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Seeking class certification of an insurance case

Care must be taken to address each of the relevant class-certification elements – a look at the the dos and don'ts

Many types of insurance disputes have been successfully prosecuted as class actions. Some examples include: life insurance ("vanishing" premiums, discriminatory premiums, improper "mortality" costs); annuities (diminished returns due to misrepresented costs, illegal surrender penalties); health insurance (systematic denial of benefits for certain types of treatment, overcharged or discriminatory premiums, low-balling provider reimbursement rates, violating state mandated-benefit laws); and auto insurance (improper use of aftermarket parts, overcharged premiums, improper medical payments practices).

To be sure, the standardized nature of insurers' policy forms and/or sales materials and their standardized internal practices often provide ideal facts for class certification. But the mere presence of a dispute arising out of an insurer's practice does not guarantee a grant of class certification. Federal and state class certification decisions have, to an increasing degree, made the class-certification process a much more scrutinized and labor-intensive effort. Although an insurance case presents many made-for-certification aspects, care must be taken to address each of the relevant class certification elements as they relate to the insurer's sales materials, policy forms, and internal practices. Here are some points to keep in mind.

Do know both state and federal class-certification principles

The vast majority of insurance class actions filed in California courts are "state" class actions, that is, they are comprised of California residents only. (Nicholas M. Pace, et al., Insurance Class Actions in the United States, RAND Corporation, Institute for Civil Justice (2007).) Even so, unless the insurer is domiciled in California (Farmers, Blue Shield of California, etc.), diversity rules under the Class Action Fairness Act allow for removal to federal court when the claims exceed $5 million. (28 U.S.C. § 1332(d)(2)). Consequently, counsel need to be conversant with both the state and federal class-certification rules.

Drawing on Code of Civil Procedure section 382 and federal precedent, California courts have set forth the essential requirements for class certification: an ascertainable class, a well-defined community of interest, and substantial benefits to the class that render it superior to the alternatives. (*Brinker Restaurant Corp. v. Superior Court* (2012) 53 Cal.4th 1004, 1021; *Sav-On Drug Stores, Inc. v. Superior Court* (2004) 34 Cal.4th 319, 326.) The "community of interest" requirement embodies the following elements: (1) predominate common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class. (*Brinker,* 53 Cal.4th at 1021.)

Rule 23 of the Federal Rules of Civil Procedure has similar requirements. Rule 23(a) requires: (1) numerosity, (2) commonality; (3) typicality; and (4) adequacy of representation. If money damages are sought, it must also be shown that common questions "predominate over any questions affecting only individual members" and that class resolution "is superior to other available methods for the fair andefficient adjudication of the controversy." (Fed. Rules Civ. Proc., rule 23(b)(3). 28 U.S.C.; *Hanon v. Dataproducts Corp.* (9th Cir. 1992) 976 F.2d 497, 508.)

If a class seeks declaratory and injunctive relief only, "predominance" and superiority are not required. It is only necessary to show that the elements of Rule 23(a) are present and that the defendant has acted on grounds that apply to the class generally. (Rule 23(b)(2).) California courts have, in the appropriate cases, looked to Rule 23(b)(2) for guidance when a class seeks declaratory and injunctive relief. (*Capitol People First v. State Dept. of Developmental Services* (2007) 155 Cal.App.4th 676, 691-692, fn. 12.) However, "California class actions can neither be certified pursuant to Rule 23(b)(2) nor barred from certification by the rule," leaving some flexibility in cases where monetary damages are not sought. (*Carter v. City of Los Angeles* (2014) 224 Cal.App.4th 808, 824.)

Don't forget to check for an arbitration provision

In the wake of *AT&T Mobility LLC v. Concepcion* (2011) 563 U.S. __ [131 S.Ct. 1740], theorizing about a potential class action involving a consumer contract must necessarily involve a consideration of whether the contract contains an enforceable arbitration provision. This is so in an insurance class action. The good news is that most insurance policies other than health do not have arbitration provisions. Whether *Concepcion* will cause insurers to routinely add arbitration provisions to other types of policies remains to be seen.

Health-insurance policies (and health-care service plans) issued in California do typically contain arbitration provisions. There are disclosure laws mandating the nature and extent of the notice that must be given to the consumer regarding arbitration and waiving the right to a jury trial. (Ins. Code, § 10123.19; Health & Saf. Code, § 1363.1.) An insurer's or health plan's failure to comply with the relevant statute's requirements renders the arbitration provision unenforceable. (See, e.g., *Rodriquez v. Blue Cross of California* (2008) 162 Cal.App.4th 330, 335-337; *Malek v. Blue Cross* (2004) 121 Cal.App.4th 44, 71.) Reviewing the policy for the presence of

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an arbitration provision, and determining whether the policy and enrollment documents make an adequate disclosure, is a necessary first step in determining whether the class allegations will disappear with the granting of a petition to compel arbitration.

Don't confuse deceptive sales practice theories with contract theories

Putative insurance class actions often contain allegations regarding fraudulent acts without asserting a true fraud claim. They are cases that, at their heart, concern contractual issues – the insurer's failure to pay a promised benefit or charge a promised rate. It is important to be clear on what the alleged wrongdoing is, and what the causes of action are seeking, because achieving class certification of a fraud claim is far more difficult than certifying a contractual claim. You don't want to be in the middle of a class-certification proceeding when you learn that you don't have the proof necessary to make the right arguments.

A deceptive-sales-practice case is typically based upon the insurer's pre-sale representations regarding the nature and extent of some policy feature. Such a case necessarily contains fraud claims – common-law fraud and violation of the fraudulent prong of Business & Professions Code section 17200 (Unfair Competition Law or "UCL"). To certify such a case, it must be shown that a common representation was communicated to the members of the class. For common-law fraud, it must be shown that reliance can be established through class-wide proof. But for UCL fraud, only the class representatives need rely on the common misrepresentation. (*In Re Tobacco II Cases* (2009) 46 Cal.4th 298, 324-326.) When a UCL "unlawful" claim is premised upon a law that prohibits some type of misrepresentation, the UCL fraud standard applies. (*Kwikset Corp. v. Superior Court* (2011) 51 Cal.4th 310, 326-327.)

Demonstrating a common misrepresentation in an insurance case will mean proving that the insurer made a statement of fact, or an actionable omission, in written sales materials that were required to be distributed to each purchaser (*Occidental Land, Inc. v. Superior Court* (1976) 18 Cal.3d 355, 363; (*In re National Western Life Ins. Deferred Annuities Litig*. (S.D. Cal. 2010) 268F.R.D. 652, 664) or that sales agents were required to use a standardized sales pitch that contained the misrepresented fact (*Vasquez v. Superior Court* (1971) 4 Cal.3d 800, 814). Defense counsel will attempt to show that the use of sales materials and the nature of the sales presentations varied from sale to sale causing individual issues to predominate. (*Kaldenbach v. Mutual of Omaha* (2009) 178 Cal.App.4th 830, 844-847 ["there was no evidence linking those common [marketing] tools to what was actually said or demonstrated in any individual sales transaction"]; (*Fairbanks v. Farmers New World Life Ins. Co.* (2011) 197 Cal.App.4th 544, 558-559, 561-564 [materials describing life insurance as "permanent" were not uniform and there was no evidence of a uniform sales pitch in this regard].)

It must also be remembered that the Achilles' heel of a sales-practices case is a prominent disclosure by the insurer of the allegedly misrepresented fact, either at the point of sale or in the contract itself. (*Broberg v. Guardian Life Ins. Co.* (2009) 171 Cal.App.4th 912.) You are unlikely to be able to prove reliance, by anyone, if the allegedly misrepresented fact was adequately disclosed before the policy was issued or in the policy itself. (*Hadland v. NN Investors Life Ins. Co.* (1994) 24 Cal.App.4th 1578, 1589 [no reliance as a matter of law on representation that was at odds with unambiguous policy language].)

The lesson here is not to make allegations about deception and fraud unless there is reason to believe the common proof necessary to prove those claims on a class basis exists. A class-certification motion that does not present adequate proof of common representations and reliance will not get off the ground.

A breach-of-contract claim, on the other hand, can provide a much easier route to class certification. There is no problem with uniformity of the promise if the contractual language at issue is materially the same across the relevant policy forms. The nature of the breach will be likewise uniform because insurers are geared toward uniformity in the application of policy provisions, schooling their claims personnel on standardized claims procedures. Courts routinely certify breach-of-contract claims because "claims arising from interpretations of a form contract appear to present the classic case for treatment as a class action . . . ." (*Kleiner v. First Nat'l Bank of Atlanta* (N.D. Cal. 1983) 97 F.R.D. 683, 691; *Menagerie Productions v. Citysearch* (C.D. Cal. 2009) 2009 U.S.Dist. Lexis 108768, *36-37.)

And while the defense will argue that an issue of the ambiguity of a policy provision will give rise to individualized issues regarding what each policyholder understood, the objective nature of policy interpretation dictates otherwise.

> [E]ven assuming that the contractual provision at issue were ambiguous, the subjective expectations of an insured class member would have little if any bearing on the breach of contract analysis.

(*Yue v. Conseco Life Ins. Co.* (C.D. Cal. 2012) 282 F.R.D. 469, 476.)

Do assert statutory claims whenever possible

Insurance is a highly regulated business. There are a number of California statutes and regulations that apply to insurance policies issued in California. Laws or regulations that are not based upon a misrepresentation and, therefore, do not require a showing of a common misrepresentation and reliance, can provide a comparatively easy road to certification.

Laws regulating health-insurance policies provide a good example. There are various provisions of the Insurance Code mandating that health insurance policies issued in California provide certain types of benefits. Many of these provisions are mirrored in the Health & Safety Code that applies to health-care service plans (that is, HMO plans.) Demonstrating that a health insurer or health plan has a practice of violating one of these mandated-benefit statutes will provide common questions that can be resolved in a class proceeding.

For instance, in *Arce v. Kaiser Foundation Health Plan, Inc.* (2010) 181 Cal.App.4th 471, the trial court dismissed

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class allegations asserting that the health plan had systematically violated Health & Safety Code section 1374.72, the Mental Health Parity Act, by failing to provide applied behavior analysis and speech therapy to children with autism. (The Insurance Code also contains a Mental Health Parity provision at section 10144.5.) The health plan argued that determining whether a given child was entitled to the denied services would entail individualized medical determinations. In reversing, the appellate court found that assessing whether the health plan violated the statute required a determination of whether the type of treatment at issue was covered within the statutory mandate, not whether treatment was medically required for a given individual.

> To adjudicate whether Kaiser has violated the Mental Health Parity Act by denying coverage for applied behavior analysis therapy and speech therapy on these grounds, the trial court would not need to engage in individualized determinations of medical necessity for each putative class member. Instead, resolution of this issue would require the trial court to decide whether the therapies are health care services under the Mental Health Parity Act, and if so, whether the statute mandates that services only be provided by health care professionals licensed or certified by the state.

(*Arce*, 181 Cal.App.4th at 494.)

In *Ticconi v. Blue Shield Life & Health Insurance Company* (2008) 160 Cal.App.4th 528, the plaintiff sought class certification of claims for declaratory and injunctive relief based upon the insurer's wrongful rescission of health-insurance policies. The insurer contended that the putative class members had made material misstatements of fact about their health histories in their applications for insurance, justifying rescission. The plaintiff alleged that the insurer had systematically violated statutes that precluded rescission unless the applications were attached to the policies, something the insurer admittedly had not done. The appellate court reversed the denial of class certification on the basis that the individual issues raised by the defendant would not affect the liability decision to be made under the relevant statutes. (*Id.* at 544-543.)

Statutory claims can be asserted under the unlawful prong of the UCL and as a breach of contract claim because laws regulating benefits are read into the contracts. (*Modglin v. State Farm Mutual Automobile Ins. Co.* (1969) 273 Cal.App.2d 693, 698.) For this reason, there is no issue in such cases regarding the uniformity of the policy language, simply the health plan's practice relative to a statutory obligation.

Do familiarize yourself with the insurance principles at issue

Knowing the insurance principles at play will often help defeat arguments regarding individualized issues. For instance, in a fraud case, the general rule is that there is no duty on behalf of a seller to disclose material facts without a fiduciary relationship, the disclosure of partial facts, etc. (*Hahn v. Mirda* (2007) 147 Cal.App.4th 740, 748.) Under Insurance Code section 332, however, "[e]ach party to a contract of insurance shall communicate . . . all facts within his knowledge . . . which the other has not the means of ascertaining." (See also *Pastoria v. Nationwide Insurance, et al.* (2003) 112 Cal.App.4th 1490, 1495 [health insurer had duty under section 332 to disclose change in premiums and benefits it knew it would be making to the disadvantage of new purchasers].)

Because an omission of a material fact is actionable in the insurance context, proof that the material fact was routinely hidden from all purchasers will satisfy the common misrepresentation element of a fraud claim. It is irrelevant what other information was conveyed or how "every sale was different," so long as there is uniformity of the nondisclosure.

Don't argue merits-only issues

The critical inquiry in the vast majority of class certification proceedings is whether common issues predominate. Ultimately, the judge must determine whether "the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants. [Citations omitted.]" (*Brinker Restaurant Corp. v. Superior Court, supra,* 53 Cal.4th at 1021.) Making a successful showing in this regard requires highlighting the relevant issues and the common proof underlying them.

"Relevant" here means those elements of a cause of action that are not strictly "merits" issues. (*Brinker,* 53 Cal.4th at 1025; *Amgen, Inc. v. Connecticut Retirement Plans and Trust Funds* (2013) 568 U.S. __ , 133 S.Ct. 1184, 1195, ["[m]erits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied"].) It is essential, therefore, to distinguish strictly merits issues from class issues to avoid being dragged into an irrelevant debate.

For instance, in a sales-practices' case alleging common-law fraud, class-wide proof of reliance can be established via a presumption that arises for each putative class member if the common representation is a material one. (*Vasquez v. Superior Court*, *supra,* 4 Cal.3d at 814 [uniform sales pitch regarding consumer goods]; (*Occidental Land, Inc. v. Superior Court*, *supra*, 18 Cal. at 363 [uniform misrepresentation and omission regarding the amount of a homeowners fee in a subdivision report presented to each purchaser]; (*In re First Alliance Mortgage Co.* (9th Cir. 2006) 471 F.3d 977, 991-992 [fraudulent system of inducing borrowers to agree to unconscionable subprime loan terms].)

Because "materiality" is determined under an objective test, turning on whether "a reasonable man would attach importance to its existence or nonexistence in determining his choice of action" (*Engalla v. Permanente Medical Group, Inc.* (1977) 15 Cal.4th 951, 977), [it should be a merits-only question.] (*Amgen, Inc. v. Connecticut Retirement Plans and Trust Funds*, *supra,* 133 S.Ct. at 1195-1196 [finding that the "materiality" element of a securities class-action fraud claim is necessarily a common question

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for purposes of a Rule 23(b)(3) analysis]; but see *Fairbanks v. Farmers New World Life Ins. Co., supra,* 197 Cal.App.4th at 555 [dicta stating that the alleged misrepresentation was not material because plaintiffs' own survey evidence showed that a majority of the responding purchasers said they would have purchased the policies even if they knew their premiums were not guaranteed].)

A court will be highly reluctant to deny class certification based upon a dispute over what should be a merits-only issue. "A certification decision is reviewed for abuse of discretion, but when the supporting reasoning reveals the court based its decision on erroneous legal assumptions about the relevant questions, that decision cannot stand. [Citations omitted.]" (*Ayala v. Antelope Valley Newspapers, Inc.* (June 30, 2014 S206874) __ Cal.4th __ [criticizing trial court for focusing on the substantive issue rather than whether common proof can be used to prove the substantive issue].) Every effort should be made to highlight why a given issue is a merits-only and not proper for consideration on certification.

Don't forget a damages model

Common proof of damages in an insurance case can often be shown through the nature and extent of an insurer's internal data. In certain cases, however, the nature of the damages sought will not be able to be shown in whole or in part through an analysis of the insurer's data. (*Ortega v. TOPA Ins. Co.* (2012) 206 Cal.App.4th 463, 479 [class certification denied because the plaintiff could not show that the auto insurer's aftermarket replacement parts were uniformly inferior]; *Negrete v. Allianz Life Ins. Co. of N. America* (C.D. Cal 2012) 287 F.R.D. 590, 605, 613 [financial modeling used to demonstrate that all members of the class were overcharged for their annuities because of insurer's alleged misrepresentations].) A damages model is critical in these circumstances. Indeed, following the United States Supreme Court's decision in *Comcast Corp. v. Behrend* (2013) 569 U.S. __ , 133 S.Ct. 1426, defense counsel will invariably assert that there are stringent new certification standards on damages that cannot be met.

In *Comcast*, the court determined in an antitrust case that the proposed damages model could not satisfy Rule 23(b)(3)'s requirements because it was not necessarily tied to the sole antitrust theory of liability certified by the district court. The court noted that the model might well have been sound if all theories had been certified. (*Comcast, supra*, 133 S.Ct. at 1434.) Properly read, *Comcast* requires plaintiff to present a model that shows the alleged damages stemmed from the alleged wrongful actions. "[P]laintiff must be able to show that their damages stemmed from the defendant's actions that created the legal liability." (*Leyva v. Medline Industries, Inc.* (9th Cir. 2013) 716 F.3d 510, 514.)

It is the model that shows how common proof can be used to prove damages for all in the class. And while it may be necessary to break out individual damage claims at some point, doing so does not destroy commonality. (*Yokoyama v. Midland National Life Ins. Co* (9th Cir. 2010) 594 F.3d 1087, 1089 ["[t]he amount of damages is invariably an individual question and does not defeat class action treatment"].)

Under substantive California law, once liability is determined, a plaintiff need only present a reasonable basis to estimate damages based on the available evidence. (*Stott v. Johnston* (1951) 36 Cal.2d 864, 875 ["[O]nce the cause and existence of damages have been so established, recovery will not be denied because the damages are difficult of ascertainment"]; (*Mardirossian & Assoc., Inc. v. Ersoff* (2007) 153 Cal.App.4th 257, 269 [affirming damages award for unpaid fees, even though plaintiff had failed to keep any formal billing records].)

Whether proof of damages in a given insurance case can be culled exclusively from the insurer's database or must be constructed from external sources, the court must be shown that common proof of damages can be presented. The class-certification motion should be accompanied by the appropriate evidence and an expert declaration establishing how the damages calculation will work. While the certification proceeding is not the time to prove damages, it is the time to show how damages can be proven without resorting to numerous individualized mini-trials.

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