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Coverage Matters

Quarterly Investigation of the Underlying Trends & Developments in Insurance Coverage

November 2024

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By: James K. Thurston

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Colorado Supreme Court Allows Recovery Under Workers' Compensation and UM/UIM Insurance for Workplace Injuries *By: Michelle Yang*

In a recent decision interpreting the interplay between the Colorado Workers' Compensation Act (WCA) and uninsured/underinsured motorist (UM/UIM) insurance, the Colorado Supreme Court ruled that an employee injured by a third-party tortfeasor may seek benefits through both a worker's compensation claim and their employer's UM/UIM carrier. In so doing, the court provided important clarification to the WCA's exclusivity provisions and immunity provision – and under what circumstances those provisions apply to employers' UM/UIM insurers. ▶ *Read More*

The Problems that Suspended Corporations Create for Insurers in Californian

By: John Podesta

In a sequel and update to "The Problem of Suspended Corporations in the Present Economic Downturn" published in the ABA Committee on Insurance Coverage Litigation newsletter (Vol 20, Number 4 July/August 2010), this article outlines problem areas and techniques and updates the areas of concern for insurers facing a situation with a suspended corporation. ▶ *Read More*

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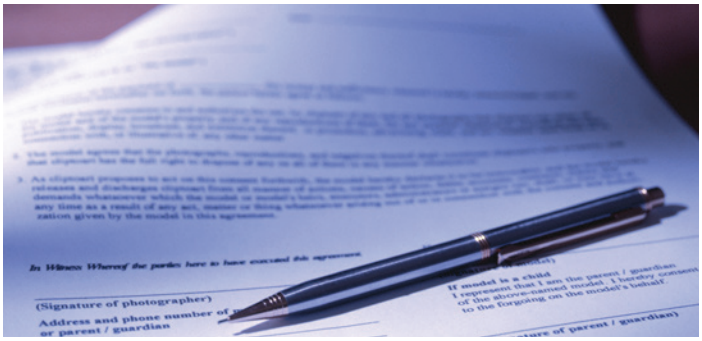
The Anatomy of a Broadly Drafted D&O Contract Exclusion

By James K. Thurston

A typical D&O policy's Contract Exclusion readily applies to an insured's potential liabilities for any breach of contract claims. However, for insurers seeking a broadly worded Contract Exclusion (for example, applying to "any Claim against any Insured based upon, arising out of, or in any way involving[1] any actual or alleged liability or obligation under any contract or agreement"), the exclusion can extend well beyond simple breach of contract claims, and even bar coverage for underlying lawsuits[2] (1) not containing any contractual causes of action, (2) involving contracts to which the insured is not a party, and (3) involving conduct that occurred prior to the contract itself.

- *First*, in order to apply to tort claims (and beyond), the Contract Exclusion cannot be limited to claims "*for* any contractual liability,"[3] but instead needs at least "arising out of" language, or other similarly broad language (*see*, Endnote 1).
- *Second*, the exclusion also needs "actual or *alleged*" language, or it may be limited to situations involving actual contractual breaches.[4]
- *Third*, the "contract" language should not be modified by "of any Insured," or the exclusion may be restricted to the Insured's contracts.
- *Lastly*, the Contract Exclusion should not be limited to claims solely under section I.C., but it should be applicable to all coverage provisions

Drafted with such language, the Contract Exclusion will have broad exclusionary powers that should be interpreted to extend beyond merely contractual liability claims. For example, the Ninth Circuit has twice held that a Contract Exclusion applies despite the absence of a breach of contract cause of action in the underlying lawsuit. In *Office Depot, Inc. v. AIG Specialty Ins. Co.*, 829 Fed. Appx. 263, 264 (9th Cir. Nov. 13, 2020), the Ninth Circuit held that a broadly worded Contract Exclusion barred coverage for an underlying lawsuit that contained a single cause of action for violation of California's False Claims Act. So long as the underlying lawsuit "arose out of … contractual obligations," the exclusion should apply.



Similarly, in *AKN Holdings, LLC v. Great Am. E & S Ins. Co.*, 2022 U.S. App. LEXIS 18903 (9th Cir. July 8, 2022), the Ninth Circuit held a Contract Exclusion applied despite the underlying lawsuit seeking damages solely for fraud representations and fraudulent concealment.[5] Indeed, if properly worded, the insured need not even be a party to the contract for the exclusion to apply.

1 Even better than "arising out of" is prefatory language that states: "based upon, arising out of, relating to, directly or indirectly resulting from or in consequence of, or in any way involving." *Global Fitness, LLC, v. Navigators Mgmt. Co., Inc.*, 854 Fed. Appx. 719, 721 (6th Cir. 2021) (such language is "staggeringly broad"); *Tricor Am., Inc. v. Ill. Union Ins. Co.*, 351 F. Appx. 225, 227 (9th Cir. 2009) (this language is "plainly intended broadly to exclude coverage").

2 Depending on the Policy's definition of "Claim," the Contract Exclusion can apply to the "entirety of Underlying Action, not just the individual causes of action…thus the provision excludes coverage of the entire case based on the clear allegations dealing with contractual liabilities of 'an Insured Person under any contract [or] agreement.'" *Paraco Gas Corp. v. Ironshore Indem., Inc.*, 2023 U.S. Dist., LEXIS 14628, *13 (S.D.N.Y. June 22, 2023), *aff'd*, 2024 U.S. App. LEXIS 14628 (2d Cir. June 17, 2024).

3 *See, e.g., GE HFS Holdings, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 2009 U.S. Dist., LEXIS 147629, *9 (D. Mass. Sept. 28, 2009) ("the policy language could not have been broader. It excluded claims '*arising from*' any contract or agreement, rather than excluding claims 'for' any contract or agreement. An exclusion with the 'for' wording makes it clear that insurers do not intend to pick up the insured company's contractual liability, without necessarily extending the exception to tort claims against individuals") (italics in original); *U.S. TelePacific Corp. v. U.S. Specialty Ins. Co.*, 2019 U.S. Dist., LEXIS 101848, *23 (C.D. Cal. June 18, 2019) ("Some of the Policy's exclusions apply to claims '*arising out of*, based upon or attributable to'…while others are limited to claims '*for*' …[t]his dichotomy suggests that the Policy, and thereby the parties, contemplated when exclusions or exceptions should apply to broad or narrow sets of circumstances.") (emphasis added).

4 *See, e.g., KM Strategic Management, LLC v. American Casualty Co. of Reading, PA*, 156 F. Supp. 3d 1154, 1171 (C.D. Cal. 2015) ("the [Contract] exclusion could have been written more broadly so as to cover all claims for injury arising out of any 'alleged' breach of contract," but instead the exclusion only applied to "an *actual* breach — not an alleged breach") (emphasis in original); *Mede Analytics, Inc. v. Fed. Ins. Co.*, 2016 U.S. Dist., LEXIS 21377, *16 (N.D. Cal. Feb. 19, 2016) (exclusion "arising out of breach of contract," did not utilize "actual or alleged" language, yet "other exclusions in the Policy here incorporate such 'actual or alleged' language."); *Saoud v. Everest Indem. Ins. Co.*, 551 F. Supp. 3d 777, 794 (E.D. Mich. 2021) ("other exclusions expressly use the word 'alleged,'" but the at issue "exclusion does not use the phrase 'actual or alleged,' the Court is not persuaded that the language of the exclusion unambiguously restricts the inquiry to what was alleged in the state court complaints").

5 Although the original lawsuit included certain contractual remedies, the "amended complaint only alleged claims for fraudulent representations and fraudulent concealment." *AKN Holdings, LLC v. Great Am. E & S Ins. Co.*, 2021 U.S. Dist, LEXIS 142777, *5 (C.D. Cal. May 14, 2021).

In *Radianse, Inc. v. Twin City Fire Ins. Co.*, 2010 U.S. Dist. LEXIS 106778, *6 (D. Mass. Oct. 6, 2010), the court held it was "of no consequence that [the insured] was not a party to [the] contract" since the contract exclusion did "not state that its application [was] limited to contracts to which [the insured was] a party."[6]

Further, a broadly worded Contract Exclusion should apply even if the underlying alleged tortious conduct occurred before the relevant contract was entered into. In *Fed. Ins. Co. v. KDW Restructuring & Liquidation Servs., LLC*, 889 F. Supp. 2d 694, 700-09 (M.D. Pa. 2012), the court rejected the argument that Contract Exclusion was "inapplicable" because negligent misrepresentation and fraud claims arose out of "pre-contractual misrepresentations and omissions" when "the injuries suffered by the class plaintiffs would not have occurred had there been no contracts and no breach thereof."[7] This can be important when the goal is to capture all of the related misconduct relating to the contractual lability into the exclusion.

In the end, a Contract Exclusion is an important tool to limit coverage for D&O liability to wrongful tortious acts of directors and officers and entities. Having the ability to avoid coverage for contract-related liability is significant to further these goals of D&O coverage, while avoiding raising premiums for everyone else based on the contract-related decisions, which spur litigation for which D&O coverage is sometimes sought.

James K. Thurston is cochair of Wilson Elser's D&O/E&O Insurance Subcommittee. He has successfully argued for the application of the Contract Exclusion in the Ninth and Second circuits. *See, Paraco Gas Corp. v. Ironshore Indem., Inc.*, 2024 U.S. App. LEXIS 14628 (2d Cir. June 17, 2024); *AKN Holdings, LLC v. Great Am. E & S Ins. Co.*, 2022 U.S. App. LEXIS 18903 (9th Cir. July 8, 2022).

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6 *See also, AKN Holdings, LLC v. Great Am. E & S Ins. Co.*, 2021 U.S. Dist., LEXIS 142777, *11-12 (C.D. Cal. May 14, 2021) ("[Insured] Plaintiff also emphasizes that it was 'not even a party to the disputed agreements.' But the exclusion applies to claims involving 'any actual or alleged breach of contract or agreement,' not just breaches of contracts to which Plaintiff was a formal party"), *aff'd*, 2022 U.S. App. LEXIS 18903 (9th Cir. July 8, 2022); *Carolina Cas. Ins. Co. v. Sowell*, 603 F. Supp. 2d 914, 931 (N.D. Tex. Feb. 17, 2009) ("The Contract Exclusion also cannot be reasonably read, as [insured] Ellis urges, to apply only to claims involving a contract to which Ellis was a party. The exclusion bars coverage of claims made against any insured based upon 'any…contract or agreement,' not based only on a contract to which the specific insured is a party.").

7 *See also, AKN Holdings, LLC v. Great Am. E & S Ins. Co.*, 2021 U.S. Dist., LEXIS 142777, *10 (C.D. Cal. May 14, 2021) ("Plaintiff tries to untether the fraud claims from the agreements, noting that the underlying complaints allege that Plaintiff 'committed actionable fraud before any contract any was ever entered into,'" but "the broad language of the exclusion is not so limited: the fraud claim need only be 'related to any actual or alleged breach of contract or agreement.'"), *aff'd*, 2022 U.S. App. LEXIS 18903 (9th Cir. July 8, 2022).

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A Recent Case Study on the Mutual Duties of Primary Insurers and Excess Insurers

By Daniel Tranen

The relationship between excess insurers and primary insurers is a complex one. There typically is no contractual relationship between them. Instead, both have contractually agreed to provide insurance coverage to a policyholder. Based on those contractual obligations, many states hold that each insurer owes the policyholder a duty of good faith and fair dealing to evaluate claims and settle them within limits if it is reasonable to do so.[1] And yet, the actions of the primary insurer and the excess insurer in fulfilling those duties can prejudice the other depending on the circumstances.

For example, an excess insurer may sue a primary insurer for failing to undertake obligations that the primary insurer owes the policyholder, typically via a claim for equitable subrogation. The excess insurer essentially steps into the policyholder's shoes and argues that the primary insurer's failures in its duties to the policyholder have damaged the excess carrier's rights or, more specifically, its pocketbook[2]. This can happen if the primary insurer fails to defend a policyholder when it should, leaving this obligation to the excess carrier. It more commonly occurs when the primary carrier has an opportunity and obligation to settle a claim within its limits to avoid exposing the policyholder or excess carrier to a judgment in excess of the primary limits but fails to do so.[3]

Conversely, the excess carrier may owe duties to the primary carrier. For example, some states provide that if a claim is likely to invade the excess layer, the excess carrier should participate financially and in a prorated fashion in the policyholder's defense.[4] Also, if the excess carrier has the opportunity and obligation to settle a claim within its limits and fails to do so, the excess carrier may be liable to the primary carrier defending the claim, which should be settled. In such an instance, the primary carrier is expending resources defending a lawsuit that should be settled,[5] and therefore, the actions of the excess carrier have prejudiced the primary carrier.

1 *See, e.g., Edwards v. Prudential Property & Cas. Co.*, 357 N.J. Super. 196 (2003) ("Such duty is grounded on the fundamental principle that in every contract there is an implied covenant that neither party shall commit any act which shall destroy or injury [sic] the rights of the other party to enjoy the fruits of the contract."); *Smith v. Citadel Ins. Co.*, 285 So. 3d 1062 (La. 2019) ("The insurer's duty to act in good faith includes the duty to deal fairly in handling claims."); *Woodie v. Berkshire Hathaway Homestate Ins. Co.*, 806 Fed. Appx. 658 (10th Cir. 2020) (duty of good faith "emanates from the special relationship of the parties to the insurance contract.").

2 *See, e.g., Scottsdale Ins. Co. v. Addison Ins. Co.*, 448 S.W.3d 818 (Mo. 2014) ("a right of subrogation belongs to one, not a volunteer, who pay's [sic] another's debt, to recover the amount paid, which in good conscience should be paid by the one primarily responsible for the loss.").

3 *Id.* ("An insurer's duty to act in good faith in settling third-party claims arises from the insurer's reservation in the policy of the exclusive right to contest and settle third-party claims. An action for the breach of that duty, while a tort, arises from a contract of insurance, which is not of a purely personal nature. Therefore, a bad faith refusal to settle action falls within the category of assignable torts.").

4 *Columbia Cas. Co. v. U.S. Fid. & Guar. Co.*, 870 .2d 1200 (Ariz App. 1994) (equity required that primary and excess share defense costs when it was apparent at the outset of the litigation that primary limits would not resolve the claim); *Pallotta v. Aetna Ins. Co.*, 322 N.Y.S. 2d 92 (1971) (same); *Celina Mut. Ins. Co. v. Citizens Ins. Co. of Am.*, 349 N.W.2d 547 (Mich. App. 1984) (primary and excess required to split defense on a pro rata basis based upon amount of settlement); *Am. Motorists Ins. Co. v. Trane Co.*, 544 F. Supp. 668 (W.D. Wisc. 1982) (finding that excess duty to defend is activated along with primary if the claim exceeds primary limit); *Teleflex Medical Incorporated v. National Union Fire Insurance Company of Pittsburgh PA*, 851 F.3d 976 (9th Cir. March 21, 2017) ("In *Diamond Heights Homeowners Association v. National American Insurance Co.*, 227 Cal. App. 3d 563 (1991), a California appellate court ruled that an excess liability insurer has three options when presented with a proposed settlement of a covered claim that has met the approval of the insured and the primary insurer. The excess insurer must (1) approve the proposed settlement, (2) reject it and take over the defense, or (3) reject it, decline to take over the defense, and face a potential lawsuit by the insured seeking contribution toward the settlement. Id. at 580–81. Under *Diamond Heights*, the insured is entitled to reimbursement if the excess insurer was given a reasonable opportunity to evaluate the proposed settlement, and the settlement was reasonable and not the product of collusion.")

5 *Am. Alternative Ins. Corp. v. Hudson Specialty Ins. Co.*, 938 F.Supp.2d 908 (C.D. Cal. 2013) ("California law allows primary and excess insurers to recover from one another for their bad faith refusal to accept a reasonable settlement offer under the theory of equitable subrogation"); *Diamond Heights Homeowners Assn. v. National Am. Ins. Co.*, 227 Cal. App. 3d 563 (1991) (the court found that the primary insurer could proceed on an equitable subrogation theory where the excess insurer arbitrarily vetoed a reasonable settlement and forced the primary insurer to proceed to trial and bear the full costs of the defense).

The recent case of *Westport Ins. Corp. v. Penn National Mutual Cas. Ins. Co.*,[6] decided by the U.S. Court of Appeals for the Fifth Circuit in September 2024, provides an interesting case study for the mutual rights and obligations between excess and primary carriers. In that case, an insurance broker was sued by a marina owner client for failing to procure insurance to cover a marina. The marina was badly damaged in a storm, and the owner sued the broker for breach of contract. During the litigation, the primary carrier for the broker received but refused to pay five different settlement demands within the primary carrier's policy limits. The case went to trial, resulting in a judgment against the broker for substantially more than the primary policy limits.

Interestingly, the primary carrier initially sued the excess carrier for breach of the excess policy via equitable subrogation. Because the judgment was more than the primary limits, and a bond was required to prevent the garnishment of the broker's assets, the primary carrier ultimately put up the bond for amounts well above its policy limit with the understanding that the excess carrier would pay its portion of any judgment. However, the excess carrier refused to pay the amount exceeding the primary carrier's limit, asserting that the primary carrier improperly handled settlement negotiations prior to the trial.

The excess carrier then counter-sued the primary carrier (again, via equitable subrogation) for breaching the primary policy by failing to settle the case within the primary limits when the primary carrier had several opportunities to do so. In its cross-claim, the excess carrier sought an additional sum it had paid beyond the amount paid by the primary carrier after the underlying judgment became final, with all appeals exhausted. Following a Texas jury trial on the coverage dispute, the jury found in favor of the excess carrier based on the primary carrier's failure to settle within its limits.

On appeal, the main issue was whether the failure of the primary carrier to pay the settlement demands within its limits was a "defense" to the excess carrier's failure to pay the judgment in excess of the primary carrier's limit of liability. The district court, on summary judgment, determined that the excess carrier breached its duties to pay, and the excess carrier did not contest this finding on appeal. Instead, the excess carrier's position was that its breaches of the excess policy did not damage the policyholder because the primary carrier had already breached its obligation to pay the settlement demands, which the excess carrier argued was a "policy defense" to its obligation to reimburse the primary carrier for the amounts it paid in excess of its limits. The district court agreed.

6 *Westport Ins v. Penn Natl Mutual*, No. 23-2082 (U.S. Court of Appeals, Fifth Cir. Sept. 18, 2024)

However, the appellate court disagreed with the excess carrier's position and the district court's decision. The appellate court held that once it was determined that the excess carrier had breached its policy, the district court should have ordered the excess carrier to reimburse the primary carrier. The appellate court also found, however, that the error was "harmless" because once the jury found that the settlement demands should have been paid by the primary carrier, the primary carrier would have had to return the funds to the excess carrier. Thus, the appellate court effectively determined that the excess carrier could not assert the primary carrier's breach of the primary policy as a defense to its failure to honor its obligations under the excess policy.

The Westport case is a stark reminder that although primary and excess carriers act concurrently in their duties to the policyholder, those duties translate into duties to each other. Ultimately, the primary carrier's duty to pay reasonable settlements when afforded the opportunity to do so may trump any duties breached by the excess carrier in the same claim.

The Westport case is a stark reminder that although primary and excess carriers act concurrently in their duties to the policyholder, those duties translate into duties to each other. Ultimately, the primary carrier's duty to pay reasonable settlements when afforded the opportunity to do so may trump any duties breached by the excess carrier in the same claim.

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The 2024 Restructure of Louisiana Bad Faith Laws: Will It Help?

By Graham R. Pulvere and Daniel E. Tranen

Each year, property owners in the Gulf Coast region of the United States brace for the possibility of a hurricane. Insurers likewise brace for the property damage claims that follow the storms. The Gulf of Mexico is warming at unprecedented rates, and the size and severity of storms and the resulting devastation are expected to rise, fueling increasing costs for residents and their insurers. With Louisiana on the Gulf Coast and a frequent victim of the power of large storm events, insurers are closely watching the effect of lawmakers' recent restructuring of Louisiana's bad faith laws.

Previously, Louisiana insureds who filed bad faith lawsuits could effectively elect between two statutes: La. R.S. 22:1892 or La. R.S. 22:1973. The statutes, while similar, imposed different duties and penalties upon insurers. This created a confusing legal landscape with uncertainty for insurers. Louisiana lawmakers sought to address these problems by enacting new bad faith laws, which took effect July 1, 2024.

Under the old version of La. R.S. 22:1892, insurers were required to issue payment for covered loss within 30 days of receipt of "satisfactory proof of loss," broadly defined to include proof enabling the insurer to recognize that the insured is probably due some reasonably determinable amount of the policy's coverage benefits. In the event of a late payment, this statute provided for the insured to recover a penalty of 50% of the amount owed under the policy or $1,000, whichever is greater, plus reasonable attorney's fees and costs.

Under the old version of La. R.S. 22:1973, insurers were required to issue payment for covered loss within 60 days of receipt of satisfactory proof of loss. In the event of a late payment, this statute provided for the insured to recover general damages or special damages sustained by the insured plus a penalty "not to exceed two times the damages sustained or $5,000, whichever is greater."

Under the new laws, La. R.S. 22:1973 was repealed, but some of its provisions are incorporated in an amended version of La. R.S. 22:1892. In the amended version of La. R.S. 22:1892, insurers have 60 days from receipt of satisfactory proof of loss to pay amounts due on residential property claims, and now have 90 days from receipt of satisfactory proof of loss to pay amounts due on commercial property claims. In the event of late payment, the insured may recover a penalty of 50% of the amount owed under the policy plus any proven economic damages or $5,000, whichever is greater, plus reasonable attorney's fees and costs. Damages are limited to "proven economic damage" arising from the breach of an insurer's duty of good faith. General damages, such as mental anguish damages, are no longer recoverable.

Significantly, the new law provides for a form of quasi-reverse bad faith, recognizing that the insured and the insured's representatives have duties of good faith and fair dealing when submitting an insurance claim. Acts constituting a breach of the insured's duty of good faith could include a failure to comply with the conditions of the policy, misrepresenting material facts in the claim process or submitting claims lacking an evidentiary basis, among others. Notably, this addition does not create a cause of action for the insurer. Rather, the trier of fact is bound to consider any breach by the insured when determining whether to award penalties or fees against the insurer.

Another noteworthy part of the new law is that for catastrophic losses involving immovable property (real property), insureds may no longer file a lawsuit for bad faith penalties and attorney's fees without first complying with a 60-day "cure period notice" requirement. If the insurer pays the total amount of the demand within 60 days, plus expenses and attorney's fees (not to exceed 20%), any bad faith claim for the amount at issue is cut off. If the insurer issues a timely partial payment, the penalty on the amount paid is reduced by half (if penalties are ultimately awarded). If an insured files suit prior to transmitting the cure period notice, the suit is automatically stayed until 60 days after the cure period notice is received. If the insurer timely pays the full amount demanded, the prematurely filed suit must be dismissed at the insured's cost.

Whether these new changes will impact insurers in Louisiana on a large scale remains unknown until after the next big storm, but certain practical impacts can be anticipated. The additional time to pay under the new law should enable insurers, typically inundated with claims in the wake of a hurricane, to comply with the timeframes more easily. Ideally, the defense of quasi-reverse bad faith, the elimination of general damages, and the narrowing of penalties will limit the number of suits. And, if payments are not timely, the insurer's opportunity to cure should prove an additional helpful deterrent to unwarranted litigation.

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Colorado Supreme Court Allows Recovery Under Workers' Compensation and UM/UIM Insurance for Workplace Injuries

By Michelle Yang

In a recent decision interpreting the interplay between the Colorado Workers' Compensation Act (WCA) and uninsured/underinsured motorist (UM/UIM) insurance, the Colorado Supreme Court ruled that an employee injured by a third-party tortfeasor may seek benefits through both a worker's compensation claim and their employer's UM/UIM carrier. In so doing, the court provided important clarification to the WCA's exclusivity provisions (which state that workers' compensation is the exclusive remedy for work-related injuries) and immunity provision (which provides immunity from liability to employers and their workers' compensation carriers) – and under what circumstances those provisions apply to employers' UM/UIM insurers. The court's decision in *Klabon v. Travelers Prop. Cas. Co. of Am.*, 2024 CO 66, was in response to a certified question from the U.S. District Court for the District of Colorado.

BACKGROUND

Colorado courts have recently struggled with this question, which resulted in conflicting precedent in interpreting and applying the WCA's exclusivity and immunity provisions in auto liability cases. For example, in *Ryser v. Shelter Mut. Ins. Co.*, 480 P.3d 1286 (Colo. 2021), the Colorado Supreme Court refused to allow an injured employee to recover from his coworker's UM/UIM insurer, expanding the exclusivity and immunity protections of the WCA beyond the employer, to include co-employees and their insurers. Yet, in the subsequent decision of *Ward v. Acuity*, No. 22-1117 (10th Cir. June 22, 2023), the Tenth Circuit Court of Appeals permitted an injured employee to recover benefits from their employer's UM/UIM carrier, holding that the WCA did *not* provide immunity to an employer's UM/UIM carrier for auto accidents caused by a third-party tortfeasor. In arriving at that conclusion, the Tenth Circuit overturned a lower court's ruling upholding the WCA's exclusivity provisions.

The Klabon case was filed into this landscape. In *Klabon*, an employee in the course and scope of employment was struck by a vehicle driven by a third party who had run a red light, causing injuries to the employee. The employee received benefits through his employer's workers' compensation carrier and settled with the other driver's carrier for the $25,000 policy limits. The employee subsequently filed for benefits from his employer's UM/UIM carrier in connection with the accident. The UM/UIM carrier advocated for upholding the exclusivity of the WCA as the sole remedy for workplace injury, while the employee argued the WCA should not apply to situations where an employee was injured by a third party. Magistrate Judge N. Reid Neureiter heard arguments and certified this question of law to the Colorado Supreme Court for an answer.

COLORADO SUPREME COURT RULING

The Colorado Supreme Court accepted certification and ruled that the UM/UIM and WCA statutory frameworks allowed an employee to receive benefits from *both* the employer's workers' compensation and the employer's UM/UIM insurer. The court's decision explicitly holds that the exclusivity and immunity provisions of the WCA apply *only* to an employer's workers' compensation carrier. A UM/UIM carrier, by contrast, is afforded no such protection by the WCA.

The court further ruled that a suit to recover UM/UIM benefits for a third party's actions does not constitute a suit against an employer/co-employee sufficient to trigger the WCA's exclusivity provisions. Instead, such action arises out of the injured employee's rights against the third-party tortfeasor. Thus, UM/UIM benefits are not "worker compensation." Rather, they are a substitute for benefits that would have been available to the injured employee had the tortfeasor been adequately insured.

ADDITIONAL CONSIDERATIONS

The Colorado Supreme Court has made clear that the WCA and UM/UIM statutes serve different functions: the WCA was enacted to provide an efficient remedy for injured employees, while the UM/UIM statute serves a separate goal of making an injured person whole. Although the benefits may overlap, they are not co-extensive.

Moving forward, any potential claims arising under a commercial auto liability policy in Colorado should be examined carefully. Carriers should be aware that merely because an employee has received workers' compensation, the employee is not barred from also claiming UM/UIM benefits for the same incident. Additionally, UM/UIM carriers will not be afforded any kind of immunity from suit for an employee's injury arising out of a third party's actions.

Although not a surprising decision for Colorado, *Klabon* is reflective of Colorado courts' continued focus on enforcing and advocating for an insured's rights, and maximizing coverage that could be available to any insured.

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The Problems that Suspended Corporations Create for Insurers in California

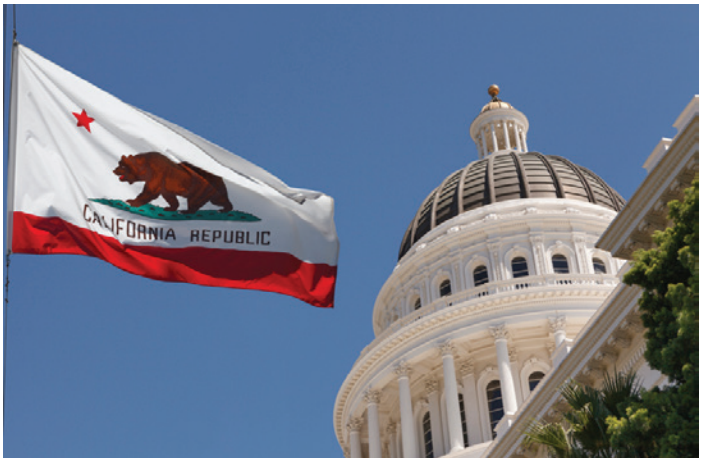
By John Podesta

In California, corporations have to pay their income taxes. Pursuant to California Revenue and Taxation Code §23301, the exercise of corporate powers, rights and privileges are suspended for the failure to pay taxes. A suspended corporation, then, is a corporation that has failed to pay its state taxes and, as a result, can no longer sue or defend itself against legal claims. California, while somewhat unique, is not alone in its treatment of corporations that fail to pay their taxes.[1]

California makes it a criminal offense for a lawyer to represent a company with its corporate powers suspended, thus making it legally impossible for an insurer to accept an insured's defense against a plaintiff's claim.[2] Because of the incapacity, plaintiffs can and will move to strike an insured defendant's answer and enter default; while the corporation can revive, and the court should allow it the chance to do so, if the corporation will not, then striking the answer and entering default is the remedy. Under Insurance Code §11580, a judgment creditor may pursue the defendant's insurer to recover the judgment, even if it is solely the result of the suspended status and no fault of the insurer. While the insurer may raise coverage defenses, liability and damages will be predetermined.

The solution for insurers is to intervene in the action as an interested party. By doing so, the insurer can assert the defenses of liability and the amount of damages of the insured. As discussed below, however, it is not the same as defending the insured, and tactical and ethical challenges can result. As well, the insurer is in an unusual position since it is a new and separate party to the lawsuit, does not have its own evidence (witnesses or documents) for the most part, yet is very interested in the outcome. Finally, since the intervening insurer is acting in its name, not the insureds' name, issues arise concerning its role in discovery and at trial.

This article is a sequel and update to "The Problem of Suspended Corporations in the Present Economic Downturn" published in the *ABA Committee on Insurance Coverage Litigation* newsletter (Vol 20, Number 4 July/August 2010). Then, as now, economic uncertainty drove a large number of insureds out of business. That scenario, in turn, created uncertainty as to how insurers were supposed to navigate the shark-infested waters of litigation. Since then, however, insurers have had actual experience, which provides guidance and warnings for lawyers and insurers alike.



1 A survey of several states indicates California is not alone in suspending the corporate rights and privileges of corporations that fail to pay state taxes. Much like California, Arizona also suspends "the corporate powers, rights and privileges of a domestic corporation "for failure to pay taxes." Ariz. Rev. Stat. 43-1152. Further, "[a]ny person who attempts or purports to exercise any of the rights, privileges or powers of any corporation suspended pursuant to section 43-1152 … shall be guilty of a class 1 misdemeanor." Ariz. Rev. Stat. 43-1154.

Similarly, Oklahoma provides for the forfeiture of corporate rights where a corporation fails to pay taxes owed to the state. 68 Okl. St. § 1212. The forfeiture of corporate rights includes the right "to sue or defend in Oklahoma courts." *Century Inv. Group, Inc. v. Bake Rite Foods, Inc.*, 2000 OK CIV APP 48, 1 (2000); Okl. St. § 1212(c). Like Arizona, Oklahoma law provides that any person who attempts to exercise the rights or privileges of a suspended corporation "shall be guilty of a misdemeanor." 68 Okl. St. § 1212 (b).

In Texas, a corporation that fails to pay state taxes will forfeit its corporate privileges. Tex. Tax Code § 171.251. Falling in line with California and Oklahoma, Texas law provides that a corporation that has forfeited its corporate privileges "shall be denied the right to sue or defend in a court of this state." Tex. Tax Code § 171.252 (1). Despite the clear language of section 171.252, it appears some Texas courts have "limited the statute to prohibit defendants from bringing cross actions, not from merely defending lawsuits." *Anoco Marine Indus. v. Patton Prod. Corp.*, 2008 Tex. App. LEXIS 6662, 6 n. 4 (Tex. App. Fort Worth Aug. 29, 2008).

While California is not unique in its handling of corporations delinquent in their payment of taxes, other states employ different legal mechanisms for dealing with said corporations. In Washington, for example, a corporation that fails to pay license fees may be administratively dissolved. Rev. Code Wash. § 23B.14.200. Once a corporation has been administratively dissolved, "it continues its corporate existence but may not carry on any business except that appropriate to wind up and liquidate its business and affairs." Rev. Code Wash. § 23B.14.050. Administrative dissolution does not "[p]revent commencement of a proceeding by or against the corporation in its corporate name." Rev. Code Wash. § 23B.14.050(2)(e).

2 California Revenue and Taxation Code section 19719 states that any person who attempts to exercise the powers, rights and privileges of a suspended corporation (which would include prosecuting or defending claims) may be punished "by a fine of not less than $250 and not exceeding $1,000, or by imprisonment not exceeding one year." In 1998, this statute was amended to exclude counsel retained by an insurer on behalf of a suspended corporation.

INTERVENTION – WHAT IS IT AND WHY DO IT?

For the insurer of a suspended corporation to be able to protect its policy and assert the liability and damages defenses of the insured, it must become a party to the lawsuit. Cal Code Civ Proc §387. Intervention can be done by ex parte application, by noticed motion, or by stipulation and order in most cases. However, the insurer doesn't have a *right* to intervene, and thus it must demonstrate that it "claims an interest relating to the property or transaction that is the subject of the action and that person is so situated that the disposition of the action may impair or impede [its] ability to protect that interest, [and that its] interest is [not] adequately represented by one or more of the existing parties." CCP §387(d)(1)(B) "The permissive intervention statute balances the interests of others who will be affected by the judgment against the interests of the original parties in pursuing their litigation unburdened by others."[3] The interest of the insurer must be direct, and not "abstract."[4] Notably, in 2017 the statute was amended to make clear that the party intervening can file a "complaint in intervention" or an "answer in intervention." The change also specifically designated one who files an answer in intervention is a new party "defendant."

Intervention is allowed specifically in the suspended corporation arena. In *Kaufman & Broad Communities, Inc. v. Performance Plastering, Inc.*[5] the Court of Appeal went through the history of suspended corporations and concluded that to assert defenses and prevent a default judgment, an insurer must intervene in its own name and cannot enter an appearance in the name of the suspended corporation. Relying on *Truck Ins. Exchange v. Superior Court*[6] the court stated it was proper to allow intervention generally if the following conditions were met: (1) The insurer has a direct and immediate interest in the litigation and (2) The intervention will not enlarge the issues in the case and (3) The reasons for intervention outweigh any opposition by the existing parties.[7] However, since the insured suspended corporation may not sue or defend itself, an intervening insurer cannot pursue rights of indemnity or subrogation, because each requires the insurer to "stand in the shoes" of its insured, who cannot sue.[8]

Once the intervention occurs, however, the intervening carrier is a new party, a new defendant in the litigation, asserting the same defenses as would have been asserted by the suspended corporation. Understanding the distinction between "standing in the shoes" or assuming the role of the suspended insured, versus being a new party to the litigation, is critical. A simple example will demonstrate. An insurer intervenes due to the insured's suspension and the insured will not cooperate, or worse, lied about evidence. This scenario is not unusual because counsel assigned to intervene will typically reach out to the insured principals for documents and the identity of fact witnesses. Since the suspended corporation cannot answer discovery, the insured could be subject to contempt or even issue, evidence or terminating sanctions. The insurer does not want to be "standing in the shoes" of that insured in that circumstance. Rather, the insurer will assert that it is a separate defendant and whatever bad acts were done by the insured do not affect the insurer's ability to force plaintiff to prove his/her/its case.

Regardless of the insured's suspended status, if there is a creative way to avoid the setup of a default judgment, it may reduce costs and should be explored. It is the risk of a default judgment that drives the decision whether to intervene.

IMPORTANT CONSIDERATIONS

In the years since the original article was published in 2010, intervention has become a normal part of insurance defense practice. Most cases are handled without drama, as the insurer's lawyer makes an appearance, conducts the discovery and resolves the case like any other, perhaps with some twists with motions in limine to avoid telling the jury that the defendant is actually the insurance company.

But, there are also circumstances where insurers and counsel can find themselves in a bind, tactically or ethically, because of the intervention. As these problematic situations are addressed, we expect the case law to evolve. At this time, however, besides the right to intervene and the reasons for it, there is little law on many problematic situations. We will explore certain circumstances that may come up in certain cases.

3 *Royal Indemnity Co. v. United Enterprises, Inc.* (2008) 162 Cal.App.4th 194, 203 [75 Cal.Rptr.3d 481].

4 *City and County of San Francisco v. State of California* (2005) 128 Cal.App.4th 1030, 1039 [27 Cal.Rptr.3d 722].

5 *Kaufman & Broad Communities, Inc* (2006) 136 Cal.App.4th 212 [39 Cal.Rptr.3d 33].

6 *Truck Insurance Exchange* (1997) 60 Cal.App.4th 342 [70 Cal.Rptr.2d 255].

7 *Kaufman & Broad Communities, Inc.* (2006) 136 Cal.App.4th 212, 218-219 [39 Cal.Rptr.3d 33].

8 *Travelers Property Casualty Co. of America v. Engel Insulation, Inc.* (2018) 29 Cal.App.5th 830, 837 [240 Cal.Rptr.3d 623]. And Truck Ins. Exchange v. Superior Court (1997) 60 Cal.App.4th 342, 350 [70 Cal.Rptr.2d 255], which held that the insurer could intervene and assert contribution claims, but not subrogation.

Not just a name change: the intervenor is a new party

Code of Civ Proc §387 allows a party with a direct stake in the litigation to intervene. It is allowed where "the person seeking intervention claims an interest relating to the property or transaction that is the subject of the action and that person is so situated that the disposition of the action may impair or impede that person's ability to protect that interest." Significantly, the intervenor becomes a party to the action.

In the case of an insurer, it would file an answer in its own name, having been given the right to do so by the court. The insurer becomes a new party to the litigation, and the answer is in its name and the purpose of the intervention is to prevent a default judgment and a judgment creditor's action to pursue insurance under Insurance Code §11580. The insurance company's interest being protected is its policy covering the insured, not the insured.

However, if the insured is not cooperating, the insurer needs to distance itself from the conduct of the insured. The insurer that intervenes has its own interests to protect, as the *Kaufman & Broad* court recognizes. The insurer may have multiple insureds in the litigation. The insurer may be reserving rights on some issues and as to some insureds, but not others. Most important, however, is that the insurer's interest in the litigation ends when it either denies coverage or the liability under the policy is defended and there is no danger of a default being taken.

As for being a separate party, the *Kaufman & Broad* decision created some confusion among practitioners with its statement that: "the insurance company must intervene in the action to protect its own interests *and those of its insured.*"[9] Ordinarily a reservation of rights is sent to the insured to apprise him or her of coverage limitations and prevent the insurer from waiving the right to rely on those limitations for purposes of indemnity. Despite the fact that the insurer has no contractual relationship with the plaintiff in an action where it intervenes, *Kaufman & Broad* continues:

> *"[A]n insurer who seeks to intervene and protect its coverage defenses may provide an explicit reservation of rights to its client and allege that reservation of rights within its pleading to put the plaintiff on notice that the insurance company is reserving those rights and asserting coverage defenses."*[10]

Arguably, this is dicta, since the holding of the case was limited to whether the insurer could intervene in its own name. In fact, the Northern District of California rejected the coverage position requirement, finding that the passage from *Kaufman & Broad* was dicta.[11] However, insurers need to be mindful that the law is evolving and that even though the intervening insurer is a new and separate party, attention should be paid to prevent waiving any coverage defenses.

Standing: The party on whose behalf the intervention is sought must present an exposure to the insurer that can only be defended by intervention.

The fundamental premise of intervention is that the insurer must intervene to protect *its* interest. If the insurer has no coverage, or no insured, it has no interest to protect and therefore intervention would be denied. One court has held that the insurer can forfeit the right to intervene if it denies coverage. "[A]n insurer who denies coverage and refuses to defend its insured does not have a direct interest in the litigation between the plaintiff and the insured to warrant intervention."[12] Where in most cases the interest is straightforward, there can be unusual circumstances where the insurer may want to intervene to avoid a default judgment but it connection to the parties is more tenuous.

9 *Kaufman & Broad Communities, Inc. v. Performance Plastering, Inc.* (2006) 136 Cal.App.4th 212, 216 [39 Cal.Rptr.3d 33].
10 *Id.* At pg. 216
11 *APL Co. Pte. Ltd. v. Valley Forge Ins. Co.* (N.D.Cal. 2010) 754 F.Supp.2d 1084, 1090, rev. on other grounds in *APL Co. Pte. v. Valley Forge Ins. Co.* (9th Cir. 2013) 541 F. App'x 770.
12 *Hinton v. Beck* (2009) 176 Cal.App.4th 1378, 1384 [98 Cal.Rptr.3d 612].

For another example of a coverage question that could affect standing, assume insured status is in question. Logic dictates that if an insurer believes there is a potential for coverage triggering a duty to defend, it should have standing to intervene to assert the defenses on behalf of that party. The language of California Code of Civil Procedure §387 allowing intervention applies where the insurer "is so situated that the disposition of the action may impair or impede [its] ability to protect that interest." Over the years, the California Supreme Court has exhorted insurers to assume the defense if there is any potential for coverage to avoid damaging an insured. For example: "If any facts stated or fairly inferable in the complaint, or otherwise known or discovered by the insurer, suggest a claim potentially covered by the policy, the insurer's duty to defend arises and is not extinguished until the insurer negates all facts suggesting potential coverage."[13] Thus, as in most states, if there is doubt as to the duty to defend, the defense should be accepted.

But should an insurer have to commit to providing coverage in order to intervene? Logically no, because any time a defense would be accepted and the carrier is willing to pay for it, that should be standing enough. However, there is a twist on that logic in the context of whether the party is an "insured." In that case, one must qualify as an "insured" before their potential liability triggers a duty to defend. In *Fireman's Fund v. Davis*, for example, the court of appeal held that a party seeking coverage had to prove they were an employee (as opposed to an independent contractor) by preponderance of the evidence before the rules governing the duty to defend applied.[14] In other words, logic dictates that if there is a "potential for coverage" such that the insurer is defending, the *Kaufman & Broad* rule regarding reservation of rights should apply to any coverage defense. Nevertheless, an insurer looking to intervene should be prepared to address why it is intervening and, especially where there is a question of insured status, whether there is an "immediate interest" that must be protected in the motion to intervene.

The intervening insurer is defending itself, not the insured

Conflicts between the insurer's interests and those of the insured are the foundation of a bad faith claim. Disputes often arise when an insurer refuses to defend, or agrees to defend but does not offer the insured independent counsel as may be required under Cal. Civil Code §2860. Another example is a duty of the insurer to accept a reasonable settlement, but the insurer rejects it and the opportunity to take the insured out of the litigation.

For an intervening insurer, however, there can be no bad faith exposure for failing to defend, provide independent counsel or accept a reasonable settlement, as there is with a viable insured. If intervention is not done and no defense provided, then a default judgment will be entered and a collection action pursued under Ins. Code §11580. The insured, however, has not been damaged by the insurer's decision not to defend, because the insurer cannot legally defend the insured and therefore has no duty to do so. The insurer may assert its coverage defenses in the subsequent action.

A similar logic applies to indemnity. The insurer may intervene to protect *its* interest in avoiding a default judgment, not the insured's interest in being defended and indemnified. But, since the insurer's conduct in accepting a settlement or not is solely to protect its interest, there is no duty owed to the insured. If there is no duty to the insured who can't be defended, there can be no tort damage for an excess verdict that can be pursued against the insurer for failure to accept a settlement. The plaintiff is limited to the amount of the policy.

Therefore, the intervening insurer has more latitude in how the defense and settlement decisions are made. Caution is important, however, because while it is logical that if the insurer can't mount a defense on behalf of the insured, that no duty is owed, there is currently no case law holding this or finding that the insurer still has a duty to attempt settlement notwithstanding the insured's incapacity. Is the suspended corporation similar to a bankrupt or dissolved corporation, or is suspended status different since the insured could theoretically revive and be an ongoing and viable business? Or, despite the inability to defend the insured and the insurer's right to allow a judgment to be entered, once the decision to intervene is made, is there a duty owed to the insured to accept a reasonable settlement, since the judgment could be in excess of the policy limit and executed on from the insured's assets? The law isn't developed yet.

13 *Scottsdale Ins. Co. v. MV Transportation* (2005) 36 Cal.4th 643, 655 [31 Cal.Rptr.3d 147, 115 P.3d 460].
14 *Fireman's Fund Ins. Co. v. Davis* (1995) 37 Cal.App.4th 1432 [44 Cal.Rptr.2d 546].

The intervening insurer also may have coverage defenses to the claim. Unlike a defending insurer, there is no obligation to provide independent counsel under Cal. Civil Code §2860, also known as "Cumis Counsel."[15] Because of this, the insurer gets more latitude in its choices concerning defense strategy. And, since it is defending its own interest, it would follow that the insurer may make litigation decisions in its best interest without having to accede to the best interest of the insured. For example, seeking special verdicts or using jury instructions that would inure to its benefit in later coverage litigation. Once again, however, there are no reported decisions in this area.

But, that latitude and lack of extra contractual exposure to the insurer relating to a suspended corporation can create conflicts for insurer-retained defense counsel if there are other insureds in the lawsuit. For example, assume a premises liability case where a contractor's employee was seriously injured in the swimming pool while performing work. Assume further that the injured plaintiff sued the premises owner and lessee of the premises (suspended corporations) as well as the manager individually.

If the owners of the building and business are suspended, but the employee is also named in the lawsuit, can counsel represent both the intervening insurer for the employer/owner along with the employee? If there are coverage issues, then the suspended corporations and the individual might have different defenses, and the insurer may owe different duties to the corporations and the individual. In addition, the insurer might owe a duty to accept a reasonable settlement as to the employee but not as to the suspended corporation. The carrier will likely have to choose whether it will treat the case as "normal" including accepting the risk of responsibility for an excess verdict factoring into its settlement decisions or hire two lawyers – one to defend the employee and the other to represent the insurer in intervention on behalf of the suspended corporations. Obviously the nature of the coverage defenses and the size of the claim will impact this decision.

Another example of the insurer having its own interest to protect is if the insurance company is involved in the initial investigation, since locking down key evidence can be critical to a successful defense. If that involvement affects the evidence, for example if any documents or physical evidence is given to the insurance company's investigators, it can create a situation where the insurance company is a potential witness. At trial, counsel for the intervening insurer would wear two hats, and insurance is irretrievably made part of the evidence that goes to the jury absent a favorable court ruling on the potential spoliation issue.

Litigation discovery and discovery sanctions

The insurer can ask the jury foundational questions relating to coverage. In the lawsuit where there is only one defendant that is suspended, counsel for the intervening insurer would conduct the defense like any other case. The insurer may not "enlarge the scope" of the issues being litigated, meaning that the insurer could not litigate and ask for a determination of whether there is coverage. However, there would appear to be no prohibition on asking the jury to determine certain facts that would drive coverage in the subsequent coverage case. For example, counsel could not ask if the damage falls within the work-product exclusions in the General Liability policy, but it could ask the jury to determine whether the alleged defect in construction caused physical damage to other property. These are examples of the greater latitude that an intervening insurer has. In a case where the insured is not suspended, the insurer normally couldn't seek special interrogatories of the jury that would determine coverage at the risk of being accused of putting its interests above those of the insured as a breach of the covenant of good faith.

The intervening insurer will be a participant in the discovery process as a "party" to the litigation. The insurer can expect written interrogatories and requests to produce documents that are in the possession, custody, or control of the insurer.[16] Counsel for plaintiffs commonly ask the intervening insurer questions that could be answered by the suspended insured, but in most cases the insurer cannot answer such questions. The first challenge is to fit the insurer's independent obligations to do a "diligent search" and "reasonable inquiry" to locate discoverable documents and answer the questions. The insurer should always take care to answer from the perspective of the insurer. As with any other party, "the obligation is well beyond an attorney dictating a response off the top of his head and looking through his file."[17] The breadth of information that technically can be considered in the party's possession or

15 From the decision in *San Diego Fed. Credit Union v. Cumis Ins. Soc'y* (1984) 162 Cal.App.3d 358 [208 Cal.Rptr. 494].
16 Code of Civ Proc §2031.010(b)
17 See *Sinaiko Healthcare Consulting, Inc. v. Pacific Healthcare Consultants* (2007) 148 Cal.App.4th 390.

under its control is broad, and includes the lawyer, Experts, Insurers, and Affiliated Companies.[18] With this breadth of an inquiry that is required under normal circumstances, it is entirely reasonable to produce the information that the intervening insurer obtains through its investigation with the insured considering the loss, assuming the suspended insured is cooperating. But even then, the response should be from the insurer, who should be careful not to respond as if it's on behalf of the insured.

But what about privileges? The second challenge is realizing that this duty to provide information does not mean that applicable privileges of insureds are overruled. For instance, while information concerning an accident would be in the insurer's possession and maintained in the claim file of the non-suspended insured, it would be bad faith for the insurer to undermine its insured and to dip into that claim file and produce privileged materials to the plaintiff.[19] As one court put it, a carrier cannot be in bad faith for failing to so something that would itself be bad faith.[20] In context, an insured is entitled to have their claim file and communications with their lawyers protected.[21] In other words, while the other claim files are in the possession of the insurance company, the normal privileges would apply. Therefore, while similar, discovery in a suspended corporation scenario is different because it's on behalf of the insurer, not the party to the accident, but we must be mindful of the privileges that would attach both from the insurer and from other insureds.

Then there is the prospect of discovery motions and discovery sanctions. In a suspended corporation situation, it is likely there will be discovery disputes if, for example the insured is suspended after the lawsuit is served and an answer filed and counsel assigned. The plaintiff serves normal discovery and the defense counsel hired for the insured (before suspension) is hamstrung and can't respond. Sanctions will be imposed against any party who makes or opposes a discovery motion and loses as a general matter in California. Sanctions will be graduated to fit the non-compliance, ranging from monetary sanctions to issue/evidence sanctions to terminating sanctions resulting in a default judgment. If there is a prospect of discovery sanctions and the insured is suspended, this should create an immediate review of whether to intervene.

As an example of "thinking ahead," in California, there is a discovery motion to have requests for admission "deemed admitted." At first glance, it appears that such an order would only affect the suspended corporation. However, that is shortsighted. Take for example a non-suspended corporation case, but a non-cooperating insured driver who didn't respond to discovery. In that case the plaintiff served requests asking the defendant to admit that they were negligent and that the medical treatment and bills were reasonable. The requests for admission were deemed admitted when the defendant did not respond. The trial court then ruled that those admissions were binding on the employer, finding that because the employee driver had the factual issue determined against him, and the employer was vicariously liable, the employer had also admitted that the driver was negligent, and the medical treatment and bills were reasonable and a several million-dollar judgment entered. On appeal, the case was reversed and sent back to a new trial for the employer.[22]

A similar tactic is tried with regard to suspended corporations, attempting to create an evidentiary record through discovery sanctions. The parallels of having key facts admitted can implicate difficult issues as to the effect of the discovery sanctions on innocent third parties. In other words, an alternate road to a default judgment to go against the insurer is discovery sanctions that could affect the other parties in the case, including a non-suspended insured. Therefore, if an insurer is facing a non-cooperating insured or a suspended corporation, the insurer needs to consider the long-term ramifications of the sanctions.

Trial issues

Trial presents several issues with the suspended corporation. Evidence of insurance at trial is not admissible to show negligence or fault.[23] In a straight intervention case without complicating factors, trial judges have typically granted motions in limine to preclude reference to the

18 A Party's Lawyer *Smith v. Superior Court* (1961) 189 Cal.App.2d 6; Experts *Sigerseth v. Superior Court* (1972) 23 Cal.App.3d 427,433; *Insurers Clark v. Superior Court* (1960) 177 Cal. App 2d 577; *Affiliated Corporations Standard Ins., Co. v. Pittsburgh Electric Insulation, Inc.* (1961, WD Pa) 29 FRD 185; *Gerling Intern. Insur. Co. v. C.I.R.* (1988,3 Cir) 839 F2d 131, 140, 141.

19 *Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688 [201 Cal.Rptr. 528] it is bad faith to improperly use one claim file's information to the detriment of that insured.

20 *Coe v. State Farm Mut. Auto. Ins. Co.* (1977) 66 Cal.App.3d 981 [136 Cal.Rptr. 331] – failing to pay policy limits without achieving a release of all claims is not bad faith; paying the limits and withdrawing from the defense would be bad faith.

21 *Soltani-Rastegar v. Superior Court* (1989) 208 Cal.App.3d 424 [256 Cal.Rptr. 255] – statements to the insurance claim representative are protected under the attorney-client privilege.

22 *Inzunza v. Naranjo* (2023) 94 Cal.App.5th 736 [312 Cal.Rptr.3d 596].

23 Evid Code §1155

insurer and refer to counsel as such for the suspended corporation to avoid the prejudice. However, that scenario may not be possible if there are allegations that the insurer actively participated in the litigation on its own, answered discovery or is part of evidence spoliation. It's an issue that comes up rarely, but it would be difficult to avoid having to have an insurance company representative at trial where the accusation is made, and it is a party to the case.

CONCLUSIONS

In the 14 years since the original article on the Problems of Suspended Corporations, there have been some new cases and laws largely supporting the original analysis and building blocks of intervention. There have been new tactics used to "get at" the insurer by using the suspended status offensively. There also has been more experience in dealing with conflict, litigation tactics and coverage issues in that context.

Herein, we have outlined some of those problem areas and techniques and updated the areas of concern for insurers facing a situation with a suspended corporation.

A few considerations:

- First, remember that to intervene, the insurer need to show a direct interest in the litigation. While there is a body of law, it is still discretionary so convince the judge of the need. Be prepared to show that if there are coverage issues, there is still an immediate interest.
- Second, intervening makes the insurer a new party to the litigation. Do not allow the court or other parties to confuse the status by using such phrases as "intervening on behalf of" or "for" the suspended corporation. Counsel's perspective in that role must be as counsel for the insurance company. Otherwise, the sins of the suspended corporation could directly affect the defense of the insurer. As a corollary to the "new party" rule, the case must be litigated from the perspective of the insurer. It is safe to issue a reservation of rights if there are coverage issues; consider raising the issues in the answer being filed. Discovery and any motions must be approached from that perspective.
- Third, the job of counsel for the intervening insurer is to protect the insurer, especially if there are any allegations that the insurer has a dual role: passively protecting the policy by defending the insured and actively creating a factual record for any coverage defenses, and defending potential direct claims and improper references to the insurer at trial.
- Fourth, trial is tricky since the intervening insurer is both a party and the insurer. It's not impossible that a plaintiffs' attorney will attempt to engineer a way that the insurance for the defendant is presented to the jury by arguing that the introduction of the intervenor is not to show negligence and thus not barred by Evidence Code §1155. Counsel should therefore seek to minimize the separate interest of the insurance company for purposes of trial even as it emphasizes separateness pre-trial.

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