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Demander beware!

A POLICY-LIMIT DEMAND IS CRUCIAL TO ANY CLAIM FOR FAILURE TO SETTLE, BUT MAKING AN INCORRECT DEMAND CAN CRIPPLE YOUR CASE

The standard for any "failure to settle" case for insurance bad faith is well known: the insurer "failed to accept a reasonable settlement demand for an amount within policy limits." (CACI 2334.) Because of that standard, the policy-limit demand – and whether it fits within the bounds of "reasonable"– is likely to be the single most important document in your eventual bad-faith case against the insurer. The structure of the demand, and the carrier's response, will ultimately dictate your fate.

Although the California Supreme Court has stated that "the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer," you are likely to hear a litany of excuses from the insurer as to why the demand could not be accepted as written. (*Johansen v. California State Auto. Ass'n Inter-Ins. Bureau* (1975) 15 Cal.3d 9, 16.) Some of these excuses will only be raised for the first time *years* after the demand was rejected, but could have been avoided with a bit of planning, and sending a policy-limit demand with the insurance bad-faith action in mind. This article will explore the basics of failure-to-settle liability, and delve into a list of potential pitfalls that my office regularly encounters when evaluating these cases, which can substantially complicate any action against the insurer.

The basics of a failure to settle

The basics of a failure-to-settle case are well established: "In each policy of liability insurance, California law implies a covenant of good faith and fair dealing," which obligates the insurance company "to make reasonable efforts to settle a third-party's lawsuit against the insured. If the insurer breaches the implied covenant by unreasonably refusing to settle the third-party suit, the

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insured may sue the insurer in tort to recover damages proximately caused by the insurer's breach." (*PPG Industries, Inc. v. Transamerica Ins. Co.* (1999) 20 Cal.4th 310, 312.) "The duty to settle is implied in law to protect the insured from exposure to liability in excess of coverage as a result of the insurer's gamble – on which only the insured might lose." (*Murphy v. Allstate Ins. Co.* (1976) 17 Cal.3d 937, 941.) Thus, "the insurer must settle within policy limits when there is substantial likelihood of recovery in excess of those limits." (*Id.*; see *Isaacson v. California Ins. Guarantee Assn.* (1988) 44 Cal.3d 775, 792, fn. 12; CACI 2334.)

Breach of the duty to settle is most "typically shown by proof that the injured party made a reasonable settlement offer within the policy limits and the insurer rejected it." (*Howard v. American Nat. Fire Ins. Co.* (2010) 187 Cal.App.4th 498, 525.) Broadly, a claim of wrongful refusal to settle will depend on a policy-limit demand that meets the following conditions: "(1) its terms are clear enough to have created an enforceable contract resolving all claims had it been accepted by the insurer; (2) all of the third-party claimants have joined in the demand; (3) it provides for a complete release of all insureds; and (4) the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure." (*Graciano v. Mercury General Corporation* (2014) 231 Cal.App.4th 414, 425.)

But that "reasonable settlement offer" can come in many shapes, sizes, and formats. Fortunately, "California law does not require claimants to begin settlement overtures with letter-perfect offers to which insurers need only respond 'Yes' or 'No.' An insurer's duty of good faith would be trifling if it did not require an insurer to explore the details of a settlement offer that could prove extremely beneficial to its insured." (*Allen v. Allstate Ins. Co.* (9th Cir. 1981) 656 F.2d 487, 490.) In fact, an insurer's summary rejection of an offer for lack of "sufficiency, competency, [and] adequacy" without an attempt to seek clarification can subject that insurer to bad faith liability.

Unfortunately, even though the structure of a demand need not be "letter-perfect," there are a number of specific pitfalls that may give the insurer an "out" for rejecting the demand. Some of the main pitfalls follow.

Ensure you are demanding the correct policy limit – send a *Boicourt* letter

It is all too common that claimants and their counsel may be operating in the dark during pre-litigation regarding the limits of the policy on which they are going to make a demand. Traffic Collision Reports, ordinary correspondence with the insurer, and publicly available records will be of little assistance. And although you can make a demand for "all available limits under the policy," it is better to be *sure* – both to obtain informed client consent (if the demand is accepted), and to further strengthen your policy-limit demand.

The best way to obtain the available limits is to send a letter under *Boicourt v. Amex Assurance Co.* (2000) 78 Cal.App.4th 1390, 1397-1398, requesting written confirmation of the insured's applicable policy limits, and stating that the claimant requires this information in order to make a demand to resolve the action within those limits. If the insurer has a blanket policy of refusing to disclose policy limits, or refuses to request permission for disclosure from the insured (under Cal. Ins. Code § 791.13), the refusal to disclose policy limits may even provide a shortcut to a finding of bad faith – because the insurer's refusal has foreclosed the possibility of settlement within policy limits. (*Ibid.*)

In short, if you're still in the dark of pre-litigation, a *Boicourt* letter may be just the trick to force disclosure of policy limits, and enable a demand for those available limits.

Give the insurer enough time

Provide the insurer sufficient time to consider the demand – and obtain proof the letter was actually received by the insurer. Again, one of the major requirements for a successful policy-limit demand is that "the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure." (*Graciano, supra,* 231 Cal.App.4th at 425.) Courts have specifically held that "the third party is entitled to set a reasonable time limit within which the insurer must accept the settlement proposal ...." (*Martin v. Hartford Acc. & Indem. Co.* (1964) 228 Cal.App.2d 178, 185.) Thus, "[w]hether [the insurer] 'refused' the 'offer,' and whether it could have acted otherwise in light of the . . . deadline imposed by the offer's terms," is usually a question of fact. (*Coe v. State Farm Mut. Auto. Ins. Co.* (1977) 66 Cal.App.3d 981, 994.) But you can dramatically limit the insurer's ability to wriggle out from a policy-limit demand by ensuring sufficient time, and that the insurer actually *had* that time after *receipt* of the demand to investigate.

Though there is no prescribed time for a policy-limit demand – even seven days may not be too short of a time, depending on the facts of the case (see *Critz v. Farmers Ins. Group.* (1965) 230 Cal.App.2d 788, 798) – it is better to err on the side of caution and provide a full 30 days to consider the offer. Providing less time can get into the vagaries of when the demand was received, how it was routed through the insurer, how the insurer had to convene to evaluate it, etc. In addition, depending on the stage of litigation, the discovery conducted, and other factors, it may also prove advisable to provide a single reasonable extension of time to complete *specific* tasks requested by a responding insurer.

Consistent with actually *providing* the insurer with a reasonable time to investigate is to double- and triple-check that you are demanding the policy limits of the correct insured under the correct policy number (negating a claim under *Graciano* that the claimant misidentified the policy/insured and party liable, see *Graciano*, at 428-429). The same is true of sending the letter to the proper address. If you have been corresponding with the insurer at a specific address, use *both* that address and the general claims address

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(found generally in the insurance policy or on the insurer's website).

Use certified mail

Send the letter certified mail, return receipt requested, so that you have concrete proof the insurer received the demand. The same is true of any letter granting an extension of time to respond, so that you can demonstrate the insurer's receipt of any new deadline. (See, e.g., *McDaniel v. Government Employees Insurance Company* (9th Cir. March 7, 2017) 2017 WL 892516, *petition for cert filed* 6/16/17 (finding that insurer who failed to realize receipt of documents – triggering the new deadline for acceptance – was not in bad faith, as its conduct was mere negligence).)

Finally, to eliminate confusion regarding acceptance of the demand, the best practice is to provide that any acceptance must be in *writing* and *received* by the claimant's attorney by a certain date and time. This eliminates any issues with whether the insurer actually sent the letter timely, post-dated it after the date for acceptance, or other quirks in these kinds of cases.

"Prove" your case to the insurer

Far too often, in evaluating these kinds of cases, the policy-limit demands are short, devoid of records, and provide only a minimal recitation of the facts, such as "your insured struck my client, who suffered injuries X, Y, and Z." But a policy-limit demand is an opportunity to go much further, and help establish your case with the insurer from the very outset. Keep in mind, in any eventual bad-faith case "the finder of fact must take into account that information available to the insurer at the time of the proposed settlement." (*Camelot by the Bay Condominium Owners' Assn. v. Scottsdale Ins. Co.* (1994) 27 Cal.App.4th 33, 48.)

One of the best ways to improve your bad-faith case is to put in the time and investigation it takes to produce a fleshed-out policy-limit demand. Explore exactly *why* the insured is going to be liable for the injuries suffered by your client. Cite to the relevant case law, CACI instructions, or statutory basis for imposing liability, and why most (if not all) of that liability is likely to rest with the insured.

On the damages side, provide the carrier with sufficient information to show the *size* of any likely verdict against the insured. Try to include a reasonable medical timeline, a description of each of the injuries suffered (and the care to treat those injuries), and perhaps most importantly, the medical bills *paid* to date, as well as the recommended *future care*. If you have reasonable verdict comparisons for the type of injury, include those too.

As to records, it is best to attach to the policy-limit demand as many relevant records as you have in your possession, and specifically list those records as being provided with the policy-limit demand. This includes the Traffic Collision Report, Google Maps/Images of the area in question, publicly available witness statements, photographs, video if available, and (even though usually extensive) as many pertinent medical records as possible. Far better to be over-inclusive than to provide the insurer an "out" down the road because they were missing records or hadn't "completed their investigation." Your goal should be to show from the very instant the insurer receives the policy-limit demand that "the potential judgment was likely to exceed the amount of the settlement demand based on [your client's] injuries or loss and [the insured's] probable liability." (CACI 2334.)

Finally, in showing that the demand is reasonable, focus your efforts on *covered* claims and damages. (*Camelot, supra,* 27 Cal.App.4th at 52 ("the insurer does not, however, insure the entire range of an insured's well-being, outside the scope of and unrelated to the insurance policy, with respect to paying third-party claims" and an insurer may "still bear in mind the distinctions between its potential monetary obligations to the third-party claimant and to its insured").) This is particularly true with respect to punitive damages. Although an insurer has a duty to accommodate and cooperate with its insured regarding their exposure to punitive damages, it has *no obligation* to "pay compensation for punitive damages in a settlement." (*J.B. Aguerre, Inc. v. American Guarantee & Liability Ins. Co.* (1997) 59 Cal.App.4th 6, 17; see also Cal. Ins. Code § 533.)

Join all claimants and offer a full release to all insureds

To ensure that you are sending a demand that is capable of acceptance by the insurer, it should be made on behalf of *all* claimants to the insurance policy, and offer to fully and finally release all insureds – including additional insureds – under the relevant policy. This flows from two separate, but related principles: (1) insurers are loath to accept piecemeal settlements that do not join all claimants, because those settlements may subject them to bad-faith liability for prematurely exhausting the policy limits (*Kinder v. Western Pioneer Ins. Co.* (1965) 231 Cal.App.2d 894, 901-903); and (2) insurers are required to ensure that a settlement for policy limit extends to *all* of its insureds, as insurers may "reject a settlement offer that does not include a complete release of all its insureds" (*Strauss v. Farmers Ins. Exchange* (1994) 26 Cal.App.4th 1017, 1021; *State Farm Mut. Auto Ins. Co. v. Crane* (1990) 217 Cal.App.3d 1127, 1136 (insurer cannot settle without a full release of insureds, as to do so would "bankroll" claimant's continuing litigation).)

This particularly comes into play in multi-vehicle accidents, with multiple claimants to a single policy, covering potentially multiple insureds (the driver, plus the owner, co-owner, etc.). And many insurance policies have both a "per person" limit, and a "per occurrence" limit. If the number of claimants exceeds the aggregate occurrence limit (i.e., on a $100,000 per person/$300,000 per occurrence policy with 4 or more claimants), join with the other claimants to make a *global* policy-limit demand that releases any and all insureds. Otherwise, you may find yourself with an insurer who has an easy "out" to avoid accepting the policy-limit demand. The one notable exception to this line of thinking is if the total

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number of claimants is less than the aggregate limit (i.e., 3 or fewer claimants in the above example); a policy-limit demand on behalf of one claimant for the "per person" policy limit would be acceptable, and the carrier's rejection could potentially subject it to bad-faith liability.

Address any liens – particularly workers' comp

Similar to the above, addressing liens in the policy-limit demand letter is akin to addressing additional claimants, and should be included in every demand. One approach is to include language that the "claimant shall be responsible for the resolution of any and all liens, and will sign an appropriate release reflecting this agreement." This helps resolve any claim by the insurer that the insured could be responsible for a subrogation action or other proceeding (such as Medi-Cal, Medicare, Medicaid, etc.) to recoup funds paid for the claimant's injuries. But don't be surprised if the insurer insists on placing known lien claimants onto the settlement check too. (*Mercado v. Allstate Ins. Co.* (9th Cir. 2003) 340 F.3d 824, 828.)

One interesting caveat has to do with liens that require the lienholder's consent to settle, which, if raised by the insurer, can be a reason to avoid accepting a policy-limit demand. (*Coe, supra,* 66 Cal.App.3d 981, 992-993 ("[b]ad-faith refusal to accept a settlement offer cannot occur where 'acceptance' would itself be bad faith").) The most likely scenario in which this will come up is with worker's compensation liens. Namely, California Labor Code § 3859(a) requires an employer with a lien in an employee's action against a tortfeasor to *consent* to any settlements between employees and tortfeasors. (*McKinnon v. Otis Elevator Co.* (2007) 149 Cal.App.4th 1125, 1132-34; *Bailey v. Reliance Insurance Co.* (2000) 79 Cal.App.4th 449, 455). For example, in *Coe*, the offer failed to mention, guarantee, or offer the consent to settlement by the worker's compensation lienholder. When the insurer raised this issue, rightfully requesting some form of guarantee of consent to the settlement, the claimant did not do so – meaning that "none of [the claimants] made an offer whose acceptance by [the insurer] would have produced a valid settlement of the claims against [the insured]." (*Coe, supra,* 66 Cal.App.3d at 993.)

There are a few different solutions to this problem. First, obtain the lienholder's consent to settle at the time of making the policy-limit demand, and include proof of that consent in the demand itself. Second, and the option suggested by *Coe*, would be to include a representation in the policy-limit demand "that the offer was intended to carry with it an assurance that before any settlement was paid the compensation carrier would be brought into a comprehensive resolution of all claims against the insured." (*Coe, supra,* 66 Cal.App.3d at 993.) Third, and perhaps most difficult, is to structure the demand as a "segregated settlement"– meaning the claimant settles their claim for an amount that is *exclusive* of the employer-provided worker's compensation benefits. (Cal. Labor Code, § 3859(b); *Insurance Co. of North America v. T.L.C. Lines* (1996) 50 Cal.App.4th 90, 98, n.2.)

Because many worker's compensation claims may still be ongoing at the time of the policy-limit demand, it may be most workable to use the second option. But if your demand uses the third, be certain to specifically describe it as a segregated settlement, provide the amount of the benefits under the policy *not* being claimed (because they are segregated for the lienholder), and carefully describe the segregation in the demand.

Don't overdo it with conditions

Conditions in policy-limit demands seem to present themselves in ever greater varieties. From declarations about excess insurance, assets, or whether the insured was in the course and scope of their employment, to requirements the insurer settle but continue to defend or hire an expert to assist in proving the claimant's case, there are a number of conditions that policy-limit demands attempt to impose. But which ones are actually proper and imposable on an insurer?

By now, most of us are likely familiar with the language from *Graciano*, holding that "when a liability insurer timely tenders its 'full policy limits' in an attempt to effectuate a reasonable settlement of its insured's liability, the insurer has acted in good faith as a matter of law." (*Graciano*, *supra,* 231 Cal.App.4th at 426 (insurer tendered policy but did not provide declarations page or check as requested in 10-day policy-limit demand, still be in good faith).) Though a later appellate decision has factually clarified this language, it is still something that insurers might seize upon, with Rutter describing that "[w]hen an insurer tenders its limits in exchange for a release of its insured within the time frame of the claimant's demand, it acts in good faith as a matter of law, even if the tender does not comply with all of the other conditions contained in the demand." (*Cal. Prac. Guide: Insurance Litigation,* Ch. 12B, § 12:349, citing *Graciano*, 231 Cal.App.4th at 426.)

Notably, *Barickman v. Mercury Casualty Company* (2016) 2 Cal.App.5th 508, 519 distinguished the language in *Graciano*. In *Barickman*, the insurer claimed that because it had timely tendered its policy limits, with settlement held up by the claimant's insistence on specific language in the release, it was in good faith as a matter of law under *Graciano*. But the insurer "read[ ] far too much into the holding and analysis in *Graciano*." Instead, *Graciano*'s holding was specific to its facts, which included an insurer who tendered its policy limits within the time limit in the demand, despite the demand misidentifying the insured and referring to an expired insurance policy. Under *those* circumstances, the insurer was held to be in good faith.

But neither *Graciano*, nor the authority it relied on in *Lehto v. Allstate Ins. Co.* (1994) 31 Cal.App.4th 60, 73, and *Crane, supra,* 217 Cal.App.3d 1127, 1136, "stand [ ] for the proposition . . . that, regardless of any other circumstances, a timely policy limits settlement offer insulates an insurer from a claim of bad

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faith." (*Barickman, supra,* 2 Cal.App.5th at 520, n.5.) Another court found that the *Graciano* case "involved the unique circumstance where the only demand ever extended was directed to a person who was not involved in the accident and whose policy had expired by the time of the accident." (*Madrigal v. Allstate Ins. Co.* (C.D. Cal. 2016) 215 F.Supp.3d 870, 911, aff'd, 9th Cir. 6/15/17) __ Fed.Appx __ .)

What conditions are appropriate?

Confusion over what conditions are appropriate for a policy-limit demand continues. For example, in *Barickman*, the insurer initially offered the policy limits. The claimant responded that it was willing to accept the policy limits, but required language in the release that would not diminish the right to restitution in a companion criminal case. The insurer failed to seek clarification, refused to accept the amended release, and failed to present a timely release that would resolve the claimant's concerns. Despite the earlier tender of policy limits, that conduct was still found to be in breach of the implied covenant. (*Barickman, supra,* 2 Cal.App.5th at 521-522.) On the other hand, in *Heredia v. Farmers Ins. Exch.* (1991) 228 Cal.App.3d 1345, 1357, the claimant sought to settle for policy limits, but still require the insurer to provide a defense (to avoid the "empty chair" issue at trial). The court found that there was "neither authority nor justification for imposing such a duty upon an insurer," and rejected claims of bad faith (*Ibid.*)

One approach is found in *Madrigal, supra,* where the policy-limit demand required the insurer to satisfy four conditions within 30 days: "(1) a photocopy of 'all available liability insurance policies,' (2) an 'appropriate release of all claims,' (3) a declaration stating that 'the insured' has no other liability insurance policies and was not acting in the course and scope of his employment at the time of the accident, and an 'asset sheet of all assets or lack thereof,' and (4) a settlement draft 'equal to the amount of all available liability insurance policy limits.'" (*Madrigal, supra,* 215 F.Supp. at 894.) The demand further provided that performance "of some, but not all, of the above condition[s] precedent will be deemed" to be a counteroffer, and that any counteroffers will be rejected. (*Ibid.*) Interestingly, even the insurer's expert agreed, stating that the demand "had a number of conditions that were appropriate that [the insurer] could deal with to accept the demand." (*Id.* at 912.) And in *Madrigal*, the failure to assist the insured in providing an asset disclosure was found to be a jury question regarding bad faith.

Ultimately, the best practice is to keep the conditions simple, and to demand only what *the insurer* has control over. Conditions that require the insured to personally take action (such as asset disclosure) or that require the carrier to expend sums beyond payment of the policy limits (such as providing a continuing defense or paying an expert) might provide a convenient "out" for the insurer if the conditions are not met. In any event, if the insurer fails to comply with the conditions, *document* why that failure makes it impossible to complete the settlement, and what can be done to resolve the issue.

Conclusion

Policy-limit demands, and the consequences when an insurer fails to accept, can be extremely complicated. But to best represent our clients, and attempt to obtain maximum recovery, it is a strategy that should be used in nearly every case, particularly when the insurer may be the only source of adequate recovery.

To ensure a reasonable shot at the eventual bad-faith case, ensure you are avoiding the pitfalls that cause so many of these cases to falter from the start.

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