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Keep digging

UTILIZING COLONIAL LIFE DISCOVERY IN AN INSURANCE BAD-FAITH CASE

Insurance breach-of-contract and bad-faith cases tend to raise a host of discovery issues – the claim and underwriting manuals and files, the conduct of the adjuster or insurer in valuing the claim, the process behind a decision to tender a policy or make a settlement offer, and so on. Insurers tend to be keenly aware that the narrower they can make a case – any problematic conduct is limited to *this* insured about *this* issue – the lower their potential exposure. Yet, for companies so highly regimented, their conduct tends to extend well beyond the insured at issue.

One way to push back – and one of the best ways to get a greater understanding of the insurer's conduct and provide yourself with the best leverage regarding the insurer's bad faith – is to conduct targeted discovery under *Colonial Life & Accident Ins. Co. v. Superior Court* (1982) 31 Cal.3d 785. *Colonial Life* and its progeny have repeatedly held that discovery into the claim files of *other insureds* can be relevant to a variety of topics, including: (1) to show insurer bad faith (past misconduct by the claims representative and the insurer's knowledge of that issue); (2) to clarify an ambiguity in the policy (such as how the insurer interpreted the term in question in other cases); (3) to show the insurer's knowledge of particular facts or relevant legal standards (such as the proper standard for determining an issue under the policy); or (4) to show a basis for punitive damages, including the insurer's course of conduct and policies/procedures that leads to a finding of malice, oppression, or fraud.

The purpose of this article is to provide an overview of *Colonial Life*, the mechanics of such discovery, and how to best position your matter for success to conduct the kind of discovery that often magnifies the value of your case.

An overview of *Colonial Life*

In *Colonial Life*, the insured was a teacher who maintained an accident policy with Colonial Life & Accident Insurance Company. During a PTA meeting, a student stepped on her big toe – within weeks, she was hospitalized with a progressive infection, and her foot (and eventually her leg) had to be amputated.

Colonial Life, through its adjuster, claimed the amputation was not covered and offered 15% of the maximum applicable benefit, contingent on surrender of the policy. The insured rejected the offer and sadly passed away without receiving any benefits. Her estate brought an action against the insurer and its claims adjuster for breach of contract, breach of the duty of good faith and fair dealing (bad faith) and the formerly available private cause of action under Insurance Code section 790.03, subdivision (h).

During discovery, the plaintiff served a request for production to "copy all documents pertaining to cases handled" by the individual adjuster who sent the lowball settlement offer. Based on objections for relevancy, overbreadth, and the Insurance Information and Privacy Protection Act (Ins. Code, §§ 791.01 et seq.), the trial court granted a motion to compel. Its order required the adjuster to produce the names and addresses of all persons whose claims for benefits under Colonial's policies were assigned to that adjuster for settlement (about 35 in all), with the trial court approving a letter to be sent by *plaintiff's counsel* to these other insureds requesting consent to the release of records. Although the parties and counsel were prohibited from contacting other insureds pending their response to the letter, they were allowed to contact those who responded.

The matter eventually made its way to the California Supreme Court, which rejected Colonial's contentions and ordered the discovery to take place. The Court noted that Colonial's suggestion that the information regarding other insureds was not relevant was "patently meritless." (*Id.* at 790.) Instead, Insurance Code section 790.03, subdivision (h) prohibits insurers from "[k]nowingly committing or performing with such frequency as to indicate a general business practice," a variety of unfair claims practices, including 16 enumerated examples, such as: (1) misrepresenting pertinent facts or policy provisions; (2) failing to acknowledge and act reasonably promptly upon communications; (3) failing to adopt standards for prompt investigation and processing of claims; (4) failing to affirm or deny coverage of claims within a reasonable time; (5) failing to attempt to effectual prompt, fair, and equitable settlements of claims; (6) lowball settlement offers and compelling insureds to institute litigation; and others. Based on that statute, and the "general business practice" language, "[d]iscovery aimed at determining the frequency of alleged unfair settlement practices is therefore likely to produce evidence directly relevant to the action." (*Colonial Life, supra,* 31 Cal.3d at 791.)

Although section 790.03 no longer provides a *direct* right of action against insurers for unfair claims settlement practices (*Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal.3d 287, 304, 313), statutory violations may still evidence a *lack of reasonableness* by the insurer in handling the insured's claim. (*Rattan v. USAA* (2000) 84 Cal.4th 715, 724; *Spray, Gould & Bowers v. Associated Int'l Ins. Co.* (1999) 71 Cal.App.4th 1260, 1271, fn. 10 [regulations may establish "prudent norms and customs, and standards of care"].) Thus, the reasoning of *Colonial Life* – that the frequency of an insurer's conduct in violation of the standards for fair claim settlement practices is *relevant* to show a general business practice and thus bad faith – still permits the inquiry into the claim files of *other* insureds to demonstrate bad faith.

As one federal court remarked, "*Colonial Life* has been followed ... by California state courts considering not only claims under § 790.03 of the Insurance Code but also common law 'bad faith' claims," and thus "the

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reasoning in *Colonial Life* applies whether bad faith is alleged under a statute or under a common law theory." (*J & M Assoc., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA* (S.D. Cal. Mar. 4, 2008) 2008 WL 638137, at *5 [citing cases]; see also *Dobro v. Allstate Ins. Co.* (S.D. Cal. Sept. 2, 2016) 2016 WL 4595149, at *5 ["In this case, Plaintiffs allege [common law] bad faith by Defendant for wrongful denial of a homeowners' insurance water loss . . . As such, the Court will examine Plaintiffs' discovery request in light of the principles and procedures articulated in *Colonial Life*."].)

In addition to demonstrating bad faith under either statutory or common law, *Colonial Life* held that "[o]ther instances of alleged unfair settlement practices may also be *highly relevant* to plaintiff's claim for punitive damages." (*Colonial Life, supra,* 31 Cal.3d at 791-792 (emphasis added).)

Specifically, "[i]ndirect evidence of the elements of punitive damages [oppression, fraud, or malice, including the conscious disregard of the plaintiff's rights] may be suggested by a pattern of unfair practices." (*Id.* at 792.) Information regarding other insureds could be relevant to a "conscious course of conduct, firmly grounded in established company policy," or to prove a "nefarious scheme to mislead and defraud thousands of policyholders," in order to justify punitive damages. (*Ibid.* citing *Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 923, *Delos v. Farmers Ins. Grp.* (1979) 93 Cal.App.3d 642, 664.)

Finally, evidence regarding previous dealings with other insureds could be "relevant to prove ratification or authorization" by the insurer of unfair acts. (*Colonial Life, supra,* 31 Cal.3d at 792, fn. 9.)

In sum, and "without doubt," the "names, addresses and files of other Colonial claimants with whom [the adjuster] attempted settlements is relevant to the subject matter of this action and may lead to admissible evidence." (*Id.* at 792.)

Acceptable uses of *Colonial Life* discovery

As discussed above, *Colonial Life* held that other insureds' claim information may be relevant to two circumstances: (1) showing a general business practice that may violate standards for fair claim settlement practices (i.e., as evidence of an insurer's bad faith); and (2) as evidence that may be "highly relevant" to a claim for punitive damages. (*Id.* at 790-792.) But other circumstances may also warrant discovery into other insureds' claim files.

First, the claim files of other insureds may be relevant to clarify an ambiguity in an insurance policy. For example, in *Carey-Canada, Inc. v. California Union Ins. Co.* (D. DC 1986) 118 FRD 242, 244, the district court was considering asbestos-related litigation where the plaintiff sought discovery into other insureds' policies regarding asbestosis and asbestos-related exclusions sold by the defendant insurers. The insurer's objection regarding relevance was found to be "meritless" as courts, including the California Judicial Council Coordination Proceeding No. 7072 (*In re Asbestos Insurance Coverage Cases*) had found the information "relevant and discoverable," as it bears on the "significance of industry usage in the interpretation of insurance contracts." (*Ibid.*)

Notably, "evidence of usage is admissible to explain a clause in a contract of insurance . . . where ambiguous words are employed." (*Ibid.*, quoting 13 J. Appleman & J. Appleman, Insurance Law & Practice § 7388 (1976).) This dovetails with California decisions finding that, where an ambiguity might be present, "[e]vidence of an insurer's representations about or interpretations of a policy term [are] generally discoverable as relevant to the contracting parties' intent." (*Ivy Hotel San Diego, LLC v. Houston Cas. Co.* (S.D. Cal. Oct. 20, 2011) 2011 WL 13240367, at *3-4 ["Discovery of other insureds' claims files is relevant to show the insurer's interpretation of the policy language at issue."], citing *Kavruck v. Blue Cross of Cal.* (2003) 108 Cal.App.4th 773, 782-83 [permitting discovery of extrinsic evidence regarding ambiguous term]; *Glenfed Dev. Corp. v. Superior Court* (1997) 53 Cal.App.4th 1113, 1118-19 [claims manual was discoverable as extrinsic evidence of insurer's expectations that may be relevant at trial]; see also *Pac. Hide & Fur Depot v. Great Am. Ins. Co.* (D. Mont. July 31, 2013) 2013 WL 11029340, at *3 ["[T]his Court finds that claims between Defendant and other insureds with policies similar to Plaintiff's policy [are] relevant and discoverable."].)

Second, such information may be relevant to show an insurer's knowledge of particular facts or relevant legal standards. For example, in *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, the insured was permitted to introduce evidence of *other* disability claims presented to the defendant, to show that the insurer "used deceptive and misleading claims review procedures" to determine "disability." (*Id.* at 621.) Namely, the other disability claims were used to show that the insurer was aware that its definition of "total disability" – and its method for determining that disability – were at variance with California law when it denied the plaintiff's claim. (*Ibid.*) The appellate court ultimately agreed with the trial court that evidence of other insurance claims was relevant to show "certain claims handling practices" of the insurer and that such claims practices were misleading. (*Id.* at 627.)

Although California law is somewhat sparse, federal decisions have repeatedly affirmed and expanded upon some of these relevant lines of discovery. For example, in *Van Duyn v. American Securities Ins. Co.* (C.D. Cal. April 14, 2009) 2009 WL 10672575, the plaintiff sought contact information for other individuals whose claims were handled by the three adjustors who allegedly mishandled the plaintiff's claim. (*Id.* at * 1.)

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In *Elkin v. New York Life Ins. Co.* (C.D. Cal. Sept. 8, 2017) 2017 WL 4047235, the plaintiff alleged that the insurance company breached its duty of good faith and fair dealing in denying claims submitted by insureds with a Russian background who received long-term care services from a specified home health care company. In support of her request for the claims file of each insured whose claim for long-term care benefits from that company was denied by the defendant, the plaintiff submitted the declaration of the company's operator. That declaration set forth facts suggesting a possible pattern of denial of long-term care benefits to Russian clients. (*Id.* at *1-2.)

Finally, in *J & M Associates, Inc.*, 2008 WL 638137, at * 5, the court ordered discovery "insofar as the requests seek information pertaining to the same type of policy at issue in this case, i.e., Staffing Services Liability policies."

Overcoming common insurer objections

Asking for *Colonial Life* discovery is sure to engender at least one thing – a motion to compel. Insurers are loath to produce this information voluntarily, no matter how limited or restricted or redactable the request. But with careful planning – making sure your complaint includes allegations that dovetail with such discovery, tailoring the requests to specific policies, procedures, adjusters, or other relevant considerations, and making the requests *early* in the litigation, to allow time for the procedure to play out – this vital discovery should be well within reach.

Insurer: Relevancy

Although the scope of discovery is well known (Code Civ. Proc., § 2017.010 – allowing discovery into "any matter . . . that is relevant to the subject matter involved in the pending action . . . if the matter either is itself admissible in evidence or appears reasonably calculated to lead to the discovery of admissible evidence"), insurers will protest that *any* discovery into other insureds' claim files seeks irrelevant material.

In addition to demonstrating the discovery falls into at least one of the four areas of inquiry discussed above, the allegations in your pleadings will become extremely important. For example, are punitive damages focused on "company practice," or ratification of malicious conduct, or a plausible nefarious scheme of insurer conduct alleged? How does the complaint plead the allegations of bad faith?

One case found sufficient allegations to engage in *Colonial Life* discovery where the complaint alleged that the insurer breached the implied covenant of good faith and fair dealing by "engaging in a *course of conduct* calculated to: (a) avoid obligations and duties under the applicable insurance policy ..." and that the insurer's conduct was "purposeful, conscious, and deliberate," and that such actions (refusing to investigate, provide coverage, etc.) are all part of a "*pattern and practice and consistent course of conduct*." Finally, the complaint further alleged the insurer had advance knowledge of its employees' "*pattern and practice* of wrongful refusal to pay covered claims," engaged in conduct "designed and calculated to deprive" plaintiff of benefits," and engaged in such acts with fraud and malice. (*Worth Bargain Outlet, Inc. v. AMCO Ins. Co.* (S.D. Cal. Mar. 24, 2010) 2010 WL 11508880, at *2 (emphasis added); see also *Kahlenberg v. Bamboo IDE8 Ins. Servs., LLC* (C.D. Cal. May 19, 2021) 2021 WL 8693114, at *4 [discussing the "pattern and practice of denying claims for specious reasons" in the First Amended Complaint].)

Be certain when drafting your complaint to include such allegations of course of conduct, pattern and practice, punitive damages, or whatever conduct may provide an insight into other insureds' claims experiences. This is particularly necessary with so many bad-faith cases being removed to federal court – heightening the necessity of artful pleading.

With careful drafting of your complaint, and knowing that *Colonial Life* discovery will be necessary and helpful to the litigation, you can front run a lot of these relevance issues to give you clear hooks to conduct the discovery.

Insurer: Unduly burdensome and oppressive

Another objection you will see essentially every time you serve *Colonial Life* discovery is that such discovery will be unduly burdensome and oppressive. But the insurer must show more than just burden, as all discovery imposes some burden, with the required showing amount to "the burden is incommensurate with the result sought." (*West Pico Furniture Co. v. Superior Court* (1961) 56 Cal.2d 407, 417.)

One of the primary cases on this subject with respect to other insureds' claim files is *Mead Reinsurance Co. v. Superior Court* (1986) 188 Cal.App.3d 313, 317. In *Mead*, the insured sought the production of "every claim similar to the claim at issue in this action relating to alleged damages to privately owned real property . . . under general liability and umbrella policies of insurance issued by Defendant Mead to governmental entities similar to those policies at issue in this action" for a period of approximately 6.5 years.

The insurer objected on the basis of an uncontroverted declaration that claimed such a production would involve hand-sorting and manual evaluation of over 13,000 claim files then open (and more in existence over the period sought) to determine which are property claims subject to the request. The insurer estimated it would take at least 1,000 man-hours to complete the task and would shut down its claims office for more than five weeks. (*Id.* at 318.) The trial court nevertheless granted the motion and gave the insurer 180 days to comply. A writ petition followed.

The appellate court ultimately found the discovery to be oppressive, finding "in view of the specific details of what would face Mead in its efforts to comply with the order, there is no question but what was ordered here, without more, falls on the side of oppression." (*Id.* at 321.) Essentially, Mead made a showing

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"of the massive extent of the burden," with the trial court making "no provision at all to mitigate that burden." (*Ibid.*; see also *Ricotta v. Allstate Ins. Co.* (S.D. CA 2002) 211 F.R.D. 622, 624 [refusing to order the discovery of "*every* report" prepared by insurer's expert because they had questionable probative value and would require examination of over 50,000 files].)

What *Mead* instead ordered was the insurer to produce the names and addresses of all public-entity claimants who opened claims with Mead during the specified time period. Plaintiff then was to prepare a letter (approved by the court) to be sent to all claimants, asking for authorization to view the contents of their claim files. For those who consented, plaintiff was then entitled to inspect and copy those files at the offices where they are maintained. (*Id.* at 323.) This essentially shifted the burden to the insured to conduct whatever review they felt necessary for the other insureds who provided authorization.

One point is made clear by *Mead* – think about conducting discovery (most likely a PMK deposition of the insurer) *before* you serve your *Colonial Life* discovery into topics including how the insurer maintains its claim files and filing systems. The information may enable you to tailor your discovery request to limit claims of oppression, such as with respect to how the insurer keeps electronic records, what "fields" are recorded and easily accessible, or what systems and searchability is available to fulfill any discovery request.

If nothing else, be sure to immediately depose any declarant the insurer might present in support of its claims of oppression, as such testimony will be highly relevant to how the court might ultimately rule on the motion to compel. (*Dobro, supra,* 2016 WL 4595149, at *9 ["The Court notes however that Plaintiffs are entitled to conduct discovery to investigate the statements contained in [insurer's] declaration and/or to determine the capabilities of Defendant's computer system"]; *J&M Associates, supra,* 2008 WL 638137, at *6 [noting plaintiff could depose insurer's personnel "regarding the organization and location of the other claims files."].)

Insurer: Privacy objections

Insurers will often claim that privacy objections may alter (and extend) the procedure for obtaining this information. The Insurance Information and Privacy Protection Act (Ins. Code, § 791.01 et seq.) creates a right of privacy with respect to consumer files, and in particular claims files maintained by insurance companies. (Ins. Code, § 791.13.) The Act provides that an insurance institution, agent, or insurance-support organization "shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction" *unless* one of a number of exceptions applies. (*Ibid.*)

Those exceptions include disclosure that is "otherwise permitted or required by law," (791.13(g)), "in response to a facially valid administrative or judicial order, including a search warrant or subpoena," (791.13(h)), or "with the written authorization of the individual." (791.13(a).) Be certain to consider what *type* of entity you are seeking records from, as the Act only applies to insurers and their agents – you may be able to locate relevant records from public adjusters or others to whom the act may not extend. (*RG Abrams Ins. V. L. Offs. Of C.R. Abrams* (C.D. Cal. July 1, 2022) 2022 WL 3133293, at *21.) And you may have success asserting the *subpoena* exception if the entity from whom discovery sought is a third party – avoiding the lengthy process discussed below.

Colonial Life recognized the more traditional approach to avoiding the Act's privacy protections – consent from the other insureds to view their claim files. Namely, *Colonial Life* recognized that section 791.13 "contains a number of exceptions" including the release of other insured information where the insured provides their written authorization that is dated, signed, and obtained one year or less before the date disclosure is sought. (31 Cal.3d at 792, fn. 10.) The Court found that the "procedure for contacting other claimants approved by the trial court [a letter drafted by plaintiff's counsel, sent to the insureds requesting authorization] should satisfy these requirements . . . ." (*Ibid.*; see also *Mead, supra,* 188 Cal.App.3d at 323 [utilizing the same procedure as *Colonial Life*, even for a much greater number of insureds].)

Decisions have generally not described the contents of this letter. But we have had success in the past with letters that follow a basic format (to be approved by the court): (1) a brief description of our office and the facts of the case at issue; (2) the discovery sought *and* the court's approval of the discovery and the letter; (3) why we are seeking their authorization and the limited use their records might yield; and (4) an easy form in order to provide their consent, with preaddressed, postage-provided envelopes to make returns as easy as possible. *Do not* let the insurer try to convince the court that they should provide or draft the notice, as it is likely you will receive a *far* lower response rate.

Following judicial approval, provide that disclosure will happen one year from the date the letter is sent, so that you comply with section 791.13. Be aware, courts have routinely prohibited contact with insureds *other than* via the letter, unless they have returned their signed authorization.

This extensive procedure is why it is so crucial to be cognizant of, and to begin the process on *Colonial Life* discovery, so early in the case – it usually takes in excess of a year from first sending the discovery requests to the insurer before you can get access to the information (even longer with courts' impacted calendars and independent discovery conference requirements). This is extended further if you take discovery on how the insurer stores its claim files before beginning *Colonial Life* discovery. In any event, start early!

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Insurer: Privilege

Although normally not raised by the procedure adopted by *Colonial Life* and *Mead*, collection of other insureds' names and addresses *could* infringe on privilege concerns that might hamper your discovery efforts. For example, in *Pollock v. Superior Court* (2001) 93 Cal.App.4th 817, 821, the court rejected *Colonial Life* discovery "because the disclosure of the names would reveal not only the identity of the claimants but also the nature of their ailments ('psychiatric disability')" and so would violate the psychotherapist-patient privilege, which "cannot be waived by the insurer." (*Id.* at 821; Evid. Code, §§ 912, 992.) This issue is rare but could be cause for concern depending on the type of policy, and in particular certain types of disability, health, life, or accidental death & dismemberment policies might cause privilege issues that require extra care in drafting and pursuing *Colonial Life* discovery.

Closing thoughts

Colonial Life discovery can be a complicated, yet powerful, tool in proving your bad faith case against a wayward insurer. But it takes careful planning, in how the case is pled and framed, in how the discovery is drafted, even in whether and how to pursue discovery of an insurer's document management systems. Nevertheless, start early and keep digging – for more than 40 years, the California Supreme Court has found this to be highly relevant and important evidence of insurer bad faith.

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