



25th Annual Claims Handling Seminars

FIGHTING THE STRATEGIC BATTLE TO WIN THE WAR

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INSURANCE COVERAGE UPDATE

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INSURANCE COVERAGE UPDATE

| | | |
|-------------|--|------|
| I. | WHO IS AN INSURED – ADDITIONAL INSURED PROVISIONS | D-4 |
| A. | <i>National Fire Ins. of Hartford v. Walsh Const. Co.</i> | D-4 |
| B. | <i>Pekin Ins. Co. v. Hallmark Homes L.L.C.</i> | D-4 |
| II. | SCOPE OF THE INSURING AGREEMENT..... | D-6 |
| A. | Property Damage Caused by an Occurrence | D-6 |
| 1. | Damage to "Other Property" in Construction Setting: <i>CMK Development Corp. v. West Bend Mut. Ins. Co.</i> | D-6 |
| 2. | Misrepresentation During Sale of Real Estate: <i>Rock v. State Farm Fire and Cas. Co.</i> | D-7 |
| B. | Coverage for Qui Tam Actions..... | D-7 |
| 1. | <i>Health Care Industry Liability Ins. Program v. Momence Meadows Nursing Center, Inc.</i> | D-7 |
| 2. | <i>ISMIE Mut. Ins. Co. v. Michaelis Jackson & Associates, LLC</i> | D-9 |
| C. | Scope of Professional Liability Coverage for Lawyers..... | D-9 |
| 1. | <i>Continental Cas. Co. v. Donald T. Bertucci, Ltd.</i> | D-9 |
| 2. | <i>Illinois State Bar Ass'n Mut. Ins. Co. v. Mondo</i> | D-10 |
| III. | NOTICE PROVISIONS: <i>AMERICAN STANDARD INS. CO. OF WISCONSIN V. SLIFER</i> | D-11 |
| IV. | EXCLUSIONS | D-11 |
| A. | Criminal Acts Exclusion: <i>Allstate Ins. Co. v. Greer</i> | D-11 |
| B. | Intentional Acts Exclusion with Self-Defense Exception: <i>Pekin Ins. Co. v. Wilson</i> | D-12 |
| C. | Assumed Liability Exclusion: <i>American Family Mut. Ins. Co. v. Fisher Development, Inc.</i> | D-13 |

| | | |
|-------------|--|------|
| V. | COVERAGE LITIGATION ISSUES..... | D-14 |
| A. | Ripeness of Declaratory Judgment Actions: <i>Gregory v. Farmers Auto. Ins. Ass'n</i> | D-14 |
| B. | Determination of Duty to Defend: <i>Farmers Auto. Ins. Ass'n v. Danner</i> | D-14 |
| C. | Attorney/Client Privilege: <i>Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.</i> | D-15 |
| D. | Conflicts of Interest | D-16 |
| 1. | Right to Independent Counsel: <i>National Cas. Co. v. Forge Indus. Staffing Inc.</i> | D-16 |
| 2. | Defense of Multiple Insureds: <i>Country Mut. Ins. Co. v. Olsak</i> | D-16 |
| E. | Settlement by the Insured: <i>Federal Ins. Co. v. Binney & Smith, Inc.</i> | D-17 |
| VI. | INTERACTIONS BETWEEN MULTIPLE INSURERS..... | D-18 |
| A. | Targeted Tender Rule | D-18 |
| 1. | Deselection: <i>State Auto Property & Cas. Ins. Co. v. Springfield Fire & Cas. Co.</i> | D-18 |
| 2. | Excess Insurance: <i>River Village I, LLC v. Central Ins. Companies</i> | D-18 |
| B. | Doctrine of Equitable Contribution: <i>American States Ins. Co. v. CFM Const. Co.</i> | D-19 |
| VII. | VEXATIOUS AND UNREASONABLE DELAY: SECTION 155 OF THE INSURANCE CODE..... | D-20 |
| A. | Standing to Bring Section 155 Claim: <i>Statewide Ins. Co. v. Houston General Ins. Co.</i> | D-20 |
| B. | Defense to Section 155 Claim: <i>American Service Ins. Co. v. Franchini</i> | D-20 |

INSURANCE COVERAGE UPDATE

I. WHO IS AN INSURED – ADDITIONAL INSURED PROVISIONS

A. *National Fire Ins. of Hartford v. Walsh Const. Co.*

In *National Fire Ins. of Hartford v. Walsh Const. Co.*, 392 Ill. App. 3d 312, 909 N.E.2d 285, 330 Ill. Dec. 572 (1st Dist. 2009) – a subcontractor added a premises owner and general contractor as additional insureds under its CGL policy. The additional insured endorsement of the CGL policy read as follows:

That person or organization is an additional insured solely for liability due to [the subcontractor's] negligence and specifically resulting from 'your work' for the additional insured which is the subject of the written contract or written agreement. No coverage applies to liability resulting from the sole negligence of the additional insured.

After an employee of the subcontractor was injured at the construction site, the employee sued the premises owner and general contractor. According to the employee's complaint, the general contractor's negligence caused his injuries, and the premises owner was vicariously liable for the general contractor's negligence. The complaint contained no factual allegations that might support a claim of negligence against the subcontractor. The insurer filed a complaint for declaratory judgment asserting that it had no duty to defend the premises owner or general contractor under the additional insured endorsement.

The Appellate Court concurred with the insurer's position. According to the court, "this is a case where the alleged negligence falls on no one other than the general contractor" and the "complaint reveals no factual allegation on which the defendants might hang [the subcontractor's] potential liability." As a consequence, without allegations that the subcontractor was negligent, the premises owner and general contractor did not qualify as additional insureds under the terms of the CGL policy. Furthermore, the Appellate Court rejected the general contractor's position "that the mere fact that an employee of a primary insured is injured on the jobsite is, by itself, sufficient to give rise to an inference of negligence on the part of [the primary insured] so as to trigger a duty to defend on the part of" the insurer. "More than some unspecified breach of the subcontractor's duty to provide a safe work place is required to support a claim that the negligence complaint implicates negligence on the part of the subcontractor, too."

B. *Pekin Ins. Co. v. Hallmark Homes L.L.C.*

In *Pekin Ins. Co. v. Hallmark Homes, L.L.C.*, 392 Ill. App. 3d 589, 912 N.E.2d 250, 322 Ill. Dec. 64 (2d Dist. 2009) – a general contractor was named as an additional insured under a

subcontractor's liability insurance policy. The additional insured endorsement naming the general contractor stated:

1. Who is An Additional Insured (Section II) is amended to include as an insured any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy. *Such person or organization is an additional insured only with respect to liability incurred solely as a result of some act or omission of the named insured and not for its own independent negligence or statutory violation.* (emphasis added).

A worker at the construction site suffered an injury and sued both the general contractor and subcontractor. The complaint against the contractor alleged two theories of relief. The first theory sought relief pursuant to Restatement (Second) of Torts § 414, which states:

One who entrusts work to an independent contractor, but who retains the control of any part of the work, is subject to liability for physical harm to others for whose safety the employer owes a duty to exercise reasonable care, which is caused by his failure to exercise his control with reasonable care.

The second theory sought relief pursuant to Restatement (Second) of Torts § 343,

under which a person who owns, possesses, or otherwise has control over land may be liable to someone who is injured on the land, if the first person knew or reasonably should have known of the dangerous condition that caused the injury and should have expected that others would be injured but failed to take adequate safety measures.

The complaint also contained a theory against the subcontractor nearly identical to the theory against the contractor pursuant to Restatement (Second) of Torts § 343.

After the general contractor sought a defense under the additional insured endorsement, the subcontractor's insurer filed a complaint for declaratory judgment asserting that it had no duty to defend the contractor. The insurer reasoned that, "because the complaint against [the contractor] alleged that [the contractor's] own negligence made it liable [to the injured worker], any possible liability could not be based solely on the negligence of [the subcontractor], as required by the endorsement." The Appellate Court disagreed and found that a duty to defend existed. According to the Appellate Court, the theory of liability against the contractor brought pursuant to Restatement (Second) of Torts § 414 could potentially impose vicarious liability onto the contractor "solely on the basis of the acts or omissions" of the subcontractor. Consequently, "[a]s at least one of the theories of negligence alleged against [the contractor] could rest solely on the acts or omissions of the named insured, [the insurer] has a duty to defend [the contractor] against all of the claims raised against it by [the injured worker]."

In rendering this ruling, the Appellate Court rejected the insurer's argument that "it need not defend [the contractor] unless the allegations of the underlying complaint specifically identify a scenario in which [the contractor's] liability rests solely on [the subcontractor's] negligence." The court reasoned that it must read the complaint against the contractor "liberally" to determine whether it alleges facts "within or *potentially* within coverage." (emphasis in original). According to the court, viewed liberally, the complaint alleged facts potentially within the scope of coverage. Moreover, the Appellate Court rebuffed the insurer's citation to "a 'whole host of decisions' . . . [holding that], where a complaint alleges that the additional insured was itself negligent, the complaint is not within the scope of the insurance provided to additional insureds." First, the court found that these cases were distinguishable based on the terms of the policies involved and facts alleged in the underlying complaints. Second, the Appellate Court found that these decisions "rest on an unduly restrictive application of the principles laid out by" the Illinois Supreme Court when determining the existence of a duty to defend. Specifically, these decisions failed "to interpret the allegations of the underlying complaints and the language of the insurance policies liberally when determining whether the insurers owe a duty to defend."

II. SCOPE OF THE INSURING AGREEMENT

A. Property Damage Caused by an Occurrence

1. Damage to "Other Property" in Construction Setting: *CMK Development Corp. v. West Bend Mut. Ins. Co.*

In *CMK Development Corp. v. West Bend Mut. Ins. Co.*, 395 Ill. App. 3d 830, 917 N.E.2d 1155, 335 Ill. Dec. 91 (1st Dist. 2009) – a contractor was insured under a CGL policy that only applied to property damage if the "'property damage' [was] caused by an 'occurrence.'" "Occurrence" was defined as "an accident" by the policy. After the contractor built a home for a buyer, the buyer submitted a list of defects with the home. Eventually, the disagreement between the buyer and contractor resulted in an arbitration. Prior to the arbitration, the contractor submitted the claim to its insurer, who denied coverage. The contractor filed suit against the insurer, and the trial court ruled in favor of the insurer.

The Appellate Court affirmed, reasoning that, in a construction setting, damage to "other property" does constitute "property damage" caused by an "occurrence." Coverage for damage to "other property," however, "is not intended to cover the insured's contractual liability when its completed project does not meet the bargained-for standard." Likewise, "[i]f the homeowners are pursuing a breach of contract claim in order to recover the loss due to the repair or replacement of the defective work or the diminished value of their home, there is no coverage." Rather, to qualify for the damage to other property rule, "[t]here must be damage to something other than the structure." In this case, the facts did not warrant the application of the damage to other property rule. The defects identified by the buyer were defects resulting from the

contractor's faulty workmanship in constructing the buyer's home; they were not damage to "other property." As such, no coverage existed.

2. Misrepresentation During Sale of Real Estate: *Rock v. State Farm Fire and Cas. Co.*

In *Rock v. State Farm Fire and Cas. Co.*, 395 Ill. App. 3d 145, 917 N.E.2d 610, 334 Ill. Dec. 784 (3d Dist. 2009) – sellers were insured under a homeowner's policy that provided coverage "if a claim is made or a suit is brought against an insured for damages because of . . . property damage . . . caused by an occurrence." The policy defined property damage as "physical damage to or destruction of tangible property, including loss of use of this property." After the sellers sold their home to buyers, the buyers sued the sellers alleging that they had falsely represented "that there were no moisture or water problems in any area of the home, there was no damage due to flood, there were no hazardous conditions such as mold, and there were no foundation problems." The sellers' insurer denied the claim, and the sellers filed a complaint for declaratory judgment. The Appellate Court ruled that no coverage existed under the policy.

According to the court, even if the misrepresentations qualified as an "occurrence" under the policy, they did not cause "property damage." For example, "the underlying complaint [did] not allege that the purportedly false statements made by the [sellers] caused any physical damage to or destruction to tangible property" and made "no reference to any physical damage to the house incurred after these statements were made." Instead, the complaint "alleged that the misrepresentations by the [sellers] caused the [buyers] to suffer economic losses stemming from their assertions that they relied upon the allegedly false statements made by the [sellers] when purchasing the home and, thus, they did not receive the value for which they bargained."

Furthermore, the court found that the inclusion of "loss of use" within the definition of "property damage" did not alter the analysis. According to the court, under the plain language of the definition of "property damage," "the phrase 'loss of use of this property' refers back to the first part of the definition of property damage as physical damage to tangible property." As a result, "[t]he loss of use of property must accompany the physical damage or destruction of that property." In this case, although the buyers claimed loss of use as part of their damages, because the complaint did not allege physical damage caused by an occurrence, the loss of use claim could not qualify as a separate claim for property damage to trigger coverage.

B. Coverage for Qui Tam Actions

1. *Health Care Industry Liability Ins. Program v. Momence Meadows Nursing Center, Inc.*

In *Health Care Industry Liability Ins. Program v. Momence Meadows Nursing Center, Inc.*, 566 F.3d 689 (7th Cir. 2009) – a nursing center was insured under a professional liability policy and CGL policy. Within the professional liability policy, the insurer promised to "pay those sums that the insured becomes legally obligated to pay as damage because of injury to which this insurance

applies.” For the professional liability policy to apply, “[t]he injury must be caused by a ‘medical incident,’” and “[t]he ‘medical incident’ must arise out of the providing or withholding of the following professional services: Medical, surgical, dental, or nursing treatment to a person.” Furthermore, under the CGL, the insurer agreed to “pay those sums that the insured becomes legally obligated to pay as damages because of ‘bodily injury’ . . . to which this insurance applies.” The policy defined “bodily injury” as “bodily injury, sickness or disease sustained by a person.”

Two employees brought a qui tam action against the nursing center alleging that the nursing center was submitting false claims to Medicare and Medicaid. The false claims stemmed from the center’s false certification “on its annual cost reports that it was meeting the required standard of care when, in fact, [the nursing center] knew that it was not.” The required standard of care was not met because the nursing center “failed to maintain the minimum [required] staffing . . . , failed to ensure its residents received their medications. . . , failed to ensure residents received adequate nutrition and assistance with meals, and failed to provide the residents with clean and dry beds, clothes, and regular baths.” As a result of these failures, the nursing center patients suffered from various maladies, including “scabies, sepsis, seizures, and death.”

After the nursing center submitted the qui tam lawsuit to its professional liability and CGL carrier, the insurer denied coverage and filed a declaratory judgment action. The district court found in favor of the insurer, and the Seventh Circuit Court of Appeals affirmed. The Seventh Circuit determined that the qui tam action did not allege an injury caused by a “medical incident” within the meaning of the professional liability policy or the possible obligation to pay “damages because of bodily injury” within the meaning of the CGL policy. In doing so, the court rejected the nursing center’s argument that the allegations of harm to nursing center residents were sufficient to trigger coverage. According to the Seventh Circuit,

The injuries to the residents as alleged by the plaintiffs relate back to [the nursing center’s] cost reports to the government where it certified that it provided quality services and care. Plaintiffs claim [the nursing center] knew that was false. The statutory damages they seek result from those allegedly false filings, and *not* from any alleged bodily injury to the residents. Although the allegations in the underlying complaint detailing the injuries suffered by [the nursing center’s] residents put a human touch on the otherwise administrative act of false billing, they need not be proven by the plaintiff to prevail. . . . [A]ll the plaintiffs need to show is that [the nursing center] billed the government for services and a level of care that it knew it was not providing.

The Seventh Circuit also noted that its decision conformed with other court decisions that “have recognized this distinction between the proof required for the [qui tam] claim and the conduct underlying the false claims.” These other courts have “uniformly [held] that an insurer is not obligated to defend a qui tam suit merely because the insurer would have to defend the insured against a suit for damages resulting from the insured’s conduct underlying the qui tam action.”

2. ISMIE Mut. Ins. Co. v. Michaelis Jackson & Associates, LLC

In *ISMIE Mut. Ins. Co. v. Michaelis Jackson & Associates, LLC*, No. 5-08-0426, 2009 WL 5185380 (5th Dist. Dec. 30, 2009) – a physician was insured under a professional liability policy wherein the insurer agreed to:

pay amounts any 'insured' is legally obligated to pay as 'damages' because of any 'claim' against that 'insured' . . . which involves 'personal injury' and is caused by 'professional services' . . .

The policy defined "damages" as "monetary compensation which is owed as a result of 'personal injury'" and defined "personal injury" as "bodily injury to . . . any patient . . . which arises out of the rendering or failure to render" care.

Two employees brought a qui tam action against the physician for performing unnecessary surgeries and submitting them for compensation under Medicare. When the physician submitted the qui tam action to his professional liability carrier, the insurer denied the claim and filed a declaratory judgment action. Adopting the reasoning set forth in *Health Care Industry Liability Ins. Program v. Momen Meadows Nursing Center, Inc.*, the Appellate Court found that no coverage existed under the professional liability policy. According to the court, "the plaintiffs in the underlying case here . . . do not seek damages for personal injury caused by medical care falling below the requisite standard of care, nor could they, because they do not have standing to sue on behalf of these patients." Moreover, the court concluded that "the proof required to sustain a claim for personal injuries, like a medical malpractice claim, is clearly distinct from the proof required for a claim for false filings of claims for medical reimbursement."

C. Scope of Professional Liability Coverage for Lawyers

1. Continental Cas. Co. v. Donald T. Bertucci, Ltd.

In *Continental Cas. Co. v. Donald T. Bertucci, Ltd.*, No. 1-09-502, 2010 WL 1033448 (1st Dist. March 19, 2010) – a lawyer was an insured under a professional liability policy that provided coverage under its insuring agreement for "all sums . . . that the Insured shall become legally obligated to pay as damages . . . because of a claim . . . by reason of any act or omission in the performance of legal services by the Insured." "Legal services" were defined as "those services performed by an Insured for others as a lawyer, arbitrator, mediator, title agent or as a notary public." "Damages" were defined as "judgments, awards and settlements" and did not include "legal fees, costs and expenses . . . charged by the Insured . . . and injuries that are a consequence of any of the foregoing."

A former client filed a lawsuit against the lawyer. The lawyer had represented the client during a medical malpractice case that settled for \$2.25 million, and the lawyer retained \$750,000 of the settlement as his fee. According to the lawsuit, the lawyer's retention of \$750,000 as a fee

violated an Illinois statute governing fees in medical malpractice cases and the client's fee agreement with the lawyer. The former client sued the lawyer for breach of contract, unjust enrichment, conversion, breach of fiduciary duty, fraud, and violation of the medical malpractice fee statute. The lawyer submitted the claim to his legal malpractice insurer, and the malpractice insurer denied the claim.

In the subsequent declaratory judgment action, the Appellate Court found that no coverage existed under the policy. First, the court found that the underlying complaint did not allege "damages" as defined by the policy because it sought the recovery of excessive legal fees and consequential damages caused by the excessive fees. The court also found that the suit did not allege "an act or omission in the performance of legal services by the Insured." When making this ruling, the court recognized a dichotomy between billing and professional services performed by a lawyer. While quoting a Massachusetts court, the Appellate Court stated:

[Professional acts or services require] specialized knowledge and skill that is acquired through rigorous intellectual training. [citation omitted] The setting for the intellectual training is often an academic one, as in architectural school, engineering school, law school, or medical school.

Against those criteria we decide that the billing function of a lawyer is not a professional service. Billing for legal services does not draw on special learning acquired through rigorous intellectual training. We are not aware that courses in billing clients appear in law school curricula. The billing function is largely ministerial. There are elements of experience and judgment in billing for legal services, but the same goes for pricing shoes. As billing is not a professional service, it does not come with the coverage of a professional liability insurance policy.

2. *Illinois State Bar Ass'n Mut. Ins. Co. v. Mondo*

In *Illinois State Bar Ass'n Mut. Ins. Co. v. Mondo*, 392 Ill. App. 3d 1032, 911 N.E.2d 1144, 331 Ill. Dec. 914 (1st Dist. 2009) – a lawyer was insured by a legal malpractice policy that covered "DAMAGES and CLAIM EXPENSES . . . which [the insured became] legally obligated to pay as a result of a CLAIM . . . provided that: 1. The CLAIM arises out of a WRONGFUL ACT." The Policy defined "WRONGFUL ACT" as "any actual or alleged negligent act, error, or omission in the rendering of or failure to render PROFESSIONAL SERVICES." PROFESSIONAL SERVICES was defined as "services rendered by [the insured] as a lawyer . . ." The lawyer operated a consulting business that provided advice concerning the design and operation of insurance plans. One of the consulting business's clients sued the lawyer and the consulting business for wrongfully convincing the client to become self-insured and to hire an administrator to manage the self-insurance program. The lawyer also failed to disclose that he had a business interest in the recommended administrator. The complaint alleged various theories of relief, including counts for fraud, breach of contract, malpractice as an insurance broker, and malpractice as a lawyer.

The lawyer submitted the claim to his malpractice insurer, and the malpractice insurer denied the claim.

In the ensuing declaratory judgment action, the Appellate Court agreed with the insurer that no coverage under the policy existed. The court reasoned, in part, that, “[i]n reading the complaint as a whole, . . . it is clear that the true nature of the complaint is related to [the insured’s] performance of duties related to his capacity as an insurance expert and not in any capacity related to his status as an attorney despite the inclusion of” the legal malpractice count.

III. NOTICE PROVISIONS: *AMERICAN STANDARD INS. CO. OF WISCONSIN V. SLIFER*

In *American Standard Ins. Co. of Wisconsin v. Slifer*, 395 Ill. App. 3d 1056, 919 N.E.2d 372, 335 Ill. Dec. 653 (4th Dist. 2009) – an insured was covered by an auto policy that stated on the first page:

IF YOU HAVE AN AUTO ACCIDENT OR LOSS NOTIFY US.

Tell us promptly. Give time, place, and details. Include names and addresses of injured persons and witnesses.

This notice provision appeared before the insuring agreement of the policy. In 2002, the insured was involved in a hit-and-run accident where he killed a pedestrian. He did not report the accident to his insurer. In 2007, he confessed to the police that he was the driver of the vehicle involved in the accident. In 2007, after the insured was sued by the pedestrian’s estate, he submitted the claim to his auto insurer. The auto insurer filed a declaratory judgment action asserting that the insured forfeited coverage. The Appellate Court agreed, finding that the 5 year delay in reporting the accident constituted a breach of the notice provision. Furthermore, the Appellate Court rejected the insured’s contention that the language of the notice provision was ambiguous because it was placed before the insuring agreement and that the notice language was insufficiently imperative to be contractually binding on the insured.

IV. EXCLUSIONS

A. Criminal Acts Exclusion: *Allstate Ins. Co. v. Greer*

In *Allstate Ins. Co. v. Greer*, 396 Ill. App. 3d 1037, 921 N.E.2d 793, 336 Ill. Dec. 937 (3d Dist. 2009) – the insureds were covered by a homeowners policy that excluded coverage for “bodily injury or property damage intended by, or which may reasonably be expected to result from the *intentional or criminal acts* or omissions of, any insured person.” This exclusion further stated that it “applie[d] regardless of whether or not such insured person is actually charged with, or convicted of a crime.” A suit was filed against the insureds. According to the suit, the insureds negligently and willfully supplied alcohol to a seventeen year old teenager, “causing him to

become intoxicated and impaired." The teenager's intoxication led to his death in a motor vehicle accident. In Illinois, supplying alcohol to a minor is a crime. After the insureds submitted a claim, their homeowners insurer denied that it had a duty to defend. According to the insurer, "(1) the statute creating liability in the lawsuit required a criminal act, (2) the insurance policy excluded coverage for conduct constituting a criminal act, and (3) the exclusion applied regardless of whether the insured was ever charged or convicted for the criminal act."

During the declaratory judgment action, the Appellate Court concurred with the insurer and found that "a comparison of the allegations in the underlying complaint to the provisions of the insurance policy show[ed] that [the insurer] does not have a duty to defend." According to the court, "[i]n the underlying complaint, the decedent's parents alleged that the [insureds] were liable for damages because they supplied alcoholic beverages to the decedent, causing him to become intoxicated and impaired, which caused him to die while driving a motor vehicle." The court found that "[t]hese allegations describe criminal conduct," and, "[b]y its plain language, the insurance policy excludes coverage for criminal acts." Furthermore, it was irrelevant to the court that the allegations of the complaint did not assert that the insureds intended to injure the teenager because the policy contained "a criminal-act exclusion under which coverage would be barred irrespective of its intentional-act exclusion."

B. Intentional Acts Exclusion with Self-Defense Exception: *Pekin Ins. Co. v. Wilson*

In *Pekin Ins. Co. v. Wilson*, 391 Ill. App. 3d 505, 909 N.E.2d 379, 330 Ill. Dec. 666 (5th Dist. 2009) – the insured was covered under two policies. The first policy contained an exclusion precluding coverage for bodily injury "expected or intended from the standpoint of the insured." The intended acts exclusion of this policy, however, contained a self-defense exception allowing coverage for "'bodily injury' resulting from the use of reasonable force to protect persons or property." The second policy contained an intended acts exclusion precluding coverage for bodily injury that was "expected or intended by the insured." The second policy had no self-defense exception.

A complaint was filed against the insured alleging assault, battery, intentional infliction of emotion distress, and negligence. The facts of the complaint asserted that the insured "screamed expletives at" the plaintiff, "struck him with [a] pipe," "lacerated his hand with a knife," "threatened to go home to get a gun to shoot" the plaintiff, and actually threatened the plaintiff with a gun a year later. Within the negligence count, the complaint "realleged all the factual assertions from the intentional torts counts" but also asserted that the insured "breached his duty of ordinary care by failing to 'adequately use tools of his employment in a safe manner[,] causing physical harm.'" In response to the complaint, the insured filed a counter-claim where he asserted that he acted in self-defense during his encounters with the plaintiff.

In the ensuing declaratory judgment action, the Appellate Court found that a duty to defend existed under the first policy but not the second policy. It first reasoned that complaint clearly

alleged facts falling within the intentional acts exclusions of both policies. According to the court,

The amended complaint in the underlying lawsuit alleges that [the insured] intentionally assaulted, battered, and inflicted emotional distress on [the plaintiff] and that he negligently used and maintained the tools of his employment, causing injury to [the plaintiff]. [The insurers] contend that the negligence count should not be considered because it is a “transparent attempt to trigger insurance coverage.” They argue that the negligence count, which was not added until after they had filed their declaratory judgment action, alleges only intentional conduct, regardless of the label [the plaintiff] applied to it. We agree. “The factual allegations of the complaint, rather than the legal theory under which the action is brought, determine whether there is a duty to defend.”

The court, however, found that the self-defense exception created a duty to defend for the first insurer. In doing so, the court rejected the first insurer’s argument that court could not look at the insured’s counter-claim to determine the applicability of self-defense exception. The court stated that the insurer “drafted and sold an insurance policy that excludes coverage for intentional conduct by the insured unless the insured used reasonable force to protect persons or property.” As such, the court needed to “consider the facts alleged in the underlying lawsuit as a whole, including the allegations in [the insured’s] counterclaim or any other defense he might plead; otherwise, the self-defense exception is largely a nullity and without any meaning.”

C. Assumed Liability Exclusion: *American Family Mut. Ins. Co. v. Fisher Development, Inc.*

In *American Family Mut. Ins. Co. v. Fisher Development, Inc.*, 391 Ill. App. 3d 521, 909 N.E.2d 274, 330 Ill. Dec. 561 (1st Dist. 2009), a general contractor entered into a construction contract with a premises owner wherein the general contractor agreed

to indemnify and hold harmless [the premises owner] . . . from and against any and all liability . . . resulting from (i) personal injury . . . arising in whole or in part by reason of, or in any way resulting from, the performance of the [contracted work], whether by [the general contractor] or by any subcontractor, or anyone directly or indirectly employed by either of them.

The general contractor was also named as an additional insured on a subcontractor’s CGL policy. The CGL policy contained an assumed liability exclusion “excluding coverage for liability for bodily injury ‘for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement.’” This exclusion contained an exception for “liability for damages[] [t]hat the insured would have in the absence of the contract or agreement.”

During the construction work, employees of the premises owner were injured. The injured employees brought a civil action against the general contractor and subcontractor and workers’

compensation claims against the premises owner. During the litigation, the premises owner brought suit against the general contractor pursuant to the above-referenced indemnity agreement. In its action, the premises owner asserted that the general contractor needed to indemnify the premises owner for the workers' compensation awards. When the general contractor submitted the premises owner's claim to the CGL insurer, the CGL insurer filed a complaint for declaratory judgment based on the policy's assumed liability exclusion.

The Appellate Court found that the assumed liability exclusion applied and that the CGL insurer had no duty to defend the general contractor. According to the court, the general contractor assumed liability through its indemnification agreement with the premises owner. Moreover, the exception to the assumed liability exclusion did not apply because the indemnification agreement imposed liability onto the general contractor that the general contractor would not have had in the absence of the agreement.

V. COVERAGE LITIGATION ISSUES

A. Ripeness of Declaratory Judgment Actions: *Gregory v. Farmers Auto. Ins. Ass'n*

In *Gregory v. Farmers Auto. Ins. Ass'n*, 392 Ill. App. 3d 159, 910 N.E.2d 763, 331 Ill. Dec. 354 (5th Dist. 2009) – the insured was covered by a personal auto policy and business auto policy. After the insured was sued in a personal injury action, the insurer provided a defense to the insured under the personal auto policy. During the pendency of the personal injury action, the insured filed a declaratory judgment action seeking a declaration that the insurer had to indemnify the insured under the business auto policy. The insurer moved to dismiss the declaratory judgment action as being premature. The Appellate Court agreed with the insurer. It ruled that, while a court can determine an insurer's duty to defend "upon the filing of a complaint against the insured, a declaratory judgment action brought to determine an insurer's duty to indemnify an insured is not ripe for adjudication until an insured becomes legally obligated to pay the damages in the underlying action."

B. Determination of Duty to Defend: *Farmers Auto. Ins. Ass'n v. Danner*

In *Farmers Auto. Ins. Ass'n v. Danner*, 394 Ill. App. 3d 403 (4th Dist. 2009) – the insured was covered under a policy that only covered bodily injury "caused by an occurrence" and excluded claims for bodily injury "which [was] expected or intended by an 'insured.'" The policy also provided that the insurer would "provide a defense at [its] expense by counsel of [its] choice, even if the suit is groundless, false[,] or fraudulent." After the insured was sued in a complaint only alleging battery, the insurer filed a declaratory judgment action asserting that it had no duty to defend. The trial court denied the insurer relief, finding:

1. That the underlying complaint . . . set forth allegations that are intentional in nature and, as such, are otherwise excluded from coverage under [the insurer's] policies of insurance.
2. That, notwithstanding the above finding by this court, the relevant provision of the . . . policies of insurance . . . states that [the insurer] owes a duty to defend its insureds, 'even if the suit is groundless, false[,] or fraudulent.

The Appellate Court reversed. According to the court, "construing the policy as a whole, the duty-to-defend provision clearly provides that [the insurer] will defend an *otherwise covered claim* or suit even if the allegations are groundless, false, or fraudulent." (emphasis added). On the other hand, "[t]he language in the policies [did] not impose a duty to defend a claim or suit against an insured for damages because of bodily injury that were not caused by an 'occurrence.'" As a consequence, "the trial court erred by reading the duty-to-defend language to impose a duty to defend any groundless, false, or fraudulent suit regardless of whether the bodily injury was caused by an 'occurrence.'"

C. Attorney/Client Privilege: *Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.*

In *Illinois Emcasco Ins. Co. v. Nationwide Mut. Ins. Co.*, 393 Ill. App. 3d 782, 913 N.E.2d 1102, 332 Ill. Dec. 812 (1st Dist. 2009) – two insurers became intertwined in an action for declaratory judgment after the resolution of a lawsuit against a contractor who was an insured under each insurer's policy. During the declaratory judgment action, one insurer served discovery seeking disclosure of all documents "which [bore] in any way upon the underlying case or insurance coverage touching upon or in any way related to tenders of defense and/or coverage afforded to" the insured. After the other insurer refused to produce communications between it and its coverage counsel, the insurer that served the discovery filed a motion to compel. The trial court granted the motion, but the Appellate Court reversed.

According to the Appellate Court, the common interest doctrine applies in Illinois. Under the common interest doctrine, "when an attorney acts for two different parties who each have a common interest, communications by either party to the attorney are not necessarily privileged in a subsequent controversy between the two parties." The court found that this was especially true "where an insured and his insurer initially have a common interest in defending an action against the former, and there is a possibility that those communications might play a role in a subsequent action between the insured and his insurer." On the other hand, the attorney/client and work product privileges "bar disclosure of any communications or materials generated in preparation for [a subsequent] declaratory judgment action."

Furthermore, the court found that the hiring of separate "coverage counsel" does not automatically bar the disclosure of communications between coverage counsel and the insurer. Instead, it ultimately depends on whether the communication was made in preparation for the declaratory judgment action or for the benefit of both the insured and insurer. During discovery

disputes, the trial court can make this determination during an *in camera* inspection of the documents. After enunciating these principles, the Appellate Court vacated the trial court's discovery order and remanded the case back to the trial court to reconsider the discovery dispute in light of the court's opinion.

D. Conflicts of Interest

1. Right to Independent Counsel: *National Cas. Co. v. Forge Indus. Staffing Inc.*

In *National Cas. Co. v. Forge Indus. Staffing, Inc.*, 567 F.3d 871 (7th Cir. 2009) – the insured was covered by an Employment Practices Liability policy that provided coverage “for intentional acts, including intentional torts such as intentionally discriminating against one of its employees.” The policy, however, excluded coverage if the insured “‘willfully failed’ to adhere to anti-discrimination laws.” The policy also did not cover awards of punitive damages. Employees of the insured filed charges with the EEOC, asserting that the insured fired them because of “their race and/or gender” and “in retaliation for complaining about [the insured’s] staffing practices, which allegedly included honoring its clients’ requests not to staff employees that were African-American, Hispanic, and/or female.” The insured requested that the insurer provide independent counsel during the EEOC proceedings. After the insurer refused, the insured filed a complaint for declaratory judgment seeking the appointment of independent counsel.

On appeal, the Seventh Circuit Court of Appeals found that the circumstances did not demand the appointment of independent counsel. First, the court concluded that the mere possibility that a claim for punitive damages could arise during a civil lawsuit following the EEOC proceedings was insufficient to create a conflict situation requiring the appointment of independent counsel. Moreover, the exclusion for willful violation of discrimination laws, by itself, did not justify the appointment of independent counsel. The EEOC complaint did not present charges that the insured “willfully violated the law” and did not contain “mutually exclusive theories of liability” or “factual allegations which when resolved would preclude coverage.” In Illinois, however, “if no fact issues appear on the face of the underlying complaint that can be conclusively resolved in such a way that insurance coverage is necessarily precluded under the policy, then appointment of independent counsel is not warranted.”

2. Defense of Multiple Insureds: *Country Mut. Ins. Co. v. Olsak*

In *Country Mut. Ins. Co. v. Olsak*, 391 Ill. App. 3d 295, 908 N.E.2d 1091, 330 Ill. Dec. 433 (1st Dist. 2009) – a hockey player attacked his hockey coach. The hockey player's father served on the board supervising the hockey team. The hockey player's father was also insured under a homeowners' insurance policy. The hockey coach sued the hockey player for battery and sued the board supervising the hockey team and the father, individually, for negligence.

During litigation against the father's insurer, the Appellate Court found that the hockey coach's lawsuit created a conflict of interest for the insurer. The court concluded that the insurer owed a

defense to two insureds (the father and son) whose interests were opposed. For instance, according to the court, it was in the board's and the father's best interest "to argue that [the hockey player] acted with the intent to deliberately injure [the hockey coach] and that the altercation was an isolated act of violence that fell outside a master-servant relationship" between the hockey player and "the hockey club and [father], as an agent and board member." Conversely, it was within the hockey player's best interest to show that he did not act intentionally, that he acted in self-defense, and that he "did not receive adequate discipline or management from [the father] and the other members of the board." The divergence of the insureds' interests presented the insurer "with an ethical conflict where it could not choose a defense strategy in the underlying litigation without harming either" of the insureds. The court also found that the insurer "failed to disclose this conflict to [the son] and obtain his consent" to represent him despite the conflict.

E. Settlement by the Insured: *Federal Ins. Co. v. Binney & Smith, Inc.*

In *Federal Ins. Co. v. Binney & Smith, Inc.*, 393 Ill. App. 3d 277, 913 N.E.2d 43, 332 Ill. Dec. 448 (1st Dist. 2009) – after reports that trace levels of asbestos were found within crayons made by the insured, plaintiffs brought class action lawsuits against the insured based on consumer fraud and breach of express and implied warranties. During various policy periods, the insured had been covered by a CGL policy issued by the insurer. In September 19, 2000, the insurer filed a declaratory judgment action asserting that it had no duty to defend or indemnify the insured during these class actions. In December 2000, the insured settled the class action lawsuits, and the settlement was subsequently approved by the trial court. After the settlement of the class actions, the insured argued that the insurer should compensate it for the full cost of the settlements. The trial court in the declaratory judgment action ruled in favor of the insureds.

Although the Appellate Court affirmed the trial court in part and reversed in part, it found that the settlements were reasonable. In Illinois, "[if] an insured settles an underlying claim prior to verdict, [to qualify for coverage,] it must show that it settled an otherwise covered loss in 'reasonable anticipation of liability.'" When meeting this burden, the insured need not establish actual liability to the party with whom it has settled "so long as a potential liability on the facts known to the [insured is] shown to exist, culminating in an amount reasonable in view of the size of possible recovery and degree of probability of claimants success against the insured."

The burden to satisfy this test falls on the insured, but the insurer "retains the right to rebut any preliminary showing of reasonableness with its own affirmative evidence bearing on the reasonableness of the settlement agreement." With these principles in mind, although the insured had defenses to the class action, the court found that the insured had settled the case in reasonable anticipation of liability given the uncertainty involved in any litigation and the doubt that the insured would have an absolute defense to liability.

VI. INTERACTIONS BETWEEN MULTIPLE INSURERS

A. Targeted Tender Rule

1. Deselection: *State Auto Property & Cas. Ins. Co. v. Springfield Fire & Cas. Co.*

In *State Auto Property & Cas. Co. v. Springfield Fire & Cas. Co.*, 394 Ill. App. 3d 414, 916 N.E.2d 157, 334 Ill. Dec. 124 (4th Dist. 2009) – a contractor was a named insured under its own CGL policy and an additional insured under a subcontractor’s CGL policy. The contractor’s CGL policy contained an “other insurance” clause. Operation of the “other insurance” clause necessitated that “other valid or collectible insurance [was] available.” The contractor also paid the premiums for its coverage under both policies. After the contractor was sued by the estate of a worker who died at the construction site, it deselected coverage under the subcontractor’s policy and only sought coverage under its own policy. The contractor’s insurer filed a declaratory judgment action contesting the contractor’s right to deselect coverage under the subcontractor’s policy.

The Appellate Court found that deselection was appropriate. According to the court, a named insured can deselect coverage where it has either paid the premiums for each policy or has “negotiated for the contracted right to be named on another’s policy.” As such, in this case, because the contractor was a named insured and had paid for the premiums for each policy, it had the right to deselect coverage under one policy in favor of exclusive coverage under the other policy. Furthermore, the presence of the “other insurance” clause did not affect the analysis. Because the contractor did not trigger coverage under the subcontractor’s policy, it “left itself with coverage through only its” own policy. Consequently, “no other insurance was ‘available,’ as that term [was] used in the” insurer’s policy.

2. Excess Insurance: *River Village I, LLC v. Central Ins. Companies*

In *River Village I, LLC v. Central Ins. Companies*, 396 Ill. App. 3d 480, 919 N.E.2d 426, 335 Ill. Dec. 707 (1st Dist. 2009) – a general contractor was an insured under its own CGL policy and an additional insured under a subcontractor’s CGL policy. The additional insured endorsement under the subcontractor’s CGL policy contained the following excess insurance clause:

This insurance is excess over: Any other valid and collectible insurance available to the additional insured whether primary, excess, contingent or on any other basis unless a contract specifically requires that this insurance be either primary or primary and noncontributing.

There was no contract that required the additional insured endorsement to provide primary insurance. After the general contractor was sued for injuries suffered during a construction accident, it attempted to target tender the subcontractor’s CGL policy. The subcontractor’s insurer filed a declaratory judgment action resisting the contractor’s target tender.

The Appellate Court agreed with the subcontractor's insurer. According to the Appellate Court, "when an insured has maintained concurrent primary insurance among multiple insurers, the presence of an 'other insurance' excess provision in one insurer's policy does not, in and of itself, overcome the insured's right to targeted tender." On the other hand,

when the insurers do not stand in the same position with respect to a potential duty of coverage, . . . an insured cannot use his targeted tender right to choose to impose a coverage duty on an insurer with an 'other insurance' excess provision in its policy to the exclusion of other co-insurers with which he holds primary policies.

In this case, because the subcontractor's policy only provided excess coverage and the contractor's own policy provided primary coverage, the contractor could not use his right to target tender to select the subcontractor's policy.

B. Doctrine of Equitable Contribution: *American States Ins. Co. v. CFM Const. Co.*

In *American States Ins. Co. v. CFM Const. Co.*, 923 N.E.2d 299, 337 Ill. Dec. 740 (2d Dist. 2010) – a general contractor was named as an additional insured under a policy issued to a subcontractor and a policy issued to an interior decorator. The general contractor hired the subcontractor to supervise the site. After an employee of the interior decorator fell at the work site and was injured, he sued the general contractor and the subcontractor. The suit alleged that each had "a duty to operate, manage, supervise, and control the construction site" and that their negligent breach of this duty led to the employee's injuries. When the general contractor submitted the claim to the interior decorator's insurer, the interior decorator's insurer requested that the subcontractor's insurer contribute to the defense. The subcontractor's insurer refused. Furthermore, when the case settled, the subcontractor's insurer refused to contribute to the settlement of the claims against the general contractor.

The interior decorator's insurer brought an equitable contribution claim against the subcontractor's insurer. The Appellate Court ruled that the insurer was entitled to equitable contribution. According to the Appellate Court, "[w]hen an insurer has paid the entire loss, the doctrine of equitable contribution allows it to be reimbursed by other insurers that are also liable for the loss." The doctrine "applies to multiple, concurrent insurance situations and is only available where the concurrent policies insure the same entities, the same interests, and the same risks." In this case, the court found that both insurers insured the same general contractor and the same risk.

VII. VEXATIOUS AND UNREASONABLE DELAY: SECTION 155 OF THE INSURANCE CODE

A. Standing to Bring Section 155 Claim: *Statewide Ins. Co. v. Houston General Ins. Co.*

In *Statewide Ins. Co. v. Houston General Ins. Co.*, 397 Ill. App. 3d 410, 920 N.E.2d 611, 336 Ill. Dec. 402 (1st Dist. 2009) – a general contractor was an insured under its own CGL policy and was an additional insured under a subcontractor’s policy. The general contractor was sued after a worker at the construction site suffered an injury. When the subcontractor’s insurer refused the defense of the general contractor after it made a selective tender, the general contractor’s insurer defended and indemnified the general contractor. When the general contractor’s insurer settled the claim, it took an assignment of the general contractor’s rights pursuant to section 155 of the Insurance Code against the subcontractor’s insurer. The general contractor’s insurer subsequently filed a declaratory judgment action against the subcontractor’s insurer and sought statutory damages pursuant to section 155. The trial court permitted the section 155 action, and the Appellate Court affirmed.

On appeal, the Appellate Court reasoned that “the remedy under section 155 is intended for the protection of both the insured and the assignee who succeeds to the insured’s position.” In this case, the terms of the settlement agreement assigned the general contractor’s insurer any rights that the general contractor would have against the subcontractor’s insurer. These rights included any right to recover statutory damages pursuant to section 155. Furthermore, the Appellate Court also rejected the argument that an assignee can only pursue a section 155 claim if it takes assignment from the insured as a judgment creditor. According to the court, the language of the statute did not support this interpretation. It also dismissed an argument that it is inappropriate for one of the insured’s insurers to take an assignment of a section 155 claim against another insurer.

B. Defense to Section 155 Claim: *American Service Ins. Co. v. Franchini*

In *American Service Ins. Co. v. Franchini*, 396 Ill. App. 3d 413, 920 N.E.2d 1142, 336 Ill. Dec. 552 (1st Dist. 2009) – the insured’s sister was involved in an accident while operating the insured’s vehicle, and the insured and his sister were subsequently sued. The insured’s sister resided with the insured and regularly operated his vehicle. This information, however, was withheld from the auto insurer when the insured applied for his policy. As a result, the insurer rescinded the policy and filed an action for declaratory judgment. The insurer nonetheless defended the insured and his sister under a reservation of rights. During the pendency of the litigation, the insurer received conflicting information about the sister’s residency on the date of the accident and the frequency with which she used the insured’s car. During the declaratory judgment action, the insured and his sister attempted to file a counter-claim seeking relief pursuant to 215 ILCS 5/155. The trial court denied their motion for leave, and the Appellate Court affirmed.

The Appellate Court reasoned that “[i]t is insufficient for a party to merely assert that the other party’s actions were ‘vexatious and unreasonable’ without also alleging facts supporting such a

claim.” The court found that the insured’s proposed counterclaim for section 155 damages lacked the facts necessary to state a claim. Indeed, to the court, the facts of the case suggested that the insurer had acted responsibly. According to the court,

[D]espite evidence of . . . misrepresentation by [the insured, the insurer] defended the [insured and his sister] against the lawsuit filed by the [plaintiffs], while reserving its right to cancel coverage should fraud or material misrepresentation by [the insured] be established. [The insurer] also filed this declaratory judgment action to have a court of law determine whether there had been such fraud or material misrepresentation. These actions by [the insurer] are precisely those endorsed by our supreme court . . . as those which a responsible insurance company should take.

Finally, the fact that the insured and his sister had to defend themselves during the declaratory judgment action was just part of the procedure for determining the insurer’s obligations under the policy and was insufficient to state a claim pursuant to section 155 of the Insurance Code.



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Patrick, a native of the Saint Louis area, has spent his entire legal career with Heyl Royster. He started as a law clerk in the Edwardsville office in 2002 and joined the firm as an associate in 2004. While in law school, Patrick also served as an Associate Editor for the *Washington University Global Studies Law Review*. At Heyl Royster, Patrick concentrates his practice on toxic tort matters, insurance coverage litigation, and complex civil litigation.

As part of his practice, Patrick routinely takes a lead role in the preparation and argument in significant pretrial motions and briefs, such as those involving issues concerning the doctrine of *forum non conveniens*, venue, the Illinois *Frye* doctrine, consumer fraud, choice-of-law issues, and insurance coverage matters. Patrick also regularly defends the firm's clients in depositions in asbestos litigation pending in Illinois and Missouri.

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