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## THE LAW AND ECONOMICS OF VANISHING PREMIUM LIFE INSURANCE

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The life insurance industry has recently come under siege. In the mid-1980s, life insurance companies sold large volumes of universal life and other new forms of whole life insurance based on illustrations of future performance that showed premiums ending (or "vanishing") after five to ten years.<sup>1</sup> Today, ten years later, numerous policyholders are being told that they will have to pay premiums for a longer period of time than initially illustrated in order to keep these policies in force.<sup>2</sup> Vanishing premiums have not vanished.

The response to this has been a wave of class action suits challenging the insurance industry's sales practices.<sup>3</sup> Such suits have

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<sup>1</sup>During the 1980s, when interest rates rose into "double-digits," sales of vanishing premium life insurance policies soared, due to the interest-rate sensitive quality and other advantages of these policies. See generally Luigi Spadafora, *Vanishing Premium: A Viable Estate Planning Tool*, 215 N.Y. L.J. 9, 11 (Apr. 29, 1996) (discussing both the problems currently associated with vanishing premium plans and the benefits of such in estate planning); Steve Bailey, *Still Paying, Now Suing 'Vanishing Premiums' That Didn't Have Customers Upset, Insurers in Court*, BOSTON GLOBE, Oct. 8, 1995, at 91 (noting the popularity of vanishing premium plans among consumers and the litigation which has stemmed from such); Miles Benson, *Many Life Insurance Policyholders Get Ugly Surprise — Value Vanishes as Interest Rates Fail to Meet Hopes*, SEATTLE TIMES, July 5, 1993, at A3 (tracing the increasing sales of vanishing premium plans and noting the problems such plans have experienced).

<sup>2</sup>Spadafora, *supra* note 1, at 11 (noting that many "life insurance policies sold during the 1980s will not perform as [initially hoped] . . . because of changes in economic conditions during the late 1980s and early 1990s") (citations omitted). See also additional sources, *supra* note 1, for reference to this problem.

<sup>3</sup>See generally Spadafora, *supra* note 1, at 11 & nn.2-7 (referencing these suits). See also Bailey, *supra* note 1, at 91 (noting that the increase in vanishing premium litigation has given the insurance industry a "black eye" while also contributing to a 10% drop in sales and

been filed against virtually every major insurer, including New York Life, Prudential, Metropolitan, Transamerica, John Hancock, Great-West, Jackson National, and Crown Life.<sup>4</sup> Some of these cases have been settled for seemingly huge amounts while many others are still pending.<sup>5</sup> In addition, state insurance regulators have also launched a series of aggressive investigations into the alleged deceptive sales practices of life insurers, resulting in the levying of record fines.<sup>6</sup> Congress has jumped into the fray as well, holding hearings on the evils of the life insurance industry.<sup>7</sup> Reflecting the negative publicity generated by these lawsuits

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an increased popularity for mutual funds). Vanishing premium litigation has not remained within U.S. borders, and Canadian insurers have found themselves to be the target of similar class actions. See Susan Yellin, *Great-West Settles Lawsuit: Canadian Life Insurer Agrees to US \$30 Million Settlement in Class Action Suit Over Vanishing-Premium Policies*, FIN. POST, Apr. 9, 1996, at 5; Susan Yellin, *Sun Life Could Face Class Action: Filing of Ontario Lawsuit Over "Vanishing Premiums" Policies May Put Insurer Into Difficulties Similar to Those Faced in U.S.*, FIN. POST, Apr. 24, 1996, at 3.

<sup>4</sup>Spadafora, *supra* note 1, at 9, 11.

<sup>5</sup>Notably, the following settlements have occurred within the last year. Prudential Insurance Company recently settled a class action by agreeing to pay at least \$410 million to resolve customer complaints. The settlement could cost Prudential well over \$1 billion. *Prudential Settlement Over Sales Practices is Approved by Judge*, WALL ST. J., Mar. 11, 1997, at B9. Crown Life settled with a class of U.S. policyholders for \$27 million. Susan Yellin, *Crown Life Offers US \$27M to Settle Suit*, FIN. POST, Nov. 15, 1996, at 1. Crown Life was also sued by a Texas policyholder earlier in 1996, which resulted in an out-of-court settlement. Susan Yellin, *Crown Life Settles Texas Lawsuit: Ends Case That Started With US \$50M Award*, FIN. POST, May 8, 1996, at 8. In this suit, a Texas jury awarded the plaintiff \$50 million in damages, which the judge subsequently reduced by \$40 million upon deciding that the broker, who was also a plaintiff, did not have standing in the suit. *Id.* An \$8.2 million damage figure was then considered by the court; however, the parties settled for an undisclosed amount, with the judge now ordering a \$1.367 million payment to the broker. *Id.*

In addition, Great West recently settled a similar class action for \$30 million, and New York Life reached a settlement of \$65 million in a vanishing premium suit. Yellin, *supra*; *Chubb Sued Over Vanishing Premiums*, BEST'S REV.-LIFE/HEALTH INS. ED., Oct. 1, 1996, at 82. Finally, Phoenix Home settled a class action for \$100 million and Prudential, while fined \$35 million by regulators, has recently agreed to spend \$410 million to reimburse policyholders, causing estimates up to \$2 billion in costs for the company. *Phoenix Home Life Mutual Ins. Co.: 'Vanishing Premiums' Case is Settled at \$100 Million*, WALL ST. J., Aug. 14, 1996, at B4; Patricia Lamiell, *Insurers Trying to Repair Image*, NEW ORLEANS TIMES, Feb. 7, 1997, at C6.

<sup>6</sup>See, e.g., *Report of the Multi-State Life Insurance Task Force and Multi-State Market Conduct Examination of the Prudential Insurance Co. of America* (July 9, 1996) [hereinafter *Report of Multi-State Life Ins. Task Force*]. See also Susan Yellin, *'Vanishing Premiums' to Disappear Under Proposed U.S. Law*, FIN. POST, June 22, 1996, at 10 (discussing regulator's response to current vanishing premium litigation).

<sup>7</sup>See *Deceptive Practices in the Sale of Life Insurance: Hearings Before the Subcomm. on Commerce, Consumer Protection, and Competitiveness of the House Committee on Energy and Commerce*, 103d Cong., 2d Sess. (1994).

and regulatory investigations, an August 1995 cover story in *Money Magazine* listed vanishing premium life insurance as one of "the eight biggest rip-offs in America."<sup>8</sup>

Life insurance can be confusing. Even financially sophisticated consumers may lack a detailed understanding of the different types of insurance products. Against this backdrop, this article has three purposes. Part I explains the economic origins of vanishing premium policies and shows how, fundamentally, the problems that resulted have been due to economy-wide changes in interest rates. Part II surveys some of the very formidable legal barriers that plaintiffs, particularly those in class action suits, face in vanishing premium cases. These legal barriers suggest that plaintiffs would have a difficult time prevailing in vanishing premium cases if any are ever litigated to judgment. Furthermore, even if plaintiffs overcome these barriers, they still must prove damages. Part III demonstrates that when damages are calculated properly, the actual exposure faced by the insurance industry from these suits is far less than the relief typically sought.

## I. THE ECONOMICS OF THE VANISHING PREMIUM PROBLEM

Traditionally, life insurers sold two generic types of policies — whole life and term.<sup>9</sup> Term insurance provides coverage for a finite period, while whole life, by definition, provides coverage for the whole of the insured's life.<sup>10</sup> The premiums on most term policies increase with age, for the simple reason that older people are more likely to die. In contrast, the premiums on most whole life policies do not increase with age.<sup>11</sup> A consumer who buys whole life pays higher premiums in the

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<sup>8</sup>Shelly Branch et al., *The Eight Biggest Rip-Offs in America . . . and How You Can Avoid Being a Victim*, MONEY, Aug. 1995, at 143.

<sup>9</sup>See JOSEPH M. BELTH, LIFE INSURANCE: A CONSUMERS HANDBOOK 19 (2d ed. 1985) (discussing the features of "renewable term" and "straight life" insurance); KENNETH BLACK, JR. & HAROLD D. SKIPPER, JR., LIFE INSURANCE (12th ed. 1994) (discussing various types of insurance products); Steve Kurylo, *Choosing the Most Appropriate Insurance Policy and Company*, 23 EST. PLAN. 366 (1996) (examining numerous types of insurance policies, including term and whole life, and suggesting factors to be considered by the consumer when deciding what type of insurance should ultimately be purchased).

<sup>10</sup>See Kurylo, *supra* note 9, at 366 (noting that the primary difference between term and whole life insurance is the period of time for which the coverage lasts).

<sup>11</sup>Kurylo, *supra* note 9, at 367.

The distinguishing feature of a whole life policy is that both the death benefit and the premium are fixed when the policy is purchased. Generally, the annual premiums are determined based on the assumption that they will remain level and be paid until the insured's death . . . .

initial years of the policy than if he or she had purchased an equivalent amount of term insurance.<sup>12</sup> In return, the purchaser of whole life faces premiums in later years that are lower than the premiums on an equivalent amount of term.

Most traditional whole life policies are "participating" policies, meaning that the purchaser receives dividends.<sup>13</sup> The level of dividends on a traditional, participating whole life policy depends on three main factors: (1) the "cash value" accumulated within the policy, (2) the financial performance of the insurance company's investment portfolio, and (3) the mortality and administrative costs that the company has incurred. Cash value reflects the extent to which prior premium payments exceeded prior charges for insurance and administrative costs.<sup>14</sup> Although the cash value in a whole life policy is low in its initial years due to high front-end sales costs, it increases over time.<sup>15</sup> Premiums on most traditional whole life policies are designed so that if the insured lives to age 100, the guaranteed cash value in the policy at that point will equal the face value of the policy. The excess payments which generate cash value provide insurance companies with funds to invest. Historically, the assets of insurance companies were invested primarily in fixed-rate securities, such as government and corporate bonds, and real estate mortgages.<sup>16</sup> The income on these investments provides insurance companies with funds to pay dividends on traditional whole life policies.

Traditional whole life insurance policies worked reasonably well,

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*Id.* See also BLACK & SKIPPER, *supra* note 9, at 99 (noting that whole life premiums generally remain constant).

<sup>12</sup>See generally BLACK & SKIPPER, *supra* note 9, at 84 (stating that term premiums are typically lower than alternative types of insurance since the coverage period is limited).

<sup>13</sup>BELTH, *supra* note 9, at 21. Although the same terminology is employed, the life insurance dividend is different than those "dividends" received from shares of stock. *Id.* Rather, dividends, in the context of life insurance, are "sometimes considered to be a refund of an overcharge in the premium, a benefit payment provided for in the premium, a share in earnings of the insurance company, or a combination of these items." *Id.* See also BLACK & SKIPPER, *supra* note 9, at 100 for reference to the dividends aspect of whole life.

<sup>14</sup>Cash value is similarly defined as "the amount that the policy-owner would receive as a refund if he cancelled the coverage and surrendered the policy to the insurer." Kurylo, *supra* note 9, at 366.

<sup>15</sup>BELTH, *supra* note 9, at 23.

<sup>16</sup>Since 1917, life insurance companies in the United States have consistently invested over 70% of their assets in government securities, corporate bonds, and mortgages. In 1994, life insurance company assets were invested as follows:

- (1) 20.4% in government securities,
- (2) 40.7% in government bonds, and
- (3) 11.1% in mortgages.

AMERICAN COUNCIL OF LIFE INSURANCE, 1995 LIFE INSURANCE FACT BOOK UPDATE 42 (1995).

provided that interest rates remained relatively stable. But, when interest rates soared in the late 1970s and early 1980s, the economics of traditional whole life insurance policies turned unattractive. Whole life insurance can be characterized as pure insurance plus a savings or investment component.<sup>17</sup> Monies invested through a traditional whole life policy earned a rate of return based on the average interest rate of the predominately fixed-rate securities in the company's investment portfolio, which generally had interest rates that were much lower than the rates then available to consumers (especially after the introduction of money market accounts).<sup>18</sup>

The high interest rates of the late 1970s and early 1980s put pressure on companies offering whole life insurance. The market share of these companies declined as new customers increasingly decided to purchase term insurance rather than whole life and numerous existing whole life customers decided to convert from whole life to term. Surrendering existing whole life policies gave consumers access to the savings (i.e., cash value) that had accumulated within the policies.<sup>19</sup> These savings could then, in turn, be reinvested in alternative investments with higher returns. In addition, the high interest rates also gave holders of whole life an incentive to borrow against the cash value in their policies because most of these policies provided the insured with the option of borrowing at rates that were far below that of the market. The resulting "disintermediation"<sup>20</sup> was similar to, though not as severe as, the comparable phenomenon that affected banks and savings and loans prior to the repeal of interest rate ceilings on savings accounts.

The whole life industry responded to this change by introducing new types of policies, the most popular of which has been universal life.<sup>21</sup> Universal life and other forms of interest-sensitive whole life are identical to traditional whole life insurance in some respects. For instance, insurance protection is provided for the whole of the insured's life, provided that the minimum required premiums are paid. Premium

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<sup>17</sup>Kurylo, *supra* note 9, at 366.

<sup>18</sup>See generally BLACK & SKIPPER, *supra* note 9, at 121.

<sup>19</sup>The "lapse rate" is a statistic that the insurance industry uses to measure trends in policy surrenders. *Id.* at 313. The lapse rate equals the number of policies that lapsed because the policy was surrendered relative to the number of policies in-force. *Id.* Between 1974 and 1978, the lapse rate for all policies in the life insurance industry averaged 6.6%. As interest rates rose, the lapse rate increased. By 1982, the lapse rate had reached 10%. AMERICAN COUNCIL OF LIFE INSURANCE, *supra* note 16, at 30.

<sup>20</sup>BLACK & SKIPPER, *supra* note 9, at 121.

<sup>21</sup>For a discussion of the universal life policy, see generally BELTH, *supra* note 9, at 25-28; BLACK & SKIPPER, *supra* note 9, at 126-42; Kurylo, *supra* note 9, at 367-68.

payments in the initial years of a universal life policy similarly exceed insurance and administrative costs. As a result, the new policies, like traditional whole life, accumulate cash value, which is commonly referred to as the "accumulation fund".

The principal difference between interest-sensitive and traditional whole life is in the determination of the return on the savings component. Rather than paying dividends based on the interest and dividend income of the insurance company's historical investments, the new policies add interest to cash value based on current interest rates.<sup>22</sup> This innovation was welcomed by consumers.<sup>23</sup> Between 1981 and 1985, sales of the new forms of policies increased from three percent to forty-two percent of total life insurance sales in the United States.<sup>24</sup> Although most of this increase in market share was at the expense of traditional whole life,<sup>25</sup> the new forms of interest-sensitive insurance also drove the market share of term insurance from its peak of nineteen percent in 1981 back to the twelve percent share it had previously held in the mid-1970s, prior to the surge in interest rates.<sup>26</sup>

Universal life and the other new forms of whole life insurance were sold with a variety of premium payment plans. One very common payment plan was the so-called "vanishing premium" plan, which has currently become the subject of much litigation.<sup>27</sup> In a vanishing premium plan, the policyholder pays higher-than-normal premiums in the early years of the policy. By making higher payments in early years, a higher fraction of premium dollars is distributed into the policy's savings account (i.e., accumulation fund), allowing the cash value of the policy to accumulate faster. The goal of a vanishing premium plan is to set premiums at a level where, after a certain number of years, enough cash value has accumulated within the policy so that future administrative and

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<sup>22</sup>BLACK & SKIPPER, *supra* note 9, at 136-38.

<sup>23</sup>The new policies contained additional innovations. Policy statements were clearer about how much of each premium dollar went to cover current insurance and administrative costs and how much represented an addition to the accumulation fund. *See generally id.* at 124-30. The new policies, particularly universal life, were also highly flexible. *Id.* Within limits specified in the insurance contracts, policyholders could alter their schedule of premium payments and the amount of protection provided by the policy. *Id.*

<sup>24</sup>A.M. BEST, BEST'S INSOLVENCY STUDY, LIFE/HEALTH INSURERS, 1976-1991, exh. 2 (June 1992).

<sup>25</sup>*See generally* BLACK & SKIPPER, *supra* note 9, at 103 (noting that traditional whole life insurance lost "significant market share" to universal life during the high interest rate period).

<sup>26</sup>BEST, *supra* note 24.

<sup>27</sup>*See generally* sources cited *supra* notes 1, 3 & 5 for a commentary on this recent trend in insurance litigation.

insurance costs can be paid out of the accumulation fund, with no further out-of-pocket payments by the policyholder.<sup>28</sup> In the mid-1980s, when the new policies were marketed most aggressively, the assumption of most vanishing premium "illustrations" was that no further out-of-pocket premiums would be required after five or ten years.<sup>29</sup>

Vanishing premium plans have not worked out as initially contemplated. For many, vanishing premiums have not vanished. The primary cause of this problem has been low interest rates. Figure 1 plots rates on one-year Treasury bills between 1983<sup>30</sup> and 1995. Although rates rose to as high as twelve percent in the mid-1980s, the early 1990s reflected a low of three percent. These declining rates upset the economics of vanishing premium plans. With the economy-wide decline in interest rates, interest-credit rates<sup>31</sup> have also dropped and cash value has not grown as assumed in the initial illustrations. In many cases, cash value in vanishing premium plans has become insufficient to pay expected future insurance and administrative costs. As a result, many consumers who bought insurance on a vanishing-premium basis will soon be forced to make additional out-of-pocket premium payments or else have their insurance terminated or death benefits reduced.

Critics are now charging that vanishing premium life insurance was a fraud from its inception. The typical class action lawsuit alleges that the scheme began in the early 1980s when interest rates were at record

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<sup>28</sup>See generally BLACK & SKIPPER, *supra* note 9, at 112-13 for a discussion of the vanishing premium plan and its mechanics. The theory behind the vanishing premium plan can be explained as follows:

Vanishing premium is not a type of life insurance policy. Instead, it is an illustration based on certain internal financing mechanisms provided by a vanishing-premium option or rider to the basic life insurance policy. The vanishing-premium illustration is a projection or prediction of the number of out-of-pocket premium payments which must be made by the policyholder to keep his or her life insurance policy in force. The illustrations, however, are based on projections of certain outside economic factors which may or may not come true.

The point in time when the premium is said to have "vanished" as reflected in the illustration does not mean that the policyholder has a fully paid-up policy. Instead, what it means is that the policy is projected to become self-perpetuating — making future premium payments automatically when due by using policy dividends, accumulated cash values and other internal financing mechanisms.

Spadafora, *supra* note 1, at 11.

<sup>29</sup>See generally BLACK & SKIPPER, *supra* note 9, at 112-13.

<sup>30</sup>Vanishing premium plans were first significantly sold in 1983.

<sup>31</sup>Interest-credit rates are the rates at which interest is credited to cash value.

highs.<sup>32</sup> Although insurers allegedly "knew" that these interest rate levels were aberrational and certain to decline, they nevertheless engaged in a deliberate scheme to mislead the public through false and misleading uniform policy illustrations based on these current, artificially high interest rates.<sup>33</sup> Prospective policyholders allegedly were induced to purchase by false assurances that premium payments would "vanish" after the initial years of the policies.<sup>34</sup> In some cases, policyholders also alleged that they were fraudulently induced to use all or part of the cash values of other policies to finance premium payments for new vanishing premium policies based on the false expectation that the new policy would offer increased benefits with no additional outlays.<sup>35</sup>

Plaintiffs in the aforementioned cases demand the "benefit" of their alleged "bargain" as relief. While plaintiffs typically do not articulate the precise nature of their damage claim, a simple version of the "benefit of the bargain" measure of damages would have two components. First, defendants would have to compensate policyholders for any premium payments made after the date on which the company represented that out-of-pocket premiums would vanish. Second, with respect to future periods after the date when out-of-pocket premiums were supposed to cease, defendants would have to make insurance available free of charge or provide money damages of equivalent value. The cost to defendants, particularly of this second component, is likely to be staggering. Due to the potentially astronomical nature of such damage claims, these suits are widely perceived to pose a significant threat to the life insurance industry.

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<sup>32</sup>See generally James F. Jorden & Ann Y. Black, *Market Conduct Class Action Litigation: Developing Themes*, SB28 ALI-ABA 255, 259-62 (Nov. 1996) (outlining the myriad of arguments currently asserted by plaintiffs in vanishing premium cases).

<sup>33</sup>See, e.g., *Chain v. General Am. Life Ins. Co.*, No. 4:96CV-96-B-B, 1996 WL 671394, at \*1 (N.D. Miss. Sept. 30, 1996) (mem. op.) (class action suit where plaintiff asserted that vanishing premium illustrations were fraudulent because they were based on "abnormally high interest rates" and "the interest rate factors were not supported by current earnings"). Vanishing premium litigation claims generally takes its form in a variety of causes of action, commonly including breach of contract, fraud, deceptive sales practices, and/or negligent misrepresentation. *Id.*

<sup>34</sup>See, e.g., *id.* (asserting that the insurance company "induced" the plaintiff to purchase policies by showing him illustrations which reflected that such policies would be fully paid off after paying premiums for two years).

<sup>35</sup>See, e.g., *In re Prudential Ins. Co. of Am. Sales Practices Litig.*, [1996-1997 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶ 99,237, at 95,287, 95,290 (D.N.J. May 10, 1996) (class action suit claiming fraud where insurance company allegedly targeted "unsophisticated" policyholders with existing, high cash value insurance and convinced them to purchase new policies by representing that such purchase could be paid for by income from their already owned policies).

## II. SOME DIFFICULT LEGAL ISSUES

The allegations made in vanishing premium cases are not based on the written insurance contracts signed by policyholders. These contracts nowhere guarantee that premiums must be paid for a fixed number of years regardless of future interest rate movements nor do they guarantee the future rates at which interest will be credited to cash value. Rather, the written contracts expressly provide that the level of future interest-credit rates are not guaranteed and depend on the discretion of the company in light of future economic events. Insurance contracts also uniformly provide that the written provisions of the contract constitute the entire agreement between the parties, disallowing any modification of these provisions, except in writing by certain high level officers of the company.<sup>36</sup> In addition, state laws frequently provide policyholders with a "free look period" during which they can back out of the contract for a designated period of time for any reason even after they have signed. In short, the key allegation of vanishing premium litigation — that policyholders were misled into believing that initial premium payments would generate enough cash value to offset future insurance and administrative costs after a fixed point of time — is directly contradicted by the written contracts themselves.

Nevertheless, class action complaints filed against most major insurers allege that *every* vanishing premium policyholder of *every* company was misled about what they were purchasing, notwithstanding this contractual language to the contrary. In the one significant opinion issued to date, Judge Alfred Wolin found "much of the complaint" filed against Prudential "to be deficient," but nevertheless allowed the bulk of the claims to go forward "despite considerable doubt as to their ultimate merits."<sup>37</sup> Aside from this opinion, however, no court has yet ruled on the important issue of whether any of the vanishing premium cases can legitimately proceed as nationwide class actions.

In the following section, we discuss some of the difficult legal issues raised by vanishing premium class action litigation. Our treatment is necessarily general because detailed analysis in particular cases requires knowledge of the facts, and legal theories and defenses advanced as well as relevant state law. Yet, as discussed below, this diversity, itself, is an

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<sup>36</sup>See generally BLACK & SKIPPER, *supra* note 9, at 200 (discussing the various provisions inherent to life insurance contracts, including the "entire contract clause").

<sup>37</sup>*Prudential Ins. Co. of Am. Sales Practices Litig.*, [1996-1997 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶ 99,237, at 95,289.

important point which strongly suggests that whatever the ultimate legal validity of these cases may be, they should not proceed as class actions.

### A. *Was There a Breach of Contract?*

Plaintiffs in vanishing premium cases have strong incentives to characterize the insurance agents' oral representations as a contract which was breached when premiums did not "vanish."<sup>38</sup> The contract paradigm has two principal advantages from the plaintiff's perspective. First, it eliminates the need to prove scienter because breach of contract is a strict liability offense.<sup>39</sup> Second, and perhaps even more importantly, the traditional damage remedy in breach of contract cases is the expectation measure which, with some limitations, awards the plaintiff the benefit of the bargain.<sup>40</sup> Reliance damages, by contrast, which are the remedy typically awarded in tort cases, are based on the harm suffered by the plaintiff as a result of the alleged misrepresentation.<sup>41</sup> These damages, as demonstrated below, will frequently be zero in vanishing premium cases or, at a minimum, a small fraction of expectation damages.

Plaintiffs in vanishing premium cases face formidable obstacles in claiming breach of contract. If a court enforces the integration clause of the written contract and excludes all evidence of oral communications under the parole evidence rule,<sup>42</sup> the basis for the breach of contract claim disappears.<sup>43</sup> Indeed, there is much to recommend such an approach. Integration clauses in written contracts, like the parole evidence rule,

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<sup>38</sup>Jorden & Black, *supra* note 32, at 262 (noting that vanishing premium claims allege that illustrations and agent's statements were part of the insurance contract which was then breached when premiums did not vanish according to such); *e.g.*, *Chain*, 1996 WL 671394, at \*1 (mem. op.) (alleging breach of contract based on policy illustrations).

<sup>39</sup>See E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 9.1, at 677 (1990) (noting that the duties imposed by contract are "absolute").

<sup>40</sup>*Id.* § 12.8, at 871. In other words, the plaintiff receives the value of what he or she would have had if the contract were performed. *Id.*

<sup>41</sup>*Id.* § 12.16, at 928. The possibility of punitive damages in this context is ignored because such are generally unavailable in contract cases.

<sup>42</sup>The parole evidence rule seeks to preserve the integrity of written agreements by refusing to permit contracting parties to attempt to alter their bargain through the use of contemporaneous oral declarations. BLACK'S LAW DICTIONARY 117 (6th ed. 1990). *See, e.g.*, *Kiehl v. Jackson Nat'l Life Ins. Co.*, No. C-95-2645FMS, 1996 U.S. Dist. LEXIS 6966, at \*1-3 (N.D. Cal. Apr. 30, 1988) (arguing that integration clause of vanishing premium policy cannot be modified by "alleged representations" of insurance agent).

<sup>43</sup>*See, e.g.*, *Continental Life & Accident Co. v. Songer*, 603 P.2d 921, 928 (Ariz. Ct. App. 1979) (barring oral representations under the parole evidence rule where unambiguous express contract language existed).

generally facilitate certainty in commercial dealings.<sup>44</sup> By focusing exclusively on the written contract, where the terms are explicitly known, the probability of error is greatly reduced. There is no need to reconstruct long past oral communications from unreliable memories of self-interested witnesses. Questions regarding what was said in a meeting many years earlier, whether the discussions constituted a contract or just preliminary negotiations, and the terms of any offer or acceptance are avoided altogether if evidence of oral communications is barred.

Moreover, focusing on the provisions of the written contract avoids the problem of awarding plaintiffs an unearned windfall under the expectation measure of damages, a prospect which, itself, enhances the unreliability of testimony about past events. The written vanishing premium life insurance contract places the risk of future interest rate changes on the purchaser. Plaintiffs seek to reduce this risk allocation by claiming that they were assured that premiums would only be owed for a fixed number of years, regardless of future interest rates. However, the insurance company will not bear this risk for nothing, and the level of premiums charged to purchasers did not reflect this risk. In other words, if the insurance company in fact sold insurance policies where it bore the risk of future investment performance, the level of premiums would have been significantly higher than what policyholders paid. Thus, plaintiffs in vanishing premium litigation are not only attempting to avoid the consequences of declining interest rates, a risk they expressly assumed under the written contract, but are also attempting to enforce an alleged oral contract with terms more favorable to them than available anywhere in the marketplace. Legal rules should be employed to discourage plaintiffs from seeking such unearned windfalls.

Unfortunately, however, judicial developments in interpreting insurance contracts make the issue less than completely clear. Courts traditionally have construed ambiguous terms in insurance contracts against the insurance company, reasoning that the company should bear this burden as the more sophisticated party responsible for drafting the contract.<sup>45</sup> As a variant on this principle, courts sometimes bind sellers

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<sup>44</sup>FARNSWORTH, *supra* note 39, § 7.2, at 469.

<sup>45</sup>*See, e.g.,* Houghton v. American Guaranty Life Ins. Co., 692 F.2d 289, 293 (3d Cir. 1982) (holding that ambiguous language in health insurance policy was required to be interpreted against the insurer); Collister v. Nationwide Life Ins. Corp., 388 A.2d 1346, 1353 (Pa. 1978), *cert. denied*, 439 U.S. 1089 (1979) (stating that temporary insurance coverage is subject to the same rules of interpretation as other insurance contracts; therefore, ambiguities in written words contained in such will be liberally construed in favor of insured and against insurer); Blue Anchor Overall Co. v. Pennsylvania Lumbermens Mut. Ins. Co., 123 A.2d 413, 415 (Pa. 1956) (interpreting ambiguous clause in fire policy in favor of the insured).

of insurance based on the "reasonable expectations" of the buyer, regardless of whether such expectations are based on the language of the contract.<sup>46</sup> For example, some courts have required insurers to provide immediate coverage from the time an agent accepts a premium payment, even though the signed agreement provides the exact opposite.<sup>47</sup> These courts have reasoned that allowing relief based on the "reasonable expectations" doctrine is necessary in cases where the policy, itself, is so confusing that the scope of coverage cannot be determined by the reasonable policyholder.<sup>48</sup> Since this ambiguity is the fault of the seller, it would be unconscionable to allow the insurer to escape obligation once it accepted payment of a premium.<sup>49</sup> Other courts, however, have refused to go this far, stressing that the "reasonable expectation" doctrine is not a license to rewrite insurance contracts.<sup>50</sup> Accordingly, these courts will only apply the doctrine where there is a genuine ambiguity in the policy language.<sup>51</sup>

Thus far, no court has ruled on the applicability and scope of the "reasonable expectations" doctrine in the vanishing premium context. At a minimum, a plaintiff would have to show that the written policy was hopelessly ambiguous and a "reasonable" policyholder would expect to

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<sup>46</sup>*See, e.g., Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1041 (D.C. Cir. 1981) (expressing need to examine plaintiff's reasonable expectations when purchasing insurance policies); *Dibble v. Security of Am. Life Ins. Co.*, 590 A.2d 352, 354 (Pa. Super. Ct. 1991) (holding that insured could have reasonably believed that insurance policy became effective when insured paid first premium); *Collister*, 388 A.2d at 1354 (examining reasonable expectation of insured, despite unambiguous language in the policy).

<sup>47</sup>*See, e.g., Langer v. Monarch Life Ins. Co.*, 966 F.2d 786, 798 (3d Cir. 1992) (stating that insured's subjective reasonable expectation as to coverage after payment of premium was a jury question); *Services Holding Co. v. Transamerica Occidental Life Ins. Co.*, 883 P.2d 435, 442 (Ariz. Ct. App. 1994) (holding that insurers' alleged oral representations gave insured reasonable expectation of coverage despite unambiguous terms to the contrary in the application); *Allen v. Metropolitan Life Ins. Co.*, 208 A.2d 638, 642 (N.J. 1965) (holding that payment of annual premium could be construed to grant coverage).

<sup>48</sup>*See, e.g., Services Holding Co.*, 883 P.2d at 442; *Collister*, 388 A.2d at 1353.

<sup>49</sup>*See, e.g., Smith v. Westland Life Ins. Co.*, 539 P.2d 433, 439 (Cal. 1975) (holding that temporary insurance is not terminated until insurer has actually rejected application and refunded premium).

<sup>50</sup>*See, e.g., Thomas v. Thomas*, 824 P.2d 971, 977 (Kan. 1992) (quoting *Tripp v. Reliable Life Ins. Co.*, 499 P.2d 1155, 1161 (Kan. 1972)) (holding that insurance policy was not issued when receipt clearly and unequivocally stated that application would be considered denied if not issued to applicant within a specific time period); *McAllister v. Millville Mutual Ins. Co.*, 640 A.2d 1283, 1288 (Pa. Super. Ct. 1994) (stating that "while reasonable expectations of the insured are the focal points in interpreting the contract language of insurance policies, an insured may not complain that his or her reasonable expectations were frustrated by policy limitations which are clear and unambiguous") (citations omitted).

<sup>51</sup>*Thomas*, 824 P.2d at 977; *McAllister*, 640 A.2d at 1288.

pay premiums for a fixed number of years. This will be difficult. Those courts that have invoked the "reasonable expectations" doctrine to resolve coverage disputes against insurers have significantly relied on the unconscionability of the seller who receives premiums but provides no insurance.<sup>52</sup> No such unconscionability problem exists, however, in the vanishing premium context. Policyholders who pay premiums are not told they have no insurance. The insurer in the vanishing premium context does not have a costless option whether or not to insure after receipt of premium payments. In other words, there is no issue regarding the existence of insurance coverage at the time the contract is signed in vanishing premium cases; rather, the issue is how much insurance will cost in the future given future interest rate movements. Moreover, since interest rates can move in either direction, the ultimate cost of insurance to policyholders can be either more or less than the parties initially assumed. The fact that interest rates have declined in recent years in no way makes the initial deal unfair or unconscionable.

At the very least, a court should be extremely reluctant to award expectation or benefit of the bargain damages in the vanishing premium context. If a court feels compelled to allow extrinsic evidence to prove an oral contract or a policyholder's "reasonable expectations," damages should be limited to the plaintiff's reliance loss, if any.<sup>53</sup> Such an award compensates plaintiffs for any out-of-pocket loss resulting from the purchase of vanishing premium insurance, while avoiding the windfall that would result if plaintiffs could obtain a better deal through the judicial process than in the marketplace.

### B. *Was There a Misrepresentation?*

Plaintiffs in vanishing premium litigation have routinely alleged fraud and negligent misrepresentation in addition to breach of contract.<sup>54</sup> It is far from obvious, however, whether plaintiffs have provided any factual basis for these alternative theories of liability. While the numerous complaints that have been filed are replete with conclusory allegations of wrongdoing, the exact specifics of what defendants or their agents are alleged to have falsely represented are much harder to find.

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<sup>52</sup>See generally *supra* notes 46-47 for reference to such cases.

<sup>53</sup>See, e.g., *Service Iron Foundry, Inc. v. M.A. Bell Co.*, 588 P.2d 463, 476 (Kan. 1978) (refusing to award "expectation damages" in a breach of warranty case so that the plaintiff would not receive an undeserved windfall).

<sup>54</sup>E.g., *Chain v. General Am. Life Ins. Co.*, No. 4:96CV-96-B-B, 1996 WL 671394 (N.D. Miss. Sept. 30, 1996) (mem. op.); *Kiehl*, 1996 U.S. Dist. LEXIS 6966, at \*1 (vanishing premium case alleging fraud and negligent misrepresentations).

At the outset, it is again worth emphasizing that plaintiffs typically do not allege that any provision of the written insurance contract is false. Rather, plaintiffs generally claim that the falsity occurs in some combination of written sales materials and oral statements by insurance agents.<sup>55</sup> But where? The most logical candidate is the interest rate assumptions used by agents when making sales presentations. Plaintiffs routinely allege that defendants sold vanishing premium policies at a time when interest rates were at historic highs "knowing" that rates would surely fall in the future.<sup>56</sup> This claim is ludicrous on its face.

First, strictly speaking, use of a given interest rate assumption in projections is not "false." It is more accurate to describe the projections showing the need for a fixed number of future premium payments as accurate but conditioned on the assumed interest rates. More fundamentally, the probable level of future interest rates is not inside information that the insurer or its agents have any special ability to forecast. In fact, the consensus of market participants regarding the relationship between current and future interest rate levels is available to everyone at all times from the term structure.<sup>57</sup> Plaintiffs' claim that defendants "knew" current rates were abnormally high in the early and mid-1980s and certain to fall implies that there was an inverted yield curve during this entire period where long-term rates were lower than short-term rates. While this can occur, it is very rare. Rates on twenty-year government bonds, for example, are almost always higher than on one-year Treasury bills. Figure 2 plots the average yield curves for the early 1980s, the late 1980s and the early 1990s. In each period, long-term rates were higher than short-term rates. In no period was there an indication from the yield curve that future interest rates would be significantly lower than current rates.

Perhaps this is not a fair reading of plaintiffs' complaints. The complaints in their entirety focus less on specific misrepresentations of fact than on how insurers and their agents deliberately created a false impression by not revealing certain negative information.<sup>58</sup> The complaints allege, for example, that insurers and their agents failed to

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<sup>55</sup>*E.g.*, *Chain*, No. 4:96CV-96-B-B, 1996 WL 671394, at \*1 (alleging that illustrations, letters, and premium notices as well as insurance agent's assurances induced the plaintiff into purchasing vanishing premium plan).

<sup>56</sup>*See generally* *Jorden & Black*, *supra* note 32, at 259 (stating that plaintiffs' accusations include, among many, that the defendant insurers "knew or should have known" that premiums would not vanish according to their illustrations if interest rates fell).

<sup>57</sup>Term structure refers to the comparison of short- and long-term rates.

<sup>58</sup>*See id.* (listing the various nondisclosure claims which have been currently asserted as well as new allegations that vanishing premiums violate federal securities laws).

disclose information, such as, the high commissions paid to agents when policyholders used cash values of existing policies to finance new purchases of vanishing premium insurance or the consequences of lower interest rates in the future.<sup>59</sup> Relatedly, the complaints further allege that the agents failed to provide policyholders with sales illustrations showing the additional period of time that premiums would have to be paid if interest-credit rates were lowered.<sup>60</sup>

There is undoubtedly some truth to these claims. Insurance is notoriously confusing and many policyholders who do not read their policies may have only a limited understanding of what they purchase. Moreover, salesmen are typically motivated by commissions and have strong incentives to convince prospective policyholders to purchase insurance and replace existing policies with new policies.<sup>61</sup> To sell most effectively, salesmen emphasize, often exaggerating, the positive aspects of the policies they are selling while minimizing the negatives. Puffery is quite common.

Nevertheless, it is doubtful whether any of the above conduct should be actionable. The law has always distinguished between false statements, particularly those made intentionally, and overly optimistic statements which create a misleading impression.<sup>62</sup> In fact, the distinction between making false statements and creating false beliefs is fundamental to our legal system.

The reasons for this different treatment are clear. Intentional misrepresentations of fact or fraud is an intentional tort with no social value.<sup>63</sup> Such misrepresentations should be deterred provided that they can be identified at a relatively low cost and distinguished from, for

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<sup>59</sup>*Id.* at 259-60.

<sup>60</sup>*See id.* at 259. Much of the present litigation surrounding vanishing premiums stems from the illustrations shown to consumers. *See generally* Damato & Scism, *supra* note 1, at C1. Although these illustrations projected vanishing premiums, such premiums were not guaranteed and many purchasers were unaware that these results rested on the present, high interest rates. *Id.*

<sup>61</sup>*See* BELTH, *supra* note 9, at 130-33 (discussing insurance agents financial incentive to sell new policies). *See also* Benson, *supra* note 1, at A3 (noting that the increased sale of vanishing premium plans resulted in increasingly high profits and commissions for agents and insurers).

<sup>62</sup>For an extensive discussion of this point, see Richard Craswell, *Interpreting Deceptive Advertising*, 65 B.U.L. REV. 658 (1985) (discussing deception in advertising and its effects on consumers). "Few advertisements contain explicit false statements; more commonly, the advertisement is said to imply a false claim. The political and legal controversies have therefore focused on the rules used to interpret ads under the anti-deception laws." *Id.* at 659.

<sup>63</sup>*See generally* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 107, at 741-42 (5th ed. 1984).

example, statements which are accurate when made but later turn out to be false due to subsequent events. The legal prohibition against fraud, enforced by stiff damage penalties, such as punitive damages, has this effect. Consumers lose nothing of value if sellers are prohibited from engaging in fraud.

Different considerations apply, however, when sellers are merely overly optimistic, thus creating the risk that some consumers will have a false impression about what they are purchasing. Glowing sales pitches, unlike intentional misrepresentations of fact, do communicate information to consumers. Learning about the positive characteristics of a product is beneficial to consumers even if negative information is suppressed.

Finally, it is important not to exaggerate the extent to which consumers will be misled by puffing. For example, consumers understand to varying degrees that insurance salesmen work on commissions and are trying to sell insurance. Exuberant sales pitches will be discounted accordingly. Similarly, many consumers will understand, again with different degrees of sophistication, that a relationship exists between future interest rate levels and their future premium obligations. These policyholders will still be disappointed if interest rates fall in the future, causing their premium obligations to increase; however, there is a big difference between regret about entering into a risky deal that did not turn out as well as expected and being defrauded from the inception of that deal.

The critical point is that there is no reason to be confident that legal intervention to deter puffing will make consumers better off. The legal prohibition against fraud is clearly beneficial because consumers are both protected from false information and denied no valuable information. Yet, unlike fraud, the effect of legal intervention in puffery is completely ambiguous. Consumers who would otherwise be misled may benefit from a prohibition on puffing. But assume, for example, that insurers respond to the spate of lawsuits and regulatory investigations regarding vanishing premiums by discontinuing the product. As a result, consumers who would have benefitted from purchase will be denied the opportunity. Alternatively, insurers may decide to minimize their liability by eliminating all oral communications, solely providing policyholders with pre-approved written materials. The resulting regimentation would preclude informal communication between buyers and sellers, denying consumers valuable information.

At first glance, it appears that this detriment to consumers could be avoided if insurers responded to the threat of legal liability by providing more disclosure. For example, insurers could provide conspicuous warnings which alert consumers that they should not purchase the product

unless they are prepared to pay more if interest rates decline in the future. These warnings could be accompanied by additional schedules depicting how future premium obligations might be affected by future changes in interest rates. Although less obvious, this idea presents the same trade-offs to consumers as other forms of legal intervention. Some consumers will still be confused, perhaps even more so than before. Depending on the nature of the warning and the amount of additional disclosure, consumers may either think that there is something wrong with the product or will be simply unwilling to spend the time and effort sifting through the now more voluminous materials. It is always important to avoid the mistake of concluding that because some information is good, more is necessarily better.

Moreover, providing warnings and/or additional disclosure to consumers offers little protection to insurers if policyholders can still later claim that sales agents told them something different than what the written materials provided. If accurate written disclosure were sufficient, insurers would face no liability in the first place. The prospect of continuing liability will give insurers an incentive to eliminate oral communications with policyholders, resulting in a detriment to consumers who would have benefitted from informal interaction. Since legal regulation of puffery may make consumers worse off, courts should be extremely reluctant to expand the definition of fraud beyond deliberate misrepresentations of fact.

### C. *Did Defendants Act with Scienter?*

A successful claim of fraud requires more than a misrepresentation. The defendant must also act with scienter or an intent to defraud.<sup>64</sup> The scienter requirement poses an additional obstacle to recovery.

Substantial overlap exists between the scienter and misrepresentation issues. The fact that projections turn out to be incorrect due to a subsequent change in interest rates does not mean that the projections were false when made nor does it mean that there was any

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<sup>64</sup>*E.g.*, *Carlson v. Arnot-Ogden Mem'l Hosp.*, 918 F.2d 411, 416-17 (3d Cir. 1990) (holding that "[i]n order to sustain a cause of action for fraud, [the plaintiff] . . . must prove, *inter alia*, that the [defendant's] . . . representatives intended to deceive him when they made misrepresentations . . . *i.e.*, that they knew that their statements were false"). In *Carlson*, the plaintiff was erroneously informed by the defendant's representatives that he was qualified for a position of employment offered to him. *Id.* at 412. Although the plaintiff relied on this misrepresentation to his detriment, *id.* at 413 n.1, the court dismissed the plaintiff's fraud claim because he "merely argue[d] that [the defendant's representatives] . . . *should have known* that he would be unable [to satisfy the requirements for the position offered]." *Id.* at 417.

intent to mislead. The scienter requirement cannot be satisfied by showing that projections used in sales materials turned out to be overly optimistic.

It is also important to emphasize that the intent to sell, which insurers and their agents clearly have, is not the same as an intent to defraud. Similarly, an incentive to sell, created by commissions, cannot be equated with an intent to defraud. Most actors in the economy, including lawyers, doctors, and other professionals, derive a direct economic benefit from marketing their goods and services. This economic incentive, which in turn motivates producers to provide what consumers want, is more accurately characterized as fundamental to a free market economy rather than as proof of an intent to defraud.

*D. Did Plaintiffs Reasonably Rely  
on Any Alleged Misrepresentation?*

A successful claim in vanishing premium cases also requires proof that the plaintiffs reasonably relied on the alleged misrepresentation. This inquiry actually involves two distinct questions: (1) did plaintiffs rely on the alleged misrepresentations; and (2) if so, was this reliance reasonable. Both questions present difficult issues.

Whether plaintiffs in fact relied on a misrepresentation obviously depends on the existence of such misrepresentation. As discussed above, this, itself, poses a significant problem. For present purposes, assume that a court concludes that the use of optimistic projections, based on the then high current interest rates, was a misrepresentation. Would the plaintiff have behaved differently had he or she been given multiple projections based on different interest rate and dividend level projections? This is far from obvious. Plaintiffs have an incentive to claim they would have behaved differently once interest rates decline and it becomes clear that the deal did not work out as well as they had hoped. This regret, however, is irrelevant. The critical inquiry focuses on what a policyholder would have done with additional information at the time of sale, prior to knowing the future direction of interest rates.

If a plaintiff can credibly establish reliance even when the issue is properly framed, he or she still must show that this reliance was reasonable.<sup>65</sup> A strong argument can be made that reliance on oral

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<sup>65</sup>See *Associates in Adolescent Psychiatry, S.C. v. Home Life Ins. Co.*, 941 F.2d 561, 570 (7th Cir. 1991), *cert. denied*, 502 U.S. 1099 (1992) (holding that "[f]raud occurs only when a person of ordinary prudence and comprehension would rely on the misrepresentations"). As noted in the recent *Prudential* case, the Third Circuit considers five primary factors to

misrepresentations made by sales agents, which are directly contradicted by the signed written contracts, is unreasonable as a matter of law, particularly because such contracts typically state expressly that agents have no authority to modify the written agreement.<sup>66</sup> Such an approach is analogous to the application of the parole evidence rule, in that it encourages consumers to read what they sign,<sup>67</sup> avoids uncertainty and unnecessary litigation, and eliminates the incentive of plaintiffs to equate disappointing outcomes with being misled from the inception.<sup>68</sup> As Judge Easterbrook has stated: "Documents that unambiguously cover a point control over remembered (or misremembered, or invented) oral statements. . . . We agree . . . that no jury could find that a reasonable investor would be misled by the statements . . . when the truth was under his nose in black and white (many times over)."<sup>69</sup> Under this approach, if the signed written contract is clear, the matter ends and there is no need for further factual investigation.

Unfortunately, many jurisdictions do not apply a per se approach for assessing reasonable reliance claims; rather, they utilize a multi-factor test.<sup>70</sup> The relevant factors generally considered include: the existence

determine whether reliance was reasonable. *Prudential Ins. Co. of Am. Sales Practices Litig.*, [1996-1997 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶ 99,237, at 95,306. These factors include: "(1) plaintiffs' sophistication; (2) whether long-standing business or personal relationships among the parties existed; (3) access to the relevant information; (4) whether a fiduciary relationship between the parties existed; and (5) plaintiffs' opportunity to detect the alleged fraud." *Id.* at \*25 (citing *Kline v. First W. Gov't Sec., Inc.*, 24 F.3d 480, 488 (3d Cir.), cert. denied, 115 S. Ct. 613 (1994)).

<sup>66</sup>See *Prudential Ins. Co. of Am. Sales Practices Litig.*, [1996-1997 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶ 99,237, at 95,305-06 (contending that plaintiffs could not have "reasonably relied" where written documents expressly contradict alleged oral misrepresentations). In order to defeat a reasonable reliance claim, "[w]ritten contradictions of alleged oral misstatements must be express and direct." *Id.* at 95,306. Although written contradictions meeting the "express and direct" standard will not per se invalidate a claim of reasonable reliance, courts give such proof extreme consideration. *Id.*

<sup>67</sup>*Id.* at 95,306 (noting that a plaintiff's failure to read relevant documents is an "unavailing" excuse in fraud claims).

<sup>68</sup>See generally *id.*

A seller who fully discloses all material information in writing should be secure in the knowledge that it has done what the law requires . . . . Otherwise even the most careful seller is at risk, for it is easy to claim: "Despite what the written documents say, one of your agents told me something else." If such a claim of oral inconsistency were enough, sellers' risk would be greatly enlarged. All buyers would have to pay a risk premium to cover this extra cost of doing business.

*Id.* (quoting *Acme Propane, Inc. v. Tenexco, Inc.*, 844 F.2d 1317, 1322 (7th Cir. 1988)).

<sup>69</sup>*Associates in Adolescent Psychiatry*, 941 F.2d at 571.

<sup>70</sup>See *supra* note 65 and case cited within for a discussion of the five prong reasonable

of a fiduciary relationship; the plaintiff's opportunity to detect the alleged fraud; the plaintiff's sophistication; the existence of a long-term course of dealing; and access to relevant information.<sup>71</sup> Use of such multi-factor tests creates the real possibility that plaintiffs will be able to pursue misrepresentation claims despite clear, written disclosure to the contrary.

### E. *Is National Class Action Certification Appropriate?*

Recently, several important court decisions have dramatically restricted the use of national class actions in mass tort cases.<sup>72</sup> These cases have ruled that national class actions should not be certified where: (1) different state laws apply to claims brought by different plaintiffs;<sup>73</sup> (2) the claims present diverse factual issues that are specific to individual

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reliance test employed by the Third Circuit. *See also* *Zobrist v. Coal-X, Inc.*, 708 F.2d 1511, 1516 (10th Cir. 1983) (setting forth an eight-prong test for determining reasonable reliance).

<sup>71</sup>*See Kline*, 24 F.3d at 488. *See also Zobrist*, 708 F.2d at 1516. The Tenth Circuit considers the following eight factors to decide whether the plaintiff reasonably relied on the defendant's misrepresentation:

- (1) the sophistication and expertise of the plaintiff in financial and securities matters;
- (2) the existence of longstanding business or personal relationships;
- (3) access to the relevant information;
- (4) the existence of a fiduciary relationship;
- (5) concealment of the fraud;
- (6) the opportunity to detect the fraud;
- (7) whether the plaintiff initiated the stock transaction or sought to expatiate the transaction; and
- (8) the generality or specificity of the misrepresentations.

*Id.*

<sup>72</sup>*See, e.g.,* *Castano v. American Tobacco Co.*, 84 F.3d 734, 737 (5th Cir. 1996) (decertifying a class action suit against tobacco companies which was brought by a class of "all nicotine-dependent persons in the United States"); *In re American Med. Sys.*, 75 F.3d 1069, 1074 (6th Cir. 1996) (granting writ of mandamus directing decertification of a products liability class action); *In re Rhone-Poulenc Rorer Inc.*, 51 F.3d 1293, 1294, 1304 (7th Cir.), *cert. denied*, 116 S. Ct. 184 (1995) (granting writ of mandamus directing decertification of "nationwide class action brought on behalf of hemophiliacs infected by the AIDS virus as a consequence of using the defendants' products").

<sup>73</sup>*See Castano*, 84 F.3d at 741, 752 (holding that the district court abused its discretion by ignoring variations in state law when certifying national class and stating that "[i]n a multi-state class action, variations in state law may swamp any common issues and defeat predominance"); *American Med. Sys.*, 75 F.3d at 1085 (asserting that class certification is inappropriate "[i]f more than a few of the laws of the fifty states differ, [because] the district judge would face an impossible task of instructing a jury on the relevant law"); *Rhone-Poulenc*, 51 F.3d at 1300 (explaining that even if the "law of negligence . . . may . . . differ among the states only in nuance, . . . nuance can be important, and its significance is suggested by a comparison of differing state pattern instructions . . . and differing judicial formulations of the meaning of negligence and the subordinate concepts").

plaintiffs and cannot be resolved in a single proceeding;<sup>74</sup> or (3) the class action device is used to extort favorable but undeserved settlements by strengthening and magnifying the number of frivolous claims.<sup>75</sup> The reasoning of these decisions casts serious doubt on whether vanishing premium cases are eligible to be certified as national class actions.

### 1. Different State Laws

Vanishing premium cases are brought on behalf of nationwide policyholders pursuant to numerous state law causes of action, which are comprised of a variety of differing, jurisdictionally based requirements.<sup>76</sup> While all jurisdictions recognize causes of action for fraud and breach of contract, significant differences still exist. There is no uniform answer to questions, such as, the scope of the parole evidence rule, what constitutes reasonable reliance, the meaning and viability of the reasonable expectations doctrine, and whether causes of action, like negligent misrepresentation, even exist.

These differences in the relevant governing legal standards create a logical nightmare. How is a court to decide how the jury should be instructed on questions of law when there is no single law that applies? Should the court choose the law of one state over the law of another? If so, on what basis? Alternatively, should the court create a composite of various state laws, although the resulting legal standard would be one that exists nowhere in the world?<sup>77</sup> And, again, what principles should the

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<sup>74</sup>See *Castano*, 84 F.3d at 745 (noting that "a fraud class action cannot be certified when individual reliance will be an issue"); *American Med. Sys.*, 75 F.3d at 1085 (stating that where the products alleged to have caused harm are different, "each plaintiff has a unique complaint, and each receives different information and assurances . . . [and] the economies of scale achieved by class treatment are more than offset by the individualization of numerous issues relevant only to a particular plaintiff") (citing *In re Northern Dist. of Cal., Dalkon Shield IUD Prods. Liab. Litig.*, 693 F.2d 847, 856 (9th Cir. 1982), *cert. denied*, 459 U.S. 1171 (1983)); *Rhone-Poulenc*, 51 F.3d at 1302 (holding that the district judge exceeded his authority by dividing "the trial of the [other] issues that he . . . certified for class-action treatment from the other issues involved in the thousands of actual and potential claims of the representatives and members of the class").

<sup>75</sup>*Castano*, 84 F.3d at 746. See *Rhone-Poulenc*, 51 F.2d at 1299 (holding that the intense pressure put on defendants to settle class actions must be balanced with the benefits of such actions).

<sup>76</sup>As of November 7, 1996, 120 class action suits had been filed regarding vanishing premiums. Jordan & Black, *supra* note 32, at 255 (citations omitted).

<sup>77</sup>See generally *Rhone-Poulenc*, 51 F.3d at 1300 (stating that the district judge, in merging the negligence standards of the 50 states, has "propose[d] to have a jury determine the negligence of the defendants under a legal standard that does not actually exist anywhere in the world").

court use to create the composite? There are no answers to these questions. For this reason alone, vanishing premium cases should not be certified as nationwide class actions.

## 2. The Absence of Common Fact Issues

Common questions of fact must predominate over individual questions of fact for a case to be eligible for certification as a class action.<sup>78</sup> It is difficult to see, however, how plaintiffs in a vanishing premium case could make this requisite showing. Absent such a showing, a class should not be certified, even on a state-wide level.

Common questions do not predominate in vanishing premium cases because these cases turn on what happened in discrete interactions between particular agents and policyholders. What representations did an agent make to a policyholder? What written materials were provided? What risks disclosed? In addition, there is the issue of reasonable reliance. Did a policyholder rely on what the agent said and, if so, was this reliance reasonable considering all the relevant circumstances? There is no reason to assume that the answers to these questions will be the same in all cases. In fact, it is quite the opposite. In other words, due to the specific nature of these cases, nothing is accomplished by having all claims adjudicated in one proceeding. One of two results will inevitably occur. The proceeding will either: (1) be an aggregate of countless, distinct, individual claims, which is a completely unattractive alternative contrary to the philosophy of class actions, or (2) issues of liability and damages will have to be relitigated in separate, individual cases. In either case, the benefits of class action treatment are non-existent. The better course is to deny class certification at the outset and allow the cases to proceed on an individual basis.

## 3. The Class Action as Extortion

Courts have also emphasized the extortionate nature of class actions in denying certification in mass tort cases where the merits of the underlying claims appear dubious.<sup>79</sup> Since class actions exponentially

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<sup>78</sup>Federal Rule of Civil Procedure 23(b)(3) requires "that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members." FED. R. CIV. P. 23(b)(3).

<sup>79</sup>See *Rhone-Poulenc*, 51 F.3d at 1298 (noting that "settlements induced by a small probability of an immense judgment in a class action" are referred to as "blackmail settlements") (quoting HENRY J. FRIENDLY, *FEDERAL JURISDICTION: A GENERAL VIEW* 120 (1973)).

increase the stakes in mass tort cases, tremendous pressure exists for defendants to settle regardless of the merits of the underlying claims.<sup>80</sup>

The same is true in vanishing premium litigation where the merits of the claims being asserted are questionable at best. Without the class action, defendants would have to defend cases as filed. The number of cases filed would in all likelihood be a trivial fraction of all policies sold. This occurs because many policyholders will reason that they were not defrauded, while others will conclude that their loss, if any, is too small to be worth dealing with the aggravation of litigation. Alternatively, others will be barred by the statute of limitations or other defenses and some may work out their differences with the insurer informally. For those cases that are filed, the insurer will prevail in many, if not most, due to the formidable legal obstacles that plaintiffs face. Finally, even if some plaintiffs do prevail, the judgments would not collaterally estop future cases because of the individual issues involved in each case.

Now consider the situation if a vanishing premium case is certified as a class action. The case is brought on behalf of all policyholders who purchased certain types of insurance over an extended period, frequently ten years. For an insurance company of any size, class plaintiffs will assert a damage claim worth billions of dollars. As a result, class plaintiffs' lawyers are in a perfect position to propose a settlement with modest benefits for policyholders, which is valued at a grossly inflated amount to justify the award of substantial attorneys fees. Defendants, when faced with such an offer, are hard pressed to refuse and a settlement is quickly reached with the biggest beneficiaries being the plaintiffs' class action lawyers. Hopefully, courts in vanishing premium cases will be sensitive to the unsavory realities of class action practice when deciding the critical certification issue and whether to approve any settlements reached.

### III. CALCULATING DAMAGES

For the reasons discussed above, courts should not apply the "benefit of the bargain" or expectation measure of damages, regardless of the legal theory advanced. This is true even under the highly unrealistic

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<sup>80</sup>*See id.* at 1298-99 (noting that class action defendant would be under intense pressure to settle due to the "small probability of an immense judgment," even though he had won 12 of the 13 previous cases against him); *Castano*, 84 F.3d at 746 (stating that "[i]n addition to skewing trial outcomes, class certification creates insurmountable pressure on defendants to settle, whereas individual trials would not") (citing Peter H. Schuck, *Mass Torts: An Institutional Evolutionist Perspective*, 80 CORNELL L. REV. 941, 958 (1995))).

assumption that plaintiffs can establish a breach of contract notwithstanding the express contrary language of the actual written contract. "Benefit of the bargain" damages risks providing policyholders with a better deal through the judicial process than they could have obtained anywhere in the marketplace. Courts should not and typically do not promulgate rules of law that create incentives for litigants to manufacture claims in search of windfalls. To avoid windfalls, courts have rejected the expectation measure of damages in favor of the reliance measure.

Reliance damages measure the harm, if any, suffered by the plaintiff as a result of any change in position caused by the alleged wrongdoing.<sup>81</sup> Applied to vanishing premium cases, reliance damages equal the difference between the policyholder's current financial condition and the financial condition that the policyholder would have been in, if he or she had satisfied his or her demand for life insurance in some other manner. More precisely, reliance damages equal the present value of the difference between (a) the cash flows out of and into the policyholder's pocket under the actual policy and (b) the cash flows out of and into the policyholder's pocket that would have occurred, and which would be expected to occur in the future, if the policyholder had satisfied his or her demand for life insurance in an alternative manner. As we now explain, for many plaintiffs in vanishing premium cases, damages measured in this manner equal zero.

#### A. *Non-Replacement Customers*

Purchasers of interest-sensitive whole life insurance can be divided into two groups: those who purchase interest-sensitive whole life to replace an existing policy ("replacement customers"), and those who either had no life insurance previously or who left existing policies in place ("non-replacement customers"). Publicly available data suggests that the majority of purchasers of interest-sensitive whole life have been non-replacement customers.<sup>82</sup> The Life Insurance Marketing and

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<sup>81</sup>See KEETON ET AL., *supra* note 63, § 110, at 767-68 (comparing the out-of-pocket and loss-of-bargain rules used to determine damages for misrepresentation). The out-of-pocket rule:

[l]ooks to the loss which the plaintiff has suffered in the transaction, and gives him the difference between the value of what he has parted with and the value of what he has received. If what he received was worth what he paid for it, he has not been damaged, and there can be no recovery.

*Id.* § 110, at 767.

<sup>82</sup>*Report of Multi-State Life Ins. Task Force, supra* note 6, at 42-44.

Research Association (LIMRA) conducts periodic surveys of insurance buyers. LIMRA data indicate that replacements, as a percent of total new sales, peaked in 1985 at forty-seven percent.<sup>83</sup> By 1994, however, replacements accounted for only sixteen percent of new sales.<sup>84</sup>

Even if defendants are found liable in vanishing premium cases, it is unlikely that many non-replacement customers suffered economic loss. If non-replacement customers had not purchased interest-sensitive whole life, a natural alternative for many would have been term insurance, which is the type of policy that many consumers bought in the late 1970s and early 1980s prior to the introduction of universal life. As previously discussed, term insurance was an attractive alternative to traditional whole life in those years because it provided consumers with a means of buying life insurance without simultaneously putting money into a savings vehicle that had a below-market rate of return.<sup>85</sup> Consumers who bought term insurance could take the difference between the term and whole life premiums and invest it in securities that provided a much higher rate of return than the return on traditional whole life policies in the late 1970s and early 1980s.<sup>86</sup>

Few non-replacement customers suffered economic loss for a variety of reasons. First, even if they had "bought term and invested the difference," these customers would have been affected by the same downturn in interest rates that affected the performance of interest-sensitive whole life. Buying term insurance and investing the difference in premiums in a hypothetical side fund would not have immunized these consumers from the low interest rates of the early 1990s.

Second, the insurance benefits available through term insurance would not have been as good as the benefits provided by whole life. For example, most whole life policies provide insurance protection through age 100, without requiring the insured to requalify for insurance.<sup>87</sup> However, with term insurance, it is rarely possible to guarantee insurance coverage after age sixty-five or seventy.<sup>88</sup> Term insurance companies sell policies on an annual renewable basis, meaning that the policyholder has a guaranteed right to renew his or her insurance without having to

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<sup>83</sup>*Id.* at 42.

<sup>84</sup>*Id.* at 44.

<sup>85</sup>See *supra* notes 9-24 and accompanying text for a discussion of this point.

<sup>86</sup>*Id.*

<sup>87</sup>BLACK & SKIPPER, *supra* note 9, at 98 (noting that whole life insurance assumes the insured dies at age 100).

<sup>88</sup>*Id.* at 85 (noting that renewability of term policies is limited based on age).

requalify.<sup>89</sup> However, such policies typically put an age limit on the period of guaranteed renewability.<sup>90</sup>

Third, annual renewable term insurance suffers from an "adverse selection" problem. As a purchaser of annual renewable term insurance ages and term premiums increase, the purchaser is more likely to renew if he or she is in relatively poor health.<sup>91</sup> Relatively sick people are generally the parties who find continued insurance protection the most attractive. This tendency is recognized by insurance companies who offer term insurance and reflected in the form of higher premiums.

Finally, the fourth reason why few non-replacement customers would have been better off if they had "bought term and invested the difference" involves taxes. Term insurance does not enjoy the important tax advantages associated with whole life. If a whole life policy is held to death, there are no taxes due on any dividends paid to the policyholder or on any increases in the policy's cash value. If the policy is surrendered before death, there are still no taxes, provided the policy is exchanged for another whole life policy. Even if the surrendered policy is not exchanged, benefits accrue because taxes are deferred and the full amount of prior premium payments, including the portion that paid insurance and administrative costs, is counted as part of the cost basis in computing the portion of the surrender value that is treated as taxable income.<sup>92</sup> No such tax benefits are enjoyed by the strategy of "buy term and invest the difference."

As previously noted, damages for non-replacement customers under the reliance measure equal the present value of the difference between (a) the cash flows out of and into the policyholder's pocket under the actual policy and (b) the cash flows out of and into the policyholder's pocket that would have occurred, and which would be expected to occur in the future, if the policyholder had "bought term and invested the difference." By construction, the actual and "but for" out-of-pocket cash flows in a "buy term and invest the difference" analysis are the same from the date the policy is issued to the present. In one case, monies are used to pay premiums on a universal life or interest-sensitive policy. In the other case, the same amount of monies are used "to buy term and invest the difference." Therefore, because actual and "but for" cash flows to date

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<sup>89</sup>BELTH, *supra* note 9, at 22; BLACK & SKIPPER, *supra* note 9, at 85.

<sup>90</sup>BELTH, *supra* note 9, at 22; BLACK & SKIPPER, *supra* note 9, at 85.

<sup>91</sup>See generally BELTH, *supra* note 9 (noting that owners of term insurance can continue coverage "with no questions asked," regardless of whether the insured's health has deteriorated or he or she is engaged in a "hazardous" occupation).

<sup>92</sup>For a more detailed discussion of the tax advantages of cash value insurance, see BLACK & SKIPPER, *supra* note 9, at 374-406.

are equal in a "buy term and invest the difference analysis," damages for non-replacement customers are measured entirely by the difference in the expected future out-of-pocket cash flows.

For an interest-sensitive policy, such as universal life, future out-of-pocket cash flows depend on future insurance and administrative costs and the ability of the policy to pay these costs out of the cash value already built up in the accumulation fund. The larger the cash value is today, the smaller the expected out-of-pocket cash flows will be in the future. For the term insurance alternative, future out-of-pocket cash flows depend on future term premiums, which, in turn, depend on future insurance and administrative costs, and the ability to pay these future premiums out of the monies already accumulated in the side fund.<sup>93</sup> The larger the side fund, the smaller the expected future out-of-pocket cash flows from the policyholder.

Due to the tax advantages of whole life insurance, \$1 in an interest-sensitive accumulation fund provides a greater ability to pay future insurance and administrative costs than \$1 in a "buy term and invest the difference" side fund, which operates outside the whole life tax umbrella. As a result, even if the hypothetical side fund in a "buy term and invest the difference" analysis was greater than the cash value in the accumulation fund of a comparable interest-sensitive policy, non-replacement customers still might not have suffered an economic loss. If, however, the cash value in the interest-sensitive accumulation fund is *greater* than the monies in the "buy term and invest the difference" side fund, the race is over. In such cases, the interest-sensitive whole life policy is the clear winner. The purchaser of the interest-sensitive policy would have the same or better insurance protection, in addition to a greater accumulation of savings that will earn interest on a tax-favored basis in the future.

Comparing the performance of universal life with "buy term and invest the difference" is a relatively simple exercise. To illustrate the analysis, Tables 1 and 2 use data from A.M. Best to compare the amount as of December 31, 1995, in the accumulation funds of universal life policies issued on January 1, 1986, relative to the amounts that would have been accumulated as of this date in the side funds of two "buy term and invest the difference" alternatives.<sup>94</sup> In Table 1, the alternative

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<sup>93</sup>The future insurance costs associated with term insurance will be higher than the future insurance costs associated with an equivalent amount of whole life because of the adverse selection phenomenon discussed above. Term insurance premiums reflect the fact that it is the relatively sick customers who are most likely to continue purchasing term insurance.

<sup>94</sup>A.M. BEST, BEST'S FLITCRAFT COMPEND 276, 320, 364, 463, 584, 603, 608 (1986);

involves investing each year's difference between the premiums on universal life and term insurance in one-year T-bills. In Table 2, the "buy term and invest the difference" alternative assumes that each year's premium difference is invested in a twenty-year Treasury bond issued in that year. Thus, the 1986 premium difference is invested in a bond issued in 1986, the 1987 premium is invested in a bond issued in 1987, and so on. In both tables, the term insurance alternative assumes that taxes are paid on interest payments, and these after-tax interest payments are then reinvested in one-year T-bills.<sup>95</sup>

The universal life data in Tables 1 and 2 are the median results from the universal life policies of 77 insurance companies. Each policy had death benefits of \$100,000 and assumed that the insured was a non-smoking male who was forty-five years old in 1986. In preparing these calculations, A.M. Best assumed that the policyholder paid a premium of \$1,500 per year for the entire ten-year period. In the term insurance alternative, we assumed that the insured had the same characteristics as noted above and held a policy with the same \$100,000 in death benefits. We further assumed that the customer would purchase annual renewable term insurance, which has renewal provisions that resemble, though do not replicate, the lifetime renewability built into universal life and other whole life policies.

Whether we use one-year T-bill rates or twenty-year Treasury bonds rates, Tables 1 and 2 show that the accumulated value in the universal life policies was greater as of December 31, 1995, than the amounts accumulated in the "buy term and invest the difference" side funds. Relative to investing in one-year T-bills, the universal life accumulation funds had an average balance that was twenty-five percent greater than the balance in the "buy term and invest the difference" side fund (\$15,935 versus \$12,724). Relative to investing in twenty-year Treasury bonds, the universal life accumulation fund was fifteen percent greater (\$15,935 versus \$13,847).

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A.M. BEST, BEST'S POLICY REPORTS/UNIVERSAL LIFE 18 (1996) (workpapers supporting the calculations shown in Tables 1 and 2 are on file at *The Delaware Journal of Corporate Law*).

<sup>95</sup>We compare universal life with an alternative that invests in one-year Treasury bills because the rate at which most insurance companies have credited interest to universal life accumulated values has fluctuated from year to year. Thus, the cash value within universal life policies has been subject to reinvestment risk not unlike the risk associated with a strategy of investing and reinvesting in one-year Treasury bills.

We also compare universal life with an alternative that invests each year's difference in premiums in 20-year bonds. We use this benchmark based on an analysis of the median rates at which issuers of universal life have credited interest to policyholders' cash value. Interest-credit rates on universal life have most closely resembled the current rates on 10 and 20-year government bonds.

The results in Tables 1 and 2 imply that the hypothetical non-replacement customer in these tables was clearly better off with his universal life policy and suffered no damages, even though the policy may not have worked out as initially contemplated. Due to the tax advantages of whole life insurance, he might have been better off even if the balance in his universal life accumulation fund had been smaller than the balance in the "buy term and invest the difference" side funds. As previously discussed, due to tax benefits, \$1 in whole life cash value covers more future insurance and administrative costs than \$1 in a "buy term and invest the difference" side fund. In Tables 1 and 2, however, the purchaser of universal life has both tax advantages *and* a universal life accumulation fund that is larger than the balance in the term insurance side funds.

The analysis in Tables 1 and 2 assumed "level" premium payments equal to \$1,500 per year. We made this assumption because that was the way in which A.M. Best reported its data on universal life policies. If the universal life policy analyzed in the tables had been sold on a vanishing premium basis, premiums in the early years would have been larger and may have ceased prior to the end of the ten-year period. A vanishing premium payment plan would tend to widen the gap between universal life and "buy term and invest the difference." If larger payments had been made earlier, the difference in after-tax returns due to the tax advantages of whole life insurance would have compounded over a longer period.

The principal goal of Tables 1 and 2 is to illustrate the correct method for analyzing damages to non-replacement customers. The method illustrated in these tables is a general method applicable to any kind of payment plan. Using data available within most insurance companies, similar analyses could be performed for an individual or a large sample of non-replacement customers.

### B. *Replacement Customers*

Whenever a policyholder purchases a whole life policy, the insurance agent earns substantial commissions. The policyholder pays for these commissions and other sales costs either at the front-end by having only a small fraction of the initial premiums contributed to cash value, or at the back-end through surrender charges that reduce the cash received by an exiting policyholder. These sales charges are a key factor in determining, *ex ante*, whether it is economical to surrender an existing whole life policy and use the cash value to purchase a replacement policy. For replacement to make economic sense for the consumer, the

advantages of the new policy must be large enough to justify incurring a second round of sales charges. As discussed below, sales charges are also a key factor in determining the size of any *ex post* damages suffered by replacement customers.

When universal life and the other forms of interest-sensitive whole life were first introduced in the early and mid-1980s, many of the purchasers were replacement customers. One of the objectives of the new policies was to attract existing policyholders who might otherwise replace their whole life policies with an equivalent amount of term insurance. The early and mid-1980s was a period when replacement was most likely to make economic sense. As discussed above, the new policies allowed customers to earn current rates on their savings while preserving the tax benefits of whole life. The economic logic of replacement during this period is widely recognized, even by groups that have harshly criticized insurance industry practices. For example, a recent report of the Multi-State Examiners Task Force that analyzed and criticized Prudential's market conduct nevertheless observed: "At the time of these [regulatory and economic] changes, when interest rates were high and universal life and 'interest-sensitive' whole life products were being developed, the replacement of old policies sold at rates based upon old mortality tables and offering low interest rates could have been viewed as a sound financial decision for many policyowners."<sup>96</sup>

The low interest rates of the early 1990s altered the economics of replacement. The profitability of replacing an existing policy depended on the spread between (a) the interest-credit rates used to determine earnings on the accumulation funds in the new policies and (b) the rate of return on the savings component of traditional policies. When interest rates fell in the early 1990s, interest-credit rates on interest-sensitive policies fell by a similar amount. Dividends on traditional policies also fell, but the decline was not as sharp. The effect of low interest rates on traditional policies was moderated by the practice of basing policy dividends on the income from insurance company investments and the presence in insurance company portfolios of large holdings of older bonds with interest rates that were now above current market rates. This narrowing or even reversing of the spread between the returns on interest-sensitive policies and the returns on traditional policies meant that, *ex post*, certain customers might have been better off if they had not replaced their traditional policies. Replacement may have been a wise

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<sup>96</sup>Report of Multi-State Life Ins. Task Force, *supra* note 6, at 7.

decision at the time it was made, but it may have been a decision that some consumers, with the benefit of hindsight, have come to regret.

The general framework for analyzing reliance damages for replacement customers is the same framework outlined above — compare actual out-of-pocket cash flows under the new, interest-sensitive policy with the "but for" out-of-pocket cash flows that would have been observed if the policyholder had kept his or her old policy.<sup>97</sup> Reliance damages for replacement customers, however, are highly policy-specific. Damages, if any, significantly depend on the amount of cash that was obtained from surrendering the old policy and the premiums and dividends that would have been paid and received by the policyholder if he or she had not surrendered the old policy. Because damages for replacement customers require information from non-defendant insurance companies, the only tractable way to estimate damages for these customers is likely to be through sampling and limited requests for third-party information.

In the end, the data on replacement customers will speak for itself. Yet, it seems unlikely that reliance damages related to replacement customers will be significantly greater than the second round of sales costs incurred when the policyholder surrendered an old policy and purchased a new one. To explain, if the rate of return on the replacement customers' new policies was greater than the return on their old policies, this difference in returns would help "cover" the additional sales costs. Under these circumstances, damages, if any, would almost certainly be less than the second round of sales costs. Damages for replacement customers could significantly exceed the additional sales costs only if the rate of return on their new policies was less than the return on the savings component of their old policies.

For some replacement customers, this situation may exist today. With the economy-wide decline in interest rates, the interest-credit rates on their new interest-sensitive policies may be less than the dividend rates on the traditional policies they replaced. However, this kind of "negative spread" is likely to be only temporary. In time, high interest bonds in insurance company portfolios will mature and will be replaced with bonds reflecting today's lower rates. When this occurs, the income on insurance company investments will decline, leading to a reduction in the dividends

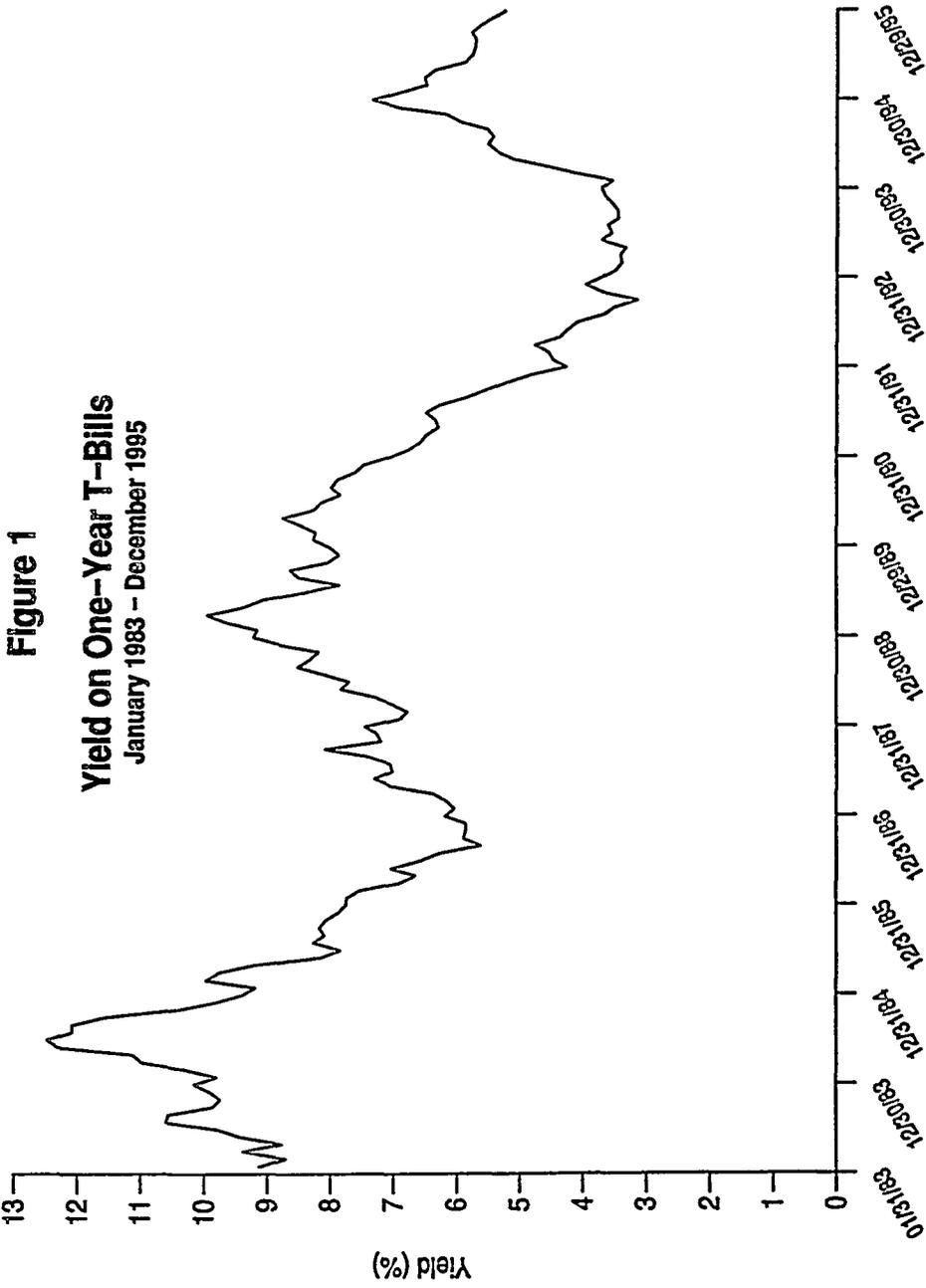
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<sup>97</sup>The death benefits on the new policy may exceed the death benefits on the old policy. If so, the "but for" scenario should be modified. The new policy should be compared with a "but for" scenario in which the old policy is maintained while, at the same time, the policyholder purchases an amount of term insurance equal to the difference between the death benefits on the new and old policies.

on traditional policies. Even if interest-credit rates today are low relative to the dividend rates on traditional policies, it must be remembered that the opposite was true throughout the 1980s. Customers who replaced their policies in the early and mid-1980s had a number of years in which they realized interest-credit rates on their new policies that were significantly higher than the returns they would have earned on the savings component of their old policies. The high returns from this era serve as an offset to any short-run "underperformance" that replacement customers may be experiencing today. In sum, while there may be some replacement customers for whom damages exceed the additional sales costs associated with replacement, the percentage of replacement customers falling into this group is likely to be small.

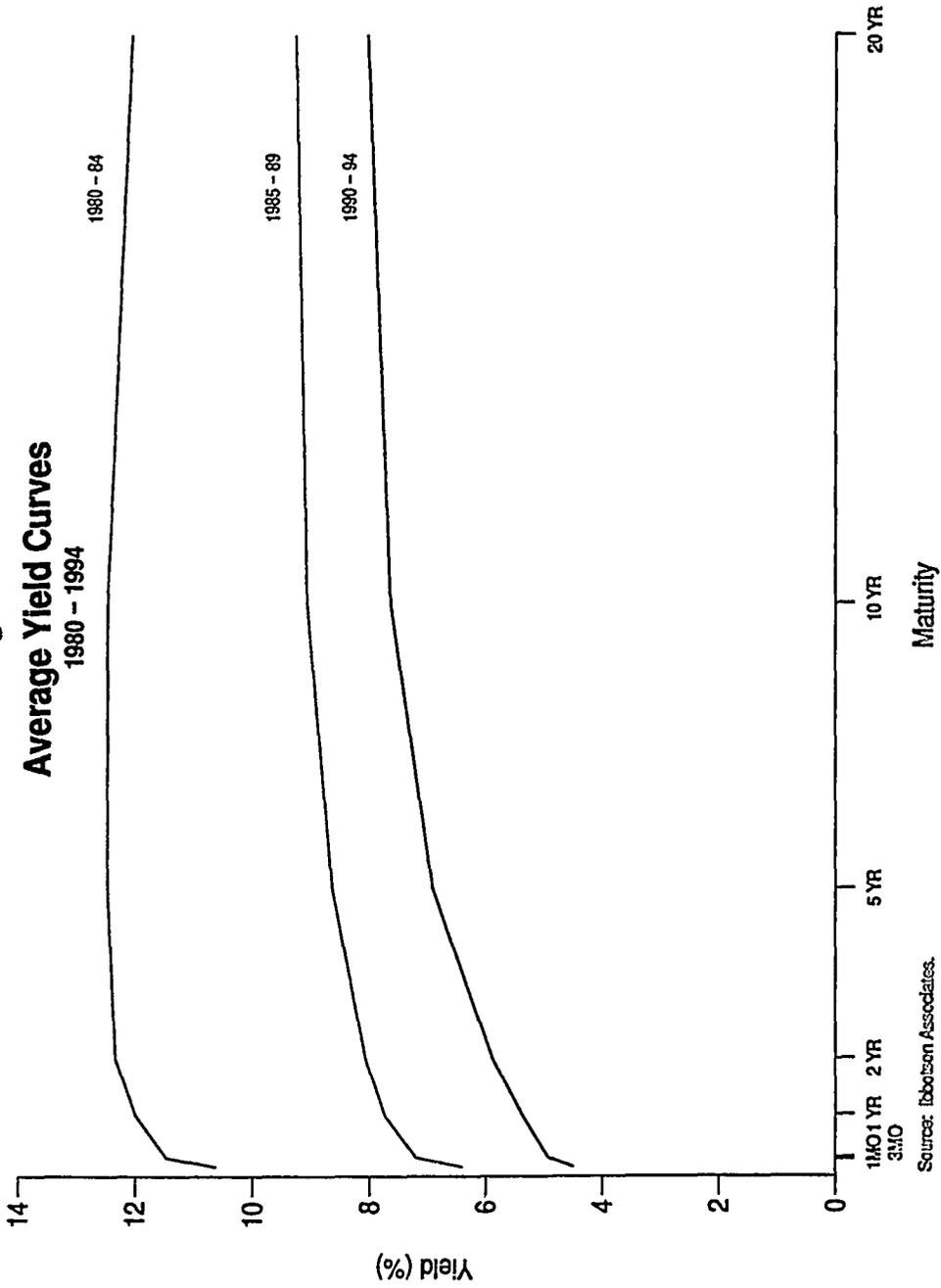
#### IV. CONCLUSION

Declining interest rates, not deceptive sales practices, are responsible for the failure of vanishing premium life insurance policies to perform as well as initially hoped. Plaintiffs, particularly those in class actions, should not be allowed to use the legal system as a form of insurance to protect against the consequences of declining interest rates. When the liability and damage issues presented in vanishing premium cases are properly analyzed, the life insurance industry's exposure is far less than commonly assumed.



Source: Ibbotson Associates.

**Figure 2**  
**Average Yield Curves**  
1980 - 1994



Source: Ibbotson Associates.

Table 1  
**Universal Life ("UL") vs. Buy Term & Invest Difference ("BTID")**

Assumes Purchase of \$100,000 UL Policy on 1/1/86 by a 45-Year Old, Nonsmoking Male, Paying Annual Premiums of \$1,500  
 Compared with Purchase of \$100,000 of Non-Convertible, Annual Renewable Term Insurance  
 Premium Difference and After-Tax Interest Invested in 1-Year T-Bills

Year	Buy Term and Invest the Difference							UL Less BTID
	UL Premium	Term Premium (1)	Premium Difference	1-Year T-Bill Rate	Federal & State Tax Rate (2)	BTID Side Fund (3)	UL Accumulated Value (4)	
1986	1,500	340	1,160	7.73%	41.26%	1,213	1,203	(10)
1987	1,500	368	1,132	6.16%	38.34%	2,434	2,503	69
1988	1,500	389	1,101	7.42%	31.40%	3,715	3,848	134
1989	1,500	432	1,068	9.20%	31.35%	5,085	5,318	233
1990	1,500	469	1,031	8.00%	31.40%	6,451	6,902	450
1991	1,500	510	990	7.06%	31.40%	7,802	n/a	n/a
1992	1,500	551	949	4.26%	31.40%	9,007	n/a	n/a
1993	1,500	594	906	3.69%	31.40%	10,163	n/a	n/a
1994	1,500	640	860	3.71%	31.40%	11,304	n/a	n/a
1995	1,500	680	810	7.30%	30.69%	12,724	15,935	3,211

**Footnotes**

- (1) Term premium equals the average of the annual renewable, non-convertible term premiums charged by Transamerica Occidental, Jackson National, Old Line, Mutual National, Lincoln Benefit, United of Omaha and United Services. Premiums include annual policy fee.
- (2) Tax rate equals the federal plus state tax rate paid by a married couple, filing jointly, with family income of \$19,630. Based on state tax rates in California, New York, Texas and Illinois.
- (3) BTID side fund assumes that each year's premium difference is invested in 1-year T-bills. Assumes that interest payments (subject for taxes) are also invested in 1-year T-bills.
- (4) UL accumulated value obtained from A.M. Best. Equals the median accumulated values from the universal life policies of 77 companies. Excludes surrender charges.

Table 2  
**Universal Life ("UL") vs. Buy Term & Invest Difference ("BTID")**

Assumes Purchase of \$100,000 UL Policy on 1/1/88 by a 45-Year Old, Nonsmoking Male, Paying Annual Premiums of \$1,500  
 Compared with Purchase of \$100,000 of Non-Convertible, Annual Renewable Term Insurance  
 Premium Difference Invested in 20-Year T-Bonds, After-Tax Interest Invested in 1-Year T-Bills

Buy Term and Invest the Difference										
Year	UL Premium	Term Premium (1)	Premium Difference	20-Year T-Bond Rate	1-Year T-Bill Rate	Federal & State Tax Rate (2)	BTID Side Fund (3)	UL Accumulated Value (4)	UL Less BTID	
1988	1,500	340	1,160	8.51%	7.73%	41.26%	1,225	1,203	(22)	
1987	1,500	388	1,132	7.84%	6.16%	38.34%	2,483	2,503	20	
1988	1,500	399	1,101	9.17%	7.42%	31.40%	3,800	3,848	48	
1989	1,500	432	1,068	9.12%	9.20%	31.35%	5,167	5,318	151	
1990	1,500	469	1,031	8.11%	8.00%	31.40%	6,568	6,902	334	
1991	1,500	510	990	8.38%	7.06%	31.40%	7,998	n/a	n/a	
1992	1,500	551	949	7.45%	4.26%	31.40%	9,427	n/a	n/a	
1993	1,500	594	906	7.43%	3.69%	31.40%	10,866	n/a	n/a	
1994	1,500	640	860	6.51%	3.71%	31.40%	12,311	n/a	n/a	
1995	1,500	690	810	8.01%	7.30%	30.99%	13,847	15,935	2,088	

**Footnotes**

- (1) Term premium equals the average of the annual renewable, non-convertible term premiums charged by Transamerica Occidental, Jackson National, Old Line, Mutual National, Lincoln Benefit, United of Omaha and United Services. Premiums include annual policy fee.
- (2) Tax rate equals the federal plus state tax rate paid by a married couple, living jointly, with family income of \$50,000. Based on state tax rates in California, New York, Texas and Florida.
- (3) BTID side fund assumes that each year's premium difference is invested at that year's 20-year T-bond rate. Assumes that interest payments (adjusted for taxes) are invested in 1-year T-bills.
- (4) UL accumulated value obtained from A.M. Best. Equals the median accumulated values from the universal life policies of 77 companies. Excludes surrender charges.