orders, and resolved that ambiguity in favour of coverage. In the underlying suit, bars and restaurants sought business interruption coverage under all-risk policies based on their inability to run or access their business location when covid-19 restrictions were in place. Cincinnati argued that the insured property experienced 'no physical change' and that the 'period of restoration' provision referenced repair or replacement of property, indicating an intention to require physical or structural alteration to property. The court rejected these arguments, emphasising that impairment of use or function can constitute physical loss and that the absence of virus exclusions reinforced a reasonable expectation of coverage. This decision is significant because it runs counter to the overwhelming majority of decisions denying pandemic-related business interruption claims, many of which have rejected the arguments adopted by the North Carolina Supreme Court here.

The legal framework

Sources of insurance law and regulation

The regulation of insurance in the United States is primarily performed by the states. In 1945, the US Congress passed the McCarran-Ferguson Act,^[9] which provides that: 'No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.'^[10] Under the McCarran-Ferguson Act, state insurance law reverse pre-empts federal law unless the federal law specifically relates to the business of insurance.

The law of insurance in the United States generally falls into one of two broad categories:

1. the regulation of entities that participate in the business of insurance; and
2. the regulation of the policyholder-insurer relationship.

State law pertaining to the regulation of entities generally comprises statutes enacted by state legislatures and administrative regulations issued by state agencies, such as departments of insurance.

Each state also has statutory and common law applicable to the policyholder-insurer relationship. State statutes address a range of topics, including the disclosure obligations of the parties to an insurance contract, the nature of a policyholder's notice obligations and the circumstances in which a victim of tortious conduct may sue a tortfeasor's insurer directly. State common law is an important source of law for resolving disputes between policyholder and insurer. Practitioners must carefully assess potentially applicable law at the outset of a dispute, as insurance law (whether common law or statutory) varies by jurisdiction.

Insurable risk

In the United States, the validity of an insurance contract ordinarily is premised on the existence of an insurable interest in the subject of the contract. An insurable interest may be defined as any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction or pecuniary damage^[11]. The insurable interest doctrine was first adopted by courts,^[12] and has since been codified in state statutes.^[13] The purpose of the insurable interest requirement, as articulated by courts and commentators, is to discourage wagering and the destruction of life and property and to avoid economic waste.

Fora and dispute resolution mechanics

Litigation of insurance disputes

The US judicial system comprises two separate court systems: federal courts – situated across each of the 50 states – that hear matters that implicate federal jurisdiction, and state courts, which typically handle disputes exclusively governed by state common or statutory law. Although there are important differences between federal and state courts, they share some key characteristics. Each judicial system has trial courts in which cases are originally filed and tried, a smaller number of intermediate appellate courts that hear appeals from the trial courts, and a single appellate court of final review.

Unlike state courts, which include courts of general jurisdiction that can address most kinds of cases, federal courts principally have jurisdiction over two types of civil cases. First, federal courts may hear cases arising out of the US Constitution, federal laws or treaties.^[14] Second, federal courts may address cases that fall under the federal 'diversity' statute, which generally authorises courts to hear controversies between citizens of different US states and controversies between citizens of the United States and citizens of a foreign state.^[15] For diversity jurisdiction to exist, there must be 'complete' diversity between litigants (i.e., no plaintiff shares a state of citizenship with any defendant) and the amount in controversy must exceed US\$75,000.

Most insurance disputes are litigated in the first instance in federal or state trial courts. Federal courts commonly exercise jurisdiction over insurance disputes under the diversity statute. In this context, an insurance company, like any other corporation, is deemed to

be a citizen of both the state in which it is incorporated and the state in which it has its principal place of business.

An insurance action that is originally filed in state court may be 'removed' to federal court based on diversity of citizenship of the litigants. In the absence of diversity of citizenship or some other basis of federal court jurisdiction, insurance disputes are litigated in state courts. In some cases, plaintiffs may seek to prevent removal by including a non-diverse party as a defendant. Such tactics may be challenged, for example, if it can be shown that the non-diverse party has no potential liability or if the party was fraudulently joined in order to prevent removal to federal court. The venue is typically determined by the place of injury or residence of the parties, or may be dictated by a forum selection clause in the governing insurance contract. The law applied to the dispute may likewise be dictated by a choice-of-law clause in the insurance contract or, in the absence of such a clause, determined by a court based on relevant choice-of-law principles, which may vary by state and are frequently decided on an issue-by-issue basis.

Arbitration of insurance disputes

Some insurance contracts contain arbitration clauses, which are usually strictly enforced. The Federal Arbitration Act (FAA)^[16] and similar state statutes empower courts to enforce arbitration agreements by compelling the parties to arbitrate. If an insurance contract contains a broadly worded arbitration clause, virtually every dispute related to or arising out of the contract typically may be resolved by arbitrators rather than a court of law. One issue that has been a point of contention in matters involving an arbitration clause is whether a non-signatory to the agreement may be compelled to arbitrate a dispute with parties to the agreement. Resolution of this issue frequently turns on whether the non-signatory is deemed to be a third-party beneficiary to the agreement or is equitably estopped from arguing that its status as a non-signatory precludes enforcement of arbitration because it seeks to benefit from other provisions of the agreement.^[17]

While all US states recognise the validity and enforceability of arbitration agreements in general, some states have made a statutory exception for arbitration clauses in insurance contracts. Although state laws that prohibit arbitration are generally pre-empted by the FAA by virtue of the Supremacy Clause in the Constitution, state anti-insurance arbitration statutes may be saved from pre-emption by the McCarran-Ferguson Act. As noted, the McCarran-Ferguson Act provides that state laws enacted for the purpose of regulating the business of insurance do not yield to conflicting federal statutes unless a federal statute specifically relates to the business of insurance. Because the FAA does not specifically relate to insurance, courts have held that the FAA may be 'reverse pre-empted' by a state anti-insurance arbitration statute if the state statute has the purpose of regulating the business of insurance.^[18]

Where an insurance dispute is resolved through arbitration, the resulting award is generally considered to be binding, although there are grounds to vacate or modify an award under the FAA, similar state statutes and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards ('New York Convention'), an international treaty that mandates enforcement of arbitration agreements. The FAA describes four limited circumstances in which an arbitration award may be vacated by a court:

1. the award was procured by corruption, fraud or undue means;

2. there was evident partiality or corruption in the arbitrators;
3. the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown or in refusing to hear evidence pertinent and material to the controversy, or if by any other misbehaviour the rights of any party have been prejudiced; or
4. the arbitrators exceeded their powers or so imperfectly executed them that a mutual, final and definite award upon the subject matter submitted was not made.^[19]

One area of legal uncertainty is whether a court may vacate an award based on an arbitrator's 'manifest disregard' of the law. Although the manifest disregard standard is not listed in the FAA, some courts have ruled that an award may be vacated on this basis.

The international arena

Complex jurisdictional issues may arise when an international insurance contract mandates arbitration of disputes, but applicable state law prohibits such arbitration. In these circumstances, courts must address the interplay between governing state law and the New York Convention. More specifically, such disputes require a determination of whether the New York Convention pre-empts state law such that arbitration is required or, conversely, whether state law reverse pre-empts the New York Convention pursuant to the McCarran-Ferguson Act such that disputes may be litigated in a court of law.

Every federal appellate court to address the issue has held that state law does not reverse-pre-empt the New York Convention under the McCarran-Ferguson Act. Most recently, in *Certain Underwriters at Lloyd's, London v. 3131 Veterans Blvd, LLC*, the Second Circuit joined this unanimous view, abrogating its decision in *Stephens v. American International Insurance Co.*^[20] and holding that state law does not reverse pre-empt the New York Convention. The First, Fourth, Fifth and Ninth Circuits have likewise rejected reverse pre-emption in this context. See *Green Enters, LLC v. Hiscox Syndicates Ltd*,^[21] *ESAB Grp, Inc v. Zurich Ins PLC*,^[22] *McDonnell Grp, LLC v. Great Lakes Ins Se*,^[23] *Safety Nat'l Cas Corp v. Certain Underwriters at Lloyd's, London*,^[24] and *CLMS Mgmt Servs Ltd P'ship v. Amwins Brokerage of Ga, LLC*.^[25] Notably, the First, Second and Ninth Circuits expressly held that the Convention is 'self-executing,' and therefore not an 'Act of Congress' subject to the McCarran-Ferguson Act, while the Fourth and Fifth Circuits reached the same result on the ground that the Act applies only to domestic statutes, not international treaties.

Outlook and conclusions

AI-related coverage issues

One of the most important stories in the financial markets has been the emergence of AI technology. While claims based on an insurance company's use of computers to assist human decision-making are not new, they are likely to proliferate in the near term as the

perceived consequences of the use of such tools become more obvious to consumers, employees, and regulators.

Courts are beginning to confront these issues directly. Several class actions have been filed alleging that health insurers unlawfully relied on algorithms or AI to deny patients necessary care. In one recent case, *Estate of Gene B Lokken v. UnitedHealth Group, Inc.*,^[26] a federal district court denied in part an insurer's motion to dismiss a putative class action lawsuit alleging that the insurer had used an AI algorithm in lieu of medical professionals to deny or limit health benefit coverage. The court dismissed most statutory and tort claims as pre-empted by the federal Medicare Act, but allowed breach-of-contract and implied covenant claims to proceed, emphasising that challenges to the contractually promised process of benefits determinations may survive even where the substance of coverage decisions is federally pre-empted.

At the same time, new legal and regulatory standards are emerging. For example, California's SB 1120 (effective 1 January 2025) mandates that only licensed healthcare professionals may make medical necessity determinations, and imposes standards and restrictions on the use of AI, algorithms and 'any other software tools'. Together, these developments highlight increased judicial and regulatory attention to the use of automated tools in insurance decision-making.

Cyber breaches, data loss and computer fraud

Data-breach incidents, cyberattacks and hacking activities designed to obtain financial gain or access to sensitive personal information continue to proliferate at an unprecedented rate. As such, courts undoubtedly will be called upon to address the parameters of both first-party property and third-party liability insurance coverage for myriad cyber-related claims. A growing body of case law is defining the scope of coverage for losses arising out of fraudulently induced wire transfers under computer-fraud provisions. In the coming months and years, courts will continue to apply governing state law to decide whether various coverage or exclusionary provisions in general liability and crime policies encompass specific factual scenarios. Additionally, courts will continue to address novel questions of law, such as:

1. whether cyber-related losses, including damage to software or other computer system components, constitute covered 'property damage' under general liability or first-party policies;
2. whether and under what circumstances hackers' intentional taking of sensitive data constitutes a publication of private information sufficient to trigger personal and advertising injury coverage;
3. the timing and number of losses or occurrences under applicable policy language; and
4. the scope of coverage under D&O policies for cyber-related claims against a company by its shareholders or by regulatory agencies.

Furthermore, the applicability of certain exclusions, including those related to acts of war or terrorism, professional services, or disputes based on contract, are likely to take centre stage in emerging cyber-coverage disputes.

Another development in this context is the issuance of formal advisories by US federal agencies relating to risks of ransomware payments. Specifically, the US Department of the Treasury's Office of Foreign Assets Control (OFAC) and its Financial Crimes Enforcement Network (FinCEN) have concurrently issued formal advisories warning cyber-insurance firms and others of the regulatory risks associated with ransomware payments to global bad actors, including certain designated persons and entities on OFAC's specially designated nationals and blocked persons (SDN) list pursuant to cyber-related sanctions implemented by the government. OFAC's advisory reiterates informal guidance, cautioning that, in the absence of a licence, it is a violation of law for a US person or entity to pay or facilitate a ransomware payment to a party on the SDN list, even if it did not know or have reason to know that it was engaging in a transaction of this kind. Relatedly, FinCEN's advisory explains the regulatory risks for entities that process ransomware payments. These and other advisories serve as a message of caution to insurance companies offering cyber insurance products that reimburse policyholders for ransomware payments to take care in ensuring that those payments do not run afoul of recently enacted regulations.

Forever chemicals

Courts have long dealt with the limits of general liability coverage for property damage and bodily injury claims arising out of exposure to various harmful substances, such as asbestos, lead paint particles, carbon monoxide, and toxic fumes. In many cases, policyholders have argued that such claims are not excluded from coverage by a pollution exclusion because they do not arise from traditional environmental contamination. An emerging area of litigation is whether claims arising out of exposure to PFAS 'forever chemicals' are excluded from coverage by virtue of pollution exclusions.

Thus far, a handful of courts have addressed insurers' coverage obligations for PFAS claims in the face of pollution exclusions. In at least three cases, the court granted insurers' motions to dismiss, concluding that pollution exclusions barred coverage for alleged bodily injuries and property damage arising out of PFAS claims as a matter of law.^[27] However, other courts have ruled that insurers are required to defend suits alleging bodily injury and property damage arising out of exposure to PFAS chemicals.^[28]

In addition to pollution exclusion clauses, future coverage litigation in this context is likely to implicate other complex questions of fact and law, including:

1. issues relating to the date of allegedly covered bodily injury or property damage;^[29]
2. questions of causation between PFAS exposure and any potential bodily injury;
3. the applicability of a 'discharge' requirement in many pollution exclusions for claims that arise out of PFAS-containing products as opposed to environmental contamination; and
4. the applicability of intended act exclusions.

Recent litigation developments also illustrate how PFAS coverage disputes may raise significant procedural questions about forum selection and jurisdiction. A notable example is *Fire-Dex, LLC v. Admiral Insurance Co.*^[30] Fire-Dex, sued by firefighters over PFAS in its gear, faced Admiral's denial of coverage under policy exclusions. After the district court

declined jurisdiction over Admiral's initial federal declaratory judgment action (a decision affirmed by the Sixth Circuit),^[31] Fire-Dex filed suit in Ohio state court for declaratory relief and damages. Admiral removed; the district court remanded the declaratory claim and stayed the damages claim pending resolution of the declaratory claim in state court. In June 2025, the Sixth Circuit vacated the remand, holding that when a federal court has jurisdiction over damages claims and no abstention doctrine applies, it must retain jurisdiction over related declaratory claims. Finding Fire-Dex's declaratory and coercive claims 'closely intertwined', the court deemed abstention an abuse of discretion, reinforcing that federal courts may be required to hear mixed declaratory and damages coverage disputes despite unsettled state law.

Climate change

Climate change is an emerging concern for insurers, based on the increasing frequency of wildfires, storms, floods and other natural disasters. The January 2025 wildfires in Los Angeles County exemplify this trend, with the Palisades and Eaton fires causing unprecedented insured losses.

Disputes over coverage are likely to intensify under both first-party property and third-party liability policies for such events. For first-party policies, complex causation issues arise, especially when losses result from a combination of covered and excluded perils, such as wind, rain, and storm surge. These issues took centre stage in prior coverage disputes, particularly after Hurricane Katrina. These same complications are expected to surface in future wildfire-related disputes, where the mix of weather conditions, fire spread and policy exclusions will require careful legal and possibly expert analysis.

Third-party liability coverage for climate-related damage is also a developing area for litigation. A central issue for courts may be whether climate change or greenhouse gas (GHG) emission claims give rise to a covered 'occurrence' for the purposes of liability coverage. In *AES Corp. v. Steadfast Insurance Co.*,^[32] the Supreme Court of Virginia held that an insurer had no duty to defend or indemnify a policyholder for underlying nuisance claims relating to carbon dioxide and GHGs, reasoning that the underlying claims did not allege an occurrence because the damage was not accidental, but rather the natural and foreseeable consequence of the policyholder's intentional emissions.

By contrast, in *Aloha Petroleum, Ltd v. National Union Fire Ins Co of Pittsburgh, PA*,^[33] Hawaii's highest court reached a different conclusion. The underlying suits in *Aloha* alleged that members of the fossil-fuel industry recklessly contributed to climate change through GHG emissions. The court held that, under Hawaii law, allegations of reckless conduct could constitute an 'occurrence' triggering the insurer's duty to defend, even if the resulting harm was foreseeable. However, the court ultimately ruled that GHG emissions fell within the scope of the policies' pollution exclusions.

These decisions illustrate the jurisdiction- and policy-specific nature of climate change coverage disputes. Whether future courts characterise GHG emissions claims as 'occurrences,' and how pollution exclusions will apply will depend on governing state law, factual allegations and policy language.

Similar coverage disputes may arise in connection with pending lawsuits against the federal government and various state governments based on the alleged failure to safeguard the environment. Should these defendants seek insurance coverage,

complicated issues pertaining to justiciability, fortuity, actual property damage and trigger and allocation of coverage are likely to follow.

Mass tort bankruptcy

Bankruptcy has become an important tool for resolving mass tort liabilities, originating in asbestos cases and more recently extending to opioids, talc and sexual abuse claims. Companies facing substantial tort exposure may use Chapter 11 of the United States Bankruptcy Code to seek finality through reorganisation plans, often with funding from insurers and third parties. In these cases, debtors and tort creditors – ordinarily adverse outside bankruptcy – may align to propose plans designed to maximise access to insurance proceeds. Such plans frequently spark insurance disputes, as insurers object to reorganisations or liquidations they view as threatening their contractual rights.^[34]

¹ Generally, the rights and obligations of the debtor and its insurers under insurance policies are not altered because of a debtor's Chapter 11 filing,^[35] as the filing of a bankruptcy petition does not alter the scope or terms of a debtor's insurance policy,^[36] nor does it permit a policyholder to 'obtain greater rights to the proceeds of [an insurance] policy'.^[37] The property interests of debtors in bankruptcy and their contractual counterparties are generally created and defined by state law.^[38]

The US Supreme Court's 2024 decision in the Purdue Pharma bankruptcy has reshaped the landscape of mass tort bankruptcies.^[39] Faced with criminal charges and thousands of claims alleging that Purdue Pharma fuelled the opioid crisis by its sale and marketing of painkiller OxyContin, Purdue filed for bankruptcy protection in 2019. The proposed plan would have granted the Sackler family – non-debtor parties and owners of Purdue Pharma implicated in opioid litigation – broad releases in exchange for a US\$5.5 billion contribution to a settlement trust, effectively shielding them from future claims. The Supreme Court held that such non-consensual third-party releases were not authorised under federal bankruptcy law outside of the asbestos context, providing insurers and other stakeholders with clearer guidance regarding the scope of protections available to non-debtor parties who contribute to settlement funding.

Although Congress explicitly authorised non-debtor releases and protections in asbestos cases under 11 USC Section 524(g), bankruptcy filings modelled on Section 524(g) have become common in other contexts, including not only opioids but talc, sex abuse, earplugs, breast implants and other mass torts. These cases typically require funding from non-debtor third parties to be successful, which in turn is usually conditioned on the ability of bankruptcy courts to provide finality to insurers and other third parties through releases and injunctive or other forms of bankruptcy court protections.

The *Purdue Pharma* decision is likely to alter strategies of liability insurers seeking definitive resolutions of uncertain exposures in mass tort bankruptcies. Other provisions of the Bankruptcy Code – though not addressed in detail by the Supreme Court in *Purdue Pharma* – should provide protections to settling non-debtor insurers against claims by other non-debtor parties. For example, Section 363,^[40] authorises bankruptcy court protections for good-faith purchasers of the debtor's property; insurers and bankrupt policyholders have used this provision in connection with the sale and buyback of insurance policies as property of the estate precisely for this reason.

The Boy Scouts of America (BSA) bankruptcy illustrates the continuing relevance of these tools. Before the Supreme Court's decision in *Purdue Pharma*, a Delaware bankruptcy court confirmed a Chapter 11 plan, resolving billions of dollars in sexual-abuse claims.^[41] A key component of the plan was a buyback of the BSA's liability insurance policies under Section 363 of the Bankruptcy Code. As part of the buyback, settling insurers received non-consensual releases of potential liability to tort claimants. Although the Third Circuit's majority opinion acknowledged that the BSA plan would now be 'unconfirmable' under *Purdue*, it upheld confirmation on the ground that unwinding the plan would disrupt a sale protected by Section 363(m).^[42] The concurring opinion cautioned, however, that this reasoning could allow practitioners to insulate controversial plan provisions from appellate review by linking them to sale of estate property. BSA foreshadows further changes in mass tort bankruptcies and how claims will be resolved using non-consensual releases of third parties and other tools.

Acknowledgements

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- 35** See *In re Amatex Corp*, 107 B.R. 856, 865-66 (E.D. Pa. 1989), *aff'd*, 908 F.2d 961 (3d Cir. 1990). [^ Back to section](#)
- 36** *In re MF Glob Holdings Ltd*, 469 B.R. 177, 193 (Bankr. S.D.N.Y. 2012). [^ Back to section](#)
- 37** *In re Denario*, 267 B.R. 496, 499 (Bankr. N.D.N.Y. 2001). [^ Back to section](#)
- 38** *Butner v. United States*, 440 U.S. 48, 51-54 (1979). [^ Back to section](#)
- 39** *Harrington v. Purdue Pharma LP*, 603 U.S. 204 (2024). [^ Back to section](#)
- 40** 11 U.S.C. § 363. [^ Back to section](#)
- 41** *In re BSA*, 642 B.R. 504 (Bankr. D. Del. 2022). [^ Back to section](#)
- 42** *In re BSA*, 137 F. 4th 126 (3d Cir. 2025). [^ Back to section](#)

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