TIME DEMANDS AND BAD FAITH FOR FAILURE TO SETTLE IN GEORGIA

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Within the last five years, counsel prosecuting and defending personal injury claims have seen a dramatic increase of the use of time limited Holt demands to either settle a stubborn case or to "set up" an insurance company for bad faith failure to settle a case against its insured within policy limits. In particular, in the second half of 2012, a flood of policy limits demands fueled by appellate decisions addressing whether or not an insurer has made a counter offer to a time limited demand landed on the desks of claims professionals who sought the advice of insurance defense and bad faith counsel. The large increase in the use of time limited demands and complaints from defense attorneys and insurance carriers eventually led to the passage of O.C.G.A. §9-11-67.1 during the legislative session of 2013.

I. Introduction

This presentation was originally directed towards educating claims professionals on how to handle policy limits time demands submitted under *Southern General v. Holt*, 262 Ga. 267, 416 S.E.2d 274 (1992). This paper will address the applicable law concerning negligent bad faith failure to settle within policy limits claims, the types of time limited demands that are typically seen by defense counsel and insurance carriers, strategies for responding to demands and insurance carriers, and the effect, of the passage of O.C.G.A. §9-11-67.1 on clarifying or providing guidance to all counsel and claims professionals on how to draft and properly respond to policy limits time demands.

II. The Applicable Law

The most common example of an insurance company's liability for bad faith arises when the insurance company fails to take advantage of a reasonable opportunity to settle a claim against its insured within policy limits. Under the majority of insurance policies, the

insurer controls the decision whether to settle, and protect its insured against a potential excess judgment. Because the liability insurers has exclusive control over the decision to settle, Georgia courts hold that to the insurer has a duty to make settlement decisions non-negligently and in good faith. This good faith duty first established, and well discussed in three separate, but related federal court decisions issued by the 5th Circuit Court of Appeals applying Georgia law from 1962 to 1967. *See, Smoot v. State Farm Mut. Auto Ins. Co*., 299 F.2d 525 (5th Cir. 1962); 337 F.2d 223 (5th Cir. 1964); and 381 F2d. 331 (5th Cir. 1967). From the *"Smoot* trilogy," the insurer's duty to settle when presented with a reasonable opportunity began to be tested by the use of time limited settlement demands.

United States Fidelity Guar. Co. v. Evans, 116 Ga. App. 93, 156 S.E. 2d 809 (1967), first discussed the equal consideration rule as a standard by which an insurance company's decision not to settle a claim within its policy limits against its insured would be measured. The *Evans* court held, "As a professional in the defense of suits, the insurer must use a degree of skill commensurate with such professional standards. As the champion of the insured, the insurer must consider as paramount his interests, rather than its own, and may not gamble with his funds." The court also stated that the insurer must accord the interest of its insured with the same faithful consideration as it gives its own interest. *Evans*, 116 Ga. App.93 at p. 96 – 97.

In *Southern General v. Holt, supra*, the Georgia Supreme Court further described the equal consideration rule. "In deciding whether to settle a claim within the policy limits, the insurance company must give equal consideration to the interests of its insured. The jury generally must decide whether the insurer, in view of the existing circumstances, has accorded the insured "the same faithful consideration it gives its own interest." In *Cotton*

States v. Brightman, 276 Ga. at 683, 580 S.E. 2d 519 (2003), the Supreme Court held that an insurer is negligent in failing to settle, if the ordinarily prudent insurer would consider that a decision to try the case created an unreasonable risk.

Smoot, Holt, Evans and *Brightman*, established the standards under which an insured may recover for the insurer's decision to fail to settle within limits. If the insurer failed to give equal consideration to the interests of the insured; failed to accord its insured the same faithful consideration it accords its own interests; refused to settle because of any arbitrary or capricious belief that the insured was not liable; or capriciously refused to entertain a settlement offer with no regard given to the position of the insured, an insurer may be negligent in failing to settle, and be held to have acted unreasonably. *See*, Insurance Bad Faith: The Law in Georgia, 2nd Ed., James Sadd, Richard Dolder and Samantha Johnson, (2013), p. 60.

The most common failure to settle within policy limits arises from the insurer's rejection of a time limited policy limits demand. The "Holt Demand" is a written offer by which an attorney for the claimant demands a settlement at or below policy limits, and states that they will file suit to obtain an excess judgment against the insured if a demand is not met within a specific time period. In addition to restating the equal consideration rule, the Supreme Court of Georgia established several important statements of law when deciding *Holt*. An insurance company does not act in bad faith solely because it fails to accept a settlement offer within the deadline set by the injured person's attorney. Whether an insurer acted reasonably in not paying a demand depended upon the circumstances of each case.

The *Holt* court cited three specific factors in determining whether or not an insurer was reasonable in deciding whether or not to accept a policy limits demand. The *Holt* court stated that the strength of the liability case against the insured, the risk to the insured of an excess judgment, and the damages the claimant may ultimately recover under applicable law must be considered when deciding whether to settle when presented with a time demand.

Last, the Supreme Court stated that nothing in the *Holt* decision was intended to establish a rule that means a plaintiff's attorney under similar circumstances, could set up an insurer for excess judgment merely by offering to settle within the policy limits, and by imposing an unreasonably short time within which the offer would remain open. Despite this language, the time limited *Holt* demand serves as the blue print to set up an insurer for excess verdicts.

Recent litigation has centered upon whether or not an insurer accepted a settlement or made a counter offer, rejecting the time limited demand. The appellate courts look to the basic law of contract formation to determine whether an enforceable settlement exists. In short, the Georgia courts hold that a claimant's attorney making an offer may condition the terms under which the offer may be accepted. Failure to accept the offer in <u>strict compliance</u> with the terms set forth in the demand, or an acceptance that purports to vary a single term is deemed a rejection. Any counter offer is a rejection of the initial offer. *See, Herring v. Dunning*, 213 Ga. App. 695, 446 S.E.2d 199 (1994); *Fortner v. Grange Mut. Ins. Co.*, 286 Ga. 189, 686 S.E.2d 93 (2009); *Frickey v. Jones*, 280 Ga. 573, 630 S.E.2d 374 (2006).

Frickey involved the very common situation when the insurer accepts the demand, but conditions the payment of policy limits on the satisfaction of medical provider liens.

The Court ruled that no settlement agreement had been made, because the insurer purported to accept the offer on the condition that all liens be resolved. The Georgia Supreme Court deemed this acceptance to be a counter offer and a rejection of the demand. This decision led to the common practice of time limited demands being conditioned upon releases containing no indemnification language or lien protection for the insurer or insured. *See also, McReynolds v. Krebs*, 290 Ga. 850, 725 S.E.2d 584 (2012).

III. Current Status of Time Demands in Georgia

Although *Southern General v. Holt* was decided in 1992, the use of *Holt* time limited demands significantly increased in the last few years, and has become more prevalent and early in the claims process. Recent appellate court decisions have been very unfriendly to insurers in negligent/bad failure to settle claims benefitted claimant's counsel and helped to create cottage industry for suing insurance companies for negligent failure to settle. The scope of damages claimed by both wronged insureds and successful claimants who have been assigned bad faith claims has greatly expanded to include not only the responsibility for underlying excess verdict, but post judgment interest, punitive damages, attorneys fees and other consequential damages. (*See, Thomas v. Atlanta Cas. Co*., 253 Ga. App. 199, 558 S.E. 2d 432 (2001), for an excellent discussion of what consequential damages can be recovered as a result of the failure to timely settle). Last, very aggressive and intelligent bad faith lawyers are now motivated to educate others in the use of time limited policy limits demands and marketing to prosecute negligent failure to settle claims against insurance companies.

Early in the claims process, more attorneys are now working to set insurers up with time limits demands to remove policy limits. Early policy limits demands frequently

contain numerous conditions which the insurer must comply with to meet the terms of the demand within the specified term based upon the holding of *Frickey v. Jones*, *supra*. The demands frequently state that, any failure to comply with the exact terms set forth in the demand is deemed to be a counter offer and a rejection of a one and only opportunity to settle which results in an immediate and permanent withdrawal of the demand and a lawsuit in which the plaintiff seeks an excess verdict. Last, the "equal consideration rule" has become the standard relied upon by the claimants attorney in which the an insurer, when considering a policy limits time demand, must give equal consideration to its insured in making a decision to settle. Stated differently, the insurer must consider what effect an excess verdict will have against its insured when responding to a time limited demand.

Prior to the filing of suit, the claimant's attorney controls the flow of information available for a claims professional and defense counsel to evaluate the claim. Frequently, claims professionals are provided with a limited number of bills, medical records, and supporting lost wage documentation when asked to meet a policy limits time demand. Of course, counsel for the claimant has had an opportunity to meet with their client, speak with their doctors and has personal knowledge of their clients injuries to allow them to predict the eventual value of the claim before a jury as their client continues treatment. Although, the insurer may not be provided with the most recent and informative medical records, policy limits time demands frequently include allegations of future surgery and continuing medical expenses which will "most certainly cause" special damages to exceed the policyholders' liability limits. There are also medical professionals who are happy to assist counsel by performing a one-time examination of the claimant, and predict in writing

that a surgery is needed. The doctors will outline exorbitant future medical costs to support a policy limits time demand.

Another recent development in failure to settle cases is the growth of the first party failure to settle a claim. Historically, an insured who had an excess verdict against him assigned their right to file a bad faith suit against the insurer to a successful plaintiff, in exchange for a release from personal liability. That plaintiff then stood in the shoes of the injured policyholder and sought the full amount of the excess verdict, post judgment interest, attorneys fees and costs associated with the litigation. However, the recent trend is for the harmed policyholder to hire a bad faith lawyer to prosecute a first party failure to settle the claim. This has serious ramifications for the insurer. The most serious is that a first party claimant can recover punitive damages against the insurance company which a successful plaintiff holding an assignment cannot do under *Holt.* The insured also argues that they are entitled to recover consequential damages resulting from an excess verdict which include damage to credit, ability to seek employment, and mental and emotional suffering. Last, the harmed policyholder sitting at the plaintiff's table, who was not protected from an excess verdict by the defendant insurance company, provides a huge strategic and sympathetic advantage before jurors that are not familiar with the claims process.

IV. Investigating a Case prior to a Pre-Suit Time Demand

Prior to the instigation of a lawsuit, and the ability of an insurance company to conduct discovery, claimant's counsel enjoys a very uneven playing field. Claimant's counsel controls the information provided to the insurance company, and frequently will refuse to allow recorded statements, or give executed medical or lost wage authorizations.

Discovery in failure to settle lawsuits typically centers upon whether the insurer promptly and thoroughly investigated the liability case against the insured, and the damages sought by the claimant. Therefore, claims professionals and defense counsel handling claims must be proactive prior to the receipt of a time limited demand, Adjusters must send correspondence to counsel, and specifically ask for all medical records, bills, and recorded statements, and executed medical and lost wage authorizations. Claims professionals should be advised to continually document their files showing their investigation and efforts to secure information from counsel representing the claimant. Claimant's counsel's refusal to provide this information must also be documented. Most importantly, the insurance carrier as well as defense counsel should always keep their insured policyholder informed of the investigation of the claim, and receipt of time limited demands.

V. Time Demands 101

The most frequent mistake I see made by claims professionals and attorneys handling time demands is a failure to carefully and repeatedly read a written demand. If a claims professional asks you to provide advice on a time demand, immediately ask them to provide you with a copy of the demand, rather than simply reciting the contents. Many demands are well written, full of conditions, or flat out tricky. My advice is to read the time demand several times, bullet point all terms and conditions, determine and highlight deadlines, and list any items for which you need to seek clarification from claimant's counsel which are not clear from the body of the demand.

A time demand must be given number one priority. Late review and response to time limited demands will not appear to be reasonable. It is often confusing to determine

exactly when the time demand is due. I have seen demands dated for a day, mailed or faxed two days later, and then finally reviewed by the insurance adjuster 7 to 10 days later after it has been scanned into their system. Although, O.C.G.A. §9-11-67.1 provides a set 30 day deadline, a frequent problem is determining exactly when the 30 days begins to run. To be safe, diary the number of days from which the date the demand is written, and then clarify if there is a certain due date set in the body of the demand, or if the demand states the offer to settle expires a certain number of days from its receipt. Always obtain and secure proof of when the demand was received. If there is contradiction concerning a due date within the demand, one should immediately seek clarification for plaintiff's counsel, and then document your conversation.

Once the conditions contained within the time demand are determined, and the due date established, one should immediately determine which conditions can be met before the demand expires, and work to meet those conditions. Frequently, there are conditions which the insurer cannot always meet, because they are dependent upon the cooperation of the insured or other factors. In particular, many demands require executed no other insurance, and or financial affidavits that must be received along with the settlement check to meet the terms of the demand. Thus, one must contact the insured immediately, send them a copy of the demand, explain its contents and ramifications, and ask for cooperation in completing the affidavits. Certainly, all conditions cannot all be met within the time deadline. However, the insurer and defense counsel should at the very least send a copy of any proposed no-other insurance affidavit or financial affidavit to the insured well before the deadline expires. Another lesson from *Cotton States v. Brightman* is that an insurer

must meet those conditions over which it has control to create a "safe harbor" from bad faith.

V. Case Evaluation in the Face of a Policy Limits Time Demand

When faced with a time limits demand, the most important question and focus should be on the amount of the policy limits. Obviously, if the policy limits are higher, a claims adjuster has more freedom to investigate a claim, especially when investigation of prior medical conditions, injuries and collection of past treatment records are essential to evaluate a claimant. On the other hand, if the policy limits are low, the margin for error in meeting a demand is much greater. Claims professionals may not have the time to collect all the records they need to properly evaluate the case, when limits are low.

Again, the standard in Georgia for responding to a time demand is negligence, as well as bad faith. Essentially, a jury or factor finder will ultimately be called upon to decide whether or not a claims professional's actions in paying or not paying a claim, or requesting additional medical and lost wage records were reasonable under the circumstances.

Historically, the standard for deciding to pay a time demand relied upon by insurers were factors discussed in *Southern General v. Holt*. The *Holt* court stated that when the liability of the insured is reasonably clear, and special damages will exceed the policy limits, the insurer may be guilty of bad faith or negligence by failing to settle. More recently, the equal consideration rule has been relied upon as the applicable standard by both the appellate courts and claimant's counsel writing demands as to whether an insurer acted reasonably in refusing to pay a time limited demand.

In cases with low limits where the margin for error is much greater, special consideration must be given to immediate and thorough view of a time demand. Although,

insurance carriers may use computer generated case evaluation software to review claims, manual reviews of all policy limits time demands are strongly advised, especially if a decision is made not to settle for policy limits. Round table reviews of demands and consultation with local defense counsel is strongly advised.

When drafting an initial response to a demand a claims professional should determine what conditions exist in the demand that can or cannot be met. Although, no other insurance affidavits are frequently straightforward, financial affidavits can be quite involved, and will ask for confidential and personal information concerning the insured's assets. The insured, who ultimately may have a claim for negligent failure to settle, may refuse to provide this confidential information or simply not want to go through the process of filing out a financial affidavit to comply with the terms of the demand. This presents a problem to the insurer, since they do not have the ability to control the actions of the insured to comply with the conditions set forth in the policy limits demand. Thus, the insurance company must show it made an early and reasonable effort to secure these affidavits from the insured, and explain to them that plaintiff's counsel has made this an express condition of his agreement to protect them from excess exposure. Ultimately, if the insured fails to provide these affidavits, documenting the file to show that a reasonable effort has been made by the insurer to secure the affidavits may insulate the insurer from a bad faith claim.

When the terms of the demand are unclear, especially as to conditions set forth in the demand, early verbal contact with plaintiff's counsel seeking clarification of these conditions is essential. In addition, a discussion of what conditions can be complied with by the insurer, and which cannot such as securing financial affidavits is advisable. Last, if

an extension of time is needed to obtain additional information on prior medical records or further investigate liability, one should verbally ask plaintiff's counsel for an extension as soon as possible. Last minute extensions will not be given, and will not appear to be reasonable. On the other hand, if an early request for an extension of time to seek reasonable information to evaluate the demand is rejected by counsel, confirming this rejection in writing will helps to build to a defense for a bad faith case.

VI. Busting the Limits: Strategies for Avoiding Setups

Serious injury cases with large medical and lost wage special damages are ripe for policy limits demands. In these cases, many claimants' attorneys will attempt to bust the limits, and set up the insurer for an excess claim to maximize their client's recovery. In fairness, plaintiff's counsel, knowing that their client has suffered serious injuries and that only a low limits policy is available to compensate them, contend that they have an ethical duty to obtain as much insurance money as possible to compensate their client. Under *Holt* and subsequent cases, existing law provides a blueprint to make a policy limits demand which may remove the policy limits, and result in more compensation for their seriously injured clients. Thus, low limits serious injury claims frequently draw time limited demands that contain numerous conditions, tricks and require a claims professional or defense counsel to predict the ultimate outcome of claim.

Plaintiff's counsel is most familiar with their client's injuries and can more easily predict future medical care or even surgery after meeting and speaking to their clients and/or their medical providers. Defense counsel and claims professionals do not have access to this important information, and frequently are only given vague details of the injuries, while counsel hints at future medical care and future special damages. In short,

plaintiff's counsel knows better what his case may be worth and will use this to his advantage in drafting time demands. In "Crystal Ball Demands," the insurer is called upon to predict what may happen to the claim from an exposure standpoint based upon limited information that is provided by plaintiff's counsel.

The Crystal Ball Demands are time limited demands which contains little or no information prior to a demand being made, but allegations of a bad injury, and future medical expenses. Counsel will not typically allow any statements or medical authorizations. The written demand is then sent to the insurer with limited information, medical records and bills, but allegations of continuing medical treatment and wage loss. Frequently, plaintiff's counsel baits the claims professional to ask for additional information rather than paying the demand which will be deemed to be a counter offer and a rejection of a one and only opportunity to settle case for policy limits to protect its insured.

In order to avoid the Crystal Ball set up, the insurer must respond to the demand as early as possible, and contact plaintiff's counsel to ask him for additional information concerning his allegations of future medical treatment and wage loss. The insurer must ask for medical and lost wage authorizations to obtain that information on their own. If plaintiff's counsel refuses to provide this information, the claims professional should follow up in writing to document the file in order to defend a potential bad faith claim. In addition, as with all demands, the insurer should inform the insured of the demand, send them a copy and ask for input.

A typical scenario is a policy limits demand which alleges future surgeries and medical expenses which will greatly exceed low policy limits. The claimant may have just

started treatment and incurred only minimal medical bills after an emergency room treatment, diagnostic testing and physical therapy which are not helping the injury. Claimant's counsel will tell the insurance professional that physical therapy has failed, and pain management, including epidural injections and all sorts of expensive treatment are forthcoming. Many times, this promised treatment has already begun, but the records are not provided. Claimant's counsel will also have the advantage of knowing whether or not the epidurals have resolved the pain, and if not whether it is likely the claimant is heading for surgery. A time demand follows stating it is a one and only opportunity to protect the insured by settling for policy limits.

The insurer is put into a tough position on whether or not to make offer based upon the information they have, or to simply ask claimant's counsel to provide them with an extension of time to respond to the predicted demand until the treatment occurs, and all bills are provided to determine whether payment of policy limits is warranted. This decision should be addressed on a case by case basis. In some instances, it may be better not to offer anything based upon the information provided to avoid the appearance of low ball counter offer to the demand. The insurer may decide it is more reasonable want to evaluate the case as policy limits case, once all the information alleged in the demand is provided.

No brainer policy limits cases with serious injuries, deaths and low policy limits are ripe for Conditional Demands. In these cases, the insurer knows that they will pay their limits. Plaintiff's counsel knows that the limits are low, and seeks an opportunity to remove the policy limits with a time demand. These Conditional Demands are long detailed demands with numerous conditions which the insurer must meet in addition to tendering

policy limits to meet the terms of the demand. Counsel dictates the form of releases, the parties and claims that they will release and whether or not they will agree to satisfaction of liens. Counsel also dictate that the check must be received in hand by a certain date. Appellate cases hold that an insurer insisting upon payment of medical or hospital liens as a part of the demand has rejected the demand. These cases also hold that the response must mirror the terms of the demand to result in an enforceable policy limits settlement.

To avoid a Conditional Demand set up, the claims professional and defense counsel should read the demand thoroughly and repeatedly, and list all conditions. If conditions are vague, one should contact the plaintiff's counsel as early as possible to attempt to seek clarification. Under *Brightman v. Cotton States*, an insurer must comply with all reasonable conditions that they can meet that are listed in a time demand. Again, demands which insist upon execution of no other insurance or financial affidavits, or any other conditions which call for the cooperation of the insured, require that the insurer inform the insured, and ask for early assistance.

Some time limited demands are just sneaky. These long detailed demands contain vague or hidden conditions concerning the form of release, indemnification and delivery of check in hand. Frequently, these terms often appear to contradict each other, and are hidden within the body of the demand which can go unnoticed if not carefully read. The sneaky setup often involves gamesmanship concerning when the demand is due. It is no coincidence that December is the time demand season. Claims professionals will likely be on vacation, and/or miss days from work due to Christmas Eve, Christmas Day, New Year's Eve and New Year's Day. Essentially, these demands are timed to burn as many days as possible when the case can be reviewed.

Last, there has been much debate as to whether or not a written time demand is required to support a failure to settle claim, or a verbal demand for policy limits within a certain date is sufficient. In *Kingsley v. State Farm,* 353 F. Supp. 2d. 1242 (N.D.Ga. 2005), the U.S. District Court stated that although the best and most certain determination of whether there is an opportunity to settle is in a written time limited demand, it is not required. However, there is no bad faith as a matter of law, even in a serious injury case, unless there is an opportunity to settle communicated to the insurer.

Reviewing the sneaky demand early and often is always a good way to avoid being setup for a bad faith claim. List the conditions and call the plaintiff's counsel to clarify the terms of demand, due dates and what conditions must be met to meet the demand. Always contact the insured to discuss the demand, and the response. Typically, the sneaky set up involves a low limits and serious injury cased designed open the limits by setting up the insured.

VII. Time Demands and Liens

A problem often faced by a claims professional are time limited demands in serious injury claims with low limits, in which a sizable hospital lien exists. In essence, the insurer is called upon pick their poison by either paying a demand when plaintiff's counsel insists that no lien indemnification be given to avoid a potential bad faith claim, or to face a large medical expense lien claim from a medical provider.

In *Southern General v. Wellstar*, 315 Ga. App. 26, 726 S.E.2d 488 (2012), the Georgia Court of Appeals stated that insurers faced with a time demand, and a refusal to pay a lien by claimant's counsel may be able to create a safe harbor from a *Holt* bad faith claim. However, the holding speaks in hypotheticals, and from the wording of the case, the insurer

must be extremely careful to ensure that the only reason that they cannot meet the demand is counsel's unreasonable refusal to honor the lien. This decision was further clarified in *Torres v. Elkins*, 371 Ga. App. 135, 730 S.E.2d 518 (2012). In *Torres*, the insurer was also faced with a time demand, but conditioned payment of policy limits on satisfaction of liens. The Court held that the insurer did not have an enforceable settlement to prevent a lawsuit, and a potential excess claim against their insured. The Court did mention, in a footnote, that the insurer may have a defense to a bad faith claim based on the refusal to pay the lien by claimant's counsel.

Due to the uncertainty of *Wellstar,* and the fact that *Torres v. Elkins*, held no enforceable settlement exists, if the insurer insists upon satisfaction of the lien, these demands should be treated on a case-by-case basis. Most often, it may be better to resolve the injured party's case, protect the insured from an excess verdict and then deal with a capped lien and a much less sympathetic plaintiff at the end of the day. On the other hand, if there is a large and sizeable lien, and the only reason for lack of policy limits settlement is that plaintiff's counsel refusal to satisfy the lien, the insurer may choose to not pay the claim and defend a bad faith claim based upon *Southern General v. Wellstar.*

However, the trend now among medical providers is to enforce a lien by filing a direct suit against the insurer who has known assets rather than insured who likely has none. O.C.G.A. §44-14-473, expressly allows a direct claim against an insurer, to enforce the lien. Thus, an insured, may argue that the insurer should have paid the time demand to protect them, and in doing so, the insurer put its interest above the policyholder, in violation of the equal consideration rule."

VIII. O.C.G.A. §9-11-67.1: A Cure or "A Band-Aid on an Open Chest Wound"

In response to the dramatic increase in the use of policy limits time demands, and the uncertainty of the law created by appellate decisions, the Georgia legislature in 2013 passed a new time demand statute, O.C.G.A. §9-11-67.1. The passage of this legislation known as HB 336, and the ultimate enactment of the statute received a good deal of attention from the legal and business community. Pressure from the insurance industry, businesses, chambers of commerce, and the defense bar and opposition from the Georgia Trial Lawyers Association resulted in a group of plaintiff and defense lawyers cooperating as a secret committee to draft a compromise bill. The bill was ultimately drafted after much discussion which included testimony, which was filled with stories of five-day time demands and unreasonable conditions. The plaintiff's bar argued that the furor over time demands was a perceived problem, and dismissed stories of five-day demands as isolated incidents. However, the trial lawyers were willing to compromise and work towards formation of a bill. Ultimately, O.C.G.A. §9-11-67.1 was enacted and signed into law by Governor Nathan Deal.

However, O.C.G.A. §9-11-67.1 only established procedures for pre-suit time demands in motor vehicle accident cases. The new code section only applies to "causes of action for personal injury, bodily injury or death arising from the use of a motor vehicle after July 1, 2013." The demand must be in writing, sent either by certified or statutory overnight return receipt requested, and contain the following material terms:

1. A 30 day time demand period from the receipt of the offer in which the demand must be accepted;

2. The specific amount of the payment;

3. The specific party or parties to be released;

4. The type of release to be accepted in exchange for payment; and

5. The claims to be released.

The code section also states that the insurance carrier "shall have the right to seek clarification regarding the terms, liens, subrogation claims, standing to release claims, medical bills and records, and other relevant facts with this attempt to seek "reasonable clarification" without this effort being deemed to be a counter offer and a rejection of the demand. Last, the code section specifies forms of payment that are acceptable.

The passage of this bill was welcomed by some as a first step in providing structure to pre-suit time demands, and it was hoped that the new statute would curb the use of tricky and excessive tactics to remove limits and claims. However, the new code section does not apply to cases that do not arise from car accidents. Moreover, after suit is filed, the statute does not apply and anything goes. The code section was also characterized by many as flawed, and as a mere "Band-Aid on a sucking chest wound," since it did not provide any caps on penalties or attorney's fees as is the case for most insurance bad faith claims created by statute in Georgia.

The passage of this bill has bred a different type of time demand. The new time demand follows the strict requirements of O.C.G.A. §9-11-67.1, and goes to great lengths to spell out the material terms. However, an examination of the acceptable release is where the focus must be centered. Although, the time demand itself tracks the language of the new statute, it will also state that in order to meet demand, the insurer must agree to an attached limited release. The release itself may not contain the specific parties that the insurer needs to be released, may exclude other claims, and often fails to address lien

indemnification. Thus, in addition to carefully reading the demand, the contents of the attached limited release needs to be thoroughly examined.

IX. The Ramifications of Negligent Failure to Settle

First and foremost, if an insurer does not meet the terms of a time demand, there is no agreement to protect the insured from an excess verdict and a suit in most cases will be filed. The lawsuit will be prosecuted to its end, and the ultimate goal of counsel is obtain an excess verdict. As stated above, in the past, the successful plaintiff's attorney would then approach the insured to seek assignment of his negligent failure/bad faith claims against the insurer. However, it has become more common for the wronged insured to find his way to a bad faith attorney in which the scope of damages is greatly expanded, and a more sympathetic party will be suing the insurance company.

If a case is tried to verdict, and an excess verdict is reached, the policy limits and any applicable interest must be paid and the insurer must advise the insured of the ramifications of the excess verdict, personal exposure and advise him of the need to personally consult counsel. Prior to a verdict, if the case was a policy limits case, but for some reason the terms of the demand could not be met, it is advisable to continue to offer policy limits to build your file. If records that were not previously available to the insurer during the life of the demand are produced or discovered, offer the policy limits and explain why you are now doing so.

Once a bad faith case is filed against the insurer, most of these cases are removed to federal court. Typically, these claims will exceed the jurisdictional amount ($75,000), and most often better judges will decide summary judgment motions in federal court, and a more conservative and less hostile jury pool will be found. However, an insurance

company as a defendant, especially against a wronged insured does not enjoy the advantage of sympathy, and may often find a hostile environment.

In bad faith litigation, discovery is broad and case law holds that the plaintiff will be entitled to the claims notes, correspondence, as well as many other internal insurance company documents that are not normally subject to discovery. Each entry in the claims notes will be carefully examined, and questioned at depositions. The depositions will be long and stressful, and at each step adjusters, supervisors and other insurance company's representatives will be called upon to explain their reasons for not paying limits in the face of a time demand. In addition, the training qualifications and claims procedures will be carefully examined, and most often, subject to discovery. When defending these claims, immediately request the claims notes, and in preparing deponents, specific entries in the claims notes become the focus of your preparation.

X. Conclusion

Although, O.C.G.A. §9-11-67.1 provides some structure to addressing pre-suit demands in motor vehicle accident claims, it has not slowed the use of the demands to attempt to make the limits of the insurer disappear in serious injury cases. From this writer's experience, the statute has not stemmed the tide of time demands, or the fact that the demands or attached releases can still contain many conditions and tricks. This writer has also seen the use of time limited demands and other personal injury lawsuits not involving motor vehicles, where none of the procedures in O.C.G.A. §9-11.67.1 apply. Last, the two year anniversary of the application of the statute is July 1, 2015, so expect numerous time demands during the latter half of 2014, and first half of 2015.

However, I have found that defense and insurance professionals have now developed better procedures for responding to time demands, and promptly and thoroughly evaluating claims. Insurers now more carefully examine time demands, have better procedures in place, and know to consult counsel when in doubt. Insurers now better engage their own insured, who ultimately will have the initial claim for failure to settle, in the settlement negotiation process and advise them to seek individual counsel to consult them if needed. Lawyers by nature are creative, and thus strategies for responding to time demands must continue to be fluid.