**Docket No. 125918**

**IN THE ILLINOIS SUPREME COURT**

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| ROSEMARIE HAAGE,<br>Plaintiff-Appellee,<br>v.<br><br>ALFONSO MONTIEL ZAVALA, PATRICIA SANTIAGO, JOSE PACHECO-VILLANUEVO, OKAN ESMEZ and ROSALINA ESMEZ,<br>Defendants,<br>and<br><br>STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,<br>Intervenor-Appellant. | On Rule 307 Interlocutory Appeal from the Circuit Court of the Nineteenth Judicial Circuit Lake County, Illinois<br><br>Consolidated Docket Nos. 2-19-0499 & 2-19-0500<br><br>Court No. 17 L 897<br><br>The Honorable Mitchell L. Hoffman, Judge Presiding |
| AGNIESZKA SURLOCK and EDWARD SURLOCK,<br>Plaintiffs-Appellees,<br>v.<br><br>DRAGOSLAV STARCEVIC,<br>Defendant,<br>and<br><br>STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,<br>Intervenor-Appellant. | On Rule 307 Interlocutory Appeal from the Circuit Court of the Nineteenth Judicial Circuit Lake County, Illinois<br><br>Consolidated Docket Nos. 2-19-0499 & 2-19-0500<br><br>Court No. 18 L 39<br><br>The Honorable Diane E. Winter, Judge Presiding |

# REPLY BRIEF OF INTERVENOR-APPELLANT

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**ORAL ARGUMENT REQUESTED**

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## REPLY BRIEF OF INTERVENOR-APPELLANT

## ARGUMENT

**Introduction and Standard of Review**

The threshold issue is the standard of appellate review. The appropriate standard is *de novo* because the appeals present issues requiring statutory construction. The appellate court applied that standard here. ¶¶ 38, 42.

Plaintiffs incorrectly assert that "the trial courts' entry of Plaintiffs' respective proposed QPOs and determination not to enter State Farm's proposed QPOs are subject to an abuse of discretion review" (Br., at 4). State Farm has not brought the appeals over a simple discovery dispute. Instead, the proper resolution of the appeals requires this Court to construe HIPAA, federal regulations, state insurance law, and state regulations. Under the applicable *de novo* standard, this Court does not defer to the trial court and determines the correctness of its ruling independently. *Advincula v. United Blood Servs*., 176 Ill. 2d 523, 526 (1996). *De novo* consideration means this Court performs the legal analysis the trial court would perform. *Khan v. BDO Seidman, LLP*, 408 Ill. App. 3d 564, 578 (1st Dist. 2011).

The effect of the Lake County protective orders, if upheld, nullifies laws and regulations authorizing or requiring insurers to retain PHI for lawful purposes under the Insurance Code. "Illinois has adopted a strong policy of regulating, controlling, and supervising the business of insurance because it affects the public interest." *Coronet Ins. Co. v. Washburn*, 201 Ill. App. 3d 633, 637-38 (1st Dist. 1990). To that end, the General Assembly enacted the Insurance Information and Privacy Protection ("IIPP") in Article XL

of the Insurance Code. The IIPP's stated purpose is to strike the appropriate balance between protecting individual privacy and the legitimate and important interests that insurers have in retaining PHI under the Insurance Code. 215 ILCS 5/1001 (West 2018). Section 1014 (215 ILCS 5/1014 (West 2018))[1] sets forth the narrow circumstances in which "personal or privileged information" can be disclosed, as Robert Wagner, a former Director of Insurance testified, subject to strict regulation by the Illinois Department of Insurance ("DOI") (R.C270-71, R.C431; R.C275-76, R.C436).

The Lake County protective orders require property and casualty insurers to return and destroy medical records obtained in discovery within 60 days of the entry of a final order and to refrain from using the information in those records for any reason other than the personal injury litigation. If the Lake County protective orders containing the "return-or destroy" provisions are upheld by this Court, it will mean that Illinois trial judges are free to impose restrictions that supersede the privacy laws and regulations that the General Assembly and insurance regulators have found are vital to the conduct and regulation of the insurance business. For this reason, the appeals present an important separation-of-powers issue for this Court to address. Under separation-of-powers principles, this Court reconciles any conflict between legislation and a judicial rule whenever possible. *Burger* v. *Lutheran Gen. Hosp*., 198 Ill. 2d 21, 33 (2001).

HIPAA and Illinois state insurance laws and regulations can be harmonized to permit property and casualty insurers to retain PHI for litigation and non-litigation purposes. HIPAA provides other ways to disclose PHI in a judicial proceeding without

[1] Section 1014 and other sections of the Insurance Code, along with insurance regulations cited herein, are included in the appendix to this reply brief for the Court's convenience.

requiring a qualified-protective order that prohibits property and casualty insurers from retaining, using, and disclosing PHI for lawful purposes outside the litigation.

The Cook County judiciary recognized that HIPAA does not conflict with Illinois insurance laws and regulations when it adopted a routine procedure for the entry of a medical protective order at the commencement of personal injury cases. The proposed protective order tendered by State Farm to the Lake County trial judges was patterned after the order routinely used in the Circuit Court of Cook County. The protective order used in the venue with the greatest volume of personal injury litigation in Illinois does not contain the return-or-destroy provision at issue. Instead, the order properly limits property and casualty insurers' retention of PHI only for the purposes specified under applicable Illinois laws or regulations. Accordingly, this case presents not only a separation of powers issue but also the opportunity for this Court to use its supervisory authority to resolve the conflict between the Cook and Lake County protective orders, establish uniform statewide standards, and correct the fundamental errors of law in the lower courts' decisions.

Because HIPAA does not require the return-or-destroy provisions at issue, Illinois insurance laws and regulations do not pose any obstacle to accomplishing and executing HIPAA's full purposes and objectives. The lower courts' finding of preemption stems from a conflict that does not exist and should be reversed under *de novo* review. This Court should remand with directions for the trial court in each case to enter the protective order tendered by State Farm, or to enter an order that does not have the return-or-destroy provisions at issue and expressly allows for the retention, use, and disclosure of PHI by insurers in conformity with all federal and state insurance laws and regulations.

## I. THE TRIAL COURT'S PROTECTIVE ORDERS CONFLICT WITH AND EFFECTIVELY NULLIFY THE LAWS AND REGULATIONS THAT AUTHORIZE PROPERTY AND CASUALTY INSURERS TO RETAIN PHI ONLY FOR PURPOSES SPECIFIED IN THE INSURANCE CODE

Plaintiffs argue (Br., at 29), and the appellate court found (¶ 52), that neither the Insurance Code nor regulations mandates the retention of PHI for any particular purpose. Section 1014 prohibits the re-disclosure of "personal or privileged information" unless "limited to that which is reasonably necessary" for specified purposes, including, *inter alia*, "to an insurance regulatory authority"; "a law enforcement authority or other governmental authority"; and as "otherwise permitted or required by law" (215 ILCS 5/1014(E)-G) (West 2018)). Retention is implicit in the statutory authorization for limited re-disclosure of PHI. There would be no reason for the General Assembly to limit re-disclosure under the Code if insurers could not lawfully retain the information in the first place. The very existence of the privacy protections in the IIPP and related regulations means insurers must be able to retain such information including medical records to comply with the uses specified.

### A. Property and Casualty Insurers Are Legally Required to Retain "Detailed Documentation" in Their Claim Files for Examination by Regulators

Plaintiffs argue that the "[d]etailed documentation" property and casualty insurers are legally required to retain in their claim files for audits and examination by DOI does not include PHI (Br., at 27). But section 919.40 defines "documentation" non-exhaustively to include a person's medical bills (50 Ill. Admins. Code 919.40 (2014)) and medical bills include PHI. 45 C.F.R. § 160.13 (2018). The requirement that insurers "shall" maintain "[d]etailed documentation" (containing PHI) means they "shall" also maintain PHI in each claim file. The one is inseparable from the other when DOI is examining claim files for

improper claim practices under section 154.6 of the Insurance Code. 215 ILCS 5/154.6 (West 2018).

The appellate court (¶ 54) and plaintiffs read section 919.30 (50 Ill. Admin. Code 919.30 (1989)) as directing examiners to look *only* at "claim data" (Br., at 27-28). But the open-ended language in section 919.30 allows examiners to look at the "[d]etailed documentation" necessary for the "reconstruction of the company's activities" for each claim file (R.C268; R.C273). Section 1014(E) contemplates such limited re-disclosure of PHI "to an insurance regulatory authority" but only as reasonably necessary to the audit.

Plaintiffs do not explain how DOI examiners can evaluate claim files for improper claim practices if they cannot look at the "[d]etailed documentation"—which may include a claimant's medical bills, but also medical history, test results, or physical or mental condition—which claim professionals use to evaluate and settle claims. Even without medical bills and records, claim files include the claim professionals' "notes and work papers" containing PHI taken from those records. Under the appellate court's holding, any "notes and work papers" containing PHI along with the records and bills themselves would have to be destroyed within 60 days of the end of the litigation.

Wagner testified that the regulations "effectively require insurers to maintain all records of each claim such that regulators can ascertain whether the claim was paid in timely fashion and in the correct amount" (R.C268; R.C273). The appellate court's interpretation rejects the experience of insurance regulators; places blinders on those who have the responsibility for determining whether an insurance company is properly and timely settling claims; and hinders the ability of insurance companies to defend their claims decisions. The appellate court's interpretation is unreasonable and should be rejected.

Plaintiffs' reliance on the FOIA responses from the State of Illinois Office of the Governor and the Illinois Department of Insurance is misplaced (Br., at 35-36). Plaintiffs rely on nothing more than FOIA responses to argue that insurers do not need to maintain PHI in their claim files (Br., at 35). The FOIA responses are not a legal interpretation of the insurance regulations and do not support their argument. The FOIA responses state that "examiners are instructed to collect claim files, which may or may not contain such [PHI] information. Any documents that may be responsive to [the FOIA] request are exam workpapers exempt from production pursuant to Section 7(1)(a) of FOIA and Section 132.5(f) of the Illinois Insurance Code [5 ILCS 140/7(1)(a); 215 ILCS 5/132.5(f)]" (R.C110; R.C114). In other words, the FOIA responses recognize that claim files contain PHI and confirm that insurers retain and re-disclose information—including PHI—as part of the audit process for improper claims practices. The fact that disciplinary action has not been taken against any insurer for failing to maintain PHI proves only that insurers' records retention practices comply with the law and does not contradict Wagner's testimony above.

### B. Property and Casualty Insurers Are Prohibited From Destroying Company "Records" Except in Conformity With the Requirements of the Insurance and Administrative Codes

Plaintiffs argue that because PHI is not specifically mentioned in the definition of "records" in section 901.10, PHI must be excluded from the definition in accordance with the maxim of *expressio unius est exclusio alterius* (Br., at 25). The maxim is a rule of construction, not a rule of law, used to resolve an ambiguity. *Haag v. Bd. of Educ. of Streator Elementary School*, 2017 IL App (3d) 150643, ¶ 17 (citing *Sulser v. Country Mut. Ins. Co.*, 147 Ill. 2d 548, 555 (1992). The maxim is inapplicable here. Nothing in the broad definition of "records" excludes "documentary materials" containing PHI.

Section 901.10 defines "records" as a domestic insurance company's "papers and documentary materials…received…in connection with the transaction of its business and preserved…as evidence…of decisions…or because of the informational data contained therein." 50 Ill. Adm. Code 901.10, codified at 7 Ill. Reg. 4213 (eff. Mar. 28, 1983). Plaintiffs, like the appellate court, fail to explain why medical records and bills would not fall within such all-inclusive terms of "informational data"—especially when any doubt is resolved in favor of treating "documentary materials" as "records" under section 901.10.

Relatedly, section 901.20 requires an insurer to retain "records" needed "for the final settlement or disposition of any claim" for the current year plus 5 years. 50 Ill. Adm. Code 901.20, amended in 40 Ill. Reg. 7895 (eff. May 23, 2016). Plaintiffs have no answer for Wagner's testimony[2] that medical bills and records must be retained for audits (R.C268; R.C276). Plaintiffs read section 901.20 as referring only to such "records" as executed releases (Br., at 27). But not every claim is disposed of by settlement. The broad wording of sections 901.10 and 901.20 encompasses more than settlement documents. Medical bills and records are "received" "in connection with" the company's claim "decisions" and "preserved" "because of the informational data contained therein" needed "for the final settlement *or* disposition" of any claim (emphasis added)." The regulation uses the disjunctive for a reason. Medical bills and records are needed for their "legal value" not only when the company settles but also when the claim is disposed of without settlement. Medical bills and records fall within the broad ambit of sections 901.10 and 901.20.

[2] Wagner's testimony distinguishes the state of the record here from *Small v. Ramsey*, 280 F.R.D. 264 (N.D. W.Va. 2012), where the district court noted that there was no "evidence before the court" to support the conclusion that medical records were necessary or required under section 910.10. *Id*. at 280.

Finally, plaintiffs argue that the burden of establishing improper claims practices is on a claimant who has the burden of proof (Br., at 30). Plaintiffs are confusing a bad-faith action against an insurance company with regulatory oversight of claims handling. Insurance regulators are not a "claimant" and entering a "new QPO" as plaintiffs suggest would not establish what medical bills and records (or claim notes containing PHI) were in the claim file when a HIPAA-qualified protective order required their destruction. Plaintiffs' argument only demonstrates the need for the retention of PHI in claim files not for 60 days but for the entire length of time required by Illinois law.

### C. The Trial Court's Protective Orders Impede Compliance With Federal Reporting Obligations

Plaintiffs argue that nothing of record suggests that there will be any conditional Medicare payments in the consolidated appeals (Br., at 33). This argument ignores that the same or similar order is now used in Lake County[3] and depending on how the appeals are resolved, the issue will be present and recurring whenever a court-approved protective order is entered at the start of the case.

The order State Farm tendered specifically authorizes the retention of PHI for "[l]egally required reporting to private, federal, or state governmental organizations, including health or medical insurance organizations, and to the Centers for Medicare and Medicaid Services (CMS)" (R.C25). Plaintiffs do not dispute that their order prohibits insurers from retaining medical records and bills regardless of the reason and that all such documentation must be destroyed within 60 days of the end of the litigation.

[3] The order in use is available at: https://www.lakecountycircuitclerk.org/docs/default-source/civil-small-claims/hipaa-qualified-protective-order.pdf?sfvrsn=0) (last visited on April 30, 2021).

Plaintiffs' argument against allowing property and casualty insurers to retain PHI to comply with the Medicare Secondary Payor Act ignores *Small*, 280 F.R.D. 264, where the district court held that the six-year retention period under West Virginia law would not impede an insurer's obligations to report settlements and judgments made to Medicare beneficiaries under 42 U.S.C. § 1395y(b)(8) (2010). *Id*. at 277. Based on *Small*, property and casualty insurers should be allowed to retain all medical records for a minimum period of six years, consistent with Illinois law under section 919.20.

### D. The Trial Court's Protective Orders Prevent Property and Casualty Insurers From Retaining, Using, and Disclosing PHI Which Is Necessary to Prevent Fraud and Carry Out Essential Insurance Functions

Plaintiffs assert that if an insurer "has a reasonable basis to believe that it is in possession of records" relevant to insurance fraud, it can seek to modify the order to share specific documents with the proper authorities (Br., at 31). Like the appellate court, plaintiffs do not explain how the fraud can be detected once the insurer destroys the records to comply with the Lake County orders' return-or-destroy provisions. Plaintiffs' argument only proves that the orders will frustrate fraud-detection despite the insurer's statutory duty to report factual information pertinent to suspected insurance fraud and criminal activity to law enforcement authorities. 215 ILCS 5/155.23(1)-(2) (West 2018); 215 ILCS 5/1014(C)(1), (F) (West 2018).

Plaintiffs' suggestion that State Farm is expanding the permitted use of PHI "for its own private business interests" lacks any support in the record (Br., at 32). If anything, the unrebutted affidavits from Wagner and high level ISO and NICB employees establish the importance of insurance-support organizations in aggregating data from claim files and

developing databases to detect patterns of fraudulent activity (R.C435, R.C440; R.C440, R.C445). Modern fraud detection involves the review and comparison of medical records to detect fraud, particularly broader schemes of fraud, which may be perpetrated by the health care provider or other actor, not necessarily the claimant. NICB Amicus Br. at 8-12. The return-or-destroy provisions will prevent the NICB from performing its job as the state-designated repository of questionable claim information and make such modern data-gathering impossible in combatting sophisticated fraud, including interstate fraud.

Finally, contrary to plaintiffs' argument, section 1014(I) authorizes re-disclosure of PHI for actuarial studies (215 ILCS 5/1014(I) (West 2018)), and Wagner testified that insurers use medical records for additional purposes, including rate-development and pricing reinsurance (R.C269; R.C274). He concluded that the retention of complete and accurate claim files promotes a heathy insurance marketplace (R.C269-70; R.C274-75).

### E. The Protective Order Tendered by State Farm Safeguards Plaintiffs' Right of Privacy Under Existing State Law While Allowing Insurers to Retain, Use, and Disclose PHI for Non-Litigation Purposes

Plaintiffs argue that privacy in medical records is a fundamental right under the Illinois Constitution and that State Farm's order violates the physician-patient privilege (Br., at 17-18). But only unreasonable invasions are prohibited and section 8-802(4) further provides that the privilege does not apply in any action in which "the patient's physical or mental condition is an issue." 735 ILCS 5/8-802(4) (West 2018). By filing suit, plaintiffs made their physical condition an issue and the litigation exception to the statute applied. *Palm v. Holocker*, 2018 IL 123152, ¶ 28. Whenever a plaintiff sues for damages on account of bodily injuries, the plaintiff cannot validly claim any greater expectation of privacy after

the lawsuit is filed than before it is filed. *Burger*, 198 Ill. 2d at 58. Indeed, filing a lawsuit diminishes, rather than increases, the expectations of privacy in information about the mental or physical condition(s) the plaintiff places at issue in the suit. *Id*. (citing *Petrillo v. Syntex Laboratories, Inc*., 148 Ill. App. 3d 581, 591 (1st Dist. 1986)).

In *Burger*, 198 Ill. 2d 21, this Court held that a statute allowing a hospital to collect PHI in connection with actual or threatened malpractice litigation and use the PHI for non-litigation purposes did not violate a patient's right of privacy. *Id*. at 59-60. There, the statute permitted intra-hospital communication of any patient's PHI to, among others:

> …those persons directly involved with providing treatment to the patient or processing the payment for that treatment, those parties responsible for peer review, utilization review, quality assurance, risk management or defense of claims brought against the hospital arising out of the care, and those parties required to be notified under the Abused and Neglected Child Reporting Act, the Illinois Sexually Transmissible Disease Control Act, or where otherwise authorized or required by law.

*Id*. at 26. In other words, the statute contemplated a range of uses—peer review, utilization review, risk management, and defense related to the hospital's function—which necessarily involved limited disclosures in conformity with regulatory requirements and ordinary hospital procedures.

Like plaintiffs and their amici here, the *Burger* plaintiff challenged the statute on grounds that, *inter alia*, disclosure and use of his PHI outside litigation violated his right of privacy under the Illinois Constitution. *Id*. at 50-51. The Court framed the question as whether the hospital had used PHI for "reasonable" or "legitimate" purposes:

> In light of the highly regulated environment in which hospitals operate, we conclude that it is reasonable and logical that hospital risk managers and hospital counsel interact on a regular basis with hospital employees, agents and staff concerning a wide array of issues which may require prompt legal guidance and *which are not related to litigation*.

* * * *

> In addition, hospitals must comply with a panoply of complex state and federal regulations and reporting requirements which may require regular consultation with legal counsel….*a hospital's risk managers and counsel have a legitimate and important interest in communicating with the hospital's medical staff, agents and employees—an interest which may be separate and apart from litigation*.

(emphasis added). *Id*. at 42-43. The Court found no unreasonable invasion of the right of privacy when the information was used reasonably for important non-litigation purposes. Plaintiffs and their amici ignore *Burger*.

The reasoning of *Burger* applies here. As in *Burger*, State Farm's protective order reflects the considered judgment of the legislature and DOI in authorizing insurers to retain and re-disclose PHI for non-litigation purposes specified in the Insurance Code. Any intrusion into privacy interests is limited, reasonable in view of the "legitimate and important interests" at stake, and subject to extensive regulatory oversight. Illinois law and regulations prohibit a property and casualty insurer from disclosing PHI without the consent of the person whose PHI is at issue, except in circumstances specified in the Insurance Code. 215 ILCS 5/1001 *et seq*. In short, State Farm's proposed protective order complies with the privacy clause's requirement that a state-invasion must be reasonable.

## II. THE APPELLATE COURT ERRED IN UPHOLDING THE TRIAL COURT'S FINDING THAT HIPAA PREEMPTS STATE LAW

### A. The Appellate Court's Finding That HIPAA Preempts State Farm's Protective Order Was Not *Obiter Dicta*

Plaintiffs argue the appellate court's finding that HIPAA preempts state insurance law and regulations is no more than "a statement of dicta" (Br., at 41). But the appellate court's statement was not dicta. *Obiter dictum* refers to a remark or expression of opinion

that a court utters as an aside, and is generally not binding authority or precedent. *Exelon Corp. v. Dept. of Revenue*, 234 Ill. 2d 266, 277 (2009). "A dictum is 'any statement made by a court for use in argument, illustration, analogy or suggestion. It is a remark, an aside, concerning some rule of law or legal proposition that is not necessarily essential to the decision and lacks the authority of adjudication.'" *Id*.

Here, the appellate court was not offering an aside or a passing remark on a rule of law. Instead, it specifically found that both parts of 45 C.F.R. § 160.202 (2018) were met for conflict preemption. The appellate court held that the protective order State Farm tendered was an obstacle to accomplishing and executing HIPAA's full objectives under one prong of section 160.202; further, it held under the other prong of section 160.202 that a covered entity would find it impossible to comply with both HIPAA and state law by allowing insurers to retain PHI for non-litigation purposes at the end of the litigation; and both holdings were made *only* because the order would "lower the floor of privacy protections HIPAA mandates." ¶ 63. Whatever else may be said about the appellate court's reasoning, it was not dicta—the court rejected the order currently used in the most populous county in the state and its finding that a HIPAA-qualified protective order was required as a matter of *federal* law was essential to the outcome. The appellate court offered no other grounds for rejecting State Farm's protective order as "contrary" to HIPAA.

### B. A Covered Entity Would Not Find It Impossible to Comply With Both State and Federal Requirements Because the Order Tendered by State Farm Is "an order of a court" Under Section 164.512(e)(1)(i)

As argued above, the appellate court held that the protective order proposed by State Farm—which Cook County has successfully used for the past four years—was

preempted only because it lacked the restrictions of a HIPAA-qualified protective order. ¶ 63. Plaintiffs offer new arguments why the order does not qualify as "an order of a court" under 45 C.F.R. § 164.512(e)(1)(i) (2018) (Br., at 16-21). These arguments—raised for the first time on appeal to this Court—have no merit as shown below.

### 1. State Farm's Order Expressly Authorized the Disclosure of PHI and Did Not Need to Determine State Law Issues of Relevancy or Admissibility Regarding Any Discovery

Plaintiffs argue that State Farm never requested "an order of a court" as an alternative to a HIPAA-qualified protective order (Br., at 15). Plaintiffs are wrong. State Farm argued that the Privacy Rule permitted other ways to comply with HIPAA and that the order it tendered was one such alternative: "The Order at issue is an 'order' as referenced under HIPAA. It is not a 'qualified protective order' and does not need to include the terms and conditions that a qualified protective order must contain" (R.C599; R.C616). State Farm's order did not purport to be a "HIPAA-*Qualified* Protective Order" (emphasis added). Instead, it was titled a "HIPAA Protective Order" (R.C24-26). It met the broader definition of "an order of a court" under subsection 164.512(e)(1)(i) and did not need to satisfy the definition in 45 C.F.R. § 164.512(e)(1)(v)(A)-(B) (2018).

According to plaintiffs, State Farm's protective order did not comply with section 164.512(e)(1)(i) because it did not expressly authorize the disclosure of PHI (Br., at 15). Alternatively, plaintiffs argue that any disclosure was without limitation and violated HIPAA (Br., at 16-17). In effect, plaintiffs argue the protective order authorized no disclosure or too much. Neither is a reasonable reading of the order.

Plaintiffs overstate what the Privacy Rule is meant to accomplish in managing discovery in litigation. "All that 45 C.F.R. § 164.512(e) should be understood to do…is to

create a procedure for obtaining authority to use medical records in litigation. Whether the records are actually admissible in evidence will depend among other things on whether they are privileged." *Northwestern Memorial Hosp. v. Ashcroft*, 362 F.3d 923, 926-27 (7th Cir. 2004). A medical protective order is entered at the beginning of every case before discovery takes place. When the order accompanies a subpoena, it authorizes the covered entity to produce medical records "in response to an order of a court" under section 164.512(e)(1)(i). The order authorizes the disclosure of the records produced and only the records produced. If the party whose records are the subject of the subpoena objects to the scope of the records request, the dispute is resolved by a Rule 201(k) conference or the court. Not even a HIPAA-qualified protective order regulates the scope and relevancy of the discovery. Those are separate state law issues resolved by the parties' agreement or motion practice.

Here, the orders in each case identically limit subpoenas—at plaintiffs' request—to "five (5) years prior to the incident and…to conditions and portions of Plaintiff's body complained of, specifically, her back, hip and lower extremities" (R.C625; R.C632). Plaintiffs obtained these restrictions on the relevancy of the documents to be produced for this litigation; they are not part of a HIPAA-qualified protective order. Plaintiffs have cited nothing in HIPAA or the federal regulations that purports to define the scope of discovery of PHI in judicial proceedings. No such regulations exist. As the Seventh Circuit pointed out in *Northwestern Memorial Hospital*, these are matters of state law.

The protective orders in the supporting record similarly create procedures for covered entities to produce medical records while allowing insurers to retain PHI at the end of litigation consistent with the state law requirements of the particular jurisdiction.

*Calderone v. Piamchon*, No. CGC15548193 (Sup. Ct., Calif., Cty. Of San Francisco, Sept. 7, 2016); *Willis v. Brown*, 16-2015-CA-1828, Div.: CV-H (Cir. Ct. of 4th Judicial Cir., Duval Cty., Fla., Nov. 10, 2015); *Zamor v. Transport AEL*, 16-2014-CA-006922-xxx-MA (Cir. Ct. of 4th Judicial Circuit, Duval Cty., Fla., Aug. 11, 2015); *Green v. Caudill*, 11-CV-00825 (E.Va. Feb. 16, 2012); *Harvey v. State Farm Mut. Auto. Ins. Co*., 1:11-cv-00467-LTB-KLM (U.S. Dist. Colo., Sept. 29, 2011) (R.C191-95, R.C196-98, R.C199-200, R.C202-04, R.C205-07, R.C208-09, R.C210-15, R.C195-99; R.C200-02, R.C203-04, R.C206-08, R.C209-11l, R.C212-13, R.C214-19). State Farm's protective order, like these protective orders, qualifies as "an order of a court" under section 164.512(e)(1)(i) without having to define the scope and relevancy of all PHI produced at the beginning of the case.[4]

### 2. State Farm's Order Is Not Overbroad and Requires All PHI to be Produced Only Through "Formal Discovery Procedures" as Provided in Supreme Court Rule 201

Plaintiffs do not quote the order proposed by State Farm for good reason. The actual terms do not support plaintiffs' strained reading of the order as authorizing "any and all" disclosure of a party's PHI. To be clear: the order does no such thing. The words "any and all" do not appear in the order. Instead, the order requires:

> 6. Other than the party who disclosed PHI or that party's attorney, no other parties or their agents are permitted to request obtain, or disclose PHI or any other type of medical bills, records, or related information other than through the formal discovery procedures authorized by the Code of Civil Procedure, Illinois Supreme Court rules, and orders of this court.

(R.C112). Thus, the order is explicit: unless the party agrees to the production, PHI can be

[4] This is not to say that the parties cannot agree at the onset to limit the scope of discovery, as happened in one such order appearing in the supporting record (R.C202-03; R.C206-07), only that HIPAA and the regulations do not require it as a matter of federal law.

disclosed only through "formal discovery procedures" and any disputes over the scope of the records to be produced are decided by "orders" of the court (R.C112).

Plaintiffs' reliance on *Kunkel v. Walton*, 179 Ill. 2d 519 (1998), is misplaced. There, unlike the case here, a statute required a plaintiff to sign a medical authorization for all prior medical records, waived any privilege of confidentiality, and allowed the requesting party to engage in *ex parte* conferences with health care providers. *Id*. at 523-25. The Court found the statute unconstitutionally encroached upon its authority to regulate judicial procedure by rule and violated the right of privacy in the Illinois constitution (Ill. Const. 1970, art. I, § 6). *Id*. at 534-41. While noting the relevant disclosure of medical information was reasonable and constitutional, the Court stressed that the statute did not allow for judicial oversight ("[T]he statute makes no provision for any judicial control of the scope of disclosure"). *Id*. at 539. The same cannot be said of the protective order State Farm tendered here, which allows for judicial oversight of all discovery disputes.[5]

### 3. State Farm's Order Does not Violate a Litigant's Right of Privacy

Plaintiffs argue that even if State Farm's protective order complies with section 164.512(e)(1)(i), the order violates the right of privacy under the Illinois constitution (Br., at 22-23). This argument depends on plaintiffs' overbroad reading of the order as calling for the discovery of "any and all" PHI and their insistence that medical protective orders

[5] This is shown by plaintiffs' further argument (another argument made for the first time here) that State Farm's order requires too much judicial oversight case-by-case and hurts the courts' ability to manage their dockets (Br., at 21-22). Plaintiffs point to nothing in the record suggesting that the use of the order has caused Cook County courts an inordinate amount of motion practice over the permitted scope of medical discovery in the past four years.

must decide all issues of relevancy and the scope of the discovery permitted at the beginning of the case. Plaintiffs admit that the question here is "one of reasonableness" which is a function of relevance (Br., at 22-23).

Rule 201(c)(1) authorizes protective orders to be entered "at any time" and even on the court's own motion without requiring the scope and relevancy of discovery to be decided before discovery proceeds. Ill. S. Ct. R.201(c)(1) (eff. July 30, 2014). Unlike the consent form at issue in *Kunkel*, State Farm's proposed protective order preserves judicial oversight and allows plaintiffs to challenge the scope and relevancy of any discovery and submit any dispute to the court for resolution. State Farm's protective order is not a "repackaging" of the statute struck down in *Kunkel* and authorized under Rule 201(c)(1). The proposed order does not permit the production of PHI unrelated to the issues in the case and *ex parte* conferences prohibited by *Kunkel* and *Best v. Taylor Mach. Works*, 179 Ill. 2d 367, 449 (1997). As such, plaintiffs misread State Farm's proposed protective order.

### C. The Order Tendered by State Farm Is Not an Obstacle to Accomplishing and Executing HIPAA's Full Purposes and Objectives

Plaintiffs assert that if the appellate court's finding was not dicta, HIPAA preempts any Illinois state law requiring the retention of PHI and allowing its use beyond the litigation (Br., at 41-43). Plaintiffs argue that Illinois state insurance law is "less stringent" and impermissibly lowers the mandated level of privacy rights and restrictions (Br., at 42).

At the same time, plaintiffs concede that HIPAA includes methods of disclosure other than a HIPAA-qualified protective order (Br., at 13-14). The very fact that HIPAA does not mandate a HIPAA-qualified protective's return-or-destroy provisions shows that those provisions do not set a "floor" and Illinois state insurance laws allowing for the

retention of PHI outside litigation do not stand as an obstacle to the accomplishment and execution of HIPAA's full purposes and objectives. *Harold-Jones v. Drury,* 422 P.3d 568, 574-75 (Alaska 2018). Plaintiffs ignore this case entirely.

Similarly, plaintiffs' reliance on the HHS waiver procedure outlined in HIPAA is misplaced (Br., at 44-45). The threshold step in conducting HIPAA's preemption analysis is whether the state law is "contrary" to HIPAA; if the state law is not contrary, no stringency analysis is required. The HHS waiver procedure has no relevance here because the regulations provide for "an order of a court" which avoids a conflict between HIPAA and state law. *See Harold-Jones,* 422 P.3d at 575.

The cases plaintiffs cite in support of HIPAA preemption do not involve non-covered entities such as property and casualty insurers (Br., at 42). Rather, they involve state laws that imposed less restrictive standards than HIPAA on how *covered entities* handled PHI (*OPIS Management Resources, LLC v. Florida Agency for Health Care Administration,* 713 F.3d 1291, 1296 (11th Cir. 2013); *Allen v. Wright,* 644 S.E.2d 814, 816-17 (2007)). Neither case supports plaintiffs' argument. Instead, section 164.512(e)(1) specifically contemplates—indeed authorizes—court orders without the restrictions of HIPAA-qualified protective orders set forth in section 164.512(e)(1)(v)(A)-(B). Section 164.512(e)(1) does not require every court order to include return-or destroy provisions. State Farm's protective order was one such HIPAA-compliant method.

### D. The Trial Court's Protective Orders Upheld by the Appellate Court Violate Rule 201(c)(1) by Prohibiting the Legally Required Retention of Information Outside Litigation

Plaintiffs draw the wrong lesson from *Skolnick v. Altheimer & Gray,* 191 Ill. 2d 214 (2000). They argue that a reviewing court will alter the terms of a protective order only

if no reasonable person would adopt the trial court's view. *Id*. at 224. But even when reviewed for an abuse of discretion, a protective order must yield to other lawful and permitted purposes of the information outside the personal injury litigation. *Id*. at 226. *See also Hall v. Spring Spectrum L.P*., 368 Ill. App. 3d 820, 824-27 (5th Dist. 2006) (affirming modification of protective order to allow documents to be produced to Federal Communications Commission). Here, the overly restrictive terms of the trial court's protective orders should be vacated because they prohibit insurers from retaining PHI outside the litigation and require its destruction contrary to insurers' regulatory obligations.

## CONCLUSION

For all the reasons set forth herein, in the opening brief and in the petition for leave to appeal or alternatively as a matter of right, the intervenor-appellant, State Farm Mutual Automobile Insurance Company, respectfully requests that the Illinois Supreme Court reverse the opinion and judgment of the Illinois Appellate Court, Second Judicial District, and enter the protective order tendered by intervenor-appellant, State Farm, or remand with directions for the entry of a protective order that expressly allows for the use, retention, and disclosure of PHI in conformity to all federal and state insurance laws and regulations.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

I certify that this reply brief conforms to the requirements of Rules 341(a) and (b) of the Supreme Court Rules. The length of this reply brief, excluding the pages containing the Rule 341**(**d) cover, the Rule 341(h)(1) table of contents and points and authorities, the supplemental appendix, and the Rule 341(c) certificate of compliance, is 20 pages.

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# SUPPLEMENTAL APPENDIX

## TABLE OF CONTENTS FOR SUPPLEMENTAL APPENDIX

5/154.6. Acts constituting improper claims practices

§ 154.6. Acts constituting improper claims practice. Any of the following acts by a company, if committed without just cause and in violation of Section 154.5, constitutes an improper claims practice:

(a) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(b) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(c) Failing to adopt and implement reasonable standards for the prompt investigations and settlement of claims arising under its policies;

(d) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

(e) Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(f) Engaging in activity which results in a disproportionate number of meritorious complaints against the insurer received by the Insurance Department;

(g) Engaging in activity which results in a disproportionate number of lawsuits to be filed against the insurer or its insureds by claimants;

(h) Refusing to pay claims without conducting a reasonable investigation based on all available information;

(i) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(j) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application or establishing unreasonable caps or limits on paint or materials when estimating vehicle repairs;

(k) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(l) Making a claims payment to a policyholder or beneficiary omitting the coverage under which each payment is being made;

(m) Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physicians of either to submit a preliminary claim report and then requiring subsequent submission of formal proof of loss forms, resulting in the duplication of verification;

(n) Failing in the case of the denial of a claim or the offer of a compromise settlement to promptly provide a reasonable and accurate explanation of the basis in the insurance policy or applicable law for such denial or compromise settlement;

(o) Failing to provide forms necessary to present claims within 15 working days of a request with such explanations as are necessary to use them effectively;

(p) Failing to adopt and implement reasonable standards to verify that a repairer designated by the insurance company to provide an estimate, perform repairs, or engage in any other service in connection with an insured loss on a vehicle is duly licensed under Section 5-301 of the Illinois Vehicle Code;[1]

(q) Failing to provide as a persistent tendency a notification on any written estimate prepared by an insurance company in connection with an insured loss that Illinois law requires that vehicle repairers must be licensed in accordance with Section 5-301 of the Illinois Vehicle Code;

(r) Engaging in any other acts which are in substance equivalent to any of the foregoing.

**Credits**

Laws 1937, p. 696, § 154.6, added by P.A. 80-926, § 1, eff. Sept. 22, 1977. Amended by P.A. 80-1495, § 31, eff. Jan. 8, 1979; P.A. 84-480, § 1, eff. Jan. 1, 1986; P.A. 84-680, § 1, eff. Jan. 1, 1986; P.A. 84-1308, Art. II, § 84, eff. Aug. 25, 1986; P.A. 90-340, § 5, eff. Aug. 8, 1997.

5/155.23. Fraud reporting

§ 155.23. Fraud reporting.

(1) The Director is authorized to promulgate reasonable rules requiring insurers, as defined in Section 155.24, doing business in the State of Illinois to report factual information in their possession that is pertinent to suspected fraudulent insurance claims, fraudulent insurance applications, or premium fraud after he has made a determination that the information is necessary to detect fraud or arson. Claim information may include:

(a) Dates and description of accident or loss.

(b) Any insurance policy relevant to the accident or loss.

(c) Name of the insurance company claims adjustor and claims adjustor supervisor processing or reviewing any claim or claims made under any insurance policy relevant to the accident or loss.

(d) Name of claimant's or insured's attorney.

(e) Name of claimant's or insured's physician, or any person rendering or purporting to render medical treatment.

(f) Description of alleged injuries, damage or loss.

(g) History of previous claims made by the claimant or insured.

(h) Places of medical treatment.

(i) Policy premium payment record.

(j) Material relating to the investigation of the accident or loss, including statements of any person, proof of loss, and any other relevant evidence.

(k) any facts evidencing fraud or arson.

The Director shall establish reporting requirements for application and premium fraud information reporting by rule.

(2) The Director of Insurance may designate one or more data processing organizations or governmental agencies to assist him in gathering such information and making compilations thereof, and may by rule establish the form and procedure for gathering and compiling such information. The rules may name any organization or agency designated by the Director to provide this service, and may in such case provide for a fee to be paid by the reporting insurers directly to the designated organization or agency to cover any of the costs associated with providing this service. After determination by the Director of substantial evidence of false or fraudulent claims, fraudulent applications, or premium fraud, the information shall be forwarded by the Director or the Director's designee to the proper law enforcement agency or prosecutor. Insurers shall have access to, and may use,

the information compiled under the provisions of this Section. Insurers shall release information to, and shall cooperate with, any law enforcement agency requesting such information.

In the absence of malice, no insurer, or person who furnishes information on its behalf, is liable for damages in a civil action or subject to criminal prosecution for any oral or written statement made or any other action taken that is necessary to supply information required pursuant to this Section.

**Credits**

Laws 1937, p. 696, § 155.23, added by P.A. 81-1361, § 1, eff. July 30, 1980. Amended by P.A. 83-851, § 2, eff. Jan. 1, 1984; P.A. 92-233, § 90, eff. Jan. 1, 2002.

5/1001. Purpose

§ 1001. Purpose. The purpose of this Article is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision. Further, this Article shall grant the Director the authority to enforce Title V of the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress).

**Credits**

Laws 1937, p. 696, § 1001, added by P.A. 81-1430, § 1, eff. Sept. 3, 1980. Amended by P.A. 92-556, § 5, eff. June 24, 2002.

5/1014. Disclosure Limitations and Conditions

§ 1014. Disclosure Limitations and Conditions. An insurance institution, agent or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(A) with the written authorization of the individual, provided:

(1) if such authorization is submitted by another insurance institution, agent or insurance-support organization, the authorization meets the requirements of Section 1007 of this Article, or

(2) if such authorization is submitted by a person other than an insurance institution, agent or insurance-support organization, the authorization is:

(a) dated,

(b) signed by the individual, and

(c) obtained one year or less prior to the date a disclosure is sought pursuant to this subsection; or

(B) to a person other than an insurance institution, agent or insurance-support organization, provided such disclosure is reasonably necessary:

(1) to enable such person to perform a business, professional or insurance function for the disclosing insurance institution, agent or insurance-support organization and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(a) would otherwise be permitted by this Section if made by an insurance institution, agent, or insurance-support organization, or

(b) is reasonably necessary, for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization, or

(2) to enable such person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(a) determining an individual's eligibility for an insurance benefit or payment, or

(b) detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction; or

(C) to an insurance institution, agent, insurance-support organization or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

(1) to detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions, or

(2) for either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

(D) to a medical care institution or medical professional for the purpose of:

(1) verifying insurance coverage or benefits,

(2) informing an individual of a medical problem of which the individual may not be aware, or

(3) conducting an operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

(E) to an insurance regulatory authority; or

(F) to a law enforcement or other governmental authority:

(1) to protect the interests of the insurance institution, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it, or

(2) if the insurance institution, agent or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

(G) otherwise permitted or required by law; or

(H) in response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

(I) made for the purpose of conducting actuarial or research studies provided:

(1) no individual may be identified in any actuarial or research report,

(2) materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed, and

(3) the actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this Section if made by an insurance institution, agent or insurance-support organization; or

(J) to a party or a representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurance institution, agent or insurance support organization, provided:

(1) prior to the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation, and

(2) the recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this Section if made by an insurance institution, agent or

insurance-support organization; or

(K) to a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(1) no medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living or general reputation is disclosed, and no classification derived from such information is disclosed,

(2) the individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed, and

(3) the person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

(L) to an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

(M) by a consumer reporting agency, provided:

the disclosure is to a person other than an insurance institution or agent; or

(N) to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

(O) to a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

(P) to a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

(Q) to a certificateholder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

(R) to a lienholder, mortgagee, assignee, lessee, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance; provided that information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy.

**Credits**

Laws 1937, p. 696, § 1014, added by P.A. 81-1430, § 1, eff. Sept. 3, 1980. Amended by P.A. 82-108, § 1, eff. Aug. 6, 1981.

50 Ill. Adm. Code 901.10

901.10. Definitions

"Non-Record" material means:

Material not filed as evidence of the company's administrative or business activities or for the informational content thereof;

Extra copies of documents or reproductions of documents maintained for convenience or reference;

Stocks of printed or reproduced documents kept for supply purposes, where file copies have been retained for record purposes;

Books, periodicals, newspapers, posters, pamphlets and other materials made or acquired and preserved solely for reference or exhibition purposes;

Private materials neither made nor received by a company pursuant to law or in connection with the transaction of its business;

Company dailies more than six (6) months after expiry or cancellation date of the policy if the data therein contained is, to the extent material or necessary to the determination of the financial condition of the company, contained in other records.

"Records" material means all books, papers and documentary materials regardless of physical form or characteristics, made, produced, executed or received by any domestic insurance company pursuant to law or in connection with the transaction of its business and preserved or appropriate for preservation by such company or its successors as evidence of the organization, function, policies, decisions, procedures, obligations and business activities of the company or because of the informational data contained therein. If doubt arises as to whether certain papers are "non-record" materials, it should be assumed that the documents are "records".

Non-Record materials may be destroyed at any time by the company in possession of such materials without the prior approval of the Director of Insurance.

50 Ill. Adm. Code 901.20

901.20 Disposal and Destruction of Records

The company is authorized to dispose of or destroy records in its custody that do not have sufficient administrative, legal or fiscal value to warrant their further preservation and are not needed:

a) in the transaction of current business;

b) for the final settlement or disposition of any claim arising out of a policy of insurance issued by the company, except that these records must be maintained for the current year plus 5 years; or

c) to determine the financial condition of the company for the period since the date of the last examination report of the company officially filed with the Department of Insurance, except that these records must be maintained for at least the current year plus 5 years.

50 Ill. Adm. Code 919.30

a) Each company's claim files for policies or certificates on Illinois risks are subject to examination and inspection by the Director of Insurance or by his duly appointed designees. Examples of the criteria which may be used to determine the frequency of examinations include but are not limited to:

1) High ratio of written complaints to premium volume or units of exposure or enrollment;

2) Examination of a percent of a particular market;

3) Examination of a particular specialty line for which claims handling, underwriting or marketing practices or procedures raise questions of compliance with any insurance laws or rule;

4) Examination of a particular company whose practice or procedure for the handling of claims, underwriting or the marketing of policies raise questions of compliance with any insurance laws or rules.

b) Each company shall maintain claim data that should be accessible and retrievable for examination by the Director. A company shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial, or date claim closed without payment. This data must be available for all open and/or closed files for the current year and the two preceding years. The examiners' review may include but need not be limited to an examination of the following claims:

1) Claims Closed With Payment;

2) Claims Denied;

3) Claims Closed Without Payment;

4) First Party Automobile Total Losses; and/or Subrogation Claims.

c) Detailed documentation shall be contained in each claim file in order to permit reconstruction of the company's activities relative to each claim file.

d) For those companies who do not maintain hard copy files, claim files must be accessible from cathode ray tube (CRT) or micrographics and capable of duplication to hard copy.

50 Ill. Adm. Code 919.40

919.40 Definitions/Explanations

"Code" means the Illinois Inurance Code [215 ILCS 5].

"Company" means any licensee of the Department of Insurance, including health maintenance organizations.

"Days", for the purpose of this Part, means calendar days.

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance.

"Documentation" means all pertinent communications, transactions, notes and work papers. All such communications, transactions, notes and work papers shall be properly dated and compiled in sufficient detail in order to allow for the reconstruction of all pertinent events relative to each claim file. Documentation shall include but not be limited to bills, explanations of benefits and worksheets.

"First Party" means any individual, corporation, association, partnership, or other legal entity asserting a contractual right to payment under an insurance policy or insurance contract arising out of the contingency or loss covered by the policy or contract.

"Insured" means, for the purposes of life, accident and health insurance or other health care or service plans, the party named on a contract as the individual, corporation or association with legal rights to the benefits provided by the contract. This includes certificate holders or subscribers to a group contract and enrollees of a health maintenance organization, any other type of health care or service plans, or third party administrator. For purposes of property and casualty insurance, the party named on the contract is the insured.

"Non-Original Manufacturer" means any manufacturer other than the manufacturer of the original part.

"Notice of Availability of the Department of Insurance", as required by this Part, shall be no less informative than the following:

> Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

"Notification of Loss" means communication, as required by the policy or that is otherwise acceptable by the insurer, from a claimant or insured to the insurer that identifies the claimant or insured and indicates that a loss has occurred or is about to occur.

"Pertinent Communication", as used in Section 154.6(b) of the Code, means all correspondence, regardless of source or type, that is materially related to the handling of the claim.

"Policy", for the purpose of this Part, means a policy, certificate or contract issued to Illinois residents, including a certificate of enrollment into a health maintenance organization or any other type of health care or service plan.

"Private Passenger Automobile" means a vehicle insured under a policy of automobile insurance as defined in Section 143.13 of the Code.

"Prompt Investigation", as used in Section 154.6(c) of the Code, means all activities of the company related directly or indirectly to the determination of liability based on claims under the coverage afforded by the policy and shall be evidenced by a bonafide effort to communicate with all insureds and claimants when liability is reasonably clear within 21 working days after a notification of loss. Evidence of bonafide effort to communicate with insureds and claimants shall be maintained in the company's claim files.

"Reasonable Promptness", as used in Section 154.6(b) of the Code, means a maximum of 15 working days from receipt of communication from a claimant or insured.

"Replacement Crash Parts", for purposes of this Part, means sheet metal or synthetic parts, e.g., plastic, fiberglass, etc., that constitute the exterior of a motor vehicle, including inner and outer panels.

"Representative" means any person expressly authorized to act on behalf of the insurer and any employee of the insurer who acts or appears to act on behalf of the insurer in matters relating to claims, including but not limited to independent contractors while performing claim services at the direction of the company.

"Settlement of Claims", as used in Section 154.6(c) of the Code, shall pertain to all activities of the company or its representatives, relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy. Evidence of those activities shall be maintained in the company's claim files.

"Third Party" refers to any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, partnership or other legal entity insured under a policy.

**Docket No. 125918**

**IN THE ILLINOIS SUPREME COURT**

| | |
|---|---|
| ROSEMARIE HAAGE,<br>Plaintiff-Appellee,<br>v.<br><br>ALFONSO MONTIEL ZAVALA, PATRICIA SANTIAGO, JOSE PACHECO-VILLANUEVO, OKAN ESMEZ and ROSALINA ESMEZ,<br>Defendants,<br>and<br><br>STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,<br>Intervenor-Appellant. | On Rule 307 Interlocutory Appeal<br>from the Circuit Court of the<br>Nineteenth Judicial Circuit<br>Lake County, Illinois<br><br>Consolidated Docket Nos. 2-19-0499 & 2-19-0500<br><br>Court No. 17 L 897<br><br>The Honorable Mitchell L. Hoffman,<br>Judge Presiding |
| AGNIESZKA SURLOCK and EDWARD SURLOCK,<br>Plaintiffs-Appellees,<br>v.<br><br>DRAGOSLAV STARCEVIC,<br>Defendant,<br>and<br><br>STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,<br>Intervenor-Appellant. | On Rule 307 Interlocutory Appeal<br>from the Circuit Court of the<br>Nineteenth Judicial Circuit<br>Lake County, Illinois<br><br>Consolidated Docket Nos. 2-19-0499 & 2-19-0500<br><br>Court No. 18 L 39<br><br>The Honorable Diane E. Winter,<br>Judge Presiding |

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**PLEASE BE ADVISED** that on this 30th day of April, 2021, we caused to be electronically filed with the Clerk of the Illinois Supreme Court, the attached reply brief on behalf of intervenor-appellant, State Farm Mutual Automobile Insurance Company, a copy of which, along with this notice of filing with proof of service, is herewith served upon you.

SmithAmundsen LLC

By: /s/ Michael Resis
Attorneys for Intervenor-Appellant

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STATE OF ILLINOIS )
) SS
COUNTY OF COOK )

**AFFIDAVIT OF SERVICE**

The undersigned, Winnie Flynn, a non-attorney, pursuant to the provisions of Section 1-109 of the Illinois Code of Civil Procedure, and Ill. S. Ct. R. 12, the undersigned certifies that the statements set forth in this instrument are true and correct, and that I caused the foregoing notice of filing and reply brief on behalf of intervenor-appellant, State Farm Mutual Automobile Insurance Company, sent to the parties listed above on this 30th day of April, 2021, by electronic mail and electronically through the Odyssey Electronic Service, from the offices of SmithAmundsen LLC.

/s/ Winnie Flynn
SmithAmundsen LLC