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Environmental Suits Alleging Non-Compliance with Laws and Regulations Did Not Assert an "Occurrence," Illinois Appellate Court Holds

The insured owned a hotel along the Chicago River. To cool its building, it had an intake/discharge system that withdrew water from the river and then returned it in the form of heated effluent. The insured had a permit to discharge the effluent into the river, but the permit expired before its application to renew was granted.

The insured continued to discharge the effluent into the river even though its permit had expired. The Illinois Environmental Protection Agency alleged that the insured violated environmental regulations, and sued the insured, seeking an injunction and civil penalties. Environmental groups intervened, alleging federal Clean Water Act violations and public nuisance. The intervenors also alleged that the insured had not taken proper steps to minimize the effect of its intake system on fish and wildlife. The court found that the insured's unpermitted discharges violated environmental laws and regulations and that the insured was liable for civil penalties.

The insured tendered the claim to its insurers for defense and indemnity. The insurers asserted several defenses to coverage, including no "occurrence." Litigation ensued and the insurers moved for judgment on the pleadings. The trial court granted their motions and the insured appealed.

The Appellate Court of Illinois first examined the policy language. Each policy defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same

general harmful conditions." The court observed that under Illinois law, the term "accident" means an unforeseen occurrence and that the natural and ordinary consequences of an act do not constitute an accident.

The court next considered what conduct to focus on. The insured urged the court to focus on whether it expected or intended that withdrawal of river water would harm fish and other aquatic life. But the insurers argued the focus should be on the insured's intentional operation of its water intake structure without a valid permit. The court agreed with the insurers that the relevant conduct is the insured's operation of its system generally, not the ultimate results of that operation.

The court next found that the statutory and regulatory violations cited in the complaint all arose from the operation of the intake/discharge system. Both the Illinois EPA's and the intervenors' claims arose from non-compliance with laws and regulations. The intervenors' complaint raised the effect of the water intake system on fish and other aquatic wildlife, but the court said this was only relevant in the larger context of statutory and regulatory compliance. The insured was not being sued for endangering the local fish population but for failing to comply with regulations that require it to study and minimize the effects of its cooling operations on fish. The court was unwilling to find that non-compliance with statutory and regulatory requirements constitute an "occurrence."

But even if the impact on fish and wildlife were the proper focus (the court never reached whether harm to fish and wildlife are "property damage"), there still would not be an "occurrence" because the insured knew that fish and aquatic life would be drawn into or trapped as part of the natural and ordinary consequence of operating its intake structure. There was no dispute, the court noted, that these concerns existed for any cooling water intake structure,

whether operating according to the law or not. That the insured may not have known the full extent of the impacts does not mean that it was unaware that its intake structure would have *some* impact on fish and wildlife in the river.

Thus, the appellate court affirmed the trial court's holding that the complaints did not allege an "occurrence."

The case is *Continental Cas. Co. v. 401 N. Wabash Venture, LLC*, No. 1-22-1625 (Ill. Ct. App. Aug. 30, 2023).

Insurer May Consider Sums Uninsured Party Would Have Paid Under Joint Defense Agreement When Assessing Costs Reasonably Related to Insured's Defense, Massachusetts Federal Court Holds

The insured, Lionbridge, and its corporate parent were sued for misappropriating trade secrets. A single law firm represented both Lionbridge and its parent in the litigation. The claim was covered under Lionbridge's insurance policy. But Lionbridge's parent did not qualify as an insured under that policy.

Lionbridge wanted its insurer to pay all defense costs on the grounds that the costs couldn't be segregated, and that Lionbridge would have incurred those expenses anyway. The insurer contended it should not have to pay for the defense of the parent, an entity not insured under its policy.

Lionbridge filed an action in Massachusetts federal court seeking to hold the insurer responsible for 100% of non-segregable defense costs – defense costs that would have been incurred to defend Lionbridge even without a co-defendant. The insurer argued that it shouldn't have to pay the entire cost of defense and then be left with the burden of having to get the money back from the non-insured party.

The court found that the insurer's duty to defend extended to all costs reasonably related to Lionbridge's defense. But the court also ordered a reasonable allocation of costs between the insured and non-insured parties. In a joint defense where no insurance was involved, the court noted, the parties likely would have negotiated each party's share. Thus, in determining what the insurer owes, the court said, "it is only fair to consider 'the allocation that reasonably would have been negotiated had each party in the joint defense paid its own legal fees.'"

The court recognized that the insurer could later pursue contribution from the uninsured party, but that did not prevent the court from reasonably allocating costs. And considering the equities, the court questioned why one corporation should be free from paying for its defense when both were sued.

Insurers will welcome this decision. At the very least, it puts a crimp in a common policyholder argument – that an insurer isn't harmed by paying the uninsured party's defense because it would have paid it to the insured anyway.

The case is *Lionbridge Technologies, LLC v. Valley Forge Ins. Co.*, No. 20-10014-WGY (D. Mass Sept. 14, 2023).

Delaware Supreme Court Finds Professional Services Exclusion Does Not Apply to False Act Claim, But Says Insurer Did Not Commit Bad Faith

The insured, Guaranteed Rate, Inc. ("GRI"), sought coverage under its management liability policy for a federal government investigation and settlement under the False Claims Act ("FCA").

GRI underwrote and issued loans to borrowers. It was approved to issue loans guaranteed by the Federal Housing Administration and Department of Veterans Affairs. GRI was accused of violating the FCA by falsely certifying to the government that the loans it endorsed were eligible

for government insurance. A former GRI employee also alleged that GRI falsely certified that it complied with all lending requirements.

The insurer, ACE American, denied coverage. ACE cited a professional services exclusion which excluded coverage "alleging, based upon, arising out of, or attributable to any Insured's rendering or failure to render professional services." GRI sued ACE in Delaware state court for the settlement amount and defense costs and alleged a bad-faith denial of coverage. The parties cross-moved for partial judgment on the pleadings. The Delaware trial court denied ACE's motion on the professional services exclusion but dismissed the bad faith claim against ACE. The parties cross-appealed.

The Delaware Supreme Court affirmed. The court held that the FCA charges and settlement fell outside the professional services exclusion because the alleged misconduct arose out of false certifications, not the professional services the insured provided to borrowers. The court rejected ACE's argument that but for the deficiencies in its underwriting, the FCA claims against GRI would have not existed. The court held that although the phrase "arising out of" in the professional services exclusion is construed broadly, there must still be "meaningful linkage" between the subject of the FCA claims – false certifications – and the underlying conduct used to demonstrate the falsity of the claims – underwriting loans.

The court added that ACE's interpretation of "arising out of" would effectively extend coverage of the exclusion to anything remotely connected to the professional service. For this reason, the court agreed with the lower court that the professional services exclusion did not bar coverage.

But the court also found that ACE's position did not lack "reasonable justification" and thus affirmed the lower court's dismissal of the bad faith claim against ACE.

The case is *ACE Am. Ins. Co. v. Guaranteed Rate, Inc.,* 2023 Del. LEXIS 307 (Del. Sep. 14, 2023).

11th Circuit Finds No Coverage for Late-Reported Opioid Matter under Claims-First-Made and Reported Policy

KVK-Tech, an opioid manufacturer, was insured by Navigators Specialty Insurance Company under a claims-made excess liability policy. In the event of a covered claim, the policy required notice to be given "as soon as practicable" but no more than thirty days after expiration of the policy.

On August 17, 2017, the first of many opioid lawsuits were filed against KVK-Tech, while the Navigators policy was in effect. KVK-Tech notified other excess carriers of other opioid lawsuits pending against it on June 25, 2019. But KVK-Tech did not notify Navigators of the opioid lawsuits until January 27, 2020.

After Navigators denied coverage, KVK-Tech sued Navigators. The district court, applying Pennsylvania law, ruled for Navigators, finding that notice was untimely. The court also found that, in the context of a claims-made policy, Navigators did not need to show that it was prejudiced by the insured's late notice.

The Eleventh Circuit affirmed. The circuit court emphasized that KVK-Tech failed to notify Navigators of any of the opioid lawsuits against it for three years, despite notifying other excess carriers sooner. For these reasons, it upheld the judgment of the district court.

The case is *KVK-Tech, Inc. v. Navigators Specialty Ins. Co*., No. 22-10245 (11th Cir. Sep. 21, 2023) (unpublished).

Texas Federal Court Rules That Insurer Did Not Fraudulently Induce TV Producer Into Buying Policies That Excluded Reality Shows

Participants in the television show "My 600-lb Life" sued the show's producer for negligence and intentional infliction of emotional distress. The producer tendered the suits to Philadelphia Indemnity Insurance Company, one of its liability insurers. Philadelphia Indemnity denied coverage because the policies had an endorsement that excluded coverage for reality TV shows.

Philadelphia Indemnity then filed a declaratory judgment action in Texas federal court to affirm that the reality TV exclusion barred coverage for the "My 600-lb Life" suits. The producers counterclaimed, asserting fraudulent inducement, illusory coverage, and violations of the Texas Insurance Code and Deceptive Trade Practices Act. The court found that the exclusion applied but allowed the producer's counterclaims to proceed to trial.

The producer's claim was based on the history of its communications (through its broker) with Philadelphia Indemnity.

The producers bought insurance from Philadelphia Indemnity for many years. In its original application for insurance, it listed the TV shows that it was producing, identifying them as "reality-based TV shows/documentaries." This included the shows "Heavy" and "Quintuplets by Surprise." When the producers sought to renew in 2011, it had added other shows to its TV lineup. One was called "Cartel City," which followed the day-to-day life of a local police department. Philadelphia Indemnity's underwriters declined to cover that show because it seemed more like a reality show than a documentary.

Going forward, Philadelphia Indemnity added an endorsement that excluded claims for "bodily injury" and "property damage" arising out of reality TV shows under the policy's general

liability coverage (the endorsement did not apply to other coverages under the policy). The producers complained, saying "Cartel City" was a documentary. In an email, Philadelphia Indemnity responded by saying that it was "okay with the other work" that the producer was doing, just not this particular project. The producer renewed with Philadelphia Indemnity.

Philadelphia later declined to cover another show, "Fugitive Recovery," for similar reasons, but purportedly assured the producer that its other shows were being covered. Philadelphia Indemnity considered the fugitive show to be more dangerous than the weight-focused productions. The producer renewed.

The producer kept renewing with Philadelphia Indemnity for about ten years. Each renewal offer from Philadelphia Indemnity contained the reality TV exclusion, and the producer accepted it each time. But the producer had not read any of policies until only recently and was unaware of the reality TV exclusion.

After considering all the evidence, the trial judge found that the producers had constructive knowledge of the unambiguous reality TV exclusion and that "My 600-lb Life" was considered a reality TV show. The court then dismissed the fraudulent inducement claim because the producer failed to show that Philadelphia Indemnity omitted a material fact that it had a duty to disclose. The court viewed the 2011 email as a general statement about coverage, not a misrepresentation of specific policy terms. And Philadelphia Indemnity had no affirmative duty to inform the producer of what's covered under the policy. Thus, Philadelphia Indemnity could not be liable for fraud for not explaining that the reality TV exclusion applied to "bodily injury" claims arising from reality TV shows. Because the producer knew of the reality TV exclusion (it should have read its policy, but in any event, was put on notice), it could not have justifiably relied on any representation or omission by Philadelphia Indemnity.

The court also noted that under Texas law, if a policy covers any claim, it is not illusory. The policies here covered other types of claims, including general liability claims not subject to the reality TV exclusion.

The court similarly rejected the producer's claims under the Texas Insurance Code and the Deceptive Trade Practices Act. The producer's mistaken belief about the scope of coverage, the court found, did not provide a basis for deceptive trade practices.

The case is *Megalomedia, Inc. v. Philadelphia Indem. Ins. Co.,* No. 4:20-cv-01644 (S.D. Tex. Sept. 28, 2023).