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Policy Limit Demands:

The New Plaintiff's Strategy and How to Protect Insurers and Defense Counsel

Summary

Plaintiffs have recently adopted a strategy of issuing policy limit demands as soon as possible and as often as possible. There's a clear need to be really careful when facing a policy limit demand, BUT, claims professionals and their lawyers have to ensure that claim inflation doesn't occur solely as a consequence of the policy limit demand made. Plaintiffs hope PLD's will increase value and we will discuss how that often happens and how to guard against it. Plus, we'll discuss some of the law re PLD's and the consequences of not meeting the demand, while really focusing, in an interactive manner, on strategies to fully protect the insurer and defense counsel when faced with a PLD, including: how to forcefully get extensions of time; how to communicate to the insured about the demand including what to say and when to say it; how to be able to properly evaluate the claim and how best to do it; tools for getting the case resolved for less than the limit; how to limit defense counsel's role to their proper role as counsel for the insured; and how best to create a record that can guard the insurer against excess exposures.

The majority of states require a demand within policy limits to trigger an insurer's duty to settle. In California, an insurer cannot be held liable for the bad faith failure to settle a claim absent either a demand within policy limits or some "other manifestation the injured party is interested in settlement." *Reid v. Mercury Insurance Co.* (Cal. 2013) 220 Cal.App.4th 262 (a mere request for information regarding the amount of policy limits was held to not be sufficient an indication of a party's interest in settlement).

In a small number of states, the insurer has an affirmative duty to initiate settlement negotiations and cannot wait for a policy limits demand (Arizona, Florida, Kansas, Lousiana, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, Tennessee and Washington) . For example:

- Florida: Lack of a formal offer to settle does not preclude a finding of bad faith. Once liability is clear, and injuries so serious that a judgment in excess of the policy limits is likely, an insurer has an affirmative duty to initiate settlement negotiations, and bad faith may be inferred from a delay in settlement negotiations which is willful and without reasonable cause. *Powell v. Prudential Property & Casualty Insurance* Company (Fla.App. 1991) 584 So.2d 12 (as a result of the delay in settlement negotiations, the court found a potential for bad faith and shifted the burden to the insurer to prove that the settlement was not possible within the policy limits).

- Louisiana: An insurer can be found liable for bad faith failure to settle under Louisiana's version of the Unfair Claims Settlement Practices Act, even in a situation where the insurer never

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received a firm settlement offer. The Act expressly states that an insurer has an "affirmative duty to . . . make a reasonable effort to settle claims with the insured or the claimant." *Kelly v. State Farm Fire & Casualty Co.* (La. 2015) 169 So. 3d 328. In *Kelly*, the state supreme court stated: "A firm settlement offer is unnecessary for an insured to sustain a cause of action against an insurer for a bad-faith failure-to-settle claim, because the insurer's duties to the insured can be triggered by information other than the mere fact that a third party has made a settlement offer." The duty to settle can be triggered the insurer's "knowledge of the particular situation," the insurer has an affirmative duty to gather this knowledge during the claims handling process, and the duty to settle requires a case-by-case analysis of the insurer's investigation and knowledge at the time of that investigation.

- Rhode Island: Insurers have an affirmative duty to engage in timely and meaningful settlement negotiations and to make and consider offers of settlement. The affirmative duty arises out of the insurer's fiduciary duty to act in the best interests of the insureds in order to protect their insureds from excess liability. *Skaling v. Aetna Ins. Co*, 799 A.2d 997 (R.I. 2002).

As a general rule, the insurer has a duty to settle if the policy covers the claim; the insured's liability is reasonably clear. The claimant has made a proper settlement demand within policy limits; and the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to an excess judgment.

Recently, Increased Frequency of Policy Limit Demands Litigation Tool for Claimants in "Bad Faith" Threats Usually Included as boiler plate. There is a significant difference between accusation of bad faith, acting in bad faith and exposure to bad faith

In best practices, work towards proper evaluation is based on liability, damages; bad faith threats should not be a factor in a case evaluation and once a case is properly evaluated, any potential excess exposure should be considered.

Proper evaluation and decisions based on that evaluation should drive the process. Threats of bad faith should not inflate the evaluation. We need to keep in mind the difference between our evaluation of the case, and our ultimate RESOLUTION STRATEGY.

In most states excessive exposure governed by "reasonableness" standards are based on all factors. Was the company's offer "reasonable" under the circumstances? Documentation of process of what we do and how we reached our evaluation will be key, and finally putting onus on claimant to participate with process and supply necessary documents is important.

In early stages, policy limit demand is often a negotiating tool. The response is to ask for full extension unless you clearly have plenty of time for full evaluation; report to management; obtain necessary material for evaluation, and finally documenting each request, including why you need it, who will do the evaluation, and what is the role of defense counsel.

    - Offer to mediate?
        - Often very effective
        - Acceptance of offer clearly takes away threat of policy limit demand

- Resolution Strategy Based on Evaluation of Risk Factors – Options

    - Pay the demand
    - Attempt to negotiate or mediate

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- Refuse the demand
  - Refuse the demand but make a counter offer
    - Often very effective
  - Continue to litigate with open mind to continued negotiations

Company may decide in proper cases to assume risk of excess exposure, but other extra-contractual should be avoided. If management is on-board with assumption of risk of excess verdict, then we have accepted strategy decision to do so.

Steps to be taken upon receipt of time-limited policy limit demand should include a review the demand thoroughly. Clarify when response due. Determine what conditions are imposed on the insurer. Develop an appropriate written response which is reflective of the information you have and the information you need to answer completely. Advise the insured of the demand (and possibly need to retain personal counsel to advise them about the demand). Determine whether affidavits are necessary (e.g. no other coverage or assets). Assess the need for releases and the form of the releases. Consider the potential of liens and other claims. Consider request for additional time to respond and be specific as to why additional time is needed.

Special Handling Required As To Policy Limit Demand Regarding Claim Valued At In Excess Of Limits And Involving Covered And Non-Covered Damages. The problem is: frequently, insurers are confronted with high damage exposure claims which exceed the policy limits, but a large portion of the claim is not covered. What steps should be taken where covered damages are within limits but the total damage exposure exceeds limits and we received a time limit demand within limits?

Additional steps to take: Insured should be advised of coverage limitations and invited to participate in discussions and offer. Appropriate reservation of rights letters should be sent, insured should understand limitations. Determine whether the jurisdiction requires reservation of rights/partial disclaimer letters be sent to the injured party or others or whether there are other statutory obligations. Generally, no obligations to make payments for non-covered claims (i.e punitive damages). Finally assess which claims are and are not covered.

On the California approach to a policy limit demand for the amount of the policy limit would be considered a policy limit demand, even if the demand letter does not expressly call it a policy limit demand. To prevail on a claim for breach of the implied covenant of good faith and fair dealing, an insured must show: (1) the claimant brought a claim against the insured that was covered by the insurer's policy; (2) the insurer failed to accept a reasonable settlement demand for an amount within policy limits; (3) the insurer's failure to accept the settlement demand was unreasonable, which means without proper cause; and (4) a monetary judgment was entered against the insured for a sum greater than the policy limits. The crux of a bad faith claim is an “unwarranted rejection of a reasonable settlement offer.” So the response to the policy limit demand has to make it clear why the insurer was acting reasonably in not accepting the demand at this time. In a response to a pre-suit or other early policy limit demand where more time is needed to evaluate damages and liability, the response letter should typically say something along these lines:

The implied covenant of good faith and fair dealing only obligates the insurer to accept "reasonable" settlement demands within policy limits. One of the requirements for a "reasonable" demand is that the time provided for acceptance of the demand does not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure. At this time, the insurer has not had an adequate opportunity to conduct a proper investigation and evaluation of the subject claim regarding either the liability alleged or the nature and extent of the damages sought. The insurer is not currently in a position to make an informed decision regarding your client's demand.

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The response letter should usually include a statement about what further investigation is needed and will be conducted. If the demand was time-limited, i.e. claimant's counsel stated that a response must be provided by a specific date, the response should also include a request for an extension of time to respond in order that the needed investigation and evaluation may be performed."

Did claimant make a proper/reasonable settlement demand within policy limits? The reasonableness of a settlement offer depends on facts known or available to the insurer at the time of the proposed settlement. *Isaacson v. California Ins. Guarantee Assn*. (Cal.1988) 44 Cal. 3d 775. The four key elements of a reasonable policy limit demand are:

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 [Cal. 2014] 231 Cal.App.4th 414.

    - The "reasonableness" of an insurer's refusal to settle a third party's claim against its insured will be judged in light of the adequacy of its efforts to investigate and evaluate the claim. The insurer owes a duty to conduct a proper investigation and is charged with notice of facts that it could have learned through such an investigation.

    - As to the "reasonableness" of the insurer's conduct, California courts have focused on: (1) the strength of the claimant's case on both liability and damages; (2) the attempts by the insurer to induce the insured to contribute to the settlement; (3) the failure of the insurer to properly investigate so as to fully consider the evidence that exists against the insured; (4) any rejection of settlement advice from the insurer's own attorney or agent; (5) the failure of an insurer to inform its insured of a demand or offer; (6) a failure to consider the amount of financial risk to which each party is exposed if there is a refusal to settle; (7) the fault of the insured in inducing the insurer to reject a demand by misleading the insurer as to the facts; and (8) other evidence that would establish or negate bad faith on the part of the insurer. Inexcusably failing to meet a time deadline regarding responding to the policy limit demand or payment of the demand are going to be viewed as "bad faith" factors.

- In handling demands, whether within policy limits or above, the insurer must do more than just act reasonably. The insurer must be able to prove that all steps taken in either negotiating a settlement or denying settlement were done reasonably. It is essential to document the claim file and keeping accurate, detailed and complete records of all communications (including e-mails and telephone discussions and unsuccessful attempts to reach the insured, counsel, etc.). Dates (day and time) regarding when each event happened must be included.

- The insurer should assume that everything within that file will be discovered by the party making a bad faith claim so gratuitous comments in correspondence or memos, whether prepared by the insurer's claims personnel or insurer-retained counsel or experts, should be avoided. However, the insurer should document any problems its personnel experience

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in being able to contact or deal with the insured, the claimant or the claimant's counsel (e.g. not being available; dishonest statements; not providing information timely; not providing all information requested).

The timing of the demand is crucial to "opening up" the policy limits. Plaintiff's attorneys will frequently make early policy limits demands in the hope that a nervous insurer will pay the demand rather than risk exposure in excess of limits. To be reasonable, however, the demand must be timed so that the insurer has had a reasonable opportunity to review the case, evaluate the damages, and discover for itself that the likely verdict meets or exceeds the policy limits. See Walbrook Ins. Co. Ltd. v. Liberty Mut. Ins. Co., 5 Cal.App.4th 1445, 1457-58 (1992).**CASES WHERE INSURER ACTED REASONABLY**

In ***McDaniel v. Gov't Employees Ins. Co***. (GEICO) (9th Cir. March 7, 2017) 681 Fed.Appx. 614, cert. denied, 2017 WL 4339979, U.S., Oct. 02, 2017,the Ninth Circuit decided that an "honest" mistake as to a settlement deadline did not justify the imposition of excess liability on the insurer. In that case, the plaintiff in a wrongful death action made a policy-limits demand of $100,000 the insured defendant, GEICO's insured, with a 15-day deadline. The deadline was extended to ten days after service of plaintiff's response to outstanding interrogations, i.e. not a date certain. Plaintiff's counsel served the interrogations on defense counsel, and defense counsel emailed the responses to the GEICO claims adjuster with a message noting the new deadline by which to accept the settlement offer. The claims adjuster missed the email, and missed the deadline. The settlement demand expired. Although GEICO offered to pay the full policy limits approximately three weeks later, plaintiff refused it.

The wrongful death action went to trial, resulting in a judgment of $3 million against the defendant-insured. Plaintiff took an assignment of the insured's claim for breach of the duty to settle and sued GEICO for the entire judgment. The District Court granted summary judgment in favor of the plaintiff and denied summary judgment in favor of GEICO. The Ninth Circuit reversed and ordered the District Court to enter judgment in favor of GEICO, holding that there was no evidence that GEICO's adjuster acted with the "required degree of culpability to have unreasonably refused to settle."

It was not disputed that the claims adjuster had made a mistake by missing the email. The Ninth Circuit, however, found that the failure did not meet the standard for "unreasonable refusal to settle." But no matter how innocent the omission, the consequences for the insured could have been catastrophic. Maybe the Ninth Circuit was influenced by the fact that the settlement demand was subject to an artificial deadline, and that the plaintiff rejected GEICO's offer to cure the default. If so, it could have reached the same result by finding that the settlement deadline itself was not reasonable. Maybe it was influenced by the fact that GEICO's insured apparently suffered no real loss because plaintiff took an assignment of the judgment. But what happens to an insured with assets and a plaintiff who won't take an assignment? Whatever the motivation, the Court's reasoning discourages insurers from being extra careful: 1) to make sure claims adjusters read their email in a timely fashion; 2) employ enough adjusters so such mistakes are less likely to be made; or 3) require their defense counsel to follow up on settlement deadlines.

Williams v. GEICO Cas. Co., 301 P.3d 1220 (Alaska,2013): Automobile insurer did not breach its duty to offer a full policy settlement in situation in which there was a substantial likelihood of an adverse verdict in excess of policy limits by offering to settle for one policy limit and the release of both insured and passenger who it was alleged may have been an insured in action stemming from motor vehicle accident, where estate of deceased pedestrian alleged a theory under which passenger may have been an insured, either as a driver or by acting in concert with named insured, insurer agreed to defend purported insured under reservation of rights, and seeking a settlement to the benefit of one insured while leaving other potential insured open to liability could have caused unfairness.

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Feijoo v. GEICO General Insurance Company (11th Cir., applying Florida law, 2017) 678 Fed.Appx. 862: Under Florida law, automobile insurer did not act in bad faith in handling automobile accident victim's personal injury claim against insured driver, which resulted in an excess judgment against insured; where insurer made numerous attempts to obtain victim's treatment information, informed insured of each settlement offer and the potential for an excess judgment, retained physicians who confirmed that victim's condition was degenerative or opined that injuries were unrelated to the accident, and made its decisions based on victim's unequivocal pretrial position that she did not plan to have future treatment or surgery.

Under Kansas law, automobile insurer did not act in bad faith in failing to respond to policy-limits demand made shortly after an automobile accident for which liability and causation were vigorously disputed, notwithstanding its failure to inform insured of offer; insurer was awaiting medical records that accident victim promised but failed to provide before withdrawing settlement offer, insurer was fulfilling its duty to investigate incident, and amount of financial risk in event of refusal to settle was not yet known. *Wade v. EMCASCO Ins. Co*. (10th Cir. applying Kansas law, 2007) 483 F.3d 657 (plaintiff's delay in providing promised medical records and manipulation of settlement deadlines was for the purpose of setting up a bad-faith claim).

Professional liability insurer conducted a reasonable investigation, as required by Montana's Unfair Trade Practices Act, and had a reasonable basis in both fact and law, before rejecting a policy limit demand by insured accounting firm's client in an underlying lawsuit against insured arising from several failed property transactions. At the time of the demand, the insurer had obtained an expert opinion as to whether tenancy-in-common shares that formed basis of suit were unregistered securities and, as such, barred from coverage, and insurer considered all information provided to it by insured before making its decision. In addition, there was a question as to whether suit was barred by the policy's exclusion of claims arising from brokerage of unregistered securities, the insurer had a legal argument as to a statute of limitations defense, and there were numerous factual questions as to calculation of client's damages. *Redding v. ProSight Specialty Management Co., Inc*., 90 F.Supp.3d 1109 (D. Mont. 2015).

In ***Grayson v. Allstate Ins. Co***, 650 Fed. Appx. 320 (9th Cir. May 2016), the court affirmed the entry of summary judgment in favor of Allstate, as there was no reasonable opportunity for Allstate to settle. In that case, Allstate's insured's vehicle struck the claimant's motorcycle, causing serious injuries. Allstate recognized soon after the accident that its insured was likely at fault and that the claims would exceed the $15,000 policy limit. Claimant's attorney sent Allstate a letter offering to settle for policy limits. Allstate responded that it was authorized to accept that demand, and because the demand did not include a release of Allstate's insured, Allstate included its standard release with the letter. However, the release contained terms not included in the original demand, and the offer was rejected. One day later, Allstate responded with a revised release explaining that it was accepting the demand and asking for claimant's attorney to contact him if he found anything else objectionable. That offer was rejected without explanation. The case proceeded to trial and claimant obtained a substantial judgment.

The claimant and insured then sued Allstate. The court granted Allstate's motion for summary judgment, finding that the settlement demand was unreasonable because it did not include a release, and even if the settlement demand was reasonable, Allstate was not unreasonable in not accepting it. The Ninth Circuit affirmed the entry of summary judgment in favor of Allstate, holding that an "insurer must be given a reasonable opportunity to settle with the policy limits and any offer must be capable of acceptance on the part of the insurer." Noting that Allstate may have breached its duty to its insured by failing to attach a release, the court held that Allstate had no reasonable opportunity to settle the case.

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In ***Shaheen v. Progressive Cas. Ins. Co***., 673 Fed. Appx. 481 (6th Cir. Dec. 2016), the court affirmed the entry of summary judgment in favor of Progressive, finding it was not bad faith to condition the offer to pay the $250,000 in policy limits on plaintiff's agreement to release and indemnify the insured. Plaintiff had demanded an unconditional payment of the full policy limits, and repeated that request in response to the offer, stating that it was unreasonable for the insured to expect to be released. Although Progressive left the offer open, no further settlement discussions took place. Ultimately, Progressive paid its limits, the insured paid $100,000, and the plaintiff signed a covenant not to execute against the insured. In the bad faith action against Progressive, the court held that Progressive's offer in exchange for a release was a proper balance between its competing duties of good faith to the plaintiff by paying the limits and to the insured by conditioning payment on a full release.

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