REDACTED

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

HELEN HANKS, on behalf of herself and all others similarly situated, Plaintiff, vs. THE LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK; VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY, formerly known as Aetna Life Insurance and Annuity Company, Defendants.	Civil Action No. 16-cv-6399 **MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF CROSS-MOTION FOR PARTIAL SUMMARY JUDGMENT BY PLAINTIFF HANKS ON BEHALF OF HERSELF AND THE CERTIFIED CLASS AND OPPOSITION TO DEFENDANT VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY'S MOTION FOR SUMMARY JUDGMENT**

TABLE OF CONTENTS

TABLE OF DEFINED TERMS

"1998 Transaction"	The 1998 indemnity reinsurance transaction between Aetna and Lincoln.
"ASOP"	Actuarial Standard of Practice
"Aetna"	Voya Retirement Insurance and Annuity Company, formerly known as Aetna Life Insurance And Annuity Company
"Aetna Br."	Aetna's Memorandum of Law in Support of its Motion for Summary Judgment (Dkt. 134)
"Aetna SUMF"	Aetna's Southern District of New York Local Rule 56.1 Statement of Undisputed Material Facts on Motion for Summary Judgment (Dkt. 135)
"Ard Decl."	Declaration of Seth Ard, filed concurrently herewith
"COI"	Cost of Insurance
"Depo."	Deposition
"Ex."	Exhibits attached to the Ard Decl.
"Foudree Report"	Expert Report of Bruce Foudree, served on March 1, 2018 by Plaintiff and attached as Ex. 6.
"Hanks Policy"	Plaintiff Helen Hanks' universal life insurance policy issued by Aetna, attached as Ex. 1.
"Hause Report"	Expert Report of Christopher Hause, served on March 1, 2018 by Plaintiff and attached as Ex. 2.
"Hause Rebuttal Report"	Expert Rebuttal Report of Christopher Hause, served on June 2, 2018 by Plaintiff and attached as Ex. 3.
"Lincoln"	The Lincoln Life & Annuity Company of New York
"Mills Report"	Expert Report of Robert Mills, served on March 1, 2018 by Plaintiff and attached as Ex. 4.
"NAIC"	National Association of Insurance Commissioners
"NYDFS"	New York Department of Financial Services
"Pltf. SUMF"	Plaintiff Helen Hanks' Southern District of New York Local Rule 56.1 Statement of Undisputed Material Facts on Motion for Summary Judgment, filed concurrently herewith
"Pearson Report"	Expert Report of Neil Pearson, served on March 1, 2018 by Plaintiff and attached as Ex. 8.
"Pearson Rebuttal Report"	Rebuttal Expert Report of Neil Pearson, served on May 1, 2018 by Plaintiff and attached as Ex. 9.
"Pfeifer Report"	Expert Report of Timothy Pfeifer, served on May 1, 2018 by Aetna and excerpted as Ex. 11.

"Purchase Assumptions"	"Expectations of the go-forward profitability" of the Aetna block of policies commissioned from Milliman by Lincoln in connection with the 1998 Transaction.
"Rector Report"	Expert Report of Neil Rector, served on May 1, 2018 by Voya and excerpted at Ex. 10.
"Resp. to Aetna SUMF"	Plaintiff Helen Hanks' Response to Aetna's Local Rule 56.1 Statement of Undisputed Material Facts on Motion for Summary Judgment, filed concurrently herewith

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Treatises

Other Authorities

I. INTRODUCTION

The life insurance policies at issue in this certified class action restrict Defendant Aetna's ability to adjust COI rates in three different ways. The policies require that any COI adjustment be: (1) on a "uniform basis," (2) on a "class basis," and (3) based on "Aetna's estimates for future cost factors." After Plaintiff Helen Hanks filed this lawsuit, the NYDFS, which regulates all insurance carriers in New York, agreed that the rate hike was illegal and breached the terms of over 10,000 policies issued in that state. Facing a potential enforcement action, Aetna chose to suspend the increase in New York, but proceeded to impose the same illegal overcharges on over 40,000 policies elsewhere, even though those policies have the *same* terms as those in New York, and there is no contractual basis to justify geographic discrimination.

Summary judgment on liability should be granted in favor of Plaintiff and the Certified Class because the COI rate hike breached those three contract provisions. A breach of any one suffices. Aetna's motion should be denied for the same reasons, and also because proof of Aetna's compliance with its (flawed) interpretation of the policies raises a host of hotly-disputed questions of material facts.

Breach #1: The "Uniform" Requirement. Aetna increased COI rates on non-New York policyholders, but did not increase rates for similarly-situated New York policyholders. That is a straightforward breach of the policies' uniformity clause. Aetna's corporate representative testified that the "uniform" requirement in the Class Policies means that "[redacted]." Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 403:9–14.[1] And Aetna's brief states that the "[redacted]." Aetna Br. at 24. And yet, all COI increase victims

[1] All emphasis is added unless otherwise noted.

(everyone outside New York) were treated differently from others in their class[2] (those inside New York), even though Aetna *admitted* that New York policies and non-New York policies *belonged to the same classes*. *See* Pltf. SUMF ¶¶ 26, 38–39; Ex. 18 (Parker 30(b)(6) Depo.) at 143:2–23

[redacted][3]

Aetna's tries to escape summary judgment by raising two meritless defenses. First, Aetna asks the Court to turn into a scrivener and *add* new words to the contracts that are not there, claiming that uniformity need only be "within each state" and that geographic discrimination is permitted if it is "fair" and not targeted at "individual characteristics." Those loopholes appear nowhere in the policies. Second, Aetna asks the Court to turn into a legislator and ignore the plain language of the policies under the guise of public policy. That too is not a defense to a breach of contract. It is not the province of the Court to re-write the insurance policies to accommodate Aetna. As Aetna itself admits: "When the provisions are unambiguous and understandable, courts are to enforce them as written." *Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marin Ins. Co.*, 472 F.3d 33, 42 (2d Cir. 2006) (quoted in Aetna Br. at 13).

It is also, quite frankly, absurd for Aetna to suggest that prohibiting COI rate discrimination nationwide is somehow commercially unreasonable, but that is the type of sophistry insurance companies advance when they breach the plain language of standardized contracts that they both drafted and certified were not ambiguous.

---

[2] For purposes of the uniformity requirement, Plaintiff is accepting Aetna's own definition of "class" as product-wide groupings as set forth in its Separate Statement of Undisputed Facts. *See* Aetna SUMF ¶ 19. As discussed elsewhere, the classes set forth in the Policies, and on which any adjustment in COI rates should have been based, are defined in the Policies by reference to age, sex, and premium class. Aetna also violated the uniformity requirement under that definition.

[3] Michael Parker was a designated Federal Rule of Civil Procedure 30(b)(6) witness for both Aetna and Lincoln.

Breach #2: The "Class Basis" Requirement. The second independent ground for granting summary judgment against Aetna is its breach of the policies' requirement that all COI "[a]djustments" be on a "class basis." The Plaintiff's policy states that policyholders' COI rates will be "based on the Insured's sex, attained age and premium class." These are contract-delineated classes set forth a mere ***five sentences*** above the "class basis" requirement. It is undisputed that Aetna did not use those classes for the COI increase; instead, Aetna *grouped* them all together and imposed a *flat-percentage* COI increase by product, except not in New York. *See* Pltf. SUMF ¶¶ 22, 39. That is a straightforward breach of the "class basis" COI adjustment provision.

To avoid this result, Aetna argues that the term should instead be defined with reference to ASOP 2. *See* Aetna SUMF ¶ 19. Aetna's suggestion that standardized terms in consumer contracts should *ignore* language provided five sentences earlier and instead be defined only by reference to specialized actuarial resources is wrong, a fact that Aetna's own brief admits. Aetna Br. at 9 n.4 ("ASOPs . . . are not part of the policy contract"). If, however, Aetna's interpretation were adopted by the Court, proof of Aetna's alleged compliance with ASOP 2 is a hotly disputed question of fact, as the parties competing actuarial experts reports debate at length. *See* Resp. to Aetna SUMF ¶ 19; *id.* at Plaintiff's Local Rule 56.1(b) additions ¶¶ 1, 14; Ex. 2 (Hause Report) at ¶¶53–60 (outlining reasons the COI increase is not consistent with ASOP 2); Ex. 49 (10/14/16 NYDFS Ltr.) at LN_HANKS00156808–09 (concluding that Aetna's COI increase violated ASOP 2).

Aetna's summary judgment brief then proceeds to *contradict* ¶ 19 of its SUMF, and states that "class basis" is actually "defined as all policyholders owning a given product." Aetna Br. at 14. That lawyer-crafted definition also does not appear in any of the policies, but if it did, the undisputed facts are that Aetna breached it as well. That's because the COI adjustment was *not* in

fact imposed on "all" policyholders owning a given product—New York owners were exempted. *See* Pltf. SUMF ¶ 39.

Breach #3: The "Aetna's Estimates" Requirement. Aetna's COI increase also was not, as the policies require, based on "Aetna's estimates for future cost factors." Instead, it was based on *Lincoln's* expected *profit* factors in 2015, compared to *Lincoln's* investment objectives from 1998, when it decided to reinsure Aetna's policies. The indisputable evidence is that the baseline assumptions used for the COI increase analysis were Lincoln's reinsurance purchase assumptions, *see* Pltf. SUMF ¶ 20, but those purchase assumptions are not "Aetna's estimates."

Aetna tries to defend that breach through more linguistic contortions, arguing that *Lincoln's* estimates magically metamorphosed into *Aetna's* estimates after Aetna allegedly reviewed Lincoln's estimates and adopted them. That too makes no sense. And like its other defenses, if the Court were to adopt Aetna's interpretation, disputed questions of fact remain because, in reality, Lincoln never even *sent* Aetna the actual assumptions underlying the COI increase nor any experience studies. Instead, Aetna rubber-stamped the recommendation for the increase after Lincoln reminded Aetna that a rejection would require Aetna to pay Lincoln tens of millions of dollars under a 'side letter' indemnification agreement. As Aetna's Chief Actuary remarked in [redacted]: "[A]s soon as I saw there was a document entitled 'side letter,' I knew we were in trouble." Ex. 60 [redacted]) at VRIAC_HANKS0000942.

As a result, the Court should deny Aetna's motion and grant summary judgment on liability in favor of Plaintiff Hanks and the certified Class on any or all three theories of breach —

"uniform," "class basis," and/or "Aetna's estimates" — so that the case can proceed to trial on damages.

II. FACTUAL BACKGROUND

A. Universal Life Insurance

Universal life insurance is a form of permanent life insurance that provides coverage as long as the policy stays in force.[4] Universal life allows for "flexible premiums," which means that there is no prescribed amount that a policyholder is required to pay each month.[5] When a premium is paid, it is added to the policyholder's "Account Value."[6] This Account Value accrues interest at a "credited rate," and insurer deducts charges from a policyholder's Account Value on a monthly basis.[7]

The largest of the monthly charges is the COI rate, which is the cost of providing pure insurance protection on the policies' net amount at risk and is driven largely by mortality rates (i.e. the probability of dying).[8] The COI rates are first determined at original pricing (i.e. before the policy is issued).[9] Actuaries price the products by making and testing assumptions about pricing factors, which can include mortality, lapse, and expenses.[10] These assumptions typically vary according to policyholder characteristics such as sex, premium class, and age, because these characteristics impact anticipated future experience (e.g., all things being equal, a non-smoker will be predicted to live longer than a non-smoker). Using these characteristics, actuaries will divide the target market into policy classes using these cohorts and determine distinct COI rates for each

[4] *See* Ex. 2 (Hause Report) ¶ 11. Permanent life policies typically pay a maturity benefit at death or a very advanced age. *Id.*
[5] *See* Resp. to Aetna SMUF ¶¶ 3–4; Ex. 2 (Hause Report) ¶¶ 12–14.
[6] *See* Ex. 2 (Hause Report) ¶ 13.
[7] *See id.*
[8] *See* Ex. 28 (Smith Depo.) at 11:13–18; Ex. 26 (Fick Depo.) at 32:7–15; Ex. 2 (Hause Report) ¶ 13.
[9] *See* Ex. 2 (Hause Report) ¶ 16.
[10] *See id.*

policy class.[11]

After issuance, insurance companies monitor the assumptions underlying the financial performance of groupings of the insurance policies by conducting experience studies that compare actual experience with the original pricing assumptions. This actual experience is used to set future expectations. When future expectations deviate significantly from those used when the product was originally priced (or re-priced), and depending on the contractual restrictions at issue, an insurer may conclude that it wants to adjust relevant "non-guaranteed elements" ("NGEs"), such as COI rates, to account for those changes in expectations within each class that has the relevant experience. Ex. 2 (Hause Report) ¶¶ 18–19.

Because higher COI rates hurt consumers, adherence to contractual restrictions is critical to protecting policyholders. One purpose of having adjustable COI rates is so that the insurance company can react prospectively if actual mortality expectations emerge that are different from what was assumed at pricing or the most recent COI or mortality adjustment. But applied improperly, COI increases can be a tool of exploitation and discrimination, requiring certain classes of policyholders to pay increased COI rates that are not justified by their class's experience, and/or resulting in elderly policyholders to "shock lapse" their policies and lose coverage. *Id.* at ¶¶ 20–21.

Policyholders are protected from potential abuse by contractual restrictions that expressly limit the form and manner in which an insurer can raise COI rates.[12] Any COI rate increase cannot

[11] *See id.* ¶¶ 43–46; *U.S. Bank Nat'l Assoc. v. PHL Variable Ins. Co.*, Case No. 12-cv-6811-CM-JCF, Dkt. 334-4 at 25 (S.D.N.Y. Jan. 22, 2014) (Expert Rebuttal Report of Timothy Pfeifer) ("[A] class means a 'group of policies with common pricing charges.'"), attached as Ex. 72 to the Ard Decl.; *id.* at 27 ("Specifically, issue age ranges, gender, policy size, etc. are all components of class because they can generate unique elements of anticipated experience factors. . . . To define class otherwise would be illogical."); *U.S. Bank Nat'l Assoc., etc. v. PHL Variable Ins. Co.*, Case No. 12-cv-6811-CM-JCF, Dkt. 337-48 at p. 16 (S.D.N.Y. Jan. 23, 2014) (Deposition of Timothy Pfeifer) ("Every pricing document that defined rates distinguishable by gender, risk class, base amount, those are all definitions of class."), attached as Ex. 73 to the Ard. Decl.

[12] *See* Ex. 2 (Hause Report) ¶ 20.

violate those contractual restrictions. *See* Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 36:21–24 ("Q. Okay. So a COI rate cannot be altered in a manner that is inconsistent with the terms of an underlying policy. A. Correct."). The enforcement of contractual restrictions is therefore an essential part of the universal-life-insurance bargain—policyholders must accept that COI rates are not set in stone and may increase, but do so with the understanding that insurers have strict contractual limitations on their ability to do so.[13]

B. The Class Policies Expressly Limit Aetna's Ability to Adjust COI Rates

Aetna issued the standardized, form Class Policies between 1983 and 2000 across eighteen product lines.[14] Aetna made and tested pricing assumptions (looking at factors like mortality, lapse, and expenses) that were broken down into policy classes (including age, sex, and premium class), calculated distinct COI rates for each policy class, and included provisions allowing Aetna to adjust COI rates on a class basis if Aetna's future cost expectations changed.[15]

Consistent with this, the Class Policies contain express limitations on when and how Aetna may adjust COI rates. The applicable restrictions from Plaintiff Helen Hanks' policy are below, with the relevant terms highlighted:

> 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.

[13] *See* Ex. 6 (Foudree Report) ¶¶ 17–18, 20–21.
[14] *See* Pltf. SMUF ¶ 6.
[15] *See id.* ¶ 7; *see, e.g.*, [redacted]

See Hanks Policy at 7; Pltf. SUMF ¶¶1–3.[16]

These express contractual limitations include:

Uniform. Each policy requires that any COI increase must be "uniform" or "non-discriminatory," which means that any adjustment must be applied in the same manner for each class.

Class Basis. Each policy states that monthly COI rates must be determined based on the insured's age, sex, and premium class, and Aetna is contractually allowed to adjust COIs only on a "class basis."

Aetna's Estimates for Future Cost Factors. Each policy states that any COI increase be based on "Aetna's estimates for future cost factors," which requires an apples-to-apples comparison of Aetna's currently projected cost estimates to Aetna's projected costs when rates were last determined. Further, the contracts require that adjustments be based solely on future "cost factors," rather than profit factors or changing profit objectives.

C. Lincoln "Purchases" the Class Policies via Indemnity Reinsurance

In 1998, Lincoln paid Aetna $1 billion in cash to become the 100% indemnity reinsurer of a block of business that included the Class Policies.[17] Pursuant to the 1998 Transactions, Lincoln agreed to administer the policies, received the rights to all premiums paid by policyholders and any interest earned thereon, and assumed all financial liabilities.[18] Aetna remained the direct insurer of the policies, but it no longer had any costs associated with the policies.[19] In conjunction with the 1998 Transaction, Lincoln commissioned actuarial consulting firm Milliman, Inc. to

[16] This policy language is substantively identical in each of the Class Policies. *See* Pltf. SMUF ¶ 4; Dkt. 110 at 2 (Order Certifying Class) (holding that all eighteen product lines have substantially-similar relevant terms), available at *Hanks v. Lincoln Life & Annuity Company*, 330 F.R.D. 374 (S.D.N.Y 2019).
[17] *See* Pltf. SMUF ¶ 9.
[18] *See id.*
[19] *See id.* ¶¶ 9, 11.

create "expectations of the go-forward profitability" of the block of policies (the "Purchase Assumptions").[20] COI rates were not redetermined in connection with the 1998 Transaction, and the Purchase Assumptions were never used to redetermine COI rates prior to the unlawful increase at issue in this case, first imposed in 2016.[21]

Policyholders did not approve the 1998 Transaction nor ratify Lincoln's Purchase Assumptions.[22] This is because Aetna and Lincoln structured the 1998 Transaction as indemnity reinsurance rather than assumption reinsurance.[23] Indemnity reinsurance avoids the need for burdensome regulatory approvals and policyholder consent.[24] But because there is no novation of the policies, indemnity reinsurers, unlike assumption reinsurers, are not in contractual privity with policyholders and have no direct rights, including the ability to adjust the customers' COI rates.[25] Thus, although Lincoln "purchased" the Aetna policies through the 1998 Transaction, it had no contractual relationship with policyholders.[26] Aetna retained those contractual responsibilities and liabilities.

Lincoln entered into both a "side letter" and a "coinsurance agreement" with Aetna that effectively gave Lincoln the right to force Aetna to impose a COI rate increase.[27] Pursuant to these agreements, Lincoln can "recommend" changes to COI rates to Aetna.[28] Aetna can reject these

---

[20] *See id.* ¶ 10.
[21] *See id.* ¶ 16.
[22] *See id.* ¶ 11; Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg) at 238:7–21 ([redacted]).
[23] *See* Ex. 8 (Pearson Report) ¶¶ 21–25, 33.
[24] *See id.* ¶¶ 21–25.
[25] *See id.* ¶¶ 26.
[26] *See* Pltf. SMUF ¶¶ 9, 11; Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 153:25–154:8 ([redacted] ").
[27] *See* Pltf. SMUF ¶ 12.
[28] *See id.* ¶ 13.

changes, but if it does, it is required to pay *all* of Lincoln's resulting losses unless it can prove the rate hike was unlawful.[29] By contrast, if Aetna approves the recommendation, Lincoln will indemnify it from all financial losses and legal costs.[30] The side letter therefore works as a carrot and a stick—Aetna faces hefty financial consequences if it rejects a proposed COI increase, but is fully indemnified for all financial and litigation costs if it accepts a recommendation.

D. Aetna Agrees to Raise COI Rates to Restore Lincoln's Profitability Targets

In 2015, Lincoln concluded that in 1998 it had vastly overpaid for the Class Policies. Lincoln therefore sought to raise COI rates on the Aetna policies to help Lincoln achieve the profitability that Lincoln projected Lincoln would generate from the 1998 Transaction. *See* Pltf. SUMF ¶ 21; Ex. 23 (Lincoln 30(b)(6) Depo. (Vary)) at 141:18–23 [redacted].").

The potential COI increase was modeled entirely by *Lincoln* actuaries using *Lincoln*'s data, experience studies, and internal tools. Lincoln justified the increase by claiming that *Lincoln*'s current estimates of *Lincoln*'s future cost factors differed from *Lincoln*'s Purchase Assumptions.[31] Lincoln did not even model Aetna's current estimates or how Lincoln's current estimates related to a prior set of Aetna's estimates, such as original pricing assumptions.[32] In addition, Lincoln ignored the contractually-delineated classes and instead grouped all policy classes together and imposed a flat percentage increase upon all policyholders within a given product line (but later carved-out owners whose policies were issued in New York).[33] Lincoln's corporative

[29] *See id.* ¶ 14.
[30] *See id.* ¶ 15.
[31] *See* Pltf. SMUF ¶ 20.
[32] *See* Ex. 18 (Parker 30(b)(6) Depo.) at 90:8–19 [redacted].
[33] *See* Pltf. SMUF ¶¶ 22–23, 39.

representative testified that Lincoln did not look at Aetna's documents to determine whether classes had been defined at original pricing or in a subsequent redeterminations.[34] Lincoln actuaries also testified that they did no analysis of marketing characteristics, underwriting characteristics, or experience studies to determine whether policies should have been grouped at a more granular level (e.g. age, sex, premium class) in modeling and analyzing the COI increase.[35]

On February 26, 2016, Lincoln sent a letter to Aetna stating that, pursuant to the Asset Purchase Agreement and Side Letter, Lincoln recommended increases in the COI rates for all Class Policies.[36] The reference to the Side Letter was no accident; [redacted] email from Aetna's Chief Actuary for the Class Policies, Patrick Lusk, stated: **"*As soon as I saw there was a document entitled 'side letter,' I knew we were in trouble.*"** Ex. 60 ([redacted]) at VRIAC_HANKS0000942; *see* Pltf. SUMF ¶ 19. Aetna's review process was consistent with Mr. Lusk's view that the increase was a foregone conclusion. Although Aetna requested some documentation from Lincoln, Aetna did not provide any of its own estimates or analysis, and Aetna did not review any of Lincoln's underlying work, data, models, current assumptions, or purchase assumptions.[37] Aetna did not even bother to review the original policy forms or actuarial memoranda, and was oblivious to Lincoln's creation of classes different from the classes used in original pricing.[38] On April 7, 2016, Aetna's Board of Directors unanimously approved Lincoln's COI recommendation without modification.[39]

---

[34] *See* Ex. 18 (Parker 30(b)(6) Depo.) at 191:17–192:11.
[35] *See* Pltf. SMUF ¶ 23.
[36] *See id.* ¶ 17.
[37] *See* Resp. to Aetna SMUF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 6-8; Ex. 16 Aetna 30(b)(6) Depo. (Brantzeg) at 212:20–213:19 (acknowledging that Aetna '[redacted]."); *id.* at 225:17–226:13 ("[redacted]").
[38] *See* Resp. to Aetna SMUF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 5, 9.
[39] *See* Resp. to Aetna SMUF 15.

E. Aetna Implements the Increase Everywhere But Suspends it in New York After NYDFS Determines that the Increase is Inconsistent with the Policy Terms

Almost immediately after Lincoln announced the COI increase, the NYDFS launched an investigation.[40] Attempting to defend their conduct, Aetna and Lincoln claimed that the COI increase was "appropriate to restore expectation of future earnings (embedded value) of this business." Ex. 35 (5/20/2016 Voya Ltr. to NYDFS) at LN_HANKS00001744–49.

NYDFS rejected this defense because Lincoln is not a party to Aetna's contracts with policyholders, making Lincoln's purchase expectations irrelevant. The NYDFS stated:

> We will need the ***original (at time of issue)*** and new pricing assumptions, including but not limited to investment return, mortality table, expenses, and lapses. ***We need to ensure the deal with the customer is not broken***. The Company [Aetna] needs to justify the increases based on changes in those assumptions. We are not interested how the new pricing compares to the pricing at the time of the Lincoln deal.

Ex. 65 (5/23/16 NYDFS Email to Aetna) at VRIAC_HANKS0009753–60. NYDFS also emphasized that the COI increase needed to be justified by *Aetna's* estimates and costs, not *Lincoln's*, demanding "a clear illustration of the credible experience ***from Voya*** [f/k/a Aetna] that justifies the proposed increase." Ex. 50 (12/5/16 NYDFS Ltr. to Aetna) at LN_HANKS00157046–47 (brackets added).

Following additional investigation and extensive discussions with Aetna and Lincoln, NYDFS also concluded that: (i) Aetna had violated the "class basis" requirement in the policies by failing to conduct the redetermination on the basis of the policy classes set forth in the Policies;[41] (ii) Aetna had failed to show that the increase was justified due to credible experience

[40] *See* Pltf. SMUF ¶ 35.

[41] Ex. 49 (10/14/16 NYDFS Ltr. to Aetna) at LN_HANKS00156808–09 ("By giving words their natural meaning, 'class basis' plainly refers to the three factors identified only five sentences above in the policy….Indeed, the policy further states 'any adjustment will be made on a uniform basis.' This requirement inherently presumes there are classes to which uniformity need be applied.").

from Aetna;[42] and (iii) "reinsurance costs"—which were really reinsurance profits—were improperly taken into account.[43]

On June 1, 2016, Aetna suspended the COI increase in New York (on 10,355 policies) but imposed the COI increase everywhere else.[44] That means policyholders with policies issued outside of New York are charged more than policyholders of the same policies in the same class issued in New York. Aetna and Lincoln have both admitted that there is no actuarial justification for this geographic discrimination.[45] Rather, the only rational for this nonuniform implementation is that "[redacted]." Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 407:24–408:4; see Pltf. SUMF ¶ 38.

III. ARGUMENT

The undisputed evidence establishes that Aetna's 2016 COI rate hike breached the Class Policies in at least 3 independent ways. If Plaintiff prevails on any of these independent theories of breach, then the increase is unlawful, and a damages trial will ensue. Each of these theories can be decided in Plaintiff's favor under the plain terms of the contract, and by reference only to the indisputable material facts. If, however, the Court were to adopt Aetna's construction for all of those same contract terms, summary judgment cannot be granted to Aetna and the case would proceed to a full trial because of all the disputed questions of fact that remain (e.g., did the increase violate ASOP; is the COI increase exception for New York only "fair"; did Aetna rubber-stamp Lincoln's current estimates for future cost factors, did Lincoln base the increase on impermissible profit factors, etc.).

---

[42] Ex. 50 (12/5/16 NYDFS Ltr. to Aetna) at LN_HANKS00157046–47.
[43] Ex. 64 (5/13/16 NYDFS Ltr. to Aetna) at VRIAC_HANKS0009701 (Defendants "should not factor in reinsurance costs.").
[44] *See* Pltf. SMUF ¶¶ 38–39.
[45] *See* Pltf. SMUF ¶¶ 38; Brantzeg 30(b)(6) Depo. at 412:16–22 ("[redacted]").

A. Legal Standard

Plaintiff agrees with the legal standard for summary judgment set forth in Aetna's brief. Aetna Br. at 13. The elements for a breach-of-contract claim are substantively identical for all relevant jurisdictions: "(1) the existence of a contract, (2) performance of the contract by one party, (3) breach by the other party, and (4) damages suffered as a result of the breach." *See Glob. Packaging Servs., LLC v. Glob. Printing & Packaging*, 248 F. Supp. 3d 487, 492 (S.D.N.Y. 2017) (listing elements); Dkt. 110 at 11 (3/13/19 Order Certifying Class) ("[S]tate contract law defines breach consistently such that the question will usually be the same in all jurisdictions." (quoting *In re U.S. Foodservice Inc. Pricing Litig.*, 729 F.3d 108, 117 (2d Cir. 2013)).

B. Summary Judgment Should Be Granted in Plaintiff's Favor Under the "Uniform Basis," "Class Basis," and/or "Aetna's Estimate" Theories of Breach; in the Alternative, if Aetna's Interpretation Is Adopted, Disputed Questions of Material Facts Remain for Trial

1. Aetna Violated the Policies' "Uniform Basis" Requirement by Imposing the COI Increase Everywhere But New York

All adjustments to COI rates must be on a "uniform basis." *See* Pltf. SUMF ¶ 3.[46] As Aetna's corporate representative explained, the "uniform basis" provision requires Aetna to apply any COI adjustment equally within each class: "[redacted]." Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 403:9–14. As Aetna's brief acknowledges, the "uniform" language protects Aetna policyowners from being "treated differently from his or her class" by a COI increase. Aetna Br. at 24 (explaining that Aetna, for example, could not differentiate between policyholders in the

[46] Certain policies use the word "non-discriminatory" instead of uniformity. As relevant here, the Court and the parties all agree there is no material difference between the terms. *See* Dkt. 110 at 2 (Order Certifying Class), available at *Hanks v. Lincoln Life & Annuity Company*, 330 F.R.D. 374 (S.D.N.Y 2019); Ex. 18 (Parker 30b)(6) Depo.) at 267:14-18 (no "important difference" between "uniform" and "nondiscriminatory basis").

same class because some became sick or started smoking).

Undisputed evidence establishes that Aetna treated policyholders belonging to what it considered to be the same class non-uniformly. When Aetna implemented the COI increase, it did so only for non-New York policyholders; New York policyholders' rates did not change.[47] As a result of this non-uniform COI increase, non-New York policyholders belonging to the same class are now paying higher COI rates than other members of their respective policy classes, in violation of the policy. This is a breach for two simple reasons.

First, undisputed evidence establishes that Aetna treated New York and non-New York policies together in the same class, as part of the "product-wide" classes used for the COI increase that Aetna implemented:

> Q. So you defined 18 separate classes, then?
> A. Yes.
> Q. Okay. And each product here was one of those 18 classes?
> A. Yes.
> Q. And you did that prior to sending those rate schedules to [Aetna]; right?
> A. Yes.
> Q. And when you defined those 18 product classes, those would have included policies in New York; right?
> A. We – we see classes as a different unique issue. But, yes, the class for each product would be product-wide across jurisdictions.
> Q. So the class for each of these 18 products would include New York policies; Right?
> A. Right. Class is an actuarial concept.
>
> Ex. 18 (Parker 30(b)(6)) at 143:2–23; *see* Pltf. SUMF ¶ 26.

Second, undisputed evidence establishes that Aetna imposed the COI increase only on non-New York policies, and left COI rates unchanged for New York policies. *See* Plfts. SUMF ¶ 39; Ex. 18 (Parker 30(b)(6) Depo.) at 129:2–6 ("Currently, the COI that is being charged in the state of New York has not been increased at this point. Therefore, the charge in New York is not the

[47] A "New York policy" is defined as a policy with [redacted]" Ex. 18 (Parker 30(b)(6) Depo.) at 149:19–150:1.

same as the charge elsewhere."). By applying the COI increase only to some, but not all, owners of the product line, Aetna violated the "uniform" term of the Class Policies.

Aetna, however, seeks to rewrite the plain language of the Class Policies to allow it to apply COI rates on a **non**-uniform basis so that it may treat everyone outside of New York differently. Aetna's pleas to ignore the policies' plain language should be rejected.

(a) Aetna's Proposed Additions of Three New Phrases to the Uniformity Clause Do Not Defeat Summary Judgment

Aetna first argues that the Court should *add* to the uniformity clause the phrase "within each state," "fair," and "individual characteristics." These proposed extra-contractual additions fly in the face of basic contract principles and the plain meaning of the contract. As Aetna's brief admits, courts cannot *add* terms to a contract under the guise of interpretation. Aetna Br. at 14 (citing *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.)). *See also In re Davenport,* 522 S.W.3d 452, 457 (Tex. 2017) ("Courts may not rewrite the parties' contract, nor should courts add to its language.")

Contract Insert #1: The proposed "within each state" addition. Aetna argues that because the Class Policies do not say "uniform nationwide" or "on a national basis," the Class Policies must necessarily mean something much narrower, with a new "uniform within a state" qualifier added afterward, even though Aeta omitted those words from the contracts that Aetna drafted. Aetna Br. at 23–24. This argument makes no sense and ignores the plain meaning of "uniform," which means no variation. *See, e.g.,* Black's Law Dictionary (11th ed. 2019) (defining "uniform" to mean "[c]haracterized by a lack of variation; identical or consistent"); Merriam-Webster's Online dictionary; http://merriam-webster.com/dictionary/uniform (last visited on September 28, 2019) (defines "uniform" to mean "having always the same form, manner, or

degree; not varying or variable").[48]

Before this COI increase, Aetna, in fact, always priced and re-priced COIs without any geographic discrimination.[49] When it first rolled-out the 2016 COI increase but before the NYDFS intervened, Aetna likewise planned to impose the COI increase on what it considered to be uniform classes, by product line for all owners across the country. *See* Pltf. SUMF ¶¶ 22, 34. And, as previously noted, Aetna witnesses testified that "uniform" means "uniform by class" and that the classes included products issued in *every* state.

Contract Insert #2: The proposed discriminate "fairly" addition. Relying only on a mis-citation to plaintiff's expert, Aetna argues that the uniformity clause is not breached if the discrimination is done "fairly" within a class of insureds. *See* Aetna Br. at 24.[50] But Aetna is again making up words that are not in the contract: some Class Policies use the term "non-discriminatory" instead of "uniform,"[51] but none limit that requirement with the term *fairness*.

Even if the word "fairness" were added to the uniformity restriction, Aetna would still lose on summary judgment. Undisputed evidence establishes that there was no actuarially fair basis for treating New York and non-New York policyholders within the same class differently. Aetna's corporate representative agreed that Aetna "[redacted] to determine "[redacted]." Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 412:16–22 ("[redacted]

[48] 11 Williston on Contracts § 30:10 (4th ed.) ("When determining the ordinary meaning of a word or phrase in connection with the interpretation of a contract, it is appropriate to look to the definitions in a recognized dictionary"); *First Inv'rs Corp. v. Liberty Mut. Ins. Co.*, 152 F.3d 162, 168 (2d Cir. 1998) ("Not surprisingly, a favored source of the average person's understanding of a term is the dictionary.").

[49] *See, e.g.*, [redacted]

[50] Aetna cites Hause's opinion that *inter*-class discrimination is permissible if it is fair, but that is a non-sequitur. Aetna Br. at 24. The issue here is *intra*-class discrimination, which everyone agrees is treated differently by the contract.

[51] *See* footnote 46.

[redacted] *see* Plfts. SUMF ¶ 38.

Contract Insert #3: The proposed "individual characteristics" addition. Aetna argues there is no breach because there is "no claim that individual policyholders were discriminated against or singled out" in the COI increase "due to their own individual characteristics." Aetna Br. at 24. This "individual characteristics" defense, whatever that means, is nowhere to be found in the uniformity clause. Indeed, if the Court adopted Aetna's argument, a policyholder residing in New Jersey when he bought a policy who later moved to New York would pay more for the same insurance coverage than a neighbor who has lived in New York all of his or her life, even though both policies contain identical terms and the policyholders belong to the same class. There is no support for this non-uniform adjustment to the COI rates within a class. "Uniform" does not mean, as Aetna contends, "everywhere but New York."

Further, Aetna's COI increase still violates this new contract term Aetna proposes because the geographic location of the insured (New York or not) is an "individual characteristic" singled out by Aetna's everywhere-but-New-York rate hike.

(b) Aetna's Public Policy Arguments Are Meritless and Not Defenses to a Breach of Contract

Resorting to abstract policy arguments, Aetna claims that applying the uniformity clause as written is "entirely illogical" because it contravenes the "understanding" that life insurance is "regulated" by different state regulators. Aetna Br. 22–24 (citing 15 U.S.C. §§1011-1015; *Wadsworth v. Allied Profs. Ins. Co.*, 748 F.3d 100, 102 (2d Cir. 2014). Aetna does not cite to *any* state statute or *regulation* that is somehow undermined by a *contractual* promise of no COI rate discrimination anywhere. The McCarran-Ferguson Act, cited by Aetna, deals strictly with the

preemptive effect of "Acts of Congress" on state insurance law, 15 U.S.C. § 1012(b), not a private, unambiguous, contractual promise of uniformity made by a carrier to treat all policyholders the same.

There is nothing illogical in promising policyholders that if they are going to be treated adversely, then the carrier must treat all others in the same class in the same way. Even if Aetna could somehow prove that a contractual promise of uniformity is illogical, that too is not a defense to a breach of contract that Aetna drafted. "[B]ecause parties may freely set the outer limits of their bargain, they will be bound by the unambiguous terms of their contracts even though the result may be harsh." 11 Williston on Contracts §32:11 (4th ed.); *see also* Restatement (Second) of Contracts § 206 (1981) ("In choosing among the reasonable meanings of a promise or agreement or a term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.").

Aetna's (irrelevant) invocation of life insurance state-specific regulation also rests on a false legal premise. States can and do exert regulatory authority over an insurer and its operations in other jurisdictions.[52] Although Aetna argues that New York should not be allowed to have "veto" power over other states, that argument is a straw man. Plaintiff's position is that the *Aetna-drafted contracts* promise that Aetna will adjust COI rates on a "uniform basis" for all

[52] For example, New York Insurance Law §4224, which NYDFS cited in its correspondence, applies on its face to any "life insurance company doing business in this state." *See also* N.Y. Ins. Law §4226 (limiting what an insurer is permitted to do "in this state."); N.Y. Ins. Law §1106(f) ("No foreign insurer … which does outside of this state any kind or combination of kinds of insurance business not permitted to be done in this state by similar domestic insurers hereafter organized, shall be or continue to be authorized to do an insurance business in this state."); Conn. Gen. State. § 38a-446 ("No life insurance company doing business in this state shall make or permit any distinction or discrimination in favor of individuals between insurants of the same class and expectation of life in the amount of payment of premiums or rates charged for policies the terms and conditions of the contracts it makes; nor shall any such company or any producer or other person make any contract of insurance or agreement as to such contract other than is plainly expressed in the policy issued thereon."); *U.S. Bank Nat. Ass'n v. PHL Variable Ins. Co.*, 2013 WL 791462 (S.D.N.Y. March 5, 2013) (allowing owners of policies issued out-of-state to pursue claims predicated on violations of Connecticut insurance law).

policyholders within a class, without any carve-out for geographic discrimination. That provision is plainly breached here. In any event, New York did not "veto" the COI increase. Instead, Aetna ***chose*** to "suspend" the increase in New York rather than proceed through any final administrative determination or judicial ruling regarding NYDFS's objections. *See* Pltf. SUMF ¶¶ 38, 40.

Aetna also claims that differentiating between New York and non-New York policyholders is permissible *inter*-class discrimination because New York has a "unique" regulatory and enforcement scheme. That argument, once again, is not a defense to a breach of contract. It is also a red herring: Aetna breached the uniformity clause by making *intra*-class distinctions when it increased COI rates in a way that treated New York and non-New York policyholders in the same classes non-uniformly. Aetna also fails to establish that there is anything "unique" about New York law that permits Aetna to treat New Yorkers differently than non-New Yorkers. Nor could it. Aetna initially adopted COI rate scales that were calculated to *include* New Yorkers and then publicly announced the COI increase would treat policyholders in *all 50 states* uniformly within their respective classes, before later suspending the increase only in New York.[53]

Aetna lastly makes the incorrect (and irrelevant) argument that other states have reached "different conclusions" regarding the COI rate hike than New York. Aetna informed regulators in only seven states about the COI increase, and this litigation has unearthed evidence that Aetna undeniably lied to at least one of the regulators.[54] Regulatory inaction against Aetna followed, *not* formal approval.[55] "[N]on-disapproval is equally consistent with lack of knowledge or neglect as

[53] *See* Pltf. SMUF ¶¶ 22, 34; Ex. 18 (Parker 30(b)(6) Depo.) at 274:6–14 [redacted]

[54] *See* Resp. to Aetna SMUF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 12-13; Ex. 18 (Parker 30(b)(6) Depo.) at 379–81 [redacted].

[55] Aetna states that Minnesota did a "full examination" of the COI increase, but cleverly forgets to mention that the examination was done on *Lincoln*, the reinsurer who has *no contract* with members of the Class, not of Aetna, the

it is with assent." *Wileman Bros. & Elliott, Inc. v. Giannini*, 909 F.2d 33, 337 (9th Cir. 1990). As Mr. Foudree, former Insurance Commissioner of Iowa and past President of the National Association of Insurance Commissioner, explains in detail, a regulator's decision not to act may be made for any number of reasons, and cannot be relied upon as blessing a decision to change COIs, and certainly not as a matter of law on summary judgment in favor of the insurer and adverse to the policyowners. *See Fleisher v. Phoenix Life Ins. Co.*, 18 F. Supp. 3d 456, 466–68 (S.D.N.Y. 2014) (even when regulator stated it had "no objection" to a proposed COI increase, the regulator never "formally approved" the increase, and those facts are insufficient for summary judgment).

2. Aetna's Increase Violated the "Class Basis" Requirement

(a) Every Policy Has Explicit Contractually-Delineated Classes

The Hanks Policy states that (a) "the Monthly Cost of Insurance is based on the Insured's sex, attained age and premium class," and (b) adjustments to the COI rate "will be on a class basis." Pltf. SUMF ¶ 1. It is undisputed that this "class basis" provision requires Aetna to analyze the COI increase separately for each class, and prevents Aetna from imposing a COI increase on a particular class that is higher than warranted for that particular class. *See* Ex. 18 (Parker 30(b)(6) Depo.) at 167 [redacted]

It is also undisputed that Aetna did not apply or analyze the increase using these contractually-delineated classes, or even by premium class; instead, Aetna grouped all classes together and imposed a flat percentage increase per product line, outside of New York. *See* Pltfs. SUMF ¶¶ 22–23, 34; Ex. 18 (Parker 30(b)(6) Depo.) at 143-44 & 375-76 ("[redacted]

direct insurer and whose breach of contract is at issue here. Dkt 136-18. The consent order with Lincoln also expressly states that it is a "settlement" and "there has been no hearing, findings of facts, or conclusions of law." *Id.*

[redacted] Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 342:4–11 [redacted].").

That is a straightforward breach of the Class Policies' "class basis" provision, and therefore summary judgment against Aetna is appropriate.

(b) Aetna's Construction of the "Class Basis" Requirement is Meritless

Aetna argues that Plaintiff's interpretation of the "class basis" provision is "inconsistent with the plain reading of the contract." Aetna Br. 20. But it is Aetna who is again attempting to rewrite the terms of the deal. Aetna claims that it is an "undisputed fact" that "the contract makes no reference to classes at original pricing." *Id.* (citing Aetna's SUMF ¶ 21).[56] But Aetna's myopic focus on *original* pricing is a red herring. Plaintiff's position is that "class basis" unambiguously refers to the classes set forth five sentences above in the policy, where it states that "The Monthly Cost of Insurance is based on the Insured's sex, attained age and premium class." *See, e.g.*, Hanks Policy at 7. While it is true that these same classes were also used at pricing,[57] that fact supports Plaintiff's interpretation of the contract. As the NYDFS explained:

[56] Aetna's factual "support" for SMUF ¶ 21 has nothing to do with whether pricing classes were named in the contract. SMUF ¶ 21 relies entirely on deposition testimony relating to the separate, distinct issue of original pricing assumptions as the baseline to determine whether future expectations have deviated. *See* Dkt. 135 at 8 (Aetna's SMUF) (citing Hause Depo. at 164:24–165:22).

[57] *See* Ex. 15 (Pfeifer Depo.) at 158:23–159:7 [redacted]

> Second, the policies do define the classes for the purpose of computing COI increases. In your letter you quote a policy which states that "[t]he Monthly Cost of Insurance is based on the Insured's sex, attained age and premium class" (emphasis added). The policy goes on to state that "[a]djustments will be on a class basis." ***By giving the words their natural meaning, "class basis" plainly refers to the three factors identified only five sentences above in the policy***, "Premium class" (subdivided into smoker and nonsmokers) is not equivalent to "class basis," but instead one of the three factors that comprise class basis, "sex, attained age and premium class." Indeed, the policy further states "any adjustment will be made on a uniform basis." This requirement inherently presumes there are classes to which uniformity need be applied.

Ex. 49 (10/14/16 NYDFS Ltr. To Aetna) at LN_HANKS00156808–09.[58] The COI increase was indisputably not conducted on the basis of those contractually-delineated classes. *See* Pltf. SUMF ¶ 22.

Aetna's argument that "there is no separate requirement that COI *adjustments* be differentiated on the basis of sex, attained age, and premium class," Aetna Br. 20 (emphasis in original), also cannot be squared with the plain language of the policies. It would be nonsensical for the monthly cost of insurance to be based on those classes but a "class basis" adjustment allowed for five sentences later in the same provision would not. And it is black letter law that "[c]ontract terms cannot be viewed in isolation because doing so distorts meaning." *Pathfinder Oil & Gas, Inc. v. Great W. Drilling, Ltd.*, 574 S.W.3d 882, 889 (Tex. 2019); *see* 11 Williston on Contracts § 32:5 (collecting cases).[59]

[58] Ex. 50 (12/5/16 NYDFS Ltr. to Aetna) at LN_HANKS00157046–47 ("Nor can we conclude that a single cohort is appropriate; a single cohort was clearly not the class determined at the time the policies were originally sold and would not be the reasonable expectation for the consumer based on the policy language."). Contrary to its current position, Aetna initially indicated to NYDFS that it concurred in this reading of "class basis." *See* Ex. 36 (7/6/16 Aetna Email to NYDFS) at LN_HANKS000001765–66 ("Specifically, the Department indicated that, in its view, the appropriate class groupings for the redetermination of CO1 increases must bear a reasonable relationship to the classes identified at the time of original pricing and must be consistent with the contract with the policyholder. Consistent with such original pricing classes, Voya should apply changes in investment income, mortality, persistency and expenses to illustrate how the COI increases are equitable to the members of these original classes and profits have remained consistent. We would like you to confirm that we are of the same mind before we perform these calculations.").

[59] Aetna cited *Pathfinder Oil* for this point in its summary judgment brief on page13.

Aetna argues in conclusory fashion that this interpretation of the "class basis" provision "leads to absurd and commercially unreasonable results that would result in a windfall for Plaintiffs." Aetna Br. 15 (internal quotation marks omitted). Aetna, however, does not and cannot explain why it is "absurd" or "commercially unreasonable" to comply with the class delineations in the contract that it drafted, nor how it is a "windfall" to enforce the plain language of the contracts that Aetna drafted that Aetna breached to pocket tens of millions of dollars in COI overcharges, an amount that continues to grow every month.

A plain language reading of the entire "class basis" provision is also consistent with commonsense policyholder understanding, industry practice, and Aetna's own historical conduct for decades leading up to this 2016 COI increase. Prospective policyholders reading the opening sentence of the COI provision would obviously and objectively not be surprised to see that COI rates would differ based on age, sex, and premium class; a 25-year old female non-smoker would not expect to pay the same life insurance rate as a 70-year old male smoker. And for those same reasons, policyholders would objectively expect that any future adjustments would also take those same distinctions into account; i.e., be redetermined on a "class" basis, as the contracts require.

Aetna's actuarial expert, Timothy Pfeifer, agrees. In an expert report submitted in a prior COI case, Mr. Pfeifer wrote: "Specifically, issue age ranges, gender, policy size, etc. are all components of class because they can generate unique elements of anticipated experience factors. . . . To define class otherwise would be **illogical**." *U.S. Bank Nat'l Assoc. v. PHL Variable Ins. Co.*, Case No. 12-cv-6811-CM-JCF, Dkt. 334-4 at 27 (S.D.N.Y. Jan. 22, 2014) (Expert Rebuttal Report of Timothy Pfeifer).[60] And this is how Aetna redetermined COI rates on the Class

[60] Attached as Ex. 72 to the Ard Decl. *See also* Ex. 7 (Foudree Report) ¶¶ 23–28 (core industry fairness standard is that "similarly situated risks should be treated the same," which can only be accomplished if similarly situated policyholders (e.g. those of the same age, sex, and premium class) are grouped together and analyzed independently); Ex. 2 (Hause Report) ¶¶ 43–46, 49 (explaining industry actuarial standards).

Polices prior to 2016. *See, e.g.*, [redacted]

Aetna is incorrect to suggest that Plaintiff's actuarial expert, Christopher Hause, "disagrees" with Plaintiff's interpretation of the contract. *See* Resp. to Aetna SUMF ¶ 19.[61] Mr. Hause repeatedly testified that he was not providing an opinion on the *legal* definition of policy terms,[62] and his expert report does not opine on contract interpretation. For good reason: it is black-letter law that an expert cannot opine on the meaning of the contract, and such testimony is inadmissible and irrelevant for summary judgment. *See Sigmon for Hindin v. Goldman Sachs Mortg. Co.*, No. 1:12-CV-3367 (ALC), 2018 WL 1517189, at *4 n.4 (S.D.N.Y. Mar. 26, 2018) ("[I]t is well-settled that contract interpretation is not a proper subject of expert testimony.").

In any event, Aetna misinterprets what Mr. Hause said. Mr. Hause testified that, *as an actuary*, he understands "class" in the insurance context to be consistent with "policy class" under ASOP 2. Ex. 14 (Hause Depo.) at 122:8 –12.[63] Nothing about that testimony conflicts with the plain language interpretation of "class basis" in the Class Policies to include the three specifically delineated classes provided for five sentences earlier. ASOP 2 likewise does not state that contractually-delineated classes can be unilaterally altered at redetermination.[64] And though

[61] Aetna also argues that another expert, Mr. Foudree, also disagrees with Plaintiffs' interpretation. *See* Aetna Br. 21 & n.9. But Mr. Foudree merely testified that the words "COI adjustments must be made on the original class basis" do not literally appear in the policies, and that he could not recall any specific standards or regulations that mandated a static definition of class. *See* Ex. 13 (Foudree Depo.) at 43:23–44:3, 85:24-86:11. Mr. Foudree never interpreted the policies to allow Aetna to disregard the contractually-defined classes. *See* Ex 7 (Foudree Report) ¶¶ 30–37 ("Defendants violated the principle of fairness when they determined and implemented the 2016 COI Increase because they (a) did not calculate the increases on the original class basis….").

[62] *See* Ex. 14 (Hause Depo.) at 44:11–45:8 (stating that he is not a lawyer and reviews contracts from an actuarial perspective).

[63] *See* ASOP 2 § 2.6 ("Policy Class—A group of policies considered together for purposes of determining a nonguaranteed charge or benefit."), attached as Ex. 71A to the Ard Decl.; *id.* § 3.4 (listing factors to consider when establishing classes in a redetermintation). The ASOPs, adopted by the Actuarial Standards Board, sets standards for appropriate actuarial practice. Ex. 2 (Hause Report) ¶ 22. ASOP 2 relates to determination and redeterminations of non-guaranteed elements. *Id.*

[64] ASOP 2 does allow classes listed in an insurer's *determination policy* to be combined in limited circumstances, but does not state that an insurer can *disregard* its contractual obligation to redetermine rates using specific, contractually-

Aetna's brief omits it, Mr. Hause made clear that Aetna's reclassification of classes in the 2016 COI increase was improper. *See* Ex. 2 (Hause Report) ¶¶ 43–65 (Aetna's use of class in the 2016 COI Increase was "contrary to industry custom and practice, Aetna's redetermination policy, actuarial principles, and Aetna's prior redeterminations").

Aetna also argues that the COI increase was on a "class basis," no matter how class is defined, because Aetna's flat percentage, non-New York product-wide increase "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." Br. at 22 (emphasis omitted). But that is precisely the problem, and it confuses the "class basis" provision with the "uniform basis" provision. As Aetna's actuarial expert, Mr. Pfeifer, explained in a previous case:

> Groups of policyholders that behave differently should ***not*** be analyzed and/or priced together. Fairness in pricing and revising non guaranteed elements of policies dictates that one group of insureds should not be required to subsidize another group simply because that group chooses to act differently.

U.S. Bank Nat'l Assoc., etc. v. PHL Variable Ins. Co., Case No. 12-cv-6811-CM-JCF, Dkt. 334-4 at p. 27 (S.D.N.Y. Jan. 22, 2014) (emphasis added). Lincoln's and Aetna's own corporate representative similarly testified: "[redacted]." Ex. 18 (Parker 30(b)(6) Depo.) at 170:19–171:5.

Aetna's argument that "class basis" is somehow synonymous with "nondiscriminatory" is therefore illogical and would render the uniformity clause superfluous, in contravention of

---

defined classes. *See* ASOP 2 § 3.4; *see also id.* § 3.1 (stating that actuaries should consider relevant policy provisions when utilizing the ASOP guidelines).

principles of contract interpretation.[65] The uniformity clause presupposes that there are classes to which uniformity must be applied. Those classes are spelled out in the policy as the groupings on which the "Monthly Cost of Insurance is based," each of which has different COI rates. Aetna cannot rewrite the policy to eliminate these classes and the requirement that each class be analyzed independently.

(c) Aetna's "ASOP 2 Only" Interpretation of "Class Basis" Is Incorrect and, Even If Adopted, Proof of Compliance with ASOP 2 Raises Triable Issues of Fact

Aetna contends that it is undisputed that the "class basis" requirement in the policies is *only* controlled by ASOP 2's rules. *See* Aetna SUMF ¶19. That is inaccurate. *See* Resp. to Aetna SUMF ¶ 19. Nothing in the contract says "class basis" should *only* be defined with reference to ASOP 2. Although Aetna was required to follow ASOP 2 in its redetermination,[66] nothing in ASOP 2 allows Aetna to ignore the *additional* contractual limitations imposed by the Class Policies five sentences earlier. The suggestion that "class basis" should be read wholly divorced from the three classes identified five sentences above in the same provisions, and instead follow a version of ASOP 2 that ***was not adopted until March 2004***, for policies issued beforehand from 1983 to 2000, makes no sense.

As Aetna knows from its discussions with the NYDFS, the only other possible construction of "class basis" as used in the policy is that it means that the redetermination must be conducted on the basis of premium class. As Aetna acknowledged, all other references in the policy to "class"

[65] *See, e.g., Petroterminal de Panama, S.A. v. Houston Cas. Co.*, 114 F. Supp. 3d 152, 160 n.4 (S.D.N.Y. 2015) ("It is a commonplace that a court will interpret a contract to give effect to all of its provisions, and will avoid an interpretation that leaves part of the contract meaningless." (quoting *Ins. Co. of N. Am. v. ABB Power Generation, Inc.*, 925 F.Supp. 1053, 1059 (S.D.N.Y.1996))).

[66] *See* Ex. 19 (Overton Depo.) at 16:19–17:3 (agreeing that actuaries can't change non-guaranteed elements inconsistently with actuarial standards of practice).

are in reference to "premium class."[67] And Aetna admitted to the NYDFS that such a construction "would also be consistent with Policy language, applicable law, and ASOP." Pltf. SUMF ¶ 37. Plaintiff would similarly be entitled to summary judgment under this construction as well because Aetna indisputably did not adjust COI rates on the basis of premium class.

If Aetna were somehow correct that ASOP 2 is the *sole* guide for determining whether Aetna adjusted rates on a "class basis," Aetna's motion for summary judgment must still be denied. There are numerous factual disputes of material issues on whether the COI increase complied with ASOP 2 and actuarial practices, including dueling actuarial expert reports on this topic. *See* Resp. to Aetna SUMF ¶¶ 19, 23 & Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 1, 14.

First, Aetna's corporate representative all but admitted that Aetna did not follow ASOP 2 in determining the policy classes used for the COI increase, and Plaintiff's actuarial expert and the NYDFS agrees. *See* Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 337–40 (agreeing that, under ASOP 2, "if policies were assigned to one class and then later assigned to another class," that would need to be disclosed, and acknowledging that Aetna never got "an answer [from Lincoln] to the question whether there were any material changes in the assignment of policies to policy classes"); Ex. 2 (Hause Report) ¶¶ 53–60, 77, 80, 101 (opining that the COI increase was not consistent with ASOP 2); Ex. 49 (10/14/16 NYDFS Ltr.) at LN_HANKS00156808–09 ("Treating the entire cohort as a single class would violate ASOP 2."). The Chief Actuary for the Class Policies, Patrick Lusk, testified that he did no work to determine "[redacted]," and was not aware of anyone at Aetna who did.

[67] *See* Hanks Policy at 2 (listing "premium class" as "nonsmoker"); *id.* at 7 ("The Monthly Cost of Insurance is based on the Insured's sex, attained age and *premium class*. Attained Insurance Rate 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.").

Ex. 27 (Lusk Depo.) at 109:9–18; *see* also Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 1, 4, 9, 11.

Second, ASOP 2 states that any "material changes in the assignment of policies to policy classes," and "any material change in the determination policy" must be documented in accordance with ASOP 2, §§ 3.6 & 4.2, as well as ASOP 41.[68] The policies at issue all included classes arising from gender, age, and premium class,[69] and these same classes were used in prior Aetna redeterminations.[70] But Aetna has *no documentation* of any analysis conducted pursuant to ASOP 2, and Aetna's witnessed confirmed that Aetna did *nothing* in this regard. Aetna and Lincoln actuaries also repeatedly testified that they made no effort to determine what prior classifications had been used and did not review Aetna's determination policy from prior redeterminations. *See* Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 3-4, 9; Ex. 22 (King Depo.) at 34:2–12 (Aetna actuary stating that he doesn't know what classes were used at pricing because "it wasn't relevant in my mind"). Mr. Hause opines this is inconsistent with ASOP 2. Ex. 2 (Hause Report) ¶¶ 57-59.

Third, ASOP 2 requires the insurer to follow a determination policy, but Aetna's corporate representative admitted the policy followed was not a determination policy as described by ASOP 2; Mr. Hause opines this alone precludes any finding that ASOP 2 was followed.[71]

---

[68] Hause Report ¶ 59. ASOP 2 and ASOP 4 are attached as Exs. 71A & 71B, respectively, to the Ard. Decl.

[69] See Pltf. SMUF ¶ 7. *See also* [redacted] *See, e.g.*, Ex. 42 [redacted] at LN_HANKS00017440.

[70] [redacted] Plaintiffs' focus here on the original pricing classes, as an independent theory of breach is that Aetna violated the "Aetna's estimates" language by using Lincoln's 1998 Purchase Assumptions as the original baseline. But like the pricing assumptions, the purchase assumptions were also done at a more granular level than the product-wide classes used in the 2016 COI Increase. *See* Ex. 15 (Pfeifer Depo.) at 125:14–19 (agreeing that the purchase assumptions were done at a level more granular than product line).

[71] *See* Resp. to Aetna SMUF ¶ 12; Ex. 18 (Parker 30(b)(6) Depo.) at 223-24 ([redacted]

Accordingly, whether the COI increase constituted an appropriate exercise of actuarial judgment under the ASOPs is a disputed question of material fact that can only be decided at trial. For each of these reasons, summary judgment in favor of Aetna regarding its alleged compliance with ASOP 2 must therefore be denied.

3. Aetna's Increase was Not Based on "Aetna's estimates for future cost factors"

The Class Policies state that the COI rates set at issuance "may be adjusted by Aetna from time to time," and that any such adjustment "will be based on Aetna's estimates for future cost factors." *See* Hanks Policy at 7. That means Aetna cannot alter COI rates unless *Aetna*'s estimated cost of insuring policyholders changes. The 2016 COI increase, however, was not based on any change in estimated cost factors by Aetna. Instead, the increase was initiated and advanced by *Lincoln* based on *Lincoln*'s comparison of (a) *Lincoln*'s estimates of *Lincoln*'s projected costs and profits as of 2015 to (b) *Lincoln*'s GAAP profit assumptions from the 1998 Transaction. *See* Pltf. SUMF ¶¶ 17, 20–21. Summary judgment is appropriate for Plaintiff because the "baseline" estimates for the COI increase were Lincoln's, not Aetna's. Summary judgement for Aetna on all other theories should be denied because Aetna's arguments raise a host of disputed questions of material facts.

(a) Summary Judgment for Plaintiff: The Use of Lincoln's 1998 Purchase Assumptions as the Baseline Breached the Policies

For a COI rate adjustment to be "based on Aetna's estimates for future cost factors," there

[redacted]."); Ex. 2 (Hause Report) ¶ 60 (defendant's concession that it did not follow a redetermination policy within meaning of ASOP "independently undermines any assertion that Defendants properly used ASOP 2 to justify the increase."). Mr. Parker improperly tried to change this testimony through an errata, but that itself creates a fact issue as to whether he was right the first time. *See Barnes v. Ross*, No. 12 CIV. 1916 PKC, 2014 WL 1329128, at *11 (S.D.N.Y. Apr. 3, 2014) ("Both the original testimony and the errata become part of the record, but at the summary judgment stage, a district court is 'on firm ground' if it does not credit an errata sheet that reflects a party's attempt to 'retrieve the situation by scratching out and recanting his original testimony'") (quoting *Podell v. Citicorp Diners Club, Inc.*, 112 F.3d 98, 103 (2d Cir.1997)).

must be a change between Aetna's current "estimates for future cost factors" and Aetna's prior, baseline "estimates for future cost factors." If Aetna's estimates for future cost factors are the same as Aetna's prior estimates for future cost factors, then there would be no rationale for altering COI rates.

While Aetna offers a variety of (uncompelling) arguments for why Lincoln's 2016 estimates for future cost factors should be "deemed" to be Aetna's, Aetna does not proffer any *facts* from which a reasonable factfinder could conclude that Lincoln's 1998 Purchase Assumptions are "Aetna's estimates." The text of the Class Policies explicitly requires that the estimates used to adjust rates be "Aetna's estimates," and there is no carve-out saying this does not apply for the baseline estimates used. *See* Pltf. SUMF ¶ 2. Lincoln commissioned Milliman to prepare the 1998 Purchase Assumptions for its own internal purposes as a counter-party to the 1998 Transaction. *See* Pltf. SUMF ¶¶ 10, 20; Pfeifer Report at ¶ 38 ("Shortly after the 1998 transaction, the actuarial consulting firm Milliman was engaged to develop a Purchase GAAP Analysis of the Aetna Block *on behalf of Lincoln*."). And the appraisal was dated "as of" the date the 1998 Transaction closed, thereby serving no benefit to Aetna.

Aetna offers no explanation for how the use of estimates developed for *Lincoln* in 1998 can morph into "Aetna's estimates," beyond the generic argument that Aetna ex post "adopted" Lincoln's estimates 20 years later when conducting the COI increase analysis. *See* Aetna Br. 16–20. This only underscores the absurdity of Aetna's interpretation of "Aetna's estimates"—Aetna's position is that it can retroactively deem as its "estimates" assumptions created nearly twenty-years earlier for a transactional counter-party and which Aetna (i) did not receive, analyze, or review at the time, and (ii) did not receive, analyze, or review even in the context of the 2016 redetermination. *See* Pltf. SUMF ¶¶ 10, 30. Applying basic principles of contract interpretation, it

is wholly unreasonable to interpret "Aetna's estimates of future cost factors" to include a third party reinsurer's "expectations of the go-forward profitability" that Aetna never received, reviewed, or analyzed.[72] Because there is no material dispute that the baseline purchase assumptions were Lincoln's estimates, and not Aetna's, *see* Pltf. SUMF ¶¶ 10, 20, Plaintiff is entitled to summary judgment on this ground alone.

(b) No Summary Judgment for Aetna: Whether Current Estimates Used for the COI Increase Are Lincoln's (not Aetna's) is a Disputed Question of Fact

As for the *current* estimates of cost factors that were compared to Lincoln's 1998 purchase assumption baseline estimates, Aetna's 30(b)(6) witness admitted that the current assumptions used were also "[redacted]." Ex. 18 (Parker 30(b)(6) Depo.) at 66; Pltf. SUMF ¶ 20. These estimates were "Lincoln's Current Expectations . . . produced by Lincoln's Asset Liability Management model of the [Aetna] business" using Lincoln data and experience studies. *See id.*; Ex. 35 (5/20/16 Aetna Ltr. to NYDFS) at LN_HANKS00001744, 748 (stating that the assumptions used in the Asset Liability Model "originate from Lincoln's internal experience studies"). That is not surprising because the 2016 COI increase was originated and modeled solely by Lincoln actuaries using only Lincoln data and tools, and the impetus for the increase was Lincoln's belief that *Lincoln's* assumed profits from the 1998 Transaction had not materialized. *See* Pltf. SUMF ¶ 21. The increase analysis was guided by Lincoln's determination policy, not

[72] Aetna's claim that Plaintiffs' expert Mr. Hause disagrees with Plaintiffs' interpretation of "Aetna's estimates" is false. *See* Resp. to Aetna SMUF ¶¶ 20–21. Mr. Hause never stated in the excerpted testimony (or at any other time in his deposition or expert reports) that the baseline comparison costs do not have to be "Aetna's estimates." *See* Ex. 14 (Hause Depo.) at 164:24–165:22. Mr. Hause's reports make clear that his opinion is that Aetna's use of Lincoln's estimates as the baseline is improper. *See* Ex. 2 (Hause Report) ¶¶ 99–106, 111; Ex. 3 (Hause Rebuttal Report) ¶¶ 49–53. Further, Plaintiffs' experts are not offering—and are not permitted to offer—opinions on policy interpretation. *See supra* Section I.B.*i.*

Aetna's. *See* Resp. to Aetna SUMF ¶ 12.[73] Aetna was not even aware that an increase was being considered until Lincoln reached out with its recommendations. *See* Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶ 16.

Despite the fact that Lincoln's own "Actuarial Justification" for the increase refers to the results of this process as "***Lincoln's estimates for future cost factors***," Ex. 54 (Lincoln's Actuarial Justification) at LN_HANKS00267788, Aetna now claims that the calculations qualify as "Aetna's estimates" because Aetna "reviewed the recommendation and formally accepted the recommendation," Aetna 18–20 (citing SUMF ¶¶ 11–15). As an initial matter, Aetna is conflating the policy term "estimates for future cost factors" and the word "recommendation." While Aetna may have reviewed and formally accepted the ***recommendation***, Aetna never received or reviewed the actual estimates for future cost factors on which the increase was allegedly based,[74] which is what the policy requires to be "Aetna's."

Aetna's contention that, as a matter of law, Lincoln's current estimates magically *morphed into* Aetna's estimates because Aetna allegedly reviewed those estimates and adopted them raises disputed issues of material fact, because the evidence shows that Aetna did nothing more than an improper rubber-stamping of Lincoln's work under the threat of draconian financial punishment and never reviewed Lincoln's estimates of future cost factors at all. *See* Pltf. SUMF ¶¶ 17, 19, 30; Resp. to Aetna SUMF ¶¶ 12–13 & Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 5-7, 8-9. In support of its summary judgment argument on this issue, Aetna lists as a purported material and undisputed fact that Aetna's "Review Team" "reviewed the anticipated future cost factors relied upon in the determination process" by Lincoln. Aetna SUMF ¶ 13. But this alleged

[73] A "Determination Policy," as defined in ASOP No. 2 for purposes of a redetermination, means "[t]he insurer's criteria or objectives for determining nonguaranteed charges or benefits for a particular policy class." ASOP 2 at § 2.3.
[74] *See* Pltf. SMUF ¶ 28.

fact – which Aetna concedes is material – is false, and controverted by Aetna's own witnesses, as illustrated in the following chart:

Aetna SUMF ¶ 13	**Aetna 30(b)(6) Testimony**
Aetna's Review Team "**reviewed the anticipated future cost factors** relied upon in the determination process …"	Aetna's "[redacted] Resp. to SUMF ¶ 13.

Indeed, the only support for Aetna's contention is a recitation in a memorandum supplied to Aetna's Board of Directors. But the members of Aetna's "Review Team," as well as Aetna's corporate representative, all disclaimed not only reviewing Lincoln's estimates for future cost factors, but receiving them at all. *See* Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶ 6. While Plaintiff maintains that Aetna's self-serving hearsay, which it cannot find a single witness to confirm, should be disregarded entirely, at a minimum summary judgment cannot be granted to Aetna because its own witnesses contradict its assertion on this concededly material issue. *Cohen v. Gerson Lehrman Grp., Inc.*, 2011 WL 4336683, at *5 (S.D.N.Y. Sept. 15, 2011) (Castel, J.) ("By definition, an assertion made by a movant in Rule 56.1 Statement is a concession that a fact is "material.").

There is other substantial evidence from which a reasonable fact-finder can infer that Aetna blindly adopted Lincoln's COI increase recommendation, making the whose-current-estimates-are-they issue inappropriate for resolution on summary judgment in favor of Aetna. For instance, Aetna actuaries considering the increase did not review *any* of the (a) policy forms, (b) actuarial memoranda describing the nature and initial pricing of the policies, nor (c) Lincoln's actuarial

models.[75] Instead of reviewing Lincoln's work, Aetna's actuaries just claimed to try to understand Lincoln's "process."[76] But even then, Aetna failed to investigate basic and important information about Lincoln's methodology.[77] Even at the time of depositions in this case, Aetna's witnesses were *still* confused as to what Lincoln had done, with Aetna's Chief Actuary believing (incorrectly) that Lincoln had used original pricing assumptions and the original policy classes. *See* Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶ 10; Ex. 27 (Lusk Depo.) at 40:18-25 ("[redacted]."). Aetna's actuarial expert acknowledged the cursory nature of Aetna's review, testifying that he would "not call it thorough." Ex. 15 (Pfeifer Depo.) at 214:22–215:3.

Aetna suggests that the Court should ignore all of this evidence and nevertheless grant summary judgment in its favor because Aetna is allowed to rely on the work of consultants and agents. Aetna Br. at 18–19. But whether Lincoln was in fact operating as a consultant or agent of Aetna is also a disputed factual question.[78] Lincoln acted as a counter-party to an arms-length

[75] *See* Resp. to Aetna SMUF (Plaintiff's Local Rule 56.1(b) additions) at ¶¶ 6-7, 8-9; Pltf. SMUF ¶ 30; Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 151:1–15 [redacted]."); *id.* at 151:24 –152:8 ([redacted]); Ex. 27 Lusk Depo. at 95:1–5 [redacted]

[76] *See* Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 91:12–16 [redacted].").

[77] *See, e.g.*, Ex. 16 (Aetna 30(b)(6) Depo. (Brantzeg)) at 206:13–16 ([redacted] "); *id.* at 340:5–10 (Lincoln never informed Aetna whether there were any material changes in the assignment of policies to policy classes); Ex. 27 (Lusk Depo.) at 130:17–22, 131:5–11 (Aetna Chief Actuary testifying that he was unaware of any prior redeterminations for the block of policies).

[78] Resp. to Aetna SMUF (Plaintiff's Local Rule 56.1(b) additions) at ¶ 2. Aetna implies that Plaintiffs' expert agrees with Aetna that it is undisputed that an agency or consulting relationship existed here. Aetna Br. 18–19 (citing Hause Depo. at 160:4–14). But the deposition excerpt makes clear that Mr. Hause was simply making the general point that an insurer can hire and rely on consultants and agents. He never testified that such a relationship existed here, and his report expressly disclaims such a relationship. *See* Ex. 3 (Hause Rebuttal Report) ¶ 70.

transaction with Aetna that gives Lincoln a direct profit interest in the adoption of its recommendation.[79] Aetna has provided no evidence that Lincoln reviewed the increase at Aetna's direction or request. Lincoln sent its recommendation to Aetna in its capacity as a *reinsurer*, not in its capacity as Aetna's administrative agent, and explicitly invoked the carrot-and-stick "Side Letter" that effectively forced Aetna to adopt Lincoln's recommendation.[80] This is not the conduct of an agent or consultant [redacted].[81]

Inventing a strawman, Aetna also claims that Plaintiff's (alleged) position that an "[Aetna] actuary should have done the initial COI Adjustment's analysis and modeling" is absurd and commercially unreasonable. Aetna Br. at 15, 19–20. But that is not Plaintiff's position. Plaintiff's position is that Aetna cannot just blindly rubber-stamp the recommendations of a third-party reinsurer using the wrong baseline and the wrong determination policy and claim that satisfies Aetna's contractual obligation to *its own policyholders* to base an increase on "Aetna's estimates."

[79] *See* Ex. 2 (Hause Rebuttal Report) ¶ 70; Ex. 9 (Pearson Rebuttal Report) ¶¶ 14–15.

[80] *See* Pltf. SMUF ¶ 17; Ex 46 (2/26/16 Lincoln Ltr to Aetna re Increase) at LN_HANKS00038037 ("The following is being offered for consideration in accord with the Second Amended and Restated Asset Purchase Agreement dated as of May 21, 1998 . . . that certain letter dated October 1, 1998 relating to the determination of policy non-guaranteed elements ('NGE') . . . and the terms of the coinsurance agreement between Aetna Life Insurance and Annuity Company (now 'Voya Retirement Insurance and Annuity Company') and Lincoln Life & Annuity Company of New York, effective 10/1/98."); Ex. 3 (Hause Rebuttal Report) ¶ 70 ("However, Lincoln sent its recommendation to Aetna pursuant to the coinsurance agreement and purchase agreement, not the administrative agent agreement. Aetna and Lincoln are counter-parties to that agreement: seller/cedant and purchaser/reinsurer. No agency was created pursuant to those agreements, and Lincoln was never made Aetna's agent for purposes of conducting an Aetna redetermination.").

[81] Aetna cites 8 Del. C. § 141(e) in support of its claim that Aetna's board could rely on Lincoln's data. *See* Aetna Br. 18. But whether Aetna's board violated Delaware Corporations Law in approving the increase is completely irrelevant to any claim or issue in this case. And in any event, the statute requires that reliance be in "good faith" and upon "reasonable belie[f]," neither of which existed here.

Finally, Aetna argues that Plaintiff's actuarial expert opinion on these cost estimate issues are "absurd," but that is a classic attack on the weight of his opinion to be decided by the fact finder. Aetna Br. at 19 (citing Hause Depo. 129:4–131:16); *see, e.g., Tyson Foods, Inc. v. Bouaphakeo et al*., 136 S. Ct. 1036, 1049 (2006) ("[Defendant], however, did not raise a challenge to [plaintiffs'] experts' methodology under *Daubert*. . . . Once a district court finds evidence to be admissible, its persuasiveness is, in general, a matter for the jury. Reasonable minds may differ as to whether the [expert testimony] is probative . . . . Resolving that question, however, is the near-exclusive province of the jury.") This attack also rests on a mischaracterization: Mr. Hause in fact testified that the analysis of an independent third party who is "specifically engaged for that activity by Aetna" could qualify as Aetna's estimates. *See* Ex. 14 (Hause Depo.) at 131:8–16. There is nothing surprising about this testimony—it is not in the least bit "absurd" for the jury to conclude that a reinsurer's review of its own data, *without* any request, input, or oversight from Aetna, combined with a threatening "Side Letter" from the reinsurer, would not and could not qualify as *Aetna's* estimates.

(c) No Summary Judgment for Aetna: The Class Policies Require New COI Rates to be Based on a Comparison of Original Assumptions, Not Purchase Assumptions

Largely glossing over the fact that neither Lincoln's 2015 current assumptions nor Lincoln's 1998 purchase assumptions were "Aetna's estimates," Aetna's brief largely focuses on Plaintiff's contention that Aetna should have used its original pricing assumptions (or assumptions from the prior redeterminations). But defense summary judgment is not appropriate on this contention either.

Aetna misreads the contract, which read in context, means that any adjustment of rates must be based on changes from when rates were originally priced or last set. If rates are being changed from one scale to another, "Aetna's estimates for future cost factors" must have changed

from when the prior scale was adopted to the time that the new scale is adopted. To allow an insurer (Aetna) to increase COI rates based on a third party's increased profit expectations (Lincoln) from *after* the policies were issued would be absurd.[82] Among other things, it would mean that Aetna could increase COI rates despite the absence of *any* change in expectations between pricing and redetermination. That is not what the "[a]djustments…will be based on Aetna's estimates of future cost factors parties" provision means, as confirmed by Aetna's own head actuary:

[redacted]

Ex. 27 (Lusk Depo.) at 55:6–56:10; *see also id.* at 48:20–49:1 [redacted]).[83]

[82]Aetna attempts to distract from these problems by claiming that it did not keep all of its original pricing documentation. This "dog ate my homework" excuse cannot relieve Aetna of its contractual obligation to base an increase on "Aetna's estimates." But even if this defense were legally cognizable, it is a disputed fact question whether Aetna's pricing assumptions were too incomplete to be utilized. Lincoln and Aetna had extensive pricing documentation. Following the launch of the NYDFS investigation, Lincoln prepared dozens of spreadsheets with excerpts from the original pricing documentation. *See* Ex. 3 (Hause Rebuttal Report) ¶ 52. And the mere fact that some portion original pricing assumptions were incomplete does not render them unusable because gaps could be filled in with comparable data from similar products. *Id.* Indeed, this was the approach suggested by Lincoln's actuarial consultant Willis Towers Watson, and the approach that Aetna's Chief Actuary (mistakenly) believed Lincoln had taken during the redetermination. *See* Ex. 68 at WTW00002908 [redacted]; Ex. 27 (Lusk Depo.) at 40:18–25 ("[redacted].").

[83] Aetna's brief quotes Plaintiff's expert Bruce Foudree as stating: "There is no requirement requiring insurance companies to have used original pricing assumptions as the baseline." Aetna Br. 16–17 (citing Foudree Depo. at 43:24–44:5). This language (nor anything like it) does not appear anywhere in Mr. Foudree's deposition transcript, let alone the pin cite that Aetna identifies. It appears to be a completed fabricated quote inserted by Aetna into its brief, on the hopes that Plaintiff and the Court would not review the underlying citations themselves.

(d) Aetna is Not Immunized by the Maximum Guaranteed COI Rate

Finally, Aetna implies that the COI adjustment was permissible because it did not raise any policyholder's COI rate above the maximum guaranteed rate. *See* Br. at 6–9. Judge Charles Breyer recently considered, and rejected, this same argument:

> The trouble with this argument is that it would, if accepted, render completely superfluous the COI calculation provision. If the only limit on the COI that State Farm charged were the COI maximum rates, then there would be no reason why the Policy would have included a list of COI factors. The Court thus agrees with Bally that the maximum COI rate provision is not the only limit on the COI that State Farm deducts from the Account Value, see Policy at 9, and thus the fact that State Farm did not violate that maximum COI provision does not insulate them from a claim for breach of contract.

Bally v. State Farm Life Ins. Co., No. 18-CV-04954-CRB, 2019 WL 3891149, at *7 (N.D. Cal. Aug. 19, 2019) (citations omitted). The Court should do the same here.

4. <u>The Court Also Cannot Grant Summary Judgment for Aetna Because Aetna Failed to Address All of Plaintiff's Breach of Contract Theories</u>

Aetna's motion for summary judgment does not address several of Plaintiff's independent theories of breach concerning its improper COI rate increase. Aetna's failure to address these is fatal to its motion seeking judgment as a matter of law on the breach of contract claim. *See, e.g.*, *Citibank, N.A. v. Wynmark Tr.*, 1993 WL 78069, at *9 (S.D.N.Y. Mar. 17, 1993) (rejecting summary judgment for certain claims because movant did not address non-movant's different theories of recovery for those claims).[84]

First, as discussed above, in focusing exclusively on whether the policies use the words "original pricing assumptions," Aetna entirely ignores Plaintiff's assertion that the use of Lincoln's

[84] *See also Ste. Marie v. Midwest Freightways, Inc.*, 2007 WL 3244671, at *4 (W.D. La. Nov. 2, 2007) ("Because the parties did not brief and argue the remaining theories of liability, those theories, including the alter ego, respondeat superior, and single business enterprise theories, remain as possible grounds for recovery"); *Angelopoulos v. Keystone Orthopedic Specialists*, S.C., 207 F. Supp. 3d 850, 862 (N.D. Ill. 2016) ("The Court concludes that Defendants are not entitled to summary judgment on Plaintiff's unjust enrichment claim. As an initial matter, the motion fails to address two of Plaintiff's three theories of unjust enrichment, which itself is sufficient reason to deny Defendants' motion on this count.").

1998 "expectations of the go-forward profitability," and in particular Lincoln's reinsurance profit assumption, violated the unambiguous policy restriction that any adjustment must be based only on "future ***cost*** factors." "Profits" are not included as a cost factor, which is unsurprising because, by definition, "profits" are not a cost. Yet Aetna endorsed a redetermination methodology that increased COI rates on policyholders simply because *Lincoln*, a reinsurer with no direct contractual relationship to policyholders, felt that *Lincoln* did not receive the profit return it expected when it paid Aetna $[redacted] in the 1998 transaction.

For example, when the Class Policies were originally priced, Aetna did not assume that any reinsurance would be used. Lincoln's 1998 "purchase," however, was largely driven by low reinsurance costs, such that Lincoln would be able to earn hefty profits due to the difference between reinsurance premiums paid and death benefits reinsured. The COI increase, in turn, was driven in large part by a decrease in Lincoln's reinsurance profits, despite the fact that Aetna did not assume any such profits when it originally priced the Class Policies. The chart below depicts reinsurance assumptions at three points in time:[85]

Date	Reinsurance Assumption
Pricing	$0
1998 Purchase	$[redacted] in profits in Projection Year 1
2016 (Pre-Increase)	$[redacted] in profits in Projection Year 1

Under Lincoln's flawed methodology, which Aetna is now forced to defend, this is a [redacted] deterioration and can be used to justify a COI increase. But it is actually a [redacted]

[85] *See* Ex. 3 (Hause Rebuttal Report) ¶ 43.

improvement from pricing. That the adjustment was not only impermissibly based on *Lincoln's* 1998 estimates of future cost factors, but also Lincoln's 1998 estimates of profits from reinsurance arbitrage, is an independent breach of the "future cost factors" provision.

Second, the entire COI adjustment methodology was profit-driven. *See* Pltf. SUMF ¶ 21; (Parker 30(b)(6) Depo.) at 62:5–7 (testifying that the COI rate increase "was an action that we took to repair the profitability of the block"). No effort was made to isolate the actual "costs" of providing insurance, or even to ensure that profits would not exceed the amount assumed at pricing. According to Lincoln's own analysis, the Class Policies will generate over $[redacted] in discounted future profits following the increase. Because Aetna's legal position is that it is not required to compare its current "estimates for future cost factors" to original pricing or maintain the level of profitability assumed at pricing, then it should not be assuming any profits at all. That is, COI rates should be designed so that they align with Aetna's projected ***costs*** of insuring the policies.[86] Aetna's failure to explain why it was permitted to reap enormous *profits* from post-increase COIs when adjustments can be based only *cost factors* is a further ground on which Aetna's motion for summary judgment must be denied.

Third, Aetna's decision to apply a flat percentage increase to all ages and premiums classes creates a fact question of whether the COI increase was "uniform" and "nondiscriminatory," even if Aetna's interpretation of the "uniform" clause were adopted and even leaving aside the non-New-York discrimination breach. *See* Resp. to Aetna SUMF (Plaintiff's Local Rule 56.1(b) additions) at ¶ 14. Because Aetna originally determined COI rates based on age, sex, and premium class, certain policyholders were paying, before the COI increase, many multiples of what other

[86] Ex. 28 (Smith Depo.) at 11:13–18 (defining COI as "the rate charged in an insurance policy to cover mortality, typically"); Ex. 26 (Fick Depo.) at 32:7–15 (COI rate is "a deduction that's usually based on, applied based on a net amount of risk, and the net amount of risk is really the mortality exposure that a company has to a death in a particular month.").

policyholders were paying. By increasing COI rates by flat percentages across entire product lines, policyholders who are already paying higher COI rates—particularly the elderly and smokers—bore a disproportionate share of the impact.[87] Again, Aetna fails to address this non-uniformity and discrimination issue, which ultimately stems from its failure to conduct the rate increase on a class basis.

C. Aetna's Request for Partial Summary Judgment Against "10%" of the Class Through 2017 Is Meritless and Depends on Stale Data

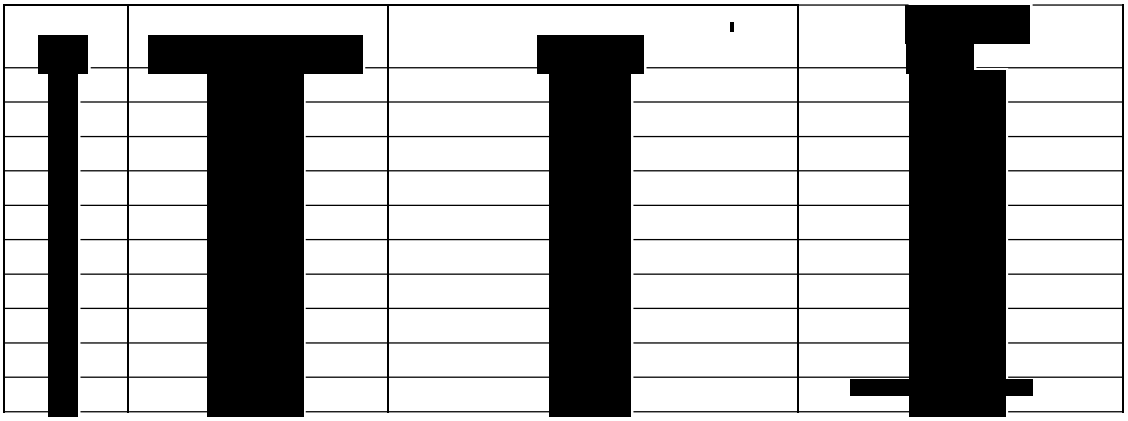
Aetna asserts that, in the alternative, the Court should grant partial summary judgment on the "10% of the policies that did not receive any increase" because those policyholders allegedly did not suffer any damages. *See* Aetna Br. At 25. This is wrong for three simple reasons.

First, Aetna's argument focuses on a limited and irrelevant time frame. Contrary to what Aetna argues, Mr. Pfeifer concluded that 10.1% of the class policies had not been charged higher COI rates **only** "from 6/1/2016 **to 12/31/2017**." *See* Pfeifer Report, Ex. I (cited in Aetna SUMF ¶ 22). But individual COI rates change each year, and just because a policy had not yet received an overcharge by December 31, 2017, it does not follow it never will. To the contrary, the record contains thousands of examples of policies that had no overcharge through December 31, 2017, but which either already suffered an overcharge or soon will, assuming the policies remain in force. For example, Exhibit 27.17 from Mr. Mills opening report shows that policy number [redacted] had not experienced an overcharge as of December 31, 2017, while Exhibit 83-A (page 1, row 17) shows that this policy already incurred an overcharge at least as early as the fiscal year beginning October 1, 2019, assuming the policy remained in force. The record contains similar evidence for

[87] For example, a 45-year-old female non-smoker might be paying approximately 13.5% of the COI rate of a 65-year-old male smoker. A 35% increase would therefore cost the 65-year-old male non-smoker ***7.4 times*** what it costs the 45-year-old female non-smoker. Put in dollar terms, a 45-year-old female non-smoker with a $1 million net amount at risk would see her COI rate increased by $1,214.64 annually. A 65-year-old male smoker with a $1 million policy would face an annual increase of $8,995.14. *See* Ex. 2 (Hause Report) ¶¶ 61-62.

thousands of other policies, as summarized in the attached declaration. *See* Ard Decl. ¶ 78 –85 & Exs. A–E. In fact, the definition of the certified class in this action is for policyowners that were "subjected to the cost of insurance rate increase announced in 2016," which necessarily means everyone with an increased cost of insurance rate *scale* with at least one COI rate higher than under the prior scale. *See Hanks v. Lincoln Life & Annuity Co. of New York*, 330 F.R.D. 374, 378 (S.D.N.Y. 2019); Ard Decl., Ex. 1 (summarizing record evidence that policies with no overcharges by December 31, 2017 have at least one higher COI rate than the prior applicable COI scales).

An unstated and false premise of Aetna's argument is that a policyholder who was paying the maximum guaranteed rate under the pre-increase COI rate scales would have continued paying the maximum rate *forever* as long as the policy stayed in-force, so the increase will never affect them. Aetna submits no evidence to prove this assertion. Nor could it; it is incorrect, as illustrated by the same G1000144 policy, where the pre-increase COI rate equaled the maximum COI rate up to age 69, but then the two diverged, resulting in higher COI rates and overcharges starting at age 70.



Second, Plaintiff does not (yet) know which policies remain in force today because Aetna has only produced data through December 31, 2017 and has *refused* Plaintiff's request to provide

[88] *See* Ard Decl. Ex. A (row 422); Ex. D (VRIAC_HANKS0000209) at Tab 336952_ULT_B1_NW_NS_F_060185.

updated data that shows the increasing percentage of policyholders who have past damages, as required by Federal Rule of Civil Procedure 26(e). *See* Ard Decl. ¶ 78.[89] Aetna is effectively trying to use discovery as a sword and a shield—cutting-off damages data through December 2017, but seeking summary judgment for all time periods on the ground that damages have not been proven. The Court should not countenance such gamesmanship and should deny the motion for this additional reason. *See* Fed. R. Civ. P. 56(d)(1) ("If a nonmovant shows by affidavit or declaration that, for specified reasons, it cannot present facts essential to justify its opposition, the court may: (1) defer considering the motion or deny it"); *see, e.g.*, *Bldg. Serv. 32BJ Health Fund v. Nutrition Mgmt. Servs. Co.*, No. 15-CV-03598 (KBF), 2017 WL 946331, at *4 (S.D.N.Y. Feb. 10, 2017) (denying motion under Rule 56(d)(1) because Plaintiffs had been denied the full ability to gather facts needed to oppose summary judgment).[90]

Third, Aetna completely ignores Mr. Mills' "methodology for calculating future COI overcharges," which this Court already recognized is "one of the common questions on the calculation for damages." *Hanks*, 330 F.R.D. at 380. In his opening report, Mr. Mills calculated the present value of future expected COI overcharges for all 37,557 policies that were active as of early January 2018. Ex. 4 (Mills Report), ¶141-168 & Table 26. Aetna's motion completely ignores this damages calculation.

In sum, Aetna's argument is built on a false premise: Aetna asks the Court to grant summary judgment "as to the Class Members whose COI rates were not affected by the COI Adjustment," Br. at 25, but that is a null set. The COI rate adjustment increased the COI rate scale

[89] The Federal Rule of Civil Procedure 56(d) Declaration of Seth Ard is filed concurrently herwewith.

[90] Neither of Aetna's cited cases are to the contrary. *See Mullins v. TestAmerica, Inc.*, 564 F.3d 386, 418 (5th Cir. 2009) (listing out elements of breach of contract under Texas law); *Bloch v. Gerdis*, No. 10 CIV. 5144 PKC AJP, 2011 WL 6003928, at *4 (S.D.N.Y. Nov. 30, 2011) (summary judgment appropriate where plaintiff was unable to provide evidence of *any* damages from the alleged breach).

for all class members. The Court should await for trial, after data has been supplemented under Rule 26(e), which by stipulation Aetna has agreed to provide 50 days before trial (current through at least the preceding month), along with supplemental damages expert reports from Plaintiff due 14 days later, Ex. 74 (April 4, 2018 email from Aetna's Counsel), to determine whether there really are any class members who have not been damaged by the COI increase.

IV. CONCLUSION

For the reasons stated above, the Court should grant Plaintiff's motion for summary judgment on liability, and deny Aetna's motion for summary judgment amd partial summary judgment.

Dated: November 6, 2019

/s/ Seth Ard

Seth Ard
Ryan C. Kirkpatrick
Susman Godfrey L.L.P.
1301 Avenue of the Americas, 32nd Floor
New York, NY 10019
Tel: 212-336-8330
Fax: 212-336-8340
sard@susmangodfrey.com
rkirkpatrick@susmangodfrey.com

Steven G. Sklaver (*pro hac vice*)
Nicholas N. Spear (*pro hac vice*)
Michael Gervais
Susman Godfrey L.L.P.
1900 Avenue of the Stars, Suite 1400
Los Angeles, CA 90067-6029
Tel: 310-789-3100
Fax: 310-789-3150
ssklaver@susmangodfrey.com
nspear@susmangodfrey.com
mgervais@susmangodfrey.com

Class Counsel

CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the foregoing instrument has been served on the following counsel, this November 6, 2019.

Alan B. Vickery
Jack G. Stern
John F. LaSalle
Andrew Villacastin
Boies Schiller Flexner LLP
575 Lexington Avenue
New York, New York 10022
Tel: (212) 446-2300
Fax: (212) 446-2350
jstern@bsfllp.com
jlasalle@bsfllp.com
avickery@bsfllp.com
avillacastin@bsfllp.com

Motty Shulman
Evelyn Fruchter
Boies Schiller Flexner LLP
333 Main Street
Armonk, New York 10504
Tel: (914) 749-8200
Fax: (914) 749-8300
mshulman@bsfllp.com
efruchter@bsfllp.com

Attorneys for Voya Retirement Insurance and Annuity Company, formerly known as Aetna Life Insurance and Annuity Company

/s/ Nicholas N. Spear
Nicholas N. Spear