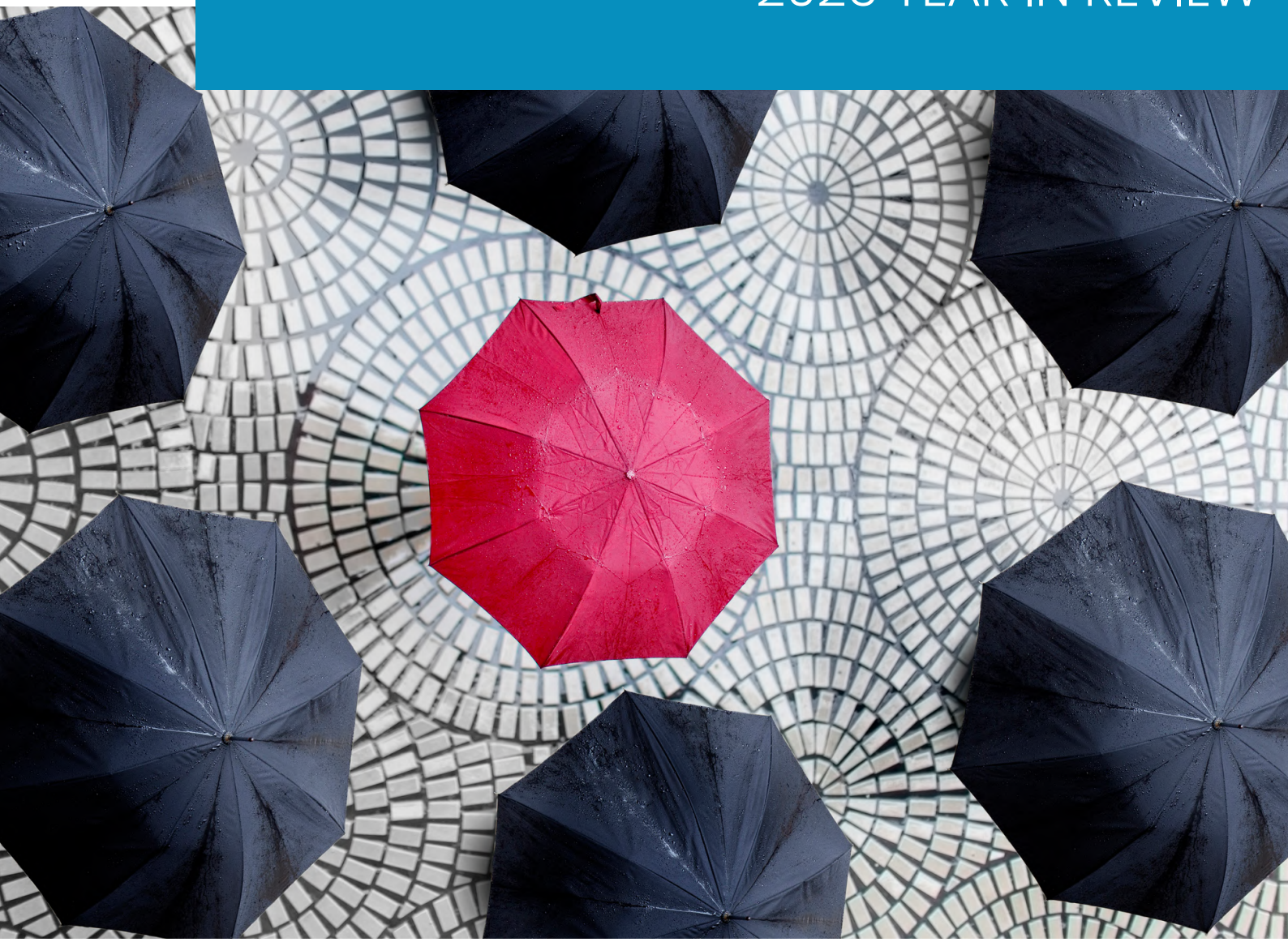
HAYNES BOONE

Insurance Recovery

2025 YEAR IN REVIEW



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Introduction

The 2025 Insurance Coverage Year in Review curates the most consequential insurance coverage rulings of the year to assist corporate policyholders, risk managers and in-house counsel with existing and future claims and policy renewals. In the liability space, 2025 continued an evolving trend where insurers have increasingly focused on challenging the satisfaction of threshold insuring agreements, as opposed to assuming the burden of proving policy exclusions. Cases involving the existence and number of "occurrences," for example, repeatedly appeared in appeals around the country. 2025 also saw key decisions on priority disputes, related-claims provisions, and "bump-up" exclusions.

On the property side, several disputes over the threshold requirement of "physical loss and damage" appear to be reclaiming ground lost in COVID-19 business interruption disputes. Across coverage types, we also saw a continuing trend toward increased reliance by insurers on facts and evidence external to the actual policy to decide coverage disputes. This trend manifested in several cases addressing the use of parol evidence to resolve ambiguities in policy terms and in a yet-to-be-decided case addressing fortuity.

As always, the first-party and third-party insurance coverage landscape is constantly evolving, but the concise summaries presented here are intended to allow corporate insureds to keep informed and ahead of the most salient developments in the domestic insurance law.

General Liability Insurance

Priority of Coverage

In some cases, the only thing worse for a policyholder than not having enough insurance coverage is having too many policies apply to the same occurrence, which can prompt disputes over allocation and priority among policies. In 2025, several courts addressed contests over the priority of coverage. In *Hartford Fire Ins. Co. v. Chubb Custom Ins. Co.*, 142 F.4th 624 (8th Cir. 2025), two liability insurers—a commercial automobile carrier ("Hartford") and a group-excess liability insurer ("Chubb") disputed which policy was obligated to pay for the settlement of an underlying motorcycle fatality claim based on the policies' respective "other insurance" clauses. Hartford's policy provided that, with respect to non-owned vehicles, its policy was "excess over any other *collectible* insurance." Chubb's policy stated that it was "excess of *all* underlying insurance." Contrary to the district court, which originally granted summary judgment to Hartford upon finding that the "other insurance" provisions were "mutually repugnant," the Eighth Circuit Court of Appeals reasoned that Chubb's policy was the "true excess policy" because it was expressly excess over any other insurance, whether collectible or not.

In another priority dispute, *Citizens Ins. Co. of the Midwest v. McNeeley*, 2025 U.S. App. LEXIS 9930, *1 (6th Cir. Apr. 23, 2025), an underinsured motorist insurer ("Citizens") sought reimbursement from the victim of an auto accident ("McNeeley") for proceeds received under a different UIM policy issued by "Allstate." The district court granted summary judgment to McNeely upon holding that Citizens did not overpay under its policy. Before the Sixth Circuit Court of Appeals, Citizens argued that its policy's "other insurance" clause justified recovery of Allstate's $500K payment to McNeely. In response, the court examined (1) the excess clause in Allstate's policy stating that "[i]f the injured person was struck as a pedestrian, ... this coverage will be excess"; and (2) the prorata clause in Citizens' policy, purporting to limit Citizens' coverage to that "proportion that our limit of liability bears to the total of all limits applicable on the same level of priority." Under Michigan law, "a policy with a pro-rata clause must pay up to its policy limit before the policy with the excess clause must pay anything." *St. Paul Fire & Marine Ins. v. Am. Home Assur. Co.*, 444 Mich. 560, 514 N.W.2d 113, 115 (Mich. 1994). Accordingly, Citizens' prorata policy is primary to Allstate's excess policy, and the Sixth Circuit affirmed.

The Existence & Number of "Occurrences"

In recent years, courts have grappled with the threshold scope of general liability coverage in decisions dealing with whether underlying lawsuits sought damages "because of" bodily injury or property damage. 2025 continued this trend, with numerous cases focused on determining the existence and number of occurrences under a general liability policy. In *Federated Mut. Ins. Co. v. Peterson's Oil Service*, 155 F.4th 1 (1st Cir. Sept. 8, 2025), the "occurrence" issue surfaced in the context of a dispute over "known loss" and "loss-in-progress" provisions as applied to class action allegations that an oil service company ("Peterson's") added biodiesel fuel to home heating oil sold to customers between 2012 and 2019, as well as after 2019. In the related coverage dispute, Peterson's insurer, Federated, argued that Peterson's knowledge of the allegations relating to sales between 2012 and 2019 triggered the "known loss" and "loss-in-progress" provisions in its 2019 policy. In response to a summary judgment motion filed by Federated, the district court reasoned that Federated still had a duty to defend claims involving sales taking place after July 2019. On appeal, the First Circuit examined Federated's fortuity arguments in the context of the number

of "occurrences" presented by the underlying class action. Applying the "usual and ordinary sense of the word," the court concluded that the provision of oil to each customer constituted a separate occurrence. And following this logic, the court also ruled that knowledge of one occurrence of property damage is not knowledge of another occurrence of property damage for purposes of Federated's known-loss and loss-in-progress provisions.

In a related matter, the First Circuit Court of Appeals also examined what constitutes an "occurrence" under the same set of facts. In *United States Fire Ins. Co. v. Peterson's Oil Service, Inc.*, 155 F.4th 22 (1st Cir. 2025), a different liability insurer ("U.S. Fire") asserted that Peterson's decision to add biodiesel to home heating oil was not an "accident" or "occurrence" warranting a defense in the underlying class action. The district court denied U.S. Fire's summary judgment motion on this issue, and the First Circuit affirmed. The allegations in the underlying class action, pleaded in support of a negligence claim, averred that Peterson may have known information suggesting that adding biodiesel created a risk of damage to underlying plaintiffs' heating equipment but acted or failed to act without regard to the risk. According to the court, reckless conduct still constitutes an accident, and even awareness that the heating oil product was creating issues for customers' heating equipment fell short of intentional conduct for purposes of establishing an "accident" or "occurrence." To fall outside of an "occurrence," the insured "must have intended or been substantially certain of the type of harm inflicted for those injuries to be deemed non-accidental." (Emphasis in original).

The issues addressed in *Peterson's Oil Service* relating to both the existence and number of occurrences under a general liability policy were only one example of many federal appellate decisions focusing on similar questions in 2025. *Sheriff of Broward Cnty. v. Evanston Ins. Co.*, 2025

John Joseph Moakley United States Courthouse

U.S. App LEXIS 29494 (11th Cir. Nov. 10, 2025) involved insurance coverage for 60 separate lawsuits filed against the Sheriff of Broward County relating to the mass shooting at Marjory Stoneman Douglas High School in Parkland, Florida in 2018. The excess policy issued by Evanston and insuring the sheriff included a $500,000-per-occurrence self-insured retention ("SIR"). In connection with the ensuing liability claims, Evanston took the position that each of the 17 students and teachers killed in the incident represented a separate "occurrence." The sheriff maintained that the shooting should be treated as a single occurrence. After the sheriff filed a declaratory judgment action, Evanston filed a motion to dismiss on the "occurrence" issue, which was denied. Cross-motions for summary judgment followed, with the district court granting the sheriff's motion and denying Evanston's motion. The Eleventh Circuit Court of Appeals affirmed after examining the Florida Supreme Court's decision in *Koikos v. Travelers Insurance Co.*, 849 So. 2d 263 (Fla. 2003). There, the *Koikos* court concluded that Florida applies the "cause theory" to questions over the number of occurrences, while ultimately reasoning that the "occurrence" term was ambiguous and must be construed in favor of the insured. The Eleventh Circuit agreed, but while resolving ambiguities in Koikos meant finding one occurrence for each shooting victim in that case, in the context of the Parkland shooting, the court held that the district court did not err in finding that there was only one occurrence under Evanston's policy.

In *State Farm Fire & Cas. Co. v. Giannone*, 2025 U.S. App. LEXIS 19854 (6th Cir. Aug. 5, 2025) a homeowner ("Giannone") sought liability coverage for underlying claims that the insured shot and killed a woman during a domestic dispute in the homeowner's driveway. Giannone's homeowner's insurer, State Farm, filed a declaratory judgment action asserting, among other things, that there was no "occurrence" or "accident" involved in the shooting. The district court granted summary judgment to State Farm. On appeal, Giannone maintained that while he intended to fire his gun, he did not intend to injure the decedent underlying plaintiff, whose death was "accidental." The Sixth Circuit relied upon Michigan precedent holding that, absent policy language to the contrary, Michigan uses a subjective standard examining whether the insured should have reasonably expected the consequences of the underlying act. Here, Giannone could not establish that the underlying plaintiff's death was not the foreseeable result of shooting at the vehicle occupied by the plaintiff. The court likewise dismissed arguments that actions taken in self-defense are "occurrences" because such actions are "intentional."[1]

In *Granite State Ins. Co. v. Primary Arms, LLC*, 2025 U.S. App. LEXIS 32275 (2d Cir. 2025), firearms retailers, including "Primary Arms," sought defense and indemnity coverage in connection with underlying lawsuits brought by state and municipal governments alleging that the retailers' intentional marketing and sales caused increased gun violence and expense relating to law enforcement and social services. Specifically, underlying plaintiffs alleged that Primary Arms marketed and sold "unfinished firearm frames and receivers" purposefully targeting customers who would not be able to purchase guns legally after a background check. Primary Arms' insurers, including "Granite State" sought a declaration that no defense or indemnity was required because the underlying liability suits did not allege an "accident" or "occurrence." The district court entered judgment in favor of insurers, and the Fifth Circuit affirmed. Specifically, the court followed the two-part test adopted in *Discover Property & Casualty Insurance Co. v. Blue Bell Creameries USA, Inc.*, 73 F.4th 322, 329 (5th Cir. 2023), which held

[1] *See also Safety Nat'l Cas. Corp. v. Bender*, 2025 U.S. App. LEXIS 26450, *2-3 (9th Cir. Oct. 10, 2025) (affirming summary judgment granted by the district court to Safety National against two individuals convicted respectively of assault with a deadly weapon and battery with a deadly weapon because "intentional torts are not accidents, they are not 'occurrences' as defined by the Policy, and Safety National is not required to provide coverage").

that an act "is not an accident when [1] [an individual] commits an intentional act that [2] results in injuries that ordinarily follow from or could be reasonably anticipated from the intentional act." Here, the court reasoned that (a) the underlying governments alleged that Primary Arms committed an "intentional act" by "intentionally marketing and selling its products to New York consumers who 'would not be able to purchase guns legally, or who want a gun that cannot be traced back to them'", and (b) the influx of "ghost guns" available to be used in the commission of violent crimes, and the "ensuing financial burdens" alleged by the underlying plaintiffs were not "fortuitous" or "unexpected." The court also rejected Primary Arms' attempts to focus on allegations of negligence within the underlying pleadings on the basis that such references and claims were nothing more than "conclusory legal labels."

Finally, in *Rosenberg v. Hudson Ins. Co.*, 2025 U.S. App. LEXIS 3195 (3d Cir. Feb. 11, 2025), homeowners ("Rosenbergs") sought liability coverage in connection with allegations that the homeowners delayed discovery of a murder weapon used when the homeowners' son shot and killed a classmate within the insured residence. The Rosenbergs' primary ("Chubb") and umbrella ("Hudson") insurers refused coverage, including on the grounds that the injury alleged in the underlying suit did not result from an "accident," which Pennsylvania courts have defined to mean "'the culmination of forces working without design, coordination or plan,' prompted by some 'degree or fortuity.'" The underlying suit alleged that the Rosenbergs "acted intentionally by concealing the handgun that would have implicated Adam [their son] and led to the earlier discovery of [the victim's] body." Accordingly, the Third Circuit found that the district court did not err in granting summary judgment against the Rosenbergs.

The number of disputes and circuit court appeals centered on the existence and number of occurrences suggest that insurers will remain focused on contesting the threshold elements of the general liability coverage grant in the year to come.

Opioid Liability Coverage

In the context of general liability claims, much attention has been given in recent years to insurance coverage for the significant opioid liability claims asserted by state and local governments (among other plaintiffs) all across the country. This year, in *In re CVS Opioid Ins. Litig.,* 346 A.3d 81 (Del. 2025), the Delaware Supreme Court addressed CVS's claims for liability coverage in connection with various underlying opioid lawsuits. After the Superior Court granted summary judgment against CVS, the Delaware Supreme Court issued the following rulings affirming the lower court's denial of coverage: (1) the court found no material difference in policy terms, including in the subject Pharmacist and Druggist Liability Endorsements, that would distinguish this case from *Rite Aid* or require a defense, (2) none of the underlying lawsuits made the subject of this appeal sought recovery for specific, individualized bodily injury triggering a duty to defend under *Rite Aid*, and (3) none of the subject underlying lawsuits alleged specific and particularized property damage. On the same grounds, the court also denied CVS's claims for indemnity relating to a national settlement agreement.

Directors & Officers Liability Insurance

Related-Claims Provisions

In addition to requiring that a "claim" be first made within the subject policy period, most claims-made policies include a provision specifying, in so many words, that all claims arising from a common set of facts are deemed

to be a single claim first made when the earliest of such factually-related claims is first made. These "related-claims" provisions are among the more litigated terms in D&O, E&O and other claims-made policies. Given the frequency with which these provisions are litigated, it is usually noteworthy when a circuit court of appeals provides direction on how these provisions are interpreted and applied. This year, such direction came from the Eleventh Circuit in *Medmarc Cas. Ins. Co. v. Fellows Labriola LLP*, 2025 U.S. App. LEXIS 26389 (11th Cir. Oct. 10, 2025). Here, a law firm ("Fellows") sought professional liability coverage for an underlying malpractice lawsuit alleging that lawyers, defending a RICO and civil forfeiture case against a married couple, the couple's respective companies and others, engaged in legal malpractice, breach of fiduciary duty, and breach of contract relating to both the disbursement of funds from the lawyer's IOLTA account and conflicts of interest. Fellows' insurer, Medmarc, refused coverage on the basis that (1) the subject professional liability policy excluded claims involving misappropriation, and (2) the underlying lawsuit alleged that Fellows misdirected client funds. In connection with the declaratory judgment lawsuit filed by Medmarc, the district court granted Fellows' motion to dismiss, finding that Medmarc had a duty to defend and its indemnity obligation was not ripe. On appeal, Medmarc made the argument that, pursuant to the policy's related-claims provision, all claims in the underlying malpractice lawsuit were precluded by the misappropriation exclusion because "all [claims] involving a single act, error or omission or a series of related acts, errors or omissions shall be deemed to be one claim ...." Responding to this argument, the Eleventh Circuit looked beyond the fact that the issue was not raised below and focused on the substance of the argument. Here, the court noted that the related-claims provision was located in the "When a Claim is Made" section of the policy, separate from the definition of "claim." Therefore, "an insured would expect that the sentence in question impacts only when a claim is first made and would not expect it to inform the meaning of 'claim' beyond that." Then, after finding that the underlying malpractice lawsuit included some claims, including those addressing conflicts of interest among jointly represented clients which fell outside the misappropriation exclusion, the court agreed that Medmarc had a duty to defend the entire suit. The court also agreed that the duty to indemnify was not ripe because it would depend on the outcome of the underlying suit.

In February 2025, the Delaware Supreme Court weighed in on a dispute over a related-claims provision in *In re Alexion Pharmaceuticals, Inc. Insurance Appeals*, 339 A.3d 694 (Del. 2025). Here, a pharmaceutical company ("Alexion") and its directors and officers sought liability coverage for a securities class action lawsuit, filed in December 2016 and alleging violations of federal securities laws in connection with a failure to disclose "a series of unethical and illegal sales and lobbying practices, including obtaining data from partner labs to identify potential customers, deploying extreme fear tactics to garner patients and funding foreign organizations." Approximately eighteen months earlier, in March 2015, the Securities and Exchange Commission ("SEC") issued a

formal order of investigation to Alexion addressing "possible violations of the federal securities laws involving inaccurate annual 8-K, 10-K, and 10-Q reports; failure to maintain adequate books and records; failure to maintain an adequate system of internal accounting controls; and bribing foreign officials and political parties." The SEC later issued a subpoena for "documents relating to Alexion's grant-making worldwide; statements regarding the recall of certain lots of Soliris; compliance with the Foreign Corrupt Practices Act ('FCPA'), including gifts and payments to public health institutions and government agents; and lobbying efforts worldwide, especially in Japan, Brazil, Russia and Turkey." Alexion gave notice of the SEC's order and subpoena under one tower of D&O insurance policies ("Tower 1"), while giving notice of the securities class action lawsuit under a different tower of D&O insurance policies ("Tower 2"). When Alexion settled the securities class action lawsuit in 2023 for $125 million, a dispute arose over which insurance tower would provide coverage for this liability, particularly given language in the limit of liability provisions of both towers stating that "[a]ll Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts ... shall be deemed to be one Claim ... first made on the date the earliest of such Claims is first made ...."

In litigation filed by Alexion, the Superior Court "ultimately concluded that 'the factual connection between the SEC Subpoena and the Securities Action is insufficient to make them related' and placed the Securities Class Action in Tower 2." The Delaware Supreme Court disagreed. Applying the same "meaningful linkage" standard used by the Superior Court, the Delaware Supreme Court reasoned that Alexion's notice of the 2015 SEC matter was notice of a "circumstance," not notice of a "claim." Instead of comparing the conduct addressed in the subpoena, the court held that the proper analysis would have focused on the conduct disclosed in the notice. With that focus, the court further concluded that "the Securities Class Action is meaningfully linked to the wrongful acts disclosed in the 2015 Notice", *i.e.*, "both involve the same alleged wrongdoing — Alexion's grantmaking activities worldwide." Therefore, coverage for the underlying settlement would be addressed under Tower 1.

Bump-Up Exclusion

In the D&O space, many policies include what is known as a "bump-up" exclusion, which generally avoids coverage for claims seeking an increase or "bump-up" in consideration from a corporate transaction involving the sale or exchange of securities. Such "bump-up" exclusions have received increased attention in recent years along with the influx of special purpose acquisition company ("SPAC") transactions and related litigation over SPACs. Although not involving a SPAC, in 2025, the Fourth Circuit Court of Appeals issued its much anticipated "bump up" exclusion decision in *Towers Watson & Co. v. National Union Fire*


Securities and Exchange Commission, SEC, Building in Washington DC.

Ins. Co., 138 F.4th 786 (4th Cir. 2025). Here, two large insurance brokers, Willis and Towers Watson, entered into a reverse triangular merger, whereby, in simplified terms, Towers Watson merged into and became a wholly owned subsidiary of Watson with Towers Watson shareholders to be compensated for their interests with Willis stock. Following the completion of the merger in 2015, Towers Watson shareholders filed class action claims asserting that the consideration paid for Towers Watson stock in the merger was limited by an undisclosed conflict involving compensation to be paid to former Towers Watson CEO, John Haley. The shareholder lawsuits ultimately settled for $90 million, which Towers Watson sought to recover from its D&O carriers, against the argument that the compensation claims asserted in the class actions were precluded by a bump-up exclusion. This exclusion provided that "[i]n the event of a Claim alleging that the price or consideration paid or proposed to be paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest in or assets of an entity is inadequate, Loss with respect to such Claim shall not include any amount of any judgment or settlement representing the amount by which such price or consideration is effectively increased." After an initial round of litigation and appeal focusing on whether the merger involved an "acquisition," the district court granted summary judgment in favor of the insurers to find that coverage for the settlement, (including the portion allocated to compensate for the shareholders' attorneys' fees) was precluded by the bump-up exclusion. In a second appeal following remand, the Fourth Circuit reasoned that, in addition to a "claim" alleging inadequate consideration, the application of the bump-up exclusion required that "the settlement of such claim must 'represent[]' an 'effective[] increase[]' in the 'price or consideration' shareholders received for that acquisition." Looking at the "real result of the situation," the court concluded that the shareholders sought for and received additional consideration for their Towers Watson shares. The court also agreed with the district court that, under the common fund doctrine, the entire settlement was subject to the bump-up exclusion, including the portion the shareholders and their counsel, in their discretion, allocated to attorneys' fees.

Property Insurance

Physical Loss & Damage

The old adage "bad facts make bad law" has largely proven true in the context of insurance coverage decisions arising out of the COVID-19 pandemic. Where many courts had historically acknowledged the "damage" and "injury" done to property from contamination prior to the pandemic, courts addressing COVID-19 business interruption claims adopted an extremely narrow view of "property damage" when that contamination involved COVID-19. Years later under different facts, new decisions are hopefully moving the law back to its prior equilibrium. In one such decision, *Maxus Metro., LLC v. Travelers Prop. Cas. Co. of Am.*, 2025 U.S. App. LEXIS 29921 (8th Cir. Nov. 17, 2025), the owner of a multi-phase apartment complex (Maxus) sought coverage for microscopic carcinogenic soot that infiltrated buildings at the project following a catastrophic fire in one building. Maxus' insurer, Travelers, urged, among other things, that microscopic soot did not constitute "physical loss or damage" required to trigger coverage under the policy. A jury ultimately awarded more than $27 million in damages to Maxus, including damages relating to the microscopic soot. Travelers appealed the ensuing judgment, including on the basis that Maxus failed to prove damage to property.

Specifically, Travelers argued that, even if the other buildings had sustained contamination from microscopic soot, echoing arguments made in the context of COVID-19, "the presence of microscopic soot is not 'physical' damage unless the soot is visible or affects the object's structural integrity." The Eighth Circuit rejected this argument, holding that "[s]oot damage—like asbestos damage and unlike a virus—is both 'directly material, perceptible or tangible' and 'permanent absent some intervention.'"

In a similar decision, *Houston Casualty Company v. Cibus US LLC*, 2025 U.S. App. LEXIS 9972 (9th Cir. Apr. 24, 2025), the Ninth Circuit ruled that canola crops that were stunted and chemically damaged from exposure to herbicide experienced "property damage" for purposes of a sublimit in a liability policy: "The claims made by the Duo canola farmers described physical damage to tangible property, including the 'cupping' and 'purpling' of new canola leaves, poor branching and weak stems. Such physical damage only occurred after the farmers applied Draft herbicide, which chemically damaged the plants."

Extra-Contractual Claims Post-Appraisal

Since the Texas Supreme Court's opinion in *Ortiz v. State Farm Lloyds*, 589 S.W.3d 127 (Tex. 2019), Texas insureds and insurers have continued to explore what extracontractual liability may exist for insurers post-appraisal. In *Senechal v. Allstate Vehicle & Prop. Ins. Co.*, 127 F.4th 976 (5th Cir. 2025), a homeowner obtained a $58,396.58 appraisal award for a water damage claim after the insurer initially issued payments totaling over $36,000. After the remaining loss (minus the applicable deductible) had been paid, the homeowner ("Senechal") filed suit seeking, among other things, interest penalties under Texas' Prompt Payment of Claims statute ("Chapter 542") and statutory bad faith claims under Chapter 541 of the Texas Insurance Code. The district court granted summary judgment in favor of the insurer ("Allstate") absent any injury separate from the loss (and interest) paid by Allstate following appraisal. On appeal, the Fifth Circuit, citing *Ortiz*, ruled that "[b]ecause Senechal has presented no evidence that he suffered an independent injury caused by Allstate's alleged delayed payment benefits, the district court did not err in granting summary judgment on these claims." However, citing *Hinojos v. State Farm Lloyds*, 619 S.W.3d 651, 652 (Tex. 2021), the Fifth Circuit also reasoned that (1) "prompt payment of an appraisal award and statutory interest does not, as a matter of Texas law, absolve an insurer of TCCPA [Chapter 542] liability"; (2) "no judgment of 'actual damages' is required for an insured to recover attorneys' fees for a violation of Chapter 542 of the Texas Insurance Code"; and (3) "[t]herefore, to the extent that the district court concluded that prompt payment of an appraisal award and statutory interest defeats TPPCA liability or that a judgment is required to recover attorneys' fees for such a violation, the district court erred."

On this same subject, the Fifth Circuit issued additional decisions in 2025 confirming that absent an "independent injury," *i.e.*, actual damages other than policy benefits, an insured compensated for lost policy benefits through the payment of an appraisal award may not recover for bad faith under Chapter 541 of the Texas Insurance Code or under the common law. *See, e.g.*, *Mirelez v. State Farm Lloyds*, 127 F.4th 949 (5th Cir. 2025) (relying on *Ortiz* to hold that "since Mirelez sought only recovery of policy benefits that State Farm had already paid pursuant to an appraisal provision, Mirelez could not recover for statutory bad faith or common law bad faith."); *First Baptist Church Daisetta Tex. v. Church Mut. Ins. Co.*, 2025 U.S. App. LEXIS 6809 (5th Cir. Mar. 24, 2025) ("Here, as in *Mirelez*, First Baptist has

'recovered [its] entitled-to insurance benefits in full through payment of the appraisal award and interest.' Because First Baptist has not presented 'evidence supporting an independent injury caused by alleged violations of Chapter 541 of the Insurance Code or an alleged breach of duty owed,' we affirm the district court's dismissal of those claims."); *Frederich v. Trisura Specialty Ins. Co.*, 2025 U.S. App. LEXIS 26063 (5th Cir. Oct. 7, 2025) ("In sum, *Mirelez* forecloses Frederich's appeal. Absent an independent injury, an insured cannot bring tort claims against an insurer under Chapter 541 after receiving an appraisal award and applicable statutory interest.").

Other Notable Insurance Coverage Decisions

BIPA Liability Coverage

Over the past several years, the Illinois Supreme Court and Seventh Circuit Court of Appeals have issued multiple rulings addressing insurance coverage for claims made under Illinois Biometric Information Privacy Act ("BIPA"). This trend continued in *Citizens Ins. Co. of Am. v. Mullins Food Prods., Inc.*, 135 F.4th 1082 (7th Cir. 2025). While most of these past decisions have resulted in narrow interpretations of various policy exclusions and favorable outcomes for policyholders, in *Mullins Foods*, the outcome was mixed. Here, a food ingredient manufacturer ("Mullins") originally sought defense and indemnity for an underlying BIPA lawsuit alleging that Mullins violated BIPA by scanning employee fingerprints and using that data to monitor and manage employee time, with the assistance of third-party vendors, without

the employees' consent. Mullins' general liability insurer, Citizens, refused coverage and ultimately filed a declaratory judgment action asserting that two exclusions—the Access or Disclosure Exclusion and the Statutory Violations Exclusion—barred coverage for the underlying BIPA lawsuit. The Access or Disclosure Exclusion bars coverage for any claim "arising out of any access to or disclosure of any person's or organization's confidential or personal information," and the list of information qualifying as confidential or personal includes "patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any other type of nonpublic information." Following the lead of both the district court in this case and the Seventh Circuit in *Thermoflex Waukegan, LLC v. Mitsui Sumitomo Ins. USA, Inc.*, 102 F.4th 438, 440-41 (7th Cir. 2024), the *Mullins* court affirmed to find that the Access or Disclosure Exclusion "is straightforward and explicit, and the ordinary understanding of an individual's 'confidential or personal information' plainly includes their biometric identifiers." However, the *Mullins* court reached a different conclusion with respect to the Statutory Violations Exclusion, which excludes coverage for: "Personal and advertising injury" arising directly or indirectly out of any action or omission that violates or is alleged to violate: (1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law; (2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law; (3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transactions Act (FACTA); or (4) Any federal, state or local statute, ordinance or regulation, other than the TCPA, CANSPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information." BIPA is clearly not addressed by the first three statutes named in the exclusion. As for the fourth, "catch-all" provision, the *Mullins* court again followed *Thermoflex* to conclude that BIPA was sufficiently different from the other statutes listed in the exclusion to justify finding that the exclusion did not preclude coverage for the underlying BIPA lawsuit against Mullins.

As a larger trend in recent years, insurers have looked for ways to avoid coverage by resorting to facts and evidence outside of the subject insurance policy. In 2025, this trend manifested in a couple of different ways, including (1) a series of cases involving the use of extrinsic parol evidence to resolve an ambiguity in policy terms and (2) an important, albeit unresolved, case addressing fortuity.

Resolving Ambiguities in Policy Terms

For decades, courts have relied upon the rule of construction known as the rule of *contra proferentum* to resolve ambiguities in contracts of all kinds, including insurance policies. Under this well-established rule, ambiguities in contractual terms are resolved against the drafting party, *i.e.*, the insurer in the context of an insurance policy. Notwithstanding the precedent behind this rule of construction, a series of courts in 2025 resorted to using extrinsic parol evidence to address ambiguities in policy terms, instead of relying on the rule of *contra proferentum*. For example, in *McDonnel Grp., L.L.C. v. Starr Surplus Lines Ins. Co.*, 126 F.4th 1100 (5th Cir. 2025), a contractor ("McDonnel") sought builders risk insurance coverage for water damage to a renovation project. McDonnel's insurers ("Starr" and "Lexington," collectively "Insurers") asserted that the subject policy's flood deductible exceeded the value of the loss such that no compensation was owed. McDonnel filed suit, and on cross-motions for summary judgment, the district court ruled that the policy's deductible provision was unambiguous and adopted the Insurers' interpretation.

In a prior appeal to the Fifth Circuit, the court reversed, finding that the deductible language was ambiguous and remanding to determine (1) whether extrinsic evidence resolves the ambiguity; and (2) "whether the presumption in favor of coverage in the case of an ambiguity applies here." This second time around, the district court concluded that the extrinsic evidence resolved the ambiguity in favor of the Insurers, without reaching the second issue. On this second appeal to the Fifth Circuit, McDonnel argued, among other things, that the district court erred by "failing to determine whether the presumption in favor of coverage applied" and by interpreting the extrinsic evidence offered by Insurers. The Fifth Circuit ultimately affirmed upon concurring that "[t]he extrinsic evidence resolved the ambiguity in favor of the insurers as a matter of law, leaving no genuine issue of material fact regarding the deductible." The court also relied upon a prior ruling in *Keiland Constr., L.L.C. v. Weeks Marine, Inc*., 109 F.4th 406, 416 (5th Cir. 2024), effectively holding that the rule of *contra proferentum* is applied, if at all, only after the contract remains ambiguous in the face of evidence regarding its intent, including "the nature of the contract, equity, usages [and] the conduct of the parties before and after the formation of the contract."

The *McDonnel* suit is only one of several cases within the last year to similarly conclude that the rule of *contra proferentum* is a doctrine of last resort to be considered after extrinsic evidence has been reviewed. *See, e.g., Hobish v. AXA Equit. Life Ins. Co.*, 43 N.Y.3d 442 (N.Y. Ct. App. 2025) ("We also agree that the extrinsic evidence in the record fails to resolve the ambiguity, leaving a triable issue of fact, and therefore plaintiffs' reliance on the doctrine of contra proferentem is misplaced. Where inconclusive extrinsic evidence has been introduced by the parties concerning the meaning of an ambiguous term, that rule of contract construction does not automatically apply in favor of the insured at the summary judgment stage …."); but *see Wilson v. Kemper Corp. Servs.*, 134 F.4th 339, 347 (5th Cir. 2025) (affirming that "[a]mbiguous or unclear language is resolved in favor of the insured" and "limitations or exclusions on coverage must be construed in favor of the insured and against the insurer").

Fortuity in First-Party Property Claims

In *Industrial Park Center LLC v. Great Northern Insurance Company*, 2025 U.S. App. LEXIS 33567 (9th Cir. Dec. 23, 2025), a commercial property owner in Arizona ("Mainspring") sought coverage under an all-risk property insurance policy for damage to concrete structures within a commercial building. Importantly, the loss was identified and claimed under Mainspring's policy with "Great Northern" years after a prior claim had been made for damage to concrete walls and stairs caused by the operations of a specific tenant in the insured building. After Great Northern initially refused coverage on the basis that the loss was excluded by the subject policy's "wear-and-tear" and "settlement" exclusions, Mainspring sued. Great Northern moved for summary judgment to deny Mainspring's claims, including on the basis that Mainspring had failed to demonstrate that the loss was fortuitous. The district court granted summary judgment in favor or Great Northern, and

Mainspring appealed. In response, the Ninth Circuit observed that "[w]hen recovery is sought under an all-risk property insurance policy, the insured must show that the loss was fortuitous to 'establish a prima facie case' of coverage," but also concluded that "Arizona's appellate courts have yet to define the parameters of when a loss is fortuitous." As a result, the case has now been certified to the Arizona Supreme Court to answer the following question: "Is damage to property a 'fortuitous' loss when, based on the insured's knowledge at the time the insurance policy issued, it was reasonably foreseeable that such damage was almost certain to occur if certain preventative measures were not taken?" While the ultimate outcome of this question will yet be determined in 2026, that decision may have significant implications for first-party property insurers and insureds both within and beyond Arizona.

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