



**Written Submission To Florida Office of Insurance Regulation
Further To October 25, 2013 Public Hearing
On Secondary Life Insurance Market**

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October 15, 2013

I. INTRODUCTION

Imagine you bought a home. You make mortgage payments for thirty years. Then, when you make the last payment, the bank announces you don't really own it. Worse yet, it won't refund you one cent of the payments you made for all those decades. And come to find out, the bank never intended to confer title. Inconceivable—at least in any rational market. But that is precisely what insurance companies are doing. They rake in premium payments, in return for promises of coverage under written policies, then renege the moment the beneficiaries seek to collect what the insurer owes them under the plain terms of the agreement.

Florida resident Barton Cotton is a typical example. See *Sciaretta v. Lincoln Nat'l Life Ins. Co.*, No. 11-cv-80427, 2011 U.S. Dist. LEXIS 157038 (S.D. Fla. Sept. 9, 2011). He purchased a life insurance policy to protect his family in case tragedy befell him. Unfortunately, it did just a few years later. He died of cancer. Until that time, Mr. Cotton held up his end of the bargain. He made all the required premium payments. But when his wife and children—the policy beneficiaries—sought to collect the proceeds, the insurer refused. It claimed the policy was void from the start merely because Mr. Cotton *considered* selling it on the secondary market. Never mind that selling it would have been perfectly legal. Never mind that he never did sell it. The insurance company refused to pay. And it insisted it was entitled to keep all the premiums it collected on the policy it now says was never valid. Mr. Cotton's widow had to hire a lawyer and sue the insurance company to force it to honor its obligations.

Florida is hardly alone in protecting the right of policyholders like Mr. Cotton to sell their insurance policies, if they so choose (and obviously, then, to at least consider selling them, as Mr. Cotton did). Many states grant that right, affirmatively fostering a robust secondary market across the country on which policyholders can sell their policies. They do it to give consumers—particularly seniors—financial flexibility. Some need money to pay their medical bills. Others don't need the policies anymore, and don't want to keep paying.

But the flexibility that is good for consumers is bad for insurance companies. Their whole business model is predicated on putting consumers in a bind. Prior to the development of the life settlement market, customers paid their premiums for many years and then did one of two things. Option 1: Stop paying and allow the policy to lapse, in which case the insurer pockets years of premiums but never has to pay a claim. Option 2: Sell the insurance policy back to the insurance company—the only available buyer—for a pittance, which yields essentially the same result. Indeed, it is common knowledge within the life insurance industry that the overwhelming majority of life policies will lapse or be surrendered to the insurer. The secondary market gives policyholders another option:

Rather than allow their policies to lapse or surrender them to the insurer for pennies on the dollar, seniors can now sell their policies for fair value on the secondary market—which, in turn, means that the insurer actually has to pay the benefits it promised to pay.

It stands to reason that life insurance companies would try to regain their position as the only buyer. And they have certainly tried, using a variety of tactics, including policy denials, lawsuits, premium retention, and cost of insurance increases.

Mindful of these dynamics, the Legislature directed the Office of Insurance Regulation to “review Florida law and regulations to determine whether there are adequate protections for purchasers of life insurance policies in the secondary life insurance market to ensure that this market continues to exist for Florida seniors.” Orrick, Herrington & Sutcliffe provides this written submission on behalf of Fortress Investment Group—an investment management firm that manages \$54.6 billion in investment assets on behalf of clients that include university endowments, public pensions, and non-profit foundations—to help inform the Office’s assessment and response to its charge from the Florida Legislature.

II. BACKGROUND

Life insurance today is more than just a way to protect against the risk of death; it is an investment that consumers use—with the insurance companies’ enthusiastic support—for income protection, growth, and even immediate financial return. It is a valuable asset that individual consumers in Florida and elsewhere can freely buy, hold, or sell as their personal and financial circumstances dictate. Until recently, however, consumers who wanted to sell this asset were limited to one potential purchaser: the company that issued the policy. Just in the last few decades, a robust secondary market has emerged to erase that market defect by empowering consumers to eschew the single buyer who was lowballing them and capture the full value that the market placed on their policies.

A. Origin of the Secondary Life Insurance Market

Life insurance has long been freely transferable. *See Grigsby v. Russell*, 222 U.S. 149, 156 (1911). Nevertheless, it only became attractive to third-party investors when insurers transformed it from a simple mechanism to protect against the risk of death into a valuable and infinitely malleable form of investment for consumers. That transformation took place largely in response to consumer dissatisfaction with the traditional and most basic form of life insurance, term life insurance. Term life insurance is simply life insurance that lasts only for a defined duration. A person pays premiums for the specified term. If she dies during the term, the death benefit is paid to the beneficiary. The problem, ironically, arises if she survives longer than the policy term. The good news is she’s alive. The bad news is that she has lost all of the premiums she paid to keep the policy in force and has nothing to

show for her investment. *See* Black and Skipper, *Life Insurance* 84 (12th ed. Prentice-Hall 1994). The insurance company, instead, captures all of her payments—almost all of it pure profit.

To make their product more appealing to consumers, insurance companies created permanent life insurance. Unlike term life insurance, permanent life insurance stays in force until the insured dies. It also accumulates a cash value from premium payments, which accrues tax-deferred interest. *Id.* at 83; *see also* Exhibit A, Charlene D. Luke, *Taxing Risk: An Approach to Variable Insurance Reform*, 55 *Buff. L. Rev.* 251, 258 (2007). Depending on the type of policy, this cash value can be withdrawn, used to pay future premiums, or used to take out a loan. These features of permanent life insurance guarantee the policyholder a return on the premiums she invests, and the ways in which this account works feel much more like an investment than term life insurance.

The vast majority of people who own life insurance today own permanent life insurance. *See* Black and Skipper, *Life Insurance* 83 (12th ed. Prentice-Hall 1994). While permanent life insurance comes in many different flavors, each of them has distinct characteristics of an investment. Universal life insurance, for example, gives policyholders flexibility to make premium payments into a savings account that accrues interest at a rate that can be tied to various factors. *Id.* at 130-36. When interest rates are high, a policyholder can pay more into this account and use this tax-deferred growth to pay future premiums. With variable life insurance, the cash value of the policy and the death benefit it pays vary directly with the performance of a separate investment account. The policy “shift[s] all or part of the investment from the insurance company to the [policy’s] owners,” making it almost a “pure investment.” Luke, 55 *Buff. L. Rev.* at 258, 261. For that reason, insurers that invest variable life insurance assets in securities are considered “investment companies” under federal law, and both they and their variable policies are subject to federal securities laws.

The insurance companies that devised these products aggressively market them as investments, variously touting them as combining “insurance protection with investment opportunity,” offering “a range of investment choices,” Exhibit B, AXA Equitable Website, Insurance Products and Services (lasted visited Oct. 14, 2013), and marketing the “upside potential of variable investment options,” Exhibit C, Lincoln Financial Group Website, Variable Life Insurance (lasted visited Oct. 14, 2013). The insurance industry’s marketing campaign worked wonders. Millions of Americans—many of them baby boomers close to or in retirement—now hold trillions of dollars of life insurance as part of their personal financial plans. In 2008, there were approximately 335 million life insurance policies in force in the United States, with a total face value of approximately \$19 trillion. Exhibit D, United States Census Bureau, Statistical Abstract of the United States, *Tables 1220, Life*

Insurance in Force and Purchases in the United States-Summary: 1990 to 2009, 754-55 (2012).

As more consumers used life insurance as investments, the liquidity of those investments became increasingly important. More and more consumers sought to monetize their investment as their personal or financial circumstances changed. In years past, when consumers wanted to cash out their investments, insurance companies offered them two options: Nothing, and next to nothing. Option 1: They could let their policies lapse and forfeit all their premiums. Option 2: They could surrender their policies for a nominal cash surrender value. The problem for consumers was that “life insurance policies were bound by a monopsony, in which there was only one buyer for the instrument.¹ If a consumer wished to sell a life insurance policy, the only buyer was the company that originally sold it.” Ron Panko, *A Matter of Trust: Financial Planning; Insurance Market*, A.M. BestWire, Dec. 1, 2002, at 22. Of course, “[i]f the insurer is the only repurchaser of its own policies, the policyholder cannot bargain effectively over the surrender value—there is no other potential buyer for the policy.” Exhibit E, Neil A. Doherty & Hal J. Singer, *The Benefits of a Secondary Market for Life Insurance*, Wharton Financial Institutions Center, Working Paper #02-41, at 18 (2002). The policyholder is “forced to either accept an amount that is substantially less than the true economic value or elect not to surrender the policy.” *Id.* Insurers profited handsomely from this arrangement because they would never have to pay the death benefits on lapsed or surrendered policies, even after raking in substantial premiums. See Geoff Chaplin et al., *Life Settlements and Longevity Structures: Pricing and Risk Management* 13-14 (John Wiley & Sons Ltd. 2009).

The rise of the life settlement market was a simple matter of new market participants correcting a glaring economic inefficiency. Individuals no longer needed or wanted to keep their policies, and investors “were willing to purchase [them] for substantially more than the pre-arranged termination terms offered by the insurance companies.” Doherty & Singer, *supra*, at 3. This broke the insurance industry’s choke hold on its customers. By giving customers another option for converting their insurance investment to cash, the secondary market enabled consumers to realize much more of the value of their policies, as much as ten times more. See Exhibit F, *Recent Innovations in Securitization: Hearing Before the Subcomm. on Capital Mkts., Ins., & Gov’t Sponsored Enter. of the H. Comm. on Fin. Serv.*, 111th Cong. 43, 68-69 (2009).

The so-called “viatical settlements” of the 1980s, which were the precursors to modern-day life settlements, show how critical the secondary market is. Viatical settlements arose when AIDS patients were unable to work but needed cash to cover their high medical expenses. See *Life Partners, Inc. v. Morrison*, 484 F.3d 284, 287 (4th Cir. 2007).

¹ A monopsony is like a monopoly but with only one buyer as opposed to one seller.

Obviously, anyone who is that strapped cannot also afford to continue paying life insurance premiums. The insurance companies gave them no out. They would let the patient cash out his policy for a pittance, leaving him with nothing to show for years of premiums—no money to cover his medical bills *and* no life insurance to leave loved ones. Into the breach entered viatical settlement companies with a solution that was as straightforward as it was welcome. The company would purchase a patient’s policy for a lump sum and assume the obligation to pay the premiums. That meant that the patient had a nest egg to cover expenses and was relieved of the burden to pay premiums. All the company required in return were the rights and obligations under the policy. *See* Chaplin et al., *supra*, at 13-14. Life insurers can look down at such arrangements, but they cannot deny that their customers were far better off with viatical settlements than with the pittance they were offering them.

Terminal illness, of course, is not the only reason to sell a life insurance policy. Some policyholders have shortened life expectancies and want to more fully enjoy the time they have left. Others simply have no further need for their policies or now find them an unjustifiable expense. Consider, for example, a retiree who depletes his 401K after living longer than expected; an octogenarian with dementia who requires round-the-clock care; a husband with no children whose wife predeceases him; a divorcee who now finds an annuity more attractive; an injured worker who took out little or no long-term disability insurance; a former business executive who, post-recession, was never able to get back on his feet; or a parent who decides she’d like to help pay for her child’s college education. Like viatical settlements, these life settlements enable consumers to realize the immediate value of their life insurance.

The life settlement market has also delivered benefits beyond expanding the options for people who already own policies. Now that consumers can sell their policies in a secondary market, a consumer who is on the fence about whether to buy insurance has more of an incentive to do so. A consumer deciding whether to buy any product—be it a painting, a piece of a company, or an insurance policy—is less likely to do so if he is told that he can never sell it to anyone but the person from whom he bought it. It is, after all, much easier—and far less risky—to invest in an asset that one can sell for its actual value than one that can only be surrendered to a market-controlling monopsonist. The opportunity to recover all of one’s capital, or more, adds appreciably to the value of a life insurance policy, as it does for any investment. *See* Doherty & Singer, *supra*, at 23 (“Economic theory holds that an active and efficient secondary market for a good improves the liquidity of the good as an asset, and thus increases the value of the good to consumers.”). And so the market evolved to empower consumers in ways that were previously unknown. Some lenders emerged to enable consumers to borrow funds to make premium payments, which further expanded this burgeoning market. But

consumers' gain was a blow to the insurance companies' business model. Recall that the insurers depend on policies lapsing. Investors will not allow that to happen. So, when the insured sells a policy that would have lapsed, the insurer loses because the company is forced to make good on its promise.

B. A Handful of Insurers Turn on the Secondary Market

While some insurance companies took steps to minimize their exposure to investor-owned life insurance policies, others, such as PHL Variable Insurance ("Phoenix"), were "experienc[ing] tremendous sales growth in [the first quarter of 2006] in universal policies . . . a prime target for life settlements." Exhibit G, Dafina Dunmore, *Our Take on the Secondary Market for Life Insurance*, Morningstar (June 16, 2006). This approach may seem counterintuitive, but greater demand and higher face values meant more of the insurance companies' life blood: premiums. On that front, the newly tapped market was a boon for business. Upper management at Phoenix, for instance, implored employees to "crank out" policies attractive to investors. "Bring it on," they boasted, "the more the merrier." Exhibit H, Deposition Transcript of James Michael Labar, at 20, 31, 33, *Fenton v. Phoenix Life Ins. Co.*, No. 1340238 (Cal. Sup. Ct. March 29, 2010); Exhibit I, Deposition Transcript of Edward James Humphrey, at 27, *Fenton v. Phoenix Life Ins. Co.*, No. 1340238 (Cal. Sup. Ct. Dec. 20, 2010). Insurance companies implemented quotas to their sales forces that simply could not be met without aggressively targeting this market. Exhibit I, Humphrey Depo. at 157–58. User guides were assembled and marketing skills developed with a particular focus on this niche. Exhibit I, Humphrey Depo. at 27. And at every level, Phoenix's managers and employees were rewarded for such sales. Exhibit H, Labar Depo. at 31. One employee saw his commission compensation rise from \$75,000 in 2004 to \$1.8 million in 2006, generating as much premium revenue on his own as some entire life insurance companies. See Exhibit J, Complaint, *Wilmington Sav. Bank v. PHL Variable Ins. Co.*, No. 12-cv-04926 at 6 (C.D. Cal. Sept. 10, 2012); Exhibit I, Humphrey Depo. at 149.

Given that investor-owned policies don't typically lapse, one might reasonably ask: why would an insurance company so enthusiastically sell policies that will almost certainly be redeemed for full face value? The answer: They won't be. After 2008, when many policies began maturing, a handful of insurers executed a multi-prong strategy to avoid paying proceeds and, in turn, chill the secondary market. Here's how it works:

Prong 1: Deny the claims. As more and more claims came in, more and more denial letters went out. Denial/resistance rates typically average about .05% across the industry. See Exhibit K, 2011 Chart of Life Insurance Policy Resistance/Denial Rates. For Phoenix, its resistance/denial rate went from less than 1% in 2008, to 12.37% in 2009, to 16.20% in 2010. *Id.* By 2011, Phoenix was resisting or denying 20.87% of its incurred death benefits—a 1,987% increase from three years earlier. *Id.* Each denial means no

payout *and* retained premiums—maximum value from the insurance company’s perspective. And this strategy has minimal repercussions for the insurance companies because other policyholders, even observing this dynamic, have no choice but to continue paying their premiums (and cross their fingers) if they want any chance to collect on their policies. In other words, the policyholder bears all the risk that the insurer will seek to invalidate the policy.

Prong 2: Litigate. Resisting efforts to cash in on policies, insurance companies began filing suits or forcing their policyholders to do so. *See, e.g., Wells Fargo Bank, N.A. v. Am. Nat’l Ins. Co.*, 493 F. App’x 838 (9th Cir. 2012); *PHL Variable Ins. Co. v. U.S. Bank N.A.*, No. 10-cv-1197, 2010 U.S. Dist. LEXIS 105576 (D. Minn. Oct. 4, 2010); *Lincoln Nat’l Life Ins. Co. v. Gordon R.A. Fishman Irrevocable Life Trust*, 638 F. Supp. 2d 1170 (C.D. Cal. 2009); *AXA Equitable Life Ins. Co. v. Infinity Fin. Group, LLC*, 608 F. Supp. 2d 1349 (S.D. Fla. 2009). They cried fraud and lack of insurance interest, among other reasons why they should not be held to their end of the bargain. The trouble was that many purchasers did nothing wrong. Under most state laws, as is the case in Florida, the insured is permitted to sell his policy provided there was an insurable interest at the time of purchase. *See* Fla. Stat. §§ 627.422, 627.404(1), 627.455. “Insurable interest” refers to the interest—personal or financial—that a person has in the life of the insured. Basically, insurable interest is meant to protect against a stranger taking out a policy on the life of an insured without the insured’s consent. Even in cases where an insurable interest existed at origination, insurance companies were claiming they did not have to pay if the purchaser simply intended at the time of purchase to sell it two years later. *See, e.g., Sciaretta*, 2011 U.S. Dist. LEXIS 157038, at *11–13. But such an intent complies with state statutory law like Florida’s which nowhere precludes one from purchasing a policy with the intent to one day resell it. Just as problematic though is the unworkability of such a rule. After all, intent is an elusive concept. Would it be enough if at the time the insured purchased the policy he figured there was a 50/50 chance he’d sell it? What if he merely entertained the prospect of doing so? Saw it as an option? Or, was simply aware state law allowed him to do so? And should it matter whether he ultimately sold it or not? What’s more, the answer to all of these questions is often complicated by the fact that the person whose intent is at issue is not infrequently dead by the time these questions are raised. *See, e.g., Sciaretta v. Lincoln Nat’l Life Ins. Co.*, 899 F. Supp. 2d 1318, 1325 (S.D. Fla. 2012) (“In this case, discovering the intent of Mr. Cotton at the time he procured the policy is complicated by the fact that he is dead.”)

Notwithstanding both the legal and practical implications of such an intent-based rule, insurers successfully convinced a handful of judges that these policies were voidable. *See, e.g., AXA Equitable Life Ins. Co.*, 608 F. Supp. 2d at 1356–57. But why would courts do so if the law is to the contrary? Some of it may just be poor interpretation of state law, but an old adage in the legal field may also help to explain it: Bad facts make for bad law. As

part of their strategy to void as many policies as possible, insurance companies—quite astutely—began their onslaught of denials and lawsuits by challenging policies involving bad actors who misrepresented information on their applications. The catch was that the companies had no remedy available to them based on the agents' misrepresentations. That's because most life insurance agreements include a contestability clause that limits insurance companies to a two-year period during which they can rescind a policy based on misrepresentation. *See, e.g., PHL Variable Ins. Co.*, 2010 U.S. Dist. LEXIS 105576, at 9–10. But because insurance companies failed to perform their due diligence in investigating applicants during the contestability period (either due to negligence or willful blindness), most claim denials and policy challenges occurred outside the two-year contestability period. *Id.* Thus, insurers had no argument based on fraud/misrepresentation. They were instead relegated to arguing lack of insurable interest. Though many courts properly understood the difference between fraud and insurable interest, others were so struck by the misrepresentation that they conflated the two to achieve a desired result. *See, e.g., Sciarretta*, 2011 U.S. Dist. LEXIS 157038, at *8–9 (concluding that an insurable interest claim was not barred by an incontestability clause but noting other jurisdictions have come to contrary conclusions).

The innocent victims, of course, were not just the insured and the original beneficiaries who were taken advantage of by the insurance companies' agents, but the millions of current and future policyholders who might one day want or need to sell their policies on the secondary market. That's because their ability to do so is inextricably bound up in investors' ability to accurately value the policies' worth. The onslaught of successful litigation has prevented investors from doing so. Here's why. Investors had no idea that some of the thousands of policies they purchased were secured through misrepresentations. And for good reason: they purchased the policies outside their contestability period. Accordingly, they assumed the policies were fully enforceable (either because they were always valid or because they could no longer be contested) and they would be entitled to their face values provided the investor continued making all premium payments. Indeed, their valuations of these policies and the amounts they paid for them assumed as much. It was only years later, after making the purchase as well as dozens of premium payments, that they received denial notices and rulings that the policies were unenforceable. Now, with no assurances that the policies they've purchased will be worth their face value (or anything at all), investors will understandably be loath to offer top dollar for policies in the future. This means that the retiree who has depleted his 401(k) won't be get much help from his life insurance policy to make ends meet in retirement and the octogenarian with dementia might not have the resources to cover the costly round-the-clock care she now needs. Thus, even if the insurers' litigation strategy does not literally dry up the market for willing investors, it may effectively do so if consumers find their policies attracting such little in return that they are simply not worth selling.

Prong 3: Retain Premiums. And it was not just the face value of the policies that insurance companies sought to deny investors. Part and parcel of their Prong 1 & 2 strategy was a plan to retain the years of premiums (and interest therefrom) paid by the original policyholders and later investors. But doing so should have been an uphill battle because the law is soundly to the contrary. Indeed, the well-settled legal rule in Florida, as elsewhere, is that where “an insurance law violation ‘renders the insurance contract void, the insured[] [is] entitled to restitution of the premiums paid on the insurance contract. The insurer must place the insured back in the same position the insured was in before the effective date of the policy through the return of the premium.’” *Gonzalez v. Eagle Ins. Co.*, 948 So. 2d 1, 3 (Fla. Dist. Ct. App. 2006) (citing 9 Fla. Jur. 2d, Cancellation § 35 (2004)). That is true even when there are misrepresentations in the policy application. *See, e.g., Towers v. Clarendon Nat’l Ins. Co.*, 927 So. 2d 913, 914 (Fla. Dist. Ct. App. 2006). But, again, waiving the specter of fraud, insurers were able to convince a few judges to defy the law and allow them to pocket premiums. *See, e.g., TTSI Irrevocable Trust v. ReliaStar Life Ins. Co.*, 60 So. 3d 1148, 1150–51 (Fla. Dist. Ct. App. 5th Dist. 2011); *see also PHL Variable Ins. Co. v. Lucille E. Morello 2007 Irrevocable Trust*, No. 08-cv-572, 2010 U.S. Dist. LEXIS 29501, at *12 (D. Minn. Mar. 2, 2010); *Wuliger v. Mfrs. Life Ins. Co. (USA)*, 567 F.3d 787, 799 (6th Cir. 2009).

This is all a bit galling considering that management at some insurance companies made an informal policy of turning a blind eye to misrepresentations by their own agents who inflated the net worth of applicants to obtain larger insurance policies. *See* Exhibit H, Labar Depo. at 28. Rather than engage in a meaningful underwriting process, some insurance companies required only that the policy be signed by “someone at the broker dealer or whatever just saying that this is their net worth, just something [our company] can hold up and say ‘Look, we did our due diligence.’” *Id.* at 25. As one industry member explained, his company “never verified [whether the net worth figures were accurate]. They never questioned it, not that I ever saw from anyone, from talking to other, you know, WMCs from business that I saw.” *Id.* at 26. In one case, Phoenix sought to retain nearly half a million dollars in premium payments after it successfully sued to invalidate a policy issued to a man who represented his net worth to be over \$1 billion comprised almost entirely of rare, uncut emeralds. *PHL Variable Ins. Co. v. The Faye Keith Jolley Irrevocable Life Ins. Trust*, 800 F. Supp. 2d 1205, 1210 (N.D. Ga. 2011). Phoenix issued the policy despite several “red flags” in the application, including evidence that the insured alternatively was employed as a cemetery worker or “in a telephone capacity.” *Id.* at 1211. That some insurers would turn a blind eye to such abuses is unsurprising given that the goal has always been to simply sign as many policies for the largest face amounts possible. Learning of a misrepresentation would preclude certain sales (and thus cut down on profits, commissions, and bonuses). To that end, all the insurance companies cared about

was getting the applicants' signature, touting: "Once that's signed, then you're covered." Exhibit H, Labar Depo. at 27, 29.

And there can be no doubt that some insurance companies knew that they had agents who were submitting false financial data to obtain larger policies. In 2010, Pruco Life Insurance managed to convince a judge to allow it to retain premiums after it pleaded complete ignorance of its agent's malfeasance. See *Pruco Life Ins. Co. v. Brasner*, No. 10-cv-80804, 2012 U.S. Dist. LEXIS 135169, at *3-7 (S.D. Fla. July 23, 2012). But the court later reversed its ruling when presented with damning evidence that Pruco, despite its contrary representations, knew about its agent's suspicious activity at least two years before filing suit but chose to do nothing about it because the policy was outside the two-year contestability period. *Id.* Ignoring the fraud, Pruco continued to accept premium payments, verified coverage under the policy and confirmed the policy's change of ownership when it was subsequently sold to an investor, all the while knowing facts which it would later use to successfully challenge the policy's validity. *Id.* Despite their complicity, insurers' ability to convince judges to allow them to keep premiums has been a boon to insurance companies. By the time these decisions are issued, insurers have pocketed hundreds of thousands of dollars in premiums from individual policies and millions collectively—all of which they were permitted to keep—not to mention the accrued interest.

Prong 4: Increase Cost of Insurance Rates. One insurance company—Phoenix—has taken its assault on the secondary market a step further by imposing discriminatory cost of insurance increases on universal life insurance policies owned by investors. Phoenix's obvious objective here is to make these policies so expensive to keep in force that the investments no longer make financial sense and investors allow the policies to lapse. Remember that an investor makes money on a policy by paying less in total premiums than the death benefit. If the cost of insurance suddenly goes up, the investor may be paying out more in premiums than the benefit amount, making the policy worthless. Unfortunately, Phoenix has been able to get away with this, for the most part. After Phoenix targeted investor-owned policies with a discriminatory cost of insurance increase in 2010, the New York Department of Financial Services told Phoenix it must rescind that increase. See Exhibit L, Letter from Michael Maffei, Assistant Deputy Superintendent and Chief, Life Bureau of State New York Insurance Department, to Kathleen A. McGah, Vice President and Counsel of Phoenix Life Insurance Co. (Sept. 6, 2011). Phoenix relented and rescinded the increase, but **only for** policyholders living in New York. That means policyholders in the rest of the United States continue to pay inflated premiums designed to force them to lapse their policies. California and Wisconsin recently stepped in to protect policyholders in their states, instructing Phoenix to rescind its rate increases there. See Exhibit M, The Phoenix Companies Form 8-K, Securities and Exchange Commission (Aug. 15, 2013). To

date, Phoenix has not done so. Phoenix is currently embroiled in litigation filed by a number of policyholders surrounding the same issue. *Id.* Just as alarming, upon sending out cost of insurance increase notices to policyholders, Phoenix has been unresponsive to customer inquiries regarding compliance with the terms of their policies. *See* Exhibit N, Letters from Diane Reynolds, Vice President of U.S. Bank Nat'l Ass'n, to Dave Jones, Ins. Commissioner of State of California (June 26, 2012).

C. The Impact: Destabilization of the Secondary Market

As the above discussion reveals, at least one insurer devised an impressive strategy to reap maximum rewards: issue as many high face-value policies as possible while turning a blind eye to potential abuses by their agents, and decide later, after collecting premiums for years, whether to contest the policies for lack of insurable interest. The strategy has proven brilliant. Policyholders have been held captive as efforts to receive assurances of their policies' validity go ignored (if not rebuffed). Exasperated by the situation, one set of policyholders brought suit requesting a declaration of their rights under their policies. *See* Exhibit J. In the meantime, until they receive such assurances, policyholders have no option but to continue making premium payments and simply hope their policies are not among those tagged for rescission. Commenting on the absurdity of it all, one federal judge poignantly inquired of an insurer's counsel, "Do you acknowledge that if your client has no intention of paying on those policies that you're not providing insurance and you are not providing any benefit to whoever holds that policy." Exhibit O, Transcript of Hearing, at 4-5, *PHL Variable Ins. v. ESQ QIF Trust*, No. 12-cv-319 (D. Del. Nov. 8, 2012). That's the point: By refusing to provide any *assurance*, insurance companies are not providing any *insurance*. Instead, they are simply holding policyholders' hostage.

This is exactly as the insurance companies like it: complete and total uncertainty. That's because "[t]he potential for invalidation decreases the value of the policy to the policyholder but increases the value to the insurer." Exhibit P, Jacob Loshin, Note, *Insurance Law's Hapless Busybody: A Case Against the Insurable Interest Requirement*, 117 Yale L.J. 474, 478 (2007). That is, with every challenge to the validity of a policy, those who purchase the policies on the secondary and tertiary markets are forced to incur substantial defense costs. And increased transaction costs depress the value of all policies because prospective investors, especially large ones, know they cannot possibly investigate the thousands of policies they purchase years after they were issued. After all, they diversify for a reason. And the prospect of having to litigate the validity of numerous policies imposes too many transaction costs and subjects policyholders to too great a risk. In turn, it depresses the value of the policies and thereby propels the market back towards the inefficient state where insurers had all of the power.

At last count, there was approximately \$35 billion in life insurance in force on the secondary market. See Exhibit Q, Oliver Suess et al., *Death Derivatives Emerge from Pension Risks of Living Too Long*, Bloomberg (May 16, 2011). This robust market creates competition that benefits seniors who want or need to monetize their policies. Unfortunately, with insurance companies employing all sorts of tactics to destabilize the secondary market, seniors will find themselves with few options to obtain fair market value for their investment.

III. PROPOSED SOLUTIONS

The impact on Florida’s senior population cannot be overstated. In a vibrant secondary market, they can get more—much more than they could in years past. One study calculated that an individual with a \$2 million life insurance policy can receive up to \$300,000 more for it on the secondary market than he would if he sold it back to the insurer. See Exhibit R, Sam Rosenfeld, *Life Settlements: Signposts to a Principal Asset Class*, Wharton Financial Institutions Center, Working Paper #09-20, at 24 (2009). With life expectancy rates increasing and health care costs skyrocketing, the ability to efficiently monetize life insurance investments has become a critically attractive option. And it will remain so as the Baby Boomers—“who tend to be characterized as ‘asset rich, cash poor’”—quickly approach retirement age. See *id.* at 6. For a state like Florida with a large senior population, it can avoid many headaches, including the prospect of increased public assistance, by helping its seniors to realize the true value of all their assets. But critical to doing so is implementing meaningful reforms that will curb the abusive practices described above. Set forth below are several specific reforms that have been considered by several other states, including Connecticut, Delaware, and Minnesota, which would allow Florida consumers to access a more efficient and effective life insurance market. See Exhibit S, Proposed Legislation in Connecticut, Delaware, and Minnesota.

A. Legislative Option #1: Clarify That Intent Is Irrelevant to Insurable Interest

The OIR and Florida Legislature should clarify that an insured’s intent is irrelevant to the issue of insurable interest. Florida law expressly permits the transferability of life insurance policies provided that at the time the agreement was entered into there was an insurable interest. See Fla. Stat. § 627.422, 627.404. Whether an insurable interest remains thereafter is irrelevant under Florida law. See Fla. Stat. § 627.404(1). Insurers have been able to cloud the issue and successfully create uncertainty in the law where none should exist. By doing so, they have chilled the market. To curb such baseless litigation and provide market stability, the OIR and Florida Legislature should make clear that intent is irrelevant to the insurable interest requirement under Florida law.

B. Legislative Option #2: Clarify That Insurable Interest Challenges Cannot Be Raised After the Contestability Period

The OIR and Florida Legislature should prohibit insurance companies from challenging policies outside the two-year contestability period. Like most states, Florida has a two-year period during which an insurer may contest the validity of a life insurance policy. See Fla. Stat. § 627.455. This period is intended to balance the insurers' rights with the insureds' by offering the insurer ample opportunity to uncover any misrepresentations during the life insurance application process while cutting off those rights after a particular amount of time so that the insured has peace of mind in knowing that he has a valid policy. As discussed above, insurers have worked around this rule by fixating on insurable interest. See, e.g., *Pruco Life Ins. Co. v. Brasner*, No. 10-80804, 2011 U.S. Dist. LEXIS 1598, at *21 (S.D. Fla. Jan. 7, 2011). Recently, however, the United States District Court for the Southern District of Florida concluded that the better rule is to only permit challenges to insurable interest within Florida's two-year contestability period. See *Pruco Life Ins. Co. v. US Bank*, No. 12-24441, 2013 U.S. Dist. LEXIS 118202, at *12 (S.D. Fla. Aug. 20, 2013). ("The public policy underlying the incontestability statute weighs in favor of barring an insurer's attempts to challenge a policy outside the statutory period, even when the insurer claims that the policy is void ab initio"). Though that ruling is a step in the right direction, the uncertainty that remains in Florida diminishes the value of life insurance policies and threatens to eliminate or significantly curtail the market. Clarifying that insurers are subject to Florida's two-year contestability period would provide greater certainty and, thus, more accurate valuations. In turn, Florida seniors would find a much more receptive and valuable market for their policies.

C. Legislative Option #3: Notices of Validity

The OIR and Florida Legislature should require insurance companies, upon inquiry, to provide notice of a policy's validity within 90 days. This requirement would dovetail nicely with enforcement of the contestability period by providing increased security in the marketplace. Rather than be permitted to rebuff good faith efforts to receive assurances of a policy's validity (which would allow for more accurate valuation), insurance companies should be required to offer a definitive response. For now, insurance companies are content offering no information and forcing their policyholders to continue making premium payments. Imposing a reasonable time limit by which insurance companies must respond to requests for a notice of validity would go a long way towards balancing the asymmetrical power dynamic that currently exists.

D. Legislative Option #4: Premium Return

The OIR and Florida Legislature should require that even when a life insurance policy is deemed invalid, the policyholder shall be entitled to the return of his premium payments. In Florida, as elsewhere, it is well settled that, when a party rescinds an agreement, she must place the opposing party in the position it occupied before the agreement was entered. *See Lang v. Horne*, 23 So. 2d 848, 853 (Fla. 1945). Despite this straightforward principle of law, some insurers have successfully convinced courts that, where a policy is unenforceable, putting the parties back in their original places is not enough; rather, the insurers should be entitled to the premiums paid under the policy. *See, e.g., PHL Variable Ins. Co.*, 2010 U.S. Dist. LEXIS 29501, at *12; *TTSI Irrevocable Trust*, 60 So. 3d at 1150–51.

Not only does such reasoning conflict with well-settled Florida law as set out in *Lang*, it creates one of the most perverse incentives imaginable. “If an insurance company could retain premiums while also obtaining rescission of a policy, it would have the undesirable effect of incentivizing insurance companies to bring rescission suits as late as possible, as they continue to collect premiums at no actual risk.” *Principal Life Ins. Co. v. Lawrence Rucker 2007 Ins. Trust*, 774 F. Supp. 2d 674, 681 (D. Del. 2011); *see also Wells Fargo Bank, N.A. v. Am. Nat’l Ins. Co.*, 2013 U.S. Dist. LEXIS 70650 (C.D. Cal. May 17, 2013) (requiring return of premiums on rescinded policy). That’s especially true when an insurance company knows well before it denies the relevant claim that it always intended do so. In such instances, the insurer is insisting upon the benefits (i.e., premiums) of a contract it claims is illegal, but providing nothing in return.

The hovering threat of premium retention has an exceptional chilling effect on the secondary market. Investor valuations must account for the possibility that they may end up doling out tens of thousands of dollars in unrecoverable premium payments. Thus, as the market tends to do, it will force consumers to compensate investors for that risk. Such compensation will inevitably take the form of lower policy values and thus deprive Florida’s seniors of the maximum benefit that they should receive for their policies on the secondary market.

E. Legislative Option #5: Adequate Cost of Insurance Increase Notice

The OIR and the Florida Legislature should vigorously monitor cost of insurance rates to prevent insurers from discriminatorily targeting investor-policyholders. As discussed above, in contravention of their policy terms, policyholders have been receiving cost of rate increases. Follow-up inquiries have been met with deaf ears. As a consequence of this silence, state governments have been forced to intervene after finding that such increases are unlawful. If investors on the secondary market must accept that any policy they purchase may be arbitrarily subject to premium increases, it decreases the worth of

these policies. Accordingly, like many other states, Florida should protect its seniors by scrupulously monitoring and investigating any suspicious cost of insurance rate increases.

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We appreciate this opportunity to share our thoughts regarding the secondary market with you. We would be happy to discuss these issues with you or anyone in your office.