A Personal Injury Lawyer's Guide to Issuing Demand Letters and Opening Third Party Policies

By Brian Kabateck and Barret Alexander

In personal injury practice, the leverage that comes from "opening" a third-party insurance policy can change the course of a case—yet it remains one of the most misunderstood concepts in practice. Recent changes in the law have formalized parts of the process and updated the resulting analysis, but the overarching principle remains unchanged. Reasonableness will dictate the outcome. Many lawyers are familiar with the concept of opening a third-party liability policy, but many do not understand how or why the rule exists.

Under specific conditions, an insurer can become liable for an excess judgment against its insured (i.e., a judgment that exceeds the insured's policy limits) if the insurer *unreasonably* refuses to settle a claim or case within policy limits.

It is important to remember, this rule protects the insured tortfeasor, not the injured victim. "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.) Understanding the distinction between the insured tortfeasor and the injured victim is critical to understanding and effectively navigating any bad faith action for extracontractual damages.

This article is intended to be a roadmap for opening third party policies, including the law, the process, and questions to consider along the way.

A. The Overview – How and Why Demand Letters Impact Third Party Policies

All liability insurance policies include an implied covenant of good faith and fair dealing. (*PPG Indus., Inc. v. Transamerica Ins. Co.* (1999) 20 Cal.4th 310, 312–15.) "This covenant imposes a number of obligations upon insurance companies, including an obligation to accept a *reasonable* offer of settlement." (*Id.* at 314–15, emphasis added.) A settlement demand letter is the critical first step to opening a third-party policy because the covenant includes an obligation to accept reasonable offers. However, an insurer is under no obligation to accept all settlement demands, and insurance policies are not opened simply because an insurer rejected the demand or requested additional time. However, if you do not make the demand then the obligation to pay the claim by itself will never open the policy.

An insurer's duty to accept a *reasonable* settlement offer is not absolute, and "failing to accept a *reasonable* settlement offer does not necessarily constitute bad faith." (*Pinto v. Farmers Ins. Exch.* (2021) 61 Cal.App.5th 676, 687, emphasis added.) Instead, a claim for bad faith based on the wrongful refusal to settle must be

Brian Kabateck is a nationally respected consumer attorney, and a preeminent leader in the fight to ensure access to the justice system. He has won many significant verdicts, judgments, and settlements in the areas of personal injury, insurance bad faith, pharmaceutical litigation, wrongful death, class action, mass torts, and disaster litigation. He is Chair of the Board of Loyola Law School and a trustee of Loyola Marymount University. Brian is a past president of CAOC, the Los Angeles County Bar Association (LACBA), and the Century City Bar Association. www.kbklawyers.com

Barret Alexander is a Senior Associate at Kabateck LLP specializing in insurance bad faith and complex coverage disputes. He represents businesses and property owners in high-stakes litigation against insurers who improperly deny, delay, or undervalue legitimate claims. Mr. Alexander has secured major settlements for clients wrongfully denied coverage, including a homeowners association facing improper compensation for hurricane damage, a restaurant chain denied business interruption coverage, a commercial property owner fighting a coverage denial, and a gymnasium owner whose insurer refused to pay for storm-related losses. www.kbklawyers.com

At trial, you will need to establish the insurer's rejection of the settlement demand was unreasonable.

supported by a showing the insurer *unreasonably* rejected the offer. (*Id*.) The "crucial issue is the basis for the insurer's decision to reject an offer of settlement." (*Id.* at 687-693.)

> The important thing to remember is 'reasonableness' should be assessed on a case-by-case basis, there is no bright line rule.

The quintessential question then becomes, what constitutes an unreasonable rejection by the insurer? "[T]he test is whether a prudent insurer without policy limits would have accepted the settlement offer." (*Crisci v. Sec. Ins. Co. of New Haven, Conn.* (1967) 66 Cal.2d 425, 429.) "Thus, 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, an ultimate judgment is likely to exceed the amount of the settlement offer." (*Johansen v. California State Auto. Assn. Inter-Ins. Bureau* (1975) 15 Cal.3d 9, 16.) The reasonableness analysis should examine the insurer's entire response to the demand including its investigation (or lack thereof), communications with its insured, retention of experts, and reports generated or received to name a few items. The important thing to remember is 'reasonableness' should be assessed on a case-by-case basis, there is no bright line rule.

Below are some appellate cases highlighting unreasonable conduct by insurers in investigating and responding to demand letters.

Refusal to investigate and/or conducting an inadequate investigation

A carrier that refuses to investigate a claim or discover evidence relevant to issues of liability or damages may be liable for bad faith. "Among the most critical factors bearing on the insurer's good faith is the adequacy of its investigation of the claim." (*Shade Foods, Inc. v. Innovative Prods. Sales & Mktg., Inc.* 78 Cal.App.4th 847, 879.)

Failure to evaluate claim fairly

"If the carrier rejects the offer to settle within policy limits without having made an honest, intelligent, and knowledgeable evaluation of the offer on its merits, then the carrier has acted in bad faith and may become liable to its assured for consequential damages caused by its bad faith rejection." *(Merritt v. Rsrv. Ins. Co.* (1973) 34 Cal.App.3d 858, 873.)

Improper delegation of claim evaluation

An insurer cannot avoid bad faith liability by delegating its duty to evaluate claims to an independent third party. (*Garner v. Am. Mut. Liab. Ins. Co.* (1973) 31 Cal. App.3d 843, 850.)

Failure to communicate with insured

An insurer has an affirmative obligation to keep its insured informed of any settlement offers, particularly when it receives a settlement offer within policy limits and the risk of excess liability is apparent, as that may create a conflict of interest between the insurer and insured. *(Martin v. Hartford Acc. & Indem. Co.* (1964) 228 Cal.App.2d 178, 183–84 ["The company, having the right to select counsel to defend the insured, had the duty to communicate to him the results of any investigation indicating liability in excess of policy limits, and any offers of settlement which were made, so that he might take proper steps to protect his own interest."].)

Preventing settlement

Obstructing or preventing a settlement, even if the settlement is proposed by the insurer, may constitute a bad faith refusal to settle. (*Barickman v. Mercury Cas. Co.* (2016) 2 Cal.App.5th 508, 520.)

Improper coverage considerations

An insurer's coverage defenses are irrelevant in this settlement demand process because coverage has no bearing on a victim's injuries or an insured's liability. "Although an insurer may reasonably underestimate the value of a case, and thus refuse settlement, an insurer does not act reasonably in using its no-coverage position to refuse settlement altogether." (*Howard v. Am. Nat'l Fire Ins. Co.* (2010) 187 Cal.App.4th 498, 529.) "Such factors

as the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage, should not affect a decision as to whether the settlement offer in question is a reasonable one." (*Johansen*, *supra*, 15 Cal.3d at p. 16.)

> Don't overthink this part of the process. The requirements are logical and when done correctly they help your case.

B. The Contents – Prelitigation Statutory Demand Letters

Effective January 1, 2023, California enacted Code of Civil Procedure section 999 et seq. which codified the prelitigation time limited settlement demand letter. All prelitigation settlement demand letters are required to:

1. Be in writing;
2. Be labeled as a time limited demand and/or must reference Code of Civil Procedure section 999.1;
3. Provide *at least 30 days* for the carrier to respond if the demand is transmitted electronically, or provide *33 days if transmitted by mail;*
4. Include a clear and unequivocal offer to settle all claims within policy limits, *including the satisfaction of all liens*;
5. Include an offer for a complete release from the claimant for the liability insurer's insured's from all present or future liability from the occurrence;
6. State the date and location of the loss;
7. State the claim number, if known;
8. Provide a description of all known injuries sustained by the claimant;
9. Include reasonable proof, which may include medical records or bills, sufficient to support the claim. (Code Civ. Proc. § 999.1).

Don't overthink this part of the process. The requirements are logical and when done correctly they help your case. All demand letters should be in writing to avoid confusion over terms, offers, evidence, or damages. Regarding timing, you should always give the insurer enough time to evaluate the merits of the claim. The statute eliminated variance in this process by mandating at least 30 days for the carrier to respond. Your demand should include in clear and unequivocal terms, the claimant's offer for a complete release in exchange for settlement within (or at) policy limits. In addition, always include supporting facts and documents, like traffic collision reports and/or medical records, to substantiate your position on liability, causation and damages.

Be sure to send your demand to the right location too. Per the statute, the demand must be transmitted to either (1) the email address or physical address designated by the liability insurer for receipt of time limited demands, if an address had been provided by the carrier to the Department of Insurance and the Department has made the address publicly available, or (2) the insurance representative assigned to the claim, if known. (Code Civ. Proc. § 999.2). The Department of Insurance posts the approved email addresses for time limited demands to its website.[1]

If the insurer intends to accept the demand, it should timely notify the claimant, in writing, that it has accepted the terms of the demand in their entirety. However, the statute provides insurers with some grace, and states that if the carrier seeks "clarification or additional information or requests an extension due to the need for further information or investigation, made during the time within which to accept a time limited demand, shall not be deemed a counteroffer or rejection of the demand." (Code Civ. Proc. § 999.3(b)).

C. The Contents – Non-statutory Post-Litigation Demand Letters

Code of Civil Procedure section 999 et seq. specifically addresses *prelitigation* demand letters. However, demand letters can be pursued post-litigation as well. The demand should, at a minimum, provide the following: (1) terms that are clear enough to have created an enforceable contract resolving all claims had it been accepted by the insurer, (2) confirm all third party claimants have joined in the demand, (3) provide a complete release of all insureds, and (4) offer a *reasonable amount of time* for the insurer to respond so as to provide an adequate opportunity to investigate and evaluate its insured's exposure. (*Graciano v. Mercury Gen. Corp.* (2014) 231 Cal. App.4th 414, 425.)

The timing issue is a critical one that many lawyers get wrong. The controlling factor is reasonableness and will be determined on a case-by-case basis. The Fourth District Court of Appeal decision in *Hedayati v. Interinsurance Exch. of the Auto. Club* (2021) 67 Cal.App.5th 833, highlights the importance of the time a plaintiff offers an insurer in a settlement demand letter.

In *Hedayati*, plaintiff sustained catastrophic injuries in October 2012 when a driver ran a red light and struck her in a crosswalk. (*Id*.) The driver, insured with the Auto Club ("AAA"), immediately authorized AAA to disclose his $25,000 policy limits and confirmed he had no other assets. (*Id*. at 836-837.) AAA initially refused to provide a copy of its insured's policy, its insured's asset declaration or any writing confirming policy limits, despite plaintiff being placed on life support. (*Id*. at 836-838.) On November 20, 2012, plaintiff's counsel issued a policy limit demand letter that demanded, among other things, AAA accept the offer in writing within seven (7) days. (*Id*. at 840.) On November 28, 2012, AAA requested additional time and plaintiff's counsel refused, arguing the time to respond lapsed. (*Id*. at 841.) The matter proceeded to trial and plaintiff obtained a $26 million judgment. (*Id*. at 837) Plaintiff sued AAA for bad faith arguing the policy was open. The trial court granted AAA's motion for summary judgment, in part, due to the "mega short limited" time for the insurer to reach a decision. Plaintiff appealed and the Fourth District Court of Appeal reversed finding a triable issue of fact on whether the one-week response time and AAA's response thereto were reasonable. This ruling confirmed the determination of an insurer's unreasonableness in response to a settlement demand was for a jury to decide.

> A trier of fact could conclude Hedayati's lawyer reasonably concluded that nothing might focus Auto Club's attention to provide necessary disclosures like a short settlement deadline. So he made a seven-day demand. Here, whether a seven-day demand was reasonable is for the trier of fact to determine; a short time limit attached to a settlement demand may or may not be reasonable *under the circumstances of a given case*.

(*Id*. at 848, emphasis added.)

Be judicious in the time you offer the carrier to respond to the demand. In *Hedayati*, the plaintiff was on life support following a vehicle versus pedestrian collision. Damages and liability were obvious, and with a modest insurance policy, the insurer should not require extensive review. However, in a contested liability accident, where a victim claims soft tissue injuries and emotional distress justifying a million-dollar policy limits demand, more time will likely be needed to respond to the demand. *Be reasonable*! If you are early in the case but have sufficient documents and information to prepare a compelling demand letter, you should do so and grant the insurer sufficient time to review the materials and information provided. There is almost always no harm to granting 30 days, and doing so may avoid future headaches. Similarly, if the insurer requests additional time to respond to the demand, evaluate the request for reasonableness.

- Was the request issued before expiration of the response time?
- Is the amount of additional time requested reasonable or necessary?
- Will the proposed extension prejudice plaintiff in any way?
- Are there any pending hearings, motions or other events that would be negatively impacted by the proposed extension?

D. What Happens If…

What happens if you issue a settlement demand in *excess* of the insurance policy limits?

You will not trigger bad faith liability for the insurer. The implied covenant of good faith and fair dealing does not obligate an insurer to accept a settlement beyond the policy limits. (*Heredia v. Farmers Ins. Exch.* (1991) 228 Cal.App.3d 1345, 1357.)

What happens if there is no coverage under the policy?

Coverage for the underlying loss is a threshold requirement for insurance bad faith. If there is no coverage, then an insurer cannot be liable in bad faith for rejecting a demand. *(Johansen*, *supra* 15 Cal.3d at p. 19, "Clearly, if defendant's belief that the policy did not provide coverage in the instant case had been vindicated, it would not be liable for damages flowing from its refusal to settle.") However, a carrier that rejects a demand for coverage reasons does so at its own risk, as it may be bad faith *if the coverage decision is wrong*. (*Id.* at 15-16.)

> If the insurer complies with your entire demand, then you cannot open the policy and must look elsewhere.

What happens if you don't provide the insurer with all the supporting materials.

Many personal injury lawyers will deliberately withhold requested materials, like medical records in a personal injury case. Personally, I've heard many lawyers refuse an insurer's request for all supporting documents, stating this isn't formal discovery. But that observation misses the bigger picture. If an insurer has all the supporting and/or requested materials provided, it can no longer argue any denial was based on lack of information. This is a favorite argument for insurers, as it often gets them past the "unreasonable standard." The simple solution to avoid this, and get ahead of the issue, is to simply produce the supporting materials requested.

What happens if the insurer asks for more time?

For prelitigation demand letters, the insurer's request for more time is controlled by Code of Civil Procedure section 999.3(b), which states any requests for additional time, made within the time period to respond, shall not be deemed a denial. In the post-litigation demand context, you should work with the carrier to establish a reasonable time for the insurer to respond in addition to providing any additional information or documents requested. For non-statutory and post litigation demand letters both, reasonableness controls the parties' conduct. It should take an insurer less time to accept a settlement demand for minimum policy limits when the plaintiff/claimant is on life support with a traumatic brain injury following a clear liability car crash, than a plaintiff/claimant with soft tissue injuries making a million-dollar policy limit demand due to a contested accident scenario.

What happens if the insurer accepts the demand?

If the insurer complies with your entire demand, then you cannot open the policy and must look elsewhere. (*Graciano v. Mercury Gen. Corp.* (2014) 231 Cal. App.4th 414, 426, ["[W]hen 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."].) However, the acceptance must be full, including your reasonable terms like proof of no other collectible insurance or a declaration.

What happens if the insurer rejects the demand?

For prelitigation settlement demands, rejection is controlled by Code of Civil Procedure section 999.3(c). The statute mandates the insurer notify the claimant, in writing, of its rejection and the basis for its decision. The rejection must be sent before the expiration of the time to respond. The injured claimant should then pursue their claim against the insured tortfeasor. If an excess judgment is obtained, the insurer's rejection letter is relevant to any subsequent bad faith action. For non-statutory and post-litigation demand letters, if the insurer rejects the demand you should continue to litigate and proceed to trial. If an excess judgment is obtained, you can then pursue a bad faith action against the insurer.

What if I go to trial, and the verdict comes in near or below policy limits?

As all litigators know, trial is unpredictable. If a plaintiff proceeds to trial and obtains less than the policy limits, then your previous attempt to open the policy failed. You can file an appeal and issue a new demand letter thereby restarting the process, or you simply lose the ability to pursue extracontractual liability. Of course, pursuing the appeal route carries the added risk of establishing bad law or impacting the unreasonableness standard.

What if I win at trial?

You should check whether the defendant will pursue an appeal. If the carrier posts a bond and agrees to pay the excess judgment if defendant loses on appeal, then you should oppose the appeal as a successful

outcome will negate any additional litigation. If you won at trial, and the defendant does not appeal, and the insurer refuses to pay any excess judgment, then you have no choice but to file a bad faith action and pursue the insurer.

What if there are multiple claimants?

Always look for and seek excess insurance policies when your client sustained grievous injuries, especially if there are multiple plaintiffs/claimants. While a million dollars sounds like a lot of money to the client, when it is split between multiple plaintiffs/claimants each with attorneys' fees and costs, that number could look dramatically different at the end of the day.

If multiple claimants, make sure all parties join in the demand.

An insurer will almost certainly reject a policy limits demand if payment to a single claimant will leave the insured without funds to settle with the remaining third-party claimants. Given this, it is imperative to include all claimants in a policy limits demand.

E. Pursuing the Bad Faith Action – Now What Happens?

You've successfully issued a demand letter within (or for) policy limits, the insurer denied the demand, and you've obtained an excess judgment far above the policy limits, now what happens?

To begin, decide how you would like to pursue the bad faith action. Remember, the rule opening third party policies exists for the benefit and protection of the defendant/insured, not the injured plaintiff. The focus of the bad faith analysis will be on the defendant insured, not the injured plaintiff. Therefore, the most straightforward approach is representing the insured in an action against their insurer. However, if you represented plaintiff in the underlying action and obtained an excess judgment, the defendant should be sufficiently motivated to retain counsel and pursue the matter to protect their assets and/or avoid filing for bankruptcy. If the defendant is unwilling to pursue their insurer, another option is to obtain an assignment of rights from the insured defendant so that the injured plaintiff can pursue the bad faith action.

However, if you proceed with the assignment, *be cautious*! The best bad faith actions are where the insurer left its insured "in the lurch" and exposed to an excess judgment. Be careful not to absolve defendant of liability for the excess judgment in exchange for an assignment of rights. This dilutes the most potent part of your bad faith action, i.e., the insured's exposure. You *will* have a much harder time arguing the insurer left its insured exposed to a massive excess judgment if you absolve the defendant of liability for the excess judgment before the bad faith action commences! Be creative, whether you execute a covenant not to execute, a deferral agreement, forbearance agreement, or some other agreement, be sure your chosen agreement does not become a release.

> The timing issue is a critical one that many lawyers get wrong.

Obviously, you cannot collude with the insured to the detriment of the insurer, nor should you ever do so. "[C]ollusion occurs when the insured and the third party claimant work together to *manufacture* a cause of action for bad faith against the insurer or to inflate the third party's recovery to artificially increase damages flowing from the insurer's breach." (*Safeco Ins. Co. of Am. v. Parks* 170 Cal.App.4th 992, 1013, emphasis added.)

From a discovery standpoint, in a bad faith action you should pursue correspondence between the attorney, the insured and the carrier during the underlying action. (Evid. Code § 962; *Glacier Gen. Assurance Co. v. Superior Ct.* (1979) 95 Cal. App.3d 836, 841, ["To permit the insurer to use the attorney-client privilege to shield from its insured, communications which relate to the insurer's decision concerning settlement would be to place the insured in a secondary rather than a primary position in his relationship with the attorney, seriously eroding the insured's ability to establish that the insurer had failed in its duty to him."].) You need to establish the insurer unreasonably denied the claim *at the time the demand was made*. To achieve this, you need to know what information the insurer had available to it, what it did with that information including any further investigations, and how it arrived at the decision to reject the demand. The reasonableness analysis changes regularly throughout a claim, and throughout a bad faith case. We cannot stress this enough!

Also, be prepared for a motion for summary judgment. The bad faith standard is far from automatic even when the insurer rejects plaintiff's policy limits demand. The standard has been, and remains, reasonableness. Given the inherent grey area, insurers are incentivized to pursue summary judgment regularly. Your best defense is to take several comprehensive depositions that pin down the insurer's positions and retain experts early. Good experts may help inform your deposition strategy, and help refine your overall case strategy as more facts and documents come to light in discovery.

At trial, you will need to establish the insurer's rejection of the settlement demand was unreasonable. "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." (*Pinto, supra*, 61 Cal.App.5th at p. 687.) Some of the questions to be answered by the jury include whether plaintiff is insured by defendant, whether claimant made a reasonable settlement demand within policy limits to the insurer, and whether the insurer unreasonably rejected claimant's demand. These are all questions to keep in mind as you work through discovery in the bad faith action.

F. Conclusion

Opening an insurance policy can provide an injured plaintiff with the ability to obtain full compensation for their injuries. But it must be done right. Any unreasonableness on your part will likely result in the inability to open the policy. If you're not reasonable, you can't lay the blame for the lack of settlement on the insurer and you will have done your client a disservice. ■

---

[1] California Department of Insurance, Insurer Contact Information for Receipt of Time Limited Demands Pursuant to Section 999.2 of the Code of Civil Procedure, https://www.insurance.ca.gov/01-consumers/upload/SENATE-BILL-1155.pdf