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REPORT TO THE JUDICIAL COUNCIL

For business meeting on: June 24, 2016

Title
Jury Instructions: Revised Civil Jury Instruction No. 2334—Supplemental Report

Rules, Forms, Standards, or Statutes Affected
Judicial Council of California Civil Jury Instructions (*CACI*)

Recommended by
Advisory Committee on Civil Jury Instructions
Hon. Martin J. Tangeman, Chair

Agenda Item Type
Action Required

Effective Date
June 24, 2016

Date of Report
June 14, 2016

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Executive Summary

This is a supplementary report covering only the Advisory Committee on Civil Jury Instructions' proposed revisions to CACI No. 2334, *Bad Faith (Third Party)—Refusal to Accept Reasonable Settlement Within Liability Policy Limits—Essential Factual Elements*. Because of the extensive controversy generated by the committee's proposed changes to this instruction, the committee believes that it is appropriate to set forth its decision and decisionmaking process about this instruction in a separate report.

Recommendation

The Advisory Committee on Civil Jury Instructions recommends that the Judicial Council, effective June 24, 2016, approve for publication under rules 2.1050 and 10.58 of the California Rules of Court revisions to CACI No. 2334. The proposed revised instruction is attached at pages 15–20. It is also included in the complete file of instructions proposed for adoption in this release that is attached to the committee's report to the council for this release.

Rationale for Recommendation

At its January 2016 meeting, the committee approved for posting a revised version of CACI No. 2334, which addresses a claim for bad-faith insurance practice if the insurer has rejected a policy-limits settlement demand, and there is a subsequent judgment against the insured in excess of the policy limits. The proposed revisions involved four significant changes to the instruction.

First, an additional element was proposed to be added:

> [3. That [*name of defendant*]'s failure to accept this settlement demand was unreasonable;][1]

Second, the following sentence was proposed to be added after the elements:

> To act or fail to act "unreasonably" means that the insurer had no proper cause for its conduct.

Third, the current last paragraph would be revised as follows:

> A settlement demand <u>for an amount within policy limits</u> is reasonable<u>, and [*name of defendant*]'s rejection of the demand is unreasonable,</u> if [*name of defendant*] knew or should have known at the time the ~~settlement~~ demand was rejected that the potential judgment was likely to exceed the amount of the ~~settlement~~ demand based on [*name of plaintiff in underlying case*]'s injuries or loss and [*name of plaintiff*]'s probable liability.

Fourth, the following sentence would be added to the end of the instruction:

> However, the demand may be unreasonable for reasons other than the amount demanded.

The committee majority[2] approved these changes in response to a 2015 case, *Graciano v. Mercury General Corp.*[3] *Graciano,* as discussed in more detail below, contained language directly supporting the first two proposed changes. The committee decided, however, that the "unreasonable failure" inquiry was limited to the insurer's evaluation of the case; i.e., liability

[1] The element was made optional because it would not apply if the insurer denied that there was coverage for the loss. See *Johansen v. California State Auto. Assn. Inter-Insurance Bureau* (1975) 15 Cal.3d 9, 15−16.

[2] The vote was 13 to 8.

[3] *Graciano v. Mercury General Corp.* (2014) 231 Cal.App.4th 414.

and damages.[4] The fourth proposed change, which proved to be noncontroversial, was to direct the jury's attention to any nonmonetary conditions in the settlement demand that may have been unreasonable.

As noted below under Comments, Alternatives, and Policy Considerations, the proposed revisions produced a barrage of comments from attorneys who represent plaintiffs in suits against insurers, all objecting to the proposed revisions to the instruction.

The opposition focused around two main arguments. First, no court has specifically stated that 2334 is wrong or incomplete, so there is no reason to change it. Second, it was claimed that the language from *Graciano* is dicta, is not the law, and should be ignored.

History: 2003−2014

The original 2003 version of CACI No. 2334, as drafted by the CACI task force and approved by the Judicial Council, included the following element:

> 2. That [*name of defendant*] unreasonably failed to accept a reasonable settlement demand for an amount within policy limits.

This element requires two separate inquiries. First, the settlement demand must be reasonable; second, the insurer's failure to accept the demand must be unreasonable.

The cases originally excerpted in the Sources and Authority perhaps did not provide solid support for this element. The closest is the following:

> An insurer's decision to contest or settle a claim " 'should be an honest and intelligent one. It must be honest and intelligent if it be a good-faith conclusion. In order that it be honest and intelligent it must be based upon a knowledge of the facts and circumstances upon which liability is predicated, and upon a knowledge of the nature and extent of the injuries so far as they reasonably can be ascertained.' "[5]

If one substitutes "reasonable" for "honest and intelligent," then there is arguably support for element 2 as originally written by the task force.

[4] See *Johansen, supra,* 15 Cal.3d at p. 16. "[[T]he 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, the ultimate judgment is likely to exceed the amount of the settlement offer."

[5] *Brown v. Guarantee Insurance Co.* (1957) 155 Cal.App.2d 679, 685−686.

In contrast, there is this 1975 language from the California Supreme Court in *Johansen v. California State Auto. Assn. Inter-Insurance Bureau*: [6]

> [W]henever it is likely that the judgment against the insured will exceed policy limits "so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interest *requires the insurer to settle* the claim." (Italics added.)

Johansen was a denial-of-coverage case. The court's holding was that if the insurer denied coverage, it did so "at its peril." If coverage is later established, then the insurer must pay the entire judgment, not just the policy limits.

The language "requires the insurer to settle" would seem to impose the same "peril" on the insurer even if there is no coverage dispute. If the insurer refuses to accept a reasonable demand for the policy limits, it is automatically on the hook for the entire judgment if its insured is found liable for a judgment in excess of the policy limits. This is the position of the authors of the many letters received in opposition to the proposed changes.

In December 2006, Justice H. Walter Croskey,[7] then the committee chair, proposed that all of the insurance bad-faith instructions be revised to clarify what it meant that the insurer's decision was "unreasonable." Justice Croskey was concerned that without any qualification, juries would construe "unreasonable" as indicating a lack of due care; that is, negligence. The law is clear that mere negligence is not bad faith.[8]

For 2334, he proposed deleting "unreasonable" from element 2, but adding explanatory words so that the element would read:

> 2. That [*name of defendant*] ~~unreasonably~~ failed to accept a reasonable settlement demand for an amount within policy limits <u>without proper cause or with no reasonable basis for such action</u>.

The committee majority, however, rejected Justice Croskey's proposal for 2334. Instead, it agreed to remove "unreasonably" from element 2, but did not add his proposed replacement language. The result was the current instruction, which extends the "at its peril" holding of *Johansen* to all cases, not just to denial of coverage. It focuses solely on the reasonableness of the demand. If the demand is reasonable, the insurer pays the entire judgment if it guessed wrong in refusing to pay the policy limits. This result may be seen as a version of "strict liability."

[6] *Johansen, supra,* 15 Cal.3d at p. 16.

[7] The late Justice Croskey was the lead-named author of The Rutter Group treatise on insurance law, *California Practice Guide: Insurance Litigation*.

[8] See, e.g., *Brown, supra,* 155 Cal.App.2d at p. 689. "Bad faith may involve negligence, or negligence may be indicative of bad faith, but negligence alone is insufficient to render the insurer liable."

It should be noted that this 2007 change was not done in response to any holding in any particular case finding CACI No. 2334 as originally drafted to be an incorrect statement of the law. Instead, the committee reevaluated the instruction and came to a different conclusion about the state of the law in 2007 than the one made by the original CACI task force in 2003.

Like its predecessor, the instruction as revised in 2007 has not been directly addressed by the courts since then, as noted by numerous commentators. Nevertheless, it did not escape criticism. In 2014, the committee received a proposal from an insurance defense attorney asking the committee to restore 2334 to its original language by returning "unreasonably failed" to element 2. The attorney argued as follows, citing authority from the California Supreme Court:

> Breach of the implied covenant of good faith and fair dealing is dubbed "bad faith" for a reason. In order for an insurer to be liable for a judgment above its policy limits, its failure to accept a settlement demand within the limits must be unreasonable—i.e., in bad faith. *Kransco v. International Ins. Co.*, 23 Cal. 4th 390, 401, 97 Cal. Rptr. 2d 151 (2000) ("An insurer that breaches its implied duty of good faith and fair dealing by *unreasonably refusing* to accept a settlement offer within policy limits may be held liable for the full amount of the judgment against the insured in excess of its policy limits") (italics added); *Commercial Union Assurance Companies v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 916-17, 610 P.2d 1038 (1980) ("an insurer may be held liable for a judgment against the insured in excess of its policy limits where it has breached its implied covenant of good faith and fair dealing by *unreasonably refusing* to accept a settlement offer within the policy limits") (italics added).

But the Supreme Court cases cited did not turn on the reasonableness of the insurer's rejection of the policy limits demand, and there is no analysis of the issue in any of them.[9]

In resolving this proposal, a working group recommended deferring any changes while closely monitoring the issue. One factor was the lack of any clear Supreme Court authority rejecting the strict liability position seemingly adopted in *Johansen*. Still, the cases cited in support of the defense position caused many members to postulate that 2334 element 2 might indeed be insufficient by not including a requirement that the insurer's rejection of the offer be unreasonable. Nevertheless, the recommendation was to wait for a clearer signal from the courts.

At its July 2014 meeting, the full committee agreed with the Working Group recommendation to defer action.

[9] See also *Hamilton v. Maryland Cas. Co.* (2012) 27 Cal.4th 718, 724–725. ("An *unreasonable* refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits.") (italics added)

2015: *Graciano v. Mercury General*

The committee did not have long to wait. On October 17, 2014, the Fourth Appellate District, Division One, published *Graciano v. Mercury General*, in which the court stated:[10]

> An insured's claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable offer to settle the claims against the insured for an amount within the policy limits. … ¶ A claim for bad faith based on an alleged wrongful refusal to settle *also* requires proof the insurer *unreasonably* failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance. (*Critz, supra*, 230 Cal.App.2d at p. 798.) (italics added)

At its July 2015 meeting, the committee agreed that *Graciano* now compelled restoring the "unreasonably rejected" language to 2334. A revised 2334 was drafted containing a new element requiring:

> [3. That [*name of defendant*]'s failure to accept this settlement demand was unreasonable or without proper cause;][11]

The proposed revised instruction was posted for public comment. Many comments were received, both opposing and supporting the proposed change. After reviewing the comments, the chair decided to pull the instruction from the release for further deliberation, based on three concerns.

First, the instruction did not address nonmonetary aspects of the policy-limits demand. As written, the instruction suggested to the jury that its only task was to evaluate the financial aspects of the offer. In fact, an offer may be unreasonable for any number of nonmonetary reasons, such as an unduly short window in which to accept it.[12]

Second, commentators opposed to the change claimed that the language from *Graciano* was dicta. The committee had not considered this possibility in its discussions of the case and the instruction.

Third, there was concern with the lack of any discussion about possible parameters of what insurer conduct the jury could evaluate for reasonableness. While cases say that the insurer's rejection of the offer must be "unreasonable" or "unwarranted," the committee had not looked at any cases that addressed whether there are limitations on the scope of insurer conduct that are

[10] *Graciano, supra*, 231 Cal.App.4th at p. 426.

[11] The element was bracketed to make it optional because it should not be given in denial-of-coverage cases.

[12] See, e.g., *Coe v. State Farm Mut. Auto. Ins. Co.* (1977) 66 Cal.App.3d 981, 992–993. Failure to include provisions for relief by the workers' compensation carrier made the settlement offer ineffective.

subject to this reasonableness inquiry. The chair was uncomfortable with leaving this inquiry open-ended without further consideration by the committee.

2016: the current proposal

On reconsideration for the current release cycle, the committee focused on the three issues above that had caused it not to proceed to recommend the revised instruction in 2015. The nonmonetary issue was noncontroversial and easily addressed. Language was added to the instruction: "However, the demand may be unreasonable for reasons other than the amount demanded." The other two issues remain without any clear resolution after another round of deliberations.

For the reasons set forth below, the committee now proposes that only the above substantive change to the instruction itself, regarding nonmonetary conditions in the demand, be made. [13] But the committee believes that bench and bar should be informed that there is a highly controversial potential additional element for the instruction. Therefore, the committee proposes adding substantial discussion of the issue in the Directions for Use.

Reasons for current proposal: no case clearly holds that the additional element is required.

The many commentators opposed to adding the element would ignore *Graciano* entirely. They claim that all of the language that supports adding the additional element is dicta, and that it is wrong anyway.

The issue of whether the crucial language in *Graciano* is or is not dicta is not so easily answered. There are several ways of identifying the actual holding of *Graciano*. The facts of the case involved a mix-up over policies covering two different insureds. The plaintiff made the demand on the wrong policy and never corrected the error. The insurer rejected the demand on the wrong policy, but eventually discovered another policy that did provide coverage. On this discovery, the insurer offered the policy limits, but the plaintiff rejected the offer as untimely.

The position of those opposed to adding the element is that the holding of *Graciano* was that there was never a valid settlement offer. Therefore, the plaintiff's bad-faith claim fails on the lack of a reasonable demand; everything that follows is dicta.

But another possible holding is in this sentence:[14]

> [A]lthough there was some delay by CAIC in locating and connecting Graciano's claim with Saul's policy, resulting in a mistaken "withholding" of policy benefits

[13] The committee proposes several nonsubstantive language changes to the last paragraph as follows: "A settlement demand <u>for an amount within policy limits</u> is reasonable if [*name of defendant*] knew or should have known at the time the ~~settlement~~ demand was rejected that the potential judgment was likely to exceed the amount of the ~~settlement~~ demand based on [*name of plaintiff in underlying case*]'s injuries or loss and [*name of plaintiff*]'s probable liability."

[14] *Graciano, supra,* 231 Cal.App.4th at p. 433.

> for a 24-hour period, such mistake was "contributed to by the very party claiming those policy benefits" and "supplies the 'proper cause'" (*ibid.*), fatal to Graciano's bad faith claim.

One may argue that "supplies the proper cause" is a holding that "proper cause" negates bad faith. But whether the *Graciano* language is a holding or dicta is not dispositive of the correct rule.[15] Whether or not the language in *Graciano* is dicta, it has its origins in language from the California Supreme Court.

As noted in the proposed addition to the Directions for Use, none of these cases—neither those seemingly creating strict liability nor those seemingly providing an opportunity for the insurer to assert that its rejection was reasonable—actually discuss, analyze, and apply this standard to reach a result. All are determined on other issues.

Reasons for current proposal: it is not clear that the reasonable-rejection inquiry can be limited to evaluation of liability and damages. The third reason that 2334 was returned for further consideration in 2015 is what has ultimately led us to the revisions now proposed for this release. Does the law place any limitations on the scope of insurer conduct that the jury must evaluate for reasonableness?

In *Johansen*, the California Supreme Court stated:[16]

> [T]he *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, the ultimate judgment is likely to exceed the amount of the settlement offer.

Application of this language would limit the scope of the reasonable-rejection inquiry. Apart from denial of coverage cases and nonmonetary provisions in the demand, there would be only one ground on which an insurer may assert that its rejection of the demand was reasonable, and that is reasonable misevaluation of liability and damages. At the January meeting, the committee majority voted in favor of this position.

Those committee members asserting the minority position argued that misevaluation is encompassed within the first step, the evaluation of whether the demand was reasonable. But the majority countered that it is possible for the demand to be reasonable, and for the insurer's rejection of the demand to also be reasonable. One member gave the example of an accident

[15] It should be noted that the language from *Johansen* quoted above—for the proposition that failure to accept a reasonable policy limits demand creates strict liability for an excess judgment—was also dicta. *Johansen* was a denial-of-coverage case. Any language that might be applied to a case in which coverage was conceded was therefore dicta.

[16] *Johansen, supra*, 15 Cal.3d at p. 16, italics added.

causing catastrophic injuries, but after a full and fair investigation, the insurer's counsel puts the likelihood of liability at less than 5 percent. The likely damage award will indisputably greatly exceed the policy limits. In such a case, one could hardly say that a policy-limits demand would be unreasonable. But can it be said that given the doubts as to liability, it was unreasonable for the insurer to reject paying the policy limits? That is exactly the issue that the jury must determine with the help of CACI No. 2334.

Thus, the committee's proposed revisions to the last paragraph would provide:

> A settlement demand for an amount within policy limits is reasonable, and [*name of defendant*]'s rejection of the demand is unreasonable, if [*name of defendant*] knew or should have known at the time the demand was rejected that the potential judgment was likely to exceed the amount of the demand based on [*name of plaintiff in underlying case*]'s injuries or loss and [*name of plaintiff*]'s probable liability.

The intent of the instruction as revised was to create a two-step reasonableness evaluation, but to tie both to the evaluation of liability and damages. First the jury looks at the plaintiff's evaluation in making the demand. Then the jury is to look at the insurer's evaluation in rejecting it. The intent was to significantly narrow the scope of the grounds that the insurer can allege to constitute a reasonable rejection.

But after considering some analysis from former chair Justice Croskey in a December 27, 2006 memorandum to a working group, and one comment in particular, the committee majority is no longer convinced that the reasonableness inquiry can be narrowed to evaluation of liability and damages.

A commentator presented the following:

> I am unaware of any cases where a jury relying upon CACI 2334 has found an insurer liable for bad faith because its adjuster was hit by a bus while in the process of mailing a letter accepting a settlement demand.

Under the originally proposed revisions, the insurer must pay in the example noted above because the reason for failing to accept was not related to its evaluation of liability and damages. Strict liability remains for bus accidents (and everything else that is not related to evaluation). But are there reasonable failures to accept that don't involve evaluation? A bus accident would seem to be one.

Justice Croskey in a 2006 memo to the committee presented the following factors that should guide the jury's determination in the prudent-insurer inquiry:[17]

> [The prudent-insurer inquiry] will always raise a jury question and will depend on the consideration of a number of factors, for example:
>
> (1) the strength of the injured claimant's case on the issues of liability and damages;
>
> (2) the nature and extent of the claimant's injuries;
>
> (3) the extent of the financial risk to which the insured would be exposed in the event of a refusal to settle;
>
> (4) whether the insurer has properly investigated the circumstances so as to ascertain the evidence against the insured as well as the evidence of the claimant's injuries;
>
> (5) whether the insurer followed advice received from its own lawyer or claims investigator;
>
> (6) whether the insurer fairly and objectively evaluated the claim;
>
> (7) whether the insurer kept the insured fully informed of any settlement offers, to enable the insured to consider adding to the "pot" to effect settlement;
>
> (8) any attempt by the insurer to induce or coerce the insured to contribute to the settlement (e.g., "if you want to avoid excess liability, you'll have to pay for it");
>
> (9) the fault of the insured, if any, in inducing the insurer's rejection of the compromise offer by misleading it as to the facts; and
>
> (10) any other facts tending to show bad faith (i.e., action without a reasonable basis or proper cause) on the part of the insurer.

[17] This list is a slight variation on a list of eight factors in *Brown, supra*, 155 Cal.App.2d at p. 689. Justice Croskey added: (2) the nature and extent of the claimant's injuries; and (6) whether the insurer fairly and objectively evaluated the claim. His factor (2) is really subsumed within factor (1). His factor (6) would be the only relevant factor under the committee's original proposed revision.

Some of these factors are clearly relevant only to case evaluation. But others, particularly (9), suggest that the prudent-insurer inquiry is not limited to evaluation.

Another scenario that caused the committee hesitation about limiting the inquiry to evaluation issues is as follows: Assume that the adjuster was supposed to contact the claimant's counsel to accept or refuse the demand. The insurer decides to accept on the last day before the offer to settle expires. But the adjuster gets called away from the office for a family emergency and neglects to accept the demand. The demand expires. This situation sounds like negligence at most, and negligence is not bad faith.[18] So should the insurer be liable for the entire judgment under "unreasonably failed?" Yes, if the reasonableness inquiry is limited to evaluation issues.

Reasons for current proposal: subjective v. objective standards and the "prudent insurer" test. Numerous commentators allege that "the posted proposed change requiring the aggrieved party to show that the insurer's conduct was unreasonable, is a subjective standard that is much harder to meet and for which no true measure even exists." The committee does not agree that the proposed new element 3 is a subjective standard. A subjective standard would allow the defendant to avoid liability as long as it actually believed that it had a good reason to reject the demand. That is not what the element said. The jury is to determine whether the insurer's rejection was justified or not justified. The jury is to put itself in the insurer's shoes and decide what the insurer should have done. This is an objective standard based on a "reasonable insurer."

Still, there is possibly a different way to phrase the element to make it totally clear that it is an objective standard. According to Justice Croskey in his 2006 memo to the committee:

> When an insurer refuses to settle on some other ground (e.g., a disagreement over the nature and extent of the claimant's injuries or the insured's liability—"damage refusal"), then it will be judged by a different standard: the so called "*prudent insurer*" standard. Here, the test is whether a prudent insurer would have settled if there were no policy limits and the insurer alone was on the risk: "The governing standard is whether a prudent insurer would have accepted the settlement offer if it alone were liable for the entire judgment." (*Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688, 706; *Crisci v. Security Ins. Co. of New Haven, Conn.* (1967) 66 Cal.2d 425, 430 436), original italics.

It could be argued that the proposed new element 3 is just a different way of expressing the prudent-insurer standard. That is perhaps true, but element 3 might also be expressed as:

> 3. That a prudent insurer would have accepted the settlement offer if it alone were liable for the entire judgment.

[18] *Brown, supra,* 155 Cal.App.2d at p. 689.

The possibility that element 3 might be better expressed differently is another factor counseling caution in making a change to the instruction itself at this time.

Reasons for current proposal: the explanation of "unreasonable" as meaning "without proper cause" is not firmly established in the third-party context. Numerous commentators point out that "without proper cause" is vague and undefined.

Two cases support defining "unreasonable" as meaning "without proper cause." One is Justice Croskey's opinion *Rappaport-Scott v. The Interinsurance Exchange of the Automobile Club*, in which he wrote: [19]

> The withholding of benefits due under the policy may constitute a breach of contract even if the conduct was reasonable, but liability in tort arises only if the conduct was unreasonable, that is, without proper cause.

But *Rappaport-Scott* was a first-party case over uninsured motorist coverage. So this language arguably (as numerous commentators did argue) does not apply in a third-party excess judgment case.

The other case is *Graciano,* in which the court said:[20]

> A bad faith claim requires "something beyond breach of the contractual duty itself" (*California Shoppers, Inc. v. Royal Globe Ins. Co., supra,* 175 Cal.App.3d at p. 54 (*California Shoppers*)), and that something more is "'refusing, *without proper cause,* to compensate its insured for a loss covered by the policy … .' [Citation.] Of course, the converse of 'without proper cause' is that declining to perform a contractual duty under the policy *with proper cause* is not a breach of the implied covenant." (*Ibid.,* italics added by *California Shoppers.*) The *California Shoppers* court then noted that "[t]o refine further the nature and extent of the duty here under analysis, in terms of a particular application of 'with proper cause,' it is our view that a *mistaken withholding* of policy benefits, at least where, as here, such mistake (as to the insured's identity and not as to the matter of coverage) has been contributed to by the very party claiming those policy benefits, is consistent with observance of the implied covenant of good faith and fair dealing because the mistake supplies the 'proper cause.'" (*Id.* at p. 55.) Applying *California Shoppers* here, although there was some delay by CAIC in locating and connecting Graciano's claim with Saul's policy, resulting in a mistaken "withholding" of policy benefits for a 24-hour period, such mistake was

[19] *Rappaport-Scott v. The Interinsurance Exchange of the Automobile Club* (2007) 146 Cal.App.4th 831, 837.

[20] *Graciano, supra,* 231 Cal.App.4th at pp. 433−434.

> "contributed to by the very party claiming those policy benefits" and "supplies the 'proper cause'" (*ibid.*), fatal to Graciano's bad faith claim. (original italics)

Graciano is a third-party case, so if it is authority, then the definition is supported. But, as pointed out extensively above, it may not be authority.

For all of the above reasons, the committee decided that some restraint would be best in actually revising the words of the instruction at this time. But the committee believes that it owes it to bench and bar to point out that CACI No. 2334 could be insufficient as currently written. The need for an additional element requiring the insurer's rejection of the demand to have been unreasonable is a plausible, but unsettled, requirement.

Comments, Alternatives Considered, and Policy Implications

The proposed additions and revisions to *CACI* circulated for comment from January 25 to March 4, 2016. Comments were received from 171 different commentators. Of these, 168 expressed opposition to the proposed changes to CACI No. 2334. Of these 168, 97 letters were identical except for the identity of the commentator;[21] 21 were almost identical, but contained slight variations. 50 of the comments were different letters drafted by the commentators. There were three comments generally supporting the changes to CACI No. 2334.

The comments received on CACI No. 2334 resulted in the committee's change in recommendation as outlined above.

The committee considered and voted on three options:

1. Leave the instruction unchanged in any way, which was the position of the many commentators who opposed the proposed changes; this option received only one vote;

2. Proceed with the revision approved in January and posted for comment, which included the additional element in the instruction itself; this option received only six votes;

3. Add language on the nonmonetary aspects of the offer, but defer adding the new element and the language in the last paragraph that tries to restrict the scope of that element; but address the possible existence of the additional element in the Directions for Use. This

[21] This is a template letter that the Consumer Attorneys of California sent to their members with a request to forward it on to the committee.

option received a unanimous 23-0 vote, including the votes of the seven members who had voted for one of the first two options.

Attachments

1. CACI No. 2334 as revised at page 15.

2334. Bad Faith (Third Party)—Refusal to Accept Reasonable Settlement Within Liability Policy Limits—Essential Factual Elements

[*Name of plaintiff***] claims that [he/she/it] was harmed by [***name of defendant***]'s breach of the obligation of good faith and fair dealing because [***name of defendant***] failed to accept a reasonable settlement demand in a lawsuit against [***name of plaintiff***]. To establish this claim, [***name of plaintiff***] must prove all of the following:**

1. **That [***name of plaintiff in underlying case***] brought a lawsuit against [***name of plaintiff***] for a claim that was covered by [***name of defendant***]'s insurance policy;**

2. **That [***name of defendant***] failed to accept a reasonable settlement demand for an amount within policy limits; and**

3. **That a monetary judgment was entered against [***name of plaintiff***] for a sum greater than the policy limits.**

"Policy limits" means the highest amount available under the policy for the claim against [*name of plaintiff***].**

A settlement demand for an amount within policy limits is reasonable if [*name of defendant***] knew or should have known at the time the demand was rejected that the potential judgment was likely to exceed the amount of the demand based on [***name of plaintiff in underlying case***]'s injuries or loss and [***name of plaintiff***]'s probable liability. However, the demand may be unreasonable for reasons other than the amount demanded.**

New September 2003; Revised December 2007, June 2012, December 2012, June 2016

Directions for Use

This instruction is for use in an "excess judgment" case; that is one in which judgment was against the insured for an amount over the policy limits, after the insurer rejected a settlement demand within policy limits.

The instructions in this series assume that the plaintiff is the insured and the defendant is the insurer. The party designations may be changed if appropriate to the facts of the case.

For instructions regarding general breach of contract issues, refer to the Contracts series (CACI No. 300 et seq.).

If it is alleged that a demand was made in excess of limits and there is a claim that the defendant should have contributed the policy limits, then this instruction will need to be modified.

This instruction should also be modified if the insurer did not accept the policy-limits demand because of

potential remaining exposure to the insured, such as a contractual indemnity claim or exposure to other claimants.

Under this instruction, if the jury finds that the policy-limits demand was reasonable, then the insurer is automatically liable for the entire excess judgment. Language from the California Supreme Court supports this view of what might be called insurer "strict liability" if the demand is reasonable. (See *Johansen v. California State Auto. Assn. Inter-Insurance Bureau* (1975) 15 Cal.3d 9, 16 [123 Cal.Rptr. 288, 538 P.2d 744] ["[W]henever it is likely that the judgment against the insured will exceed policy limits 'so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interest *requires the insurer to settle* the claim,' " italics added].)

However, there is language in numerous cases, including several from the California Supreme Court, that would require the plaintiff to also prove that the insurer's rejection of the demand was "unreasonable." (See, e.g., *Hamilton v. Maryland Cas. Co.* (2002) 27 Cal.4th 718, 724-725 [117 Cal.Rptr.2d 318, 41 P.3d 128] ["An *unreasonable* refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits," italics added]; *Graciano v. Mercury General Corp.* (2014) 231 Cal.App.4th 414, 425 [179 Cal.Rptr.3d 717] [claim for bad faith based on an alleged wrongful refusal to settle *also* requires proof the insurer *unreasonably* failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance, italics added].) Under this view, even if the policy-limits demand was reasonable, the insurer may assert that it had a legitimate reason for rejecting it. However, this option, if it exists, is not available in a denial of coverage case. (*Johansen, supra*, 15 Cal.3d at pp. 15−16.)

None of these cases, however, neither those seemingly creating strict liability nor those seemingly providing an opportunity for the insurer to assert that its rejection was reasonable, actually discuss, analyze, and apply this standard to reach a result. All are determined on other issues, leaving the pertinent language as arguably dicta.

For this reason, the committee has elected not to change the elements of the instruction at this time. Hopefully, some day there will be a definitive resolution from the courts. Until then, the need for an additional element requiring the insurer's rejection of the demand to have been unreasonable is a plausible, but unsettled, requirement. For a thorough analysis of the issue, see the committee's report to the Judicial Council for its June 2016 meeting, found at (link).

Sources and Authority

- "[T]he implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty. [¶] The insurer, in deciding whether a claim should be compromised, must take into account the interest of the insured and give it at least as much consideration as it does to its own interest. When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured's interest requires the insurer to settle the claim." (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 659 [328 P.2d 198], citation omitted.)

- “Liability is imposed not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.” (*Crisci v. Security Insurance Co. of New Haven, Connecticut* (1967) 66 Cal.2d 425, 430 [58 Cal.Rptr. 13, 426 P.2d 173].)

- “In determining whether an insurer has given consideration to the interests of the insured, the test is whether a prudent insurer without policy limits would have accepted the settlement offer.” (*Crisci, supra*, 66 Cal.2d at p. 429.)

- “[I]n deciding whether or not to compromise the claim, the insurer must conduct itself as though it alone were liable for the entire amount of the judgment. ... [T]he 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, the ultimate judgment is likely to exceed the amount of the settlement offer.” (*Johansen, supra,* 15 Cal.3d at p. 16, internal citation omitted.)

- “[A]n insurer is required to act in good faith in dealing with its insured. Thus, in deciding whether or not to settle a claim, the insurer must take into account the interests of the insured, and when there is a great risk of recovery beyond the policy limits, a good faith consideration of the insured's interests may require the insurer to settle the claim within the policy limits. An unreasonable refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits.” (*Hamilton, supra,* 27 Cal.4th at pp. 724−725.)

- “The size of the judgment recovered in the personal injury action when it exceeds the policy limits, although not conclusive, furnishes an inference that the value of the claim is the equivalent of the amount of the judgment and that acceptance of an offer within those limits was the most reasonable method of dealing with the claim.” (*Crisci*, *supra,* 66 Cal.2d at p. 431.)

- “The covenant of good faith and fair dealing implied in every insurance policy obligates the insurer, among other things, to accept a reasonable offer to settle a lawsuit by a third party against the insured within policy limits whenever there is a substantial likelihood of a recovery in excess of those limits. The insurer must evaluate the reasonableness of an offer to settle a lawsuit against the insured by considering the probable liability of the insured and the amount of that liability, without regard to any coverage defenses. An insurer that fails to accept a reasonable settlement offer within policy limits will be held liable in tort for the entire judgment against the insured, even if that amount exceeds the policy limits. An insurer’s duty to accept a reasonable settlement offer in these circumstances 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.” (*Rappaport-Scott v. Interinsurance Exch. of the Auto. Club* (2007) 146 Cal.App.4th 831, 836 [53 Cal.Rptr.3d 245], internal citations omitted.)

- “An insured's claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable offer to settle the claims against the insured for an amount within the policy limits. The offer satisfies this first element if (1) its terms are clear enough to have created an enforceable contract resolving all claims had it been accepted by the insurer, (2) all of the third party claimants have joined in the demand, (3) it provides for a complete release of all insureds, and (4) the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure.” (*Graciano, supra,* 231 Cal.App.4th at p. 425, internal citations

omitted.)

"A bad faith claim requires 'something beyond breach of the contractual duty itself, and that something more is ' "refusing, *without proper cause,* to compensate its insured for a loss covered by the policy … ." [Citation.] Of course, the converse of "without proper cause" is that declining to perform a contractual duty under the policy *with proper cause* is not a breach of the implied covenant.' " (*Graciano, supra,* 231 Cal.App.4th at p. 433, original italics.)

- "Determination of the reasonableness of a settlement offer for purposes of a reimbursement action is based on the information available to [the insurer] at the time of the proposed settlement." (*Isaacson v. California Ins. Guarantee Assn.* (1988) 44 Cal.3d 775, 793 [244 Cal.Rptr. 655, 750 P.2d 297].)

- "The third party is entitled to set a reasonable time limit within which the insurer must accept the settlement proposal … ." (*Graciano, supra,* 231 Cal.App.4th at p. 434.)

- "Whether [the insurer] 'refused' the 'offer,' and whether it could reasonably have acted otherwise in light of the 11-day deadline imposed by the offer's terms, were questions for the jury." (*Coe v. State Farm Mut. Auto. Ins. Co.* (1977) 66 Cal.App.3d 981, 994 [136 Cal.Rptr. 331].)

- "A cause of action for bad faith refusal to settle arises only after a judgment has been rendered in excess of the policy limits. ... Until judgment is actually entered, the mere possibility or probability of an excess judgment does not render the refusal to settle actionable." (*Safeco Ins. Co. of Am. v. Superior Court* (1999) 71 Cal.App.4th 782, 788 [84 Cal.Rptr.2d 43], internal citations omitted.)

- "An insurer's wrongful failure to settle may be actionable even without rendition of an excess judgment. An insured may recover for bad faith failure to settle, despite the lack of an excess judgment, where the insurer's misconduct goes beyond a simple failure to settle within policy limits or the insured suffers consequential damages apart from an excess judgment." (*Howard v. American National Fire Ins. Co.* (2010) 187 Cal.App.4th 498, 527 [115 Cal.Rptr.3d 42], internal citations omitted.)

- " 'An insurer who denies coverage *does so at its own risk and although its position may not have been entirely groundless,* 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 by the insurer's breach of the express and implied obligations of the contract.' 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." (*Johansen, supra,* 15 Cal.3d at pp. 15−16, original italics, footnotes and internal citation omitted.)

- "[W]here the *kind* of claim asserted is not covered by the insurance contract (and not simply the *amount* of the claim), an insurer has no obligation to pay money in settlement of a noncovered claim, because 'The insurer does not … insure the entire range of an insured's well-being, outside the scope of and unrelated to the insurance policy, with respect to paying third party claims.…' " (*Dewitt v. Monterey Ins. Co.* (2012) 204 Cal.App.4th 233, 244 [138 Cal.Rptr.3d 705], original italics.)

- "A good faith belief in noncoverage is not relevant to a determination of the reasonableness of a

settlement offer." (*Samson v. Transamerica Insurance Co.* (1981) 30 Cal.3d 220, 243 [178 Cal.Rptr. 343, 636 P.2d 32], internal citation omitted.)

- "An insurer that breaches its duty of reasonable settlement is liable for all the insured's damages proximately caused by the breach, regardless of policy limits. Where the underlying action has proceeded to trial and a judgment in excess of the policy limits has been entered against the insured, the insurer is ordinarily liable to its insured for the entire amount of that judgment, excluding any punitive damages awarded." (*Hamilton, supra,* 27 Cal.4th at p. 725, internal citations omitted.)

- "[I]nsurers do have a 'selfish' interest (that is, one that is peculiar to themselves) in imposing a blanket rule which effectively precludes disclosure of policy limits, and that interest can adversely affect the possibility that an excess claim against a policyholder might be settled within policy limits. Thus, a palpable conflict of interest exists in at least one context where there is no formal settlement offer. We therefore conclude that a formal settlement offer is not an absolute prerequisite to a bad faith action in the wake of an excess verdict when the claimant makes a request for policy limits and the insurer refuses to contact the policyholder about the request." (*Boicourt v. Amex Assurance Co.* (2000) 78 Cal.App.4th 1390, 1398−1399 [93 Cal.Rptr.3d 763].)

- "For bad faith liability to attach to an insurer's failure to pursue settlement discussions, in a case where the insured is exposed to a judgment beyond policy limits, there must be, at a minimum, some evidence either that the injured party has communicated to the insurer an interest in settlement, or some other circumstance demonstrating the insurer knew that settlement within policy limits could feasibly be negotiated. In the absence of such evidence, or evidence the insurer by its conduct has actively foreclosed the possibility of settlement, there is no "opportunity to settle" that an insurer may be taxed with ignoring." (*Reid v. Mercury Ins. Co.* (2013) 220 Cal.App.4th 262, 272 [162 Cal.Rptr.3d 894].)

- "**(4) [12:245] Insurer culpability required? A number of cases suggest that some degree of insurer 'culpability' is required before an insurer's refusal to settle a third party claim can be found to constitute 'bad faith.' [*Howard v. American Nat'l Fire Ins. Co.* (2010) 187 CA4th 498, 529, 115 CR3d 42, 69 (quoting text)]**

  (a) [12:246] **Good faith or mistake as excuse:** 'If the insurer has exercised good faith in all of its dealings … and if the settlement which it has rejected has been fully and fairly considered and has been based upon an *honest belief* that the insurer could defeat the action or keep any possible judgment within the limits of the policy, and its judgments are based on a fair review of the evidence after reasonable diligence in ascertaining the facts, and upon sound legal advice, a court should not subject the insurer to further liability if it ultimately turns out that its judgment is a mistaken judgment.' [See *Brown v. Guarantee Ins. Co.* (1957) 155 CA2d 679, 684, 319 P2d 69, 72 (emphasis added); *Howard v. American Nat'l Fire Ins. Co.*, supra, 187 CA4th at 529, 115 CR3d at 69—'an insurer may reasonably underestimate the value of a case, and thus refuse settlement' on this basis (acknowledging but not applying rule)]

  In short, so long as insurers are not subject to a strict liability standard, there is still room for an honest, innocent mistake.' [*Walbrook Ins. Co. Ltd. v. Liberty Mut. Ins. Co.* (1992) 5 CA4th 1445, 1460, 7 CR2d 513, 521]

1) [12:246.1] **Comment: These cases are difficult to reconcile with the 'only permissible consideration' standard of a 'reasonable settlement demand' set out in *Johansen* and CACI 2334 (see ¶12:235.1). A possible explanation is that these cases address the 'reasonableness' of the insurer's refusal to settle based on a dispute as to the value of the case (or other matters unrelated to coverage), whereas *Johansen* addressed 'reasonableness' in the context of a coverage dispute (see ¶12:235). [See *Howard v. American Nat'l Fire Ins. Co.*, supra, 187 CA4th at 529, 115 CR3d at 69 (quoting text)]" (**Croskey et al., California Practice Guide: Insurance Litigation, Ch. 12B-B, *Bad Faith Refusal To Settle*, ¶¶ 12:245–12:246.1 (The Rutter Group), bold in original.)

Secondary Sources

2 Witkin, Summary of California Law (10th ed. 2005) Insurance, §§ 257–258

Croskey et al., California Practice Guide: Insurance Litigation, Ch. 12B-A, *Implied Covenant Liability—Introduction*, ¶¶ 12:202–12:224 (The Rutter Group)

Croskey et al., California Practice Guide: Insurance Litigation, Ch. 12B-B, *Bad Faith Refusal To Settle*, ¶¶ 12:226–12:548 (The Rutter Group)

Croskey et al., California Practice Guide: Insurance Litigation, Ch. 12B-C, *Bad Faith Liability Despite Settlement Of Third Party Claims*, ¶¶ 12:575–12:581.12 (The Rutter Group)

Croskey et al., California Practice Guide: Insurance Litigation, Ch. 12B-D, *Refusal To Defend Cases*, ¶¶ 12:582–12:686, (The Rutter Group)

2 California Liability Insurance Practice: Claims and Litigation (Cont.Ed.Bar) Actions for Failure to Settle, §§ 26.1–26.35

2 California Insurance Law and Practice, Ch. 13, *Claims Handling and the Duty of Good Faith*, § 13.07[1]–[3] (Matthew Bender)

26 California Forms of Pleading and Practice, Ch. 308, *Insurance*, § 308.24 (Matthew Bender)

12 California Points and Authorities, Ch. 120, *Insurance*, §§ 120.195, 120.199, 120.205, 120.207 (Matthew Bender)