



Jul 16, 2025

Categories:
[Publications](#)

Authors:
[Michele L. Levinson](#)

The Game Is the Same, but the Rules Are Changing: Policy Limit Demands in California from Pinto to McGranahan

It is safe to say that time-limited policy limit demands (PLDs) have always been the scourge of any casualty insurance carrier in California. This is not because a carrier fears conducting a reasonable analysis as to whether a claimant should recover the full amount of an insured's per-occurrence personal injury coverage. Rather, the issue stems from the prolific amount of gamesmanship that has transpired over the years when it comes to PLDs. It would seem, as far as some are concerned, the intention is not merely to obtain a reasonable settlement for a claimant, but rather to create a scenario that intentionally allows the demand to expire, thereby exposing an insurer to bad faith.

A breach of the implied covenant of good faith and fair dealing can be shown by refusing, without proper cause, to compensate the insured for a loss under the policy—or by unreasonably delaying payments due under the policy. *Waters v. USAA* 41 CA4th 1063 (1996). To establish a breach of the implied covenant of good faith and fair dealing, a plaintiff must show that policy benefits under the policy were withheld, *and* the withholding of benefits was unreasonable or without proper cause. *Feldman v. Allstate Insurance Company*, 322 F.3d 660(2003 – 9th Circuit).

Therefore, as a general rule, a carrier is obligated to attempt to settle a case within its limits and avoid any unnecessary risk to its insured. As one court noted, “[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 consider 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.

There was a time, not that long ago, when these policy limit/time limit demands (PLD/TLDs) would be sent in such a way that one can only infer the intention was not to settle the claim but to expose the carrier to bad faith. It was not unusual for a claimant to send such a demand to a carrier late Friday afternoon, before a long holiday weekend, allowing the carrier days to settle the claim. It was also commonplace for these demands to be sent to the wrong adjuster, the wrong email account, or the wrong claims office. They could include onerous conditions, no injury information, and often no medical specials, leaving even the most conscientious insurer with quite the challenge of deciding whether to tender its insured's policy limits without being able to properly evaluate the claim, if at all.

But in the last four years things have started to change.

FBT EVENTS

Understanding Today's Coverage Risks and Nuclear Exposures: An Insurance Symposium

September 25, 2025 | FBT Cincinnati Office

Presented in partnership with the Carl H. Lindner III Center of Insurance and Risk Management, this signature Frost Brown Todd event will bring together industry leaders, insurance economists and legal professionals to discuss many of today's pressing challenges, from AI adoption to nuclear verdicts and bad faith litigation trends.

[Register for this event!](#)

The first noticeable move by California courts to stave off these shenanigans came in 2021 with the California Court of Appeals' much-anticipated decision in *Pinto v. Farmers Ins. Exchange*, 61 Cal. App. 5th 676 (2021). *Pinto* became the battleground between the plaintiff bar and the insurance industry. At issue were efforts to

have a carrier's failure/inability/refusal to accept a PLD be deemed bad faith *per se*. In other words, the attempt was to remove any justification a carrier could make in explaining why a PLD/TLD was not accepted in the manner it was submitted, by the deadline imposed. Thankfully, the California Court of Appeals did not reach that conclusion. In its holding, the *Pinto* court summed it up as follows:

The issue is whether, in the context of a third-party insurance claim, failing to accept a reasonable settlement offer constitutes bad faith *per se*. We conclude it does not. At the same time, enforced the principal that "[a]n 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."

Pinto, 61 Cal.App.5th at 688.

That same year, the California Court of Appeals published its holding in yet another precedent-setting case involving PLD/TLDs. This time, the focus was on all too familiar *conditions* contained in these demands, sometimes creating impossible scenarios for a carrier to comply in a timely manner. *CSAA Ins. Exchange v. Hodroj*, 72 Cal.App. 5th 572 (2021). Again, carriers were facing arduous demands, sometimes with nine or ten conditions that had to be met, by the deadline provided, for the settlement to be accepted. It was not enough that a carrier responded on Tuesday morning *offering to tender* the policy limits in response to a demand received at 4:45pm the Friday before Labor Day, but that it could only accept if *all conditions* were met by the deadline. Typical conditions include a certified policy declarations page or a sworn affidavit by an insured that they were not in course and scope of employment at the time. If every condition was not met with the letter, the claimant would refuse to sign a release agreement, and their counsel would deem the demand to have expired, and the policy "opened." A bad faith suit would certainly follow.

But what if the carrier unequivocally agreed to pay the policy limits and all that was left were the conditions and a signed release? Could the court consider that the carrier intended to settle even if

the release was not signed? The answer is yes. In *Hodroj*, the California Court of Appeals held that:

[A]n objective observer would conclude from those communications that the parties intended to settle Hodroj's bodily injury claim for the amount of the insurance policy limits (\$100,000) and to later memorialize those terms in a formal document. That the proposed document contained terms materially different from what had been agreed to does not change the binding effect of the initial agreement. Hodroj was under no obligation to sign a release that was inconsistent with what he agreed to. But a proposed writing that does not accurately reflect the terms of an agreement does not unwind the entire deal. The contract formed by the parties' offer, acceptance, and consideration is still enforceable. Hodroj breached the contract here by filing suit on the bodily injury claims he had agreed to settle.

CSAA Ins. Exchange v. Hodroj, 72 Cal.App. 5th 572 (2021).

Following these two decisions, California implemented procedures to codify aspects of these holdings in California Senate Bill 1155, which became *California Civil Procedure* section 999. The newly enacted code set forth the requirements for a PLD/TLD to be valid, including the requirement that a carrier be given 30 days to respond.

These changes have done a great deal to stave off some of the game playing, but the demand process is still fraught with pitfalls. The question not answered in the two prior decisions fell into a grey area: For instance, what obligations does a carrier have to accept a TLD/PLD when the injuries and damages are not clear, or if *no medical specials are provided* with the demand? Does a carrier have to simply take a claimant's word for it?

Thankfully, in March 2025, the Ninth Circuit Court of Appeals answered that very question with its ruling in *McGranahan v. GEICO Indemnity Company, et al.*, 2025 WL 869306 (9th Cir. 2025) (not certified for publication). In *McGranahan*, GEICO was sued for bad faith after receiving a PLD/TLD without corresponding medical specials. In the underlying case, the plaintiff was involved in a

motorcycle accident and claimed that he suffered serious injuries. GEICO repeatedly asked for medical specials so it could properly evaluate the claim. GEICO even requested a medical authorization so they could obtain said records. Unfortunately, GEICO received neither the medical specials nor the authorization to secure them. Instead, GEICO received a policy limit demand claiming that not only did he suffer serious injuries, but that his medical bills were over a million dollars. *Id.* at 2.

GEICO's requests for supporting documents were ignored entirely. McGranahan filed suit and obtained a stipulated judgment for \$1.5 million. GEICO's insured assigned their bad faith rights to McGranahan who filed suit, arguing that the policy was "opened" when GEICO refused to settle. The court granted summary judgment in favor of GEICO, and the plaintiff appealed.

In its holding, the Ninth Circuit reached the logical conclusion that "[a]n insurance company is entitled to receive medical records and bills to aid it in evaluating a settlement offer." *Id.* The court explained its reasoning as follows:

By asking for corroborating medical records and bills or medical authorization forms ten times before the settlement offer deadline, Geico conducted an adequate investigation and "acted reasonably as a matter of law by seeking to obtain the necessary and missing information without delay." (internal citations omitted). Because the insurer was entitled to see medical bills and records before making a settlement, and the plaintiff, despite repeated requests, declined to provide the medical bills and records, we affirm the district court's grant of summary judgment adverse to plaintiff McGranahan.

So, with *Pinto* in 2021 and *McGranahan* in 2025, observers may opine that California courts are trying to move the needle towards the middle. Get rid of the games once and for all and allow an insurer to focus on proper claim evaluation. These cases, along with the newly implemented *California Civil Procedure* section 999, seem intent on at least trying to avoid some of the more prolific gamesmanship inherent in PLD-related claims in California. Does it

mean carriers will no longer receive demands that infer treatment is needed without actual support? It is doubtful.

Yet, at a minimum, there is some new support for a thorough investigation to be conducted by a carrier without necessarily exposing themselves to bad faith in every PLD/TLD. For more information and assistance as it relates to the topics covered above, please contact the author or any attorney with the firm's [Insurance Coverage and Bad Faith Practice](#).

© 2026 FBT Gibbons LLP. May be considered attorney advertising in some jurisdictions.