UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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

DEFENDANT VOYA RETIREMENT INSURANCE AND ANNUITY COMPANY'S MEMORANDUM OF LAW IN:

1. **FURTHER SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT (ECF 133); AND**

2. **IN OPPOSITION TO PLAINTIFFS' CROSS-MOTION FOR PARTIAL SUMMARY JUDGMENT (ECF 137)**

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Defendant Voya Retirement Insurance and Annuity Company, f/k/a Aetna Life Insurance and Annuity Company ("VRIAC"), submits this memorandum of law in further support of its motion for summary judgment (ECF 133), and in opposition to Plaintiffs' cross-motion for partial summary judgment (ECF 137), dated November 6, 2019 (Mem. of Law (ECF 141) hereinafter "Plaintiffs' Brief" or "Pls.' Br.").

PRELIMINARY STATEMENT

Plaintiffs pay lip service to the idea that "policyholders must accept that COI rates are not set in stone and may increase," but in reality Plaintiffs' counsel have challenged virtually every insurer's COI rate change no matter how it is implemented, who did the analysis, and whether it was objected to or approved by insurance regulators.[1] Pls.' Br. at 7. Plaintiffs' counsel and experts play this game where they never actually articulate how they believe a COI adjustment should have been conducted, yet they continuously second guess the analyses of life insurers who collectively have hundreds of years of experience in pricing and repricing policies.[2] The

[1] *See In re Lincoln Nat'l COI Litig.*, No. 16 Civ. 6605 (E.D. Pa); *Hanks v. Lincoln Life & Annuity Co. of N.Y.*, No. 16 Civ. 6399 (S.D.N.Y); *Brach v. AXA Equitable Life Ins. Co.*, No. 16 Civ. 740 (S.D.N.Y.); *Jakobovits v. PHL Variable Ins. Co.*, No. 17 Civ. 3527 (E.D.N.Y.) (Susman withdrew May 20, 2018); *Fan v. Phoenix Life Ins. Co.*, No. 18 Civ. 1288 (S.D.N.Y.); *Advance Tr. & Life Escrow Servs., LTA v. PHL Variable Life Ins. Co.*, 18 Civ. 3444 (S.D.N.Y.); *Leonard v. John Hancock Life Ins. Co. of N.Y.*, No. 18 Civ. 4994 (S.D.N.Y.); *Advance Tr. & Life Escrow Servs., LTA v. Sec. Life of Denver Ins. Co.*, No. 18 Civ. 1897 (D. Colo.); *Advance Tr. & Life Escrow Servs., LTA v. ReliaStar Life Ins. Co.*, No. 18 Civ. 2863 (D. Minn.).

[2] Suppl. Shulman Decl. Ex. 22 (Hause Dep. Tr.) at 70-72 ("[Q.] In your reports, you basically criticize the methodology that was used in connection with the 2016 COI increase, can we agree about that? . . . A. Yes . . . [Q.] [D]o you intend to offer an opinion that says you did a 2016 COI increase wrong, but this is the way that you could have done an appropriate 2016 COI increase? A. No, I would not offer that as an opinion or as part of an expert report . . . [Q.] So you are comfortable saying that what they did was wrong, but you are not comfortable substituting your judgment for what the right way to do it is? A. Yes, I believe that's true, and I believe there is multiple ways that that could be accomplished. . . . [Q.] [D]o you believe that there was an appropriate way for the COI rates on the Aetna block to be increased? A. I have no opinion on that.").

mere disagreement of two actuaries does not automatically create a contractual breach or even a "genuine dispute as to any material fact." Fed. R. Civ. P. 56(a). As Plaintiffs' actuarial expert testified in this case: "I would not presume to substitute my judgment for the actuary developing or actuaries developing -- responsible for developing the increase." Suppl. Shulman Decl. Ex. 22 (Hause Dep. Tr.) at 71:13-16; *see also* ECF 136-6 (Hause Report) at 10 n.14 (citing ASOP 1 at § 2.10 ("Because actuarial practice commonly involves the estimation of uncertain events, there will often be a range of reasonable methods and assumptions, and two actuaries could follow a particular ASOP, both using reasonable methods and assumptions, and reach different but reasonable results.")).

While the specific fallacies of Plaintiffs' legal and factual argument are set forth below, three overarching takeaways from Plaintiffs' Brief warrant previewing.

First, Plaintiffs' alleged breaches read obligations into the contract that do not exist and are entirely divorced from a plain English reading of the contract terms. For example, Plaintiffs claim that the phrase "based on Aetna's estimates of future cost factors" somehow translates into a contractual obligation that requires "new COI rates to be based on a comparison of original assumptions" or original pricing. Pls.' Br. at 38. But the words "comparison," "original assumptions," and "original pricing" simply do not exist in the contract, as recognized by Plaintiffs' own experts. *See* ECF 135 ¶ 20. Similarly, Plaintiffs now claim that the words "class basis" can only mean one thing: "insured's age, sex, and premium class." Pls.' Br. at 8. But the contract, the dictionaries Plaintiffs rely on, and Plaintiffs' own expert do not support Plaintiffs' definition of "class basis." Under a plain reading of the Policies, VRIAC complied with each of the separate requirements in the COI provision.

Second, consistent with Plaintiffs' effort to manufacture contractual obligations that do not exist, Plaintiffs' Brief noticeably pivots away from the allegations actually alleged in the Complaint. For example, the centerpiece of Plaintiffs' Brief is now so-called "Breach #1: The 'Uniform' Requirement" and "Breach #2: The 'Class Basis' Requirement." *Id.* at 1-3. However, neither of these breaches were alleged in any way in the Complaint. ECF 1. It strains credibility for Plaintiffs to now claim that a "*flat-percentage* COI increase by product," Pls.' Br. at 3 (emphasis in original), is a "straightforward breach" of the "class basis" and "uniform basis" provisions when the Complaint makes absolutely no mention of this purportedly straightforward breach.

Similarly, Plaintiffs now claim that "Lincoln was not acting as Aetna's agent in developing 2016 estimates of future cost factors and the COI increase recommendation." ECF 139 at 22 ¶ 2. Yet, Plaintiffs' Complaint affirmatively alleges personal jurisdiction due to LLANY "acting as the administrative agent for these Aetna policies." ECF 1 ¶ 11. The Complaint also affirmatively alleges that VRIAC "put Lincoln in charge of administering these policies" and LLANY had the expertise and institutional familiarity with the relevant block of policies because "Lincoln hired the bulk of Aetna's employees who were running the business." *Id.* ¶¶ 17-18. Plaintiffs should not be allowed to avoid summary judgment through their new arguments concerning breach, which contradict the allegations in their Complaint.

Third, Plaintiffs' contractual arguments leave them no choice but to disavow the testimony of their actuarial expert, Christopher H. Hause. They do this repeatedly. For example:

Plaintiffs' Claim	Mr. Hause's Testimony
"The Class Policies require new COI rates to be based on a comparison of original assumptions." Pls.' Br. at 37.	"The Policies' contracts do not contain any contractual obligations relating to original pricing." ECF 139 at 17 ¶ 21.
"Class Basis. Each policy states that monthly COI rates must be determined based on the insured's age, sex, and premium class." Pls.' Br. at 8.	"The Policies' contractual promise that adjustments to the COI rates 'will be on a class basis' means that adjustments to the COI rates will be on a 'policy class' basis consistent with § 2.6 and § 3.4 of the Actuarial Standards of Practice (ASOP) 2." ECF 139 at 11 ¶ 19.
"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." Pls.' Br. at 41.	"The Policies' contracts do not prohibit adjusting COI rates to increase profitability levels beyond the profitability levels at original pricing." ECF 139 at 15 ¶ 20.

Plaintiffs' own actuarial expert's testimony highlights the lack of legitimacy in Plaintiffs' interpretation of the contractual terms and the lack of any genuinely disputed material facts in this case.

ARGUMENT

I. SUMMARY JUDGMENT SHOULD BE GRANTED IN VRIAC'S FAVOR ON PLAINTIFFS' SO-CALLED BREACH #3: THE AETNA'S ESTIMATES REQUIREMENT.

A. VRIAC Complied With the Contractual Promise to Base a COI Adjustment on Aetna's Estimates for Future Cost Factors.

VRIAC complied with the Policies' language that "adjustments . . . will be based on Aetna's estimates" for future cost factors. ECF 5-1 at 7. Although LLANY, as VRIAC's agent and the Policies' administrator, conducted the initial work, VRIAC conducted a two-month review of LLANY's recommendation. During that review, VRIAC specifically confirmed that the COI Adjustment was modeled using the experience and assumptions for the Aetna block of policies,

such that the COI Adjustment was "based on Aetna's estimates for future cost factors." *Id.* Plaintiffs' suggestion that the "estimates" used in the COI Adjustment are wholly foreign to the Policies is false and misleading. Pls.' Br. at 10 (claiming that "[t]he potential COI increase was modeled entirely by *Lincoln* actuaries using *Lincoln*'s data, experience studies, and internal tools").

Plaintiffs have already conceded that VRIAC was not required to conduct the COI Adjustment's analysis and modeling itself, and could instead rely on a third party's work. *Id.* at 36 (stating "that is not Plaintiff's position" that VRIAC "should have done the initial COI Adjustment's analysis and modeling"). Plaintiffs' claimed breach of the "Aetna's Estimates" provision, which substitutes their lawyers' actuarial arguments for the judgment of two life insurance companies, is premised on an improper reading of the contractual provision and their injection of terms into that provision that simply do not exist. The relevant contractual provision and each party's understanding of its meaning are set forth in the table below.

<table>
<tr><td colspan="2">Contract Provision:
"Adjustments . . . will be based on Aetna's estimates for future cost factors, such as mortality, investment income, expenses and the length of time policies stay in force." ECF 5-1 at 7.</td></tr>
<tr><td>VRIAC's Reading
COI rates must be adjusted based on the expected future cost factors of the remaining in-force Aetna policies. Examples of future cost factors are mortality, investment income, expenses and the length of time policies stay in force.</td><td>Plaintiffs' Reading
Any adjustment of COI rates 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." Pls.' Br. at 8.</td></tr>
</table>

VRIAC's reading of the contractual provision is straightforward, and consistent with the plain language of the provision. The two key phrases in this provision are: "Aetna's estimates" and "future cost factors."

First, the phrase "Aetna's estimates" requires the insurer to look at the group of policies issued by Aetna and base any adjustment on those policies, not on the experience or assumptions of some unrelated group of policies. "Aetna's estimates" does not require, as Plaintiffs themselves concede, that an Aetna actuary (as opposed to the agent or administrator) must literally push the buttons on the computer terminal or calculator.

Second, the phrase "future cost factors" tells you that any adjustment must be based on a forward-looking estimate of the expected cost of satisfying the contractual obligations. As Plaintiffs note, Aetna (now VRIAC) retained the "contractual responsibilities and liabilities" as

related to the policyholders. Pls.' Br. at 9. Putting the two phrases together thus requires any adjustment based on an estimate of the expected future costs factors of the remaining Aetna liabilities, *i.e.*, the remaining in-force policies of the Aetna block. The contract also gives examples of the future cost factors associated with Aetna's responsibilities and liabilities. These include, but are not limited to ("such as"), mortality, investment income, expenses and the length of time policies stay in force, which are among the inputs, or factors, of the expected future cost of satisfying Aetna's responsibilities to its policyholders.

VRIAC's reading is also consistent with the purpose of this provision, which is to make sure that a COI adjustment is based on expected future cost factors associated with the in-force policies, not cost factors relating to already terminated policies or some unrelated group of policies with vastly different cost factors and characteristics. As explained by Plaintiffs' actuarial expert, "'[t]he purpose of the premium adjustment is to adjust premiums to match any change in the present value of future policy costs and benefits. It is not to distribute surplus or recoup past losses.'" ECF 143-39 (sealed) (Ex. 3: Hause Rebuttal Report) ¶ 57 (quoting *Non-Participating Life Products with Non-Guaranteed Premiums Record of Society Actuaries*, Vol. 6, No. 3, 669, 679 (1980)). Accordingly, this contractual provision gives policyholders comfort that any adjustment will be forward-looking and relate only to the remaining in-force policies.

B. The Undisputed Evidence Shows that the COI Adjustment Was Based On Aetna's Estimates for Future Cost Factors.

The COI Adjustment complied with a plain reading of the "Aetna's estimates for future cost factors" provision, ECF 5-1 at 7, because the adjustment: (i) was modeled and recommended by VRIAC's agent and the Policies' administrator (and reinsurer), and was subsequently reviewed, adopted, and approved by VRIAC; (ii) was based on the remaining in-force policies in the Aetna block; and (iii) was based on forward-looking cost factors.

In 1998, LLANY was retained by Aetna, now VRIAC, to serve as its administrative agent. The Administrative Services Agreement between the two companies provides that VRIAC retained LLANY as administrator for the purpose of, among other things, "making recommendations to the Company with respect to . . . the Non-Guaranteed Elements of the Policies," which includes any adjustments to COI rates. ECF 27-9 § 2.03(m).

In February 2016, LLANY submitted a recommendation to VRIAC to adjust COI rates. VRIAC reviewed the recommendation, as well as additional supporting materials it received upon request from LLANY. VRIAC eventually accepted the recommendation by formal board vote in April 2016. ECF 135 (VRIAC SUMF) ¶¶ 9-15. In so doing, VRIAC formulated its "estimates for future cost factors," which used its agent's (LLANY's) forward-looking inputs and analysis for the relevant group of in-force policies.

Plaintiffs' own actuarial expert agreed with the uncontroversial position that an insurer could adopt another's estimates as its own:

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

ECF 136-5 (Hause Dep. Tr.) at 160:4-14. Plaintiffs now try to walk away from their own expert's opinion by claiming, without explanation, that Mr. Hause's testimony only applies to an agent or "third party who is 'specifically engaged for that activity by Aetna.'" Pls.' Br. at 37. However, Plaintiffs' attempted explanation fails because LLANY is exactly that: a "third party who is 'specifically engaged for that activity by Aetna.'" *Id.* As explained above, pursuant to the Administrative Services Agreement, VRIAC retained LLANY in

part to "mak[e] recommendations to the Company with respect to … the Non-Guaranteed Elements of the Policies." ECF 27-9 § 2.03(m).

There is therefore no genuine dispute that the COI Adjustment was based on "Aetna's estimates for future cost factors." Plaintiffs' opposition brief does not cite any authority that suggests that VRIAC is not able to rely on its agent LLANY's inputs and analysis to help form its own "estimates for future cost factors."

C. Plaintiffs' Claimed Breaches of the "Aetna's Estimates" Provision Have No Basis in the Contract.

Plaintiffs' Brief (at 30-39) invents a number of obligations they now claim the COI Adjustment violated. None, however, appear in the contract.

a. The Use of LLANY's Purchase Assumptions as the Baseline for the COI Adjustment Did Not Breach any Contractual Provision.

Plaintiffs first argue (at 30-32) that the COI Adjustment's "use of Lincoln's 1998 purchase assumptions as the baseline breached the Policies." Pls.' Br. at 30. This argument is the sole basis on which Plaintiffs move for summary judgment on this contractual provision ("Aetna's estimates"); the remaining arguments are given as defensive reasons as to why Plaintiffs argue VRIAC's motion for summary judgment should be denied. The three paragraphs dedicated to this argument do not cite any authority whatsoever, and do not create a genuine dispute of material fact as to how the "Aetna's estimates" provision should be interpreted. *Id.* at 30-32.

The phrase "Aetna's estimates for future cost factors" requires a COI adjustment to be based on the insurer's forward-looking projections of the in-force Policies' cost factors. This makes sense, because there are no future costs associated with policies that are no longer in force. The provision makes no reference whatsoever to any specific previously used baseline of cost factor estimates, against which the insurer is supposed to compare its current estimates. Such a

concept is simply not part of the contract As Plaintiffs recognize, their argument is entirely predicated on Plaintiffs' view that the contract requires an adjustment to be based on a "change between Aetna's current 'estimates for future cost factors' *and Aetna's prior, baseline 'estimates for future cost factors.*'" *Id.* at 31 (emphasis added). But even Plaintiffs' own actuarial expert testified that the "Policies' contracts do not contain any contractual obligations relating to original pricing." ECF 135 (VRIAC SUMF) ¶ 21.[3] "Because Plaintiffs' breach of contract claim is premised on a contractual obligation that does not exist in the underlying agreement, it fails." *Flatiron Acquisition Vehicle, LLC v. CSE Mortg. LLC*, No. 17 Civ. 8987, 2019 WL 1244294, at *13 (S.D.N.Y. Mar. 18, 2019).

Plaintiffs next argue that "Aetna does not proffer any *facts* from which a reasonable factfinder could conclude that Lincoln's 1998 Purchase Assumptions are 'Aetna's estimates.'" Pls.' Br. at 31. This again presupposes that there is a meaningful distinction between VRIAC and LLANY (VRIAC's agent), or that VRIAC could not rely on LLANY's analyses and recommendations. It is undisputed that LLANY has served as the Policies' administrator and reinsurer since 1998. As the Policies' administrator, LLANY was acting on behalf of VRIAC and was contractually authorized to "perform all Administrative Services . . . in the name . . . or on behalf of the Company." ECF 27-9 § 2.03. LLANY also had access to (and used) the Aetna block's data since that time. ECF 134 at 8. Since 1998, therefore, VRIAC retained and relied on

[3] In a footnote, Plaintiffs seek to minimize Hause's concession by arguing that "Plaintiffs' experts are not offering—and are not permitted to offer—opinions on policy interpretation." Pls.' Br. at 32 n.72. They do not address the more obvious point, however, that their reading of the policies' contractual obligations is so absurd that not even their experts can identify what Plaintiffs' lawyers are asserting are "contractual" obligations.

LLANY to administer the Policies and perform other services, which includes keeping track of whether adjustments relating to future cost factors were necessary.

Plaintiffs also argue that 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.'" Pls.' Br. at 32. This is an example of where Plaintiffs' have flip-flopped in their position and now try to recraft the record. Plaintiffs' Complaint affirmatively alleges that LLANY is not just VRIAC's third-party reinsurer, but also VRIAC's third-party administrative agent for the Policies. ECF 1 ¶¶ 11, 17, 18, 20, and 25. Indeed, it is the *very basis* upon which Plaintiffs asserted this Court has personal jurisdiction over Defendants. *Id.* ¶ 11. To use Plaintiffs' own words, this means that VRIAC "put Lincoln in charge of administering these policies" and LLANY had the expertise and institutional familiarity with the relevant block of policies because "Lincoln hired the bulk of Aetna's employees who were running the business, so that Lincoln could take over the administration of these policies." *Id.* ¶¶ 17-18. It is difficult to understand how Plaintiffs can now claim there is a genuine dispute of material fact as to whether LLANY was acting as VRIAC's agent. *See* ECF 139 at 22 ¶ 2 (Plaintiffs contend "Lincoln was not acting as Aetna's agent in developing 2016 estimates of future cost factors and the COI increase recommendation.")

Plaintiffs also assert that "Lincoln commissioned Milliman to prepare the 1998 Purchase Assumptions for its own internal purposes," suggesting that Lincoln's assumptions were developed separately from Aetna's. Pls.' Br. at 31. This assertion is disingenuous and misleading. Plaintiffs cite to VRIAC's actuarial expert report for the proposition that "the actuarial consulting firm Milliman was engaged to develop a Purchase GAAP Analysis of the Aetna Block *on behalf of Lincoln*," but neglect to report that LLANY was an agent of VRIAC and that the Milliman

assumptions were derived from a separate report commissioned by Aetna. Two sentences after Plaintiffs' quoted language, VRIAC's expert explains that Milliman's analysis "reflected a number of the appraisal assumptions used by the actuarial firm Tillinghast in the seller's (Aetna's) appraisal of the Aetna Block." ECF 136-8 (Pfeifer Report) ¶ 38; *see also id*. at 13 n.14 (quoting Milliman report: "The assumptions underlying the projections were based on the assumptions utilized in the actuarial appraisal commissioned by Aetna and performed by Tillinghast, dated January 26, 1998 (the Seller's Appraisal), of the Aetna life business, as well as a review of Aetna's recent historical experience.").

In sum, consistent with Plaintiffs' expert's testimony, there is no contractual requirement relating to original pricing or any requirement to compare future cost factors with "Aetna's prior, baseline 'estimates for future cost factors.'" Pls.' Br. at 31. Regardless, the 1998 Purchase Assumptions are Aetna's estimates, as the document Plaintiffs rely on expressly confirms. For these reasons, the Court should reject Plaintiff's motion for summary judgment on Plaintiffs' Breach #3. Pls.' Br. at 32 (seeking summary judgment on theory that "there is no material dispute that the baseline purchase assumptions were Lincoln's estimates, and not Aetna's"). For the same reason, there is no genuine dispute as to a material fact regarding whether VRIAC complied with the Policies' requirement that COI adjustments be based on "Aetna's estimates for future cost factors," and summary judgment should be granted in VRIAC's favor.

b. There Is No Genuine Dispute That the COI Adjustment Was Based on Aetna's Estimates of Future Cost Factors.

Plaintiffs' remaining arguments regarding this provision are entirely defensive in nature, *i.e.*, they attempt to defeat VRIAC's motion for summary judgment, not to obtain summary

judgment in Plaintiffs' favor, by seeking to create a fact disputes where none exist. Pls.' Br. at 32-37. We address these arguments in the order presented by Plaintiffs.

1. Aetna's Estimates vs. LLANY's Estimates

Plaintiffs argue (at 32-33) that a fact dispute remains as to whether the analysis used for the COI Adjustment qualifies as "Aetna's estimates." Pls.' Br. at 33. Plaintiffs concede that VRIAC was not required to conduct the COI Adjustment's analysis and modeling itself, and instead could rely on a third party's work. *Id.* at 36 (stating that it "is not Plaintiff's position" that VRIAC "should have done the initial COI Adjustment's analysis and modeling"). Instead, seeking to substitute their actuarial judgment for those of two life insurance companies, Plaintiffs essentially argue that the COI Adjustment that VRIAC reviewed and approved cannot reflect "Aetna's estimates" "because the evidence shows that Aetna did nothing more than an improper rubber-stamping of Lincoln's work." *Id.* at 33. This is not supported by the record.

- It is undisputed that LLANY was VRIAC's administrative agent and that VRIAC "put Lincoln in charge of administering these policies." ECF 1 (Complaint) ¶ 17.[4]
- It is undisputed that LLANY was contractually charged by VRIAC to "perform all Administrative Services . . . in the name . . . or on behalf of the Company," which includes making recommendations to VRIAC with respect of Non-Guaranteed Elements, like COI rate adjustments. ECF 27-9 § 2.03
- It is undisputed that VRIAC conducted a two-month long review of Lincoln's recommendation, which included "[a] detailed narrative description explaining how

[4] "[A]t the summary judgment stage, a district court may consider a statement or allegation in a superseded complaint as rebuttable evidence when determining whether summary judgment is proper." *W. Run Student Hous. Assocs., LLC v. Huntington Nat. Bank*, 712 F.3d 165, 173 (3d Cir. 2013).

Lincoln determined the COI Increase." ECF 135 (VRIAC SUMF) ¶ 10 (admitted in ECF 139).

- It is undisputed that Lincoln also provided VRIAC with "actuarial disclosures required by ASOP 2." *Id.*
- It is undisputed that "Lincoln subsequently sent a revised COI increase recommendation on March 28, 2016, at the same time that it responded to Aetna's initial questions." *Id.* ¶ 11.
- It is undisputed that a "review of the revised COI increase recommendation was 'undertaken by an internal [Voya] team consisting of Joe Fick and Joel King (the Review Team). The review consisted of an assessment of the process used by Lincoln in determining the NGE charges recommendations. To conduct the review, the Review Team reviewed' various documents provided by Lincoln and disclosures required by ASOP." *Id.* ¶ 12.
- It is undisputed that "The Review Team also 'selected and reviewed two of the proposed increases to confirm that the determination process was followed. As part of that review, the Review Team: (i) examined high level results of the calculations from Lincoln to confirm that the results generally supported the determinations made by Lincoln to increase COIs and no subsidization was being made among products, (ii) confirmed with Lincoln that the COI's did not exceed the guarantees in the contract, and (iii) reviewed the anticipated future cost factors relied upon in the determination process with the policy cost factors set forth in the policy form permitting the COI changes.'" *Id.* ¶ 13.

- It is undisputed that "[o]n April 7, 2016, based on the analysis performed by the Review Team, VRIAC management recommended that VRIAC's 'Board of Directors approve and accept the proposed NGE charges recommendations.'" *Id.* ¶ 14.
- It is undisputed that the end result of that process was that the Board of Directors of VRIAC unanimously approved "management's recommendations to accept the non-guaranteed element charges in the form of a cost of insurance increase proposed by Lincoln Financial Group." *Id.* ¶ 15 (citing ECF 136-9 at VRIAC_HANKS0007469).

In addition to the lack of any factual record supporting Plaintiffs' claim of rubber stamping, Plaintiffs do not cite any legal authority articulating what standard of review VRIAC was purportedly required to apply, or why VRIAC's review of their agent's analysis and recommendation is insufficient as a matter of law.

2. "Aetna's Estimates for Future Cost Factors" Were Used.

Plaintiffs next argue that there is a disputed material fact whether, in connection with the COI Adjustment, VRIAC "reviewed the anticipated future cost factors." Pls.' Br. at 33-34. To support this claim, Plaintiffs try to find a conflict between the following two sentences:

- "Aetna's Review Team 'reviewed the **anticipated future cost factors** relied upon in the determination process . . . .'" Pls.' Br. at 34 (quoting ECF 135 (VRIAC SUMF) ¶ 13).
- "Aetna's 'review team did not seek out to review the **assumptions** as part of [its] review process, and so at no point did [it] try to reproduce or confirm the exact assumptions that were used.'" *Id.* (quoting ECF 143-10 (Brantzeg Dep. Tr.) at 225:17-22).

Plaintiffs' claim that VRIAC's review of LLANY's recommendation was insufficient has no basis in the record, and does not create a fact dispute. The out-of-context testimony Plaintiffs rely on as the centerpiece for this "gotcha" argument is misleading, as the "assumptions" being discussed during this line of questioning at deposition did *not* concern current estimates or assumptions, but assumptions from the time of original pricing, which took place sometime in the 1980s and 1990s. *See* ECF 143-10 (Brantzeg Dep. Tr.). The preceding back-and-forth make clear that the question the witness answered concerns "original pricing assumptions." *Id.* at 225:14-19 ("MR. STERN: Original pricing assumptions. MR. SPEAR: Right. THE WITNESS: The review team did not seek out to review the assumptions . . . ."). The very next question confirms that this conversation did *not* concern current assumptions. *Id.* at 225:24-226:5 ("Q. As a representative of Voya, does Voya know if during this review period, Voya had sufficient documentation, that it could have determined the pricing assumptions, original?"). Whether or not VRIAC reviewed the original pricing assumptions, which were not used as part of the COI Adjustment, is irrelevant to the adequacy of VRIAC's review of the estimates for future cost factors for the Policies.

Putting aside Plaintiffs' counsel's sleight of hand, their own side-by-side comparison illustrates how they fundamentally misread the Policies' contractual requirements. The Policies provide that "[a]djustments . . . will be based on Aetna's estimates for future cost factors." ECF 5-1 at 7. The Policies do not set forth any separate requirement that Aetna review the detailed underlying assumptions and data, or seek "to reproduce or confirm the exact assumptions" used in modeling to establish what VRIAC's "estimates for future cost factors" are. In essence, Plaintiffs

are pointing out that VRIAC did not do something it was not required to do. For the purposes of a breach of contract claim, this does not raise a genuine issue of material fact.

The same analysis applies to Plaintiffs' criticism that VRIAC did not review policy forms, "actuarial memoranda describing the nature and initial pricing of the policies," or "Lincoln's actuarial models." Pls.' Br. at 34-35. Again, the Policies themselves set forth no requirement that any of these things must happen before a COI adjustment is implemented, and Plaintiffs cannot point to any contractual authority suggesting that doing these things was required.

VRIAC was able to assess its estimates for future cost factors from the documentation that LLANY provided, including at VRIAC's request. It is undisputed that VRIAC's review team considered numerous documents provided by Lincoln and disclosures required by ASOP 2 as to each product subject to the COI Adjustment. VRIAC also drilled down further and "selected and reviewed two of the proposed increases to confirm that the determination process was followed," and that "[a]s part of that review, the Review Team . . . examined high level results of the calculations from Lincoln to confirm that the results generally supported the determinations made by Lincoln to increase COIs and no subsidization was being made among products," and "reviewed the anticipated future cost factors relied upon in the determination process with the policy cost factors set forth in the policy form permitting the COI changes." ECF 135 ¶ 13.[5] The

[5] At various points in their "Responses to VRIAC's Statement of Undisputed Material Facts," Plaintiffs assert evidentiary "objections." For example, their response to paragraph 13 objects to a statement in VRIAC's board vote because, according to Plaintiffs, it "is inadmissible hearsay given that it is used in Aetna's motion to prove the truth of the matter stated" and because "[t]he board report was not prepared in the ordinary course of business." ECF 139 ¶ 13. These evidentiary objections are premature and, in any event, not meaningful. The document's authors were all deposed, and will be available to testify at trial. The statements contained therein are also only "contradicted" if you accept Plaintiffs' false premise that a review of "the anticipated future cost factors" necessarily entails a review of each and every individual assumption that factors into an analysis.

record is replete with evidence of VRIAC's review, and Plaintiffs concede that VRIAC was not required to independently reconstruct Lincoln's modeling or analysis. *See* Pls.' Br. at 36 (noting "that is not Plaintiff's position" that VRIAC "should have done the initial COI Adjustment's analysis and modeling"). Simply put, Plaintiffs have not put forth anything other than their say-so that VRIAC was required to do anything further under the Policies' terms.

3. LLANY Is Undisputedly VRIAC's Agent.

Plaintiffs next try to create a disputed fact issue by claiming that "whether Lincoln was in fact operating as a consultant or agent of Aetna is also a disputed factual question." Pls.' Br. at 35-36. This argument fails.

As discussed above, Plaintiffs affirmatively allege that LLANY was VRIAC's administrative agent such that VRIAC "put Lincoln in charge of administering these policies." ECF 1 ¶ 17. Plaintiffs' claim that "Aetna has provided no evidence that Lincoln reviewed the increase at Aetna's direction or request" is simply false. Pls.' Br. at 36. The very Administrative Services Agreement that Plaintiffs refer to in their Complaint expressly provides that LLANY was contractually charged by VRIAC to "perform all Administrative Services . . . in the name . . . or on behalf of the Company," which includes making recommendations to VRIAC with respect of Non-Guaranteed Elements, like COI rate adjustments. ECF 27-9 at § 2.03(m) (identifying as one service "making recommendations to the Company with respect to (i) the Non-Guaranteed Elements of the Policies and Post-Closing Policies").

Plaintiffs claim that "Lincoln sent its recommendation to Aetna in its capacity as a reinsurer, not in its capacity as Aetna's administrative agent," because the February 26, 2016, memo only references the Asset Purchase Agreement and not the Administrative Services Agreement. Pls.' Br. at 36 (emphasis omitted). This argument has no merit. The Asset Purchase

Agreement attaches the Administrative Services Agreement as Exhibit A. ECF 27-1 at 8. Moreover, the Administrative Services Agreement is specifically referenced in the memo by VRIAC's management to VRIAC's Board of Directors recommending the COI Adjustment. ECF 136-9 at VRIAC_HANKS0007472.

Regardless of whether LLANY acted as VRIAC's agent or reinsurer, VRIAC's review and adoption of LLANY's recommendation converted those estimates into Aetna's estimates upon board approval. So long as VRIAC was satisfied with the information and analysis supporting the need for the COI Adjustment, no agency relationship is required to support that reliance.

4. Plaintiffs' Expert's Position Does Not Create a Fact Issue.

VRIAC's opening brief pointed out several inconsistencies between Plaintiffs' asserted position and the testimony of their experts. VRIAC also pointed to inconsistencies between two of Plaintiffs' experts. ECF 134 at 19 (noting that Hause's testimony that another company's assessment of the Aetna block's experience could never become "Aetna's estimates" conflicts with the testimony of Plaintiffs' other expert that "[c]osts to be estimated must be costs associated with the policies"). In response, Plaintiffs argue that this criticism creates a fact dispute regarding purported Breach #3 because it "is a classic attack on the weight of his opinion to be decided by the fact finder." Pls.' Br. at 37. It does not. VRIAC maintains that Plaintiffs' experts' opinions conflict with Plaintiffs' position and each other, but since Plaintiffs now concede that Mr. Hause "was not providing an opinion on the *legal* definition of policy terms, and his expert report does not opine on contract interpretation," *id*. at 25, there is by their own admission no lingering fact dispute that would require a factfinder to weigh his testimony at all.

c. The Contract Does Not Require a COI Adjustment to Be Based on a Comparison to Original Pricing.

Plaintiffs next argue that the Court should deny VRIAC summary judgment because the Policies "require new COI rates to be based on a comparison of original assumptions, not purchase assumptions." *Id*. at 37-38. But there is no contractual provision requiring VRIAC to base the COI Adjustment on a comparison of future cost factors with the costs that were estimated at the time of issuance (original pricing). Plaintiffs' experts have already conceded that the contention that the COI Adjustment should have used original assumptions is "not a contractual obligation" at all. ECF 143-8 (Hause Dep. Tr.) at 164-24-165:22.[6]

Moreover, Plaintiffs' brief fails to identify any contractual obligation requiring use of original assumptions as the baseline, as opposed to the 1998 Purchase Assumptions. Instead, Plaintiffs include only the self-serving assertion that "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." Pls.' Br. at 37. Although it may be the case that redeterminations often do use original pricing assumptions as the baseline for calculating a COI adjustment, Plaintiffs do not identify any authority for the proposition that that is the only acceptable baseline. The Policies only require that

[6] Plaintiffs identify an error in VRIAC's opening brief, where the sentence "There is no requirement requiring insurance companies to have used original pricing assumptions as the baseline" was mistakenly presented as a direct quote to Plaintiffs' expert, Bruce W. Foudree, as opposed to a concluding sentence describing his testimony. ECF 134 at 17. Counsel regrets the error, which was not, as Plaintiffs' counsel suggests, intentionally "inserted by Aetna into its brief, on the hopes that Plaintiff and the Court would not review the underlying citations themselves." Pls.' Br. at 38 n.83. The fact remains, however, that when asked to identify a contractual requirement to use the "original class basis," Foudree testified that the Policies' COI provision "doesn't use those words that I see in the section you are referring to," and Foudree could not otherwise identify the source of any obligation to use original pricing as the baseline for the COI Adjustment.

adjustments be "based on Aetna's estimates for future cost factors." ECF 5-1. Nothing more, nothing less.

Plaintiffs argue that using anything other than original assumptions "would mean that Aetna could increase COI rates despite the absence of *any* change in expectations between pricing and redetermination." Pls.' Br. at 38. But there is no dispute that expectations *have* changed in the past three decades, and the only dispute (which is wholly actuarial in nature) is whether original pricing assumptions should have been used as the baseline. Plaintiffs cite testimony from a VRIAC actuary, Patrick Lusk, for the proposition that future expected profits should not exceed those expected at the time of "the original point of issue," but this testimony has nothing to do with the contractual obligations. Mr. Lusk was not endeavoring to interpret the Policies' terms, but was instead describing a general actuarial concept that redeterminations of non-guaranteed elements should not "recoup past losses." Suppl. Shulman Decl. Ex. 23 (Lusk Dep. Tr.) at 42:10.

More generally, however, his reference to "the original point of issue" was just an example of a baseline—he was not saying that it was the right baseline to use for the redetermination. In fact, Plaintiffs themselves concede that they lacked sufficient documentation to reconstruct what the "original pricing" assumptions were, and instead argue that "the mere fact that some portion original [sic] pricing assumptions were incomplete does not render them unusable because gaps could be filled in with comparable data from similar products." Pls.' Br. at 38 n.82. Plaintiffs' experts had access to all the same materials and could not reconstruct original pricing assumptions. Yet Plaintiffs now paradoxically claim, without any evidence, that reconstructing the original pricing documents is indeed possible. *Id.* The fact is that there were insufficient records to be able to model an increase using the baseline Plaintiffs would prefer. It would have been actuarially irresponsible to use an incomplete and unreliable set of assumptions when another complete set of

assumptions existed, the 1998 Purchase Assumptions, which were based on Aetna's own assumptions at that time. *See* Suppl. Shulman Decl. Ex. 24 at (Pfeifer Dep. Tr.) at 187:11-22.

D. Plaintiffs' Additional Breach Theories Do Not Create Genuine Disputes and Can Be Resolved as a Matter of Law in VRIAC's Favor.

Plaintiffs next assert that the Court cannot grant summary judgment in VRIAC's favor because VRIAC "does not address" several of Plaintiffs' "independent theories of breach." Pls.' Br. at 39-42. As explained below, Plaintiffs' arguments all concern extra-contractual requirements that do not appear in the Policies and, in any event, are meritless.

Plaintiffs argue that VRIAC should have directly addressed their naked assertion that the COI Adjustment was based on Lincoln's "expectations of the go-forward profitability." *Id*. at 40. But, as set forth above, the record makes clear that the COI adjustment was indeed the result of changed estimates for "future cost factors." ECF 135 ¶ 13.

Plaintiffs also take issue with the use of the word "profit" as a measure for changed estimates for future cost factors. Pls.' Br. at 40. However, this is pure semantics because when an estimate as to a "cost factor" is changed, it will by definition affect profits. It is elementary that: revenues - costs = profits. Thus, if your estimated future cost factors increase, your projected profits go down. The fact that the change in "cost factors" is expressed or measured in terms of "profits" does not mean that the COI Adjustment was "based on" profits, and not the underlying change in estimates for future cost factors that resulted in the changed expectations for profits as well.

Plaintiffs argue that Aetna "should not be assuming any profits at all" because "COI rates should be designed so that they align with Aetna's projected *costs* of insuring the policies." *Id*. at 41. Plaintiffs are unable to cite any authority for the wild proposition that an insurance company should be pricing policies to break even. Plaintiffs would not be able to support such a proposition,

as the argument is absurd and, as a matter of law, has been squarely rejected. *Norem v. Lincoln Ben. Life Co.*, 737 F.3d 1145, 1154–55 (7th Cir. 2013) ("That a for-profit life insurance company should not be allowed to make a profit on its COI rates . . . seems disconnected from the reality of insurance. Certainly no one expects that an auto or home insurer should make no profit on the premiums charged. Similarly, it is not unreasonable in a universal life insurance policy to consider profit as a secondary factor in calculating the COI rate, as no one is suggesting that Lincoln Benefit is not a for-profit entity").

Plaintiffs also seek to use reinsurance as an example of how Lincoln used its expectations "to earn hefty profits due to the difference between reinsurance premiums paid and death benefits reinsured," as opposed to "cost factors." Pls.' Br. at 40. But reinsurance is a "cost factor," whether or not Aetna "assume[d] that any reinsurance would be used" at the time of original pricing. *Id.* Each dollar in death benefits paid by a reinsurer is a dollar saved by the ceding insurer, who would otherwise have been responsible for paying the death benefit. When reinsurance premiums paid exceed the death benefits paid, it becomes a cost that is directly affected by the mortality experience of the Aetna block.

Plaintiffs next argue that "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.'" *Id.* at 41. After arguing that "the plain meaning of 'uniform' . . . means no variation," Plaintiffs now argue that "[b]y 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." *Id.* at 16, 42. This argument illustrates how Plaintiffs' readings of the various contractual provisions are impossible to harmonize.

Plaintiffs do not dispute that "[a]ny class distinctions that existed prior to the COI Adjustment were . . . preserved by the application of a uniform percentage increase." ECF 134 at 22. Rather, they appear to argue that because a *percentage* adjustment results in a different *dollar amount* adjustment for each policyholder, it is not on a "uniform basis." This defies common sense. A flat percent COI rate increase is uniform, just as a 10% across-the-board tax increase would be "uniform" yet affect each taxpayer differently on a dollar basis. Plaintiffs' suggestion that the only "uniform" adjustment possible would be to adjust COI *charges* (and not rates) by the same dollar amount also directly contradicts their argument on the class basis provision that VRIAC should have defined the redetermination "class" more granularly and treated each of those classes differently. It is equally certain that if the COI Adjustment had been performed on a dollar basis ($10 increase for all policyholders), Plaintiffs would have claimed it was discriminatory because it should have been performed on a flat percentage basis.

II. SUMMARY JUDGMENT SHOULD BE GRANTED IN VRIAC'S FAVOR ON PLAINTIFFS' SO-CALLED BREACH #1: THE "UNIFORM BASIS" REQUIREMENT AND BREACH #2: THE "CLASS BASIS" REQUREMENT.

A. The Contractual Promise to Adjust COI Rates on a "Class Basis" and "Uniform Basis."

Plaintiffs' claimed Breaches #1 and #2, of the "class basis" and "uniform basis" provisions, are premised on an improper reading of the contractual provision and the injection of terms into that provision that simply do not exist.

The two key terms in this contractual provision are "class basis" and "uniform basis." The Policies do not define either the phrase "class" or the phrase "uniform." Plaintiffs point to Black's Law Dictionary and Merriam-Webster's Online Dictionary for "determining the ordinary

meaning of a word or phrase." Pls.' Br. at 17 n.48. We agree. Those dictionaries define the terms "class" and "uniform" as follows:

	Black's Law Dictionary	Merriam-Webster's Online Dictionary
"class"	"A group of people, things, qualities, or activities that have common characteristics or attributes."	"[A] group, set, or kind sharing common attributes."
"uniform"	"Characterized by a lack of variation; identical or consistent."	"[H]aving always the same form, manner, or degree: not varying or variable."

At its most literal level, the provision "will be on a class basis," *i.e.*, by grouping of policies with common attributes, directly contradicts the provision "will be made on a uniform basis," *i.e.*, everyone identical or the same. The act of separating all policyholders into smaller groups by common characteristics (whatever those are) necessarily means that all policyholders will not get the same adjustment. Accordingly, the far more reasonable reading of the provision is that the "class basis" and "uniform basis" requirements work in tandem, meaning that you combine insureds into groups, or classes, of policyholders with common characteristics ("class basis") and then adjust everyone within each group or class in the same manner ("uniform basis").

This reading of the class and uniform basis provisions is entirely consistent with the objective of this contractual provision: to permit inter-class discrimination and prevent intra-class discrimination. As explained in VRIAC's opening brief, under the class basis provision VRIAC could not have singled out a policyholder through intra-class discrimination. ECF 134 at 5 (citing Hause Report ¶ 66 ("[A] policyholder who gets sick cannot be singled out for a COI increase that does not apply to her entire class, even though her individual life expectancy is diminished.")). This is a separate concept from *inter*-class discrimination, which is permissible

because it allows an insurer to adjust rates for particular groups of policyholders with special risks or costs associated with them. *Id.*

B. The Undisputed Facts Show The COI Adjustment Was Implemented on a Class Basis.

There is no genuine dispute that the COI Adjustment complied with the "class basis" requirement. ECF 5-1 at 7. Plaintiffs agree that the COI Adjustment was not a singular across-the-board increase for all of the Policies. ECF 135 (VRIAC SUMF) ¶ 17. Plaintiffs also agree that policies were grouped by common characteristics into classes, organized by product line and by jurisdictions that did not object to the COI increase. *Id.* Notably, Plaintiffs do not dispute that the classes used by VRIAC meets the plain language meaning of "class basis," as that phrase is regularly used in the English language. Rather, Plaintiffs' entire class basis argument is premised on its view that "class basis" is a defined term in the contract, with reference to purportedly explicitly-delineated classes. As set forth below, there is no merit to the position.

a. The Policies Specifically Do Not Define "Class" as Sex, Attained Age and Premium Class.

Plaintiffs argue "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.'" Pls.' Br. at 22. This is wrong, and an objective policyholder would understand that while COI rates must differ based on sex, age, and premium class, adjustments of those rates could be made at a larger group level so long as the resulting COI rates continued to differ based on sex, age, and premium class. Plaintiffs' interpretation is meritless for the reasons set forth below.

It is clear that Plaintiffs misread the "class basis" requirement, which is wholly separate from the generic description of the Monthly COI Charge that appears in a preceding paragraph. The Policies state that "the Monthly Cost of Insurance is based on the Insured's sex, attained age and premium

class." ECF 5-1 at 7. There is no dispute that VRIAC complied with this requirement at all points in time. COI charges varied based on the insured's sex, age, and premium class when the Policies were first issued; before the COI Adjustment was implemented; and continue to vary based on those characteristics today, after the COI Adjustment took effect. In contrast, the language at issue here appears in a separate paragraph that concerns not how the monthly COI rates are calculated, but instead how rate *adjustments* may occur.

Plaintiffs' definition of "class basis" is also contradicted by their *own expert*. Mr. Hause did not testify that "class basis" is a defined term that means sex, attained age, and premium class. Rather, he testified that the phrase "class basis means a policy class that conforms to the definition of [ASOP 2 section] 2.6 and the requirements for policy classes under paragraph 3.4." ECF 134 at 20. Even a cursory review of ASOP 2 shows that classes are not defined as sex, attained age and premium class but more broadly consistent with their plain English meaning. ECF 136-17.[7]

Plaintiffs attempt to salvage this argument by pointing out that these experts' opinions were not designed to provide either a "*legal* definition of policy terms" or "opine on the meaning of the contract." Pls.' Br. at 25. But Plaintiffs miss the point. If Plaintiffs' own actuarial expert does not read "class basis" to mean specifically defined actuarial classes of sex, attained age, and premium class, it is implausible to argue that a reasonable policyholder would read the contracts in the same manner as Plaintiffs' counsel does.

Unlike certain terms like "proceeds" or "attained age" that are defined in the contract, the term "class basis" is not a defined term. Neither is the term "class." ECF 5-1 at 5, 7 ("Proceeds means the amount payable on the death of the Insured, on the Maturity Date, or upon surrender of

[7] ASOP 2 provides that "the actuary should establish policy classes considering [a number of criteria]. . . [and] may consider combining policy classes that are reasonably consistent based on the above criteria if, in the actuary's professional judgment, such combinations would be appropriate."

this policy." "Attained age means age on the birthday nearest the first day of the policy year in which the monthly deduction day occurs.").

The term "class basis" is not found anywhere in the contract except for this one sentence. The only other place in the contract where the word "class" appears is part of the term "premium class," which refers to a distinction between smokers and nonsmokers. *See* ECF 5-1 at 2 (identifying Hanks's "PREMIUM CLASS" as "NONSMOKER"). Nowhere does the contract define the term "class" or "class basis" to mean anything, let alone to specifically refer exclusively to sex, attained age, and premium class.

The plain dictionary meaning of class, namely, a group of policies with common characteristics, makes perfect sense in the context of this sentence. There is no justification to depart from the plain meaning of the words used in the contract and adopt a hyper-narrow interpretation of the word "class" that is inconsistent with its common understanding.

Under Plaintiffs' reading of the contract, there are hundreds of combinations of classes based on the insureds' sex, attained age, and premium class.[8] Taken literally, Plaintiffs' interpretation of the "class basis" provision would have resulted in potentially hundreds of separate COI adjustments, which would have been administratively impossible and, in any event, would have rendered compliance with the Policies' "uniform basis" requirement (discussed below) virtually impossible.

Plaintiffs also say the Policies require specifically delineated classes but fail to say what exactly those classes would be, how those classes would be adjusted, or how the adjustment of these purportedly "explicit contractually-delineated classes" would have operated. Pls.' Br. at 21.

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[8] According to Plaintiffs, the "classes" could be, for example, a 25 year old male non-smoker, a 90 year old female smoker, and every possible permutation of age, sex, and smoking status in between the two extremes.

This is fatal to their argument. *See Mylan Inc. v. SmithKline Beecham Corp.*, 723 F.3d 413, 418 (3d Cir. 2013) (fact question at summary judgment only "'[i]f the nonmoving party presents a reasonable alternative reading of the contract").

None of Plaintiffs' experts has proposed the alternative method in which VRIAC should have implemented the COI Adjustment. For example, whereas Lincoln and VRIAC defined the redetermination "class" for the COI Adjustment as all owners of a given life insurance product, Plaintiffs' experts and lawyers have never suggested what the correct number of redetermination classes should have been. As a matter of common sense, this would have been easy to do if, as they assert, "every policy has explicit contractually-delineated classes."

b. New York's DFS is Wrong and Its View Carries No Weight in this Court.

Plaintiffs rely heavily on a letter from NYDFS, which is apparently their primary authority for their "class" arguments. Pls.' Br. at 23. With respect to the New York regulator, that agency's interpretation of the contract provision at issue in this case is wrong, has not been formally ruled upon, has not been tested in any proceedings, and should be afforded no weight where, as here, the Court must interpret the Policies' plain language on its own. To the extent an agency such as the DFS's reading of the Policies matters, the fact that its sister agencies in 49 other states (each with policyholders that, unlike those in New York, were actually subject to the COI Adjustment) took no issue with VRIAC's selection of its redetermination classes demonstrates that the overwhelming weight of regulatory opinion disagrees with Plaintiffs' interpretation of the Policies.[9] For example,

[9] In a footnote, Plaintiffs suggest that "[c]ontrary to its current position, Aetna initially indicated to NYDFS that it concurred in this reading of 'class basis.'" Pls.' Br. at 23 n.58. VRIAC invites the Court to read the letter itself, and to compare its understanding of the document with what Plaintiffs claim it says. Even the portion of the correspondence quoted in Plaintiffs' brief makes clear, however, that VRIAC merely sought confirmation of how NYDFS wanted VRIAC to run an alternative analysis, and at no point did VRIAC "concur" with the agency's interpretation of what the "class basis" provision means.

Minnesota's regulator conducted a full review of the COI Adjustment and did not find any violation of the "class basis" provision. ECF 134 at 23.[10] Plaintiffs' experts have admitted that DFS is a "very aggressive regulator" that has taken positions at odds with other state regulators, ECF 102-29 (Pearson Dep. Tr) at 87:9-88:15, and it would be wrong to ascribe undue weight to a regulatory position one state (out of fifty) took with respect to the COI Adjustment.[11]

Because there are no New York policies at issue in this litigation, any positions taken by the DFS with respect to the COI Adjustment are irrelevant. No policyholder who received a COI adjustment in June 2016 was adversely affected by Defendants' decision to postpone the adjustment for New York policyholders because of DFS's review. The decision to delay the COI Adjustment in New York did not cause policyholders in any other jurisdiction (any class members) to pay more than they would have paid had New York policyholders received an adjustment at the

[10] Plaintiffs' only answers to the Minnesota regulator's findings are that "the examination was done on *Lincoln*" and not VRIAC, and that because it was a settlement there were no formal findings. Pls.' Br. at 20-21 n.55. These arguments are unpersuasive. No state regulator would have entered into a settlement with either LLANY or VRIAC on those terms if the agency believed that the Policies were breached.

[11] DFS's position that the only permissible classes were those allegedly established at original pricing is inconsistent with prior guidance by the New York Office of General Counsel, which expresses opinions and provides written guidance "to regulated entities, members of the bar, public officials, and others, on legal and regulatory matters within the jurisdiction of the Department." https://www.dfs.ny.gov/industry_guidance/interpretations_and_opinions (last visited Dec. 18, 2019). Indeed, New York General Counsel opinions have repeatedly established that a "class" may appropriately be all applicants for, and insureds under, a particular policy. *See* General Counsel Opinion 7-2-2003, 2003 WL 24312445 ("The Department has stated that under N.Y. Ins. Law § 4224(a)(1), a class may appropriately be all applicants for, and insureds under, a particular policy."); General Counsel Opinion 12-13-2000 (#2), 2000 WL 34630175 ("Thus, under N.Y. Ins. Law § 4224(a)(1), a 'class' may appropriately be all applicants for, and insureds under, a particular policy."); General Counsel Opinion 2-12-2002 (#4), 2002 WL 33011225 ("Under N.Y. Ins. Law § 4224(a)(1), a 'class' may appropriately be all applicants for, and insureds under, a particular policy.").

same time. Lincoln has simply absorbed the shortfall from New York policyholders while it decides how to proceed in New York.

Plaintiffs argue that no state has "approved" of the COI Adjustment, and that 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." Pls.' Br. at 21. But given the fact that policyholders in 49 states have been receiving adjusted COI rates for the past three years, it strains credulity to argue that any state regulator believes that the COI Adjustment violated any regulation or contract provision, yet stood idly by.

c. Plaintiffs' Policyholder Expectation Argument and Other Arguments Have No Merit.

Plaintiffs claim that their reading of the "class basis" provision is "consistent with commonsense policyholder understanding" because "policyholders would objectively expect that" any future adjustments would also take those same distinctions into account; *i.e.*, any COI adjustment would be based exclusively on differences in age, sex, and premium class. *Id*. at 24.

This self-serving assertion has no basis in reality. Even Plaintiffs' named plaintiff, Helen Hanks, was unable to express an understanding of what the phrase meant. *See* Suppl. Shulman Decl. Ex. 25 at 119:14-20 ("Q. (BY MS. FRUCHTER) Okay. And do you have any understanding of what it means that the adjustments will be made – excuse me, that the adjustments will be on a class basis? MR. SPEAR: Same instruction about attorney-client privilege. A. I don't know."). There is no reason any other policyholder would expect that a sentence in one section of her insurance policy controls the definition of a term used in a different paragraph that describes a different situation. To the contrary, an objective policyholder would understand that while COI rates must differ based on sex, age, and premium class, adjustments of

those rates could be made at a larger group level so long as the resulting COI rates continued to differ based on sex, age, and premium class.

Moreover, as noted above, even Plaintiffs' own expert does not understand "class basis" to mean sex, attained age, and premium class. It is highly improbable that the "objective policyholder" would have a better understanding of this provision than Plaintiffs' hired actuarial expert.

Plaintiffs also argue that "Aetna's actuarial expert, Timothy Pfeifer, agrees" with Plaintiffs that the classes to be used in redeterminations must be the same class distinctions that were used at the time of issuance. Pls.' Br. at 24-25. To the contrary, Pfeifer's prior testimony *confirms* that the actuary is afforded a great deal of discretion in defining a redetermination class, including the ability to select "differing classes within the class of policies issued under a given policy form at a given time." In the prior case in which Pfeifer testified (in which plaintiffs' counsel faulted the insurer for defining its redetermination class too narrowly)[12] Pfeifer wrote (Plaintiffs' quoted language in yellow):

> In my opinion, the language in ASOP 2 Section 3.4.c. allows for differing classes within the class of policies issued under a given policy form at a given time. Specifically, issue age ranges, gender, policy size, etc. are all components of class because they can generate unique elements of anticipated experience factors. For example, the policies at issue contain certain COI rates banded by face amount and COI discounts (and credit interest bonuses) for older ages and higher accumulation policies. Thus, a class such as $1 million+ face and ages 68/65+ can be defined apart from all PAUL IIc, III, etc., policies because of their similarity with respect to anticipated experience factors. To define class otherwise would be illogical. An insurance company must be able to identify subsets of its policies (as classes) whose future experience may differ from originally expected experience in very unfavorable ways in order to protect its very solvency.

[12] No matter how a redetermination class is defined, class action plaintiffs' lawyers will assert that the definition violates ASOP 2 and, therefore, the contract.

ECF 143-36 at 27. Read in full, it is clear that Pfeifer's point was that an insurance company must have the ability to identify subsets of its policies as a redetermination class. But where, as here, the cost factors that led to the COI Adjustment (reinsurance and investment income) did not reflect "unique elements of anticipated experience factors" within the cohort of policyholders of a given product, treating every policyholder of a given product as within one redetermination class is perfectly appropriate. Neither the fact that reinsurance rates have increased across the industry, nor the fact that interest rates have decreased dramatically over time, merits creating different redetermination classes within the classes the COI Adjustment used.

Furthermore, the COI Adjustment preserved all class distinctions and was therefore made on a "class basis," and also implemented the adjustment in a way that complied with the separate "uniform basis" requirement. As set forth in VRIAC's opening brief, the COI Adjustment, by applying a uniform percentage increase to all policyholders owning a given product, "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." ECF 134 at 22. Because "[a]ny class distinctions that existed prior to the COI Adjustment were therefore preserved by the application of a uniform percentage increase," VRIAC's definition of class allowed it to implement the adjustment in a uniform manner as well. *Id.*

Plaintiffs' response to this is circular and confusing. First, they cite to VRIAC's expert, Pfeifer, for the proposition that "[f]airness 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." Pls.' Br. at 26. There is no evidence that one group is subsidizing another when each and every group within the same redetermination class received the same percentage adjustment. Second, they cite LLANY's Rule 30(b)(6) witness for

the statement "I, therefore, think that you would do the analysis to determine the increase for each of the classes independently." Pls.' Br. at 21. But it is an undisputed fact that a separate analysis *was* conducted for each redetermination class. *See* ECF 139 ¶ 17 & Resp. ("[T]he COI Rate Increase was differentiated by product."). This is exactly why a separate percentage adjustment was applied depending on what life insurance product was owned. The COI Adjustment was made on both a class and uniform basis.[13]

d. ASOP 2 Is Consistent with VRIAC's Reading of "Class Basis," But Is Not Necessary to Grant Summary Judgment in VRIAC's Favor.

In their final section on this topic, Plaintiffs argue that "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." Pls.' Br. at 27. VRIAC's opening brief makes clear, however, that the Court "need not" "consider extrinsic evidence to interpret the 'class basis' provision." ECF 134 at 21. Given that Plaintiffs agree that the Policies' terms are "unambiguous and understandable" and that the Court should enforce their terms as written, *see* Pls.' Br. at 2, the three pages devoted to their actuarial arguments as to what ASOP 2 requires is simply an attempt to gin up a fact dispute

[13] Plaintiffs' argument that classes must be more "granular" and that different percentage increases must be applied to different classes to reflect purported different changes in estimated future cost factors are unavailing for several reasons. First, there is nothing in the contract that requires different classes to receive different (*i.e.*, non-uniform) increases because their estimated future cost factors have changed in different ways. This is an argument NYDFS has recently conceived based on its interpretation of its regulatory authority, not based on the contract language. Second, none of the other 49 states appear to have this view. Third, the future cost factors driving the adjustment are increased reinsurance costs and expected continuation of low interest rates, which are consistent across all classes no matter how granular.

where no genuine dispute of any *material* fact exists. In any event, each of Plaintiffs' actuarial (as opposed to contractual) arguments concerning ASOP 2 is meritless.

Plaintiffs' statement that "Aetna's corporate representative all but admitted that Aetna did not follow ASOP 2 in determining the policy classes used for the COI increase" is demonstrably false. *Id*. at 28. Plaintiffs suggest that either LLANY did not tell VRIAC how the Policies were assigned to classes, or that VRIAC did not appreciate how the Policies were divided into redetermination classes. As support, Plaintiffs cite only one document, where LLANY did not specifically answer one question VRIAC had posed. But on the same page of the cited deposition transcript, VRIAC's witness testified: "We discussed the definition of class with Lincoln"; "That the class is basically defined as the marketing product and generation"; and "We had several discussions with Lincoln on the definition of policy class." ECF 143-10 at 339:19-340:16. No violation of ASOP 2 occurred on this basis.

Plaintiffs also assert that "[t]he Chief Actuary for the Class Policies, Patrick Lusk, testified that he did no work to determine 'what the appropriate policy classes were for purposes of this COI increase.'" Pls.' Br. at 28. But a mere three transcript pages later, Lusk explained that what he meant was that Lincoln initially selected the policy classes, which VRIAC was aware of as a result of the review process. *See* Suppl. Shulman Decl. Ex. 23 at 112:17-113:2 ("Because of our reliance on Lincoln for this block, for the work associated with this block of business, that work was performed by Lincoln, and was reviewed by Tony and his team; and Lincoln provided me with the reliances [sic] in their work, and Tony and his team provided me with oral descriptions of the work

they had done to review the Lincoln work. Tony and his team did not repeat or duplicate the work done by Lincoln.").

Plaintiffs argue that the COI Adjustment violated ASOP 2's requirement "that any material changes in the assignment of policies to policy classes, and any material change in the determination policy must be documented." Pls.' Br. at 29 (internal quotation marks omitted). As an initial matter, to the extent ASOP 2 describes documentation, it is not a "requirement" such that anything "must be documented." *Id.* The applicable section's exact words are: "The actuary *should* disclose the following items *when appropriate and available*." ECF 136-17 (ASOP 2) § 4.2 (emphases added). In any event, both Lincoln's actuarial memos to VRIAC and the VRIAC Review Team's memo to its board of directors comply with any ASOP 2 requirements by identifying the redetermination class being used. *See* ECF 136-9.

Plaintiffs next argue that "ASOP 2 requires the insurer to follow a determination policy, but Aetna's corporate representative admitted the policy followed was not a determination policy." Pls.' Br. at 29. As Plaintiffs admit, however, the cited deposition testimony was subsequently corrected in the witness's errata sheet, where he stated: "Having had the opportunity to further review ASOP 2, and § 2.3 in particular, I believe that I read into the ASOP requirements a level of specificity that does not exist . . . . I wish to correct my testimony and state that, in my opinion, Exhibit 5 Interrogatory No. 3 response is a determination policy under §2.3 of ASOP 2." Suppl. Shulman Decl. Exs. 26 and 27. Any "dispute" as to this point is not, as Plaintiffs' suggest, "a disputed question of material fact that can only be decided at trial." Pls.' Br. at 30. The

document contains "Lincoln's Policy Used in the Process of Determining Nonguaranteed Elements" for those within the Aetna block. In relevant part, it states:

> Cost factors that can vary are periodically reviewed and may be adjusted based on changes in prospective assumptions. These adjustments are made in such a way that past losses (i.e., experience less favorable than expected) are not recouped and past gains (i.e., experience more favorable than expected) are not distributed. These adjustments are made at the discretion of the Company. All adjustments made will be made in accordance with applicable statutes, rules, and contracts.

Suppl. Shulman Decl. Ex. 27. The Court can read this response and determine as a matter of law that its contents reflect "[t]he insurer's criteria or objectives for determining nonguaranteed charges or benefits for a particular policy class" required of a "determination policy." ECF 136-17 (ASOP 2) § 2.3.

In any event, Plaintiffs' arguments concerning this industry standard are irrelevant for the purposes of this summary judgment motion.

C. <u>The COI Adjustment Was Done on a Uniform Basis.</u>

There is also no genuine dispute that the COI Adjustment complied with the Policies' requirement that "[a]ny adjustments will be made on a uniform basis." ECF 5-1 at 7. The fact that, amongst all policyholders subject to the COI Adjustment, each received the same percentage increase as every other policyholder owning the same life insurance product means that the COI Adjustment was implemented on a "uniform basis." "Uniform" means uniform as to those who received an adjustment, and in this context is akin to the phrase "non-discriminatory," which is the phrase used instead of "uniform" in several of the Policies. *See* ECF 136-6 at 37 n.108 (recognizing that some of the Policies use "the term 'non-discriminatory,'" and in "industry usage, there is no difference between 'uniform' and 'non-discriminatory'"). Indeed, Plaintiffs

affirmatively allege that "Aetna grouped them all together and imposed a *flat-percentage* COI increase by product, except not in New York." Pls.' Br. at 3.

Plaintiffs' argument in its "uniform basis" theory of breach relies entirely on the fact that the COI Adjustment was postponed as to New York policyholders as a result of objections raised by NYDFS, and their assertion that VRIAC was thus contractually obligated to rescind the entire COI Adjustment based on the objection of one state's (out of fifty) insurance regulator. There is no legal or factual support for this argument.

Plaintiffs affirmatively allege that the "uniform basis" requirement only requires COI adjustments to be "'uniform' or 'non-discriminatory,' which means that any adjustment must be applied in the same manner for each class." Pls.' Br. at 8. As explained by Plaintiffs' actuarial expert:

> It is common industry practice to include a provision requiring adjustments to COI rates to be uniform, and many state laws also require this. These provisions reflect the actuarial principle that insurers required to change NGEs on a class basis cannot use a COI Increase to discriminate unfairly. This means that an insurer **cannot use a COI increase to discriminate between members of the same class (intra-class discrimination).** For example, a policyholder who gets sick cannot be singled out for a COI increase that does not apply to her entire class, even though her life expectancy is diminished. As another example, non-smokers who start smoking after issuance cannot be targeted for an increase because they remain part of the nonsmoker class. By contrast, insurers required to change NGEs on a class basis necessarily **are allowed to discriminate fairly between classes based on special risks or costs associated with that class as a whole (inter-class discrimination).** Thus, if mortality expectations rise for a certain class, then COI rates could be increased on that class, but not on other classes.

ECF 136-6 (Hause Report) ¶ 66 (emphases added).

Not implementing the COI Adjustment in New York due to DFS's objection is not discriminatory to other non-New York policyholders because New York's DFS created "special risks or costs," which Plaintiffs' own expert says is permissible inter-class discrimination. New York's regulator took positions that required VRIAC to delay implementation of the COI

Adjustment in New York, and accordingly made the class of New York policyholders differently situated from the class of non-New York policyholders. This is permissible inter-class discrimination that does not violate the "uniform basis" provision.

New York's DFS's actions created a situation where effectively policyholders in New York had policy language stating: "Adjustments will be exclusively on the basis of sex, attained age, and premium class"; and policyholders outside New York had policies stating: "Adjustments will be on a class basis." These are effectively two different contractual requirements and two different groupings of policyholders and entirely permissible inter-class discrimination.

Plaintiffs also argue, without any support, that because VRIAC modeled non-New York and New York policies together VRIAC cannot have a COI Adjustment for only non-New York policies. Pls.' Br. at 15. This is illogical. VRIAC modeled non-New York and New York policies together because VRIAC intended to implement a COI Adjustment in all 50 states and VRIAC only delayed the adjustment in New York at the DFS's insistence. The group of policies modeled by an insurer is never precisely the same group of policies impacted by an increase because the modeling associated with a COI adjustment can take significant time and policies are constantly terminating or being reinstated for a variety of reasons including lapse, surrender, and death.

Plaintiffs also do not present any evidence (or even an expert's opinion) that policyholders who *are* part of this certified class suffered any damages because the COI rates for New York policyholders were not adjusted as well.

Plaintiffs' argument that VRIAC was required to rescind the entire COI Adjustment based on the objection of one state's (out of fifty) insurance regulator would require an untenable and

implausible reading of the "uniform basis" provision, which, as drafted, is meant only to prevent the insurer from unfairly discriminating against any given policyholder in the course of an adjustment. According to Plaintiffs, the contract requires "nationwide or nothing." This obligation is not in the contract, is illogical, and contravenes the well-recognized understanding that life insurance is regulated by fifty different state regulators, the District of Columbia, and five U.S. territories pursuant to a myriad of state-specific statutory and regulatory requirements.

Plaintiffs argue that VRIAC raises "public policy arguments" for why the Court should interpret the uniform basis provision to not mean "uniform nationwide." *Id.* at 16, 18. Plaintiffs completely misconstrue VRIAC's argument, as VRIAC does not believe that the Court should depart from a plain language interpretation of the phrase "uniform." Rather, the fact that life insurance policies are approved and regulated on a state-by-state basis renders implausible Plaintiffs' contention that either Aetna or the policyholders ever assumed that the "uniform basis" requirement would extend to equal treatment of policyholders in different states. A reasonable policyholder in Wyoming would not expect, for example, that his COI rates would have to be doubled by operation of the "uniform basis" provision because a New York state regulator required COI rates to be doubled on similarly-situated policyholders in that state.

Plaintiffs also claim that VRIAC's interpretation of the "uniform basis" provision would require the Court to either accept "proposed additions of three new phrases" or "contract inserts." *Id.* This, however, is pure artifice. It is the Plaintiffs who are attempting to add words to the uniform basis provision by requiring that it be synonymous with "national basis" or "uniform nationwide" basis. VRIAC's position is that "uniform" means uniform as to those who received an adjustment, and in this context is akin to the phrase "non-discriminatory," which phrase is used instead of "uniform" in several of the Policies. *See* ECF 136-6 at 37 n.108 (recognizing that some

of the Policies use "the term 'non-discriminatory,'" and in "industry usage, there is no difference between 'uniform' and 'non-discriminatory'").

III. SUMMARY JUDGMENT SHOULD BE GRANTED AS TO CLASS MEMBERS WHOSE COI RATES WERE NOT INCREASED AND THUS DID NOT SUSTAIN ANY DAMAGES.

Plaintiffs concede that: (i) if a policyholder did not receive a COI Adjustment, they are not part of the class, there has been no purported breach, and they have not been damaged; and (ii) as of December 31, 2017, more than 10% of the certified class did not yet receive a COI Adjustment. Pls.' Br. at 42-43. Notwithstanding these undisputed facts, Plaintiffs argue that even if a policyholder did not receive a COI Adjustment as of December 31, 2017, he or she could possibly have received a COI Adjustment as of today's date or as of the date of trial. Plaintiffs present policy number G1000144 an example of such a policyholder. However, what Plaintiffs fail to respond to, and what is therefore appropriate for summary judgment, are policyholders who will not have received any COI Adjustment as of the date of trial. Those policyholders have no standing, no liability, and no damages. Any claim of future potential harm on behalf of those policyholders is entirely speculative as a matter of law.

For purposes of this discussion there are two different types of policyholders.

1. Policyholders who as of today or as of the date of trial have been subjected to a COI Adjustment. There is no dispute that these policyholders are part of the certified class because they have been subjected a COI Adjustment.
2. Policyholders who as of the date of trial will <u>not</u> have been subject to a COI Adjustment, but may be subject to a COI Adjustment as some point in the future (between trial and 2050) if the insured does not die, there is no lapse of the policy,

and VRIAC does not make any changes to its COI rates. As to these policyholders summary judgment is appropriate.

An example of this second group of policyholders is G1000139. Plaintiffs' expert includes nominal damages of $26,180 for this policy but concedes that this policy will not be subject to the COI Adjustment until policy year ending September 30, 2028. Moreover, Mr. Mills concedes that these damages will only be incurred if you assume "no lapses or deaths and level NAR" as well as no change by VRIAC of the COI rates. ECF 136-1 ¶ 156.

Summary judgment as to these policyholders is appropriate because as of the date of trial the policies will be unaffected by the 2016 redetermination, and therefore did not suffer any damages. ECF 135 ¶ 22.[14] These plaintiffs therefore do not have a viable breach of contract claim against VRIAC. *Mullins v. TestAmerica, Inc.*, 564 F.3d 386, 418 (5th Cir. 2009) (fourth element of breach of contract claim is "damages sustained by the plaintiff as a result of the breach").

CONCLUSION

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

DATED: December 18, 2019

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[14] The assertion that VRIAC "*refused*" Plaintiffs' request to provide updated data is demonstrably false and irrelevant. Pls.' Br. at 43-44. During the parties' communications, VRIAC's counsel asked for an explanation as to why a data refresh was necessary given that Plaintiffs' expert was already able to estimate damages. As VRIAC's counsel explained, any data refresh, which is costly and burdensome to produce, was "unnecessary, disruptive and will be immediately stale." Suppl. Shulman Decl. Ex. 28 (Oct. 4, 2019, email from M. Shulman to S. Sklaver).

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