UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

HELEN HANKS, on behalf of herself and all others similarly situated, Plaintiffs, vs. THE LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK and VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY, formerly known as Aetna Life Insurance and Annuity Company, Defendants.	Case No.: 16-CV-6399 (PKC)

DEFENDANT VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

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Defendant Voya Retirement Insurance and Annuity Company, f/k/a Aetna Life Insurance and Annuity Company ("VRIAC"), submits this memorandum of law in support of its motion for summary judgment.

PRELIMINARY STATEMENT

Plaintiffs' sole claim is for breach of contract. Specifically, Plaintiffs allege VRIAC's 2016 cost-of-insurance rate adjustment ("COI Adjustment") breached the life insurance policies' contractual terms. Instead of supporting a breach of contract cause of action, Plaintiffs' expert reports and pre-motion letters spend scores of pages arguing that the COI Adjustment breached phantom duties comprised of some elusive combination of actuarial standards, actuarial memoranda, redetermination policies, industry practice and New York insurance regulations. However, as Plaintiffs' own experts concede, there is a complete disconnect between Plaintiffs' theories and VRIAC's actual contractual obligations as set forth in the insurance policies. The insurance policies simply do not contain the contractual obligations Plaintiffs claim were breached, and Plaintiffs' various theories premised on actuarial standards, actuarial memoranda, or state regulations outside of the contract have no bearing on this case.

This motion is not about Plaintiffs' expert versus VRIAC's expert, but rather about what VRIAC's contractual obligations are – as distinct from Plaintiffs' claimed extra-contractual obligations. Summary judgment is appropriate because a factual issue only exists if this Court accepts Plaintiffs' contorted reading of the contract to create unsupported extra-contractual obligations. If this Court gives the contract its plain meaning, which it can and should as a matter of law, the actual words of the contract make clear that Plaintiffs' alleged violations, even if they occurred, are not contractual breaches. This should be decided as a matter of law in favor of

VRIAC because Plaintiffs' reading of the contract is inconsistent with its plain language and in many instances contradicted by the testimony of Plaintiffs' own experts.

BACKGROUND

A. Life Insurance and The Policies

The policies at issue are a group, or "block," of 46,918 universal life (UL) and variable universal life (VUL) insurance policies (the "Policies") issued by Aetna Life Insurance and Annuity Company ("Aetna") in the 1980s and 1990s. Dkt. 1 (Complaint) ¶ 13. Today, Aetna does not exist in its original form. Rather, VRIAC, as a successor to Aetna, assumed Aetna's obligation to pay death benefits, and Lincoln Life & Annuity Company of New York ("LLANY"), pursuant to various agreements entered into in 1998, has been responsible for the administration and reinsurance of the Aetna block. *Id.* ¶ 9; Shulman Declaration Exhibit ("Ex.") 1 (Plaintiffs' Expert Report of Robert Mills ("Mills Report"), dated March 1, 2018) ¶ 7.[1]

UL policies, like the Policies, provide policyholders flexibility in premium payment terms and an opportunity to accumulate cash value that the policyholder can access during the life of the insured through loans or withdrawals. SUMF ¶ 3; Ex. 2 (Defendants' Expert Report of David F. Babbel ("Babbel Report"), dated June 1, 2018) ¶ 9. A policy's cash value increases each month by interest credits at a rate set by the insurer. Ex. 2 (Babbel Report) ¶ 13. The insurer then takes a monthly deduction from the cash value, which is calculated by multiplying a "cost of insurance rate" by the total death benefit, net of the cash value. Ex. 3 (Hanks Policy) at 7. Typically, the cost

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[1] In support of its Motion for Summary Judgment, as required by Local Rule 56.1(a), VRIAC submits a Local Rule 56.1 Statement of Undisputed Material Facts, referred to herein a "SUMF." VRIAC also submits additional background evidence, appended to the Declaration of Motty Shulman, dated September 12, 2019. VRIAC provides these additional background materials, which are largely sourced from Plaintiffs' allegations, solely for context but does not proffer them, at this point, as material facts necessary for the adjudication of VRIAC's Motion for Summary Judgment.

of insurance (COI) rates for life insurance policies increase over time to reflect the insured's increasing mortality risk as he or she ages. If the cash value of the policy is insufficient to pay the monthly deduction and additional premiums are not paid, the policy may terminate.

UL and VUL policies provide greater flexibility than term or whole life policies, because the policyholder is not required to pay a fixed premium or abide by a fixed premium schedule to maintain coverage.[2] Ex. 4 at 31-32. UL and VUL policyholders have the option of paying additional premiums or skipping a payment if the cash value is sufficient to cover the monthly deductions. *Id.* A term policy, on the other hand, generally requires fixed premium payments to maintain coverage for the entire term, without the ability to accumulate a cash value. Whole life policies similarly require consistent fixed payments to secure permanent coverage.

Another distinguishing feature of UL and VUL policies is their use of non-guaranteed elements (NGE), including interest crediting rates and cost of insurance rates. *Id.* Any policy guarantee offered by an insurer involves the cost associated with taking on the risk of meeting that guarantee for the policyholder. While the guarantee of permanent coverage may appeal to a more risk-averse policyholder, the relatively high cost of those guarantees results in higher premiums. The non-guaranteed elements in a UL policy provide less conservative policyholders the opportunity to receive better terms at a lower cost because the insurer is not incurring the higher cost of stronger guarantees. *Id.* at 13-14. The insurer takes on the reduced risk of meeting lower guarantees, in the form of minimum guaranteed crediting rates and maximum cost of insurance rates. The policyholder, in turn, assumes the risk that future events may require non-guaranteed rates to be adjusted to less favorable levels. Ex. 2 (Babbel Report) ¶ 9.

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[2] Some of the policies in the class are VUL policies, which allows the policy cash value to be invested in securities through various subaccounts.

The guaranteed minimum interest rate is stated in the policy. Ms. Hanks's policy sets a guaranteed minimum crediting rate of 4.5%, although for many years, at VRIAC's discretion, Ms. Hanks received interest at significantly higher rates. Ex. 3 (Hanks Policy) at 7; Ex. 2 (Babbel Report) ¶ 20. The maximum guaranteed COI rates are also set forth in a table in the policy. Ex. 3 (Hanks Policy) at 4.

There is a straightforward risk vs. reward proposition for UL and VUL policies. These types of policies offer policyholders an opportunity to obtain coverage at lower cost than guaranteed forms of insurance, as well as the opportunity to accumulate cash value. In exchange, policyholders assume the risk that the policy may lapse for insufficient value if they do not adequately fund the policy's cash value. As explained by Plaintiffs' expert, UL policies "transfer the policy sufficiency risk to the policy owner in exchange for flexibility of amount and timing of premium payments." Ex. 4 (Deposition of Plaintiffs' Expert Christopher H. Hause ("Hause Dep. Tr.")) at Ex. 6. For this reason, UL and VUL policies are "much riskier than term life … because the premiums of a term life are generally fixed and there is no volatility to the premium payments required to keep the policy in force." Ex. 5 (Hause Dep. Tr.) at 188:25-189:7. By contrast, term insurance guarantees that coverage will remain in place for a specific term, provided that level premiums are paid. Whole life policies provide guaranteed permanent coverage if all premiums are paid as scheduled, albeit at a much higher cost than UL products.

B. Relevant Contract Provisions

The relevant contractual provision is the Cost of Insurance Rate provision, which is excerpted in its entirety below (Ex. 3 (Hanks Policy) at 9):

Cost of Insurance Rate	The Monthly Cost of Insurance is based on the Insured's sex, attained age and premium class. Attained age means age on the birthday nearest the first day of the policy year in which the monthly deduction day occurs. For the Initial Specified Amount, the premium class on the Date of Issue will be used. For each increase, the premium class for that increase will be used. The monthly Cost of Insurance rates may be adjusted by Ætna from time to time. Adjustments will be on a class basis and will be based on Ætna's estimates for future cost factors, such as mortality, investment income, expenses and the length of time policies stay in force. Any adjustments will be made on a uniform basis. However, the rate during any policy year may never exceed the rate shown for that year in the Table of Guaranteed Maximum Insurance Rates in this policy. Those rates are based on the 1958 Commissioners Standard Ordinary Mortality Table, male or female.

SUMF ¶ 8.

The provision starts by explaining that COI rates are determined using the insured's sex, attained age and premium class, which for Ms. Hanks would be nonsmoker. *Id.*; Ex. 5 (Hause Dep. Tr.) at 113:10-13. The provision then explains that COI rates could be adjusted by Aetna in the future from time to time subject to the following contractual requirements:

Uniform and Class Basis. The contract requires all adjustments be done on a "uniform basis" and that any distinctions between policyholders in how COI rates are adjusted be on a "class basis." This means that VRIAC cannot single out an individual policyholder for an increase or engage in what Plaintiffs' expert calls intra-class discrimination. As explained by Plaintiffs' expert, "a policyholder who gets sick cannot be singled out for a COI increase that does not apply to her entire class, even though her individual life expectancy is diminished." Ex. 6 (Hause Report) ¶ 66. The contract does, however, allow VRIAC to adjust rates differently for different classes, *i.e.*, "on a class basis," so long as it does so for the class as a whole. *Id.* This is called inter-class discrimination and is contractually permitted. *Id.* Thus, while an insurer cannot single out a particular insured for a COI adjustment, it can adjust rates for particular groups or classes of policyholders that have a "special risk or cost" associated with them. *Id.*

Based on Aetna's Estimates for Future Cost Factors. The policy also protects both VRIAC and the policyholder by requiring COI rate increases to be based on the expected future costs of the in-force policies in the group of policies at issue (in insurance jargon called a 'block'), not the already-terminated policies or some unrelated group of policies, which may have vastly different cost factors and characteristics. For example, VRIAC would breach the Policies if it adjusted COI rates based solely on historical cost factors which include terminated policies or if it based a COI adjustment on the future cost factors of some unrelated group of policies (such as group term policies).

Maximum COI Rates. Although COI rates are non-guaranteed elements, the risk of rate increases accepted by the policyholder is not unlimited. Rather, all COI rate increases are capped at the Maximum COI Rates. Each policyholder knows with certainty that their rates may increase over the life of the policy, but will never be higher than the Maximum COI Rates. Since each policyholder receives illustrations with projections showing the performance of the policy using both current and the Maximum COI Rates, policyholders are aware of the impact that increased COI rates can have on their policy.[3]

C. The COI Adjustment

In the decades since the Policies were issued, the economic environment dramatically changed. For example, there has been a dramatic decline in forward-looking interest rates, which

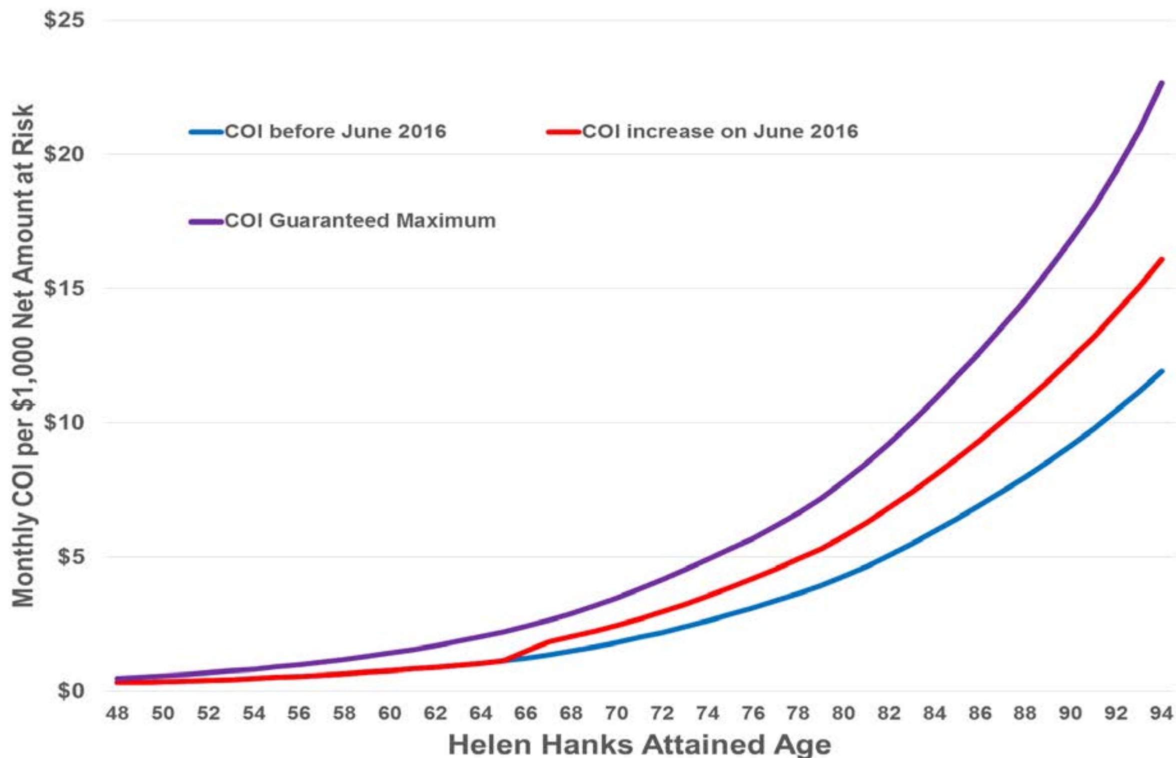
[3] At the time the policies are issued, and upon request thereafter, policyholders receive policy illustrations that project how the policy will perform, on an annual basis, assuming that premiums are paid according to a plan determined by the policyholder and his or her financial advisor. The illustration projects the performance of the policy using both guaranteed and the then-current non-guaranteed crediting rates and cost of insurance rates. Ex. 5 (Hause Dep. Tr.) at 257:22-258:6; Ex. 7 (Hanks Illustration). Ms. Hanks, like all policyholders, was thus fully informed about the range of possible COI rates they could be charged and how any adjustment to those rates might impact the sufficiency of the planned premium and policy cash value.

are a central component in the cost of life insurance. Ex. 2 (Babbel Report) ¶ 33. In the 1980s, when many of the policies were sold, the forward looking 10-Year U.S. Treasury Rate exceeded 10%. By the time the COI Adjustment was implemented in 2016, it was *below 2%. Id.* at Fig. 3. These historically low rates informed a forward-looking expectation that rates would continue to remain low compared to historical experience. *Id.* ¶ 35. Other cost factors such as mortality costs, as reflected in the cost of reinsurance, increased significantly in the years prior to the COI Adjustment (between 35% and 160%). Ex. 8 (Expert Report of Timothy C. Pfeifer ("Pfeifer Report"), dated May 1, 2018) ¶ 41. As a result of these changes in expectations, and as provided under the insurance policies, VRIAC's Board of Directors approved a COI Adjustment, also referred to as a redetermination, to be implemented as of June 1, 2016. SUMF ¶ 15; Ex. 9 (VRIAC _HANKS0007468).

VRIAC did not impose the same nominal or percentage increase for all the Policies. Instead, it segregated the policies into classes, or groupings, by similar product types (*i.e.*, UL policies were grouped separately from VUL policies and policies with a 4% guaranteed rate were grouped separately from products with a 5% guaranteed rate) and imposed a uniform percentage increase for all the policies within each product class. In all, there were eighteen different product classes and COI rate increases of between 15% and 55%. Ex. 6 (Hause Report) ¶ 2.

The vast majority of the policies' COI rates were increased by substantially lower percentages – and more than ten percent of the Policies were not increased at all – because of the contractual Maximum COI Rate. SUMF ¶22; Ex. 8 (Pfeifer Report) ¶ 46. In all, only 37.8% of the Policies received the full increase otherwise authorized under the terms of the policy contracts. Ex. 8 (Pfeifer Report). The remaining Policies received either no increase (10.1%) or a less than full increase (52.1%). *Id.*

Ms. Hanks' COI Adjustment was 35%, which meant that her COI charge increase for the month of June 2016 was $35.88. As shown below, even after the COI Adjustment, Ms. Hanks' COI rate was well below the Maximum COI Rate. Ex. 2 (Babbel Report) ¶ 23.



D. Development of the COI Adjustment

A COI adjustment or redetermination is a complicated data driven analysis and, as Plaintiffs' expert recognizes, "two actuaries, acting reasonably, may very well calculate things differently." Ex. 6 (Hause Report) ¶ 111. The COI Adjustment was analyzed and modeled by LLANY, as policy administrator and reinsurer since 1998, using the relevant data, administrative systems, and actuarial analyses and projections necessary. The COI rate increases were then recommended to VRIAC. SUMF ¶ 9; Ex. 8 (Pfeifer Report) ¶ 45. The modeling was done based on the actual data, or experience, from the Aetna block, and only the Aetna block. Ex. 8 (Pfeifer Report) ¶ 47. The data set, which contains tens if not hundreds of millions of data points, was housed on LLANY's proprietary administrative system. *Id.* LLANY's actuaries were best

positioned to model a potential COI increase because they were most familiar with the Aetna data and understood both the data and the impact to the Aetna block of any potential COI adjustment. LLANY modeled a potential COI adjustment as a percentage adjustment to the then-current COI rates, with any increases capped at the contractual Maximum COI Rates. *Id.* ¶ 45.

LLANY submitted its recommendation to adjust COI rates to VRIAC in February 2016. *Id.* ¶ 48. Shortly after receiving LLANY's recommendation, VRIAC requested additional supporting documentation from LLANY. Ex. 10 (VRIAC_HANKS0007134). VRIAC then replied to LLANY's recommendation on March 9, 2016, requesting even more information including: (i) "A detailed narrative description explaining how Lincoln determined the COI Increase"; (ii) "actuarial disclosures required by ASOP 2"[4] and (ii) "confirmation that Lincoln would provide VRIAC with a reliance letter and a completed non-guaranteed elements interrogatory."[5] After receiving the requested information, VRIAC's actuaries met telephonically with Lincoln's actuaries on March 29, 2016. VRIAC raised several issues and requested that LLANY provide it with financial projections for two representative products. Ex. 11 (LN_HANKS00269273); SUMF ¶¶ 12-13.

Upon reviewing LLANY's analysis, VRIAC's management agreed with LLANY's recommendation. SUMF ¶ 14. Management in turn prepared a recommendation memo it submitted for approval by the VRIAC Board of Directors on April 22, 2016. Ex. 12 (Dkt. 28-

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[4] ASOPs, or Actuarial Standards of Practice, are standards that govern how actuaries practice but are not part of the policy contract. Ex. 2 (Hause Dep. Tr.) 120:21-121:5.

[5] Ex. 13 (LN_HANKS00148996); *see also* Ex. 14 (VRIAC_HANKS0000946) ("Before we can accept or reject the recommendations in the Memorandum, Lincoln must consult with VRIAC and provide VRIAC with the financial, accounting, and related data it needs to evaluate the recommendations . . . .").

13). VRIAC's Board of Directors then reviewed and considered the recommendation, and adopted it by a formal board vote. SUMF ¶15.

E. Plaintiffs' Complaint and Expert Testimony

Ten weeks after the COI Adjustment was implemented, Plaintiffs filed their Complaint alleging breach of contract against VRIAC and unjust enrichment against LLANY.[6] Dkt. 1. Plaintiffs' Complaint did not allege any breach of the "uniform basis" or "class basis" provision and was largely grounded on purported breaches that ultimately had no basis in fact. *Id.*

On March 1, 2018, Plaintiffs submitted the expert report of Christopher H. Hause, Plaintiffs' only actuarial expert. Mr. Hause's report pivots away from the breach of contract allegations in the Complaint and tries to allege a breach grounded in some combination of actuarial standards, actuarial memoranda, industry practice, and New York insurance regulations. Mr. Hause's report specifically alleges the following problems, which Mr. Hause is correctly careful not to call contractual obligations or breaches, but rather "observations and conclusions" regarding "actuarial principles" and "industry practice." Ex. 6 (Hause Report) ¶¶ 5-16.

1. Aetna's Estimates for Future Cost Factors:

   a. Original Pricing: The COI Adjustment "was improperly based on changes in assumptions from those made by Lincoln when it 'purchased' the Subject Policies in 1998" instead of the original pricing at policy issuance. *Id.*

   b. Aetna's Cost Factors: The COI "was not based on permissible cost factors" because it was done to increase LLANY's profits and not based on Aetna's actual costs. *Id.*

   c. Aetna's Actuaries: The COI Adjustment "was not based on Aetna's estimates for future cost factors, as required by the policy language" because although it was approved by VRIAC the detailed modeling was done by LLANY actuaries. *Id.*

[6] The unjust enrichment claim, which was brought only against LLANY and was the only claim against LLANY, was dismissed by stipulation on September 12, 2019. Dkt. 132.

2. Class Basis: The COI Adjustment "was not calculated nor implemented on a 'class' basis" because VRIAC did not use the same classes identified at original pricing. *Id.*

3. Uniform Basis: The COI Adjustment "was not implemented on a uniform basis" because New York's DFS objected to the increase on state-specific regulatory grounds. *Id.*

On August 1, 2018, Mr. Hause was deposed in this matter. In his deposition, Mr. Hause made clear that his opinions are largely divorced from the actual contractual provisions but based on his general views regarding actuarial standards, industry practice, actuarial memoranda that were submitted to New York's insurance regulator in the 1980s, and other documents unrelated to the policy contract. For example, although Plaintiffs claim VRIAC breached the contract by not basing the COI Adjustment on Aetna's original pricing assumptions, Mr. Hause was clear that the actual contract does not contain any contractual obligations relating to original pricing and his opinions are grounded in standards, provisions, and regulations outside the contract.

> Q. Does the policy set forth any contractual obligation with regard to original pricing?
>
> A. With the same caveat that that may well be provided for in other documents and requirements and by actuarial standards and other sound actuarial practice and documents on file with the State Insurance Department, no, that's not listed in the contract.
>
> Q. If it's anything, it's a regulatory obligation, it's not a contractual obligation, correct?
>
> A. I believe that's a legal conclusion because it's not a part of the contractual obligation with the policyholder.
>
> Q. It's not a part of the contractual obligation with the policyholder?
>
> A. Correct.
>
> Q. There may or may not be a regulatory obligation, but it's not a contractual obligation?
>
> A. With the policyholder, correct, yes.

Ex. 5 (Hause Dep. Tr.) at 164:24-165:22; SUMF ¶¶ 20-21.

Plaintiffs' case is built on the house of cards testimony of Mr. Hause, which is focused on claimed violations of some amorphous combination of actuarial standards, actuarial memoranda, redetermination policies, industry practice, and New York insurance regulations that by his own admission is not tied to any contractual language in the insurance policies. Notwithstanding, for the purposes of this motion, this Court need not decide whether Mr. Hause is credible or correct. This Court need only decide what the contractual obligations of VRIAC are in connection with the COI Adjustment. Once those obligations are determined as a matter of law, VRIAC respectfully submits, this Court should find the contractual provisions were satisfied based on the limited undisputed facts set forth in VRIAC's 56.1 Statement of Undisputed Material Facts.

LEGAL STANDARD

Summary judgment "shall" be granted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A fact is material if it "might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). "A dispute regarding a material fact is genuine 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'" *Weinstock v. Columbia Univ.*, 224 F.3d 33, 41 (2d Cir. 2000).

"When the burden of proof at trial would fall on the nonmoving party, it ordinarily is sufficient for the movant to point to a lack of evidence to go to the trier of fact on an essential element of the nonmovant's claim." *Jaramillo v. Weyerhaeuser Co.*, 536 F.3d 140, 145 (2d Cir. 2008). If the moving party meets its burden, "the nonmoving party must come forward with admissible evidence sufficient to raise a genuine issue of fact for trial in order to avoid summary judgment." *Id.* "In raising a triable issue of fact, the non-movant "must demonstrate more than

some metaphysical doubt as to the materials facts, and come forward with specific facts showing that there is a genuine issue for trial." *Marom v. Blanco*, No. 15 Civ. 2017, 2019 WL 3338141, at *6 (S.D.N.Y. July 25, 2019) (Castel, J.) (internal quotation marks omitted).

ARGUMENT

I. THE COI ADJUSTMENT SATISFIES THE CONTRACTUAL OBLIGATIONS IN THE POLICY CONTRACT, WHICH THIS COURT SHOULD INTERPRET AS A MATTER OF LAW

The elements of a breach of contract claim are: "(1) the existence of a valid contract; (2) performance or tendered performance by the plaintiff; (3) breach of contract by the defendant; and (4) damages sustained by the plaintiff as a result of the breach." *Mullins v. TestAmerica, Inc.*, 564 F.3d 386, 418 (5th Cir. 2009) (internal quotation marks omitted) (applying Texas law).[7]

"Insurance policies are, in essence, creatures of contract, and, accordingly, subject to principles of contract interpretation." *In re Estates of Covert*, 97 N.Y.2d 68, 75, 761 N.E.2d 571 (2001). "When interpreting contracts, courts applying Texas law must strive to ascertain the parties' intent as expressed in the written instrument." *Mullins*, 564 F.3d at 404. When "the wording of the instrument can be given a definite or certain meaning, then it . . . must be construed as a matter of law." *Id.*; *see also Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marine Ins. Co.*, 472 F.3d 33, 42 (2d Cir. 2006) ("When the provisions are unambiguous and understandable, courts are to enforce them as written."). "Contract terms cannot be viewed in isolation, however, because doing so distorts the meaning." *Pathfinder Oil & Gas, Inc. v. Great Western Drilling, Ltd.*, 574 S.W.3d 882, 889 (Tex. 2019). Courts therefore "must consider the entire writing in an effort to harmonize and give effect to all the provisions of the contract so that none will be rendered

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[7] Each state's law applies to the Policies issued in that state. *See* Dkt. 94 at 15. However, for purposes what this Court needs to decide for this Motion, Plaintiffs' failure to demonstrate a genuine issue of material fact as to the element is breach is fatal under any state's law.

meaningless." *Id.* (internal quotation marks omitted). In so doing, courts should not read into contracts obligations that do not exist. *See First Bank v. Brumitt*, 519 S.W.3d 95, 110 (Tex. 2017) ("[C]ourts may not rely on evidence of surrounding circumstances to make the language say what it unambiguously does not say."). As this Court has found, "[c]ourts may not by construction add or excise terms, nor distort the meanings of those used and thereby make a new contract for the parties under the guise of interpreting the writing." *U.S. Bank, Nat'l Ass'n v. UBS Real Estate Sec. Inc.*, 205 F. Supp. 3d 386, 412 (S.D.N.Y. 2016) (Castel, J.) (internal quotation marks and alterations omitted). Additionally, a "court should not interpret a contract in a manner that would be 'absurd, commercially unreasonable, or contrary to the reasonable expectations of the parties." *Callahan v. Glob. Eagle Entm't Inc.*, No. 18 Civ. 8343, 2019 WL 2325903, at *3 (S.D.N.Y. May 30, 2019) (Castel, J.) (internal quotation marks omitted). Instead, a "contract must be interpreted in a manner that accords the words their fair and reasonable meaning, and achieves a practical interpretation of the expressions of the parties." *Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Monarch Payroll, Inc.*, No. 15 Civ. 3642, 2016 WL 634083, at *10 (S.D.N.Y. Feb. 17, 2016) (Castel, J.); *see also id.* (rejecting contract interpretation that was "absurd and commercially unreasonable").

The COI Adjustment satisfied each of the Policies' contractual requirements because: (i) VRIAC was the company responsible for approving the COI Adjustment and undisputedly made the adjustment based on future cost factors of the Aetna block; (ii) the adjustment was done on a class basis, with the classes defined as all policyholders owning a given product; and (iii) it was on a uniform basis, applying uniform percentage adjustments to all policyholders within the defined classes. It is undisputed that no policyholder was singled out for an increase and that every policyholder got the same increase as others in his or her class or grouping.

In stark contrast, Plaintiffs' interpretation of the contract leads to "absurd and commercially unreasonable" results that would result in a windfall for Plaintiffs. *Id.* For example, Plaintiffs ask this Court to read into the contract terms that would effectively turn what Plaintiffs' concede is a more risky non-guaranteed contract into a less risky guaranteed one without any corresponding cost. Plaintiffs' interpretation would also prevent VRIAC from relying on the persons most knowledgeable about the policies to model the potential COI adjustment, and would effectively give every state regulator nationwide veto power over COI increases across the country. Simply put, the obligations Plaintiffs allege to have been violated by VRIAC are neither found in the contract nor economically rational, conclusions this Court should reach as a matter of law. *New York Cmty. Bank v. Estate of Paraskevaides*, No 18 Civ. 3987, 2019 WL 3024703, at *7 (S.D.N.Y. July 11, 2019) (Castel, J.) (holding that "an unambiguous contractual provision . . . must be interpreted according to its plain terms").

II. PLAINTIFFS' ARGUMENTS ARE INCONSISTENT WITH A PLAIN READING OF THE CONTRACT, WHICH THIS COURT SHOULD INTERPRET AS A MATTER OF LAW

Notwithstanding VRIAC's compliance with the contractual provisions, Plaintiffs argue in their pre-motion letter that VRIAC breached the Policies in three ways: (i) the COI Adjustment was not "based on Aetna's estimates for future cost factors"; (ii) the COI Adjustment was not done on a "class basis"; and (iii) the COI Adjustment was not made on a "uniform basis." Dkt. 125 at 5-7. As discussed below, each of Plaintiffs' asserted theories is inconsistent with a plain reading of the contract language and requires contorting the Policies to "make the language say what it unambiguously does not say," and contradicts their own expert's testimony. *First Bank*, 519 S.W.3d at 110.

A. The COI Adjustment *Was* Based On Aetna's Estimates for Future Cost Factors

Plaintiffs' first asserted theory is that the COI Adjustment was not "based on Aetna's estimates for future cost factors." Dkt. 125 at 5. Plaintiffs read into these eight words three different extra-contractual requirements:

(a) Original Pricing. Plaintiffs claim this provision requires that "an increase could be based only on the oranges-to-oranges comparison between *Aetna's* original costs and *Aetna's* current costs." Dkt. 1 (Complaint) ¶ 5.

(b) Aetna's Cost Factors. Plaintiffs inject an extra word into the provision and claim it really means *Aetna's estimates for* ***<u>Aetna's</u>*** *future cost factors* and does not mean the future cost factors of the block of Aetna policies.

(c) Aetna's Actuaries. Plaintiffs claim the words *Aetna's estimates* means Aetna's actuaries – not Aetna's agent or policy administrator – must physically perform the initial detailed analysis.

As explained below, Plaintiffs' entire reading of the provision is without basis and contradicted by their own experts' testimony.

1. The Policies Do Not Require a Comparison of Estimates of Future Cost Factors to Original Pricing

There is no contractual provision requiring VRIAC to base the COI Adjustment on a comparison of future cost factors with the costs that were estimated at the time of issuance (original pricing). SUMF ¶¶ 20-21. Those words are simply not in the contract. Indeed, two of Plaintiffs' own experts unequivocally testified there is no such <u>contractual</u> obligation. As noted above, Plaintiffs' expert, Mr. Hause, testified that a comparison to original pricing may be required by regulators but "it's not a contractual obligation." Ex. 5 (Hause Dep. Tr.) at 164:24-165:22. Plaintiffs' expert, Mr. Foudree, gave similar testimony.

Q. Is there an express requirement in the cost of insurance rate provision of this policy that COI adjustments must be made on the original class basis?

> A. It doesn't use those words that I see in the section you are referring to. There is no requirement requiring insurance companies to have used original pricing assumptions as the baseline.

Ex. 15 (Deposition of Plaintiffs' Expert Bruce W. Foudree ("Foudree Dep. Tr.")) at 43:24-44:5. Plaintiffs' own experts conclude what is apparent from the plain language of the Policies: there is no contractual obligation to have modeled the COI Adjustment based on a comparison to original pricing.

2. *The Policies Do Not Require the COI Adjustment be based on Estimates of Aetna's Future Cost Factors*

Plaintiffs next assert that *Aetna*'s future cost factors were not used for the COI Adjustment because "[u]ndisputed evidence will establish that the 2016 COI Increase . . . was based on a comparison of (a) *Lincoln's* estimates of *Lincoln's* projected costs as of 2015 to (b) *Lincoln*'s assumptions from the 1998 Transaction." Dkt. 125 at 5. In this regard, Plaintiffs argue that because Aetna was reinsured by LLANY, the COI Adjustment was based on LLANY's cost factors, not Aetna's cost factors. This is incorrect. The contract requires that any COI adjustment be based on Aetna's *estimates for future cost factors*, not "Aetna's costs" or "costs that Aetna will pay." The contract specifically includes the word *Aetna* before *estimates* and omits it before *for future cost factors*.

Simply put, the contract means exactly what it says. A COI adjustment must be based on the future cost factors of the policies in question. It need not be future costs that Aetna itself pays, but must be the future cost factors for the policies, regardless of who actually bears such future costs.[8] If the Policies required – as Plaintiffs maintain – that a COI adjustment be based on Aetna's

[8] Plaintiffs' own expert testified to this point. "Q. The costs to be estimated must be costs associated with the policies, however, is that right? A. The costs derive from the policies, that's correct, or are related to." Ex. 16 (Deposition of Plaintiffs' Expert Neil R. Pearson ("Pearson Dep. Tr.")) at 77:2-6.

actual future costs, as opposed to the policies' costs, it would have said *Aetna's future* costs. Plaintiffs cannot inject words into the contract to create the illogical result they want.

Based on a plain and logical reading of the contract, this Court should conclude, as a matter of law, that the contract does not require a COI adjustment to be based on estimates of *Aetna's* future cost factors but rather on "estimates of future cost factors" for the policies.

3. VRIAC Properly Engaged LLANY to Help Develop Its Estimates of Future Cost Factors.

Plaintiffs next assert that the words *Aetna's estimates* requires VRIAC's actuaries to perform – not just review – the detailed modeling necessary for the COI Adjustment. This claim is contradicted by Plaintiffs' own expert's testimony and is once again entirely illogical.

First, the undisputed evidence confirms that LLANY submitted a recommendation to VRIAC in February 2016, and VRIAC reviewed the recommendation and formally accepted the recommendation on April 22, 2016, after a board vote. SUMF ¶¶ 11-15; Ex. 12 (Dkt. 28-13). There was and is no prohibition (contractual or otherwise) against VRIAC using LLANY's inputs and analysis to formulate its estimates for future cost factors. *See, e.g.*, 8 Del. C. § 141(e) (corporate board of directors "fully protected in relying in good faith upon . . . reports or statements presented to the corporation by . . . any other person as to matters the member reasonably believes are within such other person's professional or expert competence and who has been selected with reasonable care by or on behalf of the corporation").

Second, Plaintiff's actuarial expert specifically testified that an insurer may adopt the estimates of another, which is exactly what happened here.

> Q. So if Aetna specifically engaged another entity, a consultant or an actuary or somebody like yourself to develop future cost factors and reviewed them and adopted them, would that comply with this provision?
>
> A. Yes, I believe it would, I believe their adoption of my estimates for future cost

> factors in that case, that they were formally approved, reviewed and approved by Aetna, would make them Aetna's estimates for future cost factors.

Ex. 5 (Hause Dep. Tr.) at 160:4-14.

Third, Plaintiffs position leads to absurd results, as shown by Mr. Hause's testimony. Specifically, Mr. Hause testified that, if an Aetna actuary looked at a different company's experience and based his estimate on an entirely different block of policies, that would be considered Aetna's estimate. But if instead "the estimate was made by [an] actuary employed by a differen[t] company, say, Guardian Life Insurance Company, but it looked at . . . the Aetna policies, the Aetna experience and the Aetna investment income," that would *not* be Aetna's estimate. *Id.* at 129:4-131:16. Given the testimony from Plaintiffs' reinsurance expert that the "[c]osts to be estimated must be costs associated with the policies," Mr. Hause's conclusion on this topic is absurd. Ex. 16 (Pearson Dep. Tr.) at 77:2-6.

Fourth, Plaintiffs' construction of this provision—that a VRIAC actuary should have done the initial COI Adjustment's analysis and modeling, and not a Lincoln actuary—would inure to the detriment of the class, as it would force VRIAC to conduct an analysis without the benefit of LLANY's decades of expertise with the relevant block of policies as the policy administrator and reinsurer. The preferred course is what actually happened, where LLANY used its two decades of expertise and institutional familiarity with the relevant block to submit a recommendation, which VRIAC approved following a comprehensive review process. Plaintiffs assert that VRIAC "blindly agreed" to Lincoln's COI recommendation, Dkt. 125 at 6, but Plaintiffs cannot dispute that Lincoln and VRIAC communicated back and forth concerning Lincoln's recommendation for months, or that VRIAC reviewed actuarial memoranda and data that Lincoln provided in support of its recommendation. SUMF ¶¶ 12-14. There is therefore no credible basis for Plaintiffs'

assertion that the contract requires VRIAC to do the initial analysis or prohibits VRIAC from relying on and reviewing actuarial work initially done by the policy administrator.

B. The COI Adjustment *Was* Done on a Class Basis.

Plaintiffs' second theory of breach is that the COI Adjustment was not done a "class basis." Dkt. 125 at 7. Specifically, Plaintiffs allege that it was improper to differentiate the COI Adjustment by product class because "class basis" only allows differentiation based on the same specific groupings or classes from when the policies were originally issued. *Id.* This theory is once again inconsistent with the plain reading of the contract and Plaintiffs' own expert's testimony.

First, as discussed above, the contract makes no reference to classes at original pricing. SUMF ¶ 21. Moreover, the contract specifically differentiates its language in describing how COI rates will be grouped for purposes of the monthly COI charge from how they may be grouped for purposes of a COI Adjustment. Plaintiffs ignore this distinction and assert that the two descriptions below mean exactly the same thing.

Monthly COI Charge	COI Rate Adjustment
"The Monthly Cost of Insurance is based on the Insured's sex, attained age and premium class."	"Adjustments will be on a class basis and will be based on Aetna's estimates for future cost factors, such as mortality, investment income, expenses and the length of time policies stay in force. Any adjustments will be made on a uniform basis."

While the Policies require that the COI charges be based on sex, age, and premium class, there is no separate requirement that COI *adjustments* be differentiated on the basis of sex, attained age, and premium class.

Second, Plaintiffs' own expert, Mr. Hause, testified that "class basis" means "a policy class that conforms to the definition of [section] 2.6 and the requirements for policy classes under paragraph 3.4" of the Actuarial Standards of Practice (ASOP). Ex. 5 (Hause Dep. Tr.) at 122:8-12.

Even if the Court were to consider extrinsic evidence to interpret the "class basis" provision (it need not), ASOP 2 itself makes clear that class basis or policy basis does not mean "sex, attained age and premium class," but is a flexible analysis that considers a variety of criteria such as similarity of the policy types, the structure of the COI rate, similarity of anticipated experience factors, the time period over which the policies were issued, and the underwriting and marketing characteristics of the policies. Ex. 17 (ASOP 2) § 3.6.

Third, Plaintiffs' other expert, Mr. Foudree, also testified there is no requirement to use the original pricing classes.[9]

Fourth, seeking to diminish the fact that their own actuarial expert *agrees* with *VRIAC's* interpretations of the Policies' contractual terms, Plaintiffs' only response is that their experts "are not being offered to opine on policy interpretation" and that Hause "made clear in his testimony that he was not opining as to the legal meaning of any policy term." Dkt. 128 at 5, n.4. For the purposes of this motion, however, Hause's statements demonstrate the lack of a triable issue as to whether, as a contractual or factual matter, VRIAC breached the Policies' "class basis" requirement. Where Plaintiffs' own hired experts disagree with Class Counsel's distorted interpretations of the Policies and agree with VRIAC and its expert, it is clear that the plain language of the contracts compel summary judgment in VRIAC's favor.

[9] Ex. 15 (Foudree Dep. Tr.) at 34:24-44:5 ("Q. Is there an express requirement in the cost of insurance rate provision of this policy that COI adjustments must be made on the original class basis? A. It doesn't use those words that I see in the section you are referring to."). *See id.* at 85:24-86:11 ("Q. Are you able to identify any professional standard or regulation that was in effect in 2016 that specifically required a company to have a static definition of classes for rate determination purposes throughout the duration of a policy? A. I can't think of one at the moment that uses those words directly. There are provisions that have an impact on that, but I don't recall one that specifically says, in the statute that you have, to use the same classes.").

Fifth, although there is no contractual obligation to use the same classes as original pricing, the percentage-based COI Adjustment actually *preserved* all the original classes by implementing a uniform percentage adjustment which increased all sexes, attained ages, and premium classes within a product by the same amount. Giving the words in the contracts their natural meaning, there was a uniform percentage increase ("uniform basis") that impacted each insured differently on a "class basis." Any class distinctions that existed prior to the COI Adjustment were therefore preserved by the application of a uniform percentage increase.

C. The COI Adjustment *Was* Done on a Uniform Basis.

Plaintiffs' final breach theory is that VRIAC cannot implement a COI Adjustment anywhere in the country if even one state objects to the increase methodology on state-specific regulatory grounds. According to Plaintiffs, the contract requires nationwide or nothing. This obligation is not in the contract and is entirely illogical.

As a predicate matter, Plaintiffs' notion that, as a contractual matter, any adjustment must be nationwide or nothing flies in the face of the well-recognized understanding that life insurance is regulated by fifty different state regulators, the District of Columbia, and five U.S. territories pursuant to a myriad of state-specific statutory and regulatory requirements. *See* 15 U.S.C. §§1011-1015 (McCarran-Ferguson Act: "Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest . . . ."); *see also Wadsworth v. Allied Profs. Ins. Co.*, 748 F.3d 100, 102 (2d Cir. 2014) ("Under the McCarran-Ferguson Act, . . . the business of insurance is generally regulated by the states rather than the federal government.").

The illogic of Plaintiffs' position is well illustrated by this case. When the COI Adjustment was implemented, in 48 of 50 states no state regulator objected on any grounds. In Minnesota and

New York, the state regulators conducted a full examination of the COI Adjustment, but ultimately reached different conclusions, as discussed below:

Minnesota: After the COI Adjustment was implemented, Minnesota's Department of Commerce conducted a full examination of the COI Adjustment including "the methodology for the increase, the basis for the increase, and the communications to policyholders." Ex. 18 (Consent Decree) at 2. After this thorough review, Minnesota ultimately alleged only that LLANY "did not adequately comply with certain regulatory filings" in violation of Minn. Stat. § 72A.21. *Id.* The Minnesota inquiry was resolved with a consent decree that required LLANY to, in the future, provide Minnesota policyholders at least two notices within 90 days of any future COI increase and make a $10,000 administrative payment to the State of Minnesota for the examination. *Id.* The Minnesota consent decree has no bearing on policies outside Minnesota and the COI Adjustment was fully implemented in Minnesota and never disturbed.

New York: New York's Department of Financial Services ("DFS") also challenged the COI Adjustment under New York-specific insurance statutes. Ex. 6 (Hause Report) ¶89. New York's DFS took the position that – unlike the policy contract or ASOP 2 – New York Insur. Law § 4224(a)(1) requires any redetermination to use multiple classes with each class (or sub-class) treated differently and that § 4232(b) prohibits an insurer from considering reinsurance in a redetermination. *Id.* Given these state-specific requirements and the DFS's threats of possible large fines, the COI Adjustment has not yet been implemented in New York.

Plaintiffs now claim that, even though 49 states ultimately took no issue with the COI Adjustment methodology, the contract's uniform basis language somehow gives each state's insurance regulator the power to veto COI adjustments anywhere in the country for any reason. There is no basis for this claim and Plaintiffs' contractual hook contorts the plain language of the

contract. The contract provides that "[a]ny adjustments will be made on a uniform basis." Ex. 3 (Hanks Policy) at 7. The contract does not say adjustments must be made on a "national basis" or "uniform nationwide." Indeed, because each contract is approved and regulated on a state-by-state basis, none of the terms (including the "uniform basis" provision) can be deemed to apply on a nationwide basis.

Rather, Plaintiffs' own pre-motion letter recognizes that the term "uniform" is akin to "non-discriminatory." Dkt. 128 at 7. Indeed, Plaintiffs' expert recognized that some of the Policies actually use "the term 'non-discriminatory,'" and in "industry usage, there is no difference between 'uniform' and 'non-discriminatory.'" Ex. 6 (Hause Report) at 37, n.108. The purpose of this provision is to protect policyholders from being singled out or treated differently from his or her class. For example, VRIAC did not increase a policyholder's COI rates because he or she became sick or began smoking after the policy was issued. Rather, he or she received the same percentage adjustment as did the thousands of other policyholders owning the same insurance product he or she does. There is no claim that individual policyholders were discriminated against or singled out by the COI Adjustment due to their own individual characteristics.

Finally, even if Plaintiffs are correct that uniformity somehow means "nationwide uniformity," it is undisputed that the contract allows for inter-class distinctions and New York's unique regulatory and enforcement scheme is certainly a valid basis for making class distinctions. Plaintiffs' expert recognizes that VRIAC is "allowed to discriminate fairly between classes," a concept which Plaintiffs' expert calls "inter-class discrimination" and is entirely permissible. *Id*. ¶ 66. New York policies, which are subject to New York's unique regulatory and enforcement scheme, are differently situated from policies in the other 49 states that do not follow New York's regulations, as evidenced by the 49 other states having no issue with the COI Adjustment methodology. Thus, Plaintiffs' claim of discrimination because "the

increase was not applied to New York policyholders" is meritless. *Id.* New York's regulatory and enforcement scheme makes the class of New York policyholders differently situated from the class of non-New York policyholders and such inter-class discrimination is, by Plaintiffs' own admission, permitted.[10]

D. In the Alternative, the Court Should Grant Summary Judgment as to Class Members Who Did Not Sustain Any Damages.

The Court should also grant summary judgment in favor of VRIAC to the extent Plaintiffs' class includes owners of Policies for which no adjustment was applied. Because the COI Adjustment was not applied to Policies that were already at Maximum COI Rates, the vast majority of the policies did not receive a full increase, and over 10% of the policies did not receive any increase. These policies were unaffected by the 2016 redetermination, and therefore did not suffer any damages. SUMF ¶ 22. These plaintiffs therefore do not have a viable breach of contract claim against VRIAC. *Mullins*, 564 F.3d at 418 (fourth element of breach of contract claim is "damages sustained by the plaintiff as a result of the breach").

Where class members suffered no damages from" the COI Adjustment, the Court should grant summary judgment in VRIAC's favor on this alternative ground as to the Class Members whose COI rates were not affected by the COI Adjustment. *Bloch v. Gerdis*, No. 10 Civ. 5144, 2011 WL 6003928, at *4 (S.D.N.Y. Nov. 30, 2011) (Castel, J.).

CONCLUSION

For the foregoing reasons, the Court should grant summary judgment on the breach of contract claim and dismiss this case in its entirety.

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[10] For this reason Plaintiffs' repeated reference to New York's DFS is doubly irrelevant: the DFS's position was based on state specific regulations, not the contract, and no New York policyholders are in this lawsuit.

DATED: September 12, 2019

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