TADC INSURANCE LAW UPDATE

Fall 2008

David A. Clark
Brannon C. Dillard
Brian T. Bagley
Beirne, Maynard & Parsons, L.L.P.
Houston, Texas

This newsletter is intended to summarize the most significant cases impacting the insurance practice since the Spring 2008 newsletter. It is not a comprehensive digest of every case involving insurance issues during this period or of every holding in the cases discussed. This newsletter was not compiled for the purpose of offering legal advice. Any opinions expressed herein are those of the authors and do not necessarily reflect the views of Beirne, Maynard & Parsons, L.L.P.

INSURABILITY OF PUNITIVE DAMAGES

Am. Int'l Specialty Lines Ins. Co. v. Res-Care, Inc., 525 F.3d 649 (5th Cir. 2008)

The Fifth Circuit applied the analysis set forth in *Stephens Martin Paving* and held that insurance coverage for punitive damages would violate public policy under the unique facts of this case.

This was a coverage case between an insurer and its insured involving the allocation of a settlement between actual damages and punitive damages. The case arose out of a settlement of an underlying wrongful death case against Res-Care and one of its subsidiaries. The underlying suit resulted from the death of a group home resident due to complications from chemical burns she sustained at Res-Care's facility. A Res-Care employee was subsequently tried and convicted of recklessly causing seriously bodily injury to a disabled person. The Texas Department of Health and Human Services (TDHS) investigated the incident, found systemic problems at the facility and recommended that it be closed. The facts surrounding the resident's injuries are detailed in the court's opinion.

Res-Care was the insured under a primary policy and an umbrella policy issued by American. The primary policy had limits of $1 million and was silent as to punitive damages. The umbrella policy had limits of $15 million and specifically provided that it did not cover punitive damages.

Res-Care urged American to settle the wrongful death case. American urged Res-Care to share in the cost of any settlement due to its exposure to uncovered punitive damages. American and Res-Care entered into a non-waiver agreement that allowed American to explore settlement, while reserving the right to seek recoupment from Res-Care of any sums paid by American attributable to claims not covered by the applicable policies. American settled the wrongful death suit for $9 million and brought suit against Res-Care seeking reimbursement for the amounts attributable to uncovered claims.

The district court conducted a bench trial to apportion the settlement between covered and uncovered claims pursuant to *Enserch Corp. v. Shand Morahan & Co.*, 952 F.2d 1485 (5th Cir. 1992). After considering the evidence presented, the district court allocated $4 million of the settlement to actual damages and $5 million to punitive damages. The district court entered judgment for American for $5 million.

Res-Care appealed, arguing that the district court erred by considering evidence in the allocation trial that would not have been admissible in the trial of the wrongful death suit, that American waived all defenses to coverage by defending the case for 18 months before reserving its rights, and that since the primary policy did not specifically exclude punitive damages, the limits of that policy should be applied to punitive damages, leaving the limits of the applicable umbrella policy to pay the actual damage portion of the settlement.

The Fifth Circuit affirmed the district court's judgment. It held that *Enserch* does not stand for the proposition that only evidence that would be admissible in the trial of the underlying case can be considered in an allocation trial. Instead, the district court could consider any information influencing the settlement decision, including internal memoranda, correspondence between the insurer and the insured, investigative reports and statements, and in this case, the conviction of one of the insured's employees..

The Fifth Circuit further held that the insured's waiver and estoppel argument was

foreclosed by the non-waiver agreement entered into before the settlement.

Significantly, the Fifth Circuit applied the analysis set forth in *Fairfield Insurance Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653 (Tex. 2008), finding that the "extreme circumstances which gave pause to the Fairfield court are present in the instant case." As a result, the court found that the facts of this case "were so extreme that the purposes of punishment and deterrence of conscious indifference outweigh the normally strong public policy of permitting the right to contract between insurer and insured." Therefore, the court concluded that public policy was best served by requiring the insured to bear the costs of punitive damages and the district court did not err by failing to apportion any of the punitive damages to the primary policy.

OCCURRENCE

Nat'l Union Fire Ins. Co. v. Puget Plastics Corp., 532 F.3d 398 (5th Cir. 2008)

The Fifth Circuit held that knowing misconduct might constitute an "occurrence" -- an accident -- for purposes of the duty to indemnify.

This case was an insurance coverage dispute arising out of a judgment in an underlying lawsuit in which the insured, Puget Plastics, was found liable for knowing violations of the Texas Deceptive Trade Practices Act (the "DTPA"). Specifically, all of the underlying plaintiff's damages were based upon the jury's findings of Puget's knowing false, misleading or deceptive acts, knowing unconscionable actions and knowing failure to comply with a warranty. None of the damages awarded in the judgment were due to negligence. Thus, the coverage case involved only the duty to indemnify, not the duty to defend.

The Fifth Circuit stated that National Union's argument that knowing misconduct cannot constitute an occurrence for purposes of the duty to indemnify was foreclosed by the Texas Supreme Court's decision in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, 242 S.W.3d 1, 8 (Tex. 2007) (holding that allegations of negligence in plaintiffs' complaint, which also asserted knowing DTPA violations, gave rise to a duty to defend). The court held that there was a genuine issue of material fact as to whether Puget expected or intended the harm.

The Fifth Circuit also affirmed the district court's decision to allow the insured and the judgment creditor to present evidence in the coverage action concerning whether the insured expected or intended the injury, whether the injury was highly probable or whether certain damages were covered property damage under the policy.

"ACTUAL INJURY" OR "INJURY-IN-FACT" AS TRIGGER OF COVERAGE FOR PROPERTY DAMAGE

Don's Building Supply, Inc. v. OneBeacon Ins. Co., No. 07-0639 (Tex. Aug. 29, 2008)

In response to certified questions from the Fifth Circuit, the Texas Supreme Court addressed the proper trigger of coverage under an occurrence-based CGL policy and held that property damage occurs when "the injury happens, not when someone happens upon it." In doing so, the court rejected the manifestation trigger of coverage, which many Texas courts had previously used to determine when property damage occurs under a CGL policy.

Various homeowners filed suit against Don's Building Supply, Inc. ("DBS") alleging that, between 2003 and 2005, water leaked into their homes and caused damage because of the defective synthetic siding system known as an Exterior Insulation and Finish System ("EIFS"), which DBS sold and distributed. The EIFS was installed on the various homes from December 1, 1993 to December 1, 1996, and the homeowners alleged that the damage "actually began to occur on the occasion of the first penetration of moisture behind" the EIFS, which they claimed was "within six months to one year after the application of the EIFS." To avoid the statutes of limitations on their various claims, the homeowners pled the discovery rule arguing that the damage was "hidden from view" by the siding's undamaged exterior and "not discoverable or readily apparent to someone looking at the surface until after the policy period ended."

DBS sought a defense from OneBeacon under three occurrence-based CGL policies providing coverage from December 1, 1993 to December 1, 1996, the same period of time during which the EIFS was installed on the homes. OneBeacon initially defended DBS but later filed a declaratory judgment action seeking a ruling that it had no duty to defend and indemnify DBS under the CGL policies. The district court agreed that OneBeacon's duty did not arise until the damage became identifiable, and DBS appealed to the Fifth Circuit, which certified the following questions to the Texas Supreme Court:

1. When not specified by the relevant policy, what is the proper rule under Texas law for determining the time at which damage occurs for purposes of an occurrence-based commercially general liability policy?

2. Under the rule identified in the answer to the first question, have the pleadings in lawsuits against an insured alleged that property damage occurred within the policy period of an occurrence-based commercial general liability insurance policy, such that the insurer's duty to defend and indemnify the insured is triggered, when the pleadings allege that actual damage was continuing and progressing during the policy period, but remained undiscoverable and not readily apparent for purposes of the discovery rule until after the policy period ended because the internal damage was hidden from view by an undamaged exterior surface?

In determining when property damage occurs under a CGL policy, the court focused on the policy's language and noted that the policy provides "property damage" coverage if the "property damage" is caused by an "occurrence" that "occurs during the policy period." As the court stated, the policy's definition of "occurrence" is "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

Noting that "[a]n accident is generally understood to be a fortuitous, unexpected, and unintended event" and that "property damage" as "[p]hysical injury to tangible property," the court held that the property damage occurred when the "actual physical damage to the property occurred." Here, the property damage occurred when the homes suffered wood rot or other physical damage. According to the court, "the date that the physical damage is or could have been discovered is irrelevant under the policy." Stated differently, the court found that the policy linked "coverage to damage, not damage detection." Thus, the court adopted the "actual injury" or "injury-in-fact" trigger of coverage, which provides that an insurer must defend any claim of physical property damage that occurred during the policy term. In adopting this approach, the court rejected the "manifestation" trigger, which had been followed by most Texas courts to date, and the "exposure" trigger.

With that said, the court did stress that it did not attempt to "fashion a universally applicable 'rule' for determining when an insurer's duty to defend a claim is triggered under an insurance policy, as such determinations should be driven by the contract language – language that obviously may vary from policy to policy."

In addressing the Fifth Circuit's second question, the court stated that under the actual-injury rule, the duty to defend DBS depended on whether the homeowners' pleadings alleged property damage that occurred during the policy term. As noted by the court, "a plaintiff's claim against DBS that any amount of physical injury to tangible property occurred during the policy period and was caused by DBS's allegedly defective product triggers OneBeacon's duty to defend." Further, it noted that "[t]his duty is not diminished because the property damage was undiscoverable, or not readily apparent or 'manifest,' until after the policy period ended" and that it did not "depend on whether DBS ha[d] a valid limitations defense."

WAIVER AND ESTOPPEL

Ulico Cas. Co. v. Allied Pilots Ass'n, No. 06-0247 (Tex. Aug. 29, 2008)

The Texas Supreme Court addressed, for the first time, the so-called *Wilkinson* exception, holding that neither waiver or estoppel can effect a change in the policy's coverage. However, the court also stated that, if an insurer defends its insured in the absence of coverage without a reservation of rights, and if the insurer's actions prejudice the insured, the lack of coverage does not preclude the insured from asserting an estoppel theory to recover any damages the insured sustains due to the insurer's actions. Apparently, the measure of those damages is the amount of benefits that would have been available under the policy had the claim been covered.

Ulico issued a claims made and reported liability policy to Allied Pilots. The insuring agreement provided for payment of all "Loss" resulting from a claim first made against the insured during the policy period and required the claim to be reported during the policy period, or any applicable extended reporting period. "Loss" was defined to include defense costs.

The original policy period was extended twice by endorsement. During the second extension Allied Pilots was served with a lawsuit. It forwarded the suit papers to its insurance broker and its regular counsel, who proceeded to defend the suit. However, Ulico was not provided with notice of the suit until after the end of the policy period. Although there

was a dispute in this regard, it was ultimately determined by the Texas Supreme Court that the insured had not obtained an extended reporting period. Accordingly, since the claim was not reported to Ulico during the policy period, under the terms of the policy, it was not covered.

Nevertheless, after Ulico was notified of the suit, it acknowledged receipt of the claim and advised the insured that no defense costs could be incurred without the insurer's prior written consent. A few months later, Ulico sent a letter to Allied Pilots' counsel advising that the policy provided for defense costs and enclosing various reporting and budgeting forms to be completed by the lawyers. The lawyers did not respond to this letter.

Over a year later, Ulico again wrote counsel for Allied Pilots, stating that Ulico had agreed to reimburse Allied Pilots for reasonable and necessary defense costs. The firm responded enclosing approximately $635,000 of billings. At that point, the firm had filed a motion for summary judgment, which was later granted by the trial court. The plaintiff's appeal of the underlying lawsuit was dismissed.

Ulico filed suit seeking a declaration that it did not have coverage and did not owe defense costs. The trial court granted judgment in favor of Allied Pilots based upon jury findings that Ulico waived and was estopped from asserting that the policy did not cover the defense costs. The Fort Worth Court of Appeals affirmed, relying on *Farmers Texas County Mutual Insurance Co. v. Wilkinson*, 601 S.W.2d 520 (Tex. Civ. App.—Austin 1980, writ ref'd n.r.e.).

The Texas Supreme Court held that while an insurer may be estopped from denying benefits that would be payable under a policy if the insured's actions prejudice the insured, the doctrines of waiver and estoppel cannot be used to re-write the contract of insurance. In reversing and rendering judgment in Ulico's favor, the court noted that there was no evidence that Ulico assumed Allied Pilots' defense, or that Allied Pilots was prejudiced by Ulico's actions.

Note that, in the explanation of its ruling, this opinion contains an in-depth historical analysis of Texas case law addressing the waiver and estoppel issue that is too lengthy to summarize here. However, as stated in Justice Jefferson's concurring opinion, in which Justice O'Neill joined, it appears that the court has held that although estoppel cannot create coverage, if the insurer's actions in defending the insured without a reservation of rights result in prejudice to the insured, the insured can recover its damages based upon an estoppel theory. And, the measure of those damages is the benefits that would have been paid if the claim was in fact covered. In the words of Justice Jefferson, "a rose by any other name …."

ADDITIONAL INSURED / REASONABLENESS OF SETTLEMENT – EXCESS INSURER

Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc., 256 S.W.3d 660 (Tex. 2008)

On rehearing, the Texas Supreme Court held that ATOFINA was an additional insured under a commercial umbrella policy issued by Evanston, that the policy covered claims arising from ATOFINA's sole negligence, that Evanston is estopped to contest the reasonableness of the settlement of an underlying case against ATOFINA, and that former Art. 21.55 does not apply to third party claims and, therefore, that Evanston did not owe statutory penalties and attorneys' fees.

This case addressed the scope of insurance coverage afforded to a third-party additional insured under an umbrella policy issued by Evanston to Triple S. ATOFINA contracted with Triple S to provide maintenance work at ATOFINA's refinery. The contract contained an indemnity agreement, whereby Triple S agreed to indemnify ATOFINA for claims arising out of injuries to persons, including Triple S employees. The indemnity provision contained an exception to the extent that any such loss was "attributable to the concurrent or sole negligence, misconduct, or strict liability" of ATOFINA. In addition, Triple S agreed to maintain primary and excess insurance for any occurrence covered by the indemnity and to name ATOFINA as an additional insured.

Triple S purchased a $1 million primary CGL policy from Admiral. The Admiral policy named ATOFINA as an additional insured, but contained a provision excluding coverage for any liability arising from ATOFINA's sole negligence. Triple S purchased an excess policy with limits of $9 million from Evanston.

A Triple S employee was killed while working at the ATOFINA refinery and a wrongful death lawsuit was filed against ATOFINA. ATOFINA sought coverage from both Admiral and

Evanston. Admiral tendered its limits and Evanston denied coverage. ATOFINA settled the case and sought to recover the balance of the settlement from Evanston.

The "who is an insured" section of the Evanston policy contained several clauses describing the persons or entities insured by the policy. One clause provided that an insured included any person or organization for whom Triple S had agreed to provide insurance, "but that person or organization is an insured only with respect to operations performed by [Triple S] or on [Triple S's] behalf, or facilities owned or used by [Triple S]." Another clause contained follow form language, providing that an insured included any person or organization who was insured under a policy of underlying insurance, but that coverage under the Evanston policy was no broader than the underlying insurance.

In its original opinion issued May 5, 2006, the court held that the two clauses in the "who is an insured" section of the Evanston policy must be read together. Accordingly, the court concluded that the coverage afforded by the Evanston policy followed the form of the Admiral policy. Therefore, because the Admiral policy did not cover ATOFINA's sole negligence, ATOFINA's sole negligence would not be covered by the Evanston policy either. Because the underlying case was settled, there had been no determination whether ATOFINA's sole negligence was the cause of the accident. Accordingly, the court originally remanded the case to the trial court for a determination of the respective liability of the parties.

On rehearing, the court withdrew its prior opinion and held that the clauses in the "who is an insured" section of the Evanston policy must be read independently. The court then concluded that ATOFINA was an additional insured based upon both of the clauses in the "who is an insured" section of the policy discussed above. Since only one of those clauses provided that the Evanston policy followed the form of the underlying Admiral policy, the court concluded that the Evanston policy covered ATOFINA's sole negligence.

The court then concluded that the reasoning of *Employers Casualty Co. v. Block*, 744 S.W.2d 940 (Tex. 1988), applied equally to excess carriers. Thus, the court held that since Evanston incorrectly denied coverage, it was precluded from insisting that the insured establish the reasonableness of the settlement in order to recover the full amount of the settlement. Rather, the court held that Evanston was barred from challenging the reasonableness of ATOFINA's settlement and was required to pay the entire amount in excess of the primary coverage limit.

Finally, the court did conclude that former article 21.55 of the Texas Insurance Code did not apply because ATOFINA's claim was a third-party claim. Therefore, the court held that Evanston did not owe statutory penalties.

Justice Hecht, joined by Justice Johnson, dissented with the portion of the court's opinion holding that Evanston could not contest the reasonableness of the settlement. While agreeing with the proposition that an insurer that wrongfully refused to defend its insured should be estopped from contesting the reasonableness of a settlement, Justice Hecht noted that the excess carrier was only obligated to pay a judgment or a settlement to which it agreed. Since neither had occurred, Justice Hecht concluded that Evanston had not breached any duty to ATOFINA and there was no basis to estop it from contesting the reasonableness of the settlement.

ADDITIONAL INSURED: FAILURE TO PROVIDE NOTICE

Crocker v. Nat'l Union Fire Ins. Co., 526 F.3d 240 (5th Cir. 2008)

As discussed in the Spring 2008 newsletter, the Texas Supreme Court, on certified questions from the Fifth Circuit in *Crocker v. National Union Fire Insurance Co.*, 466 F.3d 347 (5th Cir. 2006), held that an insurer has no extra-contractual duty to inform an additional insured of the availability of liability coverage. Therefore, the additional insured's failure to comply with the notice provisions of the policy precludes coverage if the insurer is prejudiced. *See Nat'l Union Fire Ins. Co. v. Crocker*, 246 S.W.3d 603 (Tex. 2008). The court also held that the insurer's knowledge that the additional insured has been served does not establish as a matter of law that the insurer was not prejudiced by the additional insured's failure to provide the insurer with notice of service. *Id.*

Given the Texas Supreme Court's opinion, the Fifth Circuit noted that it was clear that, because the additional insured never gave National Union any notice of the suit, never complied with the National Union policy's relevant notice provisions, and never furnished copies of relevant suit papers as required by the policy, National Union owed no duty to defend him, or to notify him that its policy covered him. Thus, the court reversed the district court's

judgment and remanded the case with instructions to enter judgment that Crocker take nothing from National Union.

"STACKING"

N. Am. Specialty Ins. Co. v. Royal Surplus Lines Ins. Co., No. 07-20488 (5th Cir. Aug. 22, 2008)

The Fifth Circuit held that "Texas law prohibits stacking policies that do not overlap to provide more coverage than the highest limits of any one policy." Furthermore, "that rule applies to both the indemnity and defense portions of an eroding policy."

The underlying litigation involved claims against a nursing home and some of its employees for "continuing negligence" in the facility's care of one of its patients. The jury awarded damages to the plaintiff. Royal, one of the nursing home's primary insurers, settled the case with the plaintiff on behalf of the employees of the nursing home, exhausting the limits of its coverage. During the appeal, the nursing home's excess carrier, North American, assumed the defense of the nursing home and its parent company. (On appeal, judgment was rendered in the parent company's favor.) After a remand for a new trial against the nursing home, North American settled the case.

Seeking to recover for settlement and defense costs, North American filed suit against Royal and Evanston, the primary carrier that issued a policy that took effect after Royal's policy expired. North American contended that the underlying lawsuit involved distinct acts of negligence that occurred over three separate primary policy periods, two covered by Royal and one covered by Evanston. North American argued that the primary limits of these policies should be "stacked," and the stacked limits should be applied to both defense costs and indemnity. Furthermore, North American argued that the parent company's defense costs should be allocated to the CGL portions of the policy, not to the Hospital Professional Liability ("HPL") part. North American appealed after the district court rendered summary judgment for Royal and Evanston.

The Fifth Circuit began its analysis by explaining that North American could not recover against Evanston through equitable subrogation, and, because it decided the case on the stacking issues, the court refused to decide whether equitable subrogation applied to Royal.

When analyzing the stacking arguments, the court quickly noted that none of the parties disputed the anti-stacking rule announced in *American Physicians Insurance Exchange v. Garcia*, 876 S.W.2d 842 (Tex. 1994). Under *Garcia*, if the nursing home's negligence consisted of a single covered event, then only one coverage limit would be triggered. However, if the negligence constituted multiple, discrete covered events, then each event would trigger a separate coverage limit.

The Royal polices provided coverage for medical incidents. According to the language in the policy, "[a]ll related 'medical incidents' arising out of the providing of or failure to provide professional health care services to any one person shall be considered one 'medical incident.'" The Evanston policy contained similar language. Because the court determined that all of the nursing home's acts were "related"—as they all stemmed from a pattern of neglect and incompetence—the court held that North American could not temporally stack the polices for purposes of indemnification. Quoting from, and relying upon, *Garcia*, the court stated that North American, as the insured's equitable subrogee, was "entitled to 'whatever limit applied at the single point in time during the coverage periods of the triggered policies when the insured's limit was highest.'"

As for the defense costs, North American contended that *Garcia* does not prevent stacking for defense purposes. (The court noted that the polices at issue were "eroding" policies, and that North American failed to cite any authorities to support its argument. Additionally, the court recognized that there is a dearth of cases, nationwide, that address eroding policies in general, and even less in the context of stacking.) North American asserted that, in fairness, the insured should receive the benefit of having paid multiple premiums. The court rejected this argument, reasoning that the insured received what it bargained for: insurance coverage each year under policies that provided that related incidents involving one injured person constituted one claim. Had the insured wished for an unlimited defense obligation, it could have sought such a policy.

North American also asserted a subject-matter stacking argument. It argued that the parent company's defense costs actually triggered the CGL portion of the policies instead of, or in addition to, the HPL portion. Accordingly, the CGL and HPL parts should be stacked for defense costs purposes. The court refused to accept North American's reasoning because the underlying claims alleged a breach of professional care, which triggers HPL

coverage. CGL coverage, on the other hand, applies to non-care related negligence. Thus, the court held that CGL coverage did not exist in this case.

"EIGHT CORNERS" DOCTRINE

Indian Harbor Ins. Co. v. Valley Forge Ins. Group, No. 06-20707 (5th Cir. July 11, 2008)

Indian Harbor sued Liberty Mutual and Valley Forge seeking to recover attorney's fees and costs that Indian Harbor incurred in the defense of its insureds in an underlying lawsuit.

The underlying lawsuit involved a dispute between a property owner and its contractors relating to the construction of a building. The property owner brought suit against the general contractor and the subcontractors alleging that the concrete slab, which was laid by one of the subcontractors, Coastal, was defective, and that this defect caused damage to the building.

Coastal had a general liability policy with Indian Harbor. Indian Harbor defended and settled the claims against Coastal. (Indian Harbor also shared in the defense of the general contractor.) Liberty Mutual and Valley Forge insured two of the other subcontractors through business automobile policies. These auto policies provided that "any party that is liable for the conduct of the named insured is also covered as an insured, but only to the extent of that liability."

Indian Harbor brought suit against Liberty Mutual and Valley Forge, seeking to recover its defense and settlement costs under these auto policies. Indian Harbor argued that its insured and the general contractor both qualified as insureds under the auto policies, and that Liberty Mutual and Valley Forge owed a duty to defend Coastal and the general contractor because the underlying plaintiff's complaint sufficiently alleged facts supporting a claim against these entities. The district court found in favor of Liberty Mutual and Valley Forge, and Indian Harbor appealed.

On appeal, Indian Harbor contended that the lower court erred in its application of the "eight corners" rule because the court improperly relied upon Indian Harbor's policy when making its determination of whether there was coverage under the policies issued by Liberty Mutual and Valley Forge.

The Fifth Circuit agreed that the lower court misapplied the "eight corners" doctrine because the district court should have made a determination of whether the underlying complaint alleged that either Coastal or the general contractor were vicariously liable for the conduct of Liberty Mutual's and Valley Forge's insureds. The pertinent language in the auto policies, according to the Fifth Circuit, created coverage for any entity who was vicariously liable for the actions of the companies insured by Liberty Mutual and Valley Forge.

However, the Fifth Circuit ultimately affirmed the lower court's judgment. Essentially, after properly applying the "eight corners" doctrine, the court determined that the allegations in the underlying complaint failed to allege facts necessary to support a vicarious liability theory against the general contractor and Coastal. Accordingly, Liberty Mutual and Valley Forge had no duty to defend or indemnify.

RIGHTS/OBLIGATIONS OF CO-INSURERS

Trinity Universal Ins. Co. v. Employers Mut. Cas. Co., H-07-0878 (S.D. Tex. May 15, 2008)

In this coverage dispute, one issue was whether Texas law allows a co-insurer to recover a share of defense costs from another co-insurer when the respective policies contain identical "pro rata" or "other insurance" clauses. The United States District Court for the Southern District of Texas, relying on the Texas Supreme Court's decision in *Mid-Continent Insurance Co. v. Liberty Mutual Insurance Co.*, held that the co-insurers had no claim for contribution or subrogation against their co-insurer.

Lacy Masonry and several other entities were sued for alleged defects and deficiencies relating to the design, construction, and improvement of a building that sustained property damage from water infiltration problems. Lacy was the named insured under four CGL policies issued by Plaintiffs, Trinity Universal, Utica National, and National American, and Defendant, Employers Mutual. All of the policies contained standard "other insurance" clauses.

Lacy notified Plaintiffs and Employers of the underlying suit. Plaintiffs agreed to defend Lacy subject to reservations of rights. Conversely, Employers claimed that it had no duty to defend Lacy under its policy and did not contribute any portion of

the defense costs. Plaintiffs paid all of Lacy's defense costs. As a result, Plaintiffs filed suit against Employers asserting breach of contract and contribution claims and seeking a declaration that Employers had a duty to defend Lacy. The parties filed cross-motions for summary judgment. Among other grounds, the parties disputed whether Texas law allows a co-insurer to recover a share of defense costs from another co-insurer when their policies contain identical "pro-rata" or "other insurance" clauses.

In granting summary judgment in Employers' favor, the court discussed the Texas Supreme Court's recent holding in *Mid-Continent* that when co-primary insurance policies contain "other insurance" or "pro rata" clauses, a co-insurer that pays more than its proportionate share of a settlement has no right of reimbursement from another co-insurer through contribution and no right of recovery through subrogation if the insured was fully indemnified.

The court noted that the decision in *Hicks Rubber*, as reaffirmed in *Mid-Continent*, applied squarely to Plaintiffs' contribution claim. In doing so, it analyzed the policies' "other insurance" or "pro rata" clauses and determined that they were identical to the clauses addressed in *Mid-Continent*, thus limiting each insurer's obligation to an equal share of a covered loss, or a proportion of such loss based on a ratio of the limit of insurance under the policy to the total limits of coverage under all policies. Because the clauses rendered the Plaintiffs' and Employers' contractual obligations "several and independent of each other," the court held that Plaintiffs could not establish the common obligation element of their contribution claim. Stated differently, the inclusion of "other insurance" clauses in the policies defeated Plaintiffs' contribution claim by transforming their otherwise shared contractual obligations, including the duty to defend, into independent duties that could only be enforced, if at all, by Lacy.

As to Plaintiffs' subrogation claim, the court stated that even if Employers did breach its duty to defend Lacy by refusing to contribute any portion of the defense costs, Lacy incurred no loss because Plaintiffs had borne all costs associated with its defense. Thus, the court held that under *Mid-Continent's* rationale, the absence of loss to Lacy precluded Plaintiffs' subrogation claim. As the court noted, Plaintiffs stood in no better position than Lacy, who, having been fully defended by Plaintiffs, had no basis to recover damages against Employers for its failure to defend.

NO *STOWERS* DUTY

Home State County Mut. Ins. Co. v. Horn, (Tex. App.—Tyler June 25, 2008, pet. filed)

The Tyler Court of Appeals held no *Stowers* duty was created by an imprecise demand letter that proposed to release only one insured, who was not a party to the underlying suit.

Horn was injured in a single-car accident in which he was the passenger. The driver, Hulett, was killed. Prior to filing a lawsuit, Horn's attorney sent a letter, dated June 10, to Home State, Hulett's insurance carrier, offering to settle Horn's claim for policy limits and promising to fully release Home State's insured from all liability. The offer was conditioned on the settlement check being received on or before 5:00 p.m. on June 25. Hulett's sister, Shirley Berry, was the policy owner, but Horn alleged that Hulett was covered by the policy as a permissive user. As noted by the court, the issue of whether Hulett was covered by Berry's policy was not an issue on appeal.

Home State decided to accept the offer and sent a settlement check to Horn's attorney on June 23. However, Horn refused to accept the check claiming that it was received after the deadline set forth in the June 10 letter. Horn then caused an administrator to be appointed for Hulett's estate, sued the administrator, and recovered a judgment.

Two years later, Horn, as assignee of the administrator of Hulett's estate, sued Home State for negligent failure to settle in violation of the *Stowers* doctrine. On cross-motions for summary judgment, the trial court granted Horn's motion and denied Home State's motion. Home State appealed.

On appeal, the court noted that to prevail on a *Stowers* claim a settlement offer must propose to release the insured fully in exchange for a stated sum of money. The court then discussed Home State's argument that Horn's offer did not create a *Stowers* duty to Hulett's estate because the offer sought to release only Horn's claims against Berry. In agreeing that no *Stowers* duty was created, the court noted that the reference line of the June 10 letter defined Berry as Home State's "insured" and Hulett as Home State's "driver," and that the offer proposed to "fully release your insured from all liability" in exchange

for policy limits. The court also noted that the express language of the letter did not offer to release either Hulett or his estate; rather, it proposed to release *only* Berry.

For Horn, as assignee of Hulett's estate, to have a potential *Stowers* claim, he was required to present evidence of an offer to fully release Hulett's estate. As the court stated, "[b]ecause Horn's underlying judgment was taken only against the administrator of Hulett's estate, an offer to fully release Berry fails to demonstrate the existence of a *Stowers* duty owed to Horn by Home State." Because there was no evidence of an offer to release Hulett or his estate, the court held that Horn failed to demonstrate that Home State owed Hulett's estate a *Stowers* duty and, thus, was not entitled to summary judgment.

BIFURCATION – SUFFICIENT ALTERNATIVE TO SEVERANCE AND ABATEMENT

In re Travelers Lloyds of Tex. Ins. Co., No. 04-07-00878-CV (Tex. App.—San Antonio Sept. 17, 2008, no pet.)

The San Antonio Court of Appeals denied mandamus relief regarding a trial court's order rejecting severance and abatement of extra-contractual claims and held that the trial court's order to bifurcate evidence of a settlement offer was sufficient despite the possibility of prejudice.

Travelers paid $1,500 to its insured homeowners on their claim for hail and water damage to their home. The homeowners then claimed additional damage to their home allegedly arising from the same loss, and a dispute arose on the claim. After Travelers refused to pay any additional amounts, the homeowners filed suit. More than a year after suit was filed, Travelers offered $2,000 to settle the claim which was rejected. Travelers then moved for severance and abatement of the extra-contractual claims from the contract claim focusing on the prejudice that might result if the jury heard evidence of its settlement offer during the trial of the contract claim. The trial court denied the motion but ordered bifurcation of any admissible evidence involving the extra-contractual claims that would be prejudicial to the contract claim. Travelers sought mandamus relief.

The court noted that the primary justification for abatement of the extra-contractual claims – avoiding the effort and expense of conducting discovery on claims that may be rendered moot in a previous trial – was absent because the disposition of the contract claim would not moot the extra-contractual claims. In deciding that the trial court did not abuse its discretion, the court noted that the trial court ordered a bifurcated trial in an attempt to remedy any potential prejudice.

The court also discussed the split among the Texas courts of appeals as to whether bifurcation is a sufficient alternative to severance and abatement and decided that it would not follow the cases rejecting bifurcation. In doing so, it noted that bifurcation has been embraced by the Texas Supreme Court to address evidence of a defendant's net worth and that it saw no reason why bifurcation cannot be similarly employed to address evidence of a settlement offer. It also noted that the trial of the homeowners' extra-contractual claims was unaffected by the outcome of their contractual claim and, therefore, a single bifurcated trial preceded by unified discovery and pretrial proceedings promoted judicial economy better than severance and abatement.

LACK OF OWNERSHIP BY NAMED INSURED

Mao v. State Farm Lloyds, Inc., No. 6:07-CV-310 (E.D. Tex. May 20, 2008)

A sole shareholder of a corporation cannot recover on a claim for the loss of a dwelling owned by the corporation when that shareholder, in her individual capacity, is the only named insured on the homeowner's policy.

HO-B POLICY COVERS MOLD DAMAGE FROM PLUMBING LEAK

Page v. State Farm Lloyds, 259 S.W.3d 257 (Tex. App.—Waco 2008, Rule 53.7(f) motion granted)

The Waco Court of Appeals held that the Texas Homeowners Form B (HO-B) insurance policy covers any loss (including mold) to the dwelling or its contents resulting from a plumbing leak.

The insured discovered mold and water damage in her home and reported it to State Farm. After a test of the plumbing system revealed leaks in the sanitary sewer lines and an indoor environmental quality assessment found several forms of mold, it was recommended that both the structure and contents be remediated and certain contents

discarded. The insured provided a remediation estimate to State Farm, and State Farm issued drafts for remediation and repair of the structure and for remediation of the contents. In 2002, the insured requested additional funds to replace the carpet because of mold damage, but State Farm refused.

A dispute arose as to whether State Farm had paid sufficient funds, and the insured ultimately filed suit against State Farm. State Farm moved for summary judgment, and the trial court initially denied the motion. After the Texas Supreme Court rendered its decision in *Fiess*, State Farm filed a motion for reconsideration, which was granted. The trial court then rendered a take nothing judgment in favor of State Farm, and the insured appealed.

On appeal, the insured argued that *Fiess* does not universally exclude coverage for mold damage to a dwelling or its contents and that because the loss resulted from plumbing leaks, the Texas Supreme Court's earlier decision in *Balandran v. Safeco Insurance Co. of America* controlled and required coverage.

The issue in *Balandran* was whether the HO-B policy provided coverage for damage from foundation movement caused by an underground plumbing leak. The court noted that the Texas Supreme Court determined that issue by construing Item 9 of the "Section I-Perils Insured Against" section of the policy in conjunction with Exclusion 1.h, which excludes coverage for loss to the dwelling caused by foundation movement. The court also noted that Item 9 provides coverage of losses resulting from the "[a]ccidental discharge, leakage or overflow of water or stream from within a plumbing … system …" and that it provides that "Exclusions 1.a. through 1.h. under Section I Exclusions do not apply to loss caused by this peril." As noted by the court, the latter clause is referred to as the "exclusion repeal provision," which the Texas Supreme Court in *Balandran* held was ambiguous as it was susceptible to two reasonable interpretations.

Following *Balandran*, the court held that the exclusion repeal provision "has not lost its ambiguous character merely by the passage of time" and, thus, it remains ambiguous. Accordingly, the court held that the exclusion 1.f in the HO-B policy does not apply to loss caused by a plumbing leak.

Similarly, the court held that any mold damage to personal property within the dwelling caused by a plumbing leak was also covered. In doing so, it noted that the policy on its face provides coverage for any "physical loss … caused by a peril listed below," including in particular a loss caused by a plumbing leak and that the "named peril" in this case was the plumbing leak and not the resulting loss.

"REPLACEMENT COST" COVERAGE

Fitzhugh 25 Partners, L.P. v. KILN Syndicate KLN 501, No. 05-07-01334-CV (Tex. App.—Dallas Aug. 20, 2008, no pet.)

The insured was not allowed to recover replacement costs because the insured's purchase of another commercial property was not a "replacement" of the destroyed property, which was a condition precedent to recovering such costs.

The insured had a commercial property insurance policy covering an apartment complex, and the policy contained "replacement cost" coverage. After a fire destroyed the apartments, the insured made a claim for the loss, which the insurer paid. Less than two years later, the insured bought an interest in a commercial office park at a different location. Thereafter, the insured sought to collect under the policy for the cost of "replacing" the apartment with the office park. The insurer denied the claim, prompting the insured to bring suit.

On appeal, the sole issue for consideration by the court was whether the insured was entitled to recover on its claim for replacement costs. In response to the insurer's argument that the insured had not "replaced" the apartment, the insured posited that the replacement requirement is not a condition precedent to recovery, and even if it is, the insurer must show prejudice by the insured's failure to comply. Additionally, the insured argued that the insurer's definition of the term "replacement" was too limited as it failed to include the insured's purchase of the interest in the office park.

The policy provided, in pertinent part, as follows: "Replacement cost valuation does not apply until the damaged or destroyed property is repaired or replaced." After recognizing that this was a case of first impression in Texas, the Dallas Court of Appeals noted that throughout the country, courts have consistently determined "that such language requires repair or replacement of the destroyed property before the insured is entitled to recover replacement cost damages." In rejecting the insured's argument, the court explained that "[i]t is the act of replacing the property that causes the insured to suffer an additional loss for which he purchased additional coverage. To allow an insured to recover

replacement costs in the absence of actual replacement would permit the insured to recover for a loss he has not suffered." Therefore, the insured had to replace the property to receive replacement costs.

As for the insured's argument that the purchase of the interest in the office park constituted a "replacement" of the apartment complex, the court explained that although the insured could replace the apartments with different buildings at a different site, the insured could only recover replacement costs if those costs were associated with the purchase or construction of property that was "functionally similar" to the destroyed property. According to the court, that had not happened here because the office park, which functioned as a conduit for business, was not functionally similar to the complex, which was residential in nature. Thus, the insured had not met the condition precedent to coverage, and, as such, it could not recover for replacement costs.

SERVICES-RELATED EXCLUSIONS HELD INAPPLICABLE

Davis-Ruiz Corp. v. Mid-Continent Cas. Co., 281 Fed. Appx. 267 (5th Cir. 2008)

The Fifth Circuit held that claims of faulty inspection services of a ladder and storage tank were not barred by three services-related exclusions.

Williamson was injured when he fell off a ladder that was attached to a Marathon Ashland Petroleum storage tank. He sued Marathon alleging, among other things, that Marathon failed to properly inspect the ladder for defects. Marathon then filed a third-party complaint against Davis-Ruiz, which inspected the tank and ladder, seeking contribution and indemnity for Williamson's claims. Marathon alleged that Davis-Ruiz submitted a form indicating that the ladder had been inspected and was "acceptable." It also alleged that several of Williamson's allegations related to the inspection of the ladder.

Davis-Ruiz requested a defense under its CGL policy with Mid-Continent, but Mid-Continent refused based upon exclusions. Both Davis-Ruiz and Mid-Continent filed lawsuits, which were consolidated, and the district court converted the parties' pleadings into competing summary judgment motions on whether Mid-Continent had a duty to defend. The court ultimately granted summary judgment in Mid-Continent's favor finding that the claims were excluded by the Designated Professional Services exclusion. Davis-Ruiz appealed.

The Fifth Circuit agreed with the insured, finding that at least some of the services-related claims were covered and, thus, Mid-Continent had a duty to defend. In doing so, it analyzed three services-related exclusions raised by Mid-Continent.

As to the Designated Professional Services exclusion, the Fifth Circuit referred to the exclusion's language, which provided in part that "[w]ith respect to any professional services shown in the Schedule … [t]his insurance does not apply to 'bodily injury' … due to the rendering of or failure to render any professional service" and stated that the exclusion did not apply to all professional services but only those shown in the Schedule. It then noted that the "space in the Schedule following 'Description of Professional Services' [was] left blank" but that below the blank space, the exclusion stated "[i]f no entry appears above, information required to complete this endorsement will be shown in the Declarations … ." The court then looked to the policy's Declarations and not the general meaning of "professional services" to determine what services fell within the exclusion's scope.

However, neither the CGL Declaration nor the Policy Declaration provided a list of professional services. Instead, they described Davis-Ruiz's business as a "Radi[o]grapher Program." Davis-Ruiz argued they should be read as limiting the exclusion's applicability only to claims related to professional services involving radiography. The court agreed and noted that the inspection of the tank and ladder involved only visual inspection, not radiography. Thus, the inspection was not among those professional services described in this exclusion.

Next, the court addressed the Professional Liability endorsement exclusion noting that the endorsement provides that bodily injury or property damage arising out of the rendering or failure to render professional services is deemed to be caused by an occurrence thereby extending coverage to claims related to those services. It also noted that the services described in the endorsement were "Testing & Consulting." However, it explained that the endorsement excluded coverage for express or implied warranties. While Davis-Ruiz acknowledged that some of the claims might involve a breach of warranty, it argued that other claims did not involve warranties. Because the failure to inspect and failure to warn allegations did not appear to involve "express

or implied warranties," the court held that the exclusion did not bar coverage of the claims.

Finally, the court analyzed the Testing or Consulting Errors and Omissions exclusion, which provides that the "insurance does not apply to 'bodily injury' … arising out of … [a]n error, omission, defect or deficiency in … [a]ny test performed; or … [a]n evaluation, a consultation or advice given, by or on behalf of any insured … ." As the court noted, the policy did not define "test," "evaluation," or "consultation" and that "[u]nder … some definitions of those terms, … the exclusion might be interpreted to encompass the visual inspection of the … tank and ladder." However, the court further stated that in addition to applying the plain meaning of the policy's language, "[it] must also read the policy as a whole, giving effect to each provision."

In doing so, the court noted that a "broad reading of the Testing or Consulting exclusion … is impossible to reconcile with the rest of the policy." Specifically, it explained how the Professional Liability endorsement extends coverage to "bodily injury … arising out of the rendering or failure to render professional services" and describes those services as "testing and consulting." The court stated that if it "construed the Testing and Consulting exclusion as barring coverage of claims based on any 'testing' or 'consulting,' the Professional Liability endorsement would have no effect whatsoever, and the coverage it purports to extend would be illusory." Thus, the court agreed with Davis-Ruiz's proposal to harmonize the exclusion with the endorsement by reading the exclusion "as applying only to those testing and consulting services that do not rise to the level of 'professional' testing and consulting services." Under that reading, the inspection at issue was not excluded as it involved professional services.

STANDARD FOR "REASONABLE BELIEF" EXCLUSION

Empire Indem. Ins. Co. v. Allstate County Mut. Ins. Co., No. 3:06-cv-1415-O (N.D. Tex. May 8, 2008)

In an action between insurers, the central issue was which insurer had a duty to defend and indemnify a repossession company employee who, while street racing a repossessed car, caused an accident in which two people were severely injured. The company's commercial liability insurer argued that the company and its employee were entitled to coverage under the car owner's automobile policy because they were operating the car with a reasonable belief they were entitled to do so. The auto insurer argued that the allegations in the underlying suit against the company and employee were excluded under the auto policy's "reasonable belief" exclusion, which applies when any person uses "a vehicle without a reasonable belief that the person is entitled to do so." The insurers disagreed on whether an objective standard should be used to determine if the exclusion applied.

In resolving what standard applied, the court noted that the Texas Supreme Court had not yet addressed the issue. Accordingly, it made an *Erie* guess, relying on the Dallas Court of Appeals' analysis in *United States Fire Insurance Co. v. United Service Automobile Association*, 772 S.W.2d 218 (Tex. App.—Dallas 1989, writ denied), and held that the Texas Supreme Court would likely employ an objective test to determine whether an insured had a "reasonable belief" that he was entitled to use a vehicle.

The court then noted that the allegations in the underlying petition showed that the employee's actions of street racing at the time of the accident were done with an awareness of an extreme degree of risk but that he proceeded with conscious indifference to the rights, safety, and welfare of the underlying plaintiffs. Because those facts, viewed objectively, negated any inference that he may have had a reasonable belief that he was entitled to use the vehicle in the manner he did, the exclusion was triggered, and the auto insurer had no duty to defend.

EXTRINSIC EVIDENCE

Willbros Int'l, Inc. v. Hydrodive Int'l, Ltd., No. H-07-2479 (S.D. Tex. Aug. 27, 2008)

The United States District Court for the Southern District of Texas held that extrinsic evidence in the form of a master services agreement was admissible for purposes of determining whether a general contractor qualified as an additional insured under its subcontractor's package policy. The court noted that it was impossible to discern whether coverage was implicated by reference to the subject policy and underlying petition and that use of the agreement went to the fundamental issue of coverage – whether the GC qualified as an insured. The court also stated that there was no danger of overlapping with or questioning the truth or falsity of the facts alleged by the underlying plaintiff. As such, the agreement fit "neatly" within the narrow exception to the eight corners rule.

UM – NO COVERAGE FOR PASSENGER

Upson v. Allstate Indem. Co., No. H-08-01449 (S.D. Tex. Aug. 5, 2008)

A passenger was injured in a one-truck crash and claimed damages over $250,000. The driver's father's insurer paid the passenger the $100,000 limit under the father's liability coverage but denied coverage when the passenger sought another $100,000 under coverage for uninsured motorists.

The subject policy provided that the insurer would "pay damages which a *covered person* was legally entitled to recover from the owner or operator of an *uninsured motor vehicle* because of bodily injury sustained by a *covered person* …" and that the "owner's or the operator's liability for these damages must arise out of the ownership, maintenance or use of the *uninsured motor vehicle*." Section 1952.101(a) of the Texas Insurance Code explains that the uninsured or underinsured motorist coverage protects "insureds who are legally entitled to recover from owners or operators of uninsured or underinsured motor vehicles damages for bodily injury … resulting from the … use of any motor vehicle."

The district court noted that liability coverage protects the insured from the consequences of his own negligence. The court then noted that UM coverage protects the insured, the insured's family members, and anyone in the vehicle from the negligence of other uninsured or underinsured drivers and that vehicles owned by an insured cannot be underinsured. The court also noted that by definition, the truck was not uninsured and because the passenger's injuries were caused by the driver's own negligence while driving the truck, he was not within the coverage for uninsured motorists. As such, the policy did not extend UM coverage to the passenger.

DAMAGES UNDER SECTION 541.152(B)

Ins. Corp. of Hannover v. Polk, No. 11-06-00336-CV (Tex. App.—Eastland 2008, pet. filed)

One of the issues on appeal in this case was whether the trial court erred in awarding the insured $40,000 in actual damages and $120,000 in extra-contractual damages. The insurer argued that Section 541.152(b) of the Texas Insurance Code limits total damages recoverable to three times the actual damages and, thus, the trial court erred in quadrupling the actual damages in its total damages award of $160,000. In agreeing with the insurer, the Eastland Court of Appeals held that Section 541.152(b) limits the amount of total damages recoverable to three times the amount of actual damages. As such, the court held that the trial court should have awarded total damages of $120,000 on the insured's Insurance Code claims and modified the trial court's judgment by reducing the amount of additional damages from $120,000 to $80,000.

"BIOLOGICAL INJURIES"

Zurich Am. Ins. Co. v. Nokia, Inc., No. 06-1030 (Tex. Aug. 29, 2008)

The Texas Supreme Court held that the "biological injuries" alleged qualified as "bodily injury." Additionally, the court determined that the damages sought (because of the "biological injuries") were, in fact, sufficiently pled so as to trigger the duty to defend against claims seeking "damages because of bodily injury."

The underlying litigation involved several class action lawsuits (throughout the country, but not in Texas) in which the plaintiffs in those cases had sued Nokia, a wireless telephone manufacturer, for alleged damages resulting from exposure to radio frequency radiation (RFR). The plaintiffs—consumers who had used Nokia's cell phones—claimed that RFR from the phones had caused them "biological injury."

Nokia's insurers, Zurich, National Union, and Federal, assumed the defense under a reservation of rights. Subsequently, Zurich brought a declaratory judgment action against Nokia, National Union, and Federal, seeking a declaration that Zurich did not have a duty to defend or to indemnify, and that it was not responsible for any defense/indemnity costs incurred by National Union and Federal. Ultimately, the court determined that all three insurers had no duty to defend or indemnify Nokia in the underlying cases. Nokia appealed.

On appeal, the court of appeals reversed the lower court as to the insurers' duty to defend in all but one of the underlying cases. (The court of appeals found that the plaintiffs in one of the underlying cases had only pursued claims that did not give rise to a duty to defend under the policies at issue.) The court of appeals determined that the remaining complaints asserted claims for "bodily injury," and that they sought "damages because of

bodily injury." Thus, the allegations triggered a duty to defend under the policies.

The insurers filed a petition for review in the Texas Supreme Court. The court began its analysis by recognizing that although the implicated policies provided coverage for "all sums which [Nokia] shall become legally obligated to pay as damages because of . . . bodily injury," none of the underlying complaints employed the term "bodily injury." Instead, all of them used the terms "biological effects" or "biological injury."

The insurers argued that the court's holding in *Trinity Universal Insurance Co. v. Cowan*, 945 S.W.2d 819 (Tex. 1997)—that purely emotional injuries are not "bodily injuries"—precluded biological injuries or effects from qualifying as "bodily injury." The court rejected this argument, reasoning that *Trinity* also stated that "bodily injury" requires injury to the physical structure of the body. According to the court, the underlying complaints alleged "bodily injury" because they claimed that exposure to RFR causes adverse health consequences, such as changes in the brain.

The court also determined that the underlying plaintiffs were, in fact, seeking "damages because of bodily injury." The court found that the damages sought were "because of" bodily injury because every complaint alleged at least one theory through which tort damages could be recovered (*e.g.*, product liability). Accordingly, the court affirmed, with modification, the judgment of the court of appeals that the insurers had a duty to defend. (The modification related to one of the underlying cases in which the Texas Supreme Court concluded that the duty to defend had ceased in that case after the plaintiffs filed a second amended complaint that deleted every claim that had triggered the duty to defend.)