

Not Reported in F.Supp.2d, 2001 WL 210685 (C.D.Cal.)
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United States District Court, C.D. California.
Title: Cedric BENTON and Lucille Knight

v.

ALLSTATE INSURANCE CO., a corporation; Ray Casazza, an individual; DeLynn Thompson, an individual; Bill Davison, an individual; and Does 1–50, Inclusive

No. CV–00–00499.
Feb. 26, 2001.

Matthew J. Matern, Paul J. Weiner, Plaintiff Counsel Present.

Peter Klee, Defendant Counsel Present.

PROCEEDINGS: DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AGAINST
PLAINTIFF BENTON (filed Nov. 22, 2000)

PLAINTIFF BENTON'S *EX PARTE* APPLICATION TO CONTINUE THE SUMMARY
JUDGMENT HEARING (filed Feb. 16, 2001)

SNYDER, District J.

I. BACKGROUND

*1 This case arises from alleged bad-faith “lowballing” by a provider of automobile insurance in offering to settle the claims of two insureds. Plaintiffs Cedric Benton and Lucille Knight filed the complaint in Los Angeles Superior Court on December 8, 1999. The complaint names as defendants Allstate Insurance Co., Ray Casazza, DeLynn Thompson, Bill Davison and Does 1–50, and alleges the following claims for relief: (1) breach of the covenant of good faith and fair dealing implied in the insurance contracts, against Allstate; (2) conspiracy to defraud, against the individual defendants; (3) violation of Cal. Bus. & Prof Code § 17200, against all defendants; and (4) professional negligence, against the Doe defendants. The complaint prays for damages, injunctive relief, and attorney's fees and costs. By order issued March 22, 2000, the Court dismissed the individual defendants from this action, effectively eliminating the second claim for relief. No actual defendants have been substituted for the Doe defendants against whom the fourth claim for relief is advanced. By order issued June 5, 2000, the Court granted Allstate's motion to sever the two defendants and conduct separate trials.

The parties are now before the Court on Allstate's motion for summary judgment against Benton. The instant motion is not directed against defendant Knight. On February 16, 2001, Benton filed an *ex parte* application to continue the hearing on the summary judgment motion in order to permit additional discovery pursuant to Fed.R.Civ.P. 56(f). For the reasons set forth below, the motion for summary judgment is granted and the Rule 56(f) request for a continuance is denied.

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II. STANDARD FOR SUMMARY JUDGMENT

Summary judgment is appropriate where “there is no genuine issue as to any material fact” and “the moving party is entitled to a judgment as a matter of law.” Fed.R.Civ.P. 56(c). The moving party has the initial burden of identifying relevant portions of the record that demonstrate the absence of a fact or facts necessary for one or more essential elements of each cause of action upon which the moving party seeks judgment. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).

If the moving party has sustained its burden, the nonmoving party must then identify specific facts, drawn from materials on file, that demonstrate that there is a dispute as to material facts on the elements that the moving party has contested. *See Fed.R.Civ.P. 56(c)*. The nonmoving party must not simply rely on the pleadings and must do more than make “conclusory allegations [in] an affidavit.” *Lujan v. National Wildlife Fed'n*, 497 U.S. 871, 888 (1990). *See also Celotex Corp.*, 477 U.S. at 324. Summary judgment must be granted for the moving party if the nonmoving party “fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial.” *Id.* at 322. *See also Abromson v. American Pacific Corp.*, 114 F.3d 898, 902 (9th Cir.1997).

*2 In light of the facts presented by the nonmoving party, along with any undisputed facts, the Court must decide whether the moving party is entitled to judgment as a matter of law. *See T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Ass'n*, 809 F.2d 626, 631 & n. 3 (9th Cir.1987). When deciding a motion for summary judgment, “the inferences to be drawn from the underlying facts ... must be viewed in the light most favorable to the party opposing the motion.” *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (citation omitted); *Valley Nat'l Bank of Ariz. v. A.E. Rouse & Co.*, 121 F.3d 1332, 1335 (9th Cir.1997). Summary judgment for the moving party is proper when a rational trier of fact would not be able to find for the nonmoving party on the claims at issue. *See Matsushita*, 475 U.S. at 587.

III. FACTS

The following facts are undisputed:

On May 28, 1997, Benton reported to Allstate that he had been in a car accident the previous day. Benton reported that an uninsured motorist ran a red light and hit a car in the lane next to Benton, causing that car to collide with Benton's. Def.'s Stmt. of Uncontroverted Facts (“DSUF”) ¶ 1; Pl's. Sep. Stmt. of Disputed and Undisputed Facts (“PSDF”) ¶ 1. At that time, Benton had an automobile insurance policy with Allstate providing uninsured motorist coverage with a per-person limit of \$25,000. DSUF ¶ 2; PSDF ¶ 2. Before seeking medical attention, Benton consulted with his attorney, Matthew Matern. DSUF ¶ 4; PSDF ¶ 3. On June 6, 1997, Benton went to a chiropractor, Robyne Captanis. DSUF ¶ 5; PSDF ¶ 3. Captanis took a medical lien on Benton's future settlement with Allstate. Benton testified at deposition that he understood that any chiropractic bills he incurred would be paid out of any money he might receive from Allstate. DSUF ¶ 6; PSDF ¶ 3.

On July 2, 1997, Matern's firm, Rastegar & Matern, informed Allstate that it was repres-

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enting Benton with respect to his uninsured motorist claim. DSUF ¶ 7; PSDF ¶ 7. Allstate sent the firm a letter on July 8, 1997, requesting proof of injury and a medical release authorization. DSUF ¶ 8; PSDF ¶ 8. Plaintiff's counsel first supplied materials in response to this request over six months later, on January 20, 1998. The response included a report and a bill for \$4,318.00 from Captanis, detailing 42 visits from June 6, 1997 to December 8, 1997. It also included a bill from chiropractor Gene Bautista for \$215.00, for visits on June 16 and 17, 1997, dates on which Benton also visited Captanis. The response did not include the requested medical records release authorization or treatment records underlying Dr. Captanis' and Dr. Bautista's bills. DSUF ¶ 11–13, 16–17; PSDF ¶ 11–13, 16–17; Decl. of Ray Casazza in Supp. of Mot. for Summ. J. Exhs. 8–9.

On December 10, 1997, Dr. Captanis sent Matern a letter, in which she stated findings. Casazza Decl. Exh. 7. Dr. Captanis stated that Benton appeared at her office on June 7, 1997, and was experiencing pain in his head, back and arms. *Id.* The letter states an original diagnosis, as of June 7, 1997, of “cervical sprain/strain.” *Id.* The letter states that as of December 10, 1997, Benton was “asymptomatic.”

*3 On February 13, 1998, Allstate sent plaintiff's counsel a letter offering \$4,800.00 to settle Benton's uninsured motorist claim. DSUF ¶ 18; Casazza Decl. Exh. 10. An Allstate representative and plaintiff's counsel discussed this offer on February 25, 1998. Counsel rejected the offer, demanding \$15,000.00; Allstate raised its offer to \$5,400.00 in a letter dated March 2, 1998. DSUF ¶ 19–20; Casazza Decl. Exh. 11. The higher offer was not accepted, and in a letter dated February 26, 1998, plaintiff's counsel demanded arbitration of the claim pursuant to the terms of the policy. DSUF ¶ 21; PSDF ¶ 21. Allstate referred the claim to an arbitrator. DSUF ¶ 22; PSDF ¶ 22.

Having previously received from plaintiff only the bill and report of Dr. Captanis and the bill of Dr. Bautista, Allstate obtained plaintiff's records of treatment by Dr. Captanis and Dr. Bautista, for purposes of the arbitration, by means of a discovery request issued March 20, 1998. Decl. of John S. Popko in Supp. of Summ. J. Exh. 16. Allstate submitted these records to its expert, Dr. Stephen Forman, who produced a report. Popko Decl. Exh. 17. Dr. Forman opined as follows:

In summary, the file depicts a patient who was involved in an accident and who sustained a soft tissue injury. The severity of the injury appears to have been mild. I base this opinion on the lack of injuries at the scene on the police report, the lack of need for emergency care at the scene or later, the lack of need for care for 11 days, the lack of need for x-rays initially, the lack of need for disability status, the lack of need for second opinions, the lack of need for medications and the absence of clinical complications such as nerve injuries or disc herniations.

Given the age of the patient and the mild injuries I would have expected the patient to have required in the range of 8–14 treatments in a period of 3–6 weeks. I see nothing in the file which would support more care than this. In my opinion the excessive care seen in the file is the product of the doctor treating each episode of the patient being “sore” and even treating the patient when he was “well,” “OK” or “fine.”

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Id.

Benton visited an orthopedic surgeon, Dr. S.M. Rezaian, four times between March 4, 1998 and August 18, 1998. DSUF ¶ 37; PSDF ¶ 38. In response to discovery, plaintiff produced reports and medical records from Dr. Rezaian. Dr. Rezaian's first report, dated March 4, 1998, states that Dr. Rezaian examined Benton on March 4, 1998, and sets forth the following diagnosis: "Compressed fracture of T7–T8 with herniated disc of the thoracic spine with impingement on the chest." Popko Decl. Exh. 21. Dr. Rezaian's second report, dated March 24, 1998, states that Benton returned to Dr. Rezaian's office reporting pain; the second report restates the diagnosis that appears in the first. Popko Decl. Exh. 22.

The medical records from Dr. Rezaian's treatment of Benton included an MRI report dated April 21, 1998. DSUF ¶ 38; PSDF ¶ 38. The MRI report states that "[t]here is no evidence of any fracture or bony destruction," and that "[t]here is no evidence of any disc bulge or disc herniation." DSUF ¶ 39; PSDF ¶ 39; Decl. of Elke Ballweg in Supp. of Mot. for Summ. J. Exh. 23. The MRI report concludes thus: "IMPRESSION: NORMAL MRI OF THE THORACIC SPINE." Ballweg Decl. Exh. 23.

*4 A third report by Dr. Rezaian, dated August 19, 1998, contains the following statement regarding future medical care for Benton:

From the point of medical care in the future, based on reasonable medical certainty, it is my opinion that the symptoms, in the future will aggravate and the patient will need further medical evaluation with an orthopaedic specialist, repeat of MRI scan, and treatment which consists of non-steroidal anti-inflammatory medication, physical therapy, and epidural injection, three to four injections for the next twelve months. He may need surgical treatment in the future.

Decl. of Elke Ballweg in Supp. of Mot. for Summ. J. Exh. 25.

On September 23, 1998, Allstate sent Benton's medical records to Dr. Irvin Gettleman, an orthopedic surgeon, and requested that Benton submit to an examination by Dr. Gettleman. DSUF ¶ 41; PSDF ¶ 41. Benton acceded to this request, and Dr. Gettleman examined him on October 29, 1998. Dr. Gettleman issued a report of the examination and an opinion based on medical records, both dated November 5, 1998. Ballweg Decl. Exhs. 27–28. Dr. Gettleman's examination report concludes as follows:

It is my opinion that the injuries that might have been sustained in the accident in question would have been myofascial strains involving the cervical and thoracic area. These injuries are completely self-limiting even in the absence of any treatment and therefore reasonable care and treatment would have been perhaps for about two weeks with some over-the-counter anti-inflammatory medication, some physical therapy with some anti-inflammatory modalities followed by more importantly stretching and postural exercises. I think this could have been carried out over about a two week period of time with charges of perhaps no more than \$1,000.00. Based on the patient's clinical history, it is my opinion that this patient was unnecessarily and excessively treated for the injuries that might have been sustained. Certainly this patient did not suffer a fracture, subluxation, dislocation or spinal

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cord injury or nerve root impairment.

Ballweg Decl. Exh. 27. Dr. Gettleman's examination report notes "some slight wedging" of vertebrae T6 and T7, but states that this condition "is not at all traumatically related," and "does not represent a compression fracture or any other significant abnormality." *Id.*

Dr. Gettleman's opinion based on his review of Benton's records contains the following statements:

The total charges by the initial chiropractor Captanis were ... \$4,318.00 and by the second chiropractor Bautista, \$215.00. This, in my opinion, was excessive and completely unnecessary. There were absolutely no objective physical findings that were described by either one of the chiropractors.

The patient was referred to Dr. Rezaian, who saw him nine months after the accident in question. There is no question in my mind, after reviewing Dr. Rezaian's findings that this was gross exaggeration on his part. In addition, he described the presence of a compression fracture at T7–T8 and even insisted this was a compression fracture even after an MRI was performed and read out as normal. Dr. Rezaian apparently interpreted the MRI as demonstrating disc protrusions and bulging at T6–7, T7–8 and T8–9. Dr. Rezaian's diagnosis, which I feel is entirely incorrect, is that of a herniated disc of the thoracic spine at T6–7.

***5** It is my opinion that ... Dr. Rezaian's interpretation of the patient's symptoms and the MRI findings and x-rays are erroneous. By the time the patient saw Dr. Rezaian, the symptoms if any he was experiencing was that of postural strain and that a series of postural exercises is all that would have been necessary for him.

It is my conclusion that this patient could have been seen and treated within about a two week period of time with charges of no more than \$1,000.00 based on any injuries that might have been sustained in this accident.

Ballweg Decl. Exh. 28.

At deposition, Benton testified that he does not believe that he suffered a compressed fracture in the accident. He also testified that, following the arbitration, he did not receive any further treatment for pain or injuries associated with the accident. DSUF ¶ 45; PSDF ¶ 45.

On January 29, 1999, Benton's counsel produced to defendant a declaration from Dr. Captanis. This declaration states as follows:

Analysis of the examination/x-rays indicates that Mr. Benton suffered less than a moderate sprain and strain injury and I anticipated about 6–8 weeks of treatment. Due to Mr. Benton's poor posture, mild obesity, and poor working conditions, it took longer than expected to relieve the patient's symptoms.

DSUF ¶ 47; PSDF ¶ 47.

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The arbitration took place on February 2, 1999. Benton requested an award of \$25,000.00. DSUF ¶ 48; PSDF ¶ 48. The arbitrator considered the medical records, reports and opinions described above.

The arbitrator issued an award of \$17,614.00 for Benton on February 17, 1999. In his decision, the arbitrator stated:

All the parties agree that Mr. Benton sustained some injuries as a result of this motor vehicle accident. A dispute exists as to the reasonableness and necessity of the treatment provided and as to the amount of general damages to which Mr. Benton is entitled.... If this were a typical soft tissue injury to an otherwise healthy person I would think that the medical specials were excessive. However, each case is different and in this one I think Mr. Benton's posture and obesity problems prolonged his recovery.

DSUF ¶ 49; PSDF ¶ 49. Allstate paid the award on February 23, 1999. DSUF ¶ 50; PSDF ¶ 50.

IV. DISCUSSION

A. The Bad Faith Claim

The Ninth Circuit recently reiterated the standard in California for determining whether an insurer has breached the covenant of good faith and fair dealing implied in insurance contracts:

In order to establish a breach of the implied covenant of good faith and fair dealing under California law, a plaintiff must show: (1) benefits due under the policy were withheld; and (2) the reason for withholding benefits was unreasonable or without proper cause. *See Love v. Fire Ins. Exch.*, 221 Cal.App.3d 1136, 1151, 271 Cal.Rptr. 246 (1990). The key to a bad faith claim is whether or not the insurer's denial of coverage was reasonable.

*6 *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 992 (2001). Further, a bad faith claim can be dismissed on summary judgment if the defendant can show that there was a genuine issue as to coverage:

[A] court can conclude as a matter of law that an insurer's denial of a claim is not unreasonable, so long as there existed a genuine issue as to the insurer's liability. An insurer is liable for breach of the implied covenant of good faith and fair dealing if it acted unreasonably in denying coverage.

Lunsford v. American Guarantee & Liability Ins. Co., 18 F.3d 653, 656 (9th Cir.1994) (citing *Gruenberg v. Aetna Ins. Co.*, 9 Cal.3d 566, 571–74 (in bank)) (other citation omitted). This rule is commonly known as the “genuine issue rule” or “genuine dispute doctrine”. *Guebara*, 237 F.3d at 988–89.

In *Guebara*, the Ninth Circuit extended the well-established genuine dispute doctrine to allow summary judgment for the insurer in certain conditions that have never been addressed by the California Supreme Court. The court noted that the California Supreme Court has never

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ruled on the question of whether, under the genuine dispute doctrine, summary judgment can be granted for the insurer only where the insurer shows that the denial of benefits was based on a genuine dispute regarding the requirements of the law or the meaning of the contract, or whether a showing of a genuine dispute regarding the facts would also entitle the insurer to summary judgment on a bad faith claim. *Id.* at 992–93. Predicting, as it must in such circumstances, the result the California Supreme Court would reach, the court stated as follows:

Given the current state of California insurance law, the state appeals court's recent decision in *Fraley v. Allstate Ins. Co.*, 81 Cal.App. 4th 1282, 1291 (2000), in which the court held that “[t]he ‘genuine dispute’ doctrine may be applied where the insurer denies a claim based on the opinions of experts”] and the decisions of this court and other federal courts, we decline to limit the genuine dispute doctrine to purely legal or contractual disputes. Rather than establish a bright-line rule, we hold that the genuine dispute doctrine should be applied on a case-by-case basis. In some cases, the application of the rule to purely factual disputes will be inappropriate. In others, investigations by a defendant's independent experts will permit the invocation of the doctrine and summary judgment for the defendant on a bad faith claim.

Guebara, 237 F.3d at 994.

Benton's claim is that Allstate acted in bad faith in failing to make a higher settlement offer. Benton argues that Allstate's two settlement offers were based not on an investigation of the facts, but on the use of certain computer programs called Colossus, M.I.S.T. and M.S.R.B, and that this resulted in the offers being unreasonably low.

Plaintiff's argument regarding adequacy of investigation must be analyzed with respect to two distinct points in time: before and after the demand for arbitration. It is undisputed that, before the demand for arbitration, plaintiff failed to provide defendant with medical records release authorizations, and that defendant was able to secure complete medical records only through discovery after plaintiff invoked arbitration. At the time of the demand for arbitration, plaintiff's only response to defendant's requests was the provision of the bill and report by Dr. Captanis and the bill by Dr. Bautista. In the period after the demand for arbitration and leading up to the arbitration, defendant's investigation included all the steps indicated above: obtaining plaintiff's medical and chiropractic records and reports, obtaining a review of these records by two experts, and obtaining a physician's examination of defendant.

*7 The Court concludes that plaintiff has failed to raise a triable issue of material fact with respect to defendant's investigation in the period before the demand for arbitration. In light of plaintiff's failure to provide medical records or releases during this period, it was not unreasonable for defendant to base its settlement offers on the facts then available to it. These were the facts that plaintiff did not require emergency medical attention at the scene of the accident and sought no treatment for the ensuing ten days, that the initial diagnosis was “cervical sprain/strain,” and that plaintiff received 42 treatments over six months. On this state of facts, where plaintiff failed to make additional facts available, there was a genuine dispute as to whether plaintiff's treatment was excessive. An insurer is entitled to withhold payment “until it [can] find out on its own, to a measure of certainty” that the benefits claimed by plaintiff

were actually owed. *Blake v. Aetna Life Ins. Co.*, 99 Cal.App.3d 901, 921 (1979).

In the period after the demand for arbitration, defendant conducted a thorough investigation, as noted above. There is no basis for plaintiff's contention that defendant's investigation at that time was inadequate. Plaintiff basis his claim of an inadequate investigation on the assertion that "Allstate used its computer payment program as a subterfuge and in bad faith," and that this computer program was somehow allowed by defendant to interfere with or substitute for proper investigation. Pl's. Opp'n to Mot for Summ. J at 10–11. But there is no evidence of this in the record. Plaintiff does not even develop a concrete theory of what the computer system in question does and how its operation or some misuse of it might constitute bad faith.

Moreover, it is clear that the directly and emphatically conflicting expert reports in this case gave rise to a genuine dispute regarding the value of plaintiff's claim. As noted above, "investigations by a defendant's independent experts will permit the invocation of the [genuine dispute] doctrine and summary judgment for the defendant on a bad faith claim" in some cases. *Guebara*, 237 F.3d at 994; *see also Fraley*, 81 Cal.App. 4th at 1291. This is such a case.

FN1. At the hearing on the instant motions, plaintiff's counsel argued that defendant's expert, Dr. Gettleman, must have been dishonestly selected or must have reached unreasonable conclusions. This argument was based on three statements Dr. Gettleman made at deposition: (a) that it was reasonable for Benton to seek advice from an orthopedist (i.e., Dr. Rezaian) when, nine months after the accident, he was still experiencing pain, *see* Gettleman Depo. at 54:20–24; (b) that an MRI would have been indicated if Dr. Rezaian found, as he claimed to have found, that Benton was experiencing moderate to severe muscle spasm with severe tightness, but that Dr. Gettleman did not consider these findings credible, *see id.* at 66:1–13; and (c) that chiropractic treatments can sometimes prolong the time it takes for soft tissue injuries to heal, *see id.* at 36:12–25. Plaintiff's counsel contended at oral argument that this testimony shows dishonest selection or unreasonableness of the expert's opinion because Dr. Gettleman did not also include these opinions in his report. The Court concludes that this testimony raises no triable questions of fact with respect to dishonest selection, the reasonableness of Dr. Gettleman's expert opinion, or, generally, the genuineness of the dispute between insurer and insured regarding the value of Benton's claim.

For these reasons, the Court concludes that plaintiff has not sustained its summary judgment burden of identifying facts which raise a triable question with respect to the contention that Allstate's actions were not based on a good-faith dispute regarding the value of plaintiff's claim. Therefore, summary judgment for defendant on Benton's bad faith claim must be granted.

B. The § 17200 Claim

California's unfair competition law, Cal. Bus. & Prof.Code § 17200, creates an independent statutory cause of action for business conduct that is unlawful or unfair on other grounds. FN2 "By proscribing 'any unlawful business practice,' section 17200 borrows violations of

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other laws and treats them as unlawful practices that the unfair competition law makes independently actionable.” *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.*, 20 Cal.4th 163, 180 (1999) (citations and internal quotation marks omitted). Further, “[t]he statutory language referring to ‘any unlawful, unfair or fraudulent’ practice makes clear that a practice may be deemed unfair even if not specifically proscribed by some other law.” *Id.*

FN2. In its entirety, § 17200 provides:

As used in this chapter, unfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code [which involves advertising].

*8 Benton argues that summary judgment should be denied on his § 17200 claim because he has raised triable questions of fact with respect to underlying unlawful conduct, namely (a) his common-law bad faith claim, and (b) violations of Cal. Ins.Code §§ 790.03(h)(3), (5), and (6). The Court holds that defendant is entitled to summary judgment on the common-law bad faith claim, as stated above. Therefore only plaintiff’s § 790.03 claims remain to be considered.

Section 790.03 provides in pertinent part as follows:

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(h) [Unfair claims settlement practices] Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

The Court concludes that plaintiff has failed to raise any triable issue of fact with respect to § 790.03(h). The facts in the record pertain solely to plaintiff’s individual claim. Plaintiff has pointed to no facts relating to “committing or performing with such frequency as to indicate a general business practice” acts of any kind. The only fact in the record that might be re-

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lated to acts committed repeatedly or systematically is the fact that Allstate uses a computer system in handling claims. But as stated above, plaintiff fails to point to any evidence in the record supporting the assertion that this computer system is related to any bad faith conduct on Allstate's part.

For these reasons, the Court concludes that defendant is entitled to summary judgment on plaintiff's § 17200 claim.

C. Plaintiff's Rule 56(f) Request

In his opposition to the motion for summary judgment, plaintiff argues that he has not had an opportunity to conduct adequate discovery regarding Allstate's computer system, and that the Court should continue the motion. The opposition was filed on December 4, 2000, and requests a continuance until January 29, 2001, specifically to allow time for depositions of Allstate personnel knowledgeable about the claims-handling computer system. Plaintiff also filed a motion for a continuance to permit such discovery pursuant to Fed.R.Civ.P. 56(f) on December 11, 2000. The Court granted this motion by order issued December 12, 2000, and continued the hearing to January 29, 2001. On December 29, 2000, the Court again continued the hearing, to February 26, 2001, pursuant to the stipulation of the parties.

*9 On February 16, 2001, plaintiff filed an *ex parte* application, seeking a yet another continuance of defendant's summary judgment motion. Two grounds are set forth for the further continuance. First, plaintiff contends that *Guebara, supra*, which was filed on January 12, 2001, "has created at least five highly critical new areas of factual inquiry in an insurance bad faith case." Pl's. *Ex Parte Appl.* at 4. Second, plaintiff reports that he still has inadequate evidence regarding defendants' computer system and must depose additional Allstate personnel to obtain such evidence.

Plaintiff's characterization of *Guebara* is incorrect. As noted above, in *Guebara* the Ninth Circuit reaffirmed that the genuine dispute rule allows summary judgment to be granted for the defense in an insurance bad faith case in which the insurer withheld benefits on the basis of a genuine dispute regarding the value of plaintiff's claim. This was well-settled law. The new law stated in *Guebara* is that under the genuine dispute rule, a genuine dispute about the factual basis of plaintiff's claim can be a basis for summary judgment on bad faith as well as a genuine dispute about the applicable law or contract terms. In so holding, the court stated that certain factual disputes nevertheless will not be a basis for summary judgment:

Our decision does not eliminate bad faith claims based on an insurer's allegedly biased investigation. Expert testimony does not automatically insulate insurers from bad faith claims based on biased investigations. Although this list is not exhaustive, we can think of several circumstances where biased investigation claims could go to a jury: (1) the insurer is guilty of misrepresenting the nature of the investigatory proceedings, *see Tomaselli v. Transamerica Ins. Co.*, 25 Cal.App.4th 1269, 1281, 31 Cal.Rptr.2d 433, 439 (1994) (allowing a bad faith claim to go to the jury where an insurance company without any evidence of fraud forced an insured to submit to an examination under oath, dissuaded the insured from having an attorney present, and misled the insured about the purpose of the examination); (2) the insurer's employees lie during the depositions or to the insured; (3) the insurer dishonestly se-

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lected its experts; (4) the insurer's experts were unreasonable; and (5) the insurer failed to conduct a thorough investigation.

Thus, we hold that the district court did not err in granting summary judgment on Guebara's bad faith claims based on the genuine dispute doctrine. The genuine dispute doctrine is not limited to purely legal disputes; it should be applied on a case-by-case basis. In this case, the insurer's three independent experts and the insured's inconsistent explanations justified the invocation of the genuine dispute rule.

237 F.3d at 996. Plaintiff asserts that this passage creates new law justifying a continuance.

Guebara does not create new grounds for an insurance bad faith claim. Rather, *Guebara* reaffirms that the genuine dispute doctrine applies in California, and predicts that under California law, the genuine dispute doctrine is applicable to a broader range of disputes than has previously been recognized by the California Supreme Court. Specifically, as stated above, *Guebara* states that summary judgment may be granted on the basis of genuine factual as well as genuine legal disputes about plaintiff's entitlement to benefits.^{FN3}

FN3. *Guebara* might have provided a basis for Rule 56(f) relief if plaintiff had argued that he wishes to depose some witness who would testify regarding the possibility that defendant had obtained its expert opinions fraudulently. Plaintiff has neither made this argument nor made the pertinent offer of proof, which would require naming a specific witness and stating what the witness' testimony might be.

*10 With respect to plaintiff's request for time to seek further information regarding defendant's computer system, the Court concludes that plaintiff's *ex parte* application satisfies neither the requirements for *ex parte* relief nor the requirements of Rule 56(f).

Applications for *ex parte* orders are permitted by Local Rule 7.18. To obtain *ex parte* relief, the moving party must show (a) that the moving party's cause will be irreparably prejudiced if relief is not granted, and (b) that the moving party is without fault in creating the crisis that requires *ex parte* relief, or that the crisis occurred as a result of excusable neglect. *Mission Power Engineering Co. v. Continental Casualty Co.*, 883 F.Supp. 488, 492 (C.D.Cal.1995). Pursuant Rule 56(f), a court may continue the hearing on a motion for summary judgment where the party opposing the motion demonstrates that further discovery will enable it to discover facts essential to its opposition to summary judgment. *See Conkle v. Jeong*, 73 F.3d 909, 914 (9th Cir.1995); *Upper Deck Authenticated. Ltd. v. CPG Direct*, 971 F.Supp. 1337 (S.D.Cal.1997).

Plaintiff has not shown that he is not at fault in lacking evidence regarding the computer system. The *ex parte* application contains two contentions pertinent to plaintiff's fault. First, plaintiff states that Allstate employees previously deposed had no knowledge of the computer system in question, and that plaintiff must therefore depose additional Allstate employees.^{FN4} Second, plaintiff asserts that Allstate has recently produced documents plaintiff describes only as "internal guidelines and manuals," as to which plaintiff wishes to depose witnesses.^{FN5} Fourteen months after the filing of this action and after two previous continuances on this mo-

tion encompassing 69 days, these averments do not show that plaintiff could not have conducted the pertinent discovery before the briefing of the instant motion.

FN4. Plaintiff has noticed the depositions of Ann Del Guidice, Colleen Parreco, Elke Ballweg, Sharon Claypool, Janet Hilton, and a person most knowledgeable concerning the computer system. Plaintiff asserts that Allstate employees previously deposed named these individuals as possibly having relevant knowledge. No explanation appears in plaintiff's brief why a person most knowledgeable regarding the computer system was not deposed earlier. At oral argument, plaintiff's counsel stated that one of the Allstate employees previously deposed, Kristin Maccadino, was designated by Allstate as the person most knowledgeable. Counsel for defendant controverted plaintiff's assertion that Maccadino had failed to give substantial testimony regarding the computer system, and denied that any of the Allstate employees plaintiff has named in the *ex parte* application know more than Maccadino. Thus it appears that Allstate's person most knowledgeable on this issue has already been deposed.

FN5. Plaintiff filed on February 12, 2001 a further declaration of counsel in support of his opposition to the motion for summary judgment. This declaration reiterates the Rule 56(f) argument contained in the *ex parte* application, and attaches ten documents. Seven of these documents are copies of various Allstate guides and manuals, at least some of which appear to be related to computer systems. Two documents are deposition transcript excerpts. The tenth is a computer printout apparently displaying in side-by-side columns amounts billed by Dr. Captanis for each of the 42 days of treatment Benton received and the amounts purportedly covered by Benton's policy. No explanation of these documents is offered in the declaration to which they are attached, or elsewhere in plaintiff's opposition papers, and their significance is not self-evident.

Nor has plaintiff shown that a further continuance is necessary to prevent irreparable harm to his case, or that further discovery will enable him to obtain evidence essential to his opposition to the motion. Plaintiff's offer of proof consists entirely of conclusory allegations. Plaintiff has not satisfied the requirement that he state specific evidence he expects to elicit from specific witnesses.^{FN6}

FN6. This offer of proof reads as follows:

Plaintiff reasonably believes and makes an offer of proof that the taking of such depositions will provide the following material evidence:

Evidence that Allstate used, abused or misused the M.B.R.S. system to commit bad faith as to Plaintiff by low-balling or otherwise improperly processing and evaluating his UM claim, within the meaning of *Nager v. Allstate Ins. Co.*, 83 Cal.App. 4th 284, 99 Cal.Rptr.2d 348, 354 (2000).

Evidence that Allstate failed to conduct a full, prompt, fair and unbiased investigation of Plaintiff's UM claims, within the holding of *Guebara v. Allstate Ins. Co.*, Nos. 98-55458, 98-55459, 2001 U.S.App. LEXIS 492, 2001 Cal. Daily Op. Service 375 (9th Cir. January 12, 2001).

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Evidence (or further or additional evidence) that one or more of the following five acts or patters of bad faith occurred, within the direct holding of *Guebara, supra*, slip opinion at 26–27: [again quoting the portion of *Guebara* reproduced above, 237 F.3d at 996].

Pl's. *Ex Parte* Appl. at 7–8.

A Rule 56(f) movant does not show that further discovery will provide evidence essential to opposing summary judgment simply by stating legal rules and asserting that some evidence will be discovered to show liability thereunder.

Plaintiff's citation of *Nager* does not support his contentions. In *Nager*, the Court of Appeal affirmed summary judgment for an insurer on a bad faith suit in which it was claimed that the insurer acted in bad faith in questioning a chiropractor's bill.

For these reasons, plaintiff's *ex parte* application for a continuance is denied.

V. CONCLUSION

Defendant's motion for summary judgment against plaintiff Benton is GRANTED.

Plaintiff's *ex parte* application for a continuance of the summary judgment motion is DENIED.

IT IS SO ORDERED.

C.D.Cal.,2001.

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