Johansen v. California State Automobile Association: Has California Adopted Strict Liability for an Insurer's Failure to Settle

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The typical liability insurance policy contains a provision requiring the insurer to defend the named insured in actions filed against him within the scope of the policy's coverage. Such policies also invariably establish fixed liability limits, specific dollar amounts above which the company will not be contractually liable. If, as is often the case, the plaintiff makes a settlement demand that is within those policy limits, the insurance company attorney named to represent the insured may find himself confronted with a serious conflict of interest. It is in the insured's interest to accept the demand, thus protecting his personal assets from a verdict in excess of the policy limits. On the other hand, it may be actuarially unsound for the insurer to accept the settlement demand, particularly when liability is questionable or the extent of damages uncertain.

Various writers have argued that the best way to eliminate the potential conflict of interest is to adopt a doctrine of strict liability in this area. Under such a doctrine an insurance company which refused a settlement demand within the policy limits would be strictly liable for any amount in excess of such limits awarded against the insured in the trial. This result would obtain regardless of the insurer's good faith or the reasonableness of its decision not to settle. In 1967, the California Supreme Court in *Crisci v. Security Insurance Co.* explicated at length.


the merits of strict liability in this context but stopped short of adopting such a doctrine outright.

In the recent case of Johansen v. California State Automobile Association Inter-Insurance Bureau, the court answered plaintiff's arguments which urged the adoption of strict liability by saying that it was not necessary to resolve the issue. This note, however, will argue that Johansen and other decisions since Crisci have in fact resolved the issue in favor of an unannounced policy of strict liability for failure to settle within the policy limits. Although this result may in some respects be consistent with good public policy and, most important, may minimize the conflict of interest problem described above, it also raises a variety of practical problems, perhaps the most important of which is the possibility that this new leverage could be abused by a plaintiff acting in bad faith. This note will examine Johansen and some of the cases preceding it in detail and suggest one way of dealing with the problems raised by what amounts to an unannounced policy of strict liability.

Definitions

For purposes of this discussion, the terms below will be defined as follows:

**Excess liability cases**: those cases which consist of three basic elements: 1) a demand to settle within the policy limits; 2) a rejection of the demand; and 3) a judgment in excess of the policy limits.

**Excess liability**: a state of events requiring the insurer to pay the portions of a judgment that exceed the policy limits.

**The second suit**: the lawsuit—often called the “bad faith suit”—in which the insured or his assignee files against the insurer for failing to

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4. *Id.* at 430-31, 426 P.2d at 177, 58 Cal. Rptr. at 17. See text accompanying notes 81-83 *infra.*
5. *See* 66 Cal. 2d at 431-32, 426 P.2d at 177, 58 Cal. Rptr. at 17.
6. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).
7. *Id.* at 17 n.6, 538 P.2d at 749, 123 Cal. Rptr. at 293.
8. Although courts often use the term “offer” to refer to the plaintiff's settlement demand, personal injury and defense attorneys almost uniformly use the term “demand” to describe the plaintiff's offer and reserve the term “offer” for the defendant's offer. Interview with Joseph W. Rogers, Jr. of Pettit, Evers & Martin, in San Francisco, California, Jan. 8, 1976.
9. At times, certain jurisdictions have imposed liability for the excess judgment after a finding that the insurer has been guilty of bad faith. Although this finding is not now a requirement for the imposition of excess liability in California, the second suit is still often referred to as the “bad faith suit.” When the term “bad faith” is used, it sometimes carries a layperson's meaning rather than a particular legal meaning. For a discussion of several of these decisions, see Comment, *Insurance Carrier's Duty to Settle: Strict Liability in Excess Liability Cases?*, 6 *SETON HALL L. REV.* 662, 669-75 (1975).
accept the plaintiff's settlement demand. This cause of action arises from a breach of the covenant of good faith and fair dealing, which is implied in almost all contracts.

**Second suit perspective:** a perspective created when all three excess liability elements are present and a second suit has been filed.

**Reservation of rights:** an express communication to the insured explaining that although the insurer is offering a defense, this offer does not amount to an admission that coverage exists. The insurer thus reserves the right to raise the issue of coverage at a later time.

**The Road to Strict Liability: California Case Law Before Johansen**

The first supreme court decision in California's excess liability case law was the 1958 decision in *Comunale v. Traders & General Insurance Co.* The court in *Comunale* held that the implied covenant of good faith and fair dealing requires that

[A]n insurer, who wrongfully declines to defend and who refuses to accept a reasonable settlement within the policy limits in violation of its duty to consider in good faith the interest of the insured in the settlement, is liable for the entire judgment against the insured even if it exceeds the policy limits.

By requiring both a wrongful refusal to defend and a refusal to accept a reasonable settlement, the court seemed, if anything, to be pointing away from strict liability.

Two years later, the court of appeal in *Davy v. Public National*

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10. For example, the California Supreme Court has described this implied covenant in the following manner: "There is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." *Comunale v. Traders & Gen. Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198, 200 (1958).

11. The first court of appeal decision in this area was filed in the previous year. The court referred to decisions from other jurisdictions and found the insurer liable, announcing that the test of liability was bad faith rather than negligence alone. *Brown v. Guarantee Ins. Co.*, 155 Cal. App. 2d 679, 688-89, 319 P.2d 69, 75 (1957).

12. 50 Cal. 2d 654, 328 P.2d 198 (1958). The pedestrian Comunales were struck and injured by Sloan, whose insurer was Traders & General Insurance Company. Because Sloan did not own the truck he was driving at the time of the accident, his insurer declined coverage and refused to defend. The Comunales made a demand to settle within the policy limits. Sloan informed Traders of the demand (which he could not pay) and asked that they assume the defense and settlement. Traders refused, and the trial resulted in a judgment in excess of the policy limits. Sloan assigned his cause of action against Traders to the Comunales, who successfully maintained this bad faith action against the insurer. See *id.* at 657-58, 328 P.2d at 200.

13. See note 10 *supra*.

14. 50 Cal. 2d at 661, 328 P.2d at 202.
Insurance Co. discussed the meaning of good faith and fair dealing and said the exercise of good faith requires "an equal consideration of the interests of the insured along with those of the insurer . . . ." Most important, Davy seemed to suggest that an insurer would not be held to excess liability if a demand was rejected in good faith. In this regard the court stated with some particularity its interpretation of the term "good faith":

[A]n insurer acts in good faith in rejecting an offer of settlement after it has undertaken a reasonably diligent investigation to determine the facts of the case, is acting upon the opinion of a reasonably qualified legal advisor, and is of the honest belief that the risk of an adverse verdict is one which it would assume if there were no limits to its policy, providing the insured is informed of the offer of settlement, furnished with the results of the investigation made, and advised of the opinion upon which the rejection is based.

The court in Davy explained further that liability could not be based simply upon the failure to predict the outcome of the action, specifying that "[n]either mistaken judgment nor unreasonable judgment is the equivalent of bad faith." The dispositive factor, said the court, is whether the insurer would have made the same decision if there had been no policy limits, a determination which was to be a function of the trier of fact.

The next statement of the California Supreme Court on this issue came in 1967 in Crisci v. Security Insurance Co. The opinion in Crisci used the "determinative factor" analysis mentioned in Davy as a touchstone, saying, "the test is whether a prudent insurer without policy limits would have accepted the settlement offer." This time, however,

15. 181 Cal. App. 2d 387, 5 Cal. Rptr. 488 (1960). Davy, who operated 27 taxicabs, was sued as a result of an accident between a police motorcycle and one of Davy's cabs. Davy's insurer, Public National Insurance Company assumed the defense but rejected a demand to settle for $4,500 on a policy with $5,000 limits. The jury returned a verdict against Davy in the amount of $24,268, and the insurance company paid the $5,000 limits. Davy successfully sued the insurance company for the excess. See id. at 393-94, 5 Cal. Rptr. at 491.

16. Id. at 395, 5 Cal. Rptr. at 492.
17. Id. at 396, 5 Cal. Rptr. at 493.
18. Id.
19. Id. at 399, 5 Cal. Rptr. at 495.
20. Id. at 400, 5 Cal. Rptr. at 495.
21. 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967). Mrs. DiMare, a tenant of Mrs. Crisci, was injured on an outside staircase when a tread gave way. Mrs. DiMare sued Mrs. Crisci, who was defended by Security Insurance Company under a policy with $10,000 liability limits. Security rejected a within-limits demand, part of which Mrs. Crisci offered to pay out of personal assets. The jury awarded Mrs. DiMare $100,000. Security paid their limits, and Mrs. Crisci assigned her cause of action against Security to Mrs. DiMare, who prevailed against the insurer. See id. at 427-29, 426 P.2d at 175-76, 58 Cal. Rptr. at 15-16.
22. Id. at 429, 426 P.2d at 176, 58 Cal. Rptr. at 16.
the court stated that all that was required to impose excess liability was
that the insurer had known that the risk of a verdict beyond the limits
was "substantial" and had given more consideration to its own interests
than to the interests of the insured.23

Moreover, the court in Crisci explained that liability did not re-
quire "dishonesty, fraud, and concealment"24 but would be imposed for
"failure to meet the duty to accept reasonable settlements, a duty
included within the implied covenant of good faith and fair dealing."25

Further explanation was provided by the supreme court in the
1973 decision in Gruenberg v. Aetna Insurance Co.26 Although the
case did not itself present an excess liability fact situation,27 the notion
of the "independency of implied covenants" which the court articulated
was to become important in this area. Briefly stated, this concept
directs that although the implied covenant of good faith and fair dealing
imposes duties upon the insured as well as the insurer, the insurer will
not be excused from any implied duty merely because the insured has
breached such a duty on its own part. As the court concluded:

[T]he duty of good faith and fair dealing on the part of the de-
fendant insurance companies is an absolute one. . . . [T]he non-

23. Id. at 432, 426 P.2d at 178, 58 Cal. Rptr. at 18.
24. Id. at 430, 426 P.2d at 176, 58 Cal. Rptr. at 16.
25. Id., 426 P.2d at 177, 58 Cal. Rptr. at 17. This "duty to accept reasonable

settlements" language was to become determinative years later. See text accompanying

Another aspect of Crisci which was to become extremely important in cases which
followed was its hindsight dictum to the effect that the size of the verdict creates an
inference as to the reasonableness of the settlement offer. 66 Cal. 2d at 431, 426 P.2d
at 177, 58 Cal. Rptr. at 17. This language was greeted with approval in Johansen and

business premises were insured by the defendant insurer, Aetna Insurance Company,
against fire loss. A fire occurred, and an adjuster representing the defendant insurer
told an arson investigator the property was overinsured. Subsequently, the plaintiff was
charged with arson. The defendant demanded in writing that the plaintiff appear at the
offices of the company's legal counsel to submit to examination under oath and produce
documents for the insurer's investigation of the loss. The plaintiff's personal attorney
for the criminal charge responded by letter that he had advised his client not to make
any statements while the criminal action was pending. After the arson charges were
dismissed, the defendant insurer refused to pay on the policy because the plaintiff had
failed to appear upon request. The plaintiff prevailed in an action for breach of the
implied duty of good faith and fair dealing. Id. at 569-72, 510 P.2d at 1034-36, 108
Cal. Rptr. at 482-84. See also Note, Good Faith and Fair Dealing in Insurance Con-

27. The excess liability area can be seen as a subdivision of the larger area of
case law concerning allegations of bad faith against insurance companies. Thus, al-
though this note deals specifically with the excess liability cases, most of the language
used in any of the major bad faith cases is relevant.
performance by one party of its contractual duties cannot excuse a breach of the duty of good faith and fair dealing by the other party while the contract between them is in effect and not rescinded.28

This language would appear to have eliminated the assertion of questionable conduct on the part of the insured or the insured’s attorney as a defense29 available to the insurer in the second suit. Such conduct was nonetheless discussed in Johansen, but the court confined its comments to a footnote.30

In another 1973 decision, Garner v. American Mutual Liability Insurance Co.,31 the court of appeal repeated the notion announced in Crisci that actual bad faith on the part of the insurer is not required to impose liability for judgments in excess of the policy limits, since the insurer in any event has a duty to accept reasonable settlement demands.32 The significance of this particular language is discussed more fully below.

In Cain v. State Farm Mutual Automobile Insurance Co.,33 which preceded Johansen by only a few months, the appellate court simply applied, for the most part, concepts introduced in the previous decisions in this area. For example, the opinion in Cain restated the language in Comunale that every insurance policy contains an implied covenant requiring that settlement demands be considered in good faith34 and repeated the “prudent insurer without policy limits” test stated in Crisci.35 As will be seen, however, the decision in Cain was important because the court also approved “hindsight” dictum in Crisci that a jury may properly be instructed that the size of a judgment provides an inference as to the value of a claim.36

28. 9 Cal. 3d at 578, 510 P.2d at 1040, 108 Cal. Rptr. at 488.
29. Successful handling of claims, especially when defense of the insured is involved, requires that the insured cooperate. This cooperation is part of the mutual requirement of good faith and fair dealing. The Gruenberg decision, however, makes it difficult to enforce such behavior. See also Johansen v. Calif. State Auto. Ass'n Int'l Ins. Bureau, 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975); State Farm Mut. Auto, Ins. Co. v. Allstate Ins. Co., 9 Cal. App. 3d 508, 88 Cal. Rptr. 246 (1970).
30. 15 Cal. 3d at 21 n.12, 538 P.2d at 752, 123 Cal. Rptr. at 296.
32. Id. at 848, 107 Cal. Rptr. at 607.
33. 47 Cal. App. 3d 783, 121 Cal. Rptr. 200 (1975). Elaine Cain was injured in an accident involving an automobile owned by Bing Woo Jew and insured by State Farm. Because of a dispute over who had been driving the automobile, defendant insurer failed to accept a demand to settle within the policy limits. Bing Woo Jew assigned part of his cause of action against the insurer to Cain, and they were finally awarded compensatory as well as punitive damages in the bad faith action. See id. at 789-91, 121 Cal. Rptr. at 204-05.
34. Id. at 791, 121 Cal. Rptr. at 205.
35. Id. at 792, 121 Cal. Rptr. at 205. See text accompanying note 22 supra.
36. The jury instruction borrowed from Crisci states: “The size of a judgment re-
It was in the context of this body of case law that the court decided *Johansen v. California State Automobile Association Inter-Insurance Bureau*. As explained above, the phrase "implied covenant of good faith and fair dealing" had been interpreted up to this point to impose a duty to accept reasonable settlement demands. How this duty has become the practical equivalent of strict liability can be shown by a closer examination of the decisions in *Garner* and *Johansen*.

**Garner v. American Mutual Liability Insurance Co.**

In *Garner v. American Mutual Liability Insurance Co.*, the court of appeal ventured as far as any court prior to *Johansen* to impose liability on the insurer in an excess liability situation without finding the insurer guilty of bad faith. *Garner* grew out of a medical malpractice suit against a physician who held a $100,000 malpractice liability group policy issued by the defendant insurer. Under the provisions of the insurance agreement, an independent medical review committee was required to study claims to determine whether the physician had deviated from accepted medical practice. The understanding was that an insurer would not settle unless there was a finding by the committee that the physician’s actions constituted malpractice. In *Garner*, such a committee determined that the physician was not guilty of malpractice, and the insurer consequently declined a settlement demand for the policy limits. The result in the main suit was nevertheless a judgment of $225,000 against the physician.

Subsequently, the physician brought an action against his insurer claiming bad faith refusal to settle within the policy limits. His complaint asked for $625,000, an amount which included the excess as well as additional compensatory damages. On appeal from a trial verdict for the insurer, the court of appeal ruled against the defendant insurer, and the supreme court declined to hear the case.

covered in a personal injury action, when it exceeds the policy limits, although not conclusive, presents an inference that the value of the claim is equivalent to the amount of the judgment, and the acceptance of an offer within those limits is the most reasonable method of dealing with the claim.” Crisci v. Security Ins. Co., 66 Cal. 2d 425, 431, 426 P.2d 173, 177, 58 Cal. Rptr. 13, 17 (1967) quoted in 47 Cal. App. 3d at 796-97, 121 Cal. Rptr. at 208-09.

Some defense attorneys feel this so-called “hindsight” instruction has the practical effect of imposing strict liability because a jury in the second suit has difficulty distinguishing between an inference and a presumption and almost invariably agrees with the previous jury (which returned a verdict for the plaintiff). Address by Robert T. Lynch, San Francisco Claim Manager’s Council Monthly Meeting, in San Francisco, California, May 8, 1975.

37. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).
39. *Garner* was not cited in *Johansen*, most likely because the presence of the
An important aspect of Garner was that the insurer was held liable even though there had been clearly no finding of bad faith on its part in refusing the settlement demand:

The trial court found, inter alia, that the malpractice case had been fully and capably investigated . . . that it was concluded in good faith . . . that there was no reasonable likelihood of a verdict in favor of [plaintiff] . . . defendant concluded again in good faith, after review of the case that, even if [the insurer] were held liable, the verdict would not go over $100,000 . . . . The trial court further found, inter alia, that the rejection of the settlement offer . . . and the refusal to make a counteroffer would have occurred even if there had been no limit at all on the insurance company's liability; and that there was no bad faith or negligence in the handling of the case.40

With this record, it is difficult to view the conduct of the insurer in this case as having failed to satisfy the company's contractual obligation of good faith and fair dealing. In fact, the appellate court recognized that there had been insufficient evidence of bad faith.41 Nonetheless, the court decided that the major issue was whether or not the insurer was liable for breach of a duty to accept reasonable settlement demands.42 Apparently, if the demand to settle was reasonable, then the insurer had an unqualified duty to accept it. This duty had been breached, the court found, because the insurer had relied on the findings of a medical review society that there had been no malpractice, rather than making an independent evaluation of the case.43

There was no finding, however, that the demand would have been accepted if there had been an independent evaluation. In fact, the record indicates that it is likely the insurer would still have declined to settle in such a case.44 Therefore, there was no causal connection between failing to evaluate the case independently and the excess judgment.

The court explained its somewhat curious holding as follows:

medical review committee complicated the fact situation, making questionable any use of the case as precedent in other fact situations. The decision in Garner is valuable, however, because it illustrates the length to which the courts will go to return a verdict in favor of the insured. Justice Richardson, who concurred in the Garner decision, took a seat on the supreme court in time to concur in Johansen.

40. 31 Cal. App. 3d at 847, 107 Cal. Rptr. at 606.
41. See text accompanying note 40 supra.
42. 31 Cal. App. 3d at 847, 107 Cal. Rptr. at 607 (1973).
43. Id. at 849, 107 Cal. Rptr. at 608.
44. "The trial court found, inter alia, that the malpractice case had been fully and capably investigated . . . ." Id. at 847, 107 Cal. Rptr. at 606.

Also, the trial attorneys for the plaintiff in the malpractice case testified that based on their experience, even if malpractice had been found, they would not have expected the verdict to exceed the policy limits. Id.
There is a clear implicit consensus in the cases on this subject that the duty to consider and weigh all the factors bearing upon the advisability of a settlement in the interests of the insured is upon the insurance carrier. Obviously this legal duty is exercised normally in conjunction with the judgment of counsel defending the cases against the insured. It is equally obvious to us that neither the insured [sic] nor counsel can base its legal duty to its insured solely upon a finding by a medical review committee. . . . 45

Thus, Garner presents the somewhat anomalous situation of a breach of contract based neither on a finding of bad faith nor on a finding that the excess judgment damages were a result of the breach. 46

A possible explanation for this anomaly is that there was a basic difference in approach between the trial court and the appellate court in the second suit.

The trial court judged the conduct of the insurer from the facts existing at the time the insurer made the decision to reject the settlement demand in the malpractice case. In contrast, it seems that the appellate court viewed the conduct by looking backward and taking the excess judgment into account. From such a perspective, it would have been easy to suggest that the best course of action would have been to accept the demand. Moreover, without this perspective, it would have been impossible for the court to say that failing to make an independent evaluation damaged the insured. 47

Thus, although the court in Garner made no mention of the propriety of a “hindsight judgment,” the conclusion is inescapable that such an approach was used.

The result is that the Garner decision moved California law a step closer to what amounts to strict liability in the excess liability situation. Garner therefore helped to set the stage for the Johansen decision, filed two years later.

Johansen v. California State Automobile Association

Perhaps the best way to understand the excess liability situation as it now exists is to contrast the California Supreme Court's opinion in Johansen v. California State Automobile Association Inter-Insurance

45. Id. at 848, 107 Cal. Rptr. at 607.
46. This decision may cause serious damage to the beneficial use of medical review committees in malpractice cases. See Comment, The Medical Malpractice Crisis: Is the Medical Review Committee A Viable and Legal Alternative?, 15 SANTA CLARA LAW 405 (1975).
47. The suggestion that the Garner court used a hindsight approach has been made before: “In essence, the Garner court adopted a new, hindsight approach for determining whether an insured [sic] breached its duty to act in good faith in refusing to settle an action against its insured.” Id. at 418.
with the opinion written by Justice Kane in the court of appeal.49

The Johansens, who were injured in an automobile accident, brought suit against the Dearings who were insured by California State Automobile Association (the association). Maintaining the automobile involved in the accident was not covered by the policy, the insurer instituted a declaratory relief action to determine coverage while still providing a defense to the insured Dearings.

The Johansens made a policy limits demand which the association rejected in reliance on its claim of noncoverage. The association did, however, offer to put the limits in escrow at seven percent interest pending the outcome of the declaratory relief action.50

The Johansens were ultimately successful in obtaining judgment against the Dearings in excess of the policy limits, and the association paid the limits. The Dearings assigned their rights against the association to the Johansens in exchange for a release of personal liability for the outstanding excess, as is the common practice in such cases. The Johansens then sued the association for the excess.

In the declaratory relief action, the trial court decided in favor of the insurer, finding that there was no policy coverage. On appeal, the coverage issue was decided against the insurer.51

In the second suit, in which the Johansens sued the association for the excess liability, the trial court found for the insurer. The Johansens appealed, and the court of appeal affirmed the trial court decision.52 The supreme court reversed, finding liability on the part of the insurer for the excess on the theory it had failed to accept a reasonable demand.53

There are several basic differences between the interpretation given earlier excess liability cases by Justice Tobriner and the explanation offered by Justice Kane. For example, Justice Kane appeared to attach considerable significance to the fact that Comunale involved both the

48. 15 Cal. 3d 9, 538 P.2d 744, 123 Cal. Rptr. 288 (1975).
49. Johansen v. California State Auto. Ass'n Inter-Ins. Bureau, 116 Cal. Rptr. 546 (1974). It is important to note that since the supreme court granted a hearing, the appellate court decision is of no value as precedent in California. Cal. R. Ct. Misc. 977.
50. The supreme court did not discuss the good faith implications of this offer. Apparently such counterproposals will be viewed only as rejections of the settlement demands. See 15 Cal. 3d at 13 n.1, 538 P.2d at 746, 121 Cal. Rptr. at 290.
53. 15 Cal. 3d at 17, 538 P.2d at 749, 123 Cal. Rptr. at 293. See text accompanying note 56 infra.
failure to accept a reasonable settlement demand and a refusal to defend. By contrast, Justice Tobriner found this distinction unimportant in judging the conduct of the insurer. His opinion repeated the Comunale language that "[t]he decisive factor in fixing the extent of [the insurer's] liability is not the refusal to defend; it is the refusal to accept an offer of settlement within the policy limits." A more important difference between the court of appeal decision and the supreme court decision involves the question of whether it is necessary to find culpable conduct on the part of the insurer before liability may be imposed. Basing his conclusion on language in Comunale and Crisci, Justice Kane reasoned that a finding of liability on the part of the insurer for failure to settle within policy limits must be founded on the culpability of its conduct. He interpreted Comunale as indicating that "when the insurer assumes the defense of the insured it thereby retains control over the litigation and settlement and is therefore liable for the entire amount of a judgment against the insured, but only if in the exercise of such control it is guilty of bad faith in refusing to settle within the policy limits ..." Justice Kane also supported his conclusion by interpreting Crisci as specifying that an "unwarranted" rejection of a demand to settle is a prerequisite to liability. It was Justice Kane's opinion that the meaning of "unwarranted" implied some kind of culpability.

By contrast, Justice Tobriner emphasized that the court in Comunale had stated that an insurer denies coverage at its own risk and that, "if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused ..." In this regard, Justice Tobriner disagreed with Justice Kane's conclusion.

54. "Comunale makes it evident that the insurance company there breached both its duty to defend and to settle the claim within the policy limits. ... It follows that, since in the case at bench respondent assumed the defense of the Dearings in the damage action, the rule pertaining to a dual breach pronounced in Comunale is inapposite." 116 Cal. Rptr. at 550.

55. 15 Cal. 3d at 17, 538 P.2d at 749, 123 Cal. Rptr. at 293.


57. Justice Kane stated: "[C]ontrary to appellant's contention, Crisci reaffirms rather than negates the proposition that the culpability of the insurer is a requisite element of liability based upon its failure to settle within the policy limits." 116 Cal. Rptr. at 550.


60. See note 57 supra.

that "wrongful" necessarily implied some form of culpability, reasoning that "an insurer's 'good faith,' though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer. In a preceding footnote he had noted that "it becomes apparent that a 'wrongful' denial of coverage as used in Comunale means merely an erroneous denial of coverage . . . ."\(^6\)\(^2\)

Moreover, Justice Tobriner emphasized the existence of an independent duty to accept reasonable settlement demands\(^6\)\(^4\) and concluded that "the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer."\(^6\)\(^5\) As will be seen below, however, this language raising questions of injuries and liability is probably not a basis for defense on those issues because of the supreme court's approval of the "hindsight" approach.

The Duty To Accept Reasonable Settlement Demands

If the obligation of an insurance company, then, is to accept reasonable settlement demands, does there exist a good faith method by which a demand may be rejected and excess liability avoided by an insurer? On its face, an absolute duty to accept reasonable settlement demands would require a jury to determine, at a minimum, whether the demand made by the plaintiff was reasonable. In this regard, the reasonableness of the demand would arguably vary with each of the following factors: 1) the insurer's belief in noncoverage; 2) the likelihood of liability; 3) the extent of probable damages; and 4) the timing of the settlement demand. For instance, should a demand be considered reasonable if the liability is doubtful; or if the damages appear to be well below the settlement demand? The answer would appear to be that the California decisions cited above have systematically done away with these traditional defenses.

For example, good faith belief in noncoverage, which was present in Johansen, is simply no longer able to be raised as a defense.\(^6\)\(^6\) On its face, Justice Tobriner's phrase "in light of the victim's injuries and the

\(^{62}\) 15 Cal. 3d at 16, 538 P.2d at 748, 123 Cal. Rptr. at 292 (footnote omitted).
\(^{63}\) Id. at 16 n.4, 538 P.2d at 748, 123 Cal. Rptr. at 292.
\(^{64}\) Id. at n.5.
\(^{65}\) Id. at 16, 538 P.2d at 748, 123 Cal. Rptr. at 292.
\(^{66}\) The insurer in Johansen attempted to show that it could not be held to the duty of accepting the demand because there was a legitimate question of coverage, and it would likely be determined that coverage did not exist. The California court rejected this argument and held that an insurer's duty to accept reasonable demands remains absolute regardless of such considerations. See id.
probable liability" does seem to suggest that questionable liability or uncertain injuries could be cited by an insurer as a defense to any excess liability accruing in the second suit. Nonetheless, if the courts continue to use the kind of hindsight approach suggested in the discussion of Garner, the value of these defenses will be negated. Moreover, the court in Johansen approved the hindsight approach as it had been used in Cain. By this method, it appears a court may find that an insurer has "failed to accept a reasonable settlement offer" if, after a verdict is reached, the court can look back and determine that had the insurer accepted the demand, the insured would have been spared exposure to the excess liability. By approving this approach, the court in Johansen seems necessarily to have precluded the validity of considering likelihood of liability and the extent of damages in determining possible defenses for a rejection of a settlement demand. Eliminating these factors as possible bases for a defense comes quite close to imposing strict liability on the insurer. The only possible defense which remains concerns the timeliness of the demand. Thus, the relevant question seems to be: May an insurer assert that a settlement demand is unreasonable if it is delivered at an early date and open only for a short time?

In the 1964 decision of Critz v. Farmers Insurance Group, the court said, "The injured party . . . is under no duty to keep negotiations open after rejection of an early settlement offer." In Critz, the offer was made even before suit was filed and was open only one week. This language has not subsequently been disapproved and thus provides at least some indication that an insurer would have difficulty citing early timing and short duration of the settlement demand as conclusive evidence that it is unreasonable. In short, the erosion of traditional defenses regarding the reasonableness of a settlement demand suggests the approach of a situation in which, from a second suit perspective, all demands are reasonable.

67. Id. 68. See note 47 & accompanying text supra. 69. 15 Cal. 3d at 16-17, 538 P.2d at 749, 123 Cal. Rptr. at 293. See notes 25, 36 & accompanying text supra. 70. See note 36 & accompanying text supra. Justice Kane found such a view totally improper, saying: "The eventuality that after an extensive review the appellate court reversed the judgment does not ex post facto erase the insurer's good faith belief in the noncoverage. It is blackletter law that the reasonableness of denial of policy coverage may not be determined by hindsight, but rather with regard to the circumstances which gave rise to such belief." 116 Cal. Rptr. at 552; see Hodges v. Standard Accident Ins. Co., 198 Cal. App. 2d 564, 575, 18 Cal. Rptr. 17, 23-24 (1961). 71. 230 Cal. App. 2d 788, 41 Cal. Rptr. 401 (1964). 72. Id. at 797, 41 Cal. Rptr. at 406 (emphasis added). 73. Id. at 798, 41 Cal. Rptr. at 406.
The Strategic Ineffectuality of Declaratory Relief Actions

Assuming the foregoing is correct, is there any way an insurance company can refuse a settlement demand and still hope to avoid excess liability if such is the result of the main suit? The answer appears to be that it can, but only if at some point it has been fully and finally determined that the insured's policy does not cover the acts in question. If there is no coverage, there is no contract covering the fact situation; hence, there are no terms, express or implied, from which to impose contractual liability.

Coverage can, of course, be finally determined in a declaratory relief action. Nevertheless, as seen in Johansen, the fact that a coverage question exists and that a declaratory relief action has been initiated does not offer second suit protection to the insurer, since it is not such evidence of good faith as will prevent a judgment for the excess against the insurer.

As a result, many defense counsel now believe that Johansen demonstrates the necessity of initiating the declaratory relief action as early as possible. This tactic would naturally prove helpful if the insurer could establish noncoverage before it had to accept or reject a settlement demand. Such a result is hard to achieve, however, if the settlement demand is made early or if the noncoverage determination is appealed.

Instead, Justice Tobriner has suggested that in excess exposure cases, the insurer should first pay the demand and then look to the insured for reimbursement if the declaratory relief action is finally resolved in the insurer's favor. The declaratory relief action will thus be of value in such cases, according to Justice Tobriner, principally in

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74. In this regard, however, it is very important to distinguish actual noncoverage from good faith belief in noncoverage. As demonstrated in Johansen, the latter is of little value to the insurer: “Accordingly, contrary to the defendant's suggestion, an insurer's 'good faith,' though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer.” 15 Cal. 3d at 16, 538 P.2d at 748, 123 Cal. Rptr. at 292 (footnote omitted). See note 66 & accompanying text supra.

75. 15 Cal. 3d at 16, 538 P.2d at 748, 123 Cal. Rptr. at 292.

76. It has also been suggested that early filing of the suit for declaratory relief will give the insurer a psychological advantage, as the plaintiff will likely pursue the action less vigorously if there may be a finding of noncoverage. Interview with Michael J. Brady of Ropers, Majeski, Kohn, Bentley & Wagner, in San Francisco, California, Oct. 7, 1975; Interview with Andre V. Tolpegin of Tolpegin & Imai, in San Francisco, Aug. 29, 1975. Cases such as Johansen, however, indicate that the plaintiff will remain enthusiastic, knowing that with proper timing of the demand, he may force acceptance regardless of the coverage question.

77. 15 Cal. 3d at 19, 538 P.2d at 750, 123 Cal. Rptr. at 294.

78. The language in Johansen on the subject of coverage is even more distressing
making available after the fact recoupment of losses. Such a suit is analogous to an action for indemnity. Files presenting possible coverage disputes could be turned over to the insurance company's subrogation department for review concurrent with the main action. A company might pay the demand and then, if the subrogation department feels after an asset investigation of the insured that there is a valid coverage question, sue for declaratory relief. The insurer in the main action could preserve this option through a reservation of rights. This suggestion, however, is of little value to the insurance company when, in cases like Johansen, the insured is impecunious.

Aside from enabling the recoupment of losses, which may nonetheless prove to be impossible, an action for declaratory relief presents the insurer with a difficult choice: either it must try to move the action for declaratory relief to a final conclusion, hoping that the insured does not appeal, before the settlement demand is withdrawn, or it must reject the demand and gamble that noncoverage will be established at a later time. In light of Johansen, it is difficult to be optimistic about either approach.

when coupled with Justice Tobriner's discussion in a previous decision, Gray v. Zurich Insurance Co. In Gray, Justice Tobriner emphasized that the duty to defend was independent of the duty to indemnify and that an insurer must therefore provide a defense even if a complaint alleges only intentional conduct, which cannot be covered by a policy of indemnification. Gray v. Zurich Ins. Co., 65 Cal. 2d 263, 274, 419 P.2d 168, 175, 54 Cal. Rptr. 104, 111 (1966). See also Crocker, The Continuing Importance of Gray v. Zurich, 43 L.A.B. BULL. 239 (1968); Comment, Liability Insurance: Specific Exclusion of Liability for Injury Intentionally Caused by the Insured, 12 S.D.L. Rev. 373 (1967); Comment, Liability Insurer's Duty to Defend Suits for Intentional Injury, 24 WASH. & LEE L. REV. 271 (1967); 14 U.C.L.A.L. REV. 1328 (1967).

79. Most subrogation department work involves paying the insured on a given loss and thereupon succeeding to the legal right of the insured to pursue a responsible third party. Subrogation departments, however, also recoup losses in areas that do not actually concern subrogation. For example, if an insurer provides a tax bond, and the insured defaults, the insurer must pay the state the amount of the default. The subrogation department then approaches the insured for reimbursement for all amounts paid to the state under the bond.

80. An interesting result of suing for declaratory relief after the demand has been paid is that the insured loses a powerful ally in that suit. Once the plaintiff has been paid, he has no reason to join in finding coverage. One writer criticizing the use of the declaratory relief action doubts that the plaintiff is ever the ally of the insured, stating that “[i]n a declaratory relief action, the insurer and the injured party are aligned against the insured.” Note, The Role of Declaratory Relief and Collateral Estoppel in Determining the Insurer's Duty to Defend and Indemnify, 21 HASTINGS L.J. 191, 214 (1969). This assertion is simply not accurate. The plaintiff works to find coverage to assure that insurance company assets will be available to satisfy a judgment in the main action, especially if the insured has few assets. No plaintiff's attorney would lose this "deep pocket" without a fight.
The Court's Approval of Strict Liability

A further indication that the supreme court may have in fact adopted strict liability is the clear approval with which the court has viewed the doctrine in this context. For example, in *Crisci*, the court discussed the advantages of such a doctrine as follows:

[T]he rejection of a settlement within the limits where there is any danger of a judgment in excess of the limits can be justified, if at all, only on the basis of interests of the insurer, and, in light of the common knowledge that settlement is one of the usual methods by which an insured receives protection under a liability policy, it may not be unreasonable for an insured who purchases a policy with limits to believe that a sum of money equal to the limits is available and will be used so as to avoid liability on his part with regard to any covered accident.81

The court reasoned that if such is the insured's expectation, an insurance company should be willing to absorb whatever losses result from the rejection of a settlement demand, since it is the insurance company that stands to gain by the rejection.82

After explaining that the proposed rule would eliminate the necessity of determining whether or not a demand was reasonable and would remove any temptation to gamble with the insured's assets, the court concluded:

Finally, and most importantly, there is more than a small amount of elementary justice in a rule that would require that, in this situation where the insurer's and insured's interests necessarily conflict, the insurer, which may reap the benefits of its determination not to settle, should also suffer the detriments of its decision.83

Thus, in explicating another way to find for the insured, the court in *Crisci* indicated its approval of a system of strict liability, even though the decision was not expressly dependent on such a system. The plaintiff in *Johansen* made similar arguments for strict liability. There, the court indicated that such arguments were "well reasoned" but inapposite84 because "the excess judgment may be predicated on [the insurer's] rejection of a reasonable settlement offer."85

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81. 66 Cal. 2d at 430-31, 426 P.2d at 177, 58 Cal. Rptr. at 17.
82. Id.
83. Id. at 431, 426 P.2d at 177, 58 Cal. Rptr. at 17. See note 2 supra.
84. The court stated: "Both plaintiff and amicus curiae on behalf of plaintiff urge that we hold that whenever an insurer receives an offer to settle within policy limits and rejects it, the insurer should be held liable in every case for the amount of any final judgment. . . . In light of our conclusion that defendant's liability for the excess judgment may be predicated on its rejection of a reasonable settlement offer, we need not resolve this issue." 15 Cal. 3d at 17 n.6, 538 P.2d at 749, 123 Cal. Rptr. at 293.
85. Id. The California court apparently read a New Jersey case as having adopted a doctrine of strict liability in that state. Actually, while the New Jersey case quoted at great length from *Crisci* and indicated approval of such a doctrine, it did not adopt
Summary

As demonstrated in the above discussion, the implied covenant of good faith and fair dealing has become an absolute duty to accept reasonable settlement demands. Liability for amounts in excess of the policy limits may be imposed without any finding of bad faith or culpable conduct on the part of the insurer. It might be argued that the California courts have still not imposed strict liability as a matter of law because they still ostensibly require at least a determination that a settlement demand is reasonable. Nevertheless, given the erosion of the traditional defenses of belief in noncoverage, questionable damages or liability, and unreasonable timing of the demand, it is difficult to dismiss the notion that from a second suit perspective, all demands are reasonable. Finally, the fact that the supreme court views the doctrine of strict liability favorably forces the conclusion that as a practical matter, if an insurer does not accept a demand which is within the policy limits, it will almost certainly be liable for any excess judgment. The result, then, looks very much like an unannounced doctrine of strict liability for failure to settle.86

Strict Liability: Two Key Advantages

If it is the case that virtual strict liability has been imposed by the decisions in Johansen and its predecessors, one important ancillary benefit which should result is the elimination of the traditional conflict of interest problem in this area. As stated at the outset, whenever there is a demand to settle within the policy limits, it is in the insured's interests to accept. On the other hand, it is often true that settling at such a figure will be actuarially unsound for the insurer. Because rejection of the demand will expose the insured to a possible excess

86. Another factor which strengthens a strict liability argument is the fact that Comunale, Crisci, and Johansen were all unanimous supreme court decisions. In the excess liability area, in a case involving the rejection of a settlement within policy limits offer, an insurer has not prevailed in a published appellate decision since 1961, in Hodges v. Standard Accident Ins. Co., 198 Cal. App. 2d 564, 18 Cal. Rptr. 17 (1961). Because the court in Hodges found the hindsight approach unacceptable, it is unlikely that it is still good law. Id. at 575, 18 Cal. Rptr. at 23-24.
verdict, at this point in the suit the interests of the insured are, in some respects, aligned with those of the plaintiff. This coincidence of interests is the source of what sometimes amounts to collusion.

Conflict of interest problems are evident in Johansen, in which the plaintiff's attorney engaged in a fee splitting arrangement with the insured's attorney. It is precisely this sort of situation which a system of strict liability would eliminate. If the insured felt that his interests were being sacrificed by his insurer, he would tend to be receptive to the plaintiff's advances and might even provide early cooperation in second suit preparation. In contrast, an insured who knew that his insurer would be absolutely liable for any excess should it reject a demand would have no incentive to defect to the side of the plaintiff if a demand were made to settle within the limits. A second advantage is that a system of strict liability would dispense with the second suit entirely, since the purpose of this suit is solely to determine the insurer's liability for excess.

87. See Merritt v. Reserve Ins. Co., 34 Cal. App. 3d 858, 110 Cal. Rptr. 511 (1973). Merritt was a bad faith action against an insurer for an excess verdict in which there had been no demand to settle within the policy limits. As a result, the court reasoned that there had never been a conflict of interest, since the interests of the insured and the insurer had at all times been parallel. The issue of the insurer's bad faith in relation to the insured had never arisen. Id. at 877, 110 Cal. Rptr. at 523-24. A petition for a hearing by the California Supreme Court was denied; however, Justices Tobriner, Mosk, and Sullivan were of the opinion that the petition should have been granted. See id. at 884, 110 Cal. Rptr. at 530.

88. 15 Cal. 3d at 21 n.12, 538 P.2d at 752, 123 Cal. Rptr. at 296. At one point the arrangement was for an equal split of a 75% contingent fee. Appellant's Answer to Respondent's Petition for a Rehearing by the Supreme Court at 6, Johansen v. California State Auto. Ass'n Inter-Ins. Bureau, 15 Cal. 3d 9, 538 P.2d 752, 123 Cal. Rptr. 288 (1975). Respondent insurer argued that this fee arrangement meant that the insured's personal attorney had a financial interest in a judgment against his own client and further argued that the collusive conduct of the attorneys was, in fact, the "proximate cause" of the excess verdict. Respondent said that because an attorney is the agent of his client, the attorney's conduct is imputed to the client. Respondent's Petition for a Rehearing by the Supreme Court at 6. Appellant answered, however, that because the insured Dearing family was impecunious, the insured's personal attorney had a financial interest not in a verdict against his client, but rather in the insurance proceeds. Appellant's Answer to Respondent's Petition for a Rehearing by the Supreme Court at 6. Appellant answered the agency argument by suggesting that the fee arrangement was outside the scope of authority and that therefore the clients were not bound. Id. at 8.

Strict Liability: One Possible Drawback

One of the most unsatisfactory effects of strict liability in the context of current case law is that the plaintiff may make a demand very early, even before filing suit, and by so doing expose the insurer to excess liability if the demand is refused. The threat of this exposure provides leverage which can, of course, be abused if a plaintiff makes the demand at a very early stage, when a defendant insurer lacks sufficient information to make a proper evaluation of the claim.\footnote{90} Therefore, it is essential that the doctrine of strict liability in this area be tempered in order to minimize the sort of abuse illustrated by the hypothetical situation below.

Suppose someone slips and falls on the insured's property. The insured carries a comprehensive liability insurance policy with $100,000 liability limits. Prior to filing suit, the plaintiff's attorney writes a letter to the insured's liability insurance carrier advising that the plaintiff has ruptured a disc and requires a lumbar laminectomy with fusion; that the plaintiff has, thus far, $3,000 in medical specials;\footnote{91} that documentation of present and future medical specials will be forwarded when received; and that the plaintiff therefore makes a demand to settle for the policy limits, which demand must be accepted by the insurer within ten days. The attorney further indicates that rejection of the settlement demand will be viewed as an act of bad faith. This threat is not an empty one, for since \textit{Johansen}, an insurer who refuses such a demand takes a substantial risk of being held for the excess, if any, awarded by a jury in the main suit.

At this point, the insurer must assign counsel, assign an adjustor, establish reserves,\footnote{92} and, in appropriate cases, keep the home office and

\textit{N.W. 288} (1932). If there are valid constitutional questions, the court should have addressed the issue before allowing the virtual state of strict liability that now exists in the law.

\footnote{90} The careful plaintiff generally delivers with a demand the basic information needed by the defendant insurer to evaluate the claim. This procedure protects the plaintiff by preventing the defendant from raising the argument that information was withheld and a proper evaluation thus prohibited. Interview with Robert T. Lynch of Ericksen, Ericksen, Lynch, Mackenroth & Arbuthnot, in San Francisco, California, Sept. 3, 1975. Nevertheless, decisions like \textit{Johansen, Garner} and \textit{Cain}, which come so close to strict liability, coupled with the fact that plaintiffs' attorneys envision expanded use of the tort of bad faith, have tended to increase plaintiff confidence in this area. See California Continuing Education of the Bar, New Tort Remedies In Insurance Cases, Program Material, Oct.-Nov. 1974.

\footnote{91} Special damages are "[t]hose which are the actual, but not the necessary, result of the injury complained of, and which in fact follow it as a natural and proximate consequence in the particular case . . . ." \textit{BLACK'S LAW DICTIONARY}, 469 (4th ed. rev. 1968). In this context, the term "medical specials" refers to all medical bills resulting from the incident in question.

\footnote{92} Insurance carriers are required to estimate the possible value of each claim
the insured apprised of developments. At the same time, it must perform all of the other necessary duties involved in opening and handling a claim file.

If the demand is accepted, it will almost certainly be accepted without adequate evaluation of the case by defense counsel. A ruptured disc treated by a lumbar laminectomy with fusion could result in a plaintiff's verdict of as little as $100 or as much as $350,000. The liability question, professional evaluation of the injuries, and even the issue of policy coverage itself could be considered in a cursory manner at best.

Clearly the maxim that the law favors settlements should not be extended this far. There is a need for a method of placing sensible limits on the leverage that Johansen and its predecessors now afford to the plaintiff.

**Toward a Workable System of Strict Liability for Failure To Settle**

The result of the trend of the cases culminating in Johansen is that it has become considerably easier for a plaintiff to recover, often without trial. Because a plaintiff can, to a large extent, determine the time at which the insurer will be held to excess liability, it seems proper that reasonable bounds be placed on that leverage.

Appropriate legislation establishing a “point of excess liability” would be a useful first step. Such a scheme would fix a particular time at which an insurer could deliver the policy limits without being held liable for more. For example, the excess exposure point could be set at 120 days after the date of the within-limits demand or 5 days after the pretrial settlement conference, or the first day of trial, whichever date came first. Such a point would allow an insurer to evaluate carefully

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93. Id. on Sept. 4, 1975. Mr. Merrill stated that the figures were obtained from some fifty-eight California jury verdicts over the last four years dealing with the same injury and treatment.

94. The plaintiff should be required to make available to the insurer during this period the basic information needed to make an intelligent decision concerning the offer. Such information would include medical data relating to the extent of the plaintiff's injuries. Although this requirement would raise some tricky procedural problems, one possible way of bringing about the desired result would be to have the judge in the personal injury suit monitor the disclosure in something like a modified discovery proceeding to prevent the plaintiff from withholding necessary information until the time period for accepting the demand expired.
and, if it decided the danger of excess liability was too substantial, deliver the policy limits before the excess exposure point was reached. If, on the other hand, the insurer concluded that the value of the claim was well within the policy limits, it could proceed to trial, but it would have to accept any excess liability which resulted.

Note that this sort of scheme would eliminate the conflict of interest described above and at the same time allow the insurer to make intelligent, professional evaluations of the merits of the plaintiff's demand. Moreover, establishing a point of excess exposure by legislation or judicial decision would put an end to undue pressure by plaintiffs without compromising the merits of the plaintiffs' cases.

One significant drawback to such a plan, however, is that in a case of obvious liability, damages, and coverage, an insurer which was quite aware that it would be required to pay the limits could in any event wait 120 days before doing so. Thus, the plaintiff could be required to wait until the point of excess exposure before being paid. Nonetheless, such difficulty in a few situations would almost certainly not outweigh the advantages which would derive from the proposed scheme in the great majority of cases. Moreover, in view of the amount of time that personal injury suits usually consume, 120 days would not seem to be an inordinately long period to require the plaintiff to wait.

To incorporate the doctrine of strict liability in this area is to require the insurance industry to assume unlimited liability, regardless of contract limits specified. Therefore, it would seem to be a proper compromise to establish a point of excess exposure in order to help counterbalance that increased responsibility. Such a scheme could be implemented by legislation like that set out below:

**Excess Liability**

Whenever a demand to settle within the policy limits is received, an insurer shall either accept such a demand within the statutory period or be absolutely liable for a plaintiff's entire judgment. Such an offer shall be made by registered mail or by any other vehicle providing proof of receipt.

There shall be no excess liability exposure on the part of an insurer if there has been no such settlement demand.

Of course, if a demand were made before suit was filed, policing the situation to ensure the delivery of necessary evaluation information in conjunction with the demand would remain a serious problem. Highly specialized firms perform this function as a matter of course, but there is no easy solution for the plaintiff's attorney who is dabbling in the excess liability area for the first time.

95. See text accompanying notes 87-89 supra.
Point of Excess Exposure

The point at which an insurer may be spared excess liability by paying the policy limits or an agreed settlement within those limits shall be 120 days after the insurer has received a settlement demand, or 5 days after the pretrial conference, or the first day of trial, whichever shall occur first, provided that in no event shall the insurer have less than 48 hours in which to consider a demand.

A plaintiff may withdraw a settlement demand at any time before the demand has been accepted. If a demand has been withdrawn, the excess exposure time period will start over at the time that another demand is made.

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