SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

SB 1155 (Caballero)
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Fiscal: No
Urgency: No
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SUBJECT

Liability claims: time-limited demands

DIGEST

This bill establishes a statutory framework for settling civil claims using a "time-limited demand," as defined.

EXECUTIVE SUMMARY

Existing law implies a covenant of good faith and fair dealing in each policy of liability insurance. An insurance company is thereby obligated to make reasonable efforts to settle a third party's lawsuit against the insured. An insurance company can be found to have breached this covenant if it unreasonably refuses to settle the claim through a reasonable settlement demand. This subjects the insurer to bad faith liability in an action brought by its insured for damages awarded against an insured exceeding policy limits.

In many liability actions, a claimant will make an offer to settle claims for personal injury, property damage, bodily injury, or wrongful death against a tortfeasor with a liability insurance policy within the insurer's limit of liability insurance within a specified period of time. The insurance industry has raised concerns that these "time-limited demands" have become increasingly unreasonable and used as a litigation tactic to subject insurance companies to bad faith liability in excess of the relevant policy limits.

This bill creates a detailed statutory framework for how such demands must be made and the minimum amount of time that must be afforded the insurance company to accept. Failure to "strictly comply" with the terms of the bill results in the underlying offer being deemed unreasonable.

The bill is sponsored by the Personal Insurance Federation of California (PIFC) and the American Property Casualty Insurance Association. It is supported by other insurance

company associations. It is opposed by the Consumer Attorneys of California and other consumer advocacy groups.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Identifies unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. This includes misrepresenting the terms of an insurance policy, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies, and not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear. (Ins. Code § 790.03.)

2) Provides, through caselaw, that no private right of action for violations of the above exists. (*Moradi-Shalal v. Fireman's Fund Ins. Co.* (1988) 46 Cal. 3d 287, 304-305.)

3) Provides that not less than 10 days prior to commencement of trial or arbitration, any party may serve an offer in writing upon any other party to the action to allow judgment to be taken or an award to be entered in accordance with the terms and conditions stated at that time. The written offer shall include a statement of the offer, containing the terms and conditions of the judgment or award, and a provision that allows the accepting party to indicate acceptance of the offer by signing a statement that the offer is accepted. Any acceptance of the offer shall be in writing and shall be signed by counsel for the accepting party or, if not represented by counsel, by the accepting party. (Civ. Proc. Code § 998.)

4) Provides for the offsetting of costs based on the failure to accept an offer that is more favorable than a judgment or the provision of an offer that is less favorable than the judgment, as provided. (Civ. Proc. Code § 998.)

This bill:

1) Defines "time-limited demand" to mean any offer to settle any claim for personal injury, property damage, bodily injury, or wrongful death made by or on behalf of a claimant to a tortfeasor with a liability insurance policy for purposes of settling a claim against the tortfeasor within the insurer's limit of liability insurance, which by its terms must be accepted within a specified period of time.

2) Requires that a time-limited demand to settle any claim reference this law, be in writing and labeled as "time sensitive," sent certified mail return receipt requested to the claims department of the tortfeasor's liability insurer, and shall contain the following material terms:

a) the time period within which the demand must be accepted, which shall be not fewer than 45 days from service of the demand;
b) the amount of monetary payment demanded;
c) an offer for a complete release from all third-party claimants for the liability insurer's insureds from all present and future liability for the occurrence;
d) the date and location of the loss;
e) the claim number, if known;
f) a description of all known injuries sustained by the claimant; and
g) all relevant proof in support of the claim, including a list of the names and addresses of health care providers treating or evaluating the claimant or decedent for injuries suffered from the date of injury until the date of the time-limited demand, all pertinent medical bills, reports, and records documenting the alleged injuries and treatment received, loss of earnings documentation, and medical and other relevant liens.

3) Provides that recipients of a time-limited demand may accept the demand by providing written acceptance of the material terms outlined above in their entirety.

4) Provides recipients the right to seek, if necessary, clarification or additional information regarding terms, liens, subrogation claims, standing to release claims, medical bills, medical records, preexisting medical conditions, and other relevant facts. The bill makes clear that an attempt to seek clarification or a request for an extension due to the need for further information or investigation shall not be deemed a counteroffer or rejection of the demand.

5) Provides recipients the right to seek a list of the names and addresses of all the claimant's employers at the time the claimant was first injured until the date of the time-limited demand, records from employers and tax records documenting any loss of wages, earnings, compensation, or profits claimant or defendant is asserting, and written authorizations sufficient to allow the liability insurer to obtain those records from all employers listed.

6) Requires the insurer, if it is unable to accept a time-limited demand due to failure to receive sufficient information following requests for additional time and information, to notify the claimant that it cannot accept the demand with an itemized list of remaining factual deficiencies. The claimant has 30 days from service of the insurer's response to respond to the request for additional time, information, or clarification.

7) Provides that a time-limited demand that does not strictly comply with these terms shall not be considered to be a reasonable offer to settle the claims against the tortfeasor for an amount within the insurance policy limits and shall not be

admissible in any lawsuit alleging extracontractual damages against the tortfeasor's liability insurer.

8) Defines "extracontractual damages" to mean any amount of damage that exceeds the total available limit of liability insurance for all of a liability insurer's liability insurance policies applicable to a claim for property damage, personal injury, bodily injury, or wrongful death.

9) Clarifies that it applies to causes of action and claims for property damage, personal injury, bodily injury and death, and other damages claimed that are potentially covered under a liability insurance policy.

COMMENTS

1. State of the law on bad faith insurance claims

The Unfair Insurance Practices Act prohibits unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. (Ins. Code § 790 et seq.) Insurance Code section 790.03 specifically identifies these unfair practices. This includes misrepresenting the terms of an insurance policy, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies, and not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

Originally, the California Supreme Court held that Section 790.03 provided a private right of action against insurers for violations of the Unfair Insurance Practices Act.[1] In 1988, this holding was overruled in *Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal. 3d 287, 292. However, the Supreme Court in *Moradi-Shalal* made clear that "the courts retain jurisdiction to impose civil damages or other remedies against insurers in appropriate common law actions, based on such traditional theories as fraud, infliction of emotional distress, and (as to the insured) either breach of contract or breach of the implied covenant of good faith and fair dealing."[2]

This implied covenant places obligations on an insurer that, if breached, support a cause of action:

> In each policy of liability insurance, California law implies a covenant of good faith and fair dealing. This implied covenant obligates the insurance company, among other things, 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

[1] *Royal Globe Ins. Co. v. Superior Court* (1979) 23 Cal. 3d 880, 884.
[2] *Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal. 3d 287, 304-05.

> insured may sue the insurer in tort to recover damages proximately caused by the insurer's breach.[3]

The reasonableness determination in such cases has been continuously refined by the courts:

> In evaluating whether an insurer acted in bad faith, "the critical issue [is] the reasonableness of the insurer's conduct under the facts of the particular case." (*Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 723.) To hold an insurer liable for bad faith in failing to settle a third party claim, the evidence must establish that the failure to settle was unreasonable.[4]

A recent case before the Second District Court of Appeal prompted the latest refinement of this determination. In *Pinto v. Farmers Ins. Exch.* (2021) 61 Cal. App. 5th 676, an injured passenger in a car accident sued the vehicle owner for damages. The victim offered to settle his claim for payment of the relevant insurance policy limits. The owner's insurer failed to accept the offer and thereafter the victim won a judgment against the owner far in excess of the policy limits. The owner thereafter sued the insurer for bad faith. A jury found in favor of the owner and judgment was entered against the insurer.

The appellate court meticulously scoped out the responsibility of insurers in these cases and what a finding of "bad faith" required:

> An insurer's duty to accept a reasonable settlement offer is not absolute. "'[I]n deciding whether or not to settle a claim, the insurer must take into account the interests of the insured, and when there is a great risk of recovery beyond the policy limits, a good faith consideration of the insured's interests may require the insurer to settle the claim within the policy limits. An unreasonable refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits.
>
> Therefore, failing to accept a reasonable settlement offer does not necessarily constitute bad faith. "[T]he crucial issue is … the basis for the insurer's decision to reject an offer of settlement." "[M]ere errors by an insurer in discharging its obligations to its insured '"does not necessarily make the insurer liable in tort for violating the covenant of good faith and fair dealing; to be liable in tort, the insurer's conduct must also have been unreasonable."'" "[S]o long as insurers are not subject to a strict liability standard, there is still room for an honest, innocent mistake."

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[3] *PPG Indus., Inc. v. Transamerica Ins. Co.* (1999) 20 Cal. 4th 310, 312.
[4] *Pinto v. Farmers Ins. Exch.* (2021) 61 Cal. App. 5th 676, 687.

> A claim for bad faith based on the wrongful refusal to settle thus requires proof the insurer unreasonably failed to accept an offer.[5]

In determining whether the lower court properly analyzed the bad faith claim, it turned to the jury instruction used, which was modeled after Judicial Council of California Civil Jury Instructions 2334. That instruction required findings that the insurer failed to accept a reasonable settlement demand for an amount within policy limits and that a judgment was entered in excess of those policy limits. The court ruled that this was insufficient and missed a crucial element of the determination, bad faith:

> Although CACI No. 2334 describes three elements necessary for bad faith liability, it lacks a crucial element: Bad faith. To be liable for bad faith, an insurer must not only cause the insured's damages, it must act or fail to act without proper cause, for example by placing its own interests above those of its insured.[6]

This therefore requires a finding that not only was the rejected offer reasonable, but that the rejection itself was unreasonable.

2. Creating a statutory framework to govern time-limited demands

Despite the established case law that requires an insurance company to have unreasonably rejected a reasonable settlement offer, insurance company associations assert that insurance policy limited demands are being used as a litigation tactic:

> The use of a time-limited demand is a natural step in the process of settling a claim; however, recently it has become a litigation tactic to pressure an insurance company to settle without allowing sufficient time to fully investigate a claim (sometimes as little as five days) and to set up the insurer for a bad faith lawsuit. Current law does not specify how much time should be adequate in a time limited settlement demand. When the appropriate claim information is not provided by the party making the time limited demand, a request for additional information to evaluate the claim should be allowed and should not result in the withdrawal of a demand, unfairly prejudicing the defendant or their insurer.

In response to these concerns, the bill creates a detailed statutory framework that governs these "time-limited demands," or offers to settle any claim for personal injury, property damage, bodily injury, or wrongful death made by or on behalf of a claimant to a tortfeasor with a liability insurance policy for purposes of settling a claim against

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[5] *Id.* at 688, internal citations omitted.
[6] *Id.* at 692.

the tortfeasor within the insurer's limit of liability insurance, which by its terms must be accepted within a specified period of time.

The bill lays out a series of requirements for such demands, including that they must:

- reference this law;
- be in writing and labeled as "time sensitive";
- be sent certified mail return receipt requested to the claims department of the tortfeasor's liability insurer;
- include the time period within which the demand must be accepted and the amount demanded;
- the date and location of the loss;
- the claim number, if known; and
- a description of all known injuries sustained by the claimant.

The bill also requires that the time period provided must be at least 45 days despite how clear the extent of liability might be and the relevant evidence available. It should be noted that applicable regulations already require every insurer, upon proof of claim, to "immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part." (Cal. Code Regs. tit. 10, § 2695.7.)

The offer must also offer "a complete release from all third-party claimants for the liability insurer's insureds from all present and future liability for the occurrence." It is unclear who is encompassed within this reference to "third-party claimants" and how a claimant could or should release *all* third-party claims.

In addition to all this, the offer to settle must include *all* relevant proof in support of the claim, including a list of the names and addresses of health care providers treating or evaluating the claimant or decedent for injuries suffered from the date of injury until the date of the time-limited demand, all pertinent medical bills, reports, and records documenting the alleged injuries and treatment received, loss of earnings documentation, and medical and other relevant liens. All of this evidence is required to be included despite the actual need for such information in determining the reasonableness of the underlying demand.

The bill also provides a number of rights to recipients of these demands regarding the ability to seek extensions and even more information supporting the claim and the demand, including the right to seek a list of the names and addresses of all the claimant's employers at the time the claimant was first injured until the date of the time-limited demand, records from employers and tax records documenting any loss of wages, earnings, compensation, or profits the claimant or defendant is asserting, and written authorizations sufficient to allow the liability insurer to obtain those records from all employers listed. Recipients are also afforded the right to seek, if necessary, clarification or additional information regarding terms, liens, subrogation claims, standing to release claims, medical bills, medical records, preexisting medical

conditions, and other relevant facts. An attempt to seek clarification or a request for an extension due to the need for further information or investigation cannot be deemed a counteroffer or rejection of the demand.

Failure to *strictly comply* with all of these requirements in connection with time-limited demands essentially precludes a bad faith claim against the insurance company and deems the demand inadmissible in such proceedings, despite the reasonableness of the offer or the unreasonableness of the demand's rejection. Specifically, the bill provides:

> In any lawsuit filed by a claimant, or by a claimant as an assignee of the tortfeasor or by the tortfeasor for the benefit of the claimant, a time-limited demand that does not strictly comply with the terms of this chapter shall not be considered to be a reasonable offer to settle the claims against the tortfeasor for an amount within the insurance policy limits and shall not be admissible in any lawsuit alleging extracontractual damages against the tortfeasor's liability insurer.

If an insurer does not accept a time-limited demand due to failure to receive sufficient information following requests for additional time and information, the insurer is required to notify the claimant with an itemized list of remaining factual deficiencies.

According to the author:

> SB 1155 will create reasonable parameters and guidelines that must be followed when a time limited demand is made to an insurance company. This bill will benefit Californians by allowing insurers to meet obligations to protect their policyholder and complete reviews of a claim to ensure that only legitimate claims and charges are paid. This will also help to expedite the resolution of damage claims and avoid costly litigation for all parties. Finally, it will benefit policy holders by reducing the risk of bad faith litigation allegations that increase the cost of insurance policies.

Writing in support, the Civil Justice Association of California argues: "The current system for utilizing time-limited demands is not working. While it is a common tool for settling claims, it has turned into a litigation ploy forcing insurance companies into paying before a thorough inquiry into the claim can be done."

The sponsors of the bill write:

> Insurers are committed to investigating claims thoroughly and promptly. This legislation will simply require that certain information and documentation be included in a plaintiff's time limited demand, time parameters so that the demand letters can be adequately reviewed. These parameters will increase the efficiency with which insurers can respond to and close these demands.

Writing in opposition, the Consumer Attorneys of California push back:

> Rather than evaluating if a settlement demand is reasonable on its own merits and in the context of the circumstances, as has been the law for over 50 years, SB 1155 would require every settlement demand to remain open for at least 45 days and comply with the extensive list of documentation provided above. This could allow insurers to deny and delay settlement unnecessarily and prohibit injured individuals from demanding a quick settlement even when liability is clear. . . .
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> These requirements would allow insurers to unreasonably reject settlement offers, against the interest of their policyholder, based on minor, even irrelevant technicalities rather than the substance of the offer. It would be contrary to the protection that the law governing policy-limit demands is supposed to provide to the policyholder.

A coalition of groups in opposition, including the Consumer Federation of California and Consumer Watchdog, argue that existing law provides the appropriate balance:

> Current law strikes a balance protecting both policy holders and insurers, both of which have conflicting interests when evaluating a settlement offer. The policy holder will want to accept a settlement if it is within the policy limit to avoid personal liability and quickly resolve the dispute. However, the insurer has an incentive to reject settlement offers near the policy limit in an attempt to pay less. Even if the insurer loses in court, its payment is still generally capped by the policy limit; however, the policy holder would be subject to liability above the policy. Therefore, the additional risk of going to trial is minimal for the insurer and high for the policy holder. Decades of well established case law protects insurers when consumers present unreasonable demands and equally protects consumers when insurers unreasonably reject their valid settlement offers and place their policyholders at risk of excess liability and exposure.

They argue that the bill "disrupts and overturns" this longstanding legal framework.

There is certainly evidence that claimants and their attorneys attempt to use time-limited demands to trigger bad faith liability and "take the lid" off of insurance policy limits. However, the case law provides a clear balancing of the relevant interests. If the offer is unreasonable, the insurance company cannot be held liable for damages beyond policy limits. Even where the offer is reasonable, if the insurance company's failure to accept the demand is not unreasonable, based on lack of evidence or insufficient time to properly investigate a claim, bad faith claims do not lie. The recent *Pinto* case has further refined these guidelines.

Despite this, arguably some reasonable parameters should be placed on these demands to proactively deter the litigation tactics referenced. Guidelines such as a base period of

time, basic details that should be included, and the explicit right for insurance companies to seek additional information without it being treated as a rejection or counteroffer advance sound public policy.

However, bad faith liability exists for a reason—to encourage insurance companies to honor the implied covenant of good faith and fair dealing that exists with their insureds. Removing sufficient incentive for insurance companies to reasonably settle cases within policy limits could subject insured Californians to extensive liability that could have otherwise been avoided and increase litigation in our courts that could have been averted.

Arguably the onerous requirements of this bill and the strict compliance required swing the pendulum too far and risk undermining legitimate bad faith claims based on technical deficiencies. The bill includes language stating that it is the public policy of the state to encourage prompt settlements. This rigid structure does not effectuate that public policy.

In response to the concerns expressed in the bill, the author has agreed to the amendments included at the end of this analysis. The central changes shorten the applicable timeline, move the bill from requiring strict compliance to substantial compliance, and ease some of the prescriptive documentation requirements.

SUPPORT

American Property Casuality Insurance Association (co-sponsor)
Personal Insurance Federation of California (co-sponsor)
Civil Justice Association of California
National Association of Mutual Insurance Companies
Pacific Association of Domestic Insurance Companies

OPPOSITION

California Advocates for Nursing Home Reform
Consumer Attorneys of California
Consumer Federation of California
Consumers for Auto Reliability and Safety
Consumer Watchdog
United Policyholders

RELATED LEGISLATION

Prior Legislation: AB 2429 (Caballero, 2018) was substantially similar to the current bill. It died in the Assembly Judiciary Committee.

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AMENDMENTS

CHAPTER 3.2. Time-Limited Demands

999. (a) It is declared to be the public policy of the State of California that prompt settlements of civil actions and claims are encouraged as beneficial to claimants, policyholders, and insurers. ~~Tactics that frustrate settlement, create distrust among parties, and escalate disputes are disfavored, particularly settlement demands where the time provided for acceptance would deprive an insurer of an adequate opportunity to investigate and evaluate its insured's exposure and that are actually designed to "open" insurance policies beyond their stated limits. Both policyholders and their insurers doing business in this state are entitled to the opportunity to timely and fairly investigate claims presented without the risk of creating additional exposure.~~

(b) For purposes of this section, the following definitions apply:

(1) "Extracontractual damages" means any amount of damage that exceeds the total available limit of liability insurance for all of a liability insurer's liability insurance policies applicable to a claim for property damage, personal injury, bodily injury, or wrongful death.

(2) "Time-limited demand" means any offer **prior to the filing of a complaint** to settle any claim for personal injury, property damage, bodily injury, or wrongful death made by or on behalf of a claimant to a tortfeasor with a liability insurance policy for purposes of settling a claim against the tortfeasor within the insurer's limit of liability insurance, which by its terms must be accepted within a specified period of time.

999.1. A time-limited demand to settle any claim shall reference this section, be in writing ~~and labeled as "time sensitive," sent certified mail return receipt requested to the claims department of the tortfeasor's liability insurer,~~ and shall contain the following material terms:

(a) The time period within which the demand must be accepted, which shall be not fewer than ~~45~~**21 business** days from service of the demand.

(b) The amount of monetary payment demanded.

(c) An offer for a complete release from ~~all third-party~~ **the** claimant~~s~~ for the liability insurer's insureds from all present and future liability for the occurrence.

(d) The date and location of the loss.

(e) The claim number, if known.

(f) A description of all known injuries sustained by the claimant.

(g) ~~All r~~**R**elevant proof ~~in~~**to** support ~~of~~the claim~~, including a list of the names and addresses of health care providers treating or evaluating the claimant or decedent for injuries suffered from the date of injury until the date of the time-limited demand, all pertinent medical bills, reports, and records documenting the alleged injuries and treatment received, loss of earnings documentation, and medical and other relevant liens~~.

999.15 (a) A claimant shall send their time-limited demand to the claims department of the tortfeasor's liability insurer if the liability insurer has provided the Department of Insurance with the claims department address and the Department of Insurance has made the address publicly available.

(b) To implement this section, the Department of Insurance shall post on their internet website the claims department addresses designated by liability insurers for receipt of time-limited demands for purposes of this chapter.

999.2. (a) The recipients of a time-limited demand may accept the demand by providing written acceptance of the material terms outlined in Section 999.1 in their entirety.

(b) (1) Upon receipt of a time-limited demand, ~~the recipients shall have the right to seek, if necessary, clarification or additional information regarding terms, liens, subrogation claims, standing to release claims, medical bills, medical records, preexisting medical conditions, and other relevant facts.~~ A**a**n attempt to seek clarification**, additional information,** or a request for an extension due to the need for further information or investigation shall not be deemed a counteroffer or rejection of the demand.

~~(2) Upon receipt of a time-limited demand, the recipients shall have the right to seek a list of the names and addresses of all the claimant's employers at the time the claimant was first injured until the date of the time-limited demand, records from employers and tax records documenting any loss of wages, earnings, compensation, or profits claimant or defendant is asserting, and written authorizations sufficient to allow the liability insurer to obtain those records from all employers listed.~~

(c) If an insurer is unable to accept a time-limited demand due to failure to receive sufficient information following requests for additional time and information, the insurer shall notify the claimant that it cannot accept the demand with an itemized list of remaining factual deficiencies. This notification shall be relevant ~~as part of the admissibility~~ **in any lawsuit alleging extracontractual damages against the tortfeasor's liability insurer.** ~~rules set forth in Section 999.3.~~

~~(d) The claimant shall have 30 days from service of the insurer's response to respond to the request for additional time, information, or clarification.~~

999.3. (a) In any lawsuit filed by a claimant, or by a claimant as an assignee of the tortfeasor or by the tortfeasor for the benefit of the claimant, a time-limited demand that

does not ~~strictly~~ **substantially** comply with the terms of this chapter shall not be considered to be a reasonable offer to settle the claims against the tortfeasor for an amount within the insurance policy limits **for purposes of** ~~and shall not be admissible in~~ any lawsuit alleging extracontractual damages against the tortfeasor's liability insurer.

(b) The extent to which all reasonable proof in support of the claim, including a list of the names and addresses of health care providers treating or evaluating the claimant or decedent for injuries suffered from the date of injury until the date of the time-limited demand, pertinent medical bills, reports, and records documenting the alleged injuries and treatment received, loss of earnings documentation, and medical and other relevant liens, is provided with a time-limited demand shall be a factor in determining the nature and extent of any bad faith alleged in a lawsuit alleging extracontractual damages against the tortfeasor's liability insurer. Failure to provide all reasonable proof shall not act as a bar to such a claim.

(c) This section shall not apply to a claimant that is not represented by counsel.

(~~b~~**d**) In the event a court determines that this chapter conflicts with the Civil Discovery Act, (Title 4 (commencing with Section 2016.010) of Part 4), the Civil Discovery Act shall prevail.

999.4. This chapter shall apply to causes of action and claims for property damage, personal injury, bodily injury and death, and other damages claimed that are potentially covered under a liability insurance policy.