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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

EILEEN-GAYLE COLEMAN, and ROBERT CASTRO, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

UNITED SERVICES AUTOMOBILE ASSOCIATION and USAA GENERAL INDEMNITY COMPANY,

Defendants.

CASE NO. 3:21-cv-00217-RSH-KSC

DEFENDANTS' OPPOSITION TO PLAINTIFFS' RENEWED MOTION FOR CLASS CERTIFICATION

Hearing:
Date:
Courtroom: 3B
Judge: Hon. Robert S. Huie

PER CHAMBERS RULES, NO ORAL ARGUMENT UNLESS SEPARATELY ORDERED BY THE COURT

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I. INTRODUCTION

Plaintiffs claim "a lack of data" "hampered" them from establishing in their prior class-certification motion that common issues will predominate over individual ones. Dkt. 119 ("Mot.") at 11. Plaintiffs also say they've fixed the flaws in their prior submissions, so they can now meet their evidentiary burden at the class-certification stage. But none of that is correct. Their second bite at the apple recycles the *exact same model* that has already proven inadequate. This is not actually a "renewed" motion for class certification at all; it's a motion for reconsideration with no new facts or new law. Plaintiffs have done nothing to address the fundamental problems that Defendants identified the last time around.

Defendants, for their part, have shown a host of reasons why this case cannot be an "exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only." *Wal-Mart v. Dukes*, 564 U.S. 338, 348 (2011).

First, under Rule 23(b)(3), class actions aren't permissible unless they are "superior to other methods for fairly and efficiently adjudicating the controversy." Here, Plaintiffs' overarching theory is that USAA General Indemnity Company (GIC) policyholders in California paid too much for their auto insurance compared to the policyholders of United Services Automobile Association (United Services). But insurance rates are among the most regulated products in California—they are meticulously set and approved by the Department of Insurance based on detailed actuarial formulas built upon the particular risk exposure of each company, so as to ensure the company takes in enough premium to cover the claims of its insureds. Plaintiffs attempt to second-guess those regulator-approved rates and have this Court set different ones for roughly *200,000* policyholders via a class action.

These sorts of disputes over insurance rates are most fairly and efficiently resolved through regulatory action, not a class proceeding. Plaintiffs had (and still have) ample opportunity to raise their concerns before the Department, which has various tools to investigate and remedy excessive or discriminatory rates, or their

unlawful or unfair application to any particular group of policyholders. Plaintiffs cannot show that a class action would be "superior" to these mechanisms.

Second, the fact (and extent) of *each* GIC policyholder's injury will turn on potentially millions of individualized calculations that will engulf any common questions, making certification improper under Rule 23(b)(3)'s "predominance" and "manageability" requirements. The problem with Plaintiffs' model was never a "lack of data," as they repeatedly suggest. Mot. at 11, 13. The problem, as their expert conceded, is that the model doesn't account for the many individualized questions that need to be answered at trial—doing so would be (in his words) "unreasonable," as there are too many transactions to consider. And that problem still exists.

Third, even setting that problem aside, Plaintiffs' model depends on absurd assumptions that have literally zero basis in actuarial standards or regulatory practice, and it contravenes *Comcast Corp. v. Behrend*, 569 U.S. 27, 35 (2013), because it bears no connection to Plaintiffs' liability theory. The model does not even attempt to figure out what GIC policyholders should have paid in the counterfactual world where GIC and United Services charged the same rates. In other words, Plaintiffs' model assumes that Defendants would have (or could have) violated California law by charging class members something other than the very rates the Department approved.

In short, as was clear from the last time this was briefed, simply having a model isn't enough to certify a class. Plaintiffs' burden is to demonstrate that the model can accurately determine the existence and magnitude of supposed injuries across some 200,000 policyholders. They have once again failed to do so.

II. BACKGROUND

A. USAA's founding and gradual expansion of offerings.

Founded in 1922, USAA began by insuring just 25 Army officers. Dkt. 122-3 ("Wechsler Decl.") ¶ 9. It now provides auto insurance through four companies, each serving a different segment of the military and their families. Dkt. 109 ("Order") at 2.

USAA maintains "Company of Placement Rules" that set criteria for placing

policyholders in the appropriate USAA insurer. Wechsler Decl. ¶ 12. Since 2015, the California Department of Insurance has required all USAA insurers to file these rules with the Department as part of their public rate filings. *Id.* Plaintiffs say that, under these rules, United Services insures officers, whereas GIC insures enlisted personnel. Mot. at 1. In reality, United Services insures many enlisted personnel, and GIC insures many officers. Wechsler Decl. ¶ 13. United Services generally insures *higher-ranking* officers and enlisted personnel, and GIC generally insures *lower-ranking* officers and enlisted personnel. *Id.* ¶¶ 13–15.

B. California's prior-approval process for insurance rates.

Since 1989, insurance companies, including USAA, have had to secure "prior approval" from the Insurance Department for the rates they intend to charge California policyholders. *MacKay v. Superior Court*, 188 Cal. App. 4th 1427, 1440 (2010). They "cannot change rates in any way without [the Department's] prior approval." Wechsler Decl. ¶ 22. If any insurer tries to charge rates *other than* those the Department approved, there is a civil penalty. *Id.* (citing Cal. Ins. Code § 1858.07).

California also dictates *how* an insurer must calculate its proposed rates. In general, the Department requires each insurer to set its rates based on its particular loss history (volume of claims submitted by and paid to policyholders), to ensure the company is able to pay out all future claims, while also making a reasonable profit. Dkt. 122-1, Ex. B ("Watkins Rep.") at pp. 4–8; *see also*, *e.g.*, 10 Cal. Code Regs. § 2643.3(a). All else equal, an insurer whose typical policyholder has been in several accidents will end up with higher rates than one whose typical policyholder has not.

Insurers applying for rate approval in California must calculate their proposed rates in two steps. First, they determine the "'base rate' for a particular type of coverage, which is the same for each policyholder." Order at 2. "The base rate reflects the total annual premium the company must charge all policyholders to cover its projected losses and expenses and obtain a reasonable rate of return." *Id.* This generally means insurers with higher average losses *must* charge higher base rates to

cover anticipated future losses. Dkt. 122-2 ("Saner Decl.") ¶ 13.

Second, insurers utilize a system of rating factors to adjust the base rate to each policyholder's specific risk profile. *See* Order at 3–4. Generally speaking, policyholders presenting above-average risks will pay more than the base rate, while those presenting below-average risks will pay less. *See* Saner Decl. ¶¶ 24–25.

"Under California law, insurers are required to apply three mandatory rating factors: driving safety record, annual miles driven, and years of driving experience." Order at 3. These factors have the strongest influence on whether any particular policyholder will pay more or less than the insurer's base rate. 10 Cal. Code Regs. § 2632.8(d); Watkins Rep. at pp. 8–9. "Insurers are also permitted to apply 15 optional factors." Order at 3. These optional factors include things like a policyholder's marital status, the type of vehicle insured, and the policyholder's claim frequency and severity. 10 Cal. Code Regs. § 2632.5(d); Saner Decl. ¶ 20.

"Each rating factor is divided into two or more categories which determine whether the policyholder receives a discount or a surcharge." Order at 3. "To accomplish these adjustments, each category within a rating factor is given a relativity, which is a coefficient multiplied against the base rate." *Id.* at 3–4. "This process is repeated for all rating factors to arrive at the final premium and for each coverage the policyholder obtains." *Id.* at 4. Like base rates, relativities are calculated based on the entire risk pool's historical losses; they "indicate the potential risk of each category within a rating factor as compared to the other categories." Saner Decl. ¶ 26. Just as each company has a unique Department-approved base rate derived from the insurer's historical loss data, it also has a unique Department-approved set of rating factors and relativities. Saner Decl. ¶ 55. A policyholder's total annual premium is the sum of premiums for each of the coverages that the policyholder selects." Order at 4.

Only after the Department has approved proposed rates and relativities based on an insurer's extensive historical loss data can the insurer charge those rates and relativities to its policyholders. *E.g.*, Wechsler Decl. ¶ 22; Watkins Rep. at pp. 4–8.

C. The Department's approval of United Services' and GIC's rates and USAA's placement rules.

The Department requires each of the USAA insurers to calculate and apply for their rates independently, each based on historical loss data regarding their unique pool of policyholders. Wechsler Decl. ¶ 16. Each USAA insurer—including United Services and GIC—has separately applied for and received approval for every rate that it has charged policyholders in California. *See id.* ¶¶ 16–21; Saner Decl. ¶¶ 15–17.

As required by actuarial standards and California law, United Services' and GIC's rates and relativities are drawn from each company's unique historical loss portfolio. Wechsler Decl. ¶ 16. Each company's base rates are set in reference to its own policyholders' historical loss data. Because the average GIC policyholder has a history of greater losses than the average United Services policyholder, the Department has generally required GIC to charge higher base rates than United Services (to cover GIC's higher anticipated losses). Saner Decl. ¶¶ 13–14. And, as Plaintiffs and their experts recognize, the Department has approved different relativities for GIC and United Services. *See, e.g.*, Dkt. 119-1 ("Griglack Rep.") ¶¶ 6–8.

The Department has also reviewed and is familiar with USAA's placement rules and longstanding practice of insuring different segments of the military through four different insurers. Wechsler Decl. ¶¶ 16–21. The Department has recognized that each insurer provides the same coverage options to different segments of the military; that each charges different rates for that coverage; that United Services "had a lower base rate and [GIC] had a higher base rate"; and that USAA's placement rules determine which insurer, if any, may offer coverage to each policyholder. *Id.* ¶¶ 18–19. The Department has never suggested that the different rates and relativities it approved for each company, based on those companies' unique risk pools, were somehow unlawful or otherwise improper. *See id.* ¶ 20.

D. Plaintiffs' claims.

Plaintiffs allege that two longstanding USAA practices violate California law.

Mot. at 1–2. *First*, they allege that USAA discriminates against enlisted personnel on the basis of their "military status" because GIC's base rates are higher than United Services' (though Plaintiffs concede that thousands of GIC policyholders still pay lower *premiums* than they would pay if their policies had been issued by United Services). *See id.* Plaintiffs generally seek to represent a class of "enlisted" persons in California who paid more for their GIC policies than they would have paid had their premiums been calculated using the United Services rating system. *Id.* at 3–4.

Second, Plaintiffs allege that GIC engages in unlawful and unfair business practices, in violation of California's Unfair Competition Law, by not offering enlisted policyholders who qualify as statutory "good drivers" a rate from United Services. *See* Mot. at 1. On these claims, Plaintiffs generally seek to represent a class of "enlisted" persons in California who qualified as statutory "good drivers" and who paid more for their GIC policies than they would have paid had their premiums been calculated using the United Services rating system. *Id.* at 3.

E. Plaintiffs' original Motion for Class Certification.

Plaintiffs moved for class certification last year, supported almost entirely by an injury/damages model proposed by their expert witnesses. Dkt. 58. Plaintiffs then moved *twice* to amend their class definitions. Dkts. 85, 87. Among other things, these serial motions sought to lop off nearly a quarter of the four-year class period being analyzed (9 months out of 4 years). Plaintiffs did this, they explained, because their model proved unable to reliably calculate what GIC policyholders actually paid in premiums and what they would have paid under Plaintiffs' theory. Dkt. 85-1 at 3–4.

The Court denied class certification. Order at 20. It did not address all of USAA's arguments, but held it was enough that Plaintiffs had failed to show that common evidence and issues would predominate over individual ones. "This is not a case," the Court explained, "where the common evidence—the publicly available set of rates and relativities offered by United Services and GIC—itself establishes any of the elements of injury or damages." *Id.* at 19. Rather, "[a]s proffered by Plaintiffs,

those rates and relativities are only relevant to the extent that they provide inputs that are used by Plaintiffs' experts in developing a methodology for determining injury and damages for each of the putative class members." *Id.* And while Plaintiffs claimed their experts had "developed a model that can be used to ascertain injury and damages—whether a GIC insured overpaid, and if so, by how much"—Plaintiffs did not show how those methodologies would actually "establish common, class-wide answers to the questions posed by the elements of Plaintiffs' claims." *Id.* at 17, 19.

With the Court's permission, Plaintiffs filed a renewed motion for class certification. Dkt. 119. They now claim they were unable to satisfy Rule 23 in their prior motion because "they were hampered by lack of data." *Id.* at 2. Yet Plaintiffs make virtually all of the same arguments they made in their prior motion, and attempt to show predominance using the exact same injury/damages model from before.

III. LEGAL STANDARD

Rule 23 "imposes stringent requirements for certification that in practice exclude most claims." *Am. Express Co. v. Italian Colors Rest.*, 570 U.S. 228, 234 (2013). Plaintiffs "must actually *prove*—not simply plead—that their proposed class satisfies" the requirements of Rule 23(a) and the predominance, manageability, and superiority requirements of Rule 23(b)(3). *Olean Wholesale Grocery Coop., Inc. v. Bumble Bee Foods LLC*, 31 F.4th 651, 664 (9th Cir. 2022) (en banc). Class certification is appropriate only if, "after a rigorous analysis," the district court is satisfied that the plaintiffs have carried their burden of affirmatively demonstrating by a preponderance of evidence that each requirement is met. *Id.*

"Frequently that 'rigorous analysis' will entail some overlap with the merits of the plaintiff's underlying claim." *Dukes*, 564 U.S. at 351. Where, as here, actual injury is an element of the plaintiffs' claims, they must show they can prove, with common evidence, which putative class members were harmed by the defendants' challenged conduct. Plaintiffs cannot shirk that burden by claiming "these individualized issues of harm are 'damages issues' that can be tried separately." *Lara*

v. First Nat'l Ins. Co. of Am., 25 F.4th 1134, 1139 (9th Cir. 2022) (lack of injury is "not a damages issue; that's a merits issue").

IV. ARGUMENT

The Court should deny Plaintiffs' renewed motion for any of three reasons.

First, a class action is not a superior method of resolving this dispute. Consumers like Plaintiffs have several different mechanisms for complaining to the Insurance Department about insurance rates—and the Department has ample authority and expertise to police supposedly unlawful or discriminatory rates.

Second, Plaintiffs must demonstrate whether and to what extent any GIC policyholders were injured. Their experts' model can't do that because it estimates GIC premiums and but-for premiums only once every six months. The only way to answer these questions accurately and consistent with due process is through a series of individualized inquiries accounting for every change a policyholder made during the class period, and the resulting effect on premiums. These inquiries would engulf any common issues in a class trial and make it unmanageable, precluding certification.

Third, Plaintiffs' injury/damages model calculates the but-for premium—that is, what any given policyholder *should have* paid—based on numerous impossible assumptions, in particular that GIC could have charged different rates than those the regulator approved, in violation of California law. Plaintiffs' model also violates *Comcast* because it is untethered to their theory of the case. It doesn't measure what premiums would be in the counterfactual world where USAA charged the *same* rates to enlisted and officer policyholders—which is the problem their claims target.[1]

A. A class action isn't the superior method of resolving Plaintiffs' concerns over USAA's rates and their application to enlisted policyholders.

To certify a class, a court must be satisfied that a class action is "superior to other available methods for fairly and efficiently adjudicating the controversy," Fed. R. Civ. P. 23(b)(3)—in other words, that there is "no realistic alternative" to a class

[1] Plaintiffs continue to define their classes to include only those who were injured. As Defendants have explained, such fail-safe definitions aren't allowed. Dkt. 65 at 24–25.

action. *Valentino v. Carter-Wallace, Inc.*, 97 F.3d 1227, 1235 (9th Cir. 1996).

Here, there is one: The Insurance Department has expertise and varied tools to remedy any claimed unfairness or illegality in USAA's rates or their application. The Department comprehensively preapproves and regulates insurance rates—including GIC's and United Services' here. Wechsler Decl. ¶ 22. Should the Department come to believe those rates are unlawful or being applied unfairly, the Department has the authority to initiate a rate proceeding. *Id.* ¶ 28. And "[a]ny person may initiate or intervene" in such a proceeding. Cal. Ins. Code § 1861.10(a).

Consumers like Plaintiffs who believe they are "aggrieved by any rate charged, rating plan, [or] rating system . . . adopted by an insurer . . . may file a written complaint with the commissioner requesting that the commissioner review the manner in which the rate, plan, [or] system . . . has been applied with respect to the insurance afforded to that person." Cal. Ins. Code § 1858(a). The Commissioner has a program to investigate such complaints. *See id.* § 12921.1(a). His broad authority empowers him to "require from every insurer a full compliance with all the provisions of this code." *Id.* § 12926. That authority specifically extends to addressing "violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1"—the very article that forms the basis for Plaintiffs' "good driver" claims here. *Id.* § 12921.3(a). The Commissioner's toolkit also includes a "cease and desist order" and monetary penalties. *Id.*, § 12921.8(a).

The Commissioner's comprehensive power to address the issues at the heart of this case is not just theoretical. In 2015, his Department examined USAA's longstanding practice of segmenting military members into different companies and charging different rates for each company. The Department acknowledged that United Services "insures active military officers and noncommissioned officers while [GIC] insures active military enlisted personnel," and that United Services "had a lower base rate and [GIC] had a higher base." Weschler Decl., Ex. B at p. 43. The Department recognized that the Insurance Code (specifically Section 11628(f)) authorizes these

practices, but expressed concern about policyholders being placed into the correct company. *Id.*, Ex. B at pp. 43–44. So the Department began requiring USAA to ensure its placement rules were mutually exclusive and were filed regularly with the Department (*id.*, Ex. C at p. 47), which USAA has done ever since (*id.* ¶ 21).

Given this sort of comprehensive regulatory regime, the Western District of Washington recently dismissed a copycat lawsuit against USAA based on the exact theory Plaintiffs assert here. That court refused to entertain "claims and damages directly attack[ing] agency rates [that] would necessarily require [the court] to reevaluate agency-approved rates." *Epstein v. USAA Gen. Indem. Co., et al.*, Case No. 2:22-cv-00684-MJP, 2022 WL 11216475, at *3 (W.D. Wash. Oct. 19, 2022).

Courts have often held that this sort of comprehensive regulation mean a class action isn't a superior method of resolving disputes. For example, in *Shasta Linen Supply, Inc. v. Applied Underwriters, Inc.*, 2019 WL 358517 (E.D. Cal. Jan. 29, 2019), the court denied certification for lack of superiority in part because the plaintiffs and the would-be class members could seek relief directly from the California Department of Insurance. *Id.* at *4–5. And in *Rowden v. Pacific Parking Systems, Inc.*, 282 F.R.D. 581 (C.D. Cal. 2012), the plaintiff sued over a municipality's parking practice. The court denied class certification because disgruntled parkers could present claims directly to the government under the California Government Claims Act. *Id.* at 586. Because "California has a viable administrative claims process capable of expeditiously processing [the plaintiff's] claims," it was "simply not credible to argue that a class action is the 'superior' method." *Id.* at 587.

There are many other such cases. *E.g.*, *Pattillo v. Schlesinger*, 625 F.2d 262, 265 (9th Cir. 1980); *Lanzarone v. Guardsmark Holdings, Inc.*, 2006 WL 4393465, at *5 (C.D. Cal. Sept. 7, 2006); *Chin v. Chrysler Corp.*, 182 F.R.D. 448, 464 (D. N.J. 1998) ("there is insufficient justification to burden the judicial system with Plaintiffs' claims while there exists an administrative remedy that has been established to assess the technical merits of such claims"). The gist is that where an agency has authority

and expertise to tackle a problem, there's no need to burden courts with a class action.

Plaintiffs have never tried to avail themselves of any of these administrative remedies. They have not attempted to intervene in a rate proceeding (even though GIC's and United Services' rates have *both* been updated during the pendency of this case). Nor have they complained to the Department that GIC's rates are impermissibly higher than United Services'. Critically, should Plaintiffs prevail in this action on behalf of a class of GIC insureds, the result would be a court-ordered change to insurance rates the Department has already carefully considered and approved—any such remedy would require the Department's involvement.

In the last round of class-certification briefing, Plaintiffs argued that a class action would nonetheless be superior because the Insurance Commissioner cannot issue monetary relief. Dkt. 67 at 1 (citing *State Farm v. Lara*, 71 Cal. App. 5th 148 (2021)). But "superiority" doesn't turn on selecting the venue that maximizes the potential for monetary recovery. Rather, the "superiority" inquiry focuses on "the relative advantages of alternative procedures for handling the total controversy." Fed. R. Civ. P. 23 advisory committee's note to 1966 Amendment.

In any event, Plaintiffs are wrong: The Commissioner *does* order insurance companies to pay money directly to consumers. For example, he ordered auto insurers to refund months of premiums to policyholders during the COVID-19 Pandemic. *See* Insurance Department Bulletin (Apr. 13, 2020), at https://tinyurl.com/3anpmypk ("Commissioner Lara hereby orders insurers to make an initial premium refund for the months of March and April to all adversely impacted California policyholders"). And as recently as March of this year (well after the *Lara* decision in 2021), he ordered an insurer to refund $1.5 million to homeowners allegedly overcharged for wildfire risk. *See* Press Release (March 28, 2023), at https://tinyurl.com/5bp42zk6.

Plaintiffs also argued previously that the Commissioner had "explained that class actions challenging insurers' application of approved rates do not interfere with the work of the CDI." Dkt. 67 at 2–3. But potential "interference" with the Insurance

Department is not the relevant question at this stage. And Plaintiffs' only support for this assertion was *Rejoice! Coffee Co., LLC v. Hartford Fin. Servs., Grp., Inc.*, 2021 WL 5879118 (N.D. Cal. Dec. 9, 2021), which is readily distinguishable—it has nothing to do with class certification, and it arose in the unprecedented context of the COVID-19 pandemic. The suit in *Rejoice!* challenged the *application* of Department-approved rates, not the rates themselves. The Insurance Commissioner filed a brief urging the court not to dismiss the case because a plaintiff may challenge "'an insurer's refusal to adjust its insurance premiums to account for the changed circumstances posed by the COVID-19 pandemic.'" *Id.* at *6. Here, by contrast, Plaintiffs challenge the approved rates themselves; nothing has changed since the Commissioner approved GIC's and United Services' rates and placement rules.

Put simply, there is "insufficient justification to burden the judicial system with plaintiffs' claims while there exists an administrative remedy that has been established to assess the technical merits of such claims and that can handle those claims in a more efficient manner." *In re Ford Motor Co. Ignition Switch Prods. Liab. Litig.*, 174 F.R.D. 332, 353 (D. N.J. 1997). Because muscular administrative enforcement is a "realistic alternative" to a class action, *Valentino*, 97 F.3d at 1234–35, the Court should deny Plaintiffs' renewed motion for lack of superiority.

B. Plaintiffs cannot show who, if anyone, was injured, or in what amount.

Article III requires Plaintiffs to prove that they and all class members suffered an injury caused by Defendants. *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2205–08 (2021). Plaintiffs readily concede that not all GIC policyholders would be better off with United Services' rates. Mot. at 7, 12. So at the class certification phase, Plaintiffs must propose a methodology capable of identifying which GIC policyholders were injured and which weren't. *See Olean*, 31 F.4th at 668 & n. 12. Otherwise, uninjured GIC policyholders would be included in the class and could recover damages at trial—violating Article III. *See Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 446 (2016) (Roberts, C.J., concurring) ("Article III does not give federal courts the power to order

relief to any uninjured plaintiff, class action or not.").

If individualized inquiries are necessary to sort out which GIC policyholders were injured by the challenged conduct, Plaintiffs must prove at the certification phase that those individual questions won't overwhelm the common ones at trial. *Olean*, 31 F.4th at 668–69. When resolving "whether each individual putative class member was harmed" by the challenged conduct "would be an involved inquiry for each person, common questions do not predominate." *Lara*, 25 F.4th at 1139.

Even apart from the question of injury-or-not, Plaintiffs must also demonstrate that individual questions of damages won't overwhelm the common issues at trial. The Ninth Circuit recently emphasized that a plaintiff must put forward a "proposal for calculating damages for each class member" that—"though individualized"—is "straightforward," with "common questions continu[ing] to predominate." *Bowerman v. Field Asset Servs., Inc.*, 60 F. 4th 459, 469–70 (9th Cir. 2023).

Moreover, if Plaintiffs propose at the certification stage a model for determining the fact and extent of injury, "courts must conduct a 'rigorous analysis' to determine whether" that model is "consistent with [their] liability case." *Comcast*, 569 U.S. at 35 (cleaned up). If it isn't, Plaintiffs "cannot possibly establish that damages are susceptible of measurement across the entire class for purposes of Rule 23(b)(3)." *Id.*

Plaintiffs stumble on each of these hurdles. They continue to rely on the very same flawed injury/damages model from before. The only way to determine whether any given policyholder has actually been harmed—and in what amount—would be to account for many thousands of individualized transactions during the class period, making a class trial unmanageable and making certification inappropriate under Rule 23(b)(3) and *Olean*. Plaintiffs' model also rests on unfounded (in fact impossible) assumptions and isn't connected to their theory of liability, violating *Comcast*.

1. Determining which GIC policyholders were injured would require millions of individualized inquiries.

The parties agree that whether any given GIC policyholder was injured by the challenged conduct boils down to a straightforward subtraction problem:

What is the difference, if any, between
A (what GIC actually charged policyholders for insurance) and
B (what it *should have* charged them)?

The only way to determine whether a policyholder has actually been harmed would be to account for every transaction she entered during the class period and then to calculate the effect on both A (actual premiums) and B (but-for premiums) at each point in time. Plaintiffs' model cannot do that, as their experts admit.

The problem with Plaintiffs' model starts with variable "A," the amount that GIC actually charged policyholders for insurance. Plaintiffs do not propose proving that amount directly, say, through billing records. Instead, their experts propose what they've described as a "deriv[ation]" of the figure (Dkt. 64-1 at 126), calculated using eight one-day "snapshots" over the nearly four-year class period (less than 0.6% of the class period) of what each GIC policyholder would be expected to pay for the following six months. Griglack Rep. ¶¶ 5, 8, 31. The experts take each policyholder's information (zip code, driving history, type of vehicle(s), coverages, limits, applicable discounts, etc.) as it existed on March 31 and September 30 of each year (eight arbitrary dates, not corresponding to class members' actual policy periods), and apply GIC's base rates and relativities to determine what that policyholder would expect to pay in premium to GIC for the next six months. *Id.* ¶¶ 11–31.

Then, to calculate the other half of the equation—variable "B," or the premiums that policyholders *should have* been charged—the experts take the same eight sampling dates and try to estimate what the GIC policyholder would have paid if, instead of using its own rating system, GIC had calculated premiums using United Services' base rates and relativities. Griglack Rep. ¶¶ 4–6. Subtracting that notional United Services premium from the GIC premium supposedly identifies whether any particular policyholder was injured (i.e., if the difference yields a positive number) and if so, the amount of damages. *Id.*¶¶ 7; Mot. at 7–8, 12.

A key flaw in Plaintiffs' approach is that it doesn't account for the many

transactions that can and do change a policyholder's premium *in between* "snapshots" taken every six months—things like adding or removing a car or coverage, increasing or decreasing the limits of a coverage, getting married or divorced, getting a speeding ticket, or even cancelling a policy entirely. Dkt. 122-1, Ex. E ("Strombom Rep.") ¶ 21; Saner Decl. ¶¶ 40–41. Policyholders often make these sorts of mid-period changes to their policies, causing big differences in their premiums, both positive and negative. Saner Decl. ¶¶ 37–42; Dkt. 122-1, Ex. C ("Watkins Rebuttal Rep.") at pp. 5–7.

As explained in the expert reports of Dr. Bruce Strombom, Plaintiffs' own transaction histories demonstrate how critical it is to account for between-snapshot policy changes. Dkt. 122-1, Ex. F ("Strombom Rebuttal Rep."), Ex. 1. During one six-month period, Plaintiff Castro changed his liability coverage limits and added rideshare gap protection when he began working as a Lyft driver (increasing his premium by $174.76); changed his liability limits again and removed the rideshare gap protection from one of his vehicles (reducing his premium by $18.33); and then saw his premium go up by $135.28 when his wife no longer qualified for the good-student discount. Dkt. 122-1, Ex. J ("Castro Dep. Tr.") at 92:18–98:15. In another six-month period, Castro changed the operator information and traded in one vehicle for a new one (increasing his premium by $132.18), then changed the operator information again (reducing his premium by $68.83), and then moved (increasing his premium by $271.79). *Id.* at 101:2–105:9.

Plaintiff Coleman has a similarly complex transaction history. During one six-month policy period, she removed a vehicle from her policy (reducing her premium by $542.13) and then added another (increasing her premium by $104.38). Dkt. 122-1, Ex. K ("Coleman Dep. Tr.") at 144:12–148:21. In another six-month policy period, she got into an accident (increasing her premium by $175.38) and then changed her address to South Dakota (increasing her premium by $310.03). *Id.* at 151:11–155:10.

In total, Dr. Strombom's analysis determined that "[a]pproximately 63% of the named Plaintiffs' policies (12 of 19 policies) had at least one policy adjustment that

affected the policy premium during the six-month policy period so that the initial premium (*i.e.*, the premium as of the effective date of the policy) was *not* equal to the total premium actually paid by the policyholder." Strombom Rep. ¶ 24. And for over 40% of these policies, the difference between the initial premium and the amount actually paid was more than $100. *Id.*

Plaintiffs' approach doesn't just ignore between-snapshot policy *changes*—it also ignores between-snapshot policy *cancellations*. These too, are common. A random sampling suggests that *14.5%* of policies that Plaintiffs' experts assessed in their model had intra-period policy cancellations. Strombom Rebuttal Rep. ¶ 14. So, for example, if Plaintiffs calculated that someone paid $400 for six months of auto insurance to GIC on a snapshot date (and would have paid some other amount if insured by United Services)—but that individual actually cancelled their policy three months into the period—Plaintiffs' calculation would be off by $200 (50%).

Dr. Strombom analyzed a random sample of 400 policies to determine how accurately Mr. Griglack's model—which ignores between-snapshot policy changes and cancellations—was able to calculate the amount of premiums *actually* paid by GIC policyholders. Strombom Rebuttal Rep. ¶¶ 14–15. Unsurprisingly, the model performed very poorly. And that was the case regardless of which snapshot period the policy fell within. "Across all snapshot dates," Mr. Griglack's analysis showed, "the average difference (absolute value) between Mr. Griglack's calculated GIC premium and the actual premium paid by policyholders in the sample ranged from $72.90 to $102.50," that is, "from 6.9 percent to 10.4 percent of the total premium." *Id.* ¶ 15 & Ex. 2. To put the magnitude of Mr. Griglack's errors in perspective, across the 400 sampled policies, Mr. Griglack's calculated GIC premium figures were off by a collective absolute value of *over $172,000*. Strombom Rebuttal Rep., Ex. 2.

Plaintiffs' expert admitted his model did not account for *any* of the changes that any of the GIC policyholders might have made in the six-month periods between snapshots, or the resulting changes in their actual or but-for premiums. Dkt. 122-1,

Ex. I ("Griglack Dep. Tr.") at 101:14–105:1, 129:19–132:9. To do so, he would have needed to consider, for each of the 200,000-odd GIC policyholders, the dates of any changes they made to their policy, what they were, and the effect those changes had on the GIC premium along with the corresponding effect on the hypothetical United Services premium. Every one of those policyholder-specific transactions can have a significant impact on the *actual premiums* a policyholder paid to GIC or would have paid under the United Services rating system. Saner Decl. ¶¶ 40–42. This introduces potentially *millions* of individualized inquiries into the equation.

The Ninth Circuit has held class certification inappropriate in similar circumstances. In *Lara*, the plaintiffs asserted an insurer improperly calculated the values of policyholders' totaled vehicles. 25 F.4th at 1136. Because the insurer "only owed each putative class member the actual cash value of his or her car," the plaintiffs would have had to prove that each and every would-be class member received less than actual cash value—an inquiry that "would involve looking into the actual pre-accident value of the car and then comparing that with what each person was offered, to see if the offer was less than the actual value." *Id.* at 1139. What the plaintiffs proposed to do instead was an irrelevant shortcut—taking the amount of a supposedly illegal adjustment to insurance payouts and calling it injury. *Id.* at 1140. Because figuring out whether policyholders were *actually* injured—that is, that they received less than the true value of their totaled cars—"would involve an inquiry specific to that person," the court held that "common questions d[id] not predominate." *Id.* at 1139.

So too here. As Plaintiffs' expert admits, the only way to account for what any policyholders actually paid for GIC coverage and what they should have paid for corresponding United Services coverage is to examine "all transactions for every policyholder, which doesn't seem like a reasonable ask, given the amount of transactions that there could be within any time frame." Griglack Dep. Tr. at 131:19–132:7. That's precisely why, like the expert in *Lara*, Plaintiffs' expert here offers a shortcut—a sampling approach unable to show whether and to what extent

policyholders suffered any harm. The Court should reject this approach.

2. The individualized issues will overwhelm any common questions in a class trial, confirming that a class action is not manageable.

Even if the Court were to permit Plaintiffs to try this case on behalf of a class using their shortcut of an injury/damages model, the Court would still need to allow Defendants to exercise their rights under the Rules Enabling Act and due process to rebut liability and damages as to each of the 200,000-odd class members. *See Dukes*, 564 U.S. at 367; *Carrera v. Bayer Corp.*, 727 F.3d 300, 307 (3d Cir. 2013) ("A defendant in a class action has a due process right to raise individual challenges and defenses to claims, and a class action cannot be certified in a way that eviscerates this right or masks individual issues."). That trial would be wholly unmanageable.

Take Plaintiff Castro, for instance. At trial, Plaintiffs would say that for the six-month period starting on March 31, 2021, he paid $641.19 in GIC premiums and would have paid $508.08 in United Services premiums. Dkt. 122-1 ("Liu Decl.") ¶ 3. In response, Defendants would prove—using billing records and/or declarations pages—that these calculations were wildly inaccurate. Using Castro's actual policy period, and accounting for the mid-period changes he made to his policy, Castro *actually* paid $1,704.62 in GIC premiums during the six-month period between March 5 and September 5 of 2021. Dkt. 122-1, Ex. A ("Watkins Decl.") ¶ 60 & Ex. 4. In other words, Castro *actually* paid GIC nearly *three times* what Plaintiffs' model shows for that approximate period. And the corresponding effect on his but-for premium for that same period is completely unknown. This proves that Plaintiffs' model produces seriously flawed calculations for both A and B.

Similarly, for Coleman, Plaintiffs would say at trial that she paid a total of $1,467.33 in GIC premiums for the six-month period starting on March 31, 2018. Liu Decl. ¶ 4. But Defendants would prove that in April 2018, Coleman deleted one of her cars from the policy, causing her six-month premium to drop by $524.13. Dkt. 64-1 at 144:12-146:9. She then added a different car, increasing her premium by $104.38. *Id.* at 148:15-20. So again, Plaintiffs' model is not remotely accurate.

In the trial, Defendants would then replicate this same sort of evidentiary rebuttal across the remaining seven "snapshot" periods for Castro and Coleman. And they'd potentially go through a similar exercise 200,000 more times—once for each class member. For certain of the class members, this will confirm they are uninjured. For the vast majority of others, it will prove that Plaintiffs' calculations are way off. But there is no getting around the fact that this sort of exercise will be necessary at trial—potentially requiring over a million individualized inquiries (eight snapshot periods times 200,000 class members).

These class-member-specific calculations and evidentiary showings would engulf any common issue at trial, making a class trial unmanageable. In *Bowerman*, the Ninth Circuit held that certification was improper because it became clear (after certification) that fixing damages would not be "a simple matter," and would instead require individualized inquiries for 156 class members. 60 F. 4th at 470. The damages phase here be exponentially more involved. As illustrated above, and as Mr. Griglack testified, it would require the Court to examine "all transactions for every policyholder, which doesn't seem like a reasonable ask, given the amount of transactions that there could be within any time frame." Griglack Dep. Tr. at 131:19–132:7.

3. Plaintiffs' defenses of their "snapshot" approach do not eliminate the need for individualized inquiries.

Plaintiffs offer three arguments in a footnote dedicated to explaining why their snapshot model is good enough. *See* Mot. at 7 n.4. These arguments all fail.

First, Plaintiffs claim "it is entirely speculative" that individualized calculations will be needed to accurately show injury or damages; they fault Defendants' experts for not "answering with credible alternative calculations" of damages. Mot. at 7 n.4. But there is nothing speculative about needing to consider changes and cancellations that affect premiums throughout the class period—the failure to do so results in a model that spits out wildly inaccurate calculations. And it is not Defendants' burden to put forward "credible alternative calculations" of injury and damages; it is enough that Plaintiffs failed to meet their burden of showing predominance at this stage.

Second, Plaintiffs argue that Mr. Griglack has demonstrated "it wouldn't change the outcome" if his model *did* consider between-snapshot changes and cancellations. Mot. at 7 n.4. To explain this argument is to reject it. Essentially, Plaintiffs contend that even though their calculations of GIC premiums for any given policyholder are way off, it doesn't matter because their calculations of United Services premium amounts for any given policyholder are *also* off. The errors, Plaintiffs suggest, will cancel themselves out. As "evidence" for this theory, Plaintiffs cite only Mr. Griglack's conclusion that when his flawed analysis says a policyholder is injured on one snapshot date, it tends to reach the same conclusion for the other snapshot dates. *See id.* (citing Griglack Rep. ¶¶ 44–48, Dkt. 119-2 ("Griglack Rebuttal Rep.") ¶ 7).

This argument "assumes that the transactions impacting the GIC premium impact the United Services premium in the same way." Watkins Decl. ¶ 62. But mid-snapshot changes are made "in rating characteristics that affect GIC premiums and [United Services] premiums differently." Strombom Rebuttal Rep. ¶ 16. These include the most consequential rating characteristics, including two of the three mandatory rating factors (annual mileage and years of driving experience) that, by regulation, have *the strongest impact* on a policyholder's premium calculation. *See id.*; 10 Cal. Code Regs. § 2632.8(d). And changes to these rating characteristics aren't just consequential—they're frequent. "Years of driving experience" changes reliably (every year, like clockwork), and others (like "accident surcharges") unfortunately do too. Plaintiff Castro himself had mid-policy changes to multiple of these rating characteristics with different GIC and United Services relativities, including to a mandatory rating factor. Strombom Rebuttal Rep. at p.7 n.13.

Third, Plaintiffs assert (without citation) that common issues predominate because "the validity and accuracy of [Mr.] Griglack's work is a class-wide question in any event: either he is correct or incorrect," and "[i]n either case, the answer will be the same for all class members." Mot. at 7 n.4. This is not the law. Plaintiffs must show that their model is "consistent with [their] theory of liability," does not "contain[]

unsupported assumptions," and obviates the need for individualized inquiries. *Olean*, 31 F.4th at 666 n.9. Otherwise, *any* model would be a ticket to class certification. *See, e.g.*, *In re Bofl Holding, Inc. Secs. Litig.*, 2021 WL 3742924, at *9 (S.D. Cal. Aug. 24, 2021) (rejecting the notion "that any model of damages" "will suffice merely because the plaintiff asserts the methodology could be applied class-wide").

4. Plaintiffs' methodology rests on impossible assumptions and is untethered to their liability theory.

If the Court grants Defendants' concurrently filed *Daubert* motion (Dkt. 122), then there's no basis for class certification. But even if the Court denies that motion, the Ninth Circuit has explained that expert evidence, even if admissible, "frequently" fails to satisfy Rule 23, such as "where the evidence contained unsupported assumptions" or "where the damages evidence was not consistent with the plaintiffs' theory of liability." *Olean*, 31 F.4th at 666 n.9. Both problems are present here.

Plaintiffs' basic theory is that USAA should have not used higher rates for enlisted personnel than it used for officers. *E.g.*, Am. Compl., Dkt. 49 ¶¶ 2, 3. Plaintiffs must therefore figure out a way to identify which GIC policyholders were injured under this specific theory. *See Comcast*, 569 U.S. at 35 ("at the class-certification stage (as at trial), any model supporting a plaintiff's damages case must be consistent with its liability case" (cleaned up)). A key part of that inquiry is calculating the amount of premium each GIC policyholder should have paid in the counterfactual world where USAA *did not* charge higher rates to enlisted personnel—variable "B" in the formula. But Plaintiffs' experts didn't even attempt to do that.

Instead, they propose calculating variable B in two ways. The primary model calculates (using the same eight sampling dates with all of the same methodological shortcomings) what each GIC policyholder would have paid if, instead of using its own rating system, GIC had calculated premiums using United Services' base rates and relativities. Dkt. 119-3 ("Schwartz Rep.") ¶¶ 6–7. That's not the right counterfactual. There is no world in which one California insurer can calculate their policyholders' premiums using a different California insurance company's rating system.

Under Proposition 103, "auto insurance companies in California—including the USAA companies—can charge only those rates that have received prior approval" from the Department. Wechsler Decl. ¶ 22. And those rates are calculated by feeding the risk profile of a specific group of policyholders, including their loss history, into the Department's formulas. *Id.* ¶¶ 26, 36.

Here, the only way GIC could have charged the same rates to officers and enlisted personnel would be if GIC's and United Services' previously distinct groups of policyholders had been collapsed into one and if Defendants had applied and received approval for a new rating system common to all of them. Wechsler ¶¶ 34–38; *see also* Watkins Decl. ¶¶ 36–46; Dkt. 122-1, Ex. D ("Strombom Decl.") ¶¶ 14–16. That new rating system—the base rates and relativities that would be charged to this newly combined group of policyholders—would be completely different from United Services' current rating system, resulting in completely different "but for" premiums for each class member. Wechsler Decl. ¶ 38; Watkins Decl. ¶¶ 38–39 (only permissible re-rates would "certain[ly]" result in premium calculations that differ from Plaintiffs' experts'); Strombom Decl. ¶¶ 17–19. Likewise, moving "only *some* GIC policyholders—such as only those with collision coverage or only those who qualify as statutory 'Good Drivers'—into United Services"—would have required approvals of totally different rating systems for both insurers. Wechsler Decl. ¶ 37 n.2.

One of Plaintiffs' experts agreed that "in all likelihood" it is not actuarially sound for one company to calculate its premiums by looking to another company's rates and relativities "unless they had similar experience," Dkt. 122-1, Ex. H ("Griglack Second Dep. Tr.") at 110:20–111:4, which isn't the case here because there's no dispute that each company's membership had distinct risk profiles (which is why the rates are different to begin with). The other expert insists that *any* analysis would be defensible if consistent with a legal theory that Plaintiffs' counsel asked him to assume. Dkt. 122-1, Ex. M ("Schwartz Dep. Tr.") at 26:7-16; Dkt. 58-4 at 23, n.25.

But the assumption baked into Plaintiffs' model—that it would be actuarially

appropriate and permissible from a regulatory perspective for GIC to charge premiums using the United Services rating system—is dead wrong. Watkins Decl. ¶¶ 34–46; Saner Decl. ¶¶ 54–55. Class certification cannot be based on an injury/damages model that depends on these sorts of impossible assumptions. *See, e.g., In re New Motor Vehicles Canadian Export Antitrust Litig.*, 522 F.3d 6, 29 (1st Cir. 2008) ("If there is no *realistic* means of proof, many resources will be wasted setting up a trial that plaintiffs cannot win." (emphasis added)). And again, Plaintiffs' expert *conceded* this in his deposition. Griglack Second Dep. Tr.at 110:20–111:4, 112:23–114:12.

The expert's second method of calculating B is just a variation on the first; it cures none of these problems. *See* Watkins Decl. ¶¶ 45–46. It calls for the multiplication of B (as calculated under the first method) by a coefficient supposedly accounting for the problem that if GIC had charged its policyholders less, United Services and GIC together would have lacked sufficient premium revenue to cover all their claims liabilities. Schwartz Rep. ¶ 10; 58-4 ¶¶ 21–24. That Plaintiffs' expert performed this calculation at all suggests he was aware of the implausibility of the first model—that it didn't account for the real-world problem that insurers need the premiums they have been approved to charge to pay out all their losses and cover their expenses. But the modest tweak of this second model is no answer.

In this method, but-for premiums "are still calculated using class plan rates and relativities based on United Services' customer loss experience only." Watkins Decl. ¶ 45. The rates are by definition unreasonable because they don't even try to be "actuarially sound estimates of the expected costs for GIC policyholders." *Id.* ¶ 46.

Even more problematic is that Plaintiffs' model addresses a theory of injury that has no relationship to their liability theory. In *Comcast*, the plaintiffs proposed four liability theories, but the district court accepted only one. 569 U.S. at 31. Because the plaintiffs' proposed damages model did not "isolate damages resulting from any one theory," it could not "possibly establish that damages are susceptible of measurement across the entire class." *Id.* at 32. As a result, "[q]uestions of individual damage

calculations w[ould] inevitably overwhelm questions common to the class." *Id.* at 34. Since *Comcast*, the Ninth Circuit has confirmed that classwide injury/damages models must follow the plaintiffs' liability theory; that's why the court consistently examines whether plaintiffs' models call for remedies actually authorized by the claims they've asserted. *E.g.*, *Nguyen v. Nissan N. Am., Inc.*, 932 F.3d 811, 818–19 (9th Cir. 2019); *Pulaski & Middleman, LLC v. Google, Inc.*, 802 F.3d 979, 988–89 (9th Cir. 2015).

That's precisely the problem here. Plaintiffs' liability theory is that Defendants should have charged the same rates to both enlisted personnel and officers—but their injury/damages model makes no effort to determine what the rates would have been in that scenario. This is not an issue with the *accuracy* of the Plaintiffs' calculations; it's that they're not measuring the right thing in the first place.

Courts cannot overlook the fundamental problem of a model that addresses the wrong question. The Court in *Comcast* criticized the lower courts there for doing just that, reasoning that under their "logic, at the class-certification stage *any* method of measurement is acceptable so long as it can be applied classwide, no matter how arbitrary the measurements may be. Such a proposition would reduce Rule 23(b)(3)'s predominance requirement to a nullity." 569 U.S. at 36. This Court should not repeat that mistake here by endorsing an injury-and-damages model that pays no attention to what the counterfactual world implied by Plaintiffs' claims would require.

5. The inability to distinguish injured from uninjured policyholders risks violating Article III.

Plaintiffs have no way of figuring out how much any given GIC policyholder actually paid over the class period, or how much they would have paid over that same period in a counterfactual world that isn't totally at odds with how insurance rates must be developed and approved in California. The only way to figure out those numbers would be a series of individualized inquiries that Plaintiffs' experts confess they have no ability to perform—premised on a brand-new set of rates and relativities that Plaintiffs' experts admit they didn't calculate.

This is a predominance problem, as in *Lara*. (*See* Sections IV.B.1-3 above.)

It's a *Comcast* problem too. (*See* Section IV.B.4 above). But it's also an Article III problem. Plaintiffs and every single class member must prove they have been "*concretely harmed*" to recover damages in a federal court. *TransUnion*, 141 S. Ct. at 2205. Yet Plaintiffs are unable to identify who overpaid for insurance coverage. Their approach is very likely to misidentify large numbers of uninjured policyholders as injured. *See* Watkins Decl. ¶ 67 (not accounting for mid-period changes renders "the distinction of being injured or uninjured" in the models "arbitrary and meaningless").

Plaintiffs' expert originally said that about one-sixth of GIC policyholders were uninjured (they paid *less* for GIC coverage than they would have paid in Plaintiffs' counterfactual world). Dkt. 58-3 ¶ 35. After rethinking his approach following his deposition, the expert then said only one-eighth of GIC policyholders were uninjured. Dkt. 63-1 at ¶¶ 36–37. Now he says that actually only *three percent* of GIC policyholders were uninjured. Mot. at 7. That swing of about 13% of the class from supposedly uninjured to supposedly injured is just the tip of the iceberg.

Plaintiffs' expert also now says that around 25 to 37% of the proposed classes (depending on which of his damages models you use, which Plaintiffs puzzlingly claim is a merits question, Mot. at 10 n.5) suffered between a penny and $300 in damages. Schwartz Rep. ¶ 14. Having such a large chunk of the class so close to the injured/uninjured line means that even small adjustments to Plaintiffs' approaches to calculating what GIC policyholders actually paid and what they should have paid can change the status of those class members from injured to uninjured (or vice versa).

In sum, Plaintiffs' methodology of identifying injury is not a valid basis for class certification. It doesn't avoid the millions of individualized inquiries necessary to answer the key question of injury, it doesn't track Plaintiffs' liability theory, and it invites Article III problems. The Court should deny certification.

V. CONCLUSION

The Court should deny Plaintiffs' renewed motion for class certification.

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