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THE RECORDER

New Excess Verdict Demand Letter Requirements

By Arnie Levison
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Where an insurance company fails to accept a reasonable settlement demand within the limits of the applicable insurance policy, it can be responsible for the entirety of a judgment entered against its insured. In order for that to happen, the demand must be reasonable, and the insurer must have a reasonable opportunity to evaluate and assess the demand. See CACI 2334. In addition, there must be a finding that the insurer's conduct was unreasonable. See *Pinto v. Farmers Insurance Exchange* (2021).

An essential element is that the demand "not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure." See *Graciano v. Mercury General*. Until now there have been no express judicial or legislative standards of when and how those demands should be made. At the early stages of a case, more time would be necessary. A few weeks or even a few days might be seen as enough time if the parties were on the precipice of or in trial.

In the recent case of *Pinto,* supra, the demand letter only provided eight business days to respond and was sent to the document center in Oklahoma rather than directly to the claims adjuster in California. The jury found that the demand was reasonable but also concluded that the insurer's conduct was not unreasonable in failing to accept the demand. Under those circumstances the Court of Appeal found that the judgment was not enforceable against the insurer.

In *Hedayati v. Interinsurance Exchange* (2021), the claimant effectively gave the insurer only a couple of days to respond because it was sent just prior to the Thanksgiving holiday. Nonetheless, the court found the demand reasonable under the circumstances at hand.

Arnie Levinson of Signature Resolution. Courtesy photo

Litigants have been battling about the boundaries of what constitutes a reasonable demand and what is unreasonable conduct for years. Sometimes the demand might be a single sentence containing the demand. Other demands are lengthy discussions of the facts and law applicable to the claim. Demands also are often accompanied by requirements in addition to merely an insistence on paying the amount of the limits.

Commonly demands also request declarations regarding the amount of insurance, whether the insured has other insurance and/or was in the course and scope of employment. The insurer may or may not have a full set of medical records or authorization or subpoena power to obtain the records, as well as other pertinent information necessary to assess the scope of liability its insured faces.

The obligation to accept a reasonable demand stems from the fundamental duty of an insurer to protect its insured from verdicts in excess of coverage limits. But that duty often runs up against the insurer's rights to investigate the claim against its insured. The insurer is obligated to protect its insured but not required to ignore its rights completely.

Effective Jan. 1, 2023, the boundaries of a reasonable settlement demand are now set out by CCP§999-999.5 but only for demands prior to the filing of a complaint. The statute is intended to calm the waters around what is and what is not a reasonable settlement demand for pre-litigation matters. Once the parties are in litigation, other factors come into play such as the ability of each side to conduct discovery, pending motions such as for summary judgment and impending trials. Still, it may be good practice to abide its guidelines during litigation.

The demand must now be specifically labeled as a "time-limited demand" or reference the statute. Other key provisions are that the demand must be left open for at least 30 days (or 33 days if sent by mail) and the demand must contain "a description of all known injuries sustained by the claimant" and "reasonable proof, which may include, if applicable, medical records or bills, sufficient to support the claim." CCP§999.1(f)(g).

The statute also imposes requirements on insurers. If the insurer does not accept the demand it "shall notify the claimant, in writing, of its decision and the basis for its decision. This notification shall be sent prior to the expiration of the time-limited demand … and shall be relevant in any lawsuit alleging extracontractual damages against the tortfeasor's liability insurer. CCP §999.3(c).

Thus, the statute requires the parties to substantively exchange information before the expiration of the demand. The claimant has to provide adequate description and proof of all injuries and the insurer has to explain why those claims are insufficient. Notably, there is no requirement to notify the insured of all of this information.

There are a number of unanswered questions left unclear from the statute. What constitutes a description of all known injuries, what is reasonable proof and what is sufficient to satisfy the insurer's duty to describe the basis for its decision? Importantly, the insurer's description of the basis for its decision must be communicated before the demand expires. This means that claims personnel will need to take whatever actions may be necessary to decide whether to accept or reject the demand with sufficient time to prepare an appropriate letter describing the basis for a rejection. Requests for an extension of the demand may then need to be made well in advance of the 30-day deadline.

Also of note is that there is no specific penalty to the insurer if it fails to provide an appropriate basis for its rejection of a demand. The penalty to the claimant for failing to provide sufficient details or evidence is the failure of a subsequent bad faith action. CCP §999.4(a). The failure of the insurer to comply with its obligations likely would be evidence of possible bad faith but would not necessarily require it losing the bad faith action.

The purpose of the insurer's requirement to detail its reason is so that the claimant can know what is necessary for a reasonable settlement demand. As such, an insurer's failure to detail the basis of a rejection, could mean that the demand is thereby deemed reasonable.

The statute has a carve-out for claimants who are unrepresented by counsel. This may leave open the possibility that claimants can avoid the statute's requirements even where they are assisted by counsel as long as counsel is not representing the claimant.

As noted, the statute only applies to pre-litigation matters. However, one can anticipate that insurers and claimants may contend that the parameters set out in these statutes represents a legislative expression of the reasonable expectation of the parties in limits demand situations. More to the point, courts may adopt the standards set forth in these statutes as guidelines to judge the reasonableness of demands made during litigation.

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