IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

PHT HOLDING II LLC, on behalf of itself and all others similarly situated, Plaintiff, v. NORTH AMERICAN COMPANY FOR LIFE AND HEALTH INSURANCE, Defendant.	)	Case No. 4:18-cv-00368-SMR-HCA ORDER ON MOTIONS

Plaintiff PHT Holding II, LLC ("PHT") brought this class action lawsuit against Defendant North American Company for Life and Health Insurance ("North American") asserting a breach of contract claim. PHT and the certified class members are all policyholders of two life insurance products sold by North American. PHT alleges that North American breached the policy contract by failing to make certain adjustment to monthly charges assessed on the policies. North American disputes PHT's interpretation of the policy language.

Before the Court are several motions. North American moves for summary judgment on PHT's breach of contract claim. Both parties have also filed motions seeking to exclude various fact and expert witnesses offered by the opposing party. At the core of the dispute between the parties is the proper interpretation of two words contained in the insurance policy. That does not mean the stakes of the case are low—PHT alleges damages in excess of $100 million.

I. BACKGROUND

A. Class Policies

PHT brings its claim for breach of contract on behalf of itself and 18,585[1] universal life insurance policyholders ("Class Policies"). [ECF No. 231-1 ¶ 1]. The Class Policies are linked to two universal life insurance products named Classic Term UL I and Classic Term UL II, which were issued by North American between 1989 and 2001. *Id.* ¶ 2. Classic Term UL I was developed in 1989 and the revised Classic Term UL II was issued in 1990. *Id.* ¶ 33. Each policy was issued on one of three base policy forms, with Classic Term UL I being issued on base policy forms LS-35A and LS-35E, and Classic Term UL II was issued on base policy form LS-58B.[2] *Id.* ¶ 3. Additionally, there are variations to each base policy form that are submitted for review by insurance regulators in each state where they are sold. *Id.* ¶ 4. In addition to the policy forms, North American submitted documents pertaining to the "Actuarial Description" and a "Summary of Pricing Assumptions" to the New Jersey state insurance regulator in connection with the Classic Term UL Product. *Id.*

Universal life insurance is a type of permanent life insurance that provides the policyholder with the choice of maintaining the policy until the earlier of the maturity date (usually when the insured reaches the age of 100) or the insured's death. *Id.* ¶ 5. However, if there is a policy lapse because sufficient premiums are not paid during the grace period, the policy will terminate before the maturity date or death of the insured. *Id.* In general, when developing a specific insurance product, an insurance company undertakes a "pricing" process. *Id.* ¶ 19. The pricing process

[1] There were originally 18,592 policies in the certified class but 7 exercised their right to opt-out of the class. *See* [ECF No. 227-6 at 2].

[2] The policy now owned by PHT was originally issued using form LS-58B. Unless the differences between forms are material, the Court will refer to the policy owned by PHT.

requires an insurer to make actuarial assumptions about their products to project financial results. *Id*. ¶ 20. Among these future assumptions are policyholder premium payments, investment returns, taxes, expenses, policy surrenders, and considerations about mortality rates. *Id*. Mortality is generally understood in the actuarial profession as the probability that an insured will die. [ECF No. 244-1 ¶ 1]. To price its products, life insurance companies must make predictions about the projected deaths of their policyholders. [ECF No. 231-1 ¶ 21]. These projections often require consideration of past mortality rates. [ECF No. 244-1 ¶ 4]. Once these assumptions are made, insurance companies will conduct sensitivity tests for projected financial results of different assumptions. [ECF No. 231-1 ¶ 23]. This is commonly an iterative process where the insurance company seeks to identify the rates which best accomplish the product's design goals and earn a sufficient profit. *Id.* ¶ 24.

The Classic Term UL policies have flexible premiums, enabling policyholders to select the amounts and timing of their premium payments, subject to certain rules and restrictions. *Id*. ¶ 6. Whenever a policyholder makes a premium payment on a Classic Term UL policy, the payment contributes to the policy's accumulation value. *Id*. ¶ 7. North American deducts 3.00% of premiums paid as an expense charge and adds the remaining payment to the accumulation value. *Id*. Each month, North American adds interest to and deducts a monthly amount from the accumulation value. *Id*. ¶ 8. The policies describe the formula in full:

> **Accumulation Value**. On each Monthly Anniversary Day, the accumulation value is calculated as (1), plus (2), plus (3), plus (4), minus (5), where:
>
> (1) is the accumulation value on the preceding Monthly Anniversary Day.
>
> (2) is one month's interest on item (1).

> (3) is (a) premiums received since the preceding Monthly Anniversary Day, multiplied by (b) 100% minus the Expense Charge Rate shown in the Policy Schedule.
>
> (4) is the interest on item (3) from the date of receipt to the Monthly Anniversary Day.
>
> (5) is the monthly deduction for the month following the Monthly Anniversary Day.
>
> On any day other than a Monthly Anniversary Day, the accumulation value is calculated as (1) plus (3) minus (5) above, plus a pro-rata portion of (2) and (4) above. The accumulation value on the Policy Date is (a) the initial premium, multiplied by (b) 100% minus the Expense Charge Rate, with the result reduced by the monthly deduction for the month following the Policy Date.

[ECF No. 201-3 at 53].

The monthly deduction consists of the "Cost of Insurance," a monthly expense charge, and any applicable rider charges. [ECF No. 231-1 ¶ 9]. The accumulation value is used under certain circumstances to determine whether the policy stays in force and the value of some benefits available under the policy. *Id.* ¶ 10.

The following policy provision ("COI deduction") sets forth the calculation that largely determines the amount that is deducted from the accumulation value each month for cost of insurance:

> **Cost of Insurance**. The cost of insurance for the Insured is determined on a monthly basis. Such cost is calculated as (1) times (2), where:
>
> (1) is the cost of insurance rate as described in the Cost of Insurance Rates section. (2) is the net amount at risk, as defined in the Changing Death Benefit Options provision.

[ECF No. 201-3 at 53–54].

The "Cost of Insurance Rates" component ("COI rate") of the COI deduction provision is calculated by:

> **Cost of Insurance Rates.** The monthly cost of insurance rate is based on the sex, attained age, and rating class of the Insured. Policy duration is also a factor in determining the monthly cost of insurance rates. . . . Monthly cost of insurance rates are determined by us, based on our expectations as to future mortality experience. Any change in cost of insurance rates applies to all individuals of the same class as the Insured. Under no circumstances are cost of insurance rates for insureds in that standard risk class greater than those shown in the Table of Guaranteed Maximum Insurance Rates. Age nearest birthday is used in determining such guaranteed rates.

Id. at 54.

The "net amount at risk" in the COI deduction provision is calculated as:

> The net amount at risk equals (1) minus (2), where:
>
> (1) is the Death Benefit at the beginning of the policy month, divided by [1.0032737 or 1.0040742, depending on the policy form].
> (2) is the accumulation value at the beginning of the policy month.

Id. at 53.

Insurance providers typically set the COI rates for their products at levels below the maximum guaranteed rates as defined in the policy. [ECF No. 231-1 ¶ 14]. In the case of the Class Policies, a table of "Guaranteed Maximum Insurance Rates" was set forth in the policy. [ECF No. 201-3 at 49, 54]. Although PHT disputes that the table was the only restriction on COI rates, it is undisputed that North American has not modified the COI rate scales for its Classic Term UL products since their inception. [ECF No. 244-1 ¶ 26].

B. PHT's Policy

North American issued the policy now owned by PHT (the "Representative Policy") to "D.F."[3] in Florida in 1993. [ECF No. 231-1 ¶ 48]. D.F. was diagnosed as HIV-positive in

[3] The parties and the Court have referred to the insured and original policyholder by his initials to protect his privacy.

June 1989. *Id*. ¶ 49. However, on his policy application submitted to North American, D.F. answered "No" to the question asking if he had received any medical treatment or consultation within the past five years. *Id*. ¶ 52. D.F. acknowledged at his deposition that this answer was incorrect. *Id*. ¶ 53. Nevertheless, D.F. obtained at least seven life insurance policies and sold several of those policies to Life Partners, Inc.[4] *Id*. ¶ 54. PHT's policy had a two-year incontestability period, meaning that after two years, it could not be cancelled. *Id*. ¶ 55.

D.F. applied for a viatical settlement[5] with Life Partners in January 1996, and the company purchased his policy for $50,000, which is half of the $100,000 death benefit. *Id*. ¶ 56. As part of his application to Life Partners, D.F. authorized release of his medical records which disclosed his HIV diagnosis to the company. *Id*. ¶ 61.

In 2014, the Securities and Exchange Commission secured a judgment of $38.7 million against Life Partners for fraud, related to Life Partners' misrepresentations to its investors about the life expectancies of the insureds. [ECF No. 201-3 at 363–67]. Life Partners was reorganized in bankruptcy in 2015 and 2016, resulting in the establishment of the Life Partners Position Holder Trust. [ECF No. 231-1 ¶ 63]. This trust was formed to distribute the proceeds from the liquidation of Life Partners' assets. *Id*. ¶ 64. Advance Trust & Life Escrow Services, LTA ("Advance Trust") was designated as a securities intermediary to act as the nominal owner or depository for the life insurance policies that were held in Life Partners' portfolio. *Id*. ¶ 65. Advance Trust was the

[4] Life Partners was a company "engaged in the business of: (i) acting as a life settlement provider by purchasing individual life insurance policies insuring the lives of terminally ill individuals or seniors from third parties, and (ii) raising money to purchase such policies by selling investment contracts or 'fractional interests' to . . . [i]nvestors." [ECF No. 201-3 at 130].

[5] A viatical settlement is a transaction involving the sale of a life insurance policy by an insured individual who has been diagnosed with a terminal illness. [ECF No. 231-1 ¶ 59].

original entity who filed this suit and the original Class Representative. [ECF No. 148] (appointing Advance Trust & Life Escrow Services, LTA as class representative).

After the Court ordered class certification, Advance Trust transferred its ownership interest in the Representative Policy to PHT. [ECF No. 246]. PHT became the legal and beneficial owner of the Representative Policy and the real party in interest with respect to the policy. *Id*. at 2–3.

II. DISCUSSION

A. Motion for Summary Judgment Standard

Rule 56 of the Federal Rules of Civil Procedure provides that a party may move for summary judgment on each claim on which it asserts that there is no genuine dispute of material fact. Fed. R. Civ. P. 56(a). "Summary judgment is appropriate if viewing the record in the light most favorable to the nonmoving party, there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law." *Woods v. DaimlerChrysler Corp.*, 409 F.3d 984, 990 (8th Cir. 2005) (citing Fed. R. Civ. P. 56(c)).

On a motion for summary judgment, a court must consider the facts in the light most favorable to the non-movant. *Martinez v. W.W. Grainger, Inc.*, 664 F.3d 225, 229 (8th Cir. 2011) (citing *Skare v. Extendicare Health Servs., Inc.*, 515 F.3d 836, 840 (8th Cir. 2008)). To defeat summary judgment, "the nonmoving party must come forward with specific facts showing that there is a genuine issue for trial." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp*., 475 U.S. 574, 587 (1986) (cleaned up). Raising a genuine issue of material fact on summary judgment means a nonmovant "must substantiate [its] allegations with sufficient probative evidence that would permit a finding in [its] favor." *Segal v. Metro. Council,* 29 F.4th 399, 403 (8th Cir. 2022) (citation omitted). A material fact is one that "may affect the outcome." *Erickson v. Nationstar Mortg., LLC*, 31 F.4th 1044, 1048 (8th Cir. 2022) (internal quotation omitted). At the summary

judgment stage, the Court's function is not "to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

B. North American's Motion for Summary Judgment

The policy language at the center of the dispute between the parties provides that "[m]onthly COI rates are determined by us, based on our expectations as to future mortality experience." [ECF No. 201-3 at 54]. PHT claims that this clause imposes a duty on North American to adjust its COI rates whenever its expectations regarding future mortality experience change—specifically the expected mortality rates of the Class Policies. North American responds that PHT's reading of the contract provision is flawed and inconsistent with the policy language. It explains that other courts have found similar language in insurance contracts impose no such obligation on insurers. North American further argues that the provision allows it to consider other relevant actuarial assumptions, not just expected mortality rates, when establishing its COI rates.

In addition, North American maintains that PHT has failed to produce sufficient evidence to generate an issue of material fact that every policy in the certified class has been breached. North American urges that there are numerous instances where the company could employ rates higher than those specified by PHT and still not violate the policy. For instance, North American argues it could establish its COI rates at the same level as its current expected mortality rates, which would still be "based on expectations as to future mortality experience."

It further contends that PHT's claim is time-barred along with most of the claims of the class members. This is because a five-year statute of limitations applies to breach of contract claims under Florida law, and state law does not apply the discovery rule according to North American. The policy at issue was purchased in 1993, but PHT did not file this lawsuit until 2018.

North American argues that the continuing breach doctrine does not apply because PHT's claim represents a continuing injury that is properly understood to have accrued the first time that mortality rates allegedly improved, but North American failed to correspondingly reduce its COI rates. North American maintains that this same logic applies to other class members who may be subject to different state laws, but all of whom bought their policies a minimum of 17 years before the commencement of this lawsuit. The doctrine of laches applies as well, according to North American, because the passage of time has caused it to forfeit its ability to secure testimony from the actuaries who initially priced the Class Policies and could provide evidence about the assumptions made.

North American finally argues that summary judgment should be granted with respect to PHT's individual breach of contract claim because the Representative Policy was obtained through fraud because D.F. provided false information on his application about his severe health issues, including being HIV positive, and did not disclose other life insurance policies he had purchased around the same time. PHT stands in the shoes of these predecessors, including Life Partners, and North American contends PHT should not be allowed to profit from D.F.'s deception.

Regarding the argument that North American was not obligated to change COI rates, PHT asserts that its interpretation of the Class Policies' plain language is not only reasonable, but more reasonable than the one offered by North American. The Class Policies state that COI rates are determined "based on" expectation as to future mortality experience ("EFME"), so when EFME improves, PHT argues that the COI rates must also change consistent with the improvement. It claims that the alternate interpretation—where North American is not required to change COI rates regardless of changes in mortality—is not supported by the policy language. PHT suggests that

these competing interpretations establish, at minimum, that the Class Policies are ambiguous, and if the policy language is ambiguous, then the Court must deny summary judgment.

Next, PHT alleges that whether it has established a breach for each Class Policy is a disputed question of fact. It contends that it has provided evidence that the company's EFME improved materially for each Class Policy and identified the COI rates that North American should have charged. These hypothetical COI rates were lower than the actual COI rates charged during the Class Period. PHT acknowledges that North American's experts and PHT's experts may disagree with its position on the proper rates, but this conflict between experts precludes summary judgment.

Third, PHT responds to North American's statute-of-limitations arguments, explaining that it mischaracterizes the claim. It contends that each application of a COI rate during the Class Period that was not based on a new EFME was a separate and distinct breach of the Class Policies. PHT points out that it does not assert any claim for breach of contract outside the statute of limitations period for each separate breach of the policy.

Finally, PHT urges that the affirmative defense based on fraud is barred by the Class Policies' two-year incontestability period, which expired in 1995. PHT takes the position that Florida law clearly establishes that such provisions are a complete bar to a fraud defense in breach of contract actions. The company adds that North American cannot establish the reliance element of its fraud defense and the witnesses North American seeks to use in support of reliance were not previously disclosed by North American during discovery or are not competent to provide supporting testimony for the issue.

1. Is PHT's Interpretation Inconsistent with the Plain Language of the Policy?

The first basis on which North American asserts that it is entitled to summary judgment is that, in its view, PHT's theory for breach of contract and damages is predicated on an unreasonable interpretation of the policy language. In order for PHT's claim to survive summary judgment, North American maintains that the Court must conclude that three specific interpretations of the policy language are correct. Those interpretations are:

> *First*, the sentence 'Monthly cost of insurance rates are determined by us, based on our expectations as to future mortality experience' ***requires*** North American to undertake an actuarial analysis to adjust its scales of monthly cost of insurance rates whenever there is a change in expected mortality rates.
>
> *Second*, the phrase 'based on' means 'based ***only*** on.'
>
> *Third*, the phrase 'expectations as to future mortality experience' means '***expected mortality rates***.'

[ECF No. 203-1 at 19–20] (emphasis in original).

According to North American, if one of the above interpretations is not supported by the policy language, then PHT's interpretation is incorrect and summary judgment must be granted in its favor.

PHT responds that not only is its interpretation of the policy language reasonable, but it is the most reasonable. It contends that North American's own witnesses disavow the interpretation offered by the insurer and urges that it was crafted specifically for litigation. At minimum, PHT maintains that the parties' competing interpretations demonstrate that the policy language is ambiguous, foreclosing entitlement to summary judgment. The Court will analyze each of North American's propositions in turn.

a. Contractual obligation to adjust COI rates at certain intervals

North American begins its analysis by claiming that although the contract language requires COI rates to be "based on" its EFME, the policy does not require the insurer to change its rate scales at all. Because the policy language does not refer to if or when its rate scales must be adjusted, North American maintains that failure to do so cannot be a breach. It specifically argues, "nothing in this provision dictates that North American must redetermine COI rates at all, in any particular circumstance or at any particular time." [ECF No. 203-1 at 20]. North American's position is that the policy only requires that any adjustment to COI rates, if they are adjusted at all, be based on its EFME. However, it is under no affirmative contractual obligation to change its COI rates.

North American finds support for its position in two cases where the district courts found that because the policy language did not expressly impose a duty to adjust COI rates, an insurer could not be sued for breach of contract for failing to properly adjust the COI rates. *See Kalodner v. Genworth Life & Annuity Ins. Co*., 262 F. Supp. 3d 218, 226–27 (E.D. Pa. 2017); *Advance Tr. & Life Escrow Servs. LTA v. Protective Life Ins. Co*., No. 2:18-cv-01290-MHH, 2022 WL 3159266, at *6 (N.D. Ala. Aug. 8, 2022). North American also argues that PHT improperly conflates the COI rate provision with the COI deduction provision. In the amended complaint, PHT alleges that North American is obligated to adjust its COI rates "monthly, and at least each calendar year." [ECF No. 29 ¶ 47]. PHT's expert witness Howard Zail opines that language in the policy that addresses COI deductions also governs the regularity in which North American must adjust its COI rates. North American argues that this is error because they are separate provisions, and the COI deduction provision does not impose an obligation to redetermine COI rates at any specific interval.

The COI deduction provision states:

> **Cost of Insurance**. The cost of insurance for the Insured is determined on a monthly basis. Such cost is calculated as (1) times (2), where:
> (1) is the cost of insurance rate as described in the Cost of Insurance Rates section. (2) is the net amount at risk, as defined in the Changing Death Benefit Options provision.

[ECF No. 201-3 at 53–54].

By its own terms, the calculation of the COI deduction contains two components: COI rate and the net amount at risk. The two figures are multiplied together to arrive at the appropriate monthly deduction from a policy's accumulation value.

North American also argues that, regardless of whether it has an obligation to adjust the COI rates under the policy, PHT cannot establish that they are not in fact still "based on" its EFME. It illustrates its argument with a mathematical equation:

> For example, if $Y = X + 1$, it is proper to say that Y is 'based on' X. The same can be said if $Y = 2X + 4$. Even if expected mortality rates have changed, the COI rates can still [be] 'based on' expectations as to future mortality experience because the current COI rates may still be reasonably related to the new expected mortality rates.

[ECF No. 203-1 at 22].

North American concludes that the Court need not determine that its proposed interpretation of the policy language is correct in order to grant summary judgment. Rather, the Court must only determine that PHT offers an unreasonable interpretation of the policy.

The Court finds that PHT's interpretation of the policy language is reasonable. Although the language does not contain a direct requirement to adjust COI rates in the COI deduction provision, the language also lacks a clear indication that the COI rates are forever exempt from modifications. It is not unreasonable to read the policy as requiring a redetermination of the COI

rates at some point, particularly when it contains the phrase "determined on a monthly basis." This preliminary phrase is found in the initial paragraph of the provision—which defines the formula for the COI deduction. Notably, the COI rate component is located between the "determined on a monthly basis" clause and the "net amount at risk" component. Nothing in that language implies that the "determined on a monthly basis" refers *only* to the net amount at risk, but not the COI rate. It is ambiguous whether the clause imposes an obligation to readjust the underlying COI rate. *See Advance Tr. & Life Escrow Servs., LTA v. Reliastar Life Ins. Co.,* Civil No. 18-2863 (DWF/BRT), 2022 WL 911739, at *5 (D. Minn. Mar. 29, 2022) (finding comparable language in a COI rate provision could be reasonably construed as "mandatory and prospective").

North American's second suggestion, that COI rates may still be "based on" the EFME—even if those expectations have changed—is difficult to accept, much less grant summary judgment as a matter of law on its basis. There are several reasons why. First, nowhere does the policy language expressly grant North American such unbridled discretion. Describing the COI rates as "based on" the EFME implies that a non-negligible change in the EFME should result in an adjustment of the underlying rate. *See Yue v. Conseco Life Ins.,* 282 F.R.D. 469, 481 (C.D. Cal. 2012) (noting that "the phrase 'based on'" typically means "there must be a significant relationship between a number and any change in a variable that number is 'based on'"). It is far from unambiguous that the language providing that COI rates that are "based on" the EFME also provides that North American retains a veto-like discretion to never adjust COI rates. *See Lincoln Nat'l Life Ins. v. Bezich*, 33 N.E..3d 1160, 1171 (Ind. Ct. App. 2015) (holding it would be "absurd" for a COI rate provision to permit a unilateral increase in rates without a "parallel commitment to decrease rates despite an overwhelming improvement in mortality"). An unambiguous policy

providing such discretion should provide language notifying prospective policyholders accordingly.

Second, as PHT points out, the Class Policies are variable rate policies. [ECF No. 227-1 at 15]. Other courts considering variable rate contracts have come to similar conclusions on the impact of such language. The court in *Conseco* held that "[i]f the variable changes one way and the number does not reflect that change, then the Court must infer that the number is no longer 'based on' that variable—that, instead, the principal factor the number is 'based on' is something else." 282 F.R.D. at 481; *see also Mirkin v. XOOM Energy, LLC*, 931 F.3d 173, 177 (2d Cir. 2019) (holding that a deviation between a rate and the underlying factor in a contract for variable rate electricity charges was grounds to assert a claim for breach of contract). The Court shares the same "grave doubts" as the Indiana Court of Appeals in *Bezich* that "any policyholder of average intelligence would read [or desire] the COI rate provision to confer on [North American] that sort of 'heads we win, tails you lose' power." 33 N.E.3d at 1171.

The Court is also not persuaded by the authorities which North American offers for its interpretation. In one case, a court found "no language in the COI rate provisions in the policies at issue that obligates Protective Life to reassess COI rates monthly." *Advance Tr. & Life Escrow Servs. v. Protective Life Ins. Co.*, Case No. 2:18-cv-01290-MHH, 2022 WL 3159266, at *6 (N.D. Ala. Aug. 8, 2022). North American also cites *Kalodner* for its position that the phrase imposes no prospective redetermination requirement. 262 F. Supp. 3d at 226–27 (finding that the COI rate provision identified several factors in calculating the COI rate but "it does not impose any requirement that Defendant reassess its expectations and alter the rate accordingly"); *Dahl-Eimers v. Mut. of Omaha Life Ins. Co.*, 986 F.2d 1379, 1382 (11th Cir. 1993) (holding that "differing interpretations of the same provision is evidence of ambiguity."). Nevertheless, in light of the

foregoing discussion, the Court concludes that the phrase is at least ambiguous regarding whether North American had a prospective obligation to redetermine its COI rates. North American is not entitled to summary judgment on this basis.

b. "Based on" cannot reasonably mean "based only on"

North American's next contention is the phrase "based on" in the policy language cannot reasonably mean "based only on" in reference to its EFME's relationship to the COI rates. [ECF No. 203-1 at 23]. An interpretation requiring its EFME to be the sole consideration for setting COI rates, according to North American, would be internally inconsistent and amount to rewriting the policy by inserting words into the provision. North American argues that the internal inconsistency of interpreting "based on" to mean "based only on" arises from the fact that "based on" is used earlier in the exact same paragraph:

> The monthly cost of insurance rate is *based on* the sex, attained age, and rating class of the Insured. Policy duration is also a factor in determining the monthly cost of insurance rates. . . . Monthly cost of insurance rates are determined by us, *based on* our expectations as to future mortality experience.

[ECF No. 201-3 at 54] (emphasis added).

North American urges that this dual use of the phrase "based on" highlights PHT's faulty interpretation of the COI rate provision. Under its proffered construction, if the phrase "based on" preceded the exclusive factors on which the COI rate is based, it is non-sensical that it could be "based on" two separate things at once. North American relies on an unreported decision from the United States Court of Appeals for the Eleventh Circuit for support. *Slam Dunk I, LLC v. Conn. Gen. Life Ins. Co.*, 853 Fed. App'x. 451 (11th Cir. 2021). *Slam Dunk* was another COI rate case where an insurance company was sued for breach of contract. The provision at issue in *Slam Dunk* contained a nearly identical COI rate provision:

> The Monthly Cost of Insurance Rates are based on the Insured's Attained Age, the type of benefit, the Class of Insured and whether premiums for that Insured are paid directly to [insurer] or through payroll deductions. The Monthly Cost of Insurance Rates are determined by [insurer] based on its expectations as to future mortality experience.

853 Fed. App'x. at 452.

The Eleventh Circuit affirmed the district court's grant of a motion to dismiss in *Slam Dunk* finding that "based on its expectations as to future mortality experience" did not reasonably mean that COI rates must be based exclusively on EFME. *Id*.

The court in *Protective Life* confronted a similar provision. It found that if the phrase "based on expectations as to future mortality experience" was read to mean "based only on expectations as to future mortality experience," it would essentially "delete the first sentence" of the provision which also stated that rates were "based on the sex, attained age, and rate class of the Insured and on the policy year." 2022 WL 3159266, at *6. Accordingly, the *Protective Life* court held that such an internally inconsistent interpretation of the policy would run afoul of state laws governing some of the policies in the class. *Id*. at *6.

North American accuses PHT of seeking to similarly rewrite the policy language by claiming that its EFME must be the sole basis on which COI rates can be calculated, effectively deleting the sentence identifying "sex, attained age, and rating class of the Insured" as other relevant factors. [ECF No. 203-1 at 25].

i. Applicable Law

Insurance policies are written contracts subject to contract law principles. *Hegel v. First Liberty Ins. Ins. Corp.*, 778 F.3d 1214, 1219 (11th Cir. 2015). Florida law, which governs the Representative Policy, requires a party to establish the familiar elements for breach of contract: "(1) the existence of a contract; (2) a material breach of that contract; and (3) damages resulting

from the breach." *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1272 (11th Cir. 2009) (citation omitted). Interpretation of a contract must be consistent with the plain meaning of the language if it is unambiguous. *Travelers Indem. Co. v. PCR Inc.*, 889 So.2d 779, 785 (Fla. 2004). Contract language is ambiguous if it is "susceptible to more than one reasonable interpretation[.]" *Id.* (quoting *Swire Pac. Holdings v. Zurich Ins. Co.*, 845 So.2d 161, 165 (Fla. 2003)). Proper construction of a contract must give legal effect to all its provisions, taking into account the language drawn from the entire document. *Sugar Cane Growers Co-op of Fla., Inc. v. Pinnock*, 735 So.2d 530, 535 (Fla. Dist. Ct. App. 1999) (citation omitted). Whether a contract is ambiguous is a legal question. *DEC Elec., Inc. v. Raphael Constr. Corp.*, 558 So.2d 427, 428 (Fla. 1990). Florida law construes an ambiguous contract against the drafter as a last resort if the other tools of contract construction fail. *Arriaga v. Fla. Pac. Farms, L.L.C.*, 305 F.3d 1228, 1247–48 (11th Cir. 2002) (citation omitted).

ii. Analysis

As discussed above, the Eleventh Circuit confronted a similar COI rate provision in *Slam Dunk*. The *Slam Dunk* Court did not consider whether the policy at issue was ambiguous due to the "based on" phrase but affirmed the district court's dismissal of the complaint by holding that the plain language did not import exclusivity into the phrase "based on." 853 Fed. App'x. at 454. The United States Court of Appeals for the Eighth Circuit has also considered a COI rate provision in a life insurance contract. *Vogt v. State Farm Life Ins. Co.*, 963 F.3d 753 (8th Cir. 2020).[6] *Vogt* considered whether the "based on" phrase in the policy at issue there could connote exclusivity of

[6] Although PHT repeatedly refers *Vogt* as "binding" precedent, the Eighth Circuit was applying Missouri law under diversity jurisdiction. 963 F.3d at 763. Therefore, the case is not strictly binding but, as the following discussion will illustrate, the Court nonetheless agrees with the panel's interpretation of the contract language at issue.

factors. The policy provided that the COI rates would be "'based on' the Insured's age on the policy anniversary, sex, and applicable rate class." *Id*. at 761. In addition to the listed factors, the plaintiff alleged that the insurer was using other considerations including taxes, profit assumptions, investment earnings, and capital and reserve requirements to calculate COI rates. *Id*.

The insurer argued that the policy language permitted it to calculate the COI rate by considering factors other than those expressly stated in the provision and moved for summary judgment. *Id*. The district court denied summary judgment, finding that the policy was at least ambiguous and should be construed against the insurer. *Id*. at 762. Summary judgment was later granted in favor of the plaintiffs as to liability for breach of contract and the case proceeded to trial on damages where the jury awarded $34 million in damages. *Id*.

On appeal, the insurer argued that the phrase "based on" did not connote exclusivity and permitted it to consider other factors not identified in the policy. *Id*. at 763. The panel determined that the language was at least ambiguous and agreed that it should be construed against the drafter. *Id*. at 764. *Vogt* rejected a contrary holding by the United States Court of Appeals for the Seventh Circuit in *Norem v. Lincoln Benefit Life Co.*, 737 F.3d 1145 (7th Cir. 2013). Noting that *Norem* acknowledged that courts had differed in the exclusivity of the phrase "based on," *Vogt* was more persuaded of the phrase's ambiguity by the fact that "several courts have examined the issue in very similar circumstances and have reached differing conclusions[.]" *Id*. at 764.

As with North American's first argument about the contractual requirement to adjust the COI rate, the Court finds that "based on" is also ambiguous as to whether it connotes exclusivity of factors to consider in its calculation. Consistent with the Eighth Circuit's interpretation in *Vogt*, the Court concludes "based on" could reasonably connote exclusivity. 963 F.3d at 763–64 (holding "a person of ordinary intelligence purchasing an insurance policy would not read the

provision and understand that where the policy states that the COI fees will be calculated 'based on' listed mortality factors that the insurer would also be free to incorporate other, unlisted factors into this calculation."). North American argues that in addition to its EFME, the policy language permits it to consider changes to actuarial assumptions since the pricing of the Class Policies including policy lapses and the amount of premium payments. [ECF No. 203-1 at 16]. North American attempts to distinguish *Vogt* on the basis that it construed a policy provision containing only one use of "based on" in the COI rate provision. Because *Slam Dunk* interpreted a provision with dual "based on" phrases, the insurer claims it is more on point.

The Court disagrees that the dual use of "based on" in the provisions at issue here, and in *Slam Dunk*, makes the provision unambiguous. The dual use of "based on" in both COI rate provisions, if anything, supports that express factors in the policy could be the exclusive bases for the calculation. For example, the first provision states, "based on the sex, attained age, and rating class." The word "and" is conjunctive, meaning each thing is relevant and must be considered. *United States v. Garcon*, 54 F.4th 1274, 1278 (11th Cir. 2022) (en banc) (noting the conjunctive meaning of the word "and"). By extension, the language could be read to include an exhaustive list of terms because the terms "sex, attained age, and rating class" may indicate the policyholder considered a list of relevant factors and chose to exclude the remainder for whatever reasons. *See Witkin Design Grp., Inc. v. Travelers Prop. Cas. Co. of Am.*, CASE NO. 16-20484-CIV, 2016 WL 7670051, at *10 (S.D. Fla. Dec. 15, 2016) (discussing an example of a non-exhaustive list of activities that qualify under the provisions of an insurance contract). Furthermore, it is unclear why the policy would be drafted to include two lists of non-exclusive factors. *See Torremar Condo. Ass'n, Inc v. Great Am. Ins. Co.*, CASE NO. 15-60839-CIV-COHN/SELTZER,

2015 WL 11198246, at *3 (S.D. Fla. July 9, 2015) ("the contract should not be interpreted to achieve an absurd result.").

The ambiguity of the factors in the COI rate calculation is further exaggerated when North American insists that other, non-enumerated factors could be properly considered in its calculation. It is far from unambiguous that a policyholder of ordinary intelligence would read a policy which provides that the COI rate will be "based on A, B, and C" with a subsequent clause providing that the COI rate will be "based on D" means that E, F, and G will also be considered in setting the rate.

PHT, for its part, does not claim that "based on" is an exclusivity clause, only that it requires "a significant relationship between the monthly COI rate and updated EFME." [ECF No. 227-1 at 21]. This is how the Court reads its argument as well. Considering that North American has not adjusted its COI rate scales consistent with changes in its EFME, it is unclear to what extent the COI rate is "based on" EFME, if at all. Rather, North American maintains that the policy language "[m]onthly cost of insurance rates are determined by us, based on our expectations as to future mortality experience," unambiguously means: (i) North American can consider other unenumerated factors in the COI rate calculation; (ii) even in light of significant EFME improvements, COI rates do not need to be adjusted accordingly at any interval; and (iii) North American has a contractual prerogative to *never* adjust the COI rate, even if its EFME improves. It argues that it is entitled to judgment as a matter of law on this interpretation.

Protective Life provides a strong example of the ambiguity and difficulty interpreting the phrase "based on" in this case. That case was originally assigned to a different judge who had found that the policies imposed a prospective requirement for the insurer to redetermine COI rates. 2022 WL 3159266 at *7. The original judge later recused herself and the second judge who

presided over the case came to a different conclusion regarding the requirements of the provision. *Id*. at *4. This is a vivid illustration of the ambiguity in the phrase when judges hearing the same case come to separate conclusions. It is also relevant to the ambiguity question. *See Dahl-Eimers*, 986 F.3d at 1382 ("differing interpretations of the same provision is evidence of ambiguity"); *Hegel*, 778 F.3d at 1220 (same). PHT's interpretation of "based on" is not unreasonable and the proper interpretation of "based on" contained in the COI rate provision is ambiguous.

c. Does "expectations as to future mortality experience" reasonably mean "expected mortality rates?"

North American's final interpretive argument in support of summary judgment is that its EFME, or expectations as to future mortality experience, cannot reasonably mean "expected mortality rates." According to the insurer, this is because "future mortality experience" refers to dollars it pays out on future death claims rather than the rates of mortality for its insureds. [ECF No. 203-1 at 29]. Payouts on death claims are how an insurance company "experiences" mortality, according to North American, therefore it contends that it may appropriately consider changes in actuarial assumptions beyond only mortality rates. These considerations include premium payments received and policy lapse rates. If other considerations are permissible under the policy, North American claims that PHT's theory cannot hold up.

North American highlights that the Class Policies use the word "rate" 57 times but "experience" is only used once—implying a distinct definition for that term. Accordingly, it urges that "experience" and "rate" cannot mean the same thing and PHT's interpretation of the COI rate provision is unreasonable for doing exactly that.

Although North American argues that it is unambiguous that "experience" in "expectation as to future mortality experience" does not mean "expected mortality rates," the insurer does not cite to any external sources which interpret the term that way. Rather, North American points to

the use of "rate" versus "experience" and maintains that "experience" must have a different definition, therefore, PHT's interpretation is unreasonable. North American puts its argument plainly: "no policyholder would reasonably understand [expectations as to future mortality experience] to mean—that North American can consider only the rate at which policyholders will die." [ECF No. 244 at 12].

The Court disagrees that expectations as to future mortality experience *unambiguously* means dollars paid out on death claims rather than expected mortality rates. The Class Policies do not use "future death claims" anywhere. "Lapse" appears 13 times in the policy language but nowhere in the COI rate provision. North American has a colorable argument that "expectation as to future mortality experience" encompasses more than "expected mortality rates" but it is not unambiguous as a matter of law what the term encompasses, and PHT's interpretation is not unreasonable as a matter of law. North American is not entitled to summary judgment on its interpretive arguments. The COI rate provision of the Class Policies is ambiguous and PHT has offered a reasonable interpretation of it.

2. Is there a Question of Fact Whether the COI Rates Breached the Policies?

North American argues that PHT has also failed to present evidence to establish a question of fact that the COI rates actually applied were in breach of the policy. It asserts that PHT cannot meet its burden to establish that the COI rates applied to each policyholder were in breach of the contract because mortality rates changed in different degrees for different groups of insureds. North American dismisses the expert reports of Howard Zail and Robert Mills, claiming that the insurer could contractually assess higher rates than those identified by the two experts. According to North American, PHT must identify the maximum COI rates that it could have properly applied

in order to establish a breach of contract. Because it could have applied higher rates than the ones identified by PHT, the insurer argues that it is entitled to summary judgment.

PHT responds that North American's argument about the existence of a question of fact is unsupported by the record and incorrect. It argues that Zail does, in fact, conclude that EFME improved for all Class Policies, contradicting North American's claim that mortality rates changed in different degrees depending on the group of insureds. PHT also rejects North American's assertion that it must identify the maximum COI rates that could be properly applied without breaching the contract, arguing that position does not "make any sense" because North American conflates different contractual requirements. [ECF No. 227-1 at 32]. PHT also accuses North American of misrepresenting whether it is undisputed that North American could use rates higher than those identified by Zail and Mills.

The Court finds that whether North American has breached each class policy is a disputed question of fact that cannot be determined on summary judgment. In his report, Zail concludes that North American's EFME has improved for all Class Policies. [ECF No. 227-6 at 57–61]. North American disputes this fact on summary judgment. [ECF No. 244-1 ¶ 30]. Both parties agree that COI rates and EFME are determined for life insurance policies at the group level and not on an individual basis. [ECF No. 244-1 ¶ 24]. As PHT correctly argues, disagreement between experts is a paradigmatic factual dispute, which cannot be adjudicated on summary judgment. *See Wills v. Encompass Ins. Co.*, 47 F.4th 900, 904 (8th Cir. 2022) (holding a conflict between expert witnesses created a genuine dispute of material fact, making summary judgment "improper").

Furthermore, North American's contention that it did not exceed the Guaranteed Maximum Insurance Rates defined by the policy does not entitle it to summary judgment. This is because PHT alleges a breach of contract for failing to lower the COI rates pursuant to that contractual

provision, not a breach for exceeding the Guaranteed Maximum Insurance Rates provision. The Eighth Circuit has noted that an insurer cannot avoid liability for a breach of contract by pointing to a different provision it has not violated. *Vogt*, 963 F.3d at 764. In sum, PHT has adduced sufficient evidence of a breach by North American to generate a genuine dispute of material fact.

3. Is this Action Barred by the Statute of Limitations or the Doctrine of Laches?

North American next argues that it is entitled to summary judgment because the lawsuit is untimely, offering two reasons. First, it contends that PHT's claim on the Representative Policy is time-barred by Florida's statute of limitations and the common law doctrine of laches. Second, it asserts that the claims of other class members are also barred by the applicable statute of limitation in other states.

As to the Representative Policy, North American argues that PHT's allegation is that the insurer breached the policy nearly thirty years ago when it failed to adjust its COI rates at least each calendar year. [ECF No. 203-1 at 32–33]. North American contends that PHT cannot maintain a breach of contract action by only seeking damages within the statute of limitations period because the claim accrued long before that.

Even though PHT is not the original policyholder, the statute of limitations and the doctrine of laches still applies to its claim the same as its predecessors. *State v. Family Bank of Hallandale*, 667 So.2d 257, 259 (Fla. 1st Dist. Ct. App. 1995) ("The assignee steps into the shoes of the assignor and is subject to all equities and defenses that could have been asserted against the assignor had the assignment not been made.").

a. Applicable Law

The applicable statute of limitations period is the shorter of the period under Iowa law or the state of issuance. *Washburn v. Soper*, 319 F.3d 338, 341–42 (8th Cir. 2003). For the

Representative Policy, that is the five-year statute of limitations under Florida law. Fla. Stat. § 95.11(2)(b). Florida law does not apply the discovery doctrine which means the statute of limitations cannot be tolled for the policyholder's failure to discover the alleged breach. *Servicios de Almacen Fiscal Zona Franca Y Mandatos S.A. v. Ryder Int'l*, 264 Fed. App'x. 878, 880 (11th Cir. 2008). Florida law does not reset the statute of limitations for a "continuing injury" either. *Cohen v. World Omni Fin. Corp.*, 751 F. Supp. 2d 1289, 1294 (S.D. Fla. 2010) (citing *Lovett v. Ray*, 327 F.3d 1181, 1183 (11th Cir. 2010) (noting that a continuing injury does not toll the statute of limitations, but a continuing violation does). However, if breaches are separate and distinct, a new statute of limitations clock will start for each breach. *Tampa Bay Rays Baseball, Ltd v. Volume Servs., Inc*., Case No. 8:17-cv-2948-T-30TGW, 2018 WL 3068068, at *2 (M.D. Fla. Mar. 12, 2018) (citing *Access Ins. Planners, Inc. v. Gee*, 175 So. 3d 921, 924–25 (Fla. Dist. Ct. App. 2015)); s*ee also Circuitronix, LLC v. Shenzen Kinwong Elec. Co., Ltd.*, Case No. 17-cv-22462-UU, 2018 WL 7287192, at *8 (S.D. Fla. Jan. 31, 2018). A life insurance policy can be breached intermittently throughout its term. *Klein v. John Hancock Mut. Life Ins. Co.*, 683 F.2d 358, 360 (11th Cir. 1982).

Laches is an equitable doctrine that prohibits an action if there was a prejudicial delay by the plaintiff in bringing the claims. *Garcia v. Guerra*, 738 So.2d 459, 461 (Fla. Dist. Ct. App. 1999) ("Laches is effective to bar enforcement when there has been a substantial and inexcusable delay in enforcing the claim to arrears of support and the delay has prejudiced the defendant or led him to change his position to such an extent that enforcement of the decree would be inequitable or unjust."). A laches defense requires an "unreasonable delay in asserting a known right." *Brumby v. Brumby*, 647 So. 2d 330, 331 (Fla. Dist. Ct. App. 1994). It also requires the plaintiff to have knowledge or notice of the defendant's wrongful conduct. *Van Meter v. Kelsey*,

91 So. 2d 327, 331 (Fla. 1956). Importantly for this case, "[l]aches may be applied before the statute of limitations expires only where strong equities" apply. *Goodwin v. Blu Murray Ins. Agency, Inc.*, 939 So. 2d 1098, 1105 (Fla. 5th Dist. Ct. App. 2006).

b. Analysis

North American takes the position that the statute of limitations on the Representative Policy expired decades ago and no exception is applicable. It acknowledges that at the time the Class Policies were developed, its COI rates were not set at levels identical to the expected mortality rates. North American's expected mortality rates have improved over the past 30 years, so the insurer argues that any claim for breach of contract predicated on the Representative Policy is past the permissible statute of limitations period. North American analogizes to a case where an insurer had reduced the amount of monthly disability payments it made to a policyholder but the insured went over six years before alleging a breach of contract claim. *Dinerstein v. Paul Revere Life Ins. Co.*, 173 F.3d 826, 828 (11th Cir. 1999). The Eleventh Circuit reversed a judgment for the plaintiff in *Dinerstein*, holding that the action was barred by the statute of limitations because the lawsuit was not based on incorrect monthly payments but sought "to define the rights and obligations of the parties under the original insurance contract." *Id*. at 828–29.

PHT rejects North American's argument that its contract claim accrued decades before it filed this lawsuit. Rather, it alleges that North American breached the Class Policies every month when it applied incorrect COI rates that should have been reduced due to improvement in mortality. PHT argues that North American relies on cases which are inapposite to the fact pattern here, itself citing to other COI rate cases where courts rejected statute of limitations defenses by insurers. [ECF No. 227-1 at 35–36] (citing *Yearby v. Am. Nat'l Ins. Co*., Case No. 20-cv-09222-EMC, 2021 WL 3855833 at *13–14 (N.D. Cal. Aug. 30, 2021); *ReliaStar*, 2020 WL 5229677 at *11; *Fradianni*

v. Protective Life Ins., 73 A.3d 896, 903 (Conn. App. 2013); *Dean v. United of Omaha Life Ins.*, No. CV 05-6067-GHK (FMOx), 2007 WL 7079558 at *10–11 (C.D. Cal. Aug. 27, 2007); *Lee v. Allstate*, 838 N.E.2d 15, 23 (Ill. App. 2005). The Court agrees with PHT. The claims contained in the complaint did not accrue decades prior to the initiation of the lawsuit. PHT alleges that North American continuously violated the contract on a monthly basis through excessive COI rates. Each time that North American applies an allegedly improper COI rate, a new breach occurs. *Esys Latin Am., Inc. v. Intel Corp.*, CASE NO. 12-22265-CIV-ALTONAGA/Simonton, 2012 WL 12865249, at *6 (S.D. Fla. Aug. 28, 2012). Put simply, PHT's claim for breach of contract did not accrue years ago.

North American also claims that the decades-long delay in bringing this action entitles it to a laches defense because it has been prejudiced by the passage of time. North American contends that PHT and its predecessors knew or should have known that expected mortality rates had improved for many groups of insureds. It points to publicly available mortality tables and information published by government agencies and news media as sufficient to give PHT and its predecessors inquiry notice. North American argues that the company sent annual statements to its policyholders between 1995 and 2007 which confirmed the COI rate for the upcoming year. According to North American, this also should have put PHT and its predecessors on notice that the COI rate had not been lowered concomitantly with the expected mortality rates. [ECF No. 203-1 at 37].

The prejudice suffered, in North American's view, stems from its inability to locate the actuaries who devised the original pricing assumptions for the Class Policies. Without the availability of these employees, North American maintains that it cannot provide fulsome and

complete testimony about the pricing and actuarial assumptions that were considered in the product design process.

North American cannot establish its laches defense as a matter of law at this procedural stage. Whether PHT and its predecessors were unreasonable in failing to bring its claim sooner is a disputed fact. The same goes for whether they had knowledge or notice of the insurer's failure to adjust the COI rates. PHT argues that North America's EFME, an internal metric, was the improved variable that required a decrease in the COI rates. The EFME is non-public information and is also subject to a protective order in this case. *See* [ECF No. 38]. Whether a predecessor of PHT could have gleaned information from public sources necessary to put it on inquiry notice regarding a possible breach by North American as to the COI rates is a disputed fact which cannot be resolved on summary judgment.[7]

4. Is PHT's Claim Barred by Fraud?

Finally, North American argues that summary judgment should be granted in its favor because the Representative Policy was obtained through fraud by the insured. It is undisputed that D.F., the original policyholder of the Representative Policy, made a false representation on his policy application. On the application, D.F. responded "No" to the question: "During the past five years, [have you] been under observation, been hospitalized, received treatment, consultation, or therapy of any kind from a medical professional?" [ECF No. 231-1 ¶ 52]. He did so despite medical evidence in the summary judgment record indicating that he was seen by physicians at least 27 times between June 1989 and August 1993. *Id.* ¶ 50. D.F. received this medical treatment

[7] Beyond the Representative Policy, North American also contends all the Class Policies issued at least 17 years prior to the filing of the complaint are time-barred by every applicable statute of limitations. The statute of limitations defense and laches defense is denied on the same basis as the Representative Policy.

because he was diagnosed as HIV-positive in June 1989. *Id*. ¶ 49. The record indicates that D.F. obtained seven or eight life insurance policies on his life around this time period, several of which he sold into the life settlement market including to Life Partners. *Id*. ¶ 54.

The Representative Policy has a two-year incontestability period.[8] *Id*. ¶ 55. An incontestability period is a time limitation after which an insurance company cannot void a policy for inaccuracies. The incontestability period for the Representative Policy expired on August 8, 1995. *Id*.

North American argues that PHT's claim is barred by fraud on the basis of D.F.'s misrepresentation on his policy application. Acknowledging the incontestability clause of the Representative Policy has long expired, North American argues that the clause does not bar an affirmative defense for fraud under Florida law. Rather, its position is that the clause prevents it from *voiding* the policy but it does not prohibit the company from obtaining other legal and equitable relief on the basis of the misrepresentation.

PHT responds to this argument by asserting that North American cannot prove its affirmative defense as a matter of law. PHT rejects North American's contention that the incontestability clause applies only to voiding of the policy, asserting that it also applies to any

[8] The incontestability clause provides:

> **Incontestability**. Except for any provisions for disability benefits, this policy is incontestable after it has been in force during the lifetime of the Insured for a period of two years from the Policy Date. Any increase in Specified Amount or net amount at risk applied for when changing Death Benefit options effective after the Policy Date is incontestable only after such increase has been in force during the lifetime of the Insured for two years following the effective date of such increase.

[ECF No. 201-3 at 56].

claim that the policy is invalid. [ECF No. 227-1 at 41]. In addition to being incorrect about the law, PHT maintains that North American cannot establish the elements required for its affirmative defense regardless of the relevant standard.

a. Applicable Law

Fraud and fraudulent inducement are complete defenses to a claim for breach of contract under Florida law. *Yost v. Rieve Enters., Inc.*, 461 So. 2d 178, 183 (Fla. Dist. Ct. App. 1984). This is the application of the equitable principle that "no one shall be permitted to profit by his own fraud, or take advantage of his own wrong, or found any claim upon his own iniquity, or profit by his own crime." *Cabrerizo v. Fortune Int'l Realty*, 760 So. 2d 228, 229 (Fla. Dist. Ct. App. 2000) (quoting *Ashwood v. Patterson*, 49 So.2d 848, 850 (Fla. 1951)). Although PHT itself did not engage in any fraudulent conduct, it "stands in [the] shoes" of D.F., in the same way it does with the statute of limitations and laches issues. *SFR Servs. LLC, v. Geovera Specialty Ins. Co..*, No. 2:19-CV-466-JLB-MRM, 2021 WL 1909669, at *3 (M.D. Fla. May 12, 2021) (quoting *Pro. Consulting Servs., Inc. v. Hartford Life & Accident Ins. Co.* 849 So.2d 446, 447 (Fla. Dist. Ct. App. 2003).

Florida law requires that incontestability clauses be included in all life insurance policies. *See* Fla. Stat. Ann. § 627.455 (providing "[e]very insurance contract shall provide that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of 2 years from its date of issue[.]"). An incontestability clause prohibits an insurer from arguing that "the policy was not valid at its inception or later became invalid due to fraud." *Kuber v. Berkshire Life Ins. Co. of Am.*, CASE NO. 19-80211-CV-MIDDLEBROOKS, 2020 WL 650782, at *1 (S.D. Fla. Jan. 27, 2020).

An incontestability clause "gives the insured a guaranty against expensive litigation to defeat his policy after the lapse of the time specified, and at the same time gives the company a reasonable time and opportunity to ascertain whether the contract should remain in force." *Prudential Ins. Co. of Am. v. Prescott*, 176 So. 875, 878 (1937). Florida law strictly construes incontestability clauses against the life insurance company. *Bankers Sec. Life Ins. Soc. v. Kane*, 885 F.2d 820, 822 (11th Cir. 1989).

It is undisputed that an incontestability clause in a life insurance policy prohibits an insurer from *voiding* the policy and refusing to pay the death benefit, after the incontestability period expires. *See Sun Life Assurance Co. of Can. v. Imperial Premium Fin., LLC*, 904 F.3d 1197, 1211 (11th Cir. 2018). It also prohibits affirmative litigation based on a fraud theory. *John Hancock Life Ins. Co. v. Rubenstein*, Case No. 09-21741-CIV-UNGARO, 2009 WL 10667701, at *4 n.7 (S.D. Fla. Sept. 1, 2009) (citing *Kane*, 885 F.2d at 922). However, North American does not seek to void the policy, but seeks to use the fraud as a defense to this lawsuit for breach of contract. The issue then is whether the incontestability clause can be used as a shield by an insurer (by way of an affirmative defense) rather than solely as a sword (by voiding the policy and refusing to pay the death benefit). Case law does not directly answer this question.

b. Analysis

North American relies on the decision of the Eleventh Circuit in *Sun Life* for its position that the incontestability clause does not bar its fraud defense. In that case, an insurance company brought a lawsuit against an investment company that offered financing to insureds to pay their monthly life insurance premiums. *Sun Life*, 904 F.3d at 1202. The insurer alleged that the defendant devised a scheme to acquire policies it had underwritten in order to receive the death benefit. The insurer claimed the procurement of these policies were unlawful because it would

not have issued the policies if it was aware of the applicant's intent to use premium financing or transfer ownership of the policy to the defendant who used the policies as an investment vehicle. *Id*. at 1204.

The defendant utilized insurance agents to seek out senior citizens to procure life insurance policies which would be funded by the defendant through non-recourse financing. When assisting with the application process, the agents would falsely answer "no" to the question about whether premium financing was going to be used. *Id*. at 1204. The defendant was able to conceal from the insurer the source of the premium payments through a payment system routed through different financial institutions. The original policyholders would eventually default on the defendant's financing after two years (beyond the incontestability period). The defendant would then foreclose on the policies (pursuant to the financing agreement) and submit a change of ownership and change of beneficiary to the insurer. *Id*. at 1205. This was the first time the insurers would learn of the defendant's interest in the policy. *Id*. Because the two-year contestability period had expired, the insurer was time-barred from contesting the validity of the policies, and stuck with investor-owned policies that it actively sought to avoid. The insurer claimed it was harmed by this surreptitious assignment because sophisticated investors know how to manipulate the value of the policies in ways a typical consumer does not, reducing the profitability of the policies to the insurer. *Id*. at 1205. The insurer brought several claims against the defendant company, one of which was a fraud claim.

The district court in *Sun Life* dismissed the fraud claim against the defendant on the grounds that it was time-barred by the incontestability clause. *Id*. at 1210. The Eleventh Circuit held that the clause did not apply and reversed the dismissal, holding that, under Florida law, "a life insurance policy's incontestability clause [does] not bar a fraud claim that d[oes] not seek to void

the policy." *Id*. at 1212. It reasoned that a lawsuit for damages based on fraud does not fit within the textual definition of "contesting" a policy. *Id*. This is because the policy would remain in full force regardless of any judgment on the fraud claim. The *Sun Life* Court determined that such an interpretation did not impact the purpose behind an incontestability clause which is "'to create an absolute assurance of the benefit.'" *Id*. (quoting *Nw. Mut. Life Ins. Co. v. Johnson*, 254 U.S. 96, 101 (1920) (Holmes, J.)). The *Sun Life* panel explained that "the prevailing function of an incontestability clause is to remove from any doubt a life insurer's obligation to pay death benefits (following a reasonable period to allow the insurer to investigate) helps explain why Florida law has singularly focused its application of incontestability clauses on efforts to void policies." *Id*. Because the relief sought by the insurer in the case did not "call into question the continuing viability of the policy," the court concluded that a damages claim for fraud did not constitute "contesting" the policy for purposes of the incontestability clause. *Id*.

North American reads *Sun Life* to limit the application of an incontestability clause to instances where an insurer seeks "recission of the policy as a remedy." [ECF No. 244 at 16] (quoting *Sun Life*, 904 F.3d at 1211). Here, it asserts that it is "using D.F.'s undisputed fraud as a defense to prevent D.F.'s successor from misusing the ill-gotten policy to retroactively lower its insurance costs." *Id.* PHT, for its part, urges that *Sun Life* stands for the permissibility of fraud claims seeking damages after the incontestability period expires. PHT points out that affirmative defenses are not addressed or discussed in *Sun Life*. [ECF No. 227-1 at 41].

This is a close call. Permitting an insurer to use fraud as a defense to a breach of contract claim outside of the contestability period is a further stretch than in *Sun Life*. In that case, the insurer only sought *damages* for alleged fraudulent misrepresentation. This would be a one-time recovery. If an insurer, such as North American here, was permitted to assert fraud as a defense

to a breach of contract claim, that would not limit its application to one-time damages. If the incontestability clause did not apply here, North American could be immunized from *all* potential breaches of contract vis-à-vis the Representative Policy. This would amount to functionally voiding the policy—or the value of the benefit—even if it were not formally voided. *See Sciaretta v. Lincoln Nat. Life Ins. Co.*, 899 F. Supp. 2d 1318, 1328 (S.D. Fla. 2012) (citing *Kane*, 885 F.2d at 822) (explaining that courts must be careful to allow fraud suits that "merely provide a different means to challenge the validity of the insurance contract."). PHT would be prohibited from bringing any breach of contract claim on the Representative Policy in the future. It appears that a failure to pay the death benefit, which itself would be a potential breach of contract, would be the only scenario where the incontestability clause would prevent an affirmative defense by an insurer. PHT alleges that North American has failed to adjust its COI rates as required by the policy language. If fraud is a complete defense to a claim for any breach short of a failure to pay the death benefit, the purpose of the incontestability clause would be undermined. *Nw. Mut. Life*, 254 U.S. at 101 ("[T]o create an absolute assurance of the benefit."); *Kane*, 885 F.2d at 821–22 (rejecting an affirmative defense that no contract existed because "there [was] no meeting of the minds" because it would undermine the incontestability clause). That was simply not the case in *Sun Life* where the insurer sought damages but did not otherwise threaten the validity of the policy. Asserting a defense of fraudulent inducement to a breach of contract claim outside the contestability period threatens the benefits of the policy in a manner that would violate the purpose of the clause. Therefore, North American's fraud defense is barred by the incontestability clause.

PHT has set forth a reasonable interpretation of the COI rate provision and generated a question of fact about whether the Class Policies have been breached. North American has not established as a matter of law that the doctrine of laches should apply to PHT's claim. The fact

that the statute of limitations has not run strongly suggests that laches is inapplicable at this stage. When taken alongside the lack of evidence, denial of this defense is appropriate. North American's Motion for Summary Judgment is DENIED. [ECF No. 201].

C. PHT's Motion to Exclude Jack Gibson and Craig Merrill

Both parties move to exclude or limit the expert testimony of the opposing side's witnesses. PHT moves to exclude actuary Jack Gibson, economist Craig Merrill, underwriter Roger Hofer, and systems analyst Nancy Sparks. North American seeks exclusion of actuary Howard Zail and economist Robert Mills.

An expert's opinion will be admissible if: "(1) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (2) the testimony is based on sufficient facts or data; (3) the testimony is the product of reliable principles and methods; and (4) the expert has reliably applied the principles and methods to the facts of the case." Fed. R. Evid. 702. "The proponent of the expert testimony bears the burden to prove its admissibility." *Menz v. New Holland N. Am., Inc.*, 507 F.3d 1107, 1114 (8th Cir. 2007) (citation omitted). "Decisions concerning the admission of expert testimony lie within the broad discretion of the trial court." *Neb. Plastics, Inc. v. Holland Colors Ams., Inc.*, 408 F.3d 410, 415 (8th Cir. 2005) (citation omitted). "Courts should resolve doubts regarding the usefulness of an expert's testimony in favor of admissibility." *Marmo v. Tyson Fresh Meats, Inc.*, 457 F.3d 748, 758 (8th Cir. 2006) (citation omitted).

PHT and North American challenge the reliability of the opposing party's expert witnesses. An expert's testimony may be excluded if it is "so fundamentally unsupported that it can offer no assistance to the jury." *Wood v. Minnesota Mining & Mfg. Co.*, 112 F.3d 306, 309 (8th Cir. 1997). To satisfy the reliability requirement, the party offering expert testimony "must show by a

preponderance of the evidence both the expert is qualified to render the opinion and the methodology underlying the conclusions is scientifically valid . . . To satisfy the relevance requirement, the proponent must show that the expert's reasoning or methodology was applied properly to the facts at issue. *Khoury v. Philips Med. Sys.*, 614 F.3d 888, 892 (8th Cir. 2010) (internal citations and quotation omitted). "Vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." *Daubert v. Merrell Dow Pharm. Inc.*, 509 U.S. 579, 596 (1993).

PHT seeks to exclude three sets of opinions from North American's two expert witnesses, Jack Gibson and Craig Merrill. It argues that the specified opinions are inadmissible because they lack a reliable foundation or are contrary to law.

Jack Gibson is an actuarial consultant who North American offers for the purpose of analyzing the development, pricing, and administration of the Class Policies. He will also critique Howard Zail's model and opinions. *See* [ECF No. 193-4]. Craig Merrill is an insurance economist and professor of finance retained by North American to opine on the economics and design features of the Class Policies. *See* [ECF No. 193-5].

PHT first objects to Gibson and Merrill's interpretation of the phrase "expectations as to future mortality experience" in the Class Policies. It asserts that the experts' description of the factors included within the EFME are simply *ipse dixit*, arguing that neither expert has provided any written or oral source to support their definition. PHT also argues that North American's actuarial fact-witnesses concede that they do not know of any sources defining EFME in the same manner as Gibson and Merrill. Furthermore, PHT claims that the definition of EFME offered by Gibson and Merrill contradicts North American's own internal documents and submissions to state

insurance regulators. PHT urges that Gibson and Merrill's opinions about EFME lack a reliable foundation and should be excluded on that basis.

Next, PHT takes issue with Gibson and Merrill's criticisms of its damages model. The company argues the experts' opinions are inconsistent with law, because PHT's damages model has been explicitly endorsed by the Eighth Circuit in *Vogt*. The Eighth Circuit held that a damages model such as the one identified by PHT provides the most reasonable basis for measuring the harm to policyholders. According to PHT, Gibson and Merrill's damages opinions are contrary to law and should not be shared with the jury.

Finally, PHT seeks to preclude Merrill from opining on the Actuarial Standards of Practice ("ASOPs"). It asserts that Merrill is not qualified to offer these opinions because he is not an actuary. Merrill disclaimed at his deposition that he was offering actuarial opinions, stated that he did not write his report with a focus on the ASOPs, and does not have expertise in their interpretation. PHT maintains that despite such declarations by Merrill, his report and testimony are filled with opinions about the ASOP 2, which provides principles on the calculation of COI rates. Therefore, it argues that Merrill's opinions on the ASOPs are inadmissible.

North American opposes PHT's motion. It asserts that Gibson and Merrill are rebuttal witnesses offered to refute the opinions of PHT's experts—Zail and Mills. North American contends that PHT's arguments that the two experts' opinions are "*ipse dixit*" and not "quantified" do not provide sufficient reason to exclude their critiques as it relates to the EFME definition. North American contends that the opinions are well-supported by the experts' own expertise, experience, and documentary sources. Furthermore, North American argues that rebuttal experts are permitted to offer criticisms of another expert's opinions without providing their own detailed methodologies or calculations. North American also asserts that the opinions of both experts

regarding the damages model offered by PHT's experts are not contrary to Eighth Circuit precedent. That precedent, according to North American, actually supports its argument that an injury suffered from overcharged rates on universal life insurance policy is the "depleted account value." It argues that Merrill is qualified to refer to the ASOPs in his reports because he is an insurance economist and not providing actuarial opinions. Merrill's 30 years of experience in the insurance industry, means he is well-qualified to refer to the ASOPs that insurance company actuaries rely upon, and he refers to the ASOPs only to rebut PHT's experts. North American urges the Court to deny the motion and permit Gibson and Merrill to offer their full rebuttal opinions of PHT's experts.

1. Are Gibson and Merrill's EFME definitions unreliable?

PHT first attacks the reliability of Gibson and Merrill for their definition of EFME. It contends that their definitions of the term are unmoored from any industry definition and solely based on their own assertions. The definition of EFME contained in Gibson's report includes not only mortality in the EFME but also factors such as assumed persistency rates and assumed premium payment patterns. [ECF No. 193-4 ¶ 19]. Similarly in Merrill's report, he opines that EFME "must take into consideration all of the assumptions needed to project the cost of providing death benefits, including mortality rates, persistency rates, premium funding patterns, and the general interest rate environment, all over future periods." [ECF No. 193-5 ¶ 40]. PHT contends that when questioned about the source of their definitions of the phrase at their depositions, both experts replied that they were unaware of any definition of the phrase in actuarial treatises, dictionaries, or textbooks. [ECF No. 193 at 10]. Neither expert could point to documents internal to North American or any other company source for support, according to PHT's motion. *Id*. The lack of any support for their definition in the literature, PHT asserts, means that they cannot claim

their definition of EFME relies on a term of art within the industry. PHT asks the Court to exclude their definition because neither expert identifies a written source which supports their definitions of EFME.

North American responds that PHT's claim that Gibson's and Merrill's opinions are unsupported by industry sources is incorrect. The insurer points out the Gibson explains that a September 2021 version of ASOP 2 supports his positions that EFME differs from expected mortality rates. [ECF No. 223 at 10]. In his report, Gibson writes, "[i]t is clear to me that the reference to 'experience' and 'anticipated experience' . . . are referencing dollars, not rates or factors. The 'profit margins' referenced are computed using the anticipated experience in dollars." [ECF No. 193-4 at ¶ 103]. Gibson also draws from a textbook—U.S. GAAP for Life Insurers, a 1991 appraisal from an actuarial consulting firm, and a 2015 cash flow testing memorandum by North American. *Id*. ¶¶ 88, 104, 106.

The opinions of Gibson and Merrill as to the correct factors for EFME are not so unreliable that they must be excluded. Although PHT takes issue with the support for their definitions, as undisputedly qualified experts on the subject matter, they may permissibly opine on the term. Federal Rule of Evidence 702 provides that experience by itself can establish a sufficient foundation for expert testimony. *See* Fed. R. Evid. 702 advisory committee note to 2002 amendment (emphasizing that "[n]othing in [amended Rule 702] is intended to suggest that experience alone . . . . may not provide a sufficient foundation for expert testimony . . . Rule 702 contemplates that an expert may be qualified on the basis of experience[.]"). PHT expressly states that it "does not challenge" the qualifications of Gibson or Merrill on this point but asserts that without further support, the two experts are merely "pronouncing" their conclusion as correct

rather than offering evidence or reasoning to "render[] the conclusion reliable." [ECF No. 236 at 4].

Both experts are clearly qualified to testify on the subject matter. North American has identified portions of their reports in which they rely on sources to lend foundation to their opinions. The Court will not prohibit either expert from offering their definitions of EFME in their testimony.

The Court also finds that their opinions are not so fundamentally unreliable to be excluded because they fail to "quantify" their definition of EFME, as PHT complains. Expert witnesses may be permissibly offered for the sole purpose of critiquing the opposing party's expert without offering an alternative method. *See Mahaska Bottling Co. v. PepsiCo, Inc.*, 441 F. Supp. 3d 745, 759 (S.D. Iowa 2019) (citation omitted). Gibson and Merrill are offered as rebuttal witnesses, so their function is "to explain, repel, counteract or disprove evidence of the adverse party." *Marmo*, 457 F.3d at 758 (quoting *United States v. Lamoreaux*, 422 F.3d 750, 755 (8th Cir. 2005)). Relatedly, an expert's opinion should only be excluded when it is "so fundamentally unsupported that it can offer no assistance to the jury." *Bonner v. ISP Techs., Inc.*, 259 F.3d 924, 929–30 (8th Cir. 2001). Therefore, "[a]s a general rule, the factual basis of an expert opinion goes to the credibility of the testimony, not the admissibility, and it is up to the opposing party to examine the factual basis for the opinion in cross-examination." *Id*. at 929. Gibson and Merrill may be offered to poke holes in the expert testimony offered by PHT. A plaintiff has the burden to prove a breach of contract, North American does not have the burden to prove that it complied with it. The testimony of Jack Gibson and Craig Merrill is reliable enough that North American may offer those witnesses on the subject matter of EFME.

2. Should the experts be precluded from offering damages opinion if it contradicts Eighth Circuit precedent?

The second opinion of Gibson and Merrill that PHT seeks to exclude is their testimony on damages. Gibson stated that he did not agree that the "overcharges," for which Zail's methodology and Mills's calculations account, are a proper measure of loss in this case. [ECF No. 193-4 ¶ 10]. Gibson explains that "[i]n order to obtain the cash value of a policy, a policyholder must surrender the contract." *Id*. North American maintains that surrendering a policy entails various fees and tax withholdings which make a cash award an inappropriate remedy for an alleged breach of a life insurance policy. A more appropriate remedy, according to North American, is to "credit back" an "overcharge" to the account that suffered the depleted value because that would follow "the settled rule in all states to put the party in the same economic position as he or she would have been absent the alleged [contract] breach." [ECF No. 223 at 18].

PHT protests that because Gibson and Merrill do not agree with its proposed damages model, their opinions are contrary to law, per *Vogt*, and must be excluded. In *Vogt*, the Eighth Circuit held that a damages model that "measure[s] the lost account value for all policyholders during the period in which they held the policies, provide[s] the most reasonable basis for measuring the harm that was incurred during the life of the policyholders." 963 F.3d at 770. PHT again urges that *Vogt* is binding on the Court and must be followed, requiring exclusion of Gibson's and Merrill's opinions on its damages model.

There are a few problems with PHT's argument. First, as the Court noted earlier, *Vogt* is not binding on this class action because the panel was exercising diversity jurisdiction and applying Missouri law. Second, *Vogt* explained that the defendant in that case did not file a *Daubert* motion before the district court. Therefore, the court was limited to considering its appeal of the damages model to the extent that it challenged the sufficiency of the evidence. *Id*. at 769.

Third, the damages issue on appeal pertained to policies where a death claim was paid so the policy's beneficiaries were claimed to no longer have an interest in the depleted account value. *Id*. at 770. The panel concluded that it saw "no reason to limit damages merely because death benefits have been paid for a policyholder; that policyholder still suffered a depleted account value during his lifetime due to State Farm's overcharges of COI fees." *Id*. The *Vogt* Court was "mindful" of the standard of review on a sufficiency of the evidence challenge and rejected the insurer's argument that the damages model was insufficient to support the jury verdict. *Id*.

The Court does not believe that *Vogt* dictates that Gibson and Merrill's damages opinions are contrary to law and must be excluded. North American may present Gibson and Merrill's testimony as to the proper measure of any damages in this case.

3. Should Merrill be precluded from opining on the ASOPs?

Finally, PHT asks that Merrill be precluded from opining on actuarial standards of practice. Merrill is not a licensed actuary. PHT contends that even though he does not have actuarial expertise, he references the ASOPs repeatedly in his report. It argues he should not be allowed to provide expert testimony on actuarial standards because he does not have the expertise. PHT argues that Gibson and Zail are actuaries, so they can properly offer actuarial opinions, but because Merrill is not, he is not subject to the ASOPs.

North American writes that PHT misunderstands the nature of Merrill's testimony because he does not offer any actuarial testimony. The insurer contends that Merrill merely refers to published actuarial standards when they are relevant to his larger opinions pertaining to insurance economics but does not offer "actuarial opinions." [ECF No. 223 at 20]. North American compares Merrill's reference to ASOPs in the same way a non-lawyer may reference statutes or

administrative regulations. It urges that "Merrill need not be an actuary to read and comment on the actuarial standards he references." *Id*. at 21.

The Court finds that North American's analogy to non-lawyers is off the mark. First, non-lawyers (and even testifying lawyers) are very closely circumscribed as to testimony concerning relevant law, so as to not usurp a court's duty to define the law for the jury. Second, statutes and administrative regulations are to be understandable to lay persons to permit them to comply with the law. The ASOPs provide actuarial principles to guide actuaries but have little relevance to non-experts. North American tries to square this circle by claiming that Merrill only "references" the ASOPs rather than testify as an expert on them. This distinction—to the extent there is one—would almost certainly be lost on the jury. Therefore, the Court will prohibit Merrill from offering testimony or opinions about actuarial matters. He may not testify to his opinions as identified in the relevant Exhibits attached to PHT's motion to exclude. *See* [ECF No. 193-18–193-20]. PHT's Motion to Exclude the Opinions of Jack Gibson and Craig Merrill is GRANTED in part and DENIED in part. [ECF No. 192].

D. North American's Motion to Exclude Howard Zail

At the class certification stage, the Court denied a previous motion by North American to exclude PHT's expert witness, actuary Howard Zail. [ECF Nos. 92; 148]. The insurer renews its request to exclude Zail, describing in extensive detail the infirmities and shortcomings it believes are in the report and contends his opinion must be excluded as unreliable. North American argues that Zail's Margin Maintenance Methodology ("MMM") for redetermining COI rates for the Class Policies is impractical, internally inconsistent, and fails to satisfy the *Daubert* standard. It further alleges that Zail's methodology depends on an improper application of actuarial standards and provides legal conclusions disguised as actuarial opinions. North American maintains that Zail

admitted during his deposition that he had never discussed his methodology with any actuary outside of the litigation context, casting doubt on its soundness and giving the appearance of being made for litigation purposes. [ECF No. 195-1 at 5].

PHT resists the motion, arguing that North American's arguments are based on inaccuracies and mischaracterizations. It asserts that Zail's opinions satisfy the *Daubert* standard and highlights his extensive experience as an actuary, including designing and pricing universal life insurance products for over three decades. PHT also disputes North American's characterization of Zail's methodology as unusual and claims that there are no mathematical errors in his report. PHT contends that North American has not suggested any alternative methodology to Zail's approach, which it insists is sound. Therefore, PHT rejects North American's argument regarding the admissibility of Zail and urges the Court to permit his testimony.

1. Does the Margin Maintenance Methodology have the indicia of reliability required by *Daubert*?

North American first seeks to exclude Zail on the grounds that the MMM was specifically created by him and his colleagues for litigation purposes. The insurer contends that the MMM has never been published in actuarial, insurance, or financial industry literature. Additionally, it has never been peer-reviewed or been established independently outside of litigation. Furthermore, North American contends that Zail has not engaged in discussions regarding the MMM with other actuaries uninvolved in litigation, which further suggests a lack of general acceptance within the actuarial community. The lack of academic and industry foundation for the MMM is evidenced, in North American's view, by the extensive glossary devised by Zail at the beginning of his report.

PHT asserts that the MMM is consistent with ASOP 2 as discussed in Zail's report. It also highlights that Zail discusses analyses from reputable actuarial bodies, such as the Society of Actuaries and American Academy of Actuaries, which address the concept of maintaining a

mortality margin. PHT further notes that North American's own regulatory filings describe a margin maintenance approach, supporting the legitimacy of the MMM. Moreover, PHT points to other insurers who employ a similar margin maintenance approach by regularly reassessing their cost of insurance rates while maintaining pricing margins. This evidence suggests that the concept is utilized in the industry. Additionally, Gibson relies on a textbook that defines "mortality margin" as "the excess of the amount charged for mortality (often referred to as the COI) over the amount paid in benefit claims in excess of policyholder account balances," precisely aligning with the MMM. [ECF No. 193-4 ¶ 88].

While North American argues that the MMM lacks support beyond litigation, PHT rebuts these assertions effectively. PHT has shown that the MMM is consistent with section 3.4.2.4 of the ASOP 2. [ECF No. 226-6 at 19–20]. It also identifies external sources which are sufficiently consistent with the MMM, including those used by North American's own expert witness. The Court finds that the MMM bears a sufficient indicia of reliability and general acceptance under *Daubert*.

2. Is MMM is unreliable because PHT has admitted other analyses that would allow higher COI rates?

North American next asserts that the insurer could properly set COI rates equal to the current best estimate future mortality assumptions and still not breach the policy. [ECF No. 195-1 at 16–17]. If it did so, this would result in higher rates for some policyholders because North American maintains that it is currently applying rates lower than that its best-estimate mortality to some policies. North American adds that because the MMM is not practical to apply in reality, Zail devised a "modified" MMM which would result in a breach of the policies under PHT's theory of the case. This is because, according to North American, PHT's position is that the MMM represents the highest "but-for" COI rates that North American can contractually charge. *Id*. at 17.

But the "modified" MMM results in "but-for" COI rates which are 4% higher than the rates originally calculated under the MMM—rates which PHT purportedly argues are the highest without breaching the contract. Because there are two PHT-approved actuarial methodologies which result in rates higher than the MMM, North American urges that the MMM cannot show the highest rates North American could charge without a breach, making it an unreliable method.

PHT responds that North American's argument about whether applying the current best estimate future mortality assumptions would result in a breach is heavily disputed and, in its view, incorrect because it misstates the record. [ECF No. 225-1 at 15]. PHT contends that both Gibson and North American actuary Jeremy Bill reject the theory posited by North American in the motion. As to North American's argument regarding the "modified" MMM, PHT argues that the rates calculated by that method are still substantially lower than those charged by North American. This is not a sufficient basis to exclude PHT's damages witness. Furthermore, PHT rejects North American's assertion about the impracticality of applying historical data for the MMM, pointing out that Zail has responded that historical data can be a "reliable benchmark" for evaluating COI rates. [ECF No. 225-1 at 16]. This is because there is "no reason to believe that actual data about historical COI" will materially and systematically change over a one-year period. [ECF No. 226-13 ¶ 217]. Zail also testified that, despite the alternatives, he believes that the MMM is the best approach. North American is not entitled to exclude Zail's testimony on this basis.

3. Did Zail improperly apply actuarial ASOPs to the point of being unreliable?

Next, North American offers a litany of reasons why it believes that Zail has improperly and incorrectly applied the ASOPs. They are: (1) ignoring changes in the "severity" of expected claims experience; (2) improperly grouping policies for purposes of COI rate changes; (3) using an additive approach for changes to assumption of mortality rates, leading to "absurd" results;

(4) disregarding North American's future mortality improvement assumptions used at the pricing stage of the Class Policies; (5) unreasonably focusing on year-by-year margins rather than considering other factors listed in the ASOPs. [ECF No. 195-1 at 19–34]. The Court provides a brief overview of these contentions and then explains why they do not warrant exclusion.

a. Severity

North American argues that Zail's methodology fails because he ignores changes in the "severity" of an insured event. The "severity" in the context of life insurance is represented by the net amount at risk ("NAAR") for each policy. *Id*. at 19–20. By not considering NAAR changes from pricing to redetermination—North American claims the MMM only accounts for changes in the expected mortality rates from pricing to redetermination—it urges that the MMM is unreliable.

PHT's response to this argument is that it is simply a repackaging of the argument by North American that the EFME permits a broad range of considerations in its calculation. PHT continues that it is untrue that the MMM ignores NAAR, claiming that it plays a prominent role in Zail's analysis pointing to his calculation for the "total mortality charge." [ECF No. 226-13 ¶¶ 188, 194]. Rather than failing to consider NAAR, PHT contends that Zail simply did not consider NAAR in the manner North American preferred. Finally, PHT argues that North American does not establish that consideration of NAAR would have made a difference in the MMM calculations anyway.

b. Improper Grouping

North American contends that Zail improperly averaged the COI rate adjustment across all policyholders by applying the ASOP 2's "policy class" analysis in a manner that North American would not. He does this by using a uniform percentage to reduce COI rates for all policies at the product-level without changes in the mortality expectations for the various underwriting classes.

The underwriting classes were grouped into six classes by North American, but Zail lumps them together into a single class for each of the products in the Class Policies. This, according to North American, masks the differences within each underwriting class. Rather than his broad grouping, the insurer explains that Zail must "establish that the more equitable subdivisions of the single product class he postulates would not be appropriate. He has not done that analysis and his report should be disregarded." [ECF No. 195-1 at 24]. North American acknowledges the ASOP 2 allows averaging and grouping among classes but an actuary must reasonably construe the underlying data to determine whether to average the classes. It was unreasonable for Zail to do here, according to North American, because there are large differences in experience among the underwriting classes. Furthermore, ASOP 2 section 3.3.2 requires that in-force policies remain with their assigned policy class unless there is new information to support reassignment to a different class.

PHT responds that averaging of COI rate adjustments is not only proper, but also routine in actuarial practice. [ECF No. 225-1 at 17]. Pointing to the ASOP 2, PHT asserts that the standards expressly permit an actuary to treat particular insurance product lines as single policy classes. Other courts considering similar groupings have found that it is not unreasonable to do so. *Hanks v. Voya Ret. Ins. & Annuity Co.*, 492 F. Supp. 3d 232, 243–44 (S.D.N.Y 2020) (holding "[n]o reasonable fact finder could conclude that Voya breached the 'on a class basis' requirement of the Policy by implementing the 2016 COI Adjustment on the basis of product line classes."). Moreover, PHT contends that North American itself conducted an analysis in 2004 which entailed grouping of the Class Policies at the product-level in order to examine adjustments to COI rates. [ECF No. 226-13 ¶¶ 176–78].

c. Additive Approach

North American argues that the approach used by Zail for maintaining the margin in the MMM uses an "additive" rather than a "multiplicative" approach—yielding "absurd" results. By additive approach, North American refers to expressing a margin between two numbers as either an integer (5, the additive approach) or as a percent (50%, the multiplicative approach). North American explains that the MMM's additive approach results in a reduction of 23% in expected death benefits but a reduction of 71% in COI charges. [ECF No. 195-1 at 26]. This "absurd" result stands as an example of the unreliability of the MMM, according to North American. North American contends that Zail admitted at his deposition that an additive approach "is not the traditional way" to redetermine mortality rates. [ECF No. 226-10 at 4].

PHT maintains that North American engages in mathematical sleight of hand in its example—the disparity complained of by North American disappears when the improvement in expected death benefit is measured in dollars rather than percentages. [ECF No. 225-1 at 24]. PHT insists that North American does not offer any support for its position that the "multiplicative" approach instead of the "additive" approach is required for admissibility. As to Zail's testimony about the traditional way of redetermining rates, PHT contends that he was referencing changes in COI rates, not mortality rates as portrayed by North American in its motion. [ECF No. 226-10 at 4].

d. Historical Record of EFME

For the "Pricing EFME" used in his report, North American claims that Zail reconstructed the historical record in the way least favorable to North American. He did this primarily by "ignoring" the future mortality improvement assumptions that North American used at the pricing stage. [ECF No. 195-1 at 27–28]. It contends that the record amply demonstrates this issue with

the report. If Zail had not ignored this evidence, North American asserts that PHT's alleged class damages would be reduced by 98.4% in COI rate overcharges. These mortality assumptions are found in spreadsheets known as the Lotus123 files which North American claims it used during the pricing process. The Lotus123 files were not found in possession of the insurer but obtained from a former actuary. *Id*. at 28. After they were received, North American says that Bill and Gibson both conducted analyses to verify that the files were, in fact, the future mortality improvement assumptions used by the company at the pricing process. *Id*. By failing to use these spreadsheets when reconstructing the historical record—as required under ASOP section 3.4.2.1—the MMM is unreliable and must be excluded, according to North American.

PHT responds that the spreadsheets have questionable admissibility, do not expressly state that they are what North American purports them to be, and identifies portions of them that are "outright bizarre." [ECF No. 225-1 at 29]. Rather than relying on the Lotus123 spreadsheets, PHT states that Zail relied on pricing mortality assumptions that North American provided in regulatory filings. PHT explains the spreadsheets offered by North American in this case were never submitted to regulators and one of the submissions to regulators postdate the Lotus123 spreadsheets—suggesting they may not have been final. Additionally, the spreadsheets reference "profit mortality" rather than "pricing mortality." There is no evidence in the record that "profit mortality" is a term of art in the industry.

e. Year-by-Year adjustment

North American next takes issue with the MMM because it claims that the theory demands that the insurer apply a year-by-year rate adjustment, ignoring future years and not permitting rate redeterminations only when the company's actuaries recommend a redetermination—as provided for in the ASOP 2. It finds fault with the MMM with the year-by-year adjustment because it does

not permit consideration of periods beyond the 14-year time frame in which Zail does calculations. North American alleges that this method ignores important factors that may be permissibly considered such as the effect of rate revisions on reserves, capital, reinsurance, and taxation. The MMM also fails to consider a need for higher COI rates in the future. PHT responds with multiple pages excerpting Zail's discussion of the factors under the ASOP 2 section 3.4.2.3. [ECF No. 225-1 at 33–35].

f. Analysis

The Court concludes none of the alleged shortcomings in Zail's application of the ASOPs so undermines his opinion as to require his exclusion under Rule 702. As to North American's argument that Zail did not consider "severity" as part of the MMM, it does appear that the component is considered in his calculations. *See* [ECF No. 226-13 ¶¶ 188, 194]. North American also asserts that the grouping at the product-level, rather than the underwriting class level, was improper but that argument attacks the foundation of his analysis and does not inherently undermine his reliability. *See Hose v. Chi. Nw. Transp. Co.*, 70 F.3d 968, 974 (8th Cir. 1995) ("As a general rule, the factual basis of an expert opinion goes to the credibility of the testimony, not the admissibility, and it is up to the opposing party to examine the factual basis for the opinion in cross-examination."). Same goes for North American's position that Zail did not properly consider the Lotus123 spreadsheets. The factual basis of an expert opinion goes to the credibility of the testimony, not the admissibility only if an expert's opinion is so fundamentally unsupported that it can offer no assistance to the jury must such testimony be excluded. *United States v. Coutentos*, 651 F.3d 809, 820 (8th Cir. 2011). Any inconsistencies can be fleshed out by North American during the testimony of its own witnesses or examined during Zail's testimony.

4. Does Zail's report contain legal conclusions rather than actuarial opinions?

Lastly, North American identifies several statements in Zail's report which it argues constitute impermissible legal conclusions. It claims that his report alternates between a summary of the evidence and impermissible contract interpretation. It asserts that this is an independent reason to exclude Zail's testimony.

PHT states that Zail will not be offered to propound legal conclusions. It contends that actuarial standards require that actuaries consider the terms of policies when redetermining COI rates. PHT draws a comparison to an earlier argument by North American that Zail had failed to consider the terms of the policies at issue, then concludes with an attack on him for considering them.

The Court will not exclude Zail's entire testimony for any purported legal conclusions. He will not be permitted to testify to legal conclusions but, in the absence of specific opinions in which North American asks for exclusion, the Court will not exclude in toto on this basis. North American's Motion to Exclude Howard Zail is DENIED. [ECF No. 194].

E. North American's Motion to Exclude Robert Mills

North American asks the Court to exclude the expert opinion and testimony of economist Robert Mills. Mills was retained by PHT to provide his opinions on damages caused by North American's alleged breach of the Class Policies. Mills calculated a damages figure for the Class Policies utilizing the MMM. North American argues that Mills's opinions exceed the original scope of his work because his report and testimony are not limited to damages but opine on liability as well.

Mills identifies a set of COI rates that PHT claims are the maximum allowable rates under the Class Policies. According to North American, Mills's calculated rates are the only evidence

provided by PHT that North American used rates higher than the maximum allowable rates for any policy class. The insurer argues that, despite his repeated assertions that he is only an expert on damages, PHT has transformed Mills into an expert witness in support of liability as well.

Furthermore, North American contends that PHT combines the testimony of Mills and Zail to conceal the shortcomings of the MMM. Mills claims he only performs the calculations dictated by the MMM, but when the methodology generates peculiar or nonsensical results, Zail defers to Mills, asserting that he did not perform any calculations. When questioned about his calculations, Mills points to Zail, stating that he is just executing the necessary calculations.

North American further asserts that Mills's testimony is unreliable because he did not evaluate or validate the methodology. Rather than applying his training and experience, Mills performs his calculations using the methodology without any independent analysis or corroboration of the method. Accordingly, North American urges that Mills's testimony is unreliable without his own independent analysis, even if Zail's testimony is not itself excluded.

PHT retorts that North American's objections are easily rejected because Mills is undisputedly qualified to offer his opinions on but-for COI rates, opinions which are supported by controlling authority that is ignored or mischaracterized by North American.

As to Mills's qualifications, PHT maintains that he easily satisfies all five requirements of Federal Rule of Evidence 702 and has the expertise necessary to implement Zail's methodology across the Class Policies, given his extensive quantitative background and experience analyzing large volumes of life insurance data. The Court turns to review each of these disputes in turn.

1. Is Mills unqualified to offer opinions about liability?

North American contends that PHT offers Mills not only as an expert to calculate damages, but he is also used to support liability for breach of contract. [ECF No. 200 at 10–11]. According

to North American, this improper reliance on Mills for liability is demonstrated by an interrogatory response from PHT which stated that the rates from the MMM are "the highest cost of insurance rates that North American could have used without breaching the terms of the agreement." *Id.* at 11. This exceeds the use of Mills's testimony as calculation of damages and instead proffers a determination of liability. As econometrician, North American claims that he is not qualified to offer such an opinion.

PHT rejects North American's contention on this point because whether Mills's opinions exceed mere calculation of damages is not relevant for admissibility. It points out that North American has not challenged Mills's qualifications, and concedes he is not offering an actuarial opinion, thus there is no basis to exclude Mills.

The Court agrees with PHT on this point. Rule 702 provides that an expert's opinion will be admissible if qualified by "knowledge, skill, experience, training, or education." Fed. R. Evid. 702. North American does not claim that any of those factors are absent in Mills. Its protestation that he cannot calculate "but-for" COI rates because he is a damages expert is not a reason to exclude his testimony.

2. Is Mills unreliable because Zail is unreliable?

The second basis set forth in North American's motion to exclude Mills is that his calculations are "inextricably linked" to Zail's opinions. Concurrent with its motion to exclude Zail, North American argues that Mills should also be excluded as a result. Because the Court has denied the motion to exclude Zail, Mills will not be excluded on this ground.

3. Does Mills improperly rely on Zail's opinions without conducting his own analysis?

Regardless of the admissibility of Zail's opinions, North American argues that Mill's testimony is independently inadmissible because he did not personally evaluate the MMM to

ensure its accuracy and reliability. In this testimony, Mills acknowledges that his work is completely derived from the MMM. Pointing out that he is not an actuary, North American maintains that Mills is incapable of evaluating the MMM so he cannot determine whether it is even a reliable method to measure damages in the case.

This contention is easily rejected as the admissibility of the testimony of an expert relying on a different expert's opinion is clearly established. "[A]n expert witness may rely upon another expert's opinion if is the type reasonably relied upon by experts in that particular field." *Goss Int'l Corp. v. Tokyo Kikai Seisakusho, Ltd*., No. C00-0035, 2003 WL 25949302, at *3 (N.D. Iowa Nov. 17, 2003) (citing Fed. R. Evid. 703); *see also* Wright & Miller, 29 Fed. Prac. & Proc. Evid. § 6274 n.50 (2d ed. Apr. 2023) ("[T]he Advisory Committee clearly contemplated that experts can base opinions on the opinions of others."). It is well known that an "expert is permitted wide latitude to offer opinions, including those that are not based on firsthand knowledge." *Larson v. Kempker*, 414 F.3d 936, 941 (8th Cir. 2005) (quoting *Daubert*, 509 U.S. at 592). In fact, it "is common in technical fields for an expert to base an opinion in part on what a different expert believes on the basis of expert knowledge not possessed by the first expert." *Dura Auto. Sys. of Ind., Inc. v. CTS Corp.*, 285 F.3d 609, 613 (7th Cir. 2002). It cannot be "serious[ly] challenge[d]" that an expert testifying about damages calculations "is allowed to assume liability and address only the issue of damages." *Robroy Indus.-Texas, LLC v. Thomas & Betts Corp*., Case No. 2:15-CV-512-WCB, 2017 WL 1319553, at *4–5 (E.D. Tex. Apr. 10, 2017) (collecting cases).

As its motion to exclude Zail illustrates, North American has strong objections to the predicate facts on which Mills bases his opinions. North American will have the opportunity to question and challenge those facts at trial through cross-examination and presentation of its own witnesses.

4. Are Mills's calculations the proper measurement of damages?

The fourth reason North American sets forth to exclude Mills's testimony is the mirror image of PHT's argument regarding exclusion of Gibson's and Merrill's damages opinions. Both parties disagree whether the Eighth Circuit's decision in *Vogt* governs the damages calculation and binds this Court. For the reasons discussed earlier, the Court finds that *Vogt* is not strictly binding precedent for this class action and Mills's calculation predicated on the MMM may be presented as evidence for damages in this case. North American's Motion to Exclude Robert Mills is DENIED. [ECF No. 199].

F. PHT's Motion to Exclude Roger Hofer and Nancy Sparks

PHT seeks the exclusion of two North American witnesses whom PHT asserts were not properly disclosed pursuant to Rule 26(a)—Roger Hofer and Nancy Sparks. Hofer worked as a life insurance underwriter for three decades at Midland National Life Insurance Company ("Midland"), North American's sister company, and at North American itself. [ECF No. 201-5]. North American offers Hofer as a witness in support of its claim that D.F.'s application for a life insurance coverage would have been declined if he had accurately responded to the health-related questions on the application. *Id*. Hofer avers "it was standard industry practice for life insurance companies to decline coverage for life insurance applicants who were known to be diagnosed as HIV positive." *Id*. Hofer does not claim to have been personally involved in the issuance of the Representative Policy but states that he is "highly confident that North American would have declined any life insurance application in the 1990s had it known that the applicant was HIV positive[.]" *Id*.

Sparks is currently employed by North American as a Systems Analyst, a position she has held since 1985. [ECF No. 201-4]. She declares that North American would provide insurance

agents with software programs which the agents could use to run custom sales illustrations when selling the company's universal life insurance products, including the Classic Term UL I and Classic Term UL II. *Id.* Her testimony is offered by North American to authenticate an example of a sales illustration for a prospective policy. The illustration is used in support of North American's statue of limitation defense.

PHT argues that both witnesses should be excluded due to North American's failure to include them in their Rule 26(a) disclosures. Hofer, according to PHT, is an undisclosed expert because he does not have any personal knowledge into the specific facts surrounding the application and issuance of the Representative Policy. PHT insists that North American's failure to disclose Hofer was not substantially justified or harmless because it was deprived of the opportunity to depose Hofer and prepare its own rebuttal evidence.

PHT argues similarly as it pertains to Sparks's testimony. It contends that the dilatory disclosure of Sparks cannot be substantially justified because North American first raised a statute of limitations defense in an answer filed in February 2019. Despite the extended period of discovery in this case, PHT asserts that the late disclosure of these two witnesses prejudiced its case and cannot be justified; it seeks exclusion of them as a consequence.

North American responds that PHT is wrong because its disclosure of the witnesses complied with the requirements of Rule 26. It adds that PHT distorts the importance of the two declarations which attest to uncontroversial propositions. North American further argues that, even if the disclosures violated Rule 26, they were in fact "substantially justified" or "harmless." Lastly, it urges that if the Court believes a sanction under Rule 37 is warranted for a late disclosure, it requests a lesser sanction is appropriate—such as narrowing the scope of testimony.

1. Applicable Law

Federal Rule of Civil Procedure 26(a)(1)(A)(i) states:

> [A] party must, without awaiting a discovery request, provide to the other parties: (i) the name and, if known, the address and telephone number of each individual likely to have discoverable information—along with the subjects of that information—that the disclosing party may use to support its claims or defenses, unless the use would be solely for impeachment[.]

Rule 26(e) requires a party who has made a disclosure under Rule 26(a) to supplement or correct the disclosure "in a timely manner if the party learns that in some material respect the disclosure or response is incomplete or incorrect, and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing." Fed. R. Civ. P. 26(e)(1)(A).

The purpose of Rule 26(a) and Rule 26(e) is to ensure that all parties have access to the information they need to properly evaluate their cases and prepare for trial. Richard L. Marcus, Fed. Prac. & Proc. § 2001 (3d ed.) (noting the purposes of Rule 26(a) are "to avoid surprise and the possible miscarriage of justice, to disclose fully the nature and scope of the controversy, to narrow, simplify, and frame the issues involved, and to enable a party to obtain the information needed to prepare for trial.").

If the disclosure requirements of Rule 26 are violated, Rule 37 provides the remedy. It provides "[i]f a party fails to provide information or identify a witness as required by Rule 26(a) or (e), the party is not allowed to use that information or witness to supply evidence on a motion, at a hearing, or at a trial[.]" Fed. R. Civ. P. 37(c)(1). The exception to a Rule 37 sanction is if a court determines the failure to disclose was "substantially justified or [] harmless." *Id.* Establishing that a failure to comply with Rule 26 was substantially justified or harmless is the burden of the party resisting the sanction. *Vanderberg v. Petco Animal Supplies Stores, Inc.*,

906 F.3d 698, 705 (8th Cir. 2018). The Eighth Circuit has identified several factors to consider when considering whether a nondisclosure is justified or harmless, such as: "(1) the prejudice or surprise to the party against whom the testimony is offered; (2) the ability of the party to cure the prejudice; (3) the extent to which introducing such testimony would disrupt the trial; and (4) the moving party's bad faith or willfulness." *Rodrick v. Wal-Mart Stores E., L.P.*, 666 F.3d 1093, 1096–97 (8th Cir. 2012) (citation omitted).

2. Analysis

PHT argues that North American's disclosure of Hofer and Sparks was untimely because the company "has known or should have known for years now that it was going to proffer testimony on these subjects to support its defenses." [ECF No. 222-1 at 11]. As to Hofer's testimony, PHT points to North American's motion to amend its answer to add an *in pari delicto* defense based on D.F.'s HIV-positive status and its argument in resistance to class certification as evidence of North American's knowledge that a witness such as Hofer would be necessary to support its fraud-based defense.

Regarding the Sparks declaration, PHT argues that North American raised the statute of limitations defense in its initial answer to the complaint. [ECF No. 222-1 at 12]. The Sparks declaration is relied upon by North American to support its claim that policyholders were on inquiry notice of a potential contract breach.

North American rejects PHT's argument that it has engaged in a "trial by ambush" because its disclosure of the Hofer and Sparks declarations complied with the policy and purpose behind Rule 26. North American explains in its resistance to the motion that the Hofer and Sparks declarations "can hardly have been surprising" to PHT because they serve anodyne evidentiary purposes and stand for propositions which PHT has long been aware. [ECF No. 232 at 7]. North

American maintains that Sparks's declaration merely authenticates a sales illustration document that was produced to PHT over two years ago. Likewise, Hofer's testimony just supports "an obvious point" that North American would not have issued a life insurance policy to D.F. had he honestly apprised the company of his HIV-positive status. Rather than violating Rule 26(a), North American represents that complied with Rule 26(e).

It is clear that North American has violated Rule 26. The defenses for which both the Hofer and Sparks declarations are offered to support have long been known to North American. Its argument that it complied with Rule 26(e) must fail. The application North American seeks here would entirely swallow the Rule 26(a) requirements. Under North American's contention, no disclosure could be untimely because it could always fall under the supplemental requirements of Rule 26(e). This argument is undermined by the provision that requires supplementation of discovery production "as soon as possible." *Malozienc v. Pac. Rail Servs*., 572 F. Supp. 2d 939, 943 (N.D. Ill. 2008).

North American offers no explanation why it did not recognize that it would offer testimony from these two witnesses until the filing of its summary judgment motion. There is no assertion that the witnesses—or similar witnesses—were unknown or unavailable to North American until the last-minute. Sparks is a current employee of North American and Hofer was employed by the company until 2022. [ECF Nos. 201-4–201-5]. North American's sole justification why it qualifies as supplemental production under Rule 26(e) is because PHT should not have been surprised. North American is correct that the purpose and policy behind the rule is to avoid trial by ambush. *See United States v. Procter & Gamble Co.*, 356 U.S. 677, 682 (1958) (observing that pre-trial discovery under the Federal Rules of Civil Procedure serve to "make trial less a game of blind man's bluff and more a fair contest with the basic issues and facts disclosed

to the fullest practicable extent."). However, there is nothing in Rule 26, and North American cites to no authority, which exempts untimely disclosures as long as the opposing party is not "surprised." *See Wegener v. Johnson*, 527 F.3d 687, 692 (8th Cir. 2008) (listing relevant factors when fashioning a remedy). The reason for this, as explained by the Eighth Circuit, is that disclosure requirements "would be rendered meaningless if a party could ignore them and then claim that the nondisclosure was harmless because the other party should have read between the lines." *Vanderberg*, 906 F.3d at 704.

PHT argues that exclusion of both witnesses is the proper sanction for North American's failure to timely disclose Hofer and Sparks. Neither failure is substantially justified, according to PHT, because North American was aware of such defenses for years prior to the disclosure of the declaration. North American responds that even if its disclosure violated Rule 26, it was harmless because PHT failed to seek depositions of the two witnesses for nearly three months, so it could file a motion to exclude instead.[9] [ECF No. 232 at 9]. North American also offers that the Court could simply narrow the testimony of the two witnesses to the subject matter contained in the declarations.

PHT's reply to this argument is that the Court rejected this contention previously for other undisclosed witnesses. [ECF No. 238 at 5–6]. PHT avers that allowing the witnesses to testify about the content of their declarations is not a sanction but exactly what North American seeks.

The Court agrees that exclusion is the proper remedy here. North American has been aware of the affirmative defenses at issue since the beginning of the case. It previously stated that further discovery would not be necessary.

[9] North American filed a separate motion seeking lesser sanctions than exclusion reiterating the same argument. [ECF No. 233]. That motion is DENIED.

In short, neither witness may be offered at trial. PHT's Motion to Exclude Hofer and Sparks is GRANTED. [ECF No. 222].

III. CONCLUSION

Based on the foregoing discussion:

- North American's Motion for Summary Judgment is DENIED. [ECF No. 201].
- PHT's Motion to Exclude Jack Gibson and Craig Merrill is GRANTED in part and DENIED in part. [ECF No. 192].
- North American's Motion to Exclude Howard Zail is DENIED. [ECF No. 194].
- North American's Motion to Exclude Robert Mills is DENIED. [ECF No. 199].
- PHT's Motion to Exclude Roger Hofer and Nancy Sparks is GRANTED. [ECF No. 222].
- North American's Motion for Lesser Sanctions is DENIED. [ECF No. 233].

IT IS SO ORDERED.

Dated this 27th day of May, 2023.

STEPHANIE M. ROSE, CHIEF JUDGE
UNITED STATES DISTRICT COURT