

The new CCP section 999 and policy-limit demands in auto cases

Newly enacted CCP section 999 changes the landscape of pre-litigation settlement demands by better defining what is a "reasonable" offer to settle

By Ritsa Gountoumas

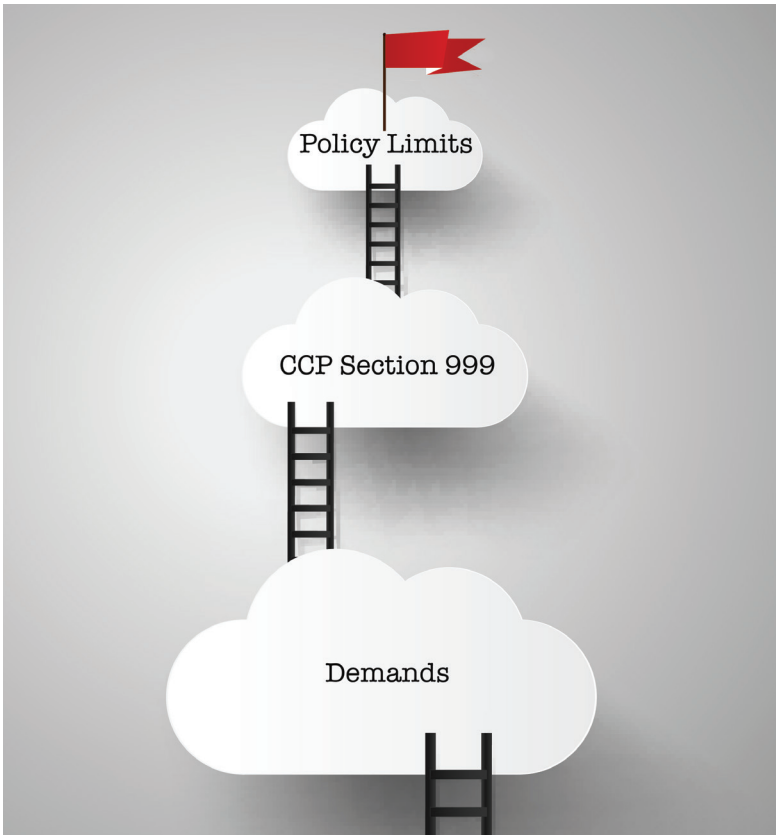
Automobile-accident victims typically seek compensation for their losses from the at-fault driver's auto insurance company (the "third-party insurer"). One of the most powerful tools claimants have in auto-accident cases is the policy-limit demand. Policy-limit demands not only allow claimants to expedite the settlement process, but also to "open" the policy and hold the insurer liable for the full amount of the claimant's damages if the insurer unreasonably denies the demand.

The impact of a policy-limit demand is significant, but it must be prepared properly to reap the benefit of an open policy. On January 1, 2023, the California legislature passed California Code of Civil Procedure 999 ("§ 999"), which created a new framework for policy-limit demands in tort cases. This article aims to discuss these recent legislative changes, address the effect § 999 will have on a claimant's pre-litigation policy-limit demand, and explain how a policy-limit demand can set the stage for a bad-faith lawsuit.

The interplay between policy- limit demands and bad-faith lawsuits

Policy limits are the maximum amount an insurance company is obligated to pay for bodily injury and property damage in a particular accident. These limits are specified in the insurance policy and typically include two components: per-person and per-accident limits. The per-person limit sets the maximum amount the insurer will pay for each individual injured in the accident. The per-accident limit represents the maximum amount payable for the entire accident, regardless of the number of injured parties. Policy-limit demands are therefore requests made by accident victims to the third-party insurer to settle their claims within the insurance policy's coverage limits.

In California, each liability insurance policy contains a covenant of good faith and fair dealing, which legally obligates insurers to deal fairly with their insureds. When insurers engage in unfair or unreasonable conduct in handling an insurance claim, they have acted in bad faith. Generally, bad faith can take various forms, including unreasonably denying or refusing to settle a valid insurance claim, delaying the claims process without justification, failing to adequately investigate a claim, failing to negotiate in good faith,



failing to put the insured's financial interests above the insurer's, or undervaluing the damages suffered by an insured.

In auto-accident cases, bad-faith lawsuits are often premised on the insurer's failure to settle a third-party claim or lawsuit against the insured within the policy limits. But what exactly rises to the level of bad faith in the context of a refusal to settle a claim? The California Court of Appeal shed some clarity on this issue in *Pinto v. Farmers Ins. Exch.* (2021) 61 Cal.App.5th 676. The court in *Pinto* stated that the implied covenant of good faith and fair dealing requires the insurer to make reasonable efforts to settle a third party's lawsuit against its insured. (*Id.* at 687). While the amount of the settlement demanded

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is an important component in determining whether to accept the demand, it is not the only factor, and an insurer's mere failure to accept a reasonable settlement demand does not necessarily constitute bad faith. (*Id*. at 687-688.)

To rise to the level of bad faith, an insurer's rejection of the settlement demand must have been *unreasonable* in some manner. (*Pinto*, 61 Cal.App.5th at 688.) Shifting the focus to the nature of the insurer's conduct, rather than just the reasonableness of the demand, ensures that the insurer will not be exposed to liability when its failure to accept a reasonable settlement demand was somehow reasonable under the particular circumstances of the case.

Therefore, to hold the insurer liable for bad faith under *Pinto*, the claimant must not only show that the settlement offer was for a reasonable amount within the policy limits, but also that the insurer's failure to accept the demand was unreasonable. When this happens, the claimant can now "open" the policy and hold the insurer liable for extracontractual damages, or damages that exceed the policy limits, as long as the requirements of § 999 are satisfied if the demand was made before the lawsuit was filed.

How to make a pre-litigation policy limit demand post-§ 999

Before the enactment of § 999, there were no clear statutory guidelines governing policy-limit demands for purposes of holding a third-party insurer liable for bad faith. As a result, plaintiffs' attorneys often sent out policy-limit demands that contained scarce details, lacked clear terms for resolving all claims, and did not give the third-party insurer sufficient time to respond, or adequately investigate and evaluate the claim. Sometimes this was through inadvertence, but the insurers typically viewed it as a tactic to set the insurer up for bad faith.

To address what they regarded as bad-faith setups, insurance companies fought for clearer legislative guidelines to help eliminate ambiguities regarding insurers' obligations with respect to policy-limit demands. To help level the playing field between insurers and claimants, the Legislature enacted § 999, which sets forth certain requirements that both claimants and insurers must abide by when issuing and responding to pre-litigation policy-limit demands. The purpose of § 999 is to ensure that both parties have a clear understanding of the guidelines that apply to pre-litigation settlement demands and encourage the parties to engage in good-faith negotiations.

Section 999 applies to pre-litigation settlement demands transmitted on or after January 1, 2023. (§ 999.5.) It defines a time-limited demand as:

> An offer *prior to the filing of the complaint or demand for arbitration* to settle any cause of action or a 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 the 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.

(Emphasis added.)

As § 999 makes clear, the statute only applies to *pre-litigation* policy-limit demands (not settlement demands made during litigation or arbitration). Moreover, it only applies to claimants represented by counsel and encompasses only property damage, personal or bodily injury, and wrongful death claims made under automobile, homeowner, motor vehicle, and commercial premises liability insurance policies. (§ 999.4; § 999.5.)

Importantly, § 999 requires that a policy-limit demand be in writing and be labeled as a "time limited demand" or explicitly reference § 999. The demand letter must also contain the following "material terms:"

1. Specify the time period within which the demand must be accepted. The claimant must provide the insurer with at least 30 days (if the demand is sent by e-mail, fax, or certified mail), or at least 33 days (if it is sent by mail);
2. Make a clear and unequivocal offer to settle all claims within policy limits, including satisfying all liens;
3. Offer a complete release from all present and future liability for the occurrence;
4. Specify the date and location of the loss;
5. Provide the claim number;
6. Include a description of all known injuries sustained by the claimant;
7. Be supported with *reasonable proof*, which may include, if applicable, medical records or bills sufficient to support the claim; and
8. Be sent to the assigned claims adjuster, or to the liability insurer's email or address designated for time-limited demands that is listed with the Department of Insurance.

(§ 999.1(a)-(g); § 999.2.)

Notably, other than medical records and bills, the statute does not define "reasonable proof" or specify what other documents the claimant must include with the demand. This will likely become a point of contention between claimants and third-party insurers in the future. However, until this ambiguity is resolved by the courts, California Civil Jury Instruction, CACI No. 2334, which defines a "reasonable settlement demand," may provide some clarification as to what constitutes "reasonable proof." Specifically, CACI No. 2334, states that:

> A settlement demand for an amount within policy limits is reasonable if defendant knew or should have known at the time it failed to accept the demand that a potential judgment against plaintiff was likely to exceed the amount of the demand based on plaintiff's injuries or losses and plaintiff's probable liability. However, the demand may be unreasonable for reasons other than the amount demanded.

Though CACI No. 2334 specifically pertains to reasonable "settlement demands," it is safe to assume that "reasonable proof" also follows a similar standard and includes all evidence that would permit a third-party insurer to

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reasonably assess the claim and amount of damages. Therefore, in addition to the material terms outlined in § 999, a time-limited settlement demand should also include: (1) a factual description of the accident, (2) an explanation of the claimant's theories of liability, (3) a discussion of liability and any potential comparative fault, (3) a summary of the extent and severity of the injuries, including a description of relevant medical treatment to date, (4) a computation of special or economic damages, such as medical expenses, property damage, lost wages, and other tangible financial losses resulting from the accident, and (5) a computation of general or non-economic damages, which includes intangible losses like pain and suffering, emotional distress, disfigurement, and loss of enjoyment of life. Obviously, the claimant must also include "reasonable proof," or thorough documentation that substantiates the demand, such as pictures of the injuries, police reports, medical records, expert reports, bills, witness statements, and any other documents that would justify the requested economic and non-economic damages.

Claimants beware: Failure to comply with § 999 renders the demand unreasonable

Significantly, if a claimant fails to substantially comply with § 999, then the policy-limit demand will not be considered a "reasonable offer to settle." (§ 999.4.) This is important because it means that the claimant will not be able to "open" the policy limits. Practically speaking, because § 999 only applies to represented claimants, this means that unrepresented claimants are afforded more flexibility when it comes to settlement demands as they do not need to comply with its stringent statutory requirements to set an insurer up for bad faith. Therefore, it is imperative that a represented claimant strictly abide by the statute to preserve the right to pursue a bad-faith lawsuit.

Further, while demands made during litigation do not technically fall within the purview of § 999, a claimant's attorney should still prepare a demand that strictly complies with its requirements (and those of CACI No. 2334) to dispel any argument by the third-party insurer that the claimant is precluded from pursuing a claim for bad faith.

In practice, if the settlement demand substantially complies with § 999 and presents a reasonable offer to settle within the limits, then the claimant should have a strong bad-faith claim against the insurer if the insurer unreasonably rejects the demand. While insurers lobbied for § 999 to protect themselves from bad-faith exposure, the legislation appears to help claimants as it simplifies the pre-litigation settlement process to some extent. This is because when an insurer receives a demand that complies with § 999, its primary inquiry should be whether the demand is reasonable given the injuries, supporting evidence, and available limits, not whether the demand is unreasonable for unrelated, procedural reasons such as its failure to provide sufficient time to respond or investigate the claim.

How can an insurer respond to a pre-litigation policy-limit demand under § 999?

Upon receiving a policy limit demand, the third-party insurer can either:
1. Accept the demand and all material terms set forth in § 999.1 in writing;
2. Request clarification, additional information, or an extension to obtain additional information or to conduct further investigation. If the insurer does this, it shall not be deemed a counteroffer or rejection of the demand so long as it is made within the time within which to accept the demand; or
3. Reject the demand prior to the expiration of the time limited demand. If the insurer rejects the demand, they must do so in writing and explain the basis for the rejection.
(§ 999.3(a)-(c).)

Though § 999.3 now requires an insurer to explain its denial of a policy-limits demand, the statute does not clarify how detailed the explanation must be. Claimants should thus be wary of situations where the insurer sends a written rejection but does not provide a reasonable explanation for the denial. Again, this is relevant to bad faith as Insurance Code section 790.03, subdivision (h), which governs unfair claims-settlement practices, requires an insurer to specifically explain the reasons for any settlement denial.

Note that the statute also does not give the insurer the option to disregard or not respond to a demand. Indeed, failing to respond to the demand entirely can also be evidence of an insurer's unreasonable conduct in a separate bad-faith action.

Ultimately, whether an insurer's conduct was reasonable for purposes of a bad-faith lawsuit is determined on a case-by-case basis. (*Pinto*, *supra*, 61 Cal.App.5th at 687.) CACI 2337, which is based off California Insurance Code section 790.03(h), provides 16 factors to consider when determining whether an insurer acted unreasonably in handling and responding to an insurance claim. These factors include, but are not limited to, when the insurer: (1) unreasonably interprets policy provisions to deny benefits, (2) fails to promptly settle a claim with clear liability, (3) fails to provide a reasonable explanation for denying a claim, and (4) delays the investigation or payment of a claim without a reasonable basis.

In the context of a failure to settle a claim, an insurer has likely acted unreasonably under *Pinto* and CACI 2337 if it rejects a reasonable settlement supported with evidence that proves that the amount of a subsequent judgment will likely exceed the settlement offer. Assuming the demand complies with section 999, the insurer has engaged in bad faith in this situation as it has failed to promptly and equitably settle a claim with clear liability.

Conclusion

The introduction of § 999 has brought about notable changes to the pre-litigation settlement process in auto-accident cases, establishing specific requirements for claimants and insurers when preparing and analyzing policy-

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limit demands. As with any new law, its full effect has yet to be seen. Nevertheless, the changes appear to be aimed at promoting transparency, and fair and efficient settlements.

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