

SURVEY OF ILLINOIS LAW: INSURANCE LAW

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I. INTRODUCTION

This survey analyzes developments and changes in Illinois Insurance law during the 2011 calendar year. Its purpose is to summarize key outcomes rather than focus on every potential development within the calendar year. This survey is compiled from materials written by the Insurance Section Council of the Illinois State Bar Association with the joint efforts of the Southern Illinois University Law Journal. This article is divided by the relevant topical areas it covers.

II. GENERAL POLICY CONDITIONS

A. Notice

In *First Chicago Insurance Co. v. Molda*,¹ the insurer sought a declaratory judgment that it had no duty to defend or indemnify defendant Molda or his employer, Metrolift, Inc., in connection with a lawsuit arising out of an automobile accident. The trial court granted First Chicago's motion for summary judgment, finding that it had not received timely notice of the accident as required by Metrolift's insurance policy. Molda appealed and the appellate court reversed, finding that multiple questions of fact precluded the entry of summary judgment in favor of First Chicago.²

On August 17, 2005, Molda and Nola Wilson, another driver, were involved in an automobile accident. At the time of the accident, Molda was on his way to visit a customer in his capacity as a territorial manager for Metrolift, a company that rented, sold, and repaired construction equipment. Molda was driving his personal automobile because Metrolift did not provide its territorial managers with company automobiles. Unbeknownst to Molda, as a Metrolift employee, he was also covered under Metrolift's insurance policy with First Chicago. Metrolift had purchased its insurance policy through Associated Specialty Insurance. The language of the policy's notice provision required Metrolift to provide

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¹ 408 Ill. App. 3d 839, 948 N.E.2d 206 (1st Dist. 2011).

² *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 844, 948 N.E.2d 206, 212 (1st Dist. 2011).

“prompt notice” of the accident to First Chicago or its authorized representative. Metrolift became aware of the accident within two days of its occurrence. Thereafter, Metrolift and Associated discussed the accident and agreed to a strategy with respect to the handling of the accident. Metrolift representatives testified that this communication was standard practice with respect to notice of potential claim, which was, in turn, denied by Associated.³

On August 13, 2007, Wilson filed suit against Molda. On January 11, 2008, Molda’s attorney contacted Metrolift advising them of the lawsuit. Metrolift then reported the lawsuit to Associated. Associated subsequently completed an Auto Loss Report and submitted it to First Chicago. First Chicago alleged that it first received notice on or about March 26, 2008. On April 24, 2008, First Chicago filed a complaint in the chancery division for declaratory judgment against Metrolift, Molda, and Wilson. In its complaint, First Chicago alleged that it received late notice of the loss and of the lawsuit. On November 9, 2009, First Chicago filed a motion for summary judgment on its declaratory judgment action. After a hearing, the trial court found that “there was a serious failure to comply with the notice requirement of the policy” and granted First Chicago’s motion for summary judgment, finding that Metrolift did not provide notice as required by the policy and, therefore, First Chicago did not owe coverage under the policy for Molda’s accident.⁴

On appeal, the defendants first argued that First Chicago was estopped from denying that it received timely notice of Molda’s accident as Associated was First Chicago’s agent for notice purposes and notice to an agent is imputed to the principal. The defendants further asserted that as to Molda, notice to First Chicago was timely. With respect to the first argument, the defendants argued that First Chicago was estopped from denying that it had received timely notice of Molda’s accident because Metrolift informed Associated of the accident during a telephone conversation less than 48 hours after it occurred, and that telephone conversation constituted notice to First Chicago’s “authorized representative.”⁵

The court acknowledged that in the insurance context, an insurance broker is generally considered to be the agent of the insured and not the insurance company unless the agent is a general agent of the insurance company.⁶ However, the court also recognized that there are situations in which an insurance broker can act as the agent of the insurance company or

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 846, 948 N.E.2d 206, 213 (1st Dist. 2011).

even as the agent of both the insured and the insurance company.⁷ Moreover, the court stated that even if the broker does not have the actual authority to act as the insurer's agent for notice, it may have apparent authority to do so.⁸ Apparent authority is that authority which a reasonably prudent person would naturally suppose the agent to possess, given the words or conduct of the principal, including the course of dealings between the broker and the insurance company.⁹ In this matter, the court found that there was conflicting evidence as to whether Associated had apparent authority to act on First Chicago's behalf with regard to accepting notice from Metrolift.¹⁰ As a result, the court held that there were sufficient facts in the record to show that there were material factual issues and that summary judgment for First Chicago was inappropriate.¹¹

With respect to the defendants' argument that as to Molda the actual notice to First Chicago was timely, the court pointed out that the notice requirement applied to Metrolift, the named insured, and not to Molda. Nevertheless, the court was not willing to say that the actual notice of accident and suit received by First Chicago in March 2008 was unreasonable as a matter of law.¹² The court identified a number of factors in determining whether notice is reasonable, including: (1) the specific language of the policy's notice provisions; (2) the degree of the insured's sophistication in the world of commerce and insurance; (3) the insured's awareness that an occurrence as defined under the terms of the policy has taken place; (4) the insured's diligence and reasonable care in ascertaining whether policy coverage is available once the awareness has occurred; and (5) any prejudice to the insurance company.¹³ On review, the court was unwilling to find that notice was unreasonable as a matter of law and determined that it was another question of fact that was not appropriate for summary judgment.¹⁴

B. Arbitration

In *Keeley & Sons, Inc. v. Zurich American Insurance Co.*,¹⁵ the plaintiff filed a complaint against Zurich American Insurance Company

⁷ *Id.*

⁸ *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 846, 948 N.E.2d 206, 214 (1st Dist. 2011).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 851, 948 N.E.2d 206, 217 (1st Dist. 2011).

¹³ *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 850, 948 N.E.2d 206, 217 (1st Dist. 2011).

¹⁴ *First Chicago Ins. Co. v. Molda*, 408 Ill. App. 3d 839, 851, 948 N.E.2d 206, 217 (1st Dist. 2011).

¹⁵ *Keeley & Sons, Inc. v. Zurich American Ins. Co.*, 409 Ill. App. 3d 515, 947 N.E.2d 876 (5th Dist. 2011).

(“Zurich”) seeking to recover alleged overpayments of premiums under two separate workers’ compensation insurance policies. Zurich filed a motion to dismiss and to compel arbitration. The trial court denied Zurich’s motion, and Zurich filed a Rule 307(a)(1) interlocutory appeal.¹⁶

Keeley is a construction company located in East St. Louis, Illinois. Zurich issued Keeley two separate workers’ compensation and employers’ liability insurance policies (“the Policies”) for Keeley’s operations. Keeley paid what was called a “standard premium” which is essentially an estimate of the actual final retrospective premium. At the end of the coverage period, and periodically thereafter, Zurich was to use a formula that took into account the actual claims made and paid on the policies to calculate the actual retrospective premium attributable to the program year. The retrospective calculation and the resulting retrospective premium for each of the Policies did not stem from the Policies. Subsequently, the parties entered into a related agreement, entitled “Incurred Loss Retrospective Rating Agreement,” that was applicable to each Policy.¹⁷

Each Incurred Loss Retrospective Rating Agreement contained an arbitration clause (“the arbitration clause”) that read, in pertinent part, as follows: “Any dispute arising out of the interpretation, performance or alleged breach of this Agreement [] shall be settled by binding arbitration administered by the American Arbitration Association (AAA) under its Commercial Arbitration Rules” Zurich asserted that the arbitration clause in the Incurred Loss Retrospective Rating Agreement should apply to Keeley’s claims. Zurich argued that, despite Keeley choosing to sue for breach of only the Policies themselves and not for breach of the Incurred Loss Retrospective Rating Agreement, the arbitration clauses were triggered by Keeley’s policy claims. Because Zurich believed that the arbitration clauses in the Incurred Loss Retrospective Rating Agreements were “generic” and contained broad language, it argued that when two agreements relate to the same subject matter and one of the documents contains a generic arbitration clause, the parties must arbitrate any dispute arising out of the overall subject matter of the agreements.¹⁸

The issue on appeal was whether the arbitration clause found in the Incurred Loss Retrospective Rating Agreements encompassed Keeley’s breach of contract claims on the Policies, neither of which contained an arbitration clause.¹⁹

¹⁶ Keeley & Sons, Inc. v. Zurich American Ins. Co., 409 Ill. App. 3d 515, 520, 947 N.E.2d 876, 881 (5th Dist. 2011).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

The Fifth District recognized that parties are only bound to arbitrate those issues which by clear language they have agreed to arbitrate.²⁰ When an arbitration clause is deemed to be “generic,” meaning that it is nonspecific in its designation of arbitrable disputes, an exception to the “clear language” general principle exists.²¹ “Arbitration clauses that provide that all claims ‘arising out of’ or ‘relating to’ an agreement [shall be decided by arbitration] have been properly categorized as ‘generic’ arbitration clauses.”²²

Although the Fifth District “partially agreed” with Zurich’s argument that the Incurred Loss Retrospective Rating Agreements contained “generic” arbitration clauses, the court also found that the language of the arbitration clauses clearly stated that the triggering events must arise from “this Agreement,” meaning the Incurred Loss Retrospective Rating Agreement.²³ The Fifth District found that an arbitration clause deemed “generic” does not necessarily reach disputes arising out of another agreement involving similar subject matter.²⁴ “When the language of a particular arbitration clause is generic and contains the phrase ‘arising out of this agreement’ (or a variation thereof) but fails to also contain the phrase ‘or relating to’ (or a variation thereof), then arbitration should properly be limited to the specific terms of the contract or agreement containing the arbitration clause.”²⁵ The court therefore affirmed the trial court’s denial of Zurich’s motion to dismiss and compel arbitration.²⁶

III. DUTY TO DEFEND

A. Effect of Conflicts of Interest

In *R.G. Wegman Construction Co. v. Admiral Insurance Co.*,²⁷ the insurer (Admiral) issued a primary liability insurance policy with a \$1 million per occurrence limit. While the policy was in effect, Budrik, a worker at a construction site managed by Wegman Construction Company,

²⁰ *Id.*

²¹ *Keeley & Sons, Inc. v. Zurich American Ins. Co.*, 409 Ill. App. 3d 515, 947 N.E.2d 876 (5th Dist. 2011), quoting *Ozdeger v. Altay*, 66 Ill. App. 3d 629, 631-32, 384 N.E.2d 82, 84 (1st Dist. 1978).

²² *Keeley & Sons, Inc. v. Zurich American Ins Co.*, 409 Ill. App. 3d 515, 947 N.E.2d 876 (5th Dist. 2011), quoting *A.E. Staley Manufacturing Co. v. Robertson*, 200 Ill. App. 3d 725, 729, 558 N.E.2d 434, 437 (1st Dist. 1990).

²³ *Keeley & Sons, Inc. v. Zurich American Ins. Co.*, 409 Ill. App. 3d 515, 522, 947 N.E.2d 876, 883 (5th Dist. 2011).

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Keeley & Sons, Inc. v. Zurich American Ins. Co.*, 409 Ill. App. 3d 515, 525, 947 N.E.2d 876, 885 (5th Dist. 2011).

²⁷ *R.G. Wegman Construction Co. v. Admiral Ins. Co.*, 629 F.3d 724 (7th Cir. 2011).

was injured in a fall and sued Wegman, an “additional insured” on the Admiral policy, which had been issued to Budrik’s employer, as well as other potentially responsible parties. Admiral accepted Wegman’s defense and appointed counsel to defend Wegman. The case went to trial, Budrik prevailed, and a judgment for a little more than \$2 million was entered against Wegman.²⁸

Wegman then sued Admiral, claiming that it would not have been liable for damages in excess of the \$1 million policy limit had Admiral discharged the implied contractual duty of good faith that insurance companies owe their insureds. In particular, Wegman alleged that Admiral failed to advise it how serious Budrik’s injuries were and that he was demanding almost \$6 million to settle. Wegman alleged that it did not realize that Budrik’s suit presented a realistic possibility of a loss in excess of Admiral’s \$1 million limit until the eve of trial. At that point, Wegman promptly notified its excess insurer, which had a \$10 million policy, but the excess insurer refused coverage on the ground that it had not received timely notice. When the Budrik suit resulted in a \$2 million judgment against it, Wegman brought the instant suit against Admiral for failing to notify it of the possibility of an excess judgment in time for Wegman to have invoked its excess coverage. (Separately, Wegman sued the attorneys who Admiral had retained to defend it.) The district court granted Admiral’s motion to dismiss, and Wegman appealed.²⁹

On appeal, the Seventh Circuit described the situation in question as “the emergence of a potential conflict of interest between insurer and insured in the midst of a suit in which the insured is represented by a lawyer procured and paid for by the insurer.” The court acknowledged that it received little guidance from the parties’ briefs, the complaint, the insurance policy, prior judicial opinions, or treatises on insurance law. Ultimately, the court reversed the dismissal of Wegman’s complaint and held that, when Admiral allegedly learned of the “nontrivial probability” of an excess verdict in Budrik’s suit, Admiral had a conflict of interest requiring it to advise Wegman of the potential exposure and requiring it to relinquish control of the defense to attorneys chosen by Wegman, if Wegman desired. The failure of notice by Admiral—assuming Wegman was indeed innocently ignorant of the substantial risk of an excess judgment until the eve of trial—foreclosed Wegman’s ability to give timely notice to its excess insurer and deprived it of its excess coverage.³⁰

The court explained that, with the insurance company’s right to defend the insured, the insurance company also has a duty to appoint

²⁸ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 726 (7th Cir. 2011).

²⁹ *Id.*

³⁰ *Id.*

competent defense counsel and to keep abreast of the litigation in order to act intelligently and in good faith on settlement offers.³¹ So, when Budrik was deposed in the underlying case, it was likely that Admiral learned from its appointed defense counsel of the extent of the injuries to which Budrik testified in his deposition, and thus knew that if the case went to trial the judgment might well exceed \$1 million. This likelihood created a conflict of interest by throwing the interests of Admiral and Wegman out of alignment.³² The court provided an example:

Suppose Admiral thought that if Budrik's case went to trial there was a 90 percent chance of a judgment no greater than \$500,000 and a 10 percent chance of a judgment of \$2 million (to simplify, we ignore other possibilities). Then the maximum expected cost to Admiral of trial would have been \$550,000 (.90 x \$500,000 + .10 x \$1,000,000, the policy limit), and so (ignoring litigation expenses) Admiral would not want to settle for any higher figure. But Wegman would be facing an expected cost of \$100,000 (.10 x (\$2,000,000 - \$1,000,000)), and no benefit, from a trial."³³

Exacerbating the misalignment of interests, Admiral had the incentive to gamble on Wegman's percentage responsibility for Budrik's injuries. If Wegman were found at trial to be no more than 25% responsible for Budrik's injuries, it would be liable only for its pro rata share of Budrik's damages³⁴, and, because there were other defendants, Admiral's appointed defense counsel thought he had a good shot at such a result. The jury found Wegman 27% responsible, however, which made Wegman jointly liable for the entire damages.³⁵ Such gambling with an insured's money is a breach of fiduciary duty.³⁶

When a potential conflict of interest between insured and insurer arises, the insurance company's duty of good faith requires it to notify the insured.³⁷ Once notified by the insurer of the conflict, the insured has the option of hiring a new lawyer—one whose loyalty will be exclusively to the insured. If the insured exercises that option, the insurance company will be obligated to reimburse the reasonable expense of the new lawyer.³⁸ Had Wegman hired a new lawyer, that lawyer could have tried to negotiate a settlement with Budrik that would not exceed the policy limit; and if the settlement was reasonable given the risk of an excess judgment, Admiral would be obligated to pay. Even more importantly, because Wegman had

³¹ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 728 (7th Cir. 2011).

³² *Id.*

³³ *Id.*

³⁴ 735 Ill. Comp. Stat. 5/2-1117 (West 2011).

³⁵ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 728 (7th Cir. 2011).

³⁶ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 729 (7th Cir. 2011).

³⁷ *Id.*

³⁸ *Id.*

substantial excess insurance, notification to it of the risk of an excess judgment would have enabled it to notify its excess insurer promptly, in order to preserve the protection that the excess coverage provided.³⁹

Admiral's main argument on appeal was that an insurance company has no duty to notify the insured of a potential conflict of interest, only of an actual one, and that no conflict arises until settlement negotiations begin or the insured demands that the insurance company try to settle the case.⁴⁰ Admiral further argued that until then the insurer has no duty of notice to the insured because it would be unethical for it to interfere with the lawyer's representation of the insured because an insurance company isn't allowed to practice law.⁴¹

The court disagreed. Having a "conflict of interest" doesn't mean that the conflicted party is engaged in conduct harmful to another party. It means that their interests are divergent, which creates a potential for such harm.⁴² The conflict in this case arose when Admiral learned that an excess judgment was a nontrivial probability in Budrik's suit. The court called "ridiculous" Admiral's contention that it would have been practicing law had it notified Wegman of the risk of excess liability. Controlling the defense, Admiral had a duty to warn Wegman when that control created a conflict of interest.⁴³

Admiral suggested that the lawyer it appointed to represent Wegman had the duty to notify Wegman, rather than Admiral. According to the court, however, the duty to notify of a conflict of interest is also the insurer's, and cannot be contracted away without the insured's consent.⁴⁴ The court acknowledged that Admiral may have a right of contribution or indemnity by the lawyer if the latter likewise failed to inform Admiral of the risk of excess liability, but that would not affect Admiral's potential liability to Wegman. Accordingly, Wegman's complaint stated a cause of action, and the dismissal was reversed.⁴⁵

B. Effect of Assignment

*Illinois Tool Works v. Commerce and Industry Insurance Co.*⁴⁶ was another duty to defend case decided in 2011. Since 1959, Binks Manufacturing Company ("Binks") leased a building and property in Colorado owned by various members of the Enssle family. Binks designed

³⁹ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 727 (7th Cir. 2011).

⁴⁰ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 730 (7th Cir. 2011).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 731 (7th Cir. 2011).

⁴⁵ R.G. Wegman Construction Co. v. Admiral Ins. Co., 629 F.3d 724, 732 (7th Cir. 2011).

⁴⁶ *Illinois Tool Works v. Commerce and Industry Ins. Co.*, 962 N.E.2d 1042 (1st Dist. 2011).

and manufactured electrostatic coating application equipment. In 1998, the plaintiff, Illinois Tool Works, Inc., entered into an agreement with Binks for the purchase and sale of assets and stock relating to Binks' electrostatic coating application equipment and related products business. With the Enssles' consent, Binks assigned the lease for the property to Illinois Tool.

In 2003, the Enssles filed suit against Illinois Tool and Binks for alleged environmental soil and groundwater contamination at the property. The Enssles alleged that Illinois Tool had informed them in 2002 that it would fix the environmental problems at the property prior to the expiration of the lease on July 31, 2003. The Enssles hired a consultant to perform a limited environmental investigation of the property, and the consultant found that, in 1987, Binks had notified the Colorado Department of Public Health and Environment ("CDPHE") that Binks was generating various hazardous waste solvents. In 1990, the CDPHE issued an inspection report identifying numerous environmental contamination violations by Binks. After the CDPHE report, Binks had an evaluation done that showed that hazardous wastes were in the groundwater and had migrated to the property boundary. Binks proposed a remediation plan and the CDPHE required Binks to implement the plan, but Binks did not perform any of the clean up. Accordingly, the Enssles alleged Binks continued contaminating the soil and groundwater after the CDPHE's order.⁴⁷

The Enssles alleged that after Illinois Tool purchased Binks in 1998, Illinois Tool substantially continued the Binks company. Through the assignment of the lease, Illinois Tool assumed and agreed to discharge all of Binks' obligations under the lease. In part, the lease required that tenants indemnify the Enssles and hold them harmless from and against any violation of the law arising from the tenants' conduct, surrender the property at the end of the lease in good condition, maintain and repair the property, and not commit waste. The Enssles' complaint alleged that Illinois Tool refused to investigate the extent of the environmental contamination of the property and to clean up the contamination in violation of the lease and the Comprehensive Environmental Response, Compensation and Liability Act. Illinois Tool filed a cross claim against Binks for indemnification.⁴⁸

The defendants, Commerce and Industry Insurance Company ("C & I") and United States Fire Insurance Company ("USF"), had each issued liability insurance policies to Binks. C & I's policies covered the period from December 1976 to December 1981. USF's policies covered from December 1981 to December 1984. Defendants defended Binks in the

⁴⁷ Illinois Tool Works v. Commerce and Industry Ins.Co., 962 N.E.2d 1042, 1046 (1st Dist. 2011).

⁴⁸ *Id.*

Enssle action, but refused to defend Illinois Tool. The Enssle case and Illinois Tool's cross claim against Binks ultimately were settled.⁴⁹

The case before the First District was an action by Illinois Tool against C & I and USF seeking a declaration that defendants had a duty to defend Illinois Tool in the Enssle case and to reimburse Illinois Tool for its defense costs in that suit. The parties filed cross-motions for judgment on the pleadings and the trial court granted defendants' motion and denied plaintiff's motion. The trial court found that defendants had no duty to defend Illinois Tool in the Enssle case, holding, among other things, that the benefits of a defense had not been assigned to plaintiff in 1998.⁵⁰

The question, as phrased by the First District, was whether the Enssle complaint triggered a duty to defend Illinois Tool, which was not a named insured on the policies. The purchase agreement between Illinois Tool and Binks included an assignment clause. When looking at the whole purchase agreement, the First District found that it was clear that Binks did not assign its actual liability insurance policies to Illinois Tool, but rather that the asset being conveyed was Binks' rights to defense and liability coverage under the insurance policies it held prior to the purchase date should Illinois Tool be pursued for any of Binks' actions prior to that date.⁵¹

Defendants' position was that they never consented to an assignment of their policies or the benefits under those policies. The First District, however, found that consent was not needed. "The policies are third-party occurrence-based policies—meaning that they provide coverage for occurrences during the coverage period, no matter when the claims for those occurrences might be pursued. They provide the insured with protection against future claims by third parties for covered losses incurred by the third parties as a result of the insured's actions during the coverage period. . . . Once a covered loss has occurred, the insured's assignment of its right to liability coverage or a defense to those losses does not require consent from the insurer because the assignment is essentially the assignment of payment of a claim already accrued, a claim consisting of the right to a defense and indemnification."⁵²

Binks' assignment to Illinois Tool occurred after the covered loss. Notwithstanding the existence of an anti-assignment or consent provision, a policy may be assigned after a loss without notice to or consent of the insurer.⁵³ Accordingly, defendants' argument that they had not consented to Binks' assignment to Illinois Tool failed.⁵⁴ The First District found that

⁴⁹ Illinois Tool Works v. Commerce and Industry Ins.Co., 962 N.E.2d 1042, 1047 (1st Dist. 2011).

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Illinois Tool Works v. Commerce and Industry Ins.Co., 962 N.E.2d 1042, 1053 (1st Dist. 2011).

⁵³ Illinois Tool Works v. Commerce and Industry Ins.Co., 962 N.E.2d 1042, 1054 (1st Dist. 2011).

⁵⁴ Illinois Tool Works v. Commerce and Industry Ins.Co., 962 N.E.2d 1042, 1055 (1st Dist. 2011).

the covered loss was not the Enssle suit filed in 2003, but Binks' contamination of the Enssles' property.⁵⁵ Ultimately, the First District held that Illinois Tool had proven that it had been assigned Binks' rights to a defense under Binks' insurance policies with defendants; the assignment was valid; no consent was required for the assignment; and the Enssle complaint alleged facts within or potentially within coverage thus triggering a duty to defend.⁵⁶

IV. LIABILITY INSURANCE

A. Definition of "Occurrence"

*Illinois Farmers Insurance Co. v. Keyser*⁵⁷ gave further guidance on the meaning of an "occurrence" in the context of a liability insurance policy. In May of 2007, Stukel filed criminal trespass charges against Keyser. In pursuing the charges, Stukel allegedly advised Joliet police officers that Keyser wrongfully entered her property after receiving verbal notice from her that such entry was forbidden. Keyser was arrested, but the criminal proceedings against him were later dismissed. Keyser then filed a civil complaint for malicious prosecution against Stukel in which he alleged that Stukel's verbal and written statements to the police were false and that Stukel knew they were false when she made them.⁵⁸

Stukel was insured under a homeowner's policy issued by Illinois Farmers. That policy obligated Illinois Farmers to defend and indemnify Stukel against damages caused by "bodily injury, property damage or personal injury resulting from an occurrence" to which coverage applies. The policy definition of "personal injury" included injury arising from "malicious prosecution." The policy defined an "occurrence" as "an accident" resulting in injury, and excluded coverage of bodily injury or personal injury intentionally caused by the insured.⁵⁹

Illinois Farmers filed a declaratory action seeking a judgment declaring that Stukel's policy did not afford her coverage in the underlying lawsuit because her acts were intentional. It claimed that such intentional acts were excluded under the policy and moved for summary judgment. Stukel and Keyser filed a cross-motion for summary judgment arguing that the underlying complaint alleged a civil tort of malicious prosecution that was specifically covered by the insurance policy. The trial court ruled that

⁵⁵ *Id.*

⁵⁶ *Illinois Tool Works v. Commerce and Industry Ins.Co.*, 962 N.E.2d 1042, 1056 (1st Dist. 2011).

⁵⁷ *Illinois Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575 (3d Dist. 2011).

⁵⁸ *Illinois Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575, 576 (3d Dist. 2011).

⁵⁹ *Id.*

the policy's inconsistent provisions created an ambiguity that should be construed in favor of the insured and granted defendants' motion.⁶⁰

On appeal, Illinois Farmers asserted that it owed no duty to defend or indemnify Stukel because its policy defined the term "occurrence" as an "accident" and excluded coverage for intentional conduct. In this regard, the Illinois Farmers' policy provided coverage for "personal injury resulting from an occurrence to which this coverage applies." The policy defined "personal injury" as "any injury arising from: (1) false arrest, imprisonment, malicious prosecution and detention." An "occurrence" was defined in the policy as "an accident including exposure to conditions which results during the policy period in bodily injury or property damage." The policy also contained an exclusionary provision, which stated "[w]e do not cover bodily injury, property damage, or personal injury . . . caused intentionally by or at the direction of an insured." Based upon the above, Illinois Farmers argued that an intentional tort such as malicious prosecution is not covered under its policy.⁶¹

In rejecting Illinois Farmers' arguments, the court first noted that the policy covers personal injury from both accidental conduct and certain enumerated intentional acts, including malicious prosecution.⁶² According to the court, if Illinois Farmers' position were accepted, then coverage for certain named intentional torts would be included under the definition of "personal injury," but removed under the meaning of "occurrence."⁶³ This would render the provision defining "personal injury" superfluous and create an ambiguity within the policy by which it would be providing coverage in one sentence and then taking it away in another, leading to "illusory coverage."⁶⁴

Illinois Farmers also argued that, if a defense of the underlying complaint is covered under the policy, it would violate public policy because it would be insuring against intentional misconduct. The court agreed that, as a general proposition, where an insurance contract indemnifies a person for damages resulting from his or her own intentional misconduct, it is void as against public policy and will not be enforced.⁶⁵ However, the court also held that whether a particular contract violates public policy depends on the nature of the risk against which insurance is sought and the insured's reasonable expectations.⁶⁶ In this regard, the court noted that Illinois courts previously have approved coverage for certain

⁶⁰ *Id.*

⁶¹ Illinois Farmers Ins. Co. v. Keyser, 956 N.E.2d 575, 577 (3d Dist. 2011).

⁶² Illinois Farmers Ins. Co. v. Keyser, 956 N.E.2d 575, 578 (3d Dist. 2011).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

intentional torts such as retaliatory discharge and defamation while simultaneously disapproving of coverage for intentional torts that are “serious crimes”—such as murder.⁶⁷ Here, Stukel contracted to be covered for liability for the intentional civil tort of malicious prosecution, and Illinois Farmers promised coverage when it accepted her premium payments. While generally excluding coverage of intentional conduct, the policy explicitly provided coverage for damages caused by malicious prosecution, and the insured could reasonably anticipate that the policy protections would apply. Therefore, public policy required Illinois Farmers to fulfill its contractual obligation to defend and indemnify.⁶⁸

In *USAA Casualty Insurance Co. v. McInerney*,⁶⁹ the Cyrs purchased a home from the McInerneys. The McInerneys disclosed in the statutory residential real property disclosure report that they were aware of “slight seepage” problems in the crawlspace and basement, but that new landscaping and two drains provided a remedy. Nevertheless, after purchasing the home, the Cyrs experienced significant water infiltration and flooding—well in excess of what could be considered “slight seepage.” The Cyrs sued the McInerneys, seeking rescission of the real estate sales contract or compensatory damages under theories of breach of contract, violation of the Residential Real Property Disclosure Act, fraud, and negligent misrepresentation.⁷⁰

In their claim for negligent misrepresentation, the Cyrs alleged that the McInerneys breached their duty to exercise reasonable care in completing the disclosure report by (1) carelessly omitting the fact that there were material defects in the basement and foundation when they should have known of such defects, and (2) disclosing that there was only slight seepage in the basement, which was based on their careless and erroneous determination as to the nature of the leakage problems. The Cyrs further alleged that, as a result the McInerneys’ negligence, they suffered loss and damage to the property and to their personal belongings, and personal injury in the way of mold-related illnesses.⁷¹

The McInerneys tendered the suit to their homeowner insurer, USAA, under their liability coverage. USAA declined to defend and filed a declaratory action to determine its obligations. USAA argued that it had no duty to defend or indemnify the McInerneys because the Cyrs’ complaint did not allege an “occurrence,” the McInerneys’ conduct was intentional, and the contract exclusion and known loss doctrine precluded coverage. It

⁶⁷ *Id.*

⁶⁸ *Illinois Farmers Ins. Co. v. Keyser*, 956 N.E.2d 575, 579 (3d Dist. 2011).

⁶⁹ *USAA Casualty Ins. Co. v. McInerney*, 960 N.E.2d 655, 658 (2d Dist. 2011).

⁷⁰ *Id.*

⁷¹ *Id.*

was undisputed that USAA did not owe the McInerneys a duty to defend the claims for breach of contract, violation of the Disclosure Act, or fraudulent misrepresentation. The only issue was whether USAA owed a duty to defend the McInerneys based on the claim for negligent misrepresentation. The McInerneys counterclaimed for their defense costs in the underlying case and brought a bad faith count for fees and penalties under Section 155 of the Insurance Code.⁷²

The trial court denied the parties' motions for judgment on the pleadings and summary judgment and conducted a bench trial. The trial court found that USAA had a duty to defend the McInerneys in the underlying suit and awarded the McInerneys the fees they had incurred, \$177,201.47. The trial court found no evidence of vexatious or unreasonable conduct by USAA and found in its favor on the bad faith claim. USAA appealed the ruling on the duty to defend.⁷³

On the issue of "occurrence," the Appellate Court noted that no Illinois court had directly addressed whether a negligent misrepresentation can be an "occurrence" under a homeowner's general liability policy.⁷⁴ Claims based on a variety of types of negligence may be covered.⁷⁵ The court found no reason why a claim for negligent misrepresentation should be treated any differently than any other claim based on negligence; the determining factor is that the insured did not expect or intend the injury.⁷⁶

The court also found *Posing v. Merit Insurance Co.*⁷⁷ instructive. In *Posing*, the underlying claimants had alleged various claims against Posing in connection with improper termite inspections and treatment and subsequent property damage, but each claimant alleged at least one count of negligence without alleging that Posing either expected or intended the pest infestation or damage. The appellate court in *Posing* held that the unintended pest infestation and damage was an "occurrence" and that Posing's insurer had a duty to defend.⁷⁸ Similarly, in the present case, the water infiltration, flooding, and mold growth was also an "occurrence" that resulted in damage to the real property and personal belongings in the basement, as well as in mold-related illnesses.⁷⁹ The Cyrs specifically alleged that the damages were proximately caused by the McInerneys'

⁷² *Id.*

⁷³ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 659 (2d Dist. 2011).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 661 (2d Dist. 2011).

⁷⁷ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655,661 (2d Dist. 2011), quoting *Posing v. Merit Insurance Co.*, 258 Ill. App. 3d 827, 629 N.E.2d 1179 (3d Dist. 1994).

⁷⁸ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 661 (2d Dist. 2011), quoting *Posing v. Merit Insurance Co.*, 258 Ill. App. 3d 827, 629 N.E.2d 1179 (3d Dist. 1994).

⁷⁹ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 661 (2d Dist. 2011), quoting *Posing v. Merit Insurance Co.*, 258 Ill. App. 3d 827, 629 N.E.2d 1179 (3d Dist. 1994).

negligent misrepresentations, which they relied on when purchasing the home, and in the negligence count did not allege that the McInerneys expected or intended the injuries.⁸⁰

USAA next argued that the duty to defend was precluded by the known loss or loss-in-progress doctrine because the McInerneys had experienced seepage before they purchased the homeowner's policy at issue, and one cannot insure against a loss that one knows will occur.⁸¹ The Appellate Court found the doctrine inapplicable based on the underlying allegations. Because the negligent misrepresentation count of the underlying complaint is based on negligence and not intentional or knowing conduct, the known loss doctrine is necessarily inapplicable.⁸²

Finally, USAA argued that the policy's contract exclusion defeated coverage because the exclusion provided that the policy does not apply to liability arising under any contract or agreement. USAA argued that the disclosure report containing the misrepresentation of "slight seepage" would not exist but for the real estate contract for the sale of the McInerneys' home to the Cyrs.⁸³ Nonetheless, the Appellate Court held that the disclosure report itself is not a contract but a creature of statute, that negligence in completing the report does not arise under the contract, and that the policy's contract exclusion was, therefore, inapplicable. The judgment against USAA was affirmed.⁸⁴

B. Definition of "Occurrence"; "Expected and Intended"

In *State Auto Property & Casualty Ins. Co. v. Kincaid*,⁸⁵ the United States District Court for the Central District of Illinois addressed the circumstances under which an insurer must provide a defense in connection with an underlying lawsuit involving allegations of intentional conduct, including sexual abuse. Kincaid and Collins were business partners in a hair salon called "The Hair Clinic" and also shared a residence. Kincaid was accused of sexually abusing a minor on the premises of The Hair Clinic as well as at the residence shared by Kincaid and Collins, and ultimately was convicted for manufacturing and possessing child pornography. Following his conviction, Kincaid allegedly transferred assets to Collins in order to prevent Doe from obtaining the assets via a future civil action.⁸⁶

⁸⁰ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 662 (2d Dist. 2011).

⁸¹ USAA Casualty Ins. Co. v. McInerney, 960 N.E.2d 655, 664 (2d Dist. 2011).

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *State Auto Property & Casualty Ins. Co. v. Kincaid*, 2011 WL 344086 (C.D. Ill 2011).

⁸⁶ *State Auto Property & Casualty Ins. Co. v. Kincaid*, 2011 WL 344086, 1 (C.D. Ill 2011).

Doe thereafter commenced civil litigation against Kincaid, Collins and The Hair Clinic. Among other things, Doe alleged that Collins was negligent in failing to protect Doe from Kincaid. Doe also alleged that The Hair Clinic was liable for negligently hiring, retaining and supervising Kincaid.⁸⁷

State Auto provided business liability insurance to “Steve Collins and Paul Kincaid DBA The Hair Clinic.” Collins notified State Auto of Doe’s claims and demanded coverage for himself and The Hair Clinic. State Auto agreed to provide a defense under a reservation of rights. It also filed a declaratory judgment seeking a judicial declaration that it was not obligated to defend or indemnify Collins or The Hair Clinic in connection with Doe’s claims.⁸⁸

State Auto asserted that it had no duty to defend Collins and The Hair Clinic as Collins knew of Kincaid’s predilections and thus “expected” Kincaid’s actions. State Auto also contended that The Hair Clinic was not a distinct entity from Collins and thus coverage should likewise be precluded for it. State Auto further asserted that coverage should not be available for The Hair Clinic as the policy did not contemplate that sexual abuse would occur on the business premises. Finally, State Auto argued that it had no duty to defend Collins for Doe’s claim that Collins engaged in a fraudulent transfer of assets, as the transfer was an intentional act.⁸⁹

Initially, the court considered the allegations of the Doe lawsuit, which it described as alleging that Collins “knew, or reasonably should have known” that Kincaid engaged in illegal activities, that Collins allowed sexual activity to occur between Kincaid and the victim, that Collins allowed “unspeakable acts” to occur, and that he allowed Kincaid to keep child pornography on the couple’s home computer.⁹⁰ The court further noted that State Auto would have a duty to defend Collins against claims that are potentially within the policy’s definition of covered “occurrences” and that, under the State Auto policy, an “occurrence” is “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”⁹¹ However, the court acknowledged that “[a]s a general rule, insurance companies have no duty to defend insureds who sexually abuse minors because the resulting harm is ‘expected’ and, therefore, not an accidental ‘occurrence’ covered by the policy [citation omitted].”⁹² The court further noted that “While one insured’s intent cannot be imputed to another insured for purposes of assessing an insurer’s

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ State Auto Property & Casualty Ins. Co. v. Kincaid, 2011 WL 344086, 2 (C.D. Ill 2011).

⁹⁰ State Auto Property & Casualty Ins. Co. v. Kincaid, 2011 WL 344086, 3 (C.D. Ill 2011).

⁹¹ State Auto Property & Casualty Ins. Co. v. Kincaid, 2011 WL 344086, 4 (C.D. Ill 2011).

⁹² State Auto Property & Casualty Ins. Co. v. Kincaid, 2011 WL 344086, 8 (C.D. Ill 2011).

coverage duties, a policy's express language coupled with a complaint's explicit allegations have been used to show that a non-abuser insured can be denied coverage when a victim's claims demonstrate that the non-abuser insured "expected" or "intended" harm [citation omitted]."⁹³

In rejecting State Auto's position, however, the court found that Doe's negligence, negligent hiring and negligent supervision claims were alleged in a manner that rendered them potentially covered by the policy and thereby triggered State Auto's duty to defend Collins and The Hair Salon. In this regard, the court viewed it as critical that Collins was not alleged to have actively encouraged or facilitated Kincaid's physical contact with Doe nor was it alleged that he intentionally disregarded indications of abuse such as those set forth in *Westfield National Insurance Co. v. Continental Community Bank and Trust Co.*,⁹⁴ the primary decision relied upon by State Auto.⁹⁵ Accordingly, the court found that the allegations of the Doe lawsuit did not establish that Collins "expected" or "intended" Doe's injuries and therefore State Auto's duty to defend Collins and The Hair Salon was triggered.⁹⁶

C. Definition of "Occurrence"; Manufacturing

*United National Insurance Co. v. Faure Brothers Corp.*⁹⁷ addressed the concept of an "occurrence" in the context of a manufacturing-related claim. Faure Brothers Corporation was in the business of warehousing chemical products for customers, relabeling them, and having them shipped per the customers' directions. Faure Brothers had commercial general liability insurance from United National. A customer, Air Products and Chemicals, Inc. ("Air Products") sued Gateway, a division of Faure Brothers, alleging that Gateway was to re-label certain chemicals for Air Products but that Gateway applied the labels to the wrong chemicals. The mislabeled chemicals were shipped to one of Air Products' customers, Henkel, and Henkel used the mislabeled chemicals in producing one of its adhesive products. Henkel's adhesive product was bought by Becton, Dickinson and Company Medical Systems ("BD") and by Smiths Medical ASD, Inc. ("Smiths"). The adhesive product did not perform as intended, and BD and Smiths sustained damages. BD and Smiths notified Henkel,

⁹³ *Id.*

⁹⁴ *State Auto Property & Casualty Ins. Co. v. Kincaid*, 2011 WL 344086 (C.D. Ill. 2011), quoting *Westfield Nat'l Ins. Co. v. Continental Community Bank and Trust Co.*, 346 Ill. App. 3d 113, 804 N.E.2d 601 (2d Dist. 2003).

⁹⁵ *State Auto Property & Casualty Ins. Co. v. Kincaid*, 2011 WL 344086, 8 (C.D. Ill. 2011).

⁹⁶ *Id.*

⁹⁷ *United Nat'l Ins. Co. v. Faure Brothers Corp.*, 409 Ill. App. 3d 711, 949 N.E.2d 1185 (1st Dist. 2011).

which made a claim against Air Products. Air Products satisfied the claims of BD, Smiths, and Henkel and brought suit against Faure Brothers, alleging that the damages that it had paid were proximately caused by the negligence of Faure Brothers in the mislabeling of the chemicals.⁹⁸

Faure Brothers tendered the complaint to United National and requested a defense. United National declined but brought a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify Faure Brothers in connection with the underlying suit. The circuit court granted summary judgment in United National's favor, reasoning that the Air Products complaint did not allege an "occurrence" as to Faure Brothers.⁹⁹

Faure Brothers appealed, arguing that it was sued for negligence and that the mislabeling was an accident and, thus, an "occurrence" under the policy language. United National argued that the labeling was an intentional act, not an "occurrence," and that, alternatively, the Air Products' complaint did not allege "property damage" under the policy and was, in any event, excluded by the "sistership" or recall exclusion.¹⁰⁰

The First District addressed the "occurrence" issue first. The policy defined "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions," but the policy did not define the term "accident."¹⁰¹ The court looked to Illinois Supreme Court precedent for the meaning of "accident" in insurance cases, including guidance that "if an act is performed with the intention of accomplishing a certain result, and if, in the attempt to accomplish that result, another result, unintended and unexpected, and not the rational and probable consequence of the intended act, in fact, occurs, such unintended result is deemed to be caused by accidental means."¹⁰² Determination of whether an occurrence is an accident is focused on whether the injury is expected or intended by the insured, not whether the acts were performed intentionally.¹⁰³

Turning to the allegations of the Air Products complaint, the court concluded that the complaint alleged an "accident" and, therefore, an "occurrence" under Faure Brothers' insurance policy. The allegations

⁹⁸ *Id.*

⁹⁹ United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 715, 949 N.E.2d 1185, 1190 (1st Dist. 2011).

¹⁰⁰ United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 719, 949 N.E.2d 1185, 1193 (1st Dist. 2011).

¹⁰¹ *Id.*

¹⁰² United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 949 N.E.2d 1185 (1st Dist. 2011), quoting Rich v. Principal Life Ins. Co., 226 Ill. 2d 359, 378, 875 N.E.2d 1082, 1094 (2007).

¹⁰³ United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 949 N.E.2d 1185 (1st Dist. 2011), quoting Lyons v. State Farm Fire & Casualty Co., 349 Ill. App. 3d 404, 409, 811 N.E.2d 718, 723 (2004).

focused solely on negligent acts and did not make any allegations that Faure Brothers expected or intended the resulting mislabeled chemicals. From the point of view of Faure Brothers, it was contracted to label the chemicals before putting them into the stream of commerce. However, unexpectedly, it mislabeled the chemicals. Therefore, the result was not expected and, thus, an accident.¹⁰⁴

United National also argued that Air Products' complaint did not make a claim for "property damage" under the policy. The policy defined "property damage" as "physical injury to tangible property, including all resulting loss of use of that property ... or ... [l]oss of use of tangible property that is not physically injured."¹⁰⁵ The court rejected United National's "property damage" argument because it was clear from the allegations in the complaint that Henkel, BD, and Smiths all had damages based on the loss of use of the defective adhesive products because of the mislabeling of the component chemical by Faure Brothers.¹⁰⁶

Finally, the court rejected United National's additional argument that the "sistership" or recall exclusion applied. That exclusion would preclude coverage for:

Damages claimed for any loss, cost or expense incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of: *** 'Your Work' *** if such . . . work . . . is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous condition in it.¹⁰⁷

The court held that the exclusion does not defeat coverage for damages caused by product or work that has already failed while in use.¹⁰⁸ Air Products' complaint alleged that it had already satisfied and paid claims based on the damages caused by the mislabeled products; it did not seek to withdraw Faure Brothers' products to prevent future damages. United National's exclusion did not preclude coverage.¹⁰⁹

Accordingly, the court found that United National had a duty to defend Faure Brothers against Air Products' complaint. The court reversed the circuit court's summary judgment in favor of United National and

¹⁰⁴ United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 718, 949 N.E.2d 1185, 1192 (1st Dist. 2011).

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ United Nat'l Ins. Co. v. Faure Brothers Corp., 409 Ill. App. 3d 711, 719, 949 N.E.2d 1185, 1193 (1st Dist. 2011).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

directed the entry of summary judgment in favor of Faure Brothers on the duty to defend.¹¹⁰

D. Number of Occurrences

In *Continental Casualty Co. v. Howard Hoffman and Associates*,¹¹¹ Continental Casualty Company (“Continental”) issued a lawyer’s professional liability policy to the law firm Howard Hoffman and Gerald H. Cohen, Lawyers (“Hoffman law firm”) with limits of liability of \$100,000 “per claim” and \$300,000 in the aggregate. During the relevant period, the Hoffman law firm notified Continental that one of its non-lawyer employees had “embezzled significant funds” from at least 16 probate estates represented by the Hoffman law firm. The Hoffman law firm also advised Continental that the total losses from this embezzlement would exceed \$300,000.¹¹²

Continental filed a declaratory judgment action seeking a determination that its indemnity obligation under the Continental policy was limited to a single \$100,000 “per claim” limit, not the \$300,000 aggregate limit. Specifically, Continental sought a declaration that the non-lawyer’s embezzlement from 16 different probate estates were deemed “related” and therefore subject to one “per claim” limit of \$100,000, pursuant to the terms of the policy.¹¹³

The Hoffman law firm argued that the Continental policy was ambiguous regarding the terms “related claims” and “related acts or omissions” defined in the policy and therefore its meaning had to be construed in favor of the Hoffman law firm. The trial court determined that the policy’s definitions of “related claims” and “related acts or omissions” were both clear and unambiguous and would therefore control any interpretation of the policy. Interpreting these policy terms, the trial court concluded that the Insured’s acts or omissions were “connected” to the non-lawyer’s “overall scheme” to divert funds to herself fraudulently. Thus, all the claims of all the probate estates would be treated as a single, related claim and only a single \$100,000 “per claim” limit would be available under the policy. The Hoffman law firm and certain estates impacted by the embezzlement appealed.¹¹⁴

The appellate court affirmed the trial court’s rulings. After determining that Continental’s declaratory judgment action was ripe for adjudication, the court of appeals first addressed whether the policy was

¹¹⁰ *Id.*

¹¹¹ *Continental Casualty Co. v. Howard Hoffman and Associates*, 955 N.E.2d 151 (1st Dist. 2011).

¹¹² *Id.* at 154.

¹¹³ *Id.* at 155.

¹¹⁴ *Id.*

ambiguous. The appellants argued that the Continental policy's inclusion of "logically ... connected" resulted in an ambiguity. The appellate court disagreed, holding that two other jurisdictions had found the relevant policy language in the policy to be unambiguous and enforceable.¹¹⁵ Thus, the court concluded that the policy definitions of "related claims" and "related acts or omissions" were not ambiguous and that related claims would be treated as a "single" claim for purposes of determining the limits available for such claims.¹¹⁶

The appellate court then analyzed whether the Hoffman law firm's alleged acts and omissions were related to be considered as a single claim subject to the \$100,000 "per claim" limit of liability under the policy.¹¹⁷ The court first concluded that the nature of the embezzlement was a "scheme" that constitutes a common fact, circumstance, situation or decision under the policy.¹¹⁸ The court next held that all of the allegations against the Hoffman law firm were logically and causally connected by the non-lawyer's scheme to embezzle funds.¹¹⁹ Thus, the appellate court affirmed the trial court's holding that all of the claims against the Hoffman law firm were related, as defined by the policy, and thus the \$100,000 "per claim" limit of liability applied in this matter.¹²⁰

E. Exclusions—Pollution Exclusion

In *Erie Insurance Exchange v. Imperial Marble Corp.*,¹²¹ Erie Insurance Exchange ("Erie") filed a declaratory judgment action asserting that it owed no duty to defend or indemnify Imperial Marble Corporation ("Imperial"), a manufacturer of cultured marble vanities and countertops, in an underlying class action filed by homeowners residing near its facility, arising from alleged harm caused by emissions from insured's manufacturing operations. Imperial asserted estoppel as an affirmative defense and filed a counterclaim seeking a declaration that Erie owed it defense and indemnification, and for breach of contract based on Erie's denial of coverage.¹²²

Following cross-motions for summary judgment, the trial court held that Imperial's emissions constituted traditional environmental pollution and that coverage was precluded under the policy's pollution exclusion.

¹¹⁵ *Id.* at 156.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 167.

¹²⁰ *Id.* at 172.

¹²¹ *Erie Ins. Exchange v. Imperial Marble Corp.*, 957 N.E.2d 1214 (3d Dist. 2011).

¹²² *Erie Ins. Exchange v. Imperial Marble Corp.*, 957 N.E.2d 1214, 1216 (3d Dist. 2011).

The trial court looked to the allegations in the underlying complaint which characterized Imperial's emissions as hazardous and migrating off of Imperial's premises. The trial court rejected Imperial's argument that under the CAA and IEPA the emissions were neither pollution nor hazardous. The trial court further found that it was inappropriate to replace the language in the policy's pollution exclusion with the definition of pollution under the United States Environmental Protection Agency (USEPA) and the IEPA. The circuit court entered summary judgment in favor of Erie and Imperial appealed.¹²³

The Third District reversed and remanded. The court noted that the complaint alleged personal injuries and property damage resulting from the invasion of the plaintiffs' person and property "by noxious odors, volatile organic materials (VOMs) and hazardous air pollutants (HAPs), including, but not limited to STYRENE and Methyl Methacrylate (MMA), air contaminants and other hazardous material" in the emissions generated "as part of Imperial's normal business operations." The complaint also alleged that Imperial emitted VOMs and HAPs in violation of IEPA regulations and released more than the amounts of VOMs and HAPs allowed under its permit. The complaint also alleged that Imperial knew or should have known, and was aware of, expected, and intended the emissions to occur.¹²⁴

The appellate court first determined that there was a potential "occurrence" alleged in the complaint. Because the alleged bodily injury and property damage were unexpected results of Imperial's intended emissions, they constitute an accident under the policy.¹²⁵

Next, the court considered the "expected or intended injury" exclusion and applied the "same analysis in determining" whether the underlying complaint alleged an occurrence under the policy language.¹²⁶ The court focused on whether the injury was expected or intended, not on whether the act that caused the injury was expected or intended.¹²⁷ In finding that the expected or intended injury exclusion did not preclude coverage, the court relied on the underlying complaint allegations that asserted, in part, that Imperial emitted noxious odors as part of its normal business operations and that the emissions violated the applicable IEPA regulations.¹²⁸ The court concluded that "because Imperial operated pursuant to an emissions permit, it cannot be considered to have expected or intended to injure the underlying plaintiffs' persons or properties."¹²⁹

¹²³ *Id.*

¹²⁴ *Id.* at 1217.

¹²⁵ *Id.* at 1219.

¹²⁶ *Id.*

¹²⁷ *Id.* at 1220.

¹²⁸ *Id.*

¹²⁹ *Id.*

Finally, the court interpreted the pollution exclusion which bars coverage for “[b]odily injury’ or ‘property damage’ arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of ‘pollutants.’”¹³⁰ The policy defined “pollutants” as “[a]ny solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemical, and waste.” Relying on *American States Insurance Co. v. Koloms*,¹³¹ the court found that the policy’s pollution exclusion was ambiguous as to whether Imperial’s emissions constituted traditional environmental pollution and concluded that it was unclear whether permitted emissions constitute traditional environmental pollution excluded under the Erie policy.¹³² Resolving the ambiguity in favor of Imperial, the appellate court reversed and remanded the case to the trial court.¹³³

F. Exclusion—“Criminal” Conduct

In *Grinnell Mutual Reinsurance Co. v. Ferando*,¹³⁴ the insured, Ferando, was involved in a shooting incident with the McCoys that resulted in criminal charges being brought against Ferando. Specifically, Ferando was charged with two counts of attempted murder, aggravated discharge of a firearm, and aggravated unlawful restraint with a deadly weapon after he fired several shots in the direction of the McCoys. Ferando pled guilty to the aggravated discharge of a firearm and aggravated unlawful restraint charges, and was sentenced to four years imprisonment.¹³⁵

The McCoys sued Ferando seeking compensatory and punitive damages. The McCoys alleged that they “were lawfully in their respective vehicles,” that Ferando “recklessly and carelessly discharged a firearm multiple times in the direction of [the McCoys],” that Ferando “had a duty of due care for the safety of the [McCoys],” and that “[t]he aforesaid willful and wanton and reckless conduct of [Ferando] proximately caused [the McCoys] to incur, and . . . may in the future incur, severe emotional distress accompanied by physical symptoms, substantial expenses in efforts to cure [themselves] of [their] injuries, and loss of [their] normal [lives].”¹³⁶

Ferando had liability insurance under a lessor and renter’s policy with Grinnell Mutual Reinsurance Company. Grinnell declined to defend

¹³⁰ *Id.*

¹³¹ *Erie Ins. Exchange v. Imperial Marble Corp.*, 957 N.E.2d 1214 (3d Dist. 2011), quoting *American States Insurance Co. v. Koloms*, 177 Ill. 2d 473, 487, 687 N.E.2d 72, 78-79 (1997).

¹³² *Id.* at 1221.

¹³³ *Id.*

¹³⁴ *Grinnell Mut. Reinsurance Co. v. Ferando*, 2011 WL 3489782 (S. D. Ill. 2011)

¹³⁵ *Id.* at 1.

¹³⁶ *Id.* at 10.

Ferando, relying on his guilty pleas to aggravated discharge and aggravated unlawful restraint and on the following policy exclusion:

We do not cover ‘bodily injury’ or ‘property damage’ which results from an act committed by any ‘insured’:

In the course of or in the furtherance [*4] of any:

- (1) Crime;
- (2) Offense of a violent nature; or
- (3) Physical Abuse; or

If a reasonable person would expect or intend ‘bodily injury’ or ‘property damage’ to result from the act.

This exclusion applies regardless of whether such ‘insured’ is charged with or convicted

of a crime and even if:

The ‘bodily injury’ or ‘property damage’ is of a different kind or degree than was intended or could reasonably be expected to result from the act; or

The ‘bodily injury’ or ‘property damage’ is sustained by a different person than was intended or could reasonably have been expected.

Grinnell brought a declaratory action and moved for summary judgment that it had no duty to defend or indemnify Ferando. Grinnell first argued that the McCoys’ complaint alleged that Ferando had committed a criminal act, specifically, the crime of aggravated discharge of a firearm, thereby triggering the policy exclusion for criminal acts. The court disagreed. The crime of aggravated discharge requires that the defendant “knowingly or intentionally” discharge the firearm in the direction of another person. The McCoys’ complaint, however, alleged a different mental state—that Ferando “recklessly and carelessly” discharged the firearm. The McCoys’ complaint, therefore, did not allege the crime of aggravated discharge of a firearm, and the criminal acts exclusion was not sufficiently invoked.¹³⁷

Next, Grinnell argued that Ferando’s guilty pleas should estop him and thereby establish the policy’s criminal acts exclusion.¹³⁸ In rejecting Grinnell’s argument, the court explained that collateral estoppel is an equitable doctrine and that, even where the elements of collateral estoppel

¹³⁷ *Id.* at 2.

¹³⁸ *Id.* at 3.

are satisfied, a court must determine whether application of the doctrine is fair under the circumstances.¹³⁹ Here, Ferando was charged with two counts of attempted murder. He had a great incentive to plead guilty to aggravated discharge and aggravated restraint, even if he was innocent, because of the disparity in sentences for those crimes compared to attempted murder.¹⁴⁰ While he received a sentence of four years imprisonment for aggravated discharge and aggravated restraint, he would have received an additional twenty years had he been found guilty of attempted murder.¹⁴¹ Under the circumstances, Ferando did not have a strong incentive to contest the criminal charges, and collateral estoppel should not be applied.¹⁴²

The court denied Grinnell's motion for summary judgment and entered an order affirmatively directing Grinnell to undertake Ferando's defense against the McCoys' civil claims.¹⁴³

G. Telephone Consumer Protection Act

In *Landmark American Insurance Co. v. NIP Group*,¹⁴⁴ an underlying class action lawsuit sought damages from NIP Group, an insurance broker, for its alleged practice of sending unsolicited advertisements via facsimile. The underlying complaint sought relief pursuant to: (1) the federal Telephone Consumer Protection Act ("TCPA"), (2) the Illinois Consumer Fraud and Deceptive Business Practices Act, and (3) common law conversion. NIP tendered the defense of the suit to Landmark, NIP's professional liability insurer. Landmark denied coverage and filed a declaratory judgment action against NIP. In its lawsuit, Landmark asserted that the sending of unsolicited fax advertisements did not constitute the "rendering or failure to render professional services" and asserted the applicability of various policy exclusions including exclusions for damages caused by conversion, property damage, or intentional acts.¹⁴⁵

NIP moved to stay or dismiss Landmark's complaint pursuant to *Maryland Casualty Co. v. Peppers*,¹⁴⁶ because resolution of the Landmark lawsuit would require the determination of factual matters at issue in the underlying litigation including the extent to which NIP had acted

¹³⁹ *Id.* at 5.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.* at 6.

¹⁴⁴ *Landmark American Ins. Co. v. NIP Group*, 962 N.E.2d 562 (1st Dist. 2011).

¹⁴⁵ *Id.* at 568.

¹⁴⁶ *Landmark American Ins. Co. v. NIP Group*, 962 N.E.2d 562 (1st Dist. 2011), quoting *Maryland Cas. Co. v. Peppers*, 64 Ill. 2d 187, 355 N.E.2d 24 (1976).

intentionally. The trial court denied NIP's motion, and NIP subsequently filed its answer and affirmative defenses to Landmark's suit. Among those defenses were assertions that Landmark's failure to defend had resulted in any policy defenses being waived or barred by the doctrine of estoppel. NIP also contended that, as Landmark's policy specifically included coverage for "Advertising Liability," any argument that the underlying lawsuit was not covered was contrary to public policy and improperly rendered coverage illusory.¹⁴⁷

Landmark filed a motion for summary judgment asserting that the sending of unsolicited fax advertisements was not a covered "professional service." In response, NIP (after unsuccessfully attempting to argue *forum non conveniens*) responded to Landmark's motion by asserting that New Jersey law applied, as opposed to Illinois law, and under relevant New Jersey precedent the policy provided coverage. The trial court considered the choice of law issue and held that because there was generally no relevant conflict between the law of Illinois and New Jersey law, it would apply the law of the forum, Illinois. The court thereafter found that the Landmark policy did not provide coverage and granted Landmark's motion for summary judgment.¹⁴⁸

On appeal, the First District held that the trial court: (1) properly denied NIP's *forum non conveniens* motion; (2) improperly refused to stay a portion of the suit; and (3) improperly granted summary judgment in favor of Landmark.¹⁴⁹ With respect to the grant of summary judgment in favor of Landmark, the court noted that the underlying complaint alleged that NIP had a "practice of faxing unsolicited advertisements" and claimed damages because NIP's practice of sending such faxes "unlawfully interrupted Brodsky's and the other class members' privacy interests in being left alone." In comparison, the policy Landmark issued to NIP provided coverage for claims "arising out of * * * Advertising Liability * * * in the rendering or failure to render professional services as described in the Declarations."¹⁵⁰ In turn, the policy defined "Advertising Liability" to include "[o]ral or written publication of material that violates a person's right of privacy." The court noted that courts applying both Illinois and New Jersey law have found that allegedly unsolicited fax advertisements, which violate a claimant's right to privacy, fall within such a policy definition.¹⁵¹ The only specifically relevant limitation on the "Advertising Liability" coverage was contained in a provision excluding coverage for "[f]alse advertising or misrepresentation in advertising, but only regarding

¹⁴⁷ *Id.* at 569.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* at 572.

¹⁵¹ *Id.* at 573.

intentionally false, misleading, deceptive, fraudulent, or misrepresenting statements in advertising the insured's own product or service," but the underlying complaint did not allege conduct which would trigger the limitation.¹⁵²

In rejecting Landmark's argument that NIP's practice of advertising its products and services could never be construed as a "professional service," the court held that such an argument was an overly broad interpretation of prior Illinois case law.¹⁵³ In this regard, the court distinguished prior decisions addressing unsolicited fax advertisements based upon the specific policy wording at issue in those matters.¹⁵⁴ The court further noted that if the exclusionary language of NIP's policy is to have any meaning, the language of the policy's insuring agreement must include NIP's advertising for its various insurance-related functions within the scope of coverage for liability incurred in the rendering or failure to render one of its listed professional services.¹⁵⁵ According to the court, because the language of the policy excluded coverage only for specific types of advertising, but did not exclude the types of advertising alleged in the underlying complaint, coverage must be deemed available for the underlying litigation.¹⁵⁶

G. Construction Defects

In *Nautilus Insurance Co. v. 1735 W. Diversley, LLC*,¹⁵⁷ the defendant 1735 Diversley, LLC ("1735") renovated a vacant apartment building in Chicago and, in connection with the renovation, purchased two liability policies that covered the periods from June 1998 through June 1999 and June 1999 through June 2000. In January of 2000, 1735 announced its intention to convert the building into condominiums. Once the renovation was complete, the condominiums were sold and the Regal Lofts Condominium Association was organized to govern common areas.¹⁵⁸

In November 2005, one of the unit owners complained that water was leaking into his unit. The association's board of directors hired Construction Resources, Inc. ("CRI") to investigate the cause of the water leakage. CRI concluded that the primary cause of water infiltration was the deteriorated conditions of the exterior brick masonry walls, localized

¹⁵² *Id.* at 583.

¹⁵³ *Id.* at 585.

¹⁵⁴ *Id.* at 576.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 579.

¹⁵⁷ *Nautilus Ins. Co. v. 1735 W. Diversley, LLC*, 2011 WL 3176675, (N.D. Ill. 2011).

¹⁵⁸ *Id.* at 1.

openings and failures in the facade sealant joints, and the lack of window/door flashing systems. CRI also concluded that the deteriorated conditions resulted from prolonged and repeated water penetration into the brick walls combined with cyclic freeze-thaw action. Finally, CRI concluded that water penetration was occurring because the walls had not been adequately restored to a reasonably water-tight and serviceable condition.¹⁵⁹

In January of 2008, the association filed a complaint against 1735 alleging that it had failed to properly construct, develop or repair the common areas, including the exterior walls, such that they suffered substantial structural defects and needed to be rebuilt or repaired. 1735 tendered the matter to Nautilus and requested that Nautilus indemnify and defend 1735 in connection with the association's lawsuit. Nautilus denied coverage under both policies, and after numerous attempts by 1735 to re-tender the matter, Nautilus filed the instant declaratory judgment action seeking a declaration of its rights and obligations to 1735 in connection with the association's lawsuit.¹⁶⁰

The Nautilus insurance policies provided coverage for bodily injuries and property damaged caused by an occurrence, defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."¹⁶¹ The policies also contained an exclusion which precluded coverage for property damage occurring away from premises that the insured owns or rents and arising out of its product or work (the "Products-Completed Operations Hazard" exclusion). For purposes of the Products-Completed Operations Hazard exclusion, the policies deemed 1735's work to be completed at the earliest of the following times: (1) when all of the work called for in the contract has been completed; (2) when all of the work to be done at the site has been completed; or (3) when that part of the work done at the job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project.¹⁶²

In considering the extent to which Nautilus was obligated to defend 1735 in connection with the underlying claims, the court first acknowledged that any obligation on the part of Nautilus was dependent upon whether the alleged "property damage" in question was caused by an "occurrence".¹⁶³ In this regard, the court acknowledged that under Illinois law an "occurrence" is generally regarded as an "accident" and that the natural and ordinary consequences of an act do not generally constitute an

¹⁵⁹ *Id.*

¹⁶⁰ *Id.* at 2.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.* at 3.

accident.¹⁶⁴ As a result, the court noted that Illinois courts have consistently concluded that damages caused by construction defects are not accidents as they are the natural and ordinary consequences of the defective workmanship.¹⁶⁵ According to the court, in order for the damages associated with a construction defect to be classified as an “occurrence,” the defect in question must damage something other than the project itself.¹⁶⁶

1735 argued that the underlying complaint triggered Nautilus’ duty to defend because the complaint alleged that 1735’s negligent workmanship resulted in damage to parts of the building that 1735 did not work upon and thus was not damage limited to the project itself. 1735 further argued that as the complaint did not allege that 1735 intended its negligence to cause damage to the property, Nautilus should be obligated to provide coverage.¹⁶⁷

In rejecting 1735’s arguments, the court noted that the underlying complaint only alleged damage to the building itself—whether in the form of cracks to the exterior masonry or efflorescence and spalling in the interior walls. The court found that it was the condominium complex itself that was damaged, not something within and separate from the condominiums. According to the court, the failure to adequately detect and repair the structural defects in the property damaged the building itself, and under Illinois law, damage to the structure itself—regardless of whether the Insureds worked on that particular part of the structure—cannot be an accident.¹⁶⁸ The court further held that the mere fact that the underlying complaint did not specifically allege that the 1735 intended to damage the condominiums is of “no consequence.”¹⁶⁹ In this regard, the court found that Illinois law holds that damage to a property caused by negligent workmanship is the natural and ordinary consequence of that workmanship, and the underlying complaint need not specifically allege that such damage was intended.¹⁷⁰

Finally, the court also rejected 1735’s argument that because the underlying complaint alleged that its negligent workmanship caused damages to personal property, Nautilus was obligated to provide a defense to the defendants.¹⁷¹ However, the court determined that coverage was likewise unavailable for the complaint by virtue of the policy’s Products–

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 4.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 5.

¹⁶⁹ *Id.* at 6.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

Completed Operations Hazard exclusion.¹⁷² In this regard, the court found significant that the complaint alleged that the Insureds sold individual condominium units to the homeowners represented by the underlying plaintiff and that the first allegations of damages were made by one of the owners of the individual condominium units.¹⁷³ The court found these allegations sufficient to establish that the property damage occurred away from premises owned by the Insureds.¹⁷⁴ In addition, the court found that the property damage occurred after the work was completed.¹⁷⁵ According to the court, because the owners of the individual condominium units had moved personal property into the units, then the owners were putting the property to its intended use, which makes the Insureds' work "completed" under the terms of the policies.¹⁷⁶ As a result, the court held that the complaint made clear that any damage to personal property occurred both after the work on the project was completed and after the Insureds had transferred ownership to the individual condominium unit owners. Therefore, the Products—Completed Operations Hazard exclusion applied and precluded coverage under the policy.¹⁷⁷

V. HEALTH INSURANCE

Illinois Public Act 96-1523,¹⁷⁸ effective June 1, 2011, addresses a procedure known as "balance billing" of insured patients for services provided by certain medical-service providers outside the patients' insurance networks at in-network facilities.¹⁷⁹ The Act provides that a "non-participating facility-based provider" shall be prohibited from billing an insured patient for anything other than the applicable deductible and co-pay that would apply if the provider were a participating provider and that any remaining payment to the provider must be sought from the patient's insurer or health plan, not the patient.¹⁸⁰ The Act defines "facility-based provider" as "a physician or other provider who provides radiology, anesthesiology, pathology, neonatology, or emergency department services to insureds, beneficiaries, or enrollees in a participating facility or participating ambulatory surgical treatment center" (emphasis added).¹⁸¹

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 7.

¹⁷⁸ 215 Ill. Comp. Stat. 5/356z.3a (West 2011).

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

Nonparticipating physicians who are not listed in that statutory definition—e.g., internal-medicine physicians, general practitioners, cardiologists, pediatricians, general surgeons, and surgical specialists—are not subject to the prohibitions in the Act and, thus, are permitted to bill patients for amounts beyond what would be payable by insurance if the physician were a participating network provider.¹⁸²

In *Peoria Tazewell Pathology Group, S.C. v. Messmore*,¹⁸³ the plaintiffs, certain providers of pathology services, brought suit to declare the Act unconstitutional as unfairly targeting their specialty, pathology, while permitting balance billing by non-network physicians of other specialties. Plaintiffs cast their constitutional arguments in terms of equal protection, due process, impairment of contract, and vagueness. The court dismissed the suit in its entirety.¹⁸⁴

On the equal protection challenge, the court held that plaintiffs failed to allege sufficient facts supporting the absence of a rational basis for the statute. Moreover, the court concluded that the defendants, the State of Illinois and certain officials, had set forth a rational basis for the Act in their Motion to Dismiss.¹⁸⁵

In the court's understanding, the problem sought to be remedied by the Act is this: insured patients who choose a physician within their network at a hospital within their network are being balance billed by providers of ancillary medical services who were not in their insurance network, even though those providers of ancillary services were not specifically selected by the patients. More particularly, a person with health insurance is aware that not all doctors are within their covered network, and she understands that she should select her general practitioner from a list of those within her network. If she requires a surgical procedure, an insured patient can understand the need to locate a facility within her network and to have the surgery performed by a general surgeon or surgical specialist within her network in order to obtain the maximum benefit through her insurance plan. But she would not select the radiologist who takes a necessary X-ray or the anesthesiologist who puts her under before her chosen surgeon operates. These services are ancillary to the one she has specifically chosen, and there is a rational basis for the legislature to single out those ancillary-service providers for purposes of a law designed to limit patients' exposure to uncovered medical expenses.¹⁸⁶

¹⁸² *Id.*

¹⁸³ *Peoria Tazewell Pathology Group, S.C. v. Messmore*, 2011 WL 4498937 (N.D. Ill. 2011).

¹⁸⁴ *Id.* at 1.

¹⁸⁵ *Id.* at 4.

¹⁸⁶ *Id.*

With respect to plaintiffs' due process challenge, they did not specify whether the alleged due process violations were substantive or procedural. Their argument appeared to be that the Act violated their right to "occupational liberty," which would be an issue of procedural rather than substantive due process.¹⁸⁷ As a matter of procedural due process, plaintiffs would have to allege that the State has made it impossible for plaintiffs to find a position in their chosen field, pathology, and has effectively excluded them from that occupation.¹⁸⁸ At best, plaintiffs claimed that their current arrangement at specific hospitals is potentially less lucrative or more burdensome than it was before the Act was enacted. That was not enough to support a claim that the State has deprived them of procedural due process. To the extent plaintiffs would argue that their right to substantive due process was violated, the claim failed for the same reason as their equal protection claim.¹⁸⁹ The process for determining whether a law is "arbitrary" in violation of the due process clause is analogous to determining whether a law lacks a "rational basis" in violation of the equal protection clause.¹⁹⁰

In rejecting plaintiffs' impairment of contracts claim, the court held that plaintiffs simply did not allege a precise contractual right that has been impaired and the nature of the statutory impairment.¹⁹¹ Although they complained that their financial relationship with patients has been affected by the Act, plaintiffs did not allege the existence of any contracts between plaintiffs and patients. The only specific contract alleged is between plaintiffs and the healthcare facilities where they work, and the only specific term alleged is plaintiffs' obligation to provide services to patients. There is no allegation that this obligation has been impaired, and plaintiffs alleged no specific contractual right conferred on plaintiffs in return. Rather, plaintiffs alleged only that they accepted that obligation because they could charge full value for their services and collect from patients amounts beyond what insurers would pay. They did not actually allege that their ability to charge full value to their patients was a contractual right arising from their contract with the hospitals. And even if the existence of such a contractual right reasonably could be inferred from plaintiffs' allegations, it would be, at most, plaintiffs' right to charge patients without any limit imposed by the hospitals. Thus, there was no allegation that the Act altered any right flowing from the hospitals to plaintiffs, or vice versa.¹⁹²

¹⁸⁷ *Id.* at 5.

¹⁸⁸ *Id.* at 6.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 7.

¹⁹² *Id.* at 8.

Finally, on plaintiffs' void-for-vagueness argument, the court held that there is no constitutional requirement that a person affected by a law understand why he is affected by that law; he need only know what is prohibited.¹⁹³ Here, there was nothing vague about the classification of physicians covered by the Act. Plaintiffs are pathologists, and pathologists are specifically included in the definition of "facility-based providers."¹⁹⁴ Nor is there anything vague about what is prohibited: direct balance billing of insured patients.¹⁹⁵

VI. AUTO INSURANCE/UM/UIM

A. Definition of "Insured"

In *Czapski v. Maher*,¹⁹⁶ defendant Christopher Maher was test-driving a BMW automobile owned by defendant Motor Werks of Barrington (Motor Werks), accompanied by Motor Werks' salesperson Roger Czapski, who was seated in the BMW's front passenger seat. Czapski was killed when the BMW collided with another vehicle. The collision resulted in wrongful death and personal injury claims against Maher. The underlying wrongful death claim went to trial, resulting in a \$13.72 million judgment against defendant Maher.¹⁹⁷

Prior to trial, plaintiffs, as well as the other passengers, filed a declaratory judgment action seeking declarations of coverage available to Maher under both: (1) certain insurance policies issued to Motor Werks, and (2) certain insurance policies issued to Kevin Maher, Christopher Maher's father. The dealership, Motor Werks, had purchased a \$5 million umbrella policy from defendant National Casualty Company (National) and a \$10 million excess policy from defendant Federal Insurance Company (Federal). These policies were purchased to protect defendant Motor Werks from liability in excess of its \$1 million primary policy. Defendant Motor Werks was a party in the declaratory judgment action, but not in the underlying wrongful death litigation.¹⁹⁸

Motor Werks' umbrella and excess policies stated that the term "insured" does not include the dealership's "customers." In particular, National's policy stated under the heading "Auto Dealership Limitation Endorsement": "Your customers are not 'named insureds' or 'insureds' as

¹⁹³ *Id.* at 9.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Czapski v. Maher*, 954 N.E.2d 237 (1st Dist. 2011).

¹⁹⁷ *Id.* at 378.

¹⁹⁸ *Id.* at 379.

defined in this policy.” The trial court found that the term “customer” could be read to include only a person who has already made a purchase, and since Maher had not yet made a purchase, he therefore was not a “customer.” The trial court also reviewed various dictionary definitions and concluded that, even if the term “customer” could be interpreted to include a test-driver, this meant that the term was subject to multiple meanings and, therefore, was ambiguous.¹⁹⁹

The First District reversed. The appellate court agreed with the insurers that the plain and ordinary meaning of the term “customer,” as used in a policy issued to an auto dealership, includes one who test-drives an auto that the dealership holds out for sale.²⁰⁰ The court analyzed case law in Illinois and other jurisdictions addressing the term “customer” as well as various dictionary definitions to support its conclusion.²⁰¹ The court did not find the dictionary definitions helpful, however, because if the term “customer” applied only to a person who had already made a purchase, then the exclusion in the policy here would have little or no meaning, as it would only apply to people who have previously purchased motor vehicles and are now test-driving another vehicle.²⁰²

The court concluded that the plain and ordinary meaning of the term “customer” in the context of an insurance policy includes a test-driver of an automobile when the dealership gives permission to test-drive the vehicle.²⁰³ The court found that the term “customer” in this context is not subject to more than one reasonable interpretation.²⁰⁴ In sum, the plain and ordinary meaning of the term “customer” as used in an insurance policy issued to an automobile dealership would reasonably include one who test-drives an automobile before purchase.²⁰⁵

B. “Use” of an Auto

In *Affton Fabricating & Welding Co. v. Carolina Casualty Insurance Co.*,²⁰⁶ two companies (Affton and Parrish) had been doing business together for approximately ten years. Affton fabricated structural steel, and Parrish and Affton worked together to get the finished product to Affton’s customers. To do so, Parrish left its empty trailers at Affton’s plant, and Affton loaded its finished steel product on the empty trailer that Parrish dropped off for that purpose. Affton then took the loaded trailer to a

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 380.

²⁰¹ *Id.*

²⁰² *Id.* at 383.

²⁰³ *Id.*

²⁰⁴ *Id.* at 384.

²⁰⁵ *Id.*

²⁰⁶ *Affton Fabricating & Welding Co., Inc. v. Carolina Cas. Ins. Co.*, 2011 WL 222169 (S. D. Ill. 2011).

designated location, leaving it unattended and without power, where Parrish could access the trailer at a later time, attaching a truck, and delivering the product to the customer for which it is intended. Thereafter, the empty trailer was returned to the Affton factory where the process was repeated.²⁰⁷

On June 29, 2008, a motorist ran into a Parrish flatbed trailer that had been loaded with Affton steel and parked by Affton at the end of a street about three weeks earlier, waiting to be picked up by Parrish for delivery of the steel to its customers. Affton had used its own power unit to move and park the trailer at the end of the street.²⁰⁸

When the injured motorist brought suit against Affton and Parrish, Affton sought a defense from Parrish's insurer, Carolina Casualty, under the omnibus provision of the policy, which included as an insured, with certain exceptions, "[a]nyone else while using with your [Parrish's] permission a covered 'auto' you own, hire or borrow." Carolina Casualty refused to defend Affton, contending that Affton was not "using" the trailer at the time of the accident. Affton brought a declaratory judgment action of Illinois, and the parties cross-moved for summary judgment.²⁰⁹

Carolina Casualty argued that Affton was not a user and that in order to constitute a "user" or be a "user" of a vehicle, or here a trailer, one must be in operation or control of the vehicle. The court disagreed.²¹⁰ Relying on *Schultz v. Illinois Farmers Insurance Co.*,²¹¹ the court held that "use" is a very general word synonymous with "employ," "utilize," or "apply" and that a "user," in the generic sense, is simply one who makes use of a thing.²¹² The court found that the injuries of the motorist who ran into the trailer arose out of Affton's use of the trailer, having loaded it with product and parked it for pick-up by Parrish and delivery.²¹³ Affton was "using" the trailer at the time of the accident, and the trailer indeed was in constant "use," that is, providing transportation or satisfying some other related need of the users, Parrish and Affton.²¹⁴ Thus, the court found Affton to be an insured under Carolina Casualty's policy and entitled to a defense.²¹⁵

²⁰⁷ *Id.* at 1.

²⁰⁸ *Id.*

²⁰⁹ *Id.* at 2.

²¹⁰ *Id.* at 3.

²¹¹ *Affton Fabricating & Welding Co., Inc. v. Carolina Cas. Ins. Co.*, 2011 WL 222169 (S. D. Ill. 2011), quoting *Schultz v. Illinois Farmers Insurance Co.*, 37 Ill. 2d 391, 930 N.E.2d 943 (2010).

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.* at 4.

C. Rescission

*American Service Insurance Co. v. United Automobile Insurance Co.*²¹⁶, addressed the circumstances under which an auto policy could be rescinded. On April 9, 2003, Baker applied for an auto policy with United Automobile Insurance Company. The application asked her to identify any operators in her household under 25 years of age. Baker answered “none.” The policy was issued by United Auto effective April 9, 2003 and listed Baker as the only driver. On May 4, 2003, the policy was amended to change the covered vehicle, and a new declarations page was issued stating that the insured warrants that there are no other drivers in the household other than those listed on the application or policy. On May 14, 2003, Baker’s son, who resided with her, received his learner’s driving permit, and on June 10, 2003 the son was in a car accident with a light pole, resulting in property damage but no injuries. Baker reported the accident to United Auto, both Baker and her son gave recorded statements to United Auto, and both stated that the son had been driving even prior to receiving his learner’s permit on May 14, 2003, and since at least April 9, 2003. Subsequent to the light pole accident, the son obtained his driver’s license on August 14, 2003, and the insurance policy was again amended to change the insured vehicle sometime prior to February 1, 2004. On neither of those dates was the son’s name added to the policy.²¹⁷

On February 2, 2004, Baker’s son was involved in another accident while driving he insured vehicle. Terrell, a passenger in the car, sustained injuries. After learning of this accident, United Auto rescinded the insurance policy on March 15, 2004 as a result of Baker’s failure to disclose on the application that her son was an under-25 driver in the household.²¹⁸

Terrell had auto insurance with American Service Insurance Company (“ASI”) with coverage against uninsured motorists. She made an uninsured motorist claim to ASI because the United Auto policy had been rescinded, and ASI then brought a declaratory action against United Auto seeking a declaration that the United Auto policy was improperly rescinded, that Baker’s son was insured by United Auto, and that ASI therefore had no duty to provide uninsured motorist coverage to Terrell.²¹⁹

The trial court granted summary judgment in favor of United Auto and denied summary judgment in favor of ASI. The trial court concluded

²¹⁶ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 947 N.E.2d 382 (1st Dist. 2011).

²¹⁷ *Id.*

²¹⁸ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 34, 947 N.E.2d 382, 389 (1st Dist. 2011).

²¹⁹ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 31, 947 N.E.2d 382, 387 (1st Dist. 2011).

that United Auto properly rescinded its policy because Baker's failure to disclose her son on her application was a material misrepresentation. Moreover, Baker failed to comply with her duty of good faith and fair dealing when she failed to update United Auto with the material information that her son had obtained his driver's permit. The trial court further concluded that United Auto did not waive its right to rescind the policy. ASI appealed.²²⁰

The appellate court affirmed on all issues. On the issue of material misrepresentation, the court explained that, pursuant to Section 154 of the Illinois Insurance Code,²²¹ an insurer may rescind if the insured's misrepresentation is made with actual intent to deceive or if the misrepresentation materially affects the acceptance of the risk or the hazard assumed by the insurance company.²²² Baker's denial on the application that there was a driver in her household under the age of 25 was a material misrepresentation.²²³ The court reasons that "[i]t is a matter of common knowledge that the rate frequency of accidents for drivers between the ages of sixteen and twenty-four is substantially greater than that for all drivers who are twenty-five years of age or more."²²⁴

ASI argued that Baker's failure to disclose her son at the time of the application on April 9, 2003 was not a material misrepresentation because he did not receive his learner's permit until May 14, 2003. The evidence, however, was that Baker's son was driving his mother's vehicle even before he received his learner's permit. And even if he was not a driver as of the date of the application, Baker had a post-application obligation to update United Auto with the new driver information.²²⁵ The court held that "[e]ven assuming it was not a material misrepresentation to omit [her son] as an operator on the April 9, 2003, application, [Baker] had an obligation, as a condition of the policy, to inform [United Auto] once [her son] did begin driving the vehicle."²²⁶ Moreover, the amended declarations page issued as a result of the May 4, 2003, request to update the vehicle information stated that the "insured warrants that there are no other drivers in the household other than those listed in the application or

²²⁰ *Id.*

²²¹ 215 Ill. Comp. Stat. 5/154 (West 2011).

²²² *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 29, 947 N.E.2d 382, 385 (1st Dist. 2011).

²²³ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 32, 947 N.E.2d 382, 387 (1st Dist. 2011).

²²⁴ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 33, 947 N.E.2d 382, 388 (1st Dist. 2011).

²²⁵ *Id.*

²²⁶ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 34, 947 N.E.2d 382, 389 (1st Dist. 2011).

endorsement.”²²⁷ As a result of Baker’s failure to disclose her son as a driver, United Auto had a right to rescind the policy.²²⁸

ASI next argued that United Auto waived its right to rescind by failing to promptly act when it learned, shortly after the light pole accident of June 10, 2003, that Baker’s son was driving the vehicle. In rejecting the waiver argument, the court held that Section 154 allows an insurer up to one year to rescind.²²⁹ “The statute does not merely create a bar for when an insurance policy can no longer be rescinded. As stated in *Illinois State Bar Ass’n Mutual Insurance Co. v. Coregis Insurance Co.*,²³⁰ the legislature created a time period, namely, one year, that satisfies ‘prompt’ rescission.”²³¹ Because United Auto’s rescission was less than one year after Janice’s misrepresentation, it was timely and not waived.²³²

D. UM/UIM Statute of Limitations

In *Country Preferred Insurance Co. v. Whitehead*,²³³ the defendant, presumably an Illinois resident, although not stated in the opinion, was in a car accident in Wisconsin on July 27, 2007. The other vehicle was driven by an uninsured motorist. Whitehead was insured by Country Preferred, whose policy provided that disputes with uninsured motorists were to be decided by arbitration. A different provision of the policy, also relating to uninsured coverage, stated that “any suit, action or arbitration will be barred unless commenced within two years from the date of the accident.”²³⁴

Whitehead notified Country Preferred of her accident shortly after it occurred. A claim number was assigned and Country Preferred corresponded with Whitehead on numerous occasions. On October 6, 2009, Whitehead’s counsel made a written demand for arbitration on Whitehead’s uninsured motorist claim. Country Preferred immediately filed a declaratory judgment action alleging that Whitehead was barred from making an uninsured motorist claim under her policy because she had not made a written demand for arbitration within two years of the accident.

²²⁷ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 947 N.E.2d 382 (1st Dist. 2011).

²²⁸ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 35, 947 N.E.2d 382, 389 (1st Dist. 2011).

²²⁹ *Id.*

²³⁰ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 947 N.E.2d 382 (1st Dist. 2011), quoting *Illinois State Bar Ass’n Mut. Ins. Co. v. Coregis Ins. Co.*, 355 Ill. App. 3d 156, 821 N.E.2d 706 (1st Dist. 2004).

²³¹ *American Service Ins. Co. v. United Auto. Ins. Co.*, 409 Ill. App. 3d 27, 36, 947 N.E.2d 382, 390 (1st Dist. 2011).

²³² *Id.*

²³³ *Country Preferred Ins. Co. v. Whitehead*, 955 N.E.2d 689 (3d Dist. 2011).

²³⁴ *Id.* at 690.

In the trial court, Whitehead filed a motion to compel arbitration, which was denied.²³⁵

On appeal, the Third District relied on the often stated principle that “where a provision of an insurance contract is in conflict with public policy, courts will not enforce it.” The court discussed the Illinois requirement that insurers offer uninsured motorist coverage in all automobile policies and the public policy behind such coverage to “place the injured party in substantially the same position he would have been in if the uninsured driver had been insured.” The court held that “[a]n insurance policy violates Illinois public policy when it places an injured party in a substantially different position than if the tortfeasor had carried insurance.”²³⁶

The issue, as framed by the Third District, was “whether Illinois public policy is served when an insurance policy limits coverage to two years when an accident occurred in a state that has a three-year statute of limitations.”²³⁷ The court discussed the holdings in *Burgo v. Illinois Farmers Insurance Co.* and *Severs v. Country Mutual Insurance Company*. In *Burgo*, the First District held that a provision requiring insureds to demand arbitration within one year of an accident violated Illinois’s uninsured motorist statute because it shortened the applicable two-year statute of limitations.²³⁸ In *Severs*, the Supreme Court held that a two-year contractual limitation against a minor was unenforceable because it shortened the time within which the minor was required to file suit.²³⁹ The Third District relied on the explanation given by the *Severs* court that the uninsured motorist statute requires that the minor be allowed the same period of time within which to bring the suit as the minor would have had if the driver had been insured.²⁴⁰

The Third District found that the two-year period contained in the policy violated public policy as to Whitehead because it effectively shortened the applicable Wisconsin statute of limitations from three years to two years.²⁴¹ In rejecting Country Preferred’s arguments that two-year contract limitation periods have been approved by Illinois courts, the court distinguished those decisions on the basis that the contractual limitation was the same length as the statute of limitations for personal injuries occurring

²³⁵ *Id.*

²³⁶ *Id.* at 691.

²³⁷ *Id.*

²³⁸ *Country Preferred Ins. Co. v. Whitehead*, 955 N.E.2d 689 (3d Dist. 2011), quoting *Burgo v. Illinois Farmers Insurance Co.*, 8 Ill. App. 3d 259, 263-64, 290 N.E.2d 371, 374 (1st Dist. 1972).

²³⁹ *Country Preferred Ins. Co. v. Whitehead*, 955 N.E.2d 689 (3d Dist. 2011), quoting *Severs v. Country Mut. Ins. Co.*, 89 Ill. 2d 515, 519-20, 434 N.E.2d 290, 291-292 (1982).

²⁴⁰ *Country Preferred Ins. Co. v. Whitehead*, 955 N.E.2d 689, 691 (3d Dist. 2011).

²⁴¹ *Id.* at 692.

in Illinois.²⁴² The court found Whitehead's situation distinguishable, because the two-year limitation period in the policy was less than the three-year statute of limitations in Wisconsin.²⁴³ The Third District reversed and remanded.

Justice McDade dissented. In her dissent, Justice McDade stated that she did not believe that an Illinois court could use a foreign jurisdiction's laws to establish a violation of Illinois public policy.²⁴⁴ She agreed with Country Preferred's reading of Illinois case law finding a two-year contractual limitation not to violate Illinois public policy.²⁴⁵ Additionally, Justice McDade criticized the majority for not performing a conflict of laws analysis and stated that it was inappropriate to assume the applicability of Wisconsin law.²⁴⁶

E. Interrelation with Workers Compensation Insurance

In *Burcham v. West Bend Mutual Insurance Co.*,²⁴⁷ the plaintiff, Burcham, was involved in a motor vehicle accident with an uninsured driver. At the time of the accident, Burcham was driving a vehicle owned by his employer, P&M Mercury Mechanical Corporation ("P&M") within the scope of his employment. As a result of the accident, Burcham underwent several surgeries and was still off-work at the time of the appeal in this case.²⁴⁸

P&M had a workers' compensation policy with West Bend Mutual Insurance Company ("West Bend"), as well as an auto policy providing uninsured ("UM") and underinsured ("UIM") motorist coverage. Under the workers' compensation policy, West Bend paid Burcham \$490,879.71 for medical expenses, which amount was discounted from \$679,404.67 in charges from the various medical providers. Under the workers' compensation policy, West Bend also paid Burcham over \$100,000 in temporary total incapacity for work payments and was continuing to pay him a weekly amount while the workers' compensation claim was still open because no permanency award had been made. In addition to workers' compensation coverage, Burcham sought UM coverage from West Bend through P&M's auto policy. Central to the dispute, the policy contained the following limitation provision: "We will not pay for any element of 'loss' if

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.* at 694.

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Burcham v. West Bend Mut. Ins. Co.*, 961 N.E.2d 453 (2d Dist. 2011).

²⁴⁸ *Burcham v. West Bend Mut. Ins. Co.*, 961 N.E.2d 453, 455 (2d Dist. 2011).

a person is entitled to receive payment for the same element of 'loss' under any workers' compensation, disability benefits or similar law."²⁴⁹

Burcham filed a declaratory judgment action against West Bend to determine what elements of loss he would be entitled to claim in the arbitration of his UM claim. In particular, he sought a declaration that he was eligible to seek UM coverage for: (1) disfigurement resulting from his injuries; (2) loss of a normal life experienced and reasonably certain to be experienced in the future; (3) increased risk of future harm resulting from the injuries; (4) pain and suffering experienced and reasonably certain to be experienced in the future; (5) the reasonable expense of medical care received and the present cash value of treatment reasonably certain to be received in the future; and (6) the value of earnings and benefits lost and the present cash value of those reasonably certain to be lost in the future. Plaintiff alleged that compensation for these elements of loss would not be duplicative payments for the same elements of loss compensated in his workers' compensation claim, and he sought a declaration to this effect.²⁵⁰

On cross-motions for summary judgment, the trial court entered an order finding that Burcham was entitled to make claims in the UM arbitration for the following elements of loss: (1) disfigurement not awarded in his workers' compensation claim; (2) loss of a normal life; (3) increased risk of future harm; (4) pain and suffering; (5) the discounted amount of the medical expenses totaling \$188,524.96, and (6) loss of earnings in excess of the amount actually paid in his workers' compensation claim.²⁵¹ West Bend appealed, arguing that the trial court erred in entering summary judgment for Burcham and allowing him to claim damages for disfigurement, loss of a normal life, the discounted amount of medical expenses, and loss of earnings greater than the amount paid from workers' compensation.²⁵² West Bend did not dispute the trial court's grant of summary judgment for the claim for increased risk of future harm or for pain and suffering.²⁵³

With respect to disfigurement, the appellate court held that, while disfigurement may be compensated in some workers' compensation claims, no amount is payable when there is workers' compensation for wage loss differential, loss of use of a body part, or permanent disability.²⁵⁴ Therefore, the court agreed with the trial court that Burcham would be

²⁴⁹ *Id.*

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *Id.* at 456.

allowed to seek compensation in his UM arbitration for any disfigurement not awarded in the workers' compensation proceeding.²⁵⁵

As to the loss of normal life element, the appellate court agreed with West Bend that the trial court erred. "Loss of normal life" and "disability" are phrases for the same element of loss. Because disability is payable under the Workers' Compensation Act, Burcham could not seek recovery for loss of normal life in his UM claim.²⁵⁶

As to medical expenses, West Bend argued that the trial court erred in declaring that Burcham could seek in his UM claim the difference of \$188,524.96 between the billed medical expenses and the negotiated amount paid under the workers' compensation claim. The appellate court agreed with West Bend that the plain and ordinary meaning of the phrase "element of loss" used in the UM coverage limitation would include the broad category of medical expenses, regardless of the dollar amount paid. In contrast, the UIM coverage of the policy contained a setoff for amounts "paid or payable" under worker's compensation.²⁵⁷ For Burcham to obtain the difference between the billed rate and the amount paid would give no meaning to the "element of loss" phrase in the UM limitation and would treat the provision the same as the setoff in the UIM coverage, which it clearly is not. Further, Burcham's reliance on the collateral source rule as set forth in *Wills v. Foster*,²⁵⁸ is misplaced because a UM claim is not a tort claim like in *Wills*, but rather a contract matter.²⁵⁹

Finally, as to lost earnings, West Bend argued that the trial court erred in ruling that Burcham could claim in the UM arbitration the loss of earnings in excess of the amount actually paid on his workers' compensation claim. Consistent with the appellate courts analysis of medical payments, the court agree with West bend that loss of earnings would be a category of loss included in the phrase "element of loss."²⁶⁰ Regardless of the dollar amount, Burcham is receiving payment for lost earnings under the Workers' Compensation Act and, pursuant to the policy limitation, may not seek such damages in the UM arbitration.²⁶¹ Just as with his argument regarding medical payments, Burcham's interpretation would treat the limitation provision as a setoff provision, which is contrary to the provision's plain language.²⁶² Therefore, the trial court erred in

²⁵⁵ *Id.*

²⁵⁶ *Id.* at 457.

²⁵⁷ *Id.*

²⁵⁸ *Burcham v. West Bend Mut. Ins. Co.*, 961 N.E.2d 453 (2d Dist. 2011), quoting *Wills v. Foster*, 229 Ill. 2d 393, 892 N.E.2d 1018 (2008).

²⁵⁹ *Burcham v. West Bend Mut. Ins. Co.*, 961 N.E.2d 453, 458 (2d Dist. 2011).

²⁶⁰ *Id.* at 459.

²⁶¹ *Id.*

²⁶² *Id.*

holding that Burcham could claim in arbitration the loss of earnings over the amount paid in his workers' compensation case.²⁶³

Justice McLaren partially dissented from the court's construction of "element of loss," believing it ambiguous, and would have allowed Burcham to attempt to recover in the UM claim the full amount of both his medical expenses and his lost wages.²⁶⁴

F. Spoliation

In *Universal Underwriters Ins. Co. v. LKQ Smart Parts*,²⁶⁵ the plaintiff ("Universal") brought an action for declaratory judgment against its insured, LKQ Corporation, and its subsidiary, LKQ Smart Parts, Inc., (collectively "LKQ"), and a putative additional insured, Illinois Farmers Insurance Company ("Farmers"), seeking a declaration that its insurance policy did not cover a spoliation of evidence claim brought against LKQ and Farmers arising out of a passenger's death in a single-car rollover accident. The decedent's father filed a wrongful death lawsuit against Nissan alleging the accident was caused by a defect in the vehicle. The car was destroyed while at LKQ's salvage yard, and the estate alleged spoliation of evidence against LKQ and Farmers, the insurer of the vehicle.²⁶⁶

Universal argued that the spoliation claim involved loss of value of the plaintiff's cause of action, which did not involve "physical damage" to "tangible property." On cross-motions for summary judgment, the trial court found that the policy did not cover the spoliation claim and, as a result, Universal had no duty to defend or indemnify LKQ or Farmers. The trial court granted summary judgment in favor of Universal and denied LKQ's and Farmers' cross-motions.²⁶⁷

LKQ appealed and the First District reversed. LKQ argued that coverage existed under the "Auto Inventory Physical Damage" policy part, which requires Universal to pay for "LOSS of or to a COVERED AUTO from any cause, including sums an INSURED legally must pay as damages as a result of LOSS to a CUSTOMER'S AUTO * * *." The policy further provided:

COVERED AUTO means an AUTO (1) owned by or acquired by YOU or (2) not owned by YOU but in YOUR care, custody, or control.

²⁶³ *Id.*

²⁶⁴ *Id.* at 460.

²⁶⁵ *Universal Underwriters Ins. Co. v. LKQ Smart Parts*, 963 N.E.2d 930 (1st Dist. 2011).

²⁶⁶ *Id.* at 933.

²⁶⁷ *Id.* at 935.

CUSTOMER'S AUTO means a COVERED AUTO not owned or acquired by YOU but in YOUR care, custody or control for safekeeping, storage, service or repair.

* * *

LOSS means direct and accidental physical loss or damage, occurring during the Coverage Part period. LOSS, with respect to a CUSTOMER'S AUTO, includes resulting loss of use.²⁶⁸

In finding coverage under the auto inventory policy, the court noted that the underlying action alleged that the plaintiff had lost the use of the vehicle because of its destruction and that it was no longer available for testing or inspection by plaintiff's experts.²⁶⁹ The court thus rejected Universal's argument that there was no physical injury to tangible property.²⁷⁰ The court found that the complaint clearly alleged "loss" by alleging physical loss or damage in describing the destruction of the vehicle.²⁷¹ It also alleged resulting loss of use when it described plaintiff's inability to use the vehicle in support of his products liability claim.²⁷²

In reaching that conclusion, the court distinguished two other Illinois appellate court cases involving spoliation that had found no coverage under CGL policies—*Essex Insurance Co. v. Wright*,²⁷³ and *United Fire & Casualty Co. v. Keeley & Sons, Inc.*²⁷⁴ While the court agreed that *Essex* found that the claim for spoliation, like the claim for spoliation before it, could be described as seeking recovery for the diminution of value of the product liability claim resulting from the destruction of evidence, the plaintiff here did not argue that the products liability claim was the "property" that was damaged.²⁷⁵ LKQ instead argued that the destruction of the vehicle and the resulting inability to use it in the lawsuit constituted "loss" under the policy.²⁷⁶ The court also distinguished *Keeley & Sons*, where the insured also argued that the property at issue was the underlying cause of action, in order to avoid the "care, custody or control" exclusion in the policy.²⁷⁷ Having found a duty to defend and indemnify, the court

²⁶⁸ *Id.*

²⁶⁹ *Id.*

²⁷⁰ *Id.* at 939.

²⁷¹ *Id.*

²⁷² *Id.*

²⁷³ *Universal Underwriters Ins. Co. v. LKQ Smart Parts*, 963 N.E.2d 930 (1st Dist. 2011), quoting *Essex Ins. Co. v. Wright*, 371 Ill. App. 3d 437, 862 N.E.2d 1194 (1st Dist. 2007).

²⁷⁴ *Universal Underwriters Ins. Co. v. LKQ Smart Parts*, 963 N.E.2d 930 (1st Dist. 2011), quoting *United Fire & Cas. Co. v. Keeley & Sons, Inc.*, 381 Ill. App. 3d 1119, 887 N.E.2d 911 (5th Dist. 2008).

²⁷⁵ *Universal Underwriters Ins. Co. v. LKQ Smart Parts*, 963 N.E.2d 930, 941 (1st Dist. 2011).

²⁷⁶ *Id.* at 942.

²⁷⁷ *Id.*

remanded the case to the trial court for a determination on whether the settlement amount was reasonable under the circumstances.²⁷⁸

G. Arbitration (UIM)

In *Phoenix Insurance Company (“Phoenix”) v. Rosen*,²⁷⁹ Ms. Rosen was injured by an underinsured vehicle and made a claim under the underinsured-motorist provision of her Phoenix policy. The Phoenix policy contained an arbitration agreement provision that stated arbitration was binding only if the amount awarded did not exceed the minimum limit for bodily injury liability specified by the Illinois Safety Responsibility Law. If the amount exceeded that statutory minimum limit, arbitration would not be considered binding and either party could demand the right to a trial *de novo*. At arbitration, Rosen was awarded \$382,500.00 and Phoenix filed a complaint rejecting the award and demanded a jury trial. Rosen asserted in an affirmative defense that the “trial *de novo*” provision was invalid and unenforceable as against public policy. Rosen also filed a counterclaim seeking to enforce the arbitration award. The trial court struck the affirmative defense and dismissed the counterclaim.²⁸⁰

The First District Appellate Court reversed and found that the trial *de novo* provision unfairly favored the insurer because while an award of \$20,000 or less was binding on the insured, the insurer was free to reject an award above \$20,000. The Appellate Court also ruled the trial *de novo* provision violated public policy considerations favoring arbitration. The Illinois Supreme Court reversed the First District Appellate Court and affirmed the trial court, holding that the trial *de novo* clause was valid and enforceable as part of underinsured motorist arbitration. The Supreme Court noted that a similar clause was required as part of uninsured motorist arbitration under the Insurance Code and upheld in a previous ruling of the Supreme Court in *Reed v. Illinois Farmers Ins. Co.*²⁸¹

Although underinsured motorist arbitration was not mandated by statute, public policy favored arbitration.²⁸² In addition, the underinsured motorist statute was closely linked to the uninsured motorist statute.²⁸³ The Supreme Court reasoned that because public policy, as laid out by the legislature in the Insurance Code, required the trial *de novo* clause in an uninsured motorist arbitration, it would be inconsistent to hold that a similar

²⁷⁸ *Id.* at 944.

²⁷⁹ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 949 N.E.2d 639 (2011).

²⁸⁰ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 53, 949 N.E.2d 639, 644 (2011).

²⁸¹ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 949 N.E.2d 639 (2011), quoting *Reed v. Farmers Insurance Group*, 88 Ill.2d 168, 175, 720 N.E.2d 1052, (1999).

²⁸² *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 59, 949 N.E.2d 639, 647 (2011).

²⁸³ *Id.*

provision violated public policy when part of the underinsured motorist arbitration.²⁸⁴

The arbitration clause at issue in *Phoenix* promoted the public policy concept behind arbitration because it ensured that awards that were \$20,000 and less were resolved efficiently and with finality.²⁸⁵ While the insurer may benefit when the arbitration resulted in a damage award of \$20,000 or less, the court stated that, nevertheless, the insured has been fully compensated from the tortfeasor's liability insurance.²⁸⁶ Underinsured motorist coverage is not a guarantee that the insured will recover in excess of the statutory minimum limits of bodily injury liability.²⁸⁷

Finally, the Supreme Court refused to invalidate the clause on the grounds that the insurance policy was a contract of adhesion.²⁸⁸ The Supreme Court found that the clause was not so one-sided as to be unconscionable when both, the insured and the insurer, have the same exact right, both had the ability to reject awards above \$20,000.²⁸⁹ In sum, a provision in an underinsured-motorist policy that allows either party to reject an award over the statutory minimum for liability coverage and request a trial is not unconscionable and does not violate public policy.²⁹⁰

VII. BAD FAITH

*American Safety Casualty Insurance Co. v. City of Waukegan*²⁹¹ provides an analysis of the scope of expert opinion concerning insurance claim practices in the context of insurance coverage and bad faith. American Safety Casualty Insurance Company ("American Safety") filed a complaint against the City of Waukegan seeking a declaration that it did not owe coverage for a verdict entered against Waukegan in a civil lawsuit. Waukegan's expert, Donald Brayer, prepared a report addressing various claim handling issues. American Safety and other insurers filed a motion to strike Brayer's report because they claimed it consisted of inadmissible legal conclusions.²⁹²

Expert testimony is allowed when it helps the trier of fact understand the evidence or determine a fact in issue. However, interpretation of an insurance policy is a question of law.²⁹³ "Although experts may provide

²⁸⁴ *Id.*

²⁸⁵ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 67, 949 N.E.2d 651 (2011).

²⁸⁶ *Id.*

²⁸⁷ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 69, 949 N.E.2d 639, 652 (2011).

²⁸⁸ *Id.*

²⁸⁹ *Phoenix Ins. Co. v. Rosen*, 242 Ill.2d 48, 75, 949 N.E.2d 639, 656 (2011).

²⁹⁰ *Id.*

²⁹¹ *American Safety Cas. Ins. Co. v. City of Waukegan*, 776 F.Supp.2d 670 (N.D. Ill. 2011).

²⁹² *Id.* at 676.

²⁹³ *Id.* at 695.

opinions as to the ultimate issues in a case, they may not testify as to legal conclusions that will determine the outcome of the case.”²⁹⁴

The court found that the sections of Brayer’s report detailing the customs and standards for claim handling were a proper subject for expert opinion.²⁹⁵ These sections described in general terms principles employed by claim handlers and the liability claim handling process. Further, it was proper for Brayer to describe how a claims handler determines coverage under an occurrence-based policy.²⁹⁶ This type of information is helpful to the trier of fact in understanding general principles that claim handlers use in analyzing claims.²⁹⁷

Expert testimony is improper, however, when stating legal conclusions based upon contract interpretation.²⁹⁸ Opinions about the legal obligations and duties under an insurance policy are improper legal conclusions. “Argument about the meaning of contracts belongs in briefs, not in expert reports” and contract interpretation is a question of law to be resolved by the court.²⁹⁹ “The interpretation of an insurer’s policy is a legal rather than factual question that must be determined by the court.”³⁰⁰ For example, an opinion that a claims handler should have recognized that a policy term was ambiguous is a legal conclusion.³⁰¹

The court found that Brayer’s analysis with regard to insurance policy language and what a reasonable claims handler would conclude about coverage was essentially contract interpretation and therefore an improper legal conclusion.³⁰² But, Brayer’s analysis of the procedures employed by the claims handlers in determining coverage was a proper subject for expert testimony. An expert may testify to the customs and standards of an industry and opine as to how a party’s conduct measured up against the standards.³⁰³ For instance, in a bad faith case, the expert may testify to the insurer’s failure to comply with industry standards and why such failure supported a finding that the insurer acted in bad faith, so long as the expert did not instruct the jury as to the applicable law and make an ultimate conclusion that the insurer acted in bad faith.³⁰⁴

²⁹⁴ *Id.* at 677.

²⁹⁵ *Id.*

²⁹⁶ *Id.* at 678.

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ *Id.* at 697.

³⁰⁰ *Id.*

³⁰¹ *Id.*

³⁰² *Id.* at 698.

³⁰³ *Id.*

³⁰⁴ *Id.* at 700.

VIII. CONCLUSION

Illinois courts have continued to develop our state's body of insurance law in a number of key areas, and this guidance will no doubt assist both policyholders and insurers alike in construing their insurance policies and in evaluating actual or potential disputes under those policies. The 2011 calendar year provided instructive case law in the area of insurance law.