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TEXAS INSURANCE LAW UPDATE

THIRD QUARTER 2023

There were several noteworthy decisions from the Fifth Circuit and Texas state and federal courts handed down in the Third Quarter of 2023 which may be relevant to your claims handling. Topics include, for example, illusory coverage, *Stowers* demands and release, the duty to reimburse counsel selected by an insured, recovery of attorney fees under the Prompt Payment Act, and misrepresentation by an Insurer. In addition, we note some cases from other jurisdictions pertaining to the Federal Motor Carrier Safety Act.

This quarterly update addresses court opinions in the following insurance coverage areas: Commercial General Liability/Excess/Umbrella; Personal and Commercial Auto; Professional Liability; Homeowners and Commercial Property; Motor Carrier; and General Matters

If you would like to discuss any of the cases below in more detail, please reach out to one of our team members at Cox PLLC.

COMMERCIAL GENERAL LIABILITY/EXCESS/UMBRELLA

THE FIFTH CIRCUIT WEIGHS IN ON THE CONCEPT OF "ILLUSORY COVERAGE" WITH RESPECT TO PERSONAL AND ADVERTISING INJURY.

The liability lawsuit underlying the Fifth Circuit coverage case *Princeton Excess & Surplus Lines Ins. Co. v. A.H.D. Hous., Inc.*,[1] involved sixteen professional models (the Models) who sued three Texas strip clubs (the Clubs) following the Clubs' use of the Models' likeness for advertising campaigns without the Models' consent. The Clubs' advertising material was manipulated to give the impression that the Models endorsed the Clubs or worked as strippers in the Clubs. The Models "were depicted in various sexually charged social media and Internet posts . . . encouraging patrons to visit [t]he Clubs." According to the Models, the Clubs participated in the selection, creation, and dissemination of these advertisements. The state trial court granted summary judgment for the Models and awarded $1,405,000 in damages.

Princeton Excess and Surplus Lines Insurance Company (PESLIC) issued two commercial liability insurance policies to the Clubs covering the time period relevant to the Models' claims: (referred to as the 01 Policy and the 02 Policy). At issue under both policies was Coverage B - Personal and Advertising Injury Liability. Both policies contained the same relevant insuring agreement but had different exclusions.

The 01 Policy contained a "Field of Entertainment Exclusion," which read:

This insurance does not apply to any loss, claim, "suit", cost, expense, or liability for damages, directly or indirectly based on, attributable to, arising out of, involving, resulting from or in any way related to:
a. Actual or alleged activity which is claimed to be an intellectual property infringement or violation of any of the following rights or laws: copyright, patent, trade dress, trade secrets, trade name, trademark or service mark;
b. Actual or alleged invasion of privacy;
c. Actual or alleged libel, slander, or any form or defamation;
d. Actual or alleged unauthorized use of titles, slogans, names, formats, ideas, characters, artwork, theme, plots or other material;
e. Actual or alleged infringement of copyright or common law rights in literary, artistic or musical material, or actual or alleged infringement of literary, artistic or musical rights codes; . . . .

In the district court, PESLIC argued that the Field of Entertainment Exclusion excluded from coverage Personal and Advertising Injury subsections d., e., and g., while leaving in force subsection f., coverage for use of another's advertising idea and that coverage for the claim under the 01 Policy turned on whether the Clubs used the Models' "advertising idea," as the sole surviving relevant category of coverage.

The 02 Policy contained an "Exhibitions and Related Marketing Exclusion" that curtails coverage for Personal and Advertising Injury subsections d. through g. The exclusion read:

This insurance does not apply to:
. . .
The following parts of "personal and advertising injury":
d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organizations goods, products, or services;
e. Oral or written publication, in any manner, of material that violates a person's right of privacy;
f. The use of another's advertising idea in your "advertisement"; or
g. Infringing upon another's copyright, trade dress or slogan in your "advertisement";
If such activities arise out of or are part of "exhibitions and related marketing" . . . .

"Exhibitions and related marketing" means:
(a) The creation, production, publication, performance, exhibition, distribution, or exploitation of motion pictures, television programs, commercials, web or internet productions, theatrical shows, sporting events, music, promotional events, celebrity image or likeness, literary works and similar productions or work, in any medium including videos, phonographic recordings, tapes, compact discs, DVDs, memory cards, electronic software or media books, magazines, social media, webcasts and websites.

(b) The conduct of individuals in shows, theatrical productions, concerts, sporting events, or any other form of exhibition.
(c) Merchandising, advertising or publicity programs or material for the operations and material described in (a) or (b) above.

The parties disputed whether this exclusion rendered the Personal and Advertising Injury coverage in the 02 Policy illusory. If it did not, then the Clubs had no coverage applicable to the Models' claims; if it did, then they have coverage, as the district court held.

PESLIC argued that the policies did not obligate it to defend or indemnify the Clubs. The district court granted the Models' and the Clubs' motions for summary judgment and denied PESLIC's. As to the 01 Policy, the district court found that the Models' pleadings in the underlying lawsuit sufficiently alleged that that the Clubs used [the] Models' images (i.e., their “advertising ideas”) and placed them in their own “advertisements." Consequently, the district court held that PESLIC had a duty to defend and indemnify the Clubs under the 01 Policy. As to the 02 Policy, the parties disputed whether that policy's Exhibitions and Related Marketing Exclusion rendered illusory the Personal and Advertising Injury coverage. The district court agreed with the Models and the Clubs that it did and declined to give effect to the Exhibition and Related Marketing exclusion. The court thus held that PESLIC had a duty to defend the Clubs and that PESLIC had a duty to indemnify the Clubs under the 02 Policy.

The Fifth Circuit found that because the Field of Entertainment Exclusion eliminated coverage for most of the "advertising injuries" but expressly excepted injuries for the use of another's "advertising idea," the exclusion is enforceable and did not render the coverage illusory. In discussing the models’ claim the court held that there is no distinction in Texas law between an invasion of privacy and violation of the right to privacy. As to whether the Clubs' unlawful use of the Models' images constituted use of their "advertising idea," bringing the Models' underlying claims within the ambit of subsection f, the court noted that it and Texas courts had not spoken directly to the definition of an “advertising idea” in CGL policies. The court concluded the Clubs' misappropriation of the Models' images did not amount to use of their "advertising idea" because the Models' images are their products, not their advertising ideas. The Clubs took those products and used them without permission. and taking and then advertising another's product is different from taking another's advertising idea. Accordingly, PESLIC had no duty to defend or indemnify the Clubs based on the 01 Policy's "advertising idea" coverage.

With regard to the 02 Policy, the question was whether the policy's Exhibition and Related Marketing Exclusion, which eliminated coverage for Personal and Advertising Injury subsections d. through g. (pertaining to advertising injuries), but which left in force subsections a. through c. (covering personal injuries, rendered the relevant coverage illusory. The Models and the Clubs argued that CGL policies historically separated these forms of coverage, as personal injury and advertising injury are distinct types of injuries and that the 02 Policy's Personal and Advertising Injury coverage really provided two separable subcategories of coverage. They reasoned that because the exclusion curtailed the policy's advertising injury coverage, it rendered that subcategory of coverage illusory and should thus not be given effect. The court held that Personal and Advertising Injury coverage is one unit of coverage, with seven covered types of injuries listed in subsections a. through g. "Advertising Injury" is nowhere defined separately. Per the court, considering the plain policy text, the use of "and" to link "Personal and Advertising Injury," this indicated that the policy grouped these injuries under

the single rubric of "Coverage B—Personal and Advertising Injury Liability." And because the policy's Exhibition and Related Marketing Exclusion largely eliminates coverage for subsections d. through g., while leaving subsections a. to c. in force, the exclusion was enforceable and the 02 Policy was not illusory.

U.S. DISTRICT COURT FINDS SETTLEMENT DEMANDS WERE VALID STOWERS DEMANDS AND THAT A FULL RELEASE UNDER STOWERS NEED NOT INCLUDE THE RELEASE OF POTENTIAL, UNASSERTED, DISTINCT CLAIMS MADE BY THIRD PARTIES AGAINST THE INSURED.

In *Westport Ins. Corp. v. Pennsylvania National Mutual Casualty Ins. Co*.,[2] after a jury trial, a judgment was entered against Westport Insurance Corporation ("Westport") for violating its *Stowers* duty by not accepting three settlement demands from the plaintiff. After the judgment, Westport moved for judgment as a matter of law arguing that there was not a legally sufficient evidentiary basis for a reasonable jury to find that Westport violated its *Stowers* duty because the first demand did not provide for settlement and release of a third-party defendant's potential indemnity claim against the insured, and the two subsequent demands lacked clear and definite terms. The United States District Court for the Southern District held that the plaintiff's settlement demands were valid *Stowers* demands and there was a legally sufficient evidentiary basis for the jury to have found that the insurer violated its *Stowers* duty.

Regarding the first settlement demand, Westport argued that the demand did not address a "risk of future liability" the insured faced from a potential indemnity claim by CRC Insurance Services, Inc. ("CRC"). The court found that at the time of the demand, CRC had not asserted a claim against the insured/defendant; rather, the insured/defendant brought a third-party claim against CRC, and CRC filed an answer in which CRC referenced an indemnity provision in the contract between CRC and the insured/defendant as a defense to the insured/defendant's claims against CRC. Thus, at the time of the demand, the only claim as to CRC was the claim brought against it by the insured/defendant. The court found that Westport had not pointed to any case law to support the contention that a full release under *Stowers* includes the release of potential, unasserted, and distinct claims made by third parties.

With regard to the other two settlement demands, Westport argued that the oral $3.6 million settlement demands lacked clear and undisputed terms. The court rejected this argument as well. The evidence adduced at trial supported the conclusion that the jury found the terms clear and unconditional. Specifically, there was legally sufficient evidence to support the conclusion that the two demands were extensions of a Mediator's Proposal from 2009 and 2010 and carried with them the same terms and conditions as the Mediator's Proposal—including a term that provided for a full release in exchange for the payment of money.

PERSONAL AND COMMERCIAL AUTO

FIFTH CIRCUIT EXAMINES UIM COVERAGE FOR RIDE SHARE DRIVER IN A SHOOTING AND CHASE INCIDENT.

The coverage lawsuit underlying the Fifth Circuit coverage case *Neptune v. Indian Harbor Ins. Co.*,[3] involved a shooting and subsequent chase incident, in which Maria Neptune sought coverage for

injuries she sustained as a result of the incident while working as a Lyft driver. Lyft's insurer, Indian Harbor Insurance Company, denied coverage.

In the early hours of April 22, 2019, Maria Neptune, while working as a Lyft driver, accepted a request for a short ride from Houston to Cypress. At the pick-up spot, a young man got into her SUV. As was her Practice, Neptune then locked the doors but before she could begin driving, a man wearing a hoodie tried to get into the SUV. Neptune had noticed the man walking behind the passenger but at a distance, so she asked her passenger "if he was coming with someone." The passenger answered no and told her to drive away quickly. As she did, the man in the hoodie began shooting at her SUV, ultimately breaking her back window. Neptune drove straight to the drop-off location, a gated apartment complex. Her passenger did not have the correct gate code, so she drove around the complex trying the various gates. While trying a gate at the front of the complex, a vehicle pulled behind hers and began shooting at her, hitting one of her tires. Neptune managed to do a U-turn and drive away. About two miles from where she last saw the shooter, while trying to get to the highway, Neptune hit an "island or sidewalk before crashing into a wall." She and her passenger hid in the grass and waited for the police.

Texas law requires Lyft to have uninured/underinsured motorist coverage for its drivers.[4] Lyft had coverage through Indian Harbor. The policy stated:

> We will pay damages which an "insured" is legally entitled to recover from the owner or operator of an "uninsured motor vehicle" because of "bodily injury" sustained by an "insured" or "property damage" caused by an "accident." The owner's or operator's liability for these damages must arise out of the ownership, maintenance, or use of the "uninsured motor vehicle."

The policy in part defines "uninsured motor vehicle" as:

> "A land or motor vehicle or 'trailer' of any type…which is a hit-and-run vehicle whose operator or owner cannot be identified. The vehicle must hit an 'insured', a covered 'auto' or vehicle an 'insured' is occupying.

Neptune sued Indian Harbor and the unidentified driver in state court, seeking in part, a declaratory judgment that Indian Harbor's policy covered the accident. Indian Harbor removed the case to federal court and, after discovery, moved for summary judgment. The district court granted the motion, explaining that the policy's plain language only covered uninsured motorist accidents if the uninsured motorist hit the insured or the insured's car. Finding that Neptune produced no evidence that the shooter's vehicle hit hers, the court concluded her coverage claim failed as a matter of law. On appeal, Neptune argued that the district court erred in holding that she failed to establish Lyft's Indian Harbor policy covered her injuries in two ways: (1) by concluding her claim did not involve the "use" of the uninsured vehicle and (2) by finding that she presented no evidence of physical contact between her vehicle and the unidentified driver.

The Fifth Circuit found that in order to establish coverage, Neptune must show not only that her injuries stem from the "use" of the uninsured vehicle, but also that the uninsured vehicle hit her or her vehicle. Indian Harbor presented evidence of Neptune's repeated deposition testimony in

which she stated that she crashed because she hit an island while trying to turn right and she repeatedly stated that she did "not recall" the uninsured vehicle hitting her when she crashed. The Fifth Circuit agreed with the district court's assessment of the summary judgment record. Neptune did not submit any rebuttal evidence in response to Indian Harbor's motion, instead she stated that the "unknown Defendant driver hit Plaintiff's vehicle from behind causing Plaintiff to lose control of her vehicle and crash which caused her to suffer serious and permanent bodily injuries." Neptune bore the burden of designating specific facts showing that there is a genuine dispute for trial.[5] Even if the uninsured driver hit her at some point, Neptune presented no evidence connecting that contact to her crash. In fact, her testimony was that she last saw the uninsured vehicle at a point more than two miles from the accident location. Neptune failed to show a genuine dispute of fact on the physical contact requirement of the insurance policy. Thus, the Fifth Circuit affirmed the win for the carrier, relying primarily on the lack of evidence showing there was physical contact with the other vehicle.

It is worth noting that Indian Harbor's briefing also focused on whether a drive-by shooting can satisfy the physical contact requirement for purposes of insurance coverage, but Neptune stated that she was not asserting that the shooting caused her injuries, so the Fifth Circuit did not address that argument.

PROFESSIONAL LIABILITY

TEXAS COURT OF APPEALS FINDS AN INSURER HAS NO DUTY TO REIMBURSE THE COSTS OF DEFENSE OF COUNSEL CHOSEN BY THE INSURED

On interlocutory appeal, a Texas appellate court had occasion to consider whether an insurer had a duty to reimburse its insureds for fees and expenses incurred by an attorney chosen by the insured after the insured elected to hire separate counsel.[6]

Mid-Continent Casualty Company (Mid-Continent) insured Harris County Municipal Utility District No. 400 (MUD 400), Anne Marie Wright (Wright), and Cheryl Smith (Smith) under a D&O Policy. The dispute arose from an underlying lawsuit filed by Edgar Clayton (Clayton) in June 2018 (the "Clayton Suit"). In the Clayton Suit, Clayton challenged the result of the May 5, 2018 election of two open at-large director positions on the MUD 400 board of directors. Clayton, who placed third in the election, sued MUD 400, Wright, and Smith. In the petition, he alleged violations of the Texas Election Code, specifically that (1) illegal votes were counted because voters were not prevented from voting more than once, and individuals who were not entitled to vote cast votes that were counted; (2) voters who were eligible to vote were turned away from the polls due to failures with availability of the temporary voting trailer; and (3) election officials were engaged in fraud, illegal conduct, or made mistakes regarding the ballots by mail that resulted in ballots by mail not being counted, verified, or authenticated. Clayton asked the trial court to declare the election void and order a new election.

On July 2, 2018, attorney James Stilwell, acting on behalf of MUD 400, Wright, and Smith, notified Mid-Continent of the Clayton Suit and requested coverage. On July 24, 2018, Mid-Continent responded by offering a defense, subject to a reservation of rights. Mid-Continent notified the Insureds that attorney Britt Harris had been retained by Mid-Continent to defend all Insureds in the Clayton Suit. In its reservation of rights letter, Mid-Continent informed the Insureds that the policy

exclusion III. B. (4) may preclude or limit coverage (the exclusion precluded coverage if "(1) An insured received an advantage; and (2) that advantage was one the insured was not legally entitled to."). After receiving Mid-Continent's reservation of rights letter, Stilwell responded by letter dated August 1, 2018, stating that there was "the possibility of a conflict [of interest] in representation regarding Mid-Continent's desire to have a single attorney represent all (3) defendants in the case." Stilwell further stated that "[d]ue to potential differences in interest by and between the directors, and the Board as a whole, the three defendants currently have separate representation in the lawsuit." Stilwell further stated that he "would be discussing Mid-Continent's reservation of rights with the Defendants with respect to whether the exclusion raised in the letter raises an actual conflict of interest with the insurer controlling the defense of the lawsuit." Mid-Continent wrote to Stilwell again on November 21, 2018 informing him that Mid-Continent had consulted with a coverage attorney who concluded that Mid-Continent had the right to select defense counsel "because the facts to be adjudicated are not necessarily the same facts that control coverage." The Clayton Suit was eventually dismissed in favor of all Insureds.

Stilwell wrote Mid-Continent demanding reimbursement for attorneys' fees and expenses because the insureds proceeded with utilizing their own counsel, which Mid-Continent denied. Specifically, the policy at issue provided that Mid-Continent had the right and duty to defend, and further, that Mid-Continent would not reimburse fees incurred without Mid-Continent's written consent. Because there was no actual conflict in the Clayton Suit, Mid-Continent maintained that the insureds had no right to independent counsel. The insureds filed suit against Mid-Continent alleging breach of contract , violations of the Texas Insurance Code, and breach of the duty of good faith and fair dealing. Mid-Continent filed a No-Evidence Motion For Summary Judgment Or Partial Summary Judgment, which was denied on the basis that Mid-Continent had a duty to reimburse the insureds' defense costs, and Mid-Continent appealed.

First, the court considered whether Mid-Continent owed a duty to reimburse the Insureds for fees and expenses incurred by attorneys chosen by the Insureds to defend the Insureds in the Clayton Suit. After examining the allegations in the Petition and the wording in the policy, the appellate court agreed with Mid-Continent that the facts upon which coverage depended would not be adjudicated in the underlying suit. The court reasoned, "[n]owhere in Clayton's pleadings does Clayton allege that Wright, Smith, or MUD 400 received a monetary advantage. The pleadings fail to allege that either Wright or Smith received illegal votes. Along those same lines, MUD 400's argument that it received the 'advantage' of not holding and paying for a new election may mean MUD 400 avoided further expense of a new election, but it does not mean that the election of May 18th provided MUD 400 with a monetary advantage. Rather, at most, it means MUD 400 would avoid a disadvantage if the election was not set aside as void. Furthermore, the trial in the Clayton Suit, based on the allegations in the Clayton Petition, would not adjudicate whether the Insureds received a monetary advantage to which they were not legally entitled." Thus, the court concluded that the Clayton Suit did not give rise to a disqualifying conflict of interest between the Insureds and Mid-Continent.

Next, the court considered whether Mid-Continent owed a duty to reimburse its Insureds for the costs they incurred in hiring separate counsel to defend each Insured in the Clayton Suit. The court reviewed Texas Disciplinary Rules of Professional Conduct Rule 1.06, which governs conflicts of interest in representation. From this, the court concluded that a lawyer may only represent multiple clients in a substantially related matter if (1) the lawyer reasonably believes the representation of each

client will not be materially affected and (2) each of the clients consent after full disclosure of the existence, nature, implications, and possible adverse consequences of the common representation and the advantages involved. As evidence of a conflict between the Insureds that necessitated separate counsel for each Insured, MUD 400 relied on deposition and affidavit testimony from attorneys Bruce Tough (who represented Wright in the Clayton Suit), Kenna Seiler (who represented Smith in the Clayton Suit), and Chris Skinner (general counsel for MUD 400). The deposition testimony and affidavit generally alleged that a MUD 400 board meeting discussion uncovered material conflicts among Wright, Smith, and MUD 400; that the three Insureds would not waive those conflicts, and that the Insureds requested separate counsel. Moreover, MUD 400 contends that Mid-Continent received actual notice of the multi-party conflict. The court of appeals disagreed, noting that the information that the insureds relied upon fell outside the eight-corners of the pleadings and the policy. Based on the evidence in the record, the court held that the evidence was only that of potential conflicts. Applying the eight-corners rule, the court concluded that Clayton's petition did not allege facts that would necessitate separate counsel, reasoning “Clayton does not allege anything in his petition that would make the interests of Wright, Smith, or MUD 400 adverse to the interests of each other. Nor did Clayton allege facts that would limit a single lawyer’s responsibilities to each Insured. Instead, the petition alleges that violations of the Texas Election Code occurred, specifically that (1) illegal votes were counted because voters were not prevented from voting more than once, and individuals who were not entitled to vote cast votes that were counted; (2) voters who were eligible to vote were turned away from the polls due to failures with availability of the temporary voting trailer; and (3) election officials were engaged in fraud, illegal conduct, or made mistakes regarding the ballots by mail that resulted in ballots by mail not being counted, verified, or authenticated.” Therefore, the court held that Mid-Continent had no duty to reimburse its insureds for costs they incurred in hiring separate counsel because the petition did not allege facts or claims that indicated there was a conflict, and the evidence described only potential conflicts.

HOMEOWNERS AND COMMERCIAL PROPERTY

FIFTH CIRCUIT CERTIFIES QUESTION TO TEXAS SUPREME COURT REGARDING RECOVERY OF ATTORNEY’S FEES UNDER THE TEXAS PROMPT PAYMENT OF CLAIMS ACT

On October 4, 2023, the Texas Supreme Court is scheduled to hear oral arguments regarding the Fifth Circuit’s certified question as to whether payment by an insurer of the full appraisal award plus any possible statutory interest precludes recovery of attorney’s fees under Chapter 542 of the Texas Prompt Payment of Claims Act (“TPPCA”).

Rodriguez v. Safeco Ins. Co. of Indiana[7] involved a tornado claim under a homeowner’s policy. A tornado damaged Mario Rodriguez’s home in May 2019. After an inspection of Rodriguez’s property, the Safeco adjuster found covered damage in the amount of $1,295.55. Rodriguez disagreed and sent notice to Safeco that he believed he was entitled to another $29,500 under his policy. After there was no response from Safeco, Rodriguez filed suit, alleging unfair settlement practices violations of Section 541 and delayed payment violations of Section 542 of the Texas Insurance Code.

Subsequently, Safeco invoked the policy’s appraisal provision and an appraisal panel determined that the replacement cost of the damage to the home was $36,514.52. Safeco then paid

Rodriguez $32,447.73, which Safeco claimed was the actual cash value of the appraisal award less Rodriguez's deductible, the applicable policy limits, and Safeco's prior payment. Safeco paid Rodriguez an additional $9,458.40, which allegedly represented the maximum possible penalty interest penalty that could be due under the TPPCA. Safeco then moved for summary judgment on the grounds that based on the 2017 amendments to Section 542, Safeco's payment of the appraisal award plus interest foreclosed Rodriguez's claim for attorney fees un the TPPCA. Rodriguez appealed.

In 2017, the Texas Legislature made amendments to Chapter 542, which amended the method for determining the amount of attorney's fees and interest that could be awarded by a court under the TPPCA with regard to weather-related insurance disputes. The Fifth Circuit noted that the Texas Supreme Court had previously held that an appraisal award payment does not eliminate an insured's ability to collect TPPCA damages and that one Texas appellate court had clarified the pre-payment of interest does not change the finding; however, the Fifth Circuit acknowledged those cases were not subject to the 2017 amendments.

The Fifth Circuit noted that the central issue is how the 2017 amendments change an insured's ability to collect TPPCA damages, if at all, when an insurer pays an appraisal award and estimated interest. The court noted a split in the federal courts that have addressed the issue and that only one Texas appellate court has ruled on the effect of the 2017 amendments.

For example, as we addressed in our Second Quarter 2023 update, in *Morakabian v. Allstate Vehicle & Property*,[8] the Eastern District of Texas held that the plain language of Section 542 makes clear that payment of an appraisal award forecloses a plaintiff's right to attorney fees. However, the Fifth Circuit also noted that in *Gonzalez v. Allstate Fire & Casualty Insurance Company*,[9] a 2019 Western District of Texas case, the court held that while the Texas legislature intended to place a limit on attorney's fees, there is no indication the legislature intended to read attorney's fees out of the statute.

The Fifth Circuit noted that the court in *Gonzalez* found that the alternative interpretation of Section 542 would mean "insurers could systematically avoid liability for TPPCA attorney's fees by, (i) first, paying only a small fraction of the alleged claim amount; (ii) second, invoking appraisal; and (iii) third, only following appraisal, paying the difference and any interest owed to the claimant."[10]

This question is of importance to both the plaintiffs' bar and insurance companies. Therefore, we will continue to monitor this case and provide an update once the Texas Supreme Court issues its decision.

MOTOR CARRIER

GEORGIA FEDERAL DISTRICT COURT HOLDS THAT THE MCS-90 ENDORSEMENT IS NOT TRIGGERED WHEN THE INSURED HAS SUFFICIENT INSURANCE COVERAGE AS AN ADDITONAL INSURED TO FULFILL THE FULL AMOUNT OF THE MCS-90'S OBLIGATIONS

In *Brooklyn Specialty Ins. Co. Risk Retention Grp. v. Bison Advisors, LLC*,[11] the Middle District of Georgia considered a coverage dispute regarding if an MCS-90 was applicable to a motor vehicle

accident despite the insured being afforded coverage for defense and indemnity as an additional insured on another policy.

On March 22, 2019, Peggy Lynn Evans and Jackie Lynn Evans ("the Evans") died in a motor vehicle accident involving a tractor trailer owned by Paper Impex USA, Inc. (“Paper Impex”) and leased to Raptor Auto Shipping Inc. ("Raptor"). At the time of the accident, the tractor trailer was being operated by a Raptor employee, Bunyod Kushnazarov.

Brooklyn Specialty Insurance Company Risk Retention Group, Inc. ("BSIC") issued an automotive liability insurance policy to Paper Impex effective November 12, 2018, to May 3, 2019 (“BSIC Policy”). Coverage under the BSIC Policy was limited to vehicles included on the BSIC Policy's list of scheduled vehicles. Neither the truck nor the trailer involved in the accident were listed on the schedule. Likewise, coverage under the BSIC Policy was limited to drivers included on the BSIC Policy's list of scheduled drivers. Kushnazarov was not listed on the BSIC Policy's schedule of drivers. However, the BSIC Policy contained an MCS-90 Endorsement with a limit of $750,000. Under the terms of this endorsement, Paper Impex agreed to reimburse BSIC for any payment that BSIC would not have been obligated to make under the provisions of the policy except for the agreement contained in the MCS-90.

Ultimately, Bison Advisors, LLC, (“Bison”) served as the Special Administrator and Personal Representative of the Evans' estate and filed a wrongful death suit against Kushnazarov, Paper Impex, Raptor and RPM Freight Systems, LLC ("RPM"). BSIC denied coverage to Paper Impex under the BSIC Policy for the claims asserted against it. Bison resolved the underlying lawsuit by entering into a Compromise, Settlement and Release Agreement with all defendants to resolve all pending claims. In the Settlement Agreement, Bison released and discharged Paper Impex from "all claims, demands, causes of action, known or unknown, liabilities and damages, of any kind, at common law, statutory, or otherwise, which presently exist, or which may arise in the future, directly or indirectly, attributable to the Incident of March 22, 2019 made the basis of the Lawsuit."

At the time of the accident, Raptor was insured under an insurance policy issued by ATG Insurance Risk Retention Group, Inc. ("ATG") which provided $1,000,000.00 in liability limits (the "ATG Policy"). Paper Impex was an additional insured under the ATG Policy, and ATG provided a defense and indemnity to Paper Impex in the Underlying Lawsuit. ATG paid a sum in excess of $900,000.00 to resolve the case. Overall, Bison received payments in excess of $2,000,000.00 from insurers in settlement of the Underlying Lawsuit. BSIC was not involved in the defense of Paper Impex, involved in any settlement negotiations, and did not consent to the release of Paper Impex in the Settlement Agreement. Nevertheless, Bison demanded that BSIC pay the $750,000.00 consent judgment against Paper Impex. In response, BSIC filed this coverage analysis to determine its obligations with respect to the Settlement Agreement.

Ultimately, the Court granted BSIC’s summary judgment and issued an obligation that BSIC had no obligation to pay anything under the terms of the BSIC Policy's MCS-90 endorsement. In its reasoning, the Court explained that the MCS-90 is triggered only when: (1) the underlying insurance policy (to which the endorsement is attached) does not provide liability coverage for the accident, and (2) the carrier's other insurance coverage is either insufficient to meet the federally-mandated

minimums or nonexistent. If a motor carrier's insurance pays a judgment satisfying the regulatory minimum, the goal of public financial responsibility has been accomplished and the endorsement does not apply. The Court noted that Paper Imex was an additional insured under Raptor's policy with ATG and this policy had a liability limit that was greater than the amount of the BSIC's MCS-90 endorsement. In addition, ATG ultimately paid out $900,000 on behalf of Paper Impex which was also greater than the limit of the MCS-90. Therefore, the ATG policy satisfied the regulatory minimum, and the MCS-90 Endorsement was not triggered.

This case demonstrates the benefits of conducting thorough outbound risk transfer analysis to ensure that risks are properly shifted and shouldered by other parties. However, it should be noted that a contract requiring a party to be named as an additional insured does not ensure a party will be classified as an additional insured because the transportation industry has recently followed the lead of the construction industry in encouraging a number of states to pass anti-indemnity acts to restrict risk transfer between motor carriers. Therefore, retaining a coverage attorney to pursue potential viable methods of risk transfer is essential given the evolution this area of law is currently experiencing.

ILLINOIS FEDERAL DISTRICT COURT UPHOLDS THAT THE PHRASE "DIRECT PHYSICAL LOSS OR DAMAGE" REQUIRES A CLEAR SHOWING OF PHYSICAL ALTERATION OF CARGO AND DOES NOT COVER PURELY ECONOMIC INJURIES

In *Am. Highway, Inc v. Travelers Co.*,[12] the Eastern District of Illinois considered a coverage dispute regarding if a Commercial Inland Marine insurance policy afforded coverage for reimbursement to a motor carrier for a shipment of a food product that was rejected upon delivery. The main dispute was whether the subject shipment suffered "direct physical loss or damage" for purposes of bringing a claim within coverage of the policy.

In November of 2017, Kerry Foods ("Kerry") contacted freight broker C.H. Robinson to ship 19 pallets of a potato-based, food-grade product called ProtaStar from Illinois to California. C.H. Robinson selected American Highway, Inc. ("American Highway") to carry the load. American Highway picked up the load at Kerry's distribution center in Illinois on November 29, 2017. Kerry sealed the trailer that contained the ProtaStar with a metal identification tag. Kerry seals the trailers to ensure that the load is not contaminated or otherwise adulterated during transit. On the way to California, the trailer experienced a mechanical issue, so American Highway broke the trailer's seal and moved the ProtaStar to a new trailer with a new seal. Upon delivery, the recipient rejected the load because the original seal had been broken. On January 5, 2018, American Highway issued a "Guaranty" to Kerry that stated the goods were not tampered, contaminated, adulterated, or otherwise altered during transportation.

Kerry made a claim to C.H. Robinson for a breach of their carriage contract due to the broken seal, and C.H. Robinson paid the full amount of the claim ($48,296.17) without a suit or any adversarial proceeding. C.H. Robinson's contract with American Highway allowed C.H. Robinson to exercise a setoff right where American Highway's actions created liability for C.H. Robinson to its customers. To recoup its loss, C.H. Robinson exercised its setoff right by withholding $48,296.17 that it owed to American Highway for unrelated jobs.

Travelers Property Casualty Company of America ("Travelers") issued American Highway a Commercial Inland Marine insurance policy (the "Policy"). In the Policy, Travelers committed to paying American Highway "those sums you become legally obligated to pay as damages as a Motor Carrier, Warehouseman, Freight Forwarder, Logistics Service Provider or Other Bailee for direct physical loss of or damage to Covered Property caused by or resulting from a Covered Cause of Loss." American Highway made a claim under the Policy for the money it lost when C.H. Robinson exercised its contractual setoff right. In response, Travelers denied coverage because "a missing seal does not constitute physical damages" under the Policy and there was no physical damage noted on the delivery date. Following the denial, American Highway initiated a lawsuit against Travelers.

The main dispute between the parties was determining the meaning of the phrase "direct physical loss of or damage to Covered Property". The Court looked to previous precedent from the 7th Circuit to interpret this phrase to require the phrase "direct physical" as modifying to both the words loss and damage. Accordingly, under the Policy, damage to Covered Property must be physical for the insured's claim to be covered. The Court further noted that the Supreme Court of Illinois had previously held that that a "physical" injury to property occurs when property is altered in appearance, shape, color or in other material dimension, and does not take place upon the occurrence of an economic injury, such as diminution in value.

American Highway attempted to argue that the purpose of the seal that broke was to guarantee the ProtaStar remained unadulterated. Therefore, it was American Highway's position that breaking the seal created the possibility of physical damage, making the ProtaStar worthless. The Court was unpersuaded by this argument stating the breaking of the seal presented a risk of adulteration, not actual adulteration of the food product. Therefore, the claim constituted a claim for an economic injury. Furthermore, the Court bolstered its reasoning by citing to the Guaranty where American Highway had confirmed the ProtaStar was not "tampered, contaminated, adulterated, or otherwise altered." While in its possession. Therefore, there was no genuine issue of material fact that the ProtaStar did not suffer "direct physical loss" or "direct physical damage". Accordingly, American Highway's claim falls outside the Policy language and was not covered.

The Court also noted that the Carmack Amendment did not apply to this case because Carmack only applies to a carrier's liability to the person entitled to recover under the receipt or bill of lading. However, Carmack does not preempt claims that do not affect a carrier's liability for lost or damaged goods—such as a suit by a carrier against a person entitled to recover for non-payment. American Highway's claim did not assert a claim for a carrier's liability. Instead, the suit concerns an insured's recovery under an insurance policy, not a suit brought by a person entitled to recover against a carrier under a receipt or bill of lading. Accordingly, Carmack did not apply.

<u>This case demonstrates the specificity with which courts will interpret specific language of an insurance policy and that courts can interpret certain phrases contained in an insuring agreement to expand or contract the scope of coverage afforded to an insured. In addition, this case demonstrates the importance of researching the local jurisdiction's viewpoint on interpretation of certain phrases within a policy before issuing a denial. Finally, this case demonstrates that courts do not view the Carmack Amendment as applying to disputes between insureds and insurers even when the underlying claim involves the damage goods allegedly sustained during interstate transportation.</u>

CALIFORNIA FEDERAL DISTRICT COURT UPHOLDS THE VALIDITY OF RADIUS OF OPERATIONS LIMITATION ENDORSEMENT

In *Garnicas Transp., LLC v. Commer. All. Ins. Co.*,[13] the Eastern District of California analyzed the conscionability of a Radius of Operation Limitation endorsement contained in a Commercial Auto Policy issued by Commercial Alliance Insurance Company ("CAIC") to Garnicas Transport, LLC ("Garnicas").

Garnicas was a trucking company that hauls Tesla products from Mexico into the United States. Garnicas hired a third-party broker, Morris Seguros, to assist in procuring commercial automotive insurance for Garnicas' fleet of trucks when, and only when, they make a trip from Mexico into the United States. The person with whom Gamero communicated at Morris Seguros was Claudia Ponce. Ms. Ponce was an "independent broker" who represented many insurance companies. Garnicas first learned of CAIC through Ms. Ponce. CAIC did not have any direct negotiations with Garnicas regarding their coverage, nor did CAIC make any representations to Garnicas regarding what would or would not be covered.

Ultimately, the Policy purchased by Garnicas from CAIC contained a Radius of Operation Limitation endorsement. Under this provision, each truck listed on the Policy was registered by the insured with a specific radius of operation mileage, which means that the Policy provided coverage from the port of entry into the United States up to the number of miles selected by the customer under the Radius of Operation Limitation endorsement contained in the Policy. However, Garnicas could change the radius of operation mileage from day to day if they would like, by calling their broker and making that request. The Radius of Operation Limitation appeared first in the declarations page of the Policy, but it also appeared on a separate page within the policy, with a header reading "LIMITED RADIUS OF OPERATION ENDORSEMENT" in big, bold, blue typeface. Garnicas designated a radius of operation for each of his trucks that he normally operated. In addition, he had a 2010 Volvo that he considered a "backup" truck in case of emergencies. Garnicas informed Ms. Ponce regarding this truck in Spanish and requested her to "insure it as an extra in case of emergency". When requested to clarify the radius of operation for this vehicle, Garnicas stated 250 miles. Garnicas did not inform Ms. Ponce that he needed enough coverage on the "backup" truck so that it could be covered when it was needed in place of another truck that was already assigned a 1,000-mile radius of operation.

On July 3, 2019, Garnicas was utilizing the "backup" truck to perform a delivery of Tesla products from Mexico when it was involved in a fatal accident in or near Tonopah, Nevada. The decedent, Dario Baez ("Baez"), was operating a commercial vehicle on behalf of his employer Panella Trucking. The location where the accident occurred was more than 250 miles from its port of entry into the United States. Shortly after the accident, Garnicas submitted a claim to CAIC. Ultimately, CAIC denied coverage for the claim on the basis that the loss "occurred outside of the 250-mile radius".

The family of decedent Baez and his employer's Panella Trucking's workers compensation insurer, Insurance Company of the West, filed separate lawsuits against Garnicas. Despite not owing any duty to defend Garnicas against either lawsuit, CAIC reached out to the Baez family and Insurance Company of the West, with Garnicas' knowledge and consent, to help facilitate an early resolution of those claims. CAIC paid its $750,000 surety obligation under the MCS-90 to the Baez family and Insurance Company of the West in exchange for dismissals with prejudice of the lawsuits and a full

release of all claims as against Garnicas and all affiliated entities. CAIC explicitly gave Garnicas advance notice of its intent to settle the underlying claims and of its reservation of its absolute right of reimbursement against Garnicas for the amounts paid pursuant to the MCS-90 form.

After resolution of the lawsuits, Garnicas sued CAIC alleging that CAIC engaged in breach of contract and breach of the implied covenant of good faith and fair dealing by denying coverage under the Policy and refusing tender of defense of the wrongful death and workers' compensation suits. CAIC counterclaimed that it was entitled to reimbursement for payments it paid pursuant to the MCS-90 endorsement to settle the wrongful death and workers' compensation suits.

The main issue raised by Garnicas in the coverage lawsuit was that the Radius of Operations Limitation endorsement should be struck from the Policy because it was unconscionable. The Court held that California law applied to the interpretation of the Policy and would determine the validity of this argument. Under California law, unconscionability has both a procedural and a substantive element. The procedural element of unconscionability focuses on two factors: oppression and surprise.

The “oppression” component arises from an inequality of bargaining power of the parties to the contract and an absence of real negotiation or a meaningful choice on the part of the weaker party. The Court determined that Garnicas failed to establish oppression for a number of reasons including Garnicas had hired an independent broker to assist him in procuring insurance and Garnicas had a meaningful choice of procuring insurance from other companies at the time the CAIC Policy was purchased. In addition, the Court noted that the Radius of Operation Limitation was not a "standardized" term such that Garnicas had no choice but to adhere to it or reject it. Also, Garnicas understood that it had to select a radius of operation mileage for each truck in the fleet and that it had the right to change the radius of operation mileage "from day to day" as it wished. Finally, Garnicas explicitly selected a radius of 0-250 miles for the “backup” truck.

The “surprise” component involves the extent to which the terms of the bargain are hidden in a 'prolix printed form' drafted by a party in a superior bargaining position. The Court found Garnicas could not satisfy this component because the Radius of Operation Limitation was not hidden or buried in a prolix form. In addition to its inclusion on the declarations page of the Policy, the limitation was clearly identified on its own page of the Policy and is set forth under the heading "LIMITED RADIUS OF OPERATION ENDORSEMENT" in large, bold, blue typeface. The purpose of the heading was to make the Radius of Operation Limitation "open and obvious" within the Policy. California Courts have held that exclusions in insurance policies that are "conspicuous and unambiguous" are not "surprising" to an insured.

Finally, the Court noted that Garnicas could not establish substantive unconscionability meaning that the provision was "unduly oppressive," "so one-sided as to shock the conscience," or "unreasonably favorable to the more powerful party." In fact, the Court refuted this position by noting that Garnicas knowingly made a choice to select a radius of operation for each of the trucks based on the distances within the United States they would travel. Garnicas could have chosen a radius as small as 50 miles across the border or as large as the entire contiguous United States. Also, it could have changed the radius from day to day depending on the range of the delivery. Accordingly, given this flexibility, the Court found the limitation was not unreasonably favorable to CAIC.

For these reasons, the Court found that the Radius of Operation limitation exclusion applied to preclude CAIC's coverage. Accordingly, it dismissed Garnicas claims against GAIC and entered a declaration that CAIC was entitled to reimbursement from Garnicas for the full amount it paid pursuant to the MCS-90.

Unconscionability is a topic of contract law that exists in some capacity in every state. However, it is not an issue that is often raised because it has historically been difficult to establish that a provision in a contract should be nullified because it is considered unconscionable. This case provides a glimpse into how courts may analyze this issue and provides guidance on how to ensure that an insurer's policy provisions will be considered valid and not voided under this legal doctrine.

OTHER NOTEWORTHY CASES AND GENERAL INSURANCE LAW CASES

SOUTHERN DISTRICT OF TEXAS FINDS INSURER DID NOT MISREPRESENT COVERAGE TO REALITY TELEVISION PRODUCER-INSURED IN ISSUING A POLICY THAT EXCLUDED REALITY TELEVISION PRODUCTIONS

In *Megalomedia, Inc. v. Phila. Indemn. Ins. Co.*, Philadelphia Indemnity Insurance Company ("Philadelphia") insured Megalomedia Studios, LLC ("Megalomedia" or the "Insured").[14] Megalomedia is a television production studio based in Austin, Texas that produces programs such as *Shipping Wars, Heavy*, and *My 600-Lb Life*. In 2010, Megalomedia sought to obtain commercial general liability insurance coverage for its television productions. In its application, Megalomedia was required to provide information about the products for which coverage was sought and listed the productions *Heavy* and *Quintuplets by Surprise* on its original application, identifying them as "reality based TV shows/documentaries." Thus, one of the pre-issuance determinations made by Philadelphia was whether the production was a reality show or a documentary; documentaries would be covered, and reality shows would be excluded by endorsement. In 2011, Megalomedia sought coverage for a new production, *Cartel City*, which followed the "day-to-day life of the LaJoya Police Department," which Philadelphia declined to cover. In a June 6, 2011, email to Megalomedia's broker, a Philadelphia underwriter listed the dangers inherent with *Cartel City* before stating that Philadelphia Indemnity was "okay" with Megalomedia's other shows. Going forward, Philadelphia Indemnity amended Megalomedia's existing Policy by adding an endorsement, form number CG2153, titled "Exclusion — Designated Ongoing Operations" (the "reality TV exclusion").

Later that year, as Megalomedia was considering renewing its Policy with Philadelphia, Megalomedia inquired about new language in its quote that stated the Policy's intent was not to cover reality shows. An email from one of Philadelphia's account representatives to its underwriter reflected that Megalomedia asked Philadelphia about whether its Policy would cover Megalomedia's other productions in light of certain renewal quote language: "Please note it is not this [P]olicy's intent to cover film and production of TV series and film and production of reality shows." Megalomedia subsequently provided a description of upcoming projects, including *Quints by Surprise*, which was listed on the original application. The only show that Philadelphia Indemnity expressed a concern about was *Fugitive Recovery*, due to its similarity to *Cops.* Megalomedia's CFO testified that its insurance broker "talked to someone at Philadelphia [Indemnity], and they had given him those same

assurances" that Megalomedia's other shows were being covered." Thereafter, for each year from 2011 to 2019, Philadelphia renewed the policy on a form that included the reality TV exclusion.

In 2020, several former participants of My *600-Lb Life* sued Megalomedia, alleging that they suffered bodily injury as the result of their participation in the show. Philadelphia denied Megalomedia's claims for defense and indemnity on each of the *My 600-Lb Life* lawsuits, based on the reality TV exclusion. Philadelphia filed the subject lawsuit against Megalomedia as a declaratory judgment action on May 11, 2020. On November 23, 2020, Philadelphia Indemnity filed a Motion for Summary Judgment regarding its contractual duty to defend and/or indemnify Megalomedia in the underlying litigation, which was granted, as the court concluded that the exclusion was unambiguous. Megalomedia brought fraudulent inducement and violations of the Texas Insurance Code and the Deceptive Trade Practices Act claims. As to the fraud claims, the court held that Megalomedia failed to establish that Philadelphia failed to disclose a material fact. Specifically, Philadelphia had no duty to affirmatively inform Megalomedia what was, and what was not, covered, and thus no obligation to explain the scope of the reality TV exclusion, which the court noted was "unambiguous; it has only one reasonable meaning." Further, the court found that because Megalomedia had actual knowledge that the CG 2153 reality TV exclusion was part of the Policy, and it had actual knowledge that *My 600-Lb Life* was a reality TV show, it could not have justifiably relied on any representation made by Philadelphia. Additionally, the court was not persuaded that the policy was illusory because the policy did provide coverage for other types of CGL claims *not* subject to the reality TV exclusion. Regarding the Insurance code ad DTPA claims, the court noted that Philadelphia's emails regarding coverage for programming "was a general statement that the Philadelphia Indemnity Policy provided coverage, rather than a misrepresentation of specific policy terms." Further, as a result of its findings that Philadelphia did not engage of fraud or violate the Insurance code or DTPA, the court held there were no bases for bad faith.

FIFTH CIRCUIT COURT OF APPEALS FINDS THAT DIRECTORS AND OFFICERS QUALIFIED AS INSUREDS UNDER CGL POLICY BASED UPON THE EIGHT-CORNERS RULE

In *Discover Prop. & Cas. Ins. Co. v. Blue Bell Creameries USA, Inc.*, a listeria outbreak led to a shut-down of the insured's factories, a product recall, and financial losses that resulted in a shareholder lawsuit brought by the company's shareholders (the "Shareholder Lawsuit"). The Underlying Lawsuit alleged that the insured's D&Os "breached their fiduciary duties of care and loyalty by failing 'to comply with regulations and establish controls.'" The complaint also alleged that the directors and officers knew that Blue Bell's manufacturing plants had repeatedly and consistently tested positive for *Listeria* contamination, yet they continued to manufacture and distribute ice cream products in conscious disregard of the known risks. The complaint asserted that, "[a]s a result of the breaches of fiduciary duty alleged [in the complaint], the Company and its stockholders suffered injury in the amount of at least hundreds of millions of dollars." As to liability, it was contended that the directors and officers are personally liable for the violations against Blue Bell and its shareholders. As compensation, he asked that the court award "Blue Bell the damages sustained by it as a result of the breaches of fiduciary duties." The district court granted summary judgment in favor of the insurer based on three independent grounds: (1) the directors and officers were not "insureds" under the policy when sued for "breach of a duty owed to the corporation"; (2) the shareholder lawsuit did not stem from either an "accident" or "occurrence" because the alleged misconducts were "undertaken with knowledge"; and (3) the Shareholder Lawsuit did not allege damages "because of bodily injury."

The insureds appealed.

On appeal, the court disagreed that the company's D&Os were not insureds. Noting that, in this instance, to qualify as an insured the D&Os had to be "acting with respect to their duties" during the alleged violations of fiduciary duties, the court adopted a definition of duty to be analogous to "job" or "role." The court then reasoned that "the shareholder did not allege that the directors and officers were taking any action that was outside the scope of 'managing and operating the ice cream company.' To the contrary, the complaint alleged that the directors and officers violated their fiduciary duties because they 'continued the Company's production and distribution of ice-cream' when they should not have." From this the court concluded that "while it is possible that they violated their fiduciary duties by failing to stop production and distribution of ice-cream, their deciding to continue is plainly within the scope of their role."

However, the court found that there was no occurrence because the shareholder complaint alleged that the D&Os "knowingly disregarded contamination risk and safety compliance" and "willfully failed to exercise" their authority. The insured argued that the part of the definition that defines occurrence as "repeated exposure to substantial the same general harmful condition" was pertinent to finding an occurrence in this case because the shareholder lawsuit alleged that Blue Bell's plants "contained harmful conditions that allowed the *Listeria* to multiply through continuous exposure." The insured contended that because such an allegation signified "continuous or repeated exposure to substantially the same general harmful conditions," the shareholder lawsuit alleged an occurrence. Thus, the insured proposed that the court read the dependent clause (*i.e.*, "including continuous or repeated exposure to substantially the same general harmful conditions") as extending the scope of the definition. However, the court refused to do so, opining that to do so was unpersuasive when the court applied the "whole-text canon." In other words, when the definition was read in context, it was evident that the function of the dependent clause was to "limit the number of occurrences an insured can claim for what the policy deems to be a single accident."

Second, the insured argued that, because the policy included an explicit exclusion for "bodily injury" expected or intended, some intentional conduct must fall within the definition of "occurrence." Or else, the insured contended, the explicit exclusion would be rendered meaningless. Again, the court was not persuaded, explaining that the "occurrence" / "accident" analysis was meaningfully different from the exclusion for "expected or intended" injuries. Third, the insured argued that even assuming *arguendo* that their previous arguments failed, coverage still existed because "there are not enough details in the Underlying Suit to conclude that a *Listeria* outbreak was an expected result of Appellants' actions." The court reasoned that relevant question was not whether the complaint "conclusively show scientifically" that the injuries were probable but rather that the injuries "could be reasonably anticipated" to result from the misconduct. Here, the underlying complaint alleged that the company management had received "increasingly frequent and continuing positive presumptive test results for *Listeria*" from several governmental authorities and on multiple different occasions. And the complaint also alleged that the company had received "repeated positive results . . . on consecutive samples" from its own third-party laboratory. Therefore, the court held that there was no occurrence.

Finally, the court addressed whether the complaint sought damages because of bodily injury. The insured argued that because the "damages contemplated by the [shareholder lawsuit] are

factually attributable to bodily injuries suffered by Blue Bell customers," the damages were "because of" bodily injury. The court disagreed, making an *Erie guess* as to how the Supreme Court of Texas would determine the issue. The court noted that the Shareholder Lawsuit sought damages to compensate for Blue Bell's economic loss caused by its D&Os breach of fiduciary duties; it did not seek to recover any damages on behalf of customers who may have suffered "bodily injury" from the *Lysteria* outbreak. Accordingly, the court held that the damages in the Shareholder Lawsuit were not covered under the plain terms of the policy.

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[1] 2023 U.S. App. LEXIS 22504 (5th Cir. 2023).

[2] No. 4:16-CV-01947, 2023 U.S. Dist. 146468, 2023 WL 5352619 (S.D. Texas [Houston Division], Aug. 21, 2023, mem. op.).

[3] No. 22-20592, 2023 WL 4884863 (5th Cir. Aug. 1, 2023).

[4] *See* Tex. Ins. Code § 1954.053.

[5] *Little v. Liquid Air Corp.*, 37 F.3d 1069, 1079 (5th Cir. 1994) (en banc).

[6] *Mid-Continent Cas. Co. v. Harris County Mun. Util. Dist. No. 400*, 2023 Tex. App. LEXIS 6935 (Aug. 21, 2023).

[7] 73 F.4th 352 (5th Cir. July 12, 2023).

[8] No. 4:21-CV-100-SDJ, 2023 U.S. Dist. LEXIS 55320 (E.D. Tex. 2023).

[9] No. SA-18-CV-00283-OLG, 2019 U.S. Dist. LEXIS 240142, 2019 WL 13082120 (W.D. Tex. Dec. 2, 2019).

[10] *Rodriguez*, 73 F.4th at 355 (citing *Gonzalez*, 2019 U.S. Dist. LEXIS 240142, at *6).

[11] No. 3:22-CV- 06, 2023 U.S. Dist. LEXIS 163694, WL 5986123 (M.D. Ga. Sept. 14, 2023).

[12] No. 19 C 01660, 2023 U.S. Dist. LEXIS 141316, WL 5211584 (E.D. Ill. Aug. 14, 2023).

[13] No. 1:21-cv-01018-SKO 2023 U.S. Dist. LEXIS 143341, WL 5274704 (E.D. Cal. Aug. 15, 2023).

[14] *Megalomedia, Inc. v. Phila. Indem. Ins. Co.*, 2023 U.S. Dist. LEXIS 174495 (S.D. Tex. Sept. 28, 2023).