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CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

REAGAN WILSON, Plaintiff and Appellant, v. 21ST CENTURY INSURANCE COMPANY, Defendant and Respondent.	B180323 (Los Angeles County Super. Ct. No. BC301588)

APPEAL from a judgment of the Superior Court of Los Angeles County. Paul Gutman, Judge. Reversed with directions.

Hall & Bailey and Donald R. Hall for Plaintiff and Appellant

Horvitz & Levy, Barry R. Levy, Bradley S. Pauley; Lewis Brisbois Bisgaard & Smith and N. David Lyons for Defendant and Respondent.

Plaintiff Reagan Wilson appeals from the judgment in favor of defendant 21st Century Insurance Company after the trial court granted defendant's motion for summary judgment in an action for breach of contract and tortious bad faith in adjusting Wilson's underinsured motorist claim. We reverse. Triable issues of fact exist as to whether 21st Century failed to thoroughly investigate and evaluate plaintiff's claim. Furthermore, plaintiff should have the opportunity to conduct discovery into 21st Century's use of a computer software program known as Colossus in the evaluation of bodily injury claims because such discovery appears reasonably calculated to lead to the discovery of admissible evidence on the issues of breach of contract, bad faith and punitive damages.

FACTS AND PROCEEDINGS BELOW

In November 2000 Wilson suffered injuries to her neck and spine in a collision caused by a drunk driver. There was never any question about the other driver's full responsibility for the accident. The only issue was the extent of Wilson's injuries.

The other driver carried bodily injury insurance for $15,000 but Wilson had a policy with 21st Century which provided underinsured motorist coverage (UIM) up to $100,000. The other driver's insurance company paid Wilson its policy limit of $15,000 and Wilson requested 21st Century to pay the $100,000 policy limit under her UIM coverage.[1] Wilson accompanied her request with a police report of the accident which attributed fault entirely to the intoxicated driver of the other car, photographs of her demolished vehicle and medical reports from the emergency room and her treating physicians including Dr. Southern, an orthopedist. Wilson's attorney advised 21st Century "we would value the case in the range of $500,000 to $1.5 million if a suit were brought against the driver who caused the accident.

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[1] Wilson acknowledged 21st Century was entitled to offset the other insurer's $15,000 payment against her $100,000 UIM policy.

Initially 21st Century rejected Wilson's policy limit demand. It concluded from the medical reports she submitted and her physical activities following the accident the $15,000 Wilson received from the other party's insurer plus the $5,000 Wilson received from 21st Century under her medical payments coverage "fully compensated for her injuries."[2]

Over the next two years doctors retained by Wilson examined and evaluated her and arrived at different conclusions. All the doctors agreed Wilson had undergone cervical disc changes which they variously described as "atypical," "slight," "very slight," and "minimal." The doctors disagreed, however, as to the appropriate course of treatment. One recommended physical therapy, one recommended surgery, one recommended against surgery. The matter was resolved in June 2003 when a neurosurgeon retained by 21st Century examined Wilson and reviewed her medical records. This doctor concluded "surgical intervention would be indicated" and Wilson had "an 80% likelihood of obtaining benefit from surgical intervention." Less than a month later 21st Century paid Wilson the remaining amount of her UIM coverage, $85,000.

A month after receiving full payment from 21st Century Wilson brought this action for breach of contract and bad faith. Both causes of action stem from 21st Century's alleged unreasonable delay in paying the policy limits under Wilson's UIM coverage. Wilson attributes this delay to the insurer's failure to conduct a prompt, fair, reasonable and adequate investigation of her claim. Wilson also contends 21st Century acted in bad faith and violated the terms of her policy by initially offsetting the $5,000 it paid her under her medical payments coverage against her UIM coverage.

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[2] As we discuss more fully below, 21st Century initially determined Wilson's general damage from the accident was $20,000 against which it offset the $15,000 paid by the other driver's insurer (see footnote 1, *ante*) and the $5,000 it paid to Wilson under the medical payments provision of her policy leaving no benefits due under Wilson's UIM coverage. See further discussion at pages 17-19, *ante*.

During the discovery phase of this action Wilson learned 21st Century had available a software program known as Colossus for evaluating bodily injury claims but did not use Colossus in evaluating her claim.[3] In deposing the claims adjuster who initially handled her UIM claim Wilson sought to discover whether the adjuster had used Colossus in adjusting other claims, how long he had used Colossus in adjusting claims and whether he considered Colossus "to be a tool which would assist you in arriving at a fair and accurate evaluation of somebody's claim[.]" Counsel for 21st Century instructed the adjuster not to answer these or any other questions "about the parameters of Colossus." Wilson moved to compel answers to this and other questions regarding 21st Century's use of Colossus and to vacate the trial date to permit such discovery. The trial court denied these motions.

21st Century moved for summary judgment contending there were no disputed issues of material fact and it was entitled to judgment on both causes of action as a matter of law. The trial court agreed. It granted the motion and subsequently entered judgment for the insurer. Wilson filed a timely appeal from the judgment. Our review is de novo.[4]

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[3] Colossus is the trade name for a software program which provides insurance companies help in assessing damages in personal injury claims. See discussion at pages 14-16, *infra*.

[4] *Merrill v. Navegar, Inc.* (2001) 26 Cal.4th 465, 476.

DISCUSSION

I. TRIABLE ISSUES OF FACT EXIST AS TO WHETHER 21ST CENTURY COMMITTED A TORTIOUS BREACH OF ITS DUTY OF GOOD FAITH AND FAIR DEALING IN ADJUSTING WILSON'S CLAIM TO UNDERINSURED MOTORIST BENEFITS.

Under the implied covenant of good faith and fair dealing an insurer owes its insured a duty "not to withhold unreasonably payments due under a policy."[5] Wilson contends 21st Century breached this duty by denying her UIM claim without conducting a thorough investigation of her injuries, by failing to conduct an objective evaluation of the evidence Wilson supplied to it and by unlawfully offsetting benefits under Wilson's medical payments coverage against the payment due under her underinsured motorist coverage.

A. Triable Issues of Fact Exist As To Whether 21st Century Conducted A Thorough Investigation Of Wilson's Injuries And Her Need For Treatment.

It is undisputed Wilson eventually recovered – some two years later – the full policy limit of her underinsured motorist coverage. The issue is whether 21st Century is guilty of bad faith in its *initial* evaluation and adjustment of her claim.[6] Unreasonable withholding of benefits encompasses not only the failure to pay full benefits due under the policy but the unreasonable delay in payments.[7]

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[5] *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, 573.

[6] *Richardson v. Employers Liab. Assur. Corp.* (1972) 25 Cal.App.3d 232, 238.

[7] *Love v. Fire Insurance Exchange* (1990) 221 Cal.App.3d 1136, 1153; *Austero v. National Cas. Co.* (1978) 84 Cal.App.3d 1, 29-30.

"[A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial."[8] This rule applies to coverage decisions[9] as well as decisions about the amount of benefits due under the policy.[10]

Wilson contends 21st Century breached its duty to thoroughly investigate her claim by failing to conduct its own medical evaluation of her injuries to determine whether they were more than mere "soft tissue" injuries as the initial claims adjuster determined and whether Wilson required surgery rather than just physical therapy.

1. 21st Century's failure to have Wilson examined by a doctor of its choice or to consult with Wilson's treating physician.

As is well established, when proper adjustment of a claim turns on a medical evaluation of the insured's condition an insurer breaches its duty to thoroughly investigate the claim if it fails to have the insured examined by a doctor of its choice or at least to consult with the insured's treating physician.

In *Egan v. Mutual of Omaha* for example a claims adjuster classified the insured's condition as a noncovered "illness" rather than as a covered "injury" solely on the basis of the adjuster's review of the insured's medical records. The adjuster made no effort to discuss the case with the insured's attending physicians or to obtain an independent medical evaluation even though the insured stated he was willing to be examined by any doctor the insurer chose. Trial testimony established efforts to discuss the case with the insured's physicians would ordinarily have been made by a claims adjuster.[11] In defining

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[8] *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819.

[9] *Egan v. Mutual of Omaha Ins. Co.*, *supra*, 24 Cal.3d at pages 819-820.

[10] *Neal v. Farmers Ins. Exchange* (1978) 21 Cal.3d 910, 921; *Richardson v. Employers Liab. Assur. Corp.*, *supra*, 25 Cal.App.3d at page 242.

[11] *Egan v. Mutual of Omaha Ins. Co.*, *supra*, 24 Cal.3d at pages 816-817.

the insurer's duty to investigate, the Supreme Court held "it is essential that an insurer fully inquire into possible bases that might support the insured's claim."[12] The court concluded, "the evidence is undisputed that Mutual failed to properly investigate plaintiff's claim; hence the trial court correctly instructed the jury that a breach of the implied covenant of good faith and fair dealing was established."[13]

Similarly, in *Mariscal v. Old Republic Life Ins. Co.*[14] a claims adjuster denied a widow's claim for accidental death benefits on the ground her husband's death following a car accident was caused by a pre-existing heart disease not from injuries suffered in the accident. The adjuster based his decision on a report by the attending physician, Dr. Diaz, attributing the condition directly leading to death to "cardiopulmonary arrest with antecedent causes being myocardial and atherosclerotic heart disease."[15] The death certificate also stated the immediate cause of death was heart failure. A jury found the insurer guilty of bad faith and it appealed, arguing it did not breach the covenant of good faith and fair dealing because "it obtained every writing in existence setting forth the insured's cause of death [and] these writings reflect that the cause of death was the insured's heart failure and not the injuries he sustained in the automobile accident."[16] The Court of Appeal rejected this argument because among other things "Old Republic never discussed the matter with Doctor Diaz" and despite the fact the claims adjuster "did not understand medical terms or conditions . . . Old Republic did not consult with its own doctor."[17] When Doctor Diaz testified at trial, he described what he would have said had the insurance company bothered to ask. He would have explained it is routine medical practice for a physician to identify the immediate cause of death on the death certificate

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[12] *Egan v. Mutual of Omaha Ins. Co.*, *supra,* 24 Cal.3d at page 819.

[13] *Egan v. Mutual of Omaha Ins. Co.*, *supra,* 24 Cal.3d at page 819.

[14] *Mariscal v. Old Republic Life Ins. Co.* (1996) 42 Cal.App.4th 1617.

[15] *Mariscal v. Old Republic Life Ins. Co.*, *supra,* 42 Cal.App.4th at pages 1621-1622.

[16] *Mariscal v. Old Republic Life Ins. Co.*, *supra,* 42 Cal.App.4th at page 1624.

[17] *Mariscal v. Old Republic Life Ins. Co.*, *supra,* 42 Cal.App.4th at pages 1624-1625.

but that the decedent's heart failure was not brought on by disease but by trauma to the head which eventually caused ventricular fibrillation and death.[18]

Like the insurer in *Mariscal*, 21st Century based its initial determination of benefits solely on its own in-house review of Wilson's medical records without any attempt to consult her treating orthopedist, Dr. Southern. From that review 21st Century concluded Wilson "sustain[ed] *soft tissue injuries* superimposed by a *pre-existing* degenerative disc disease." (Italics added.)

21st Century did not have Wilson examined by a neurosurgeon before making its initial claims decision although it was a neurosurgeon retained by 21st Century who eventually determined "surgical intervention would be indicated" and Wilson had "an 80% likelihood of obtaining benefit from surgical intervention." Nor did 21st Century produce evidence insurers ordinarily do not discuss cases with the insureds' treating physicians or make referrals for independent medical evaluations before adjusting claims for physical injury. Furthermore, 21st Century produced no evidence the claims adjuster and supervisors who initially handled Wilson's claim understood the numerous medical terms Dr. Southern used in his reports and it did not explain how they arrived at the conclusion Wilson's physical damage was nothing more than a soft tissue injury overlaying a pre-existing disc disease. Neither of these findings was expressed in the reports they had before them. Six months after the accident Wilson told 21st Century she was still experiencing pain "on a regular basis." Dr. Southern also reported Wilson was suffering pain in her neck and back. There is no evidence 21st Century followed up on this information by attempting to determine the level of Wilson's pain and its expected duration by questioning either Wilson or Dr. Southern. There is no evidence 21st Century inquired whether Wilson was taking pain medication and whether the medication was effective in relieving her pain.

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[18] *Mariscal v. Old Republic Life Ins. Co., supra,* 42 Cal.App.4th at page 1625.

2. 21st Century's willingness to reconsider its decision

21st Century maintains it acted reasonably because it considered all the evidence supplied by Wilson and expressed a willingness to reconsider its decision "should [Wilson] wish to forward additional documents to substantiate [her] claim."[19] As *Egan* and *Mariscal* demonstrate, however, relying solely on the insured to provide evidence to support her claim does not satisfy the insurer's duty to thoroughly investigate the claim where, as here, there appear to be obvious avenues of inquiry in support of the claim which the insurer could have pursued but did not. As the court explained in *Hughes v. Blue Cross of Northern California*, "[t]he covenant of good faith and fair dealing . . . places the burden on the insurer to seek information relevant to the claim."[20]

3. 21st Century's "genuine dispute of fact" defense.

As a further defense to Wilson's bad faith claim 21st Century contends it cannot be held liable in the present case because there was a genuine dispute between the parties concerning the value of Wilson's UIM claim: 21st Century valued the claim at $20,000; Wilson valued it at between $500,000 and $1.5 million. In support of this argument 21st Century cites *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* which held "an insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not liable in bad faith even though it might

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[19] See *Austero v. National Cas. Co., supra,* 84 Cal.App.3d at page 35 [evidence insurer was willing to reevaluate claim in light of new information is evidence of insurer's good faith].

[20] *Hughes v. Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, 846.

be liable for breach of contract. [Citation.]"[21] The key word here is "genuine." As the *Chateau Chamberay* court recognized, the genuine dispute defense does not apply when the dispute arises because "the insurer failed to conduct a thorough investigation."[22] In other words, a breach of the covenant of good faith and fair dealing can be found even where the insurer harbors actual doubts about the amount of benefits which should be paid on a covered claim if a reasonable investigation would have disclosed information making those doubts no longer tenable.

At trial, of course, Wilson will have to prove by a preponderance of the evidence that if 21st Century initially had conducted a thorough investigation of her claim and otherwise acted reasonably it would have offered her a higher settlement than it did.[23] At this stage of the proceedings, however, the issue of causation remains an issue of fact.

4. 21st Century's failure to have Wilson's case evaluated by an attorney competent in the field of personal injury suits.

We asked the parties to brief the question whether, in a case involving underinsured motorist coverage, the insurer's duty to "fully inquire into possible bases that might support the insured's claim"[24] requires the insurer to have the insured's case evaluated by an attorney experienced in the field of personal injury law, or at least to consult with the insured's attorney if she has one, to determine the value of the insured's case were it to proceed to trial against the other driver.

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[21] *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, 347.

[22] *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.*, *supra*, 90 Cal.App.4th at pages 348-349.

[23] Compare *Murray v. State Farm Fire & Casualty Co.* (1990) 219 Cal.App.3d 58, 65-66 [like all torts, tort of bad faith requires proof of causation].

[24] *Egan v. Mutual of Omaha Ins. Co.*, *supra*, 24 Cal.3d at page 819.

Under Insurance Code section 11580.2, subdivision (a)(1), applicable to uninsured and underinsured motorist coverage,[25] all policies of bodily injury liability insurance sold in California must insure "the insured . . . for all sums within the limits that [she] shall be legally entitled to recover as damages for bodily injury or wrongful death from the owner or operator of an uninsured motor vehicle." In addition Wilson's UIM coverage states: "OUR PROMISE TO YOU . . . We will pay all sums which a person insured shall be legally entitled to recover as damages from the owner or operator of an [underinsured] motor vehicle because of bodily injury sustained by a person insured [up to the policy limit]." The "sums" which the insured "shall be legally entitled to recover as damages for bodily injury" are "such damages as a California court would award."[26]

Thus, in order to reasonably evaluate an insured's claim under her underinsured motorist protection, the insurer must determine the probable award the insured would receive from a jury if she were to file a negligence action against the other driver. This evaluation would normally take into consideration such factors as the location of the trial and jury verdicts in similar cases in that location. A reasonable evaluation would also take into account subjective values such as the demeanor of witnesses in depositions, any unusual circumstances surrounding the acts of the defendant that caused the injury (e.g., drunk driving) and the ability or inability of witnesses to portray their testimony in a convincing and persuasive manner. As the court noted in *Richardson v. Employers Liab. Assur. Corp.*, "the evidence of the expert witness, an attorney, as to the reasonable settlement value of the claim was clearly relevant to the good faith issue."[27] If this value had approximated the policy limits, the court explained, a jury might have concluded Employers acted in bad faith in not settling the claim for the policy limits without arbitration.

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[25] The term "uninsured motor vehicle" generally includes "underinsured" motor vehicles. (*Quintano v. Mercury Cas. Co.* (1995) 11 Cal.4th 1049, 1053.)

[26] *Ramirez v. Wilshire Ins. Co.* (1970) 13 Cal.App.3d 622, 631.

[27] *Richardson v. Employers Liab. Assur. Corp.*, *supra*, 25 Cal.App.3d at page 242.

We do not believe there should be a per se rule which makes failure to consult a personal injury attorney evidence of bad faith in every underinsured motorist claim. As Wilson pointed out at oral argument there are many experienced claims adjusters who can determine the value of a litigated case as well as can an experienced personal injury attorney. We do emphasize, however, the litigation value of the case is a factor to be considered by the insurer in settling a claim for underinsured motorist coverage and valuation by a claims adjuster without input from experienced trial counsel may be insufficient to discharge the insurer's duty to perform a complete review of the claim.

B. Triable Issues Of Fact Exist As To Whether 21st Century Failed To Objectively Evaluate Wilson's Claim.

Gathering relevant information about the insured's claim would be pointless, of course, if the insurer does not objectively evaluate the information it gathers. For example, in *Mariscal v. Old Republic*, discussed above, the insurer was guilty of bad faith for failing to thoroughly investigate the insured's claim and for ignoring the evidence it did gather which supported the claim.[28]

1. 21st Century's failure to objectively evaluate Wilson's pain and suffering.

21st Century's initial adjustment of Wilson's claim suggests it failed to objectively evaluate her pain and suffering.

As previously noted, the insurer's finding Wilson was suffering solely from a "soft-tissue injury" which was "pre-existing" does not appear to have a basis in the medical reports submitted by Dr. Southern. To the contrary a radiology report prepared a week after the accident and submitted to 21st Century stated an examination of Wilson's

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[28] *Mariscal v. Old Republic Life Ins. Co., supra,* 42 Cal.App.4th at pages 1624-1625.

cervical spine revealed no soft tissue swelling. Furthermore, Dr. Southern's report describes Wilson's condition as "degenerative disk changes as a result of occult disk injury at the levels in the neck from her high speed motor vehicle accident." 21st Century's diagnosis of soft tissue injury seems to have been based on the modest amount of Wilson's medical bills rather than on the medical evidence.

The attorney representing Wilson wrote to 21st Century during the initial evaluation stage informing it that despite her continued pain, "One of Reagan's 'life-long' dreams was to study abroad and Reagan is now in Australia and expected to return in November." In an internal report rejecting Wilson's claim for the UIM policy limit the claims adjuster transformed her study abroad into a "vacation in Australia." Whether this was just an honest mistake or an expression of bias against Wilson is a question for a jury to decide. The claims adjuster also expressed his personal opinion, without consulting Wilson or Dr. Southern, anyone "on vacation in Australia" cannot be suffering from "severe" pain. Obviously, it is as possible to suffer "severe pain" in Australia as in Southern California.

2. 21st Century's failure to use Colossus to assist in evaluating Wilson's damages.

Wilson contends there may be circumstances in which the way an insurer utilizes Colossus or some other computer software program in its claims adjustment practice breaches the covenant of good faith and fair dealing. Therefore, she asserts, the trial court erred in denying her motion to compel the adjuster who initially evaluated her claim to answer questions about the use of Colossus in 21st Century's claims practice.

We agree with Wilson's first contention. However, because there may have been a procedural reason why the trial court denied Wilson's motion to compel, we cannot say the court erred in denying the motion.[29] Instead, because this cause is being remanded to

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[29] No order on the motion to compel is included in the record on appeal. It is clear from the record, however, the trial court denied the motion.

the trial court for other reasons, we will instruct the court to afford Wilson the opportunity to renew her motion, after satisfying statutory requirements.

Colossus is the trade name for a software program which provides insurance companies help in assessing damages in personal injury claims.[30] Each insurer licensing Colossus customizes the program to reflect its own settlement philosophies. Generally "a company will conduct roundtables to 'assess the claim value factors' in an injury claim. The insurance company's most skilled and experienced casualty claims professionals come together to 'evaluate hypothetical injury claims.' Next, the insurance company may conduct a closed study to compare the baseline values determined by the roundtables to its claims practice history. The insurer uses both the closed claim study and the roundtables to assign values to injury severity."[31] Once Colossus is programmed to reflect the insurer's "settlement philosophies"[32] its claims adjusters can evaluate an injury. After the adjuster enters all diagnosed and accident related injuries Colossus guides the adjuster through a series of questions regarding the treatment, prognosis, pre-existing conditions, and symptoms of the injury as well as questions about the claimant such as her pre-accident interests and hobbies and her ability to continue those activities.[33] Once all the data has been entered Colossus assigns severity points to the injury. Then, using the insurance company's information regarding the value of injuries, Colossus recommends a value for the injury claim. The claims adjuster uses this information as a guide in determining the settlement value of the claim.[34]

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[30] Bonnett, The Use Of Colossus To Measure The General Damages Of A Personal Injury Claim Demonstrates Good Faith Claims Handling (2005) 53 Clev. St. L. Rev. 107, 110. (Hereafter Bonnett.)

[31] Bonnett, *supra,* at pages 111-112, footnotes omitted.

[32] Bonnett, *supra,* at page 111.

[33] Bonnett, *supra,* at page 112.

[34] Bonnett, *supra,* at page 112.

Proponents of Colossus stress it is properly used only as a guide to determining the value of a claim; it is not a robotic claims adjuster.[35] When used as a guide, however, it can help insurance companies avoid bad faith suits by making sure the claims adjuster has performed due diligence in the assessment of the claim.[36] Proper use of Colossus requires the claims adjuster to examine and enter all medical records, the injury's prognosis, the type of treatment the claimant has received, the future treatment the claimant will need, the amount of time the claimant will need medical care or living assistance, the claimant's economic damages.[37] Furthermore, by comparing the settlement values suggested by Colossus with past and present settlements actually paid company management can assess whether the company is making fair and consistent payments in cases with similar circumstances.[38] One insurance industry evaluation of Colossus observes its ability to assist the insurer to produce consistent and reasonable evaluations of bodily injury claims "is particularly important in the area of uninsured and underinsured motorist claims that tend to draw a significant number of bad faith claims on the basis of the allegation that the claim professional has erroneously undervalued the bodily injury portion of the claim."[39] Colossus also helps insurers steer clear of bad faith claims by "training new adjusters in the proper techniques for evaluating bodily injury

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[35] Bonnett, *supra,* at pages 123, 132; Barker & Love, Bad Faith Risk Reduction:Company Procedures (2001) Vol. 23 Nos. 20 & 21 Ins. Litig. Rep. 645**,** 653**.** (Hereafter Barker & Love.) In *Meier v. Aetna Life & Cas. Standard Fire Ins.* (Ill.App. 1986) 500 N.E.2d 1096, 1098, 1101 the court upheld a verdict of bad faith where the insurer refused to budge from the value of the insured's car as determined by a computer program even though the insurer's claims adjuster could not explain how the program arrived at an automobile's value. But in *Kosierowski v. Allstate Ins. Co.* (E.D.Pa. 1999) 51 F.Supp.2d 583, 595 the court granted summary judgment to the insurer in a bad faith case where the evidence showed the claims adjuster used Colossus in calculating the plaintiff's claim but did not rely on the result in making his settlement offer.

[36] Bonnett, *supra,* at pages 116-125; Barker & Love, *supra,* at pages 652-653.

[37] Bonnett, *supra,* at pages 122-125.

[38] Bonnett, *supra,* at page 132.

[39] Barker & Love, *supra,* at page 652.

claims. The data input function of Colossus forces the trainee to focus on all of the important information necessary to properly evaluate the value of a bodily injury claim."[40]

During the deposition of Paul Le, the adjuster who first handled Wilson's claim, counsel for 21st Century directed Le not to answer any questions about the role Colossus plays in 21st Century's claims practice. He based his objection on the ground Le did not use Colossus in evaluating Wilson's claim and therefore questions about Colossus were irrelevant and speculative. These objections lacked merit.

Deposition questions are not objectionable on the ground the answers might be excluded at trial. Under Code of Civil Procedure section 2017.010 a party is entitled to discovery "regarding any matter, not privileged, that is relevant to the subject matter involved in the pending action or to the determination of any motion made in that action, if the matter either is itself admissible in evidence or appears reasonably calculated to lead to the discovery of admissible evidence." This statute has been liberally construed to mean "[i]n the context of discovery, evidence is 'relevant' if it might reasonably assist a party in evaluating its case, preparing for trial, or facilitating a settlement."[41]

Because this bad faith case turns on whether the insurer failed to reasonably investigate and evaluate the insured's claim, the insurer's claims handling practices are certainly a matter subject to discovery.[42] If good practice points toward the use of Colossus in underinsured motorist claims[43] the fact Le did not use Colossus in evaluating Wilson's claim does not render irrelevant 21st Century's guidelines with respect to the

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[40] Barker & Love, *supra,* at page 652.

[41] *Glenfed Development Corp. v. Superior Court* (1997) 53 Cal.App.4th 1113, 1117.

[42] *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 627.

[43] See discussion at page 15, *ante*; Barker & Love, *supra,* at pages 652-653

use of Colossus.[44] On the contrary Le's failure to use Colossus may be as important in this case as the dog's failure to bark in the famous Sherlock Holmes case of "Silver Blaze."[45] It would certainly be "relevant" to know whether Le's failure to use Colossus violated company policy and if so the frequency with which Le violated that policy.[46]

21st Century argued in the trial court, as it does on appeal, Wilson's motion to compel was fatally flawed because she failed to "meet and confer" with 21st Century prior to filing the motion.[47] Wilson does not dispute this failure.

It is particularly important in this case the parties meet and make a good faith attempt to resolve the scope of discovery regarding the use (or nonuse) of Colossus. Some of this information may be privileged or proprietary business information subject to trade secret protection or not discoverable for some other reason. We suggest the parties and the trial court consult *York v. Hartford Underwriters Insurance Company*, a federal district court ruling on the parameters of Colossus discovery.[48]

C. The Undisputed Facts Show There Was No Unlawful Offset Of Wilson's Medical Payments Coverage Against Her Underinsured Motorist Coverage.

When 21st Century initially adjusted her claim, Wilson contends, it unlawfully offset the benefits due her under the medical payments portion of her policy against the

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[44] See *Silberg v. California Life Ins. Co.* (1974) 11 Cal.3d 452, 462 (insurer's deviation from custom in the industry is relevant to determining whether insurer breached its duty of good faith and fair dealing).

[45] Doyle, "Silver Blaze" (1967) The Annotated Sherlock Holmes 260, 281.

[46] See *Colonial Life & Accident Ins. Co. v. Superior Court* (1982) 31 Cal.3d 785, 791 (frequency of unfair settlement practices "highly relevant" to plaintiff's claim for punitive damages).

[47] Code of Civil Procedure section 2025.480, subdivision (b) states a motion to compel "shall be accompanied by a meet and confer declaration[.]"

[48] *York v. Hartford Underwriters Insurance Company* (N.D.Okla. 2002) WL 31465306.

benefits due her under the underinsured motorist portion of her policy. In other words, because 21st Century initially valued her personal injury damages from the accident at $20,000 she should have received $25,000 in total—$15,000 from the other driver's insurer, $5,000 from 21st Century under her underinsured motorist coverage for her pain and suffering and $5,000 under her medical payments coverage to cover her medical bills.

An insurer which unreasonably interprets a policy provision or a statute governing a policy provision may be liable in tort for breach of the covenant of good faith and fair dealing.[49] In the present case, however, 21st Century abided by Insurance Code section 11580.2, subdivision (e) and the terms of its policy in offsetting Wilson's medical payment benefits against her total personal injury damages.

Insurance Code section 11580.2, subdivision (e) states: "The policy or endorsement added thereto may provide that if the insured has valid and collectible automobile medical payment insurance available to him or her, the damages that the insured shall be entitled to recover from the owner or operator of an uninsured motor vehicle shall be reduced for purposes of uninsured motorist coverage by the amounts paid or due to be paid under the automobile medical payment insurance." Wilson's policy contains such a provision. It states: "The damages which a person insured is entitled to recover from the owner or operator of an uninsured motor vehicle shall be reduced by the amounts paid or due to be paid under any valid and collectible automobile medical payments insurance available to such person insured."

The crucial word in understanding these provisions is "damages." The amount paid under the insured's medical payments coverage is set off against the damages the insured would be entitled to recover from the underinsured driver, not against the "loss payable" by the insured's insurer, (i.e. the policy limit). For example, assume A carries $100,000 in underinsured motorist coverage and $5,000 in medical payments coverage. A's reasonably evaluated damage for bodily injury, including medical bills, is $103,000.

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[49] *Moore v. American United Life Ins. Co.*, *supra*, 150 Cal.App.3d at page 638.

The $5,000 in medical payment coverage is set off against A's total claim of $103,000 not against his policy limit of $100,000 so that A's net award is $98,000, not $95,000.[50] Next, assume B only carries $30,000 in underinsured motorist coverage and $5,000 in medical payments coverage and her total bodily injury damage, including medical bills, is $120,000. B receives the full $30,000 under her UIM coverage, not $25,000 because the medical payments coverage is offset against her total damage, not against her UIM policy limit.[51]

In the case before us the claims adjuster, Le, during his deposition testified he placed a total value on Wilson's claim of $20,000 which included her pain and suffering, inconvenience and her medical bills. Asked by Wilson's counsel why Wilson was not entitled to the $15,000 from the other driver's insurer, another $5,000 from 21st Century to reach $20,000 and then an additional $5,000 payment under her medical payments coverage Le replied: "In valuing the claim, $20,000 is the evaluation. She has the $15,000 from [the other driver's] policy, which she has already received. Our med pay policy is, as it says, a permissible offset. So the $20,000 is reduced from the damages."

When 21st Century subsequently reevaluated Wilson's claim after it determined she would need surgery it determined the total value of her damages equaled or exceeded $105,000 which is why Wilson received a payment of $85,000 under her underinsured motorist coverage instead of $80,000.

D. Conclusion

For the reasons discussed in Subparts A and B above we conclude there exist triable issues of fact from which a reasonable jury could but not necessarily would find

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[50] California Uninsured Motorist Practice (Cont. Ed. Bar 2d ed. 2005) Section 1.76, page 62.1.

[51] Croskey et al., California Practice Guide, Insurance Litigation (2005) Section 6:2238, page 6G-30.

21st Century breached its duty of good faith and fair dealing in adjusting Wilson's claim. These triable issues preclude summary adjudication as to her bad faith cause of action.

II. TRIABLE ISSUES OF FACT EXIST AS TO WHETHER 21ST CENTURY BREACHED ITS CONTRACTUAL DUTY OF GOOD FAITH AND FAIR DEALING IN ADJUSTING WILSON'S CLAIM TO UNDERINSURED MOTORIST BENEFITS.

The same acts which constitute tortious bad faith in the handling of an insured's claim may also constitute a breach of the duty of good faith and fair dealing implied in every contract.[52] Therefore, triable issues of fact exist as to Wilson's breach of contract cause of action for the reasons discussed in Part I, above.

21st Century argues Wilson cannot recover on a breach of contract action because she suffered no damages—she received the full amount due under the policy. Wilson responds she did suffer damage because she lost the use of the money she would have received had her claim been properly investigated and evaluated when it was first presented.

As a general rule an insured has no right to prejudgment interest on an unliquidated claim.[53] A trial court has discretion, however, to award prejudgment interest based on such factors as the length of delay in payment, the prevailing interest rates during the delay, rejection of the plaintiff's settlement offers and principles of equity and fairness.[54] On the basis of the record before us we cannot say as a matter of law it would be an abuse of discretion for the trial court to award prejudgment interest in this case.

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[52] *Egan v. Mutual of Omaha Ins. Co.*, *supra*, 24 Cal.3d at pages 814-815, 817.

[53] *Bear Creek Planning Com. v. Title Ins. & Trust Co.* (1985) 164 Cal.App.3d 1227, 1247.

[54] Civil Code section 3287, subdivision (b); *A & M Produce Co. v. FMC Corp.* (1982) 135 Cal.App.3d 473, 496-497.

We conclude therefore 21st Century was not entitled to summary adjudication of Wilson's cause of action for breach of contract.

III. THE UNDISPUTED FACTS ARE INSUFFICIENT TO SUPPORT AN AWARD OF PUNITIVE DAMAGES BUT WILSON IS ENTITLED TO CONDUCT ADDITIONAL DISCOVERY.

A plaintiff may recover punitive damages against a defendant if the plaintiff proves by clear and convincing evidence "the defendant has been guilty of oppression, fraud or malice[.]"[55]

"'Oppression' means despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights."[56] "'Malice' means conduct which is intended by the defendant to cause injury to the plaintiff or despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others."[57] Under the plain language of the statute oppression and malice require more than just conscious disregard for the rights of the insured; the insurer's conduct must be intended to cause injury or "despicable." As our Supreme Court observed in *College Hospital, Inc. v. Superior Court*, "the adjective 'despicable' is a powerful term that refers to circumstances that are 'base,' 'vile,' or 'contemptible.' [Citation.]"[58] From our de novo review of the record we find no evidence from which a reasonable trier of fact could conclude 21st Century, or any of its employees, intended to cause Wilson injury or engaged in "despicable" conduct. We recognize there are older cases in which awards of punitive damages were upheld based solely on the insurer's failure to thoroughly investigate and evaluate the insured's claim but those cases involved

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[55] Civil Code section 3294, subdivision (a).

[56] Civil Code section 3294, subdivision (c)(2).

[57] Civil Code section 3294, subdivision (c)(1).

[58] *College Hospital, Inc. v. Superior Court* (1994) 8 Cal.4th 704, 725.

judgments entered before the 1987 amendment to the statute adding the requirement the conduct be "despicable."[59] Those cases are no longer reliable precedent.[60]

"'Fraud' means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury."[61] It might be argued claims adjuster Le's statements Wilson suffered merely "soft tissue injury" coupled with "pre-existing degenerative disc disease" constituted intentional misrepresentations of fact. Properly understood, however, these statements were expressions of Le's opinions which a jury could reasonably find resulted from Le's failure to thoroughly investigate and evaluate Wilson's injury.

In light of the evidence before us 21st Century would be entitled to summary adjudication on the issue of punitive damages and normally we would instruct the trial court to make such an order. However, as discussed above, Wilson has not had an opportunity to conduct discovery into 21st Century's policy and practice in the use of Colossus in evaluating bodily injury claims.[62] Such discovery could lead to admissible evidence supporting an award of punitive damages but come too late for Wilson to move for reconsideration of the summary adjudication order.[63] Therefore, we will not direct the trial court to grant summary adjudication on the issue of punitive damages but instead instruct the court to afford Wilson the opportunity to renew her motion to compel discovery regarding Colossus consistent with the views expressed above.[64]

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[59] See e.g., *Hughes v. Blue Cross of Northern California*, *supra,* 215 Cal.App.3d at page 846.

[60] See *College Hospital, Inc. v. Superior Court*, *supra,* 8 Cal.4th at page 725.

[61] Civil Code section 3294, subdivision (c)(3).

[62] See discussion at pages 13-16, *ante*.

[63] Code of Civil Procedure section 1008, subdivision (a) allows only 10 days for a party affected by an order to request reconsideration based on new facts.

[64] See discussion at pages 13-16, *ante*.

DISPOSITION

The judgment is reversed and the cause is remanded to the trial court with directions to permit plaintiff to renew her motion to compel discovery and thereafter to proceed in accordance with law and the views expressed in this opinion.

Appellant is awarded her costs on appeal.

CERTIFIED FOR PUBLICATION

JOHNSON, Acting P. J.

We concur:

WOODS, J.

ZELON, J.