Martin, Disiere, Jefferson & Wisdom

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DEEPWATER HORIZON: TEXAS SUPREME COURT HOLDS UNDERLYING CONTRACT MAY GOVERN SCOPE OF ADDITIONAL-INSURED COVERAGE

Last Friday, the Supreme Court of Texas issued its long-awaited opinion in *In Re Deepwater Horizon*, No. 13-0670 (Tex. Feb. 13, 2015). MDJW has been following this important insurance case for nearly two years, and previously reported on it in Texas Insurance Law Newsbrief, March 11, 2013 and Texas Insurance Law Newsbrief, September 10, 2013.

At the heart of this case is the question of whether and to what extent a service contract between two parties may control the scope of insurance coverage available to one party as an additional insured under a policy purchased by the other party. Here, Transocean and BP entered into a Drilling Contract which required Transocean to indemnify BP for a certain set of liabilities (above-surface pollution), and required BP to indemnify Transocean for all other pollution risks, i.e., subsurface pollution. The Drilling Contract also required Transocean to obtain insurance and to name BP as an additional insured "for liabilities assumed by [Transocean] under the terms of [the Drilling Contract]." The policies purchased by Transocean extended additional-insured status to any person or entity to whom the insured was obliged by way of an "insured contract" to provide such insurance.

The journey to this result has been a long and winding one. Initially, a federal district court ruled in favor of Transocean and its insurers, holding BP was not entitled to additional-insured coverage under Transocean's policies for the subsurface pollution claims arising from the Deepwater Horizon disaster. In March 2013, the Fifth Circuit reversed the district court, relying on *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008). However, six months later, after rehearing, the Fifth Circuit withdrew that opinion and certified two questions to the Supreme Court of Texas. Last Friday, the Supreme Court answered those questions with eight justices reaching a result adverse to BP.

In a refreshingly clear opinion on an important issue of Texas insurance law which has remained clouded for some time, the Supreme Court affirmed its commitment to the traditional Texas principle of "the policy means what it says." While BP argued that under *ATOFINA* the scope of its additional-insured coverage must be determined solely from the four corners of the policy, the court rather wryly pointed out that if one were to look only at the policy itself, BP would not be entitled to any coverage at all, since BP is not named as an insured of any sort anywhere on the face of the policy. Rather, the policy directs one to look to an "insured contract" to determine BP's status. The court recognized that an insurance policy may incorporate an external document, stating:

Thus, while our inquiry must begin with the language in an insurance policy, it does not necessarily end there. In other words, we determine the scope of coverage from the language employed in the insurance policy, and if the policy directs us elsewhere, we will refer to an incorporated document to the extent required by the policy. Unless obligated to do so by the terms of the policy, however, we do not consider coverage limitations in underlying transactional documents. … [A]n insurance policy may incorporate an external limit on additional-insured coverage. In such cases, the external limit is, in effect, an endorsement on the insurance policy.

The court distinguished this situation from that previously addressed in *ATOFINA*, stating:

ATOFINA, on the other hand, recognizes that a named insured may gratuitously choose to secure more coverage for an additional insured than it is contractually required to provide. This occurs when the language of the insurance policy does not link coverage to the terms of an agreement to provide additional-insured coverage. In that event, only coverage restrictions embodied in the policy will be given effect.

Ultimately, the lesson drawn from this Court's analysis of *ATOFINA* is that "we rely on the policy's language in determining the extent to which, if any, we must look to an underlying service contact to ascertain the existence and scope of additional-insured coverage." In other words, under *Deepwater Horizon*, the general rule of *ATOFINA* remains undisturbed: One must look to the policy to determine coverage. But last week's decision from the Court added this corollary: If the policy directs one to consult an underlying contract in order to determine coverage, then one not only may do so, but ***must*** do so.

Moving to the language of the Drilling Contract in this case, the court rejected BP's effort to hinge the entire $750 million of coverage on the presence or absence of a comma in the additional-insured provision of the Drilling Contract. BP argued that the phrase "except

Workers' Compensation for liabilities assumed by [Transocean] under the terms of this contract" only carved out workers' compensation claims from the Drilling Contract's insurance mandate. Instead, the court stated: "… a carve-out for workers' compensation policies covering Transocean's employees adds nothing and would, therefore, be superfluous and functionally inoperative. We will not construe the absence of a comma to produce an unreasonable construction."

The Fifth Circuit also certified the question of whether the rule of *contra proferentum*, or construing a document against the drafter, is amenable to a "sophisticated insured" exception. The court observed that *contra proferentum* only comes into play when there is more than one reasonable construction of the document and, because it had already found there was only one reasonable construction of the policies and Drilling Contract, it declined to answer this question.

Justice Johnson issued a lone dissent arguing that while the policy required one to look to the Drilling Contract to determine ***whether*** BP is an additional insured, it was silent as to the ***extent*** of BP's coverage. In other words, the policy at issue did not use common limiting language such as, "but only to the extent and for the limits of liability agreed to…" Therefore, Johnson argued, *ATOFINA* should lead to the conclusion that after referring to the Drilling Contract to determine that BP is in fact an additional insured, one should then return strictly to the policy language unless the policy language also requires one to check the Drilling Contract for the scope of coverage provided. Johnson also argued the Drilling Contract was not incorporated into the policy with sufficient explicitness, a point the majority subtly rejected by its refusal to require "magic words."

Finally, Justice Johnson argued that BP met the policy's definition of an "insured" and therefore was entitled to all coverage granted to the "insured" in the policy. The majority rejected this as well stating in a footnote that such a reading would include allowing BP, an additional insured on a policy purchased by Transocean, the ability to add even more insureds to the policy by simply entering into "insured contracts" with other entities. The majority concluded the resulting potentially endless chain of insureds, all allegedly entitled to full coverage, could not possibly be correct and characterized any construction that would permit such a scenario as "facially suspect." In this regard, the majority's common sense appears to have saved the Transocean insurers from an extremely expensive drafting issue in punctuation of the primary policy.

FEDERAL DISTRICT COURT REJECTS ACTUAL PREJUDICE ARGUMENT IN LATE NOTICE CASE

Last Monday, Houston Federal District Court Judge Gray Miller denied an insurer's motion for summary judgment based on late notice of a first-party theft claim under a business policy. Texas law requires a carrier relying on late notice of a claim to prove it was prejudiced by the lack of timely notice and Judge Miller's opinion is an object lesson on the difficulty of proving actual prejudice.

In *Campuzano v. Sentinel Ins. Co.*, No. CIV.A. H-13-2522, 2015 WL 520901 (S.D. Tex. Feb. 9, 2015), the insured was a small business owner who operated a booth at an antique and flea market. On November 22, the insured submitted a claim for theft of approximately $60,000 of inventory from his booth which allegedly occurred on October 16. After the carrier denied the claim on the ground that the policy was canceled in August due to non-payment of premiums, the insured reported a new claim on December 1, claiming that an earlier, previously unreported theft of $49,000 worth of inventory had occurred on July 26—***before the policy was canceled***. Although the insured claimed he had promptly reported the July theft to the police, he was never able to produce a police report for the July theft, instead claiming the police report for the second theft listed all missing items from both thefts. The entire chain of events appeared highly suspicious, and might lead an objective observer to wonder if any theft took place at all. However, Judge Miller took a methodical approach and determined that fact questions existed which precluded summary judgment on the insured's breach of contract claim.

The carrier moved for summary judgment based on the insured's violation of the policy's prompt notice condition, arguing it had been prejudiced by the lack of prompt notice of the July theft because the insured could not differentiate between the inventory items allegedly stolen during the policy period and those allegedly stolen after the policy was canceled. The carrier argued if it had received timely notice of the July theft, it could have made a site visit to identify the inventory missing versus what was still present, which became impossible due to the insured's delay. Judge Miller rejected this argument holding the accounting of missing inventory could be "easily recreated at trial through documents."

The carrier also argued the insured had violated his duty to provide documents. However, the court observed the insured did provide *some* documents, and the real question was their adequacy to prove the claimed loss. Judge Miller concluded the insured had complied with this duty "to the extent possible given the record-keeping practices of his business," and saw this not as a violation of a policy condition, but as an evidentiary question for the jury. The court expressed confidence that if the insured could not adequately prove his claim at trial, he would be the one to pay the price, not the carrier.

In a silver lining, Judge Miller granted a no-evidence summary judgment in favor of the carrier on the insured's extra-contractual claims, which included common-law bad faith and fraud.

[Editor's Note: Carriers should remember the actual prejudice standard under Texas law does not require that the claim investigation be impossible, but merely requires that it be more difficult as a result of the prejudicial delay by the insured in reporting the claim. Judge Miller's treatment of the issues, however, does reinforce the reality that getting a summary judgment on these issues remains very difficult under Texas law and many of these types of claims have to be taken to trial and won for the issues to be finally resolved in favor of the carrier.]