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The Role of the Actuary in Litigation Support

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Summary: In recent years, lawyers representing aggrieved policyholders have successfully launched class action lawsuits against many life insurance companies for alleged deficiencies in policy performance, agent misrepresentation, and related market conduct issues. The actuary has important roles in identifying the problem, quantifying the exposure, and determining the financial consequences of any proposed settlement.

The session presents a fictional class action case study. Presenters introduce the situation, identify the issues, and describe possible approaches to resolving the issues.

Mr. Stephen Hildenbrand: One of our speakers is Allan Horwich. Allan is a partner in a law firm located in Chicago. Allan and I have worked together on a particular matter, and I thought it would be a very good idea to have Allan give his point of view with respect to how he would view the role of the actuary in litigation matters. I think he will have a very interesting viewpoint with respect to this particular issue. I'm going to start off. I'm going to do this in a case-study format.

We're going to talk about what has been going on in the last three to four years in the life insurance industry with respect to class-action lawsuits that have taken place, particularly the vanishing premium performance-type class-action litigation. Most of you are at least somewhat familiar with the companies that have been involved in these types of cases. We'll talk a little bit more about how this process

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has worked to date, where the actuarial issues are, where the legal issues are, where they come together, and where the current trends are in this area.

So let's start with a fictitious company. This is the Wright Life Insurance Company founded in Kitty Hawk, North Carolina, and it's what I would characterize as a company that has been around for more or less 100 years. It's a mutual life insurance company. The company is very solid, very conservatively run, and basically it writes the standard-vanilla ordinary life and term insurance. It introduced universal life back in the mid 1980s along with 80% of the other life insurance companies at that time. And that's, by the way, where I was back then. I was with a life insurance company. That's exactly what we did. I can remember developing universal life in 1982 or 1983 just to keep up with everybody else. At the time we were all shaking our heads wondering if it was really a good thing or a bad thing.

So basically we're going to start with a very generic vanilla-type company and go through its history as it leads up to the issues at stake in these class actions. It's a conservatively managed mutual life company serving the middle market. I would characterize it as a small- to medium-sized company. The issues are more or less the same. The big and small companies pretty much have the same types of issues. Assets are $750 million. Surplus is $80 million, and there is a modest number of policies in force—20,000 policies. Again, this is as of December 31, 1980. This is before things really started to get cracking.

Most of you are familiar with this scenario. I certainly am because I have worked through it. As interest rates started increasing in the early 1980s, there was a lot of change taking place in the industry. Products were being designed and developed to respond to that. In 1982 this company saw its first decline in sales in its history, and it's because a lot of these other companies were coming out with these new products and were taking away some of their business. In 1983, to respond to that, they developed a universal life product. In addition to that, they began developing software to sell their products in a more attractive way to take advantage of higher illustrated dividends and higher illustrated interest rates. I can remember actually going out in 1983 and 1984 with an Apple II E. I think it was 64K at the time. The agents and I wondered, "Are we creating a problem here or not?" Basically it was a very creative new tool. They could go out and show a lot of great-looking things with these illustrations.

In addition, there were companies that had formal or somewhat informal programs in which their policyholders or policyholders from other companies could, in fact, take advantage of these new products by rolling over or replacing their existing coverage with these new coverages that were being developed and sold. So there

was a reasonable amount of replacement within the industry. Much of it was internal. Most of this took place in the mid 1980s. In this particular instance, this company didn't keep any formal records of who replaced what to do what. It didn't keep records of who saw an illustration of what particular type. Some companies did, but a lot of companies did not, so they don't know for sure what a policyholder saw at the time these policies were sold to them.

In 1986 credited rates had peaked. They were crediting at around 11% at that point in time, which was not unusual for that era. By 1989, interest rates had fallen and credited rates had come down to 9%; then they went down to 8% in 1991. The current rate right now is 7%. This is fairly typical with the pattern of what's gone on with the interest rate element of these products over the years.

In 1991 Wright Life received its first policyholder complaint. It was an individual complaint about a policy that they bought that was illustrated on a basis that they did not have to pay or should not have had to pay a premium after the premium that was due in 1990. Then 1991 rolled around and, lo and behold, they got a premium notice. Because the dividends had gone down, they had one unhappy customer. Shortly thereafter, similar complaints started rolling in. The company began to deal with these things on a one-on-one basis, and this company did not deal with it in a formal or regimented fashion. It tried to get a release every time it had to deal with these claims.

In 1997 the plaintiff's bar had gotten a hold of this and, after the big company cases like New York Life, Phoenix Home, and Prudential, they finally got to this company. They got to Wright Life, and they filed a class-action lawsuit alleging a whole bunch of things that Allan Horwich will now talk about. He will explain what the issues were and what the matters were that were being addressed in the complaint that was filed by the plaintiff's bar.

Mr. Horwich: In the typical lawsuit, you have one plaintiff suing one defendant or maybe a group of defendants. For those of you who don't know what a class action is, let me just give you a real quick primer on that. This is a situation where one or two or more plaintiffs bring the lawsuit, but they sue not only on their own behalf, but on behalf of all persons who are allegedly similarly situated. In the case of these life insurance lawsuits that we've been talking about, there can be millions of people in the class. There may be thousands or tens of thousands, but in some cases there are millions. The essence of a class action is simply that the claim of the class representative, and the people whose names are on the lawsuit as the plaintiff bringing the lawsuit, have claims that are allegedly typical of those of all the people in the class they seek to represent. In these class-action suits in the insurance area, the named plaintiff is the one who actually brings the lawsuit due to the purchase of

the policy, or due to the replacement of one policy with another, or due to otherwise buying a policy in circumstances where the plaintiff was allegedly mislead. The practices that lead the plaintiff to sue are substantially similar to the circumstances of all of the other people in the class. This allows the court, if the court finds that there is this commonality or predominating common factor, to proceed on behalf of all of the people in the class.

In this situation, the class representatives and their lawyers have chosen to sue on behalf of everybody who bought either the whole life or UL policy at any time from January 1, 1984 through the end of 1998. Even for a relatively small company this is thousands of people. While the class action is brought on behalf of those who purchase during that period, it is not necessarily limited to those whose policies are still in force at the time the lawsuit is brought forth. In fact, it is brought on behalf of those who bought it during this period, regardless of whether their policy is still in force or whether it was terminated. In many situations the people will be disappointed because the dividend performance is not what they expected. They may feel that they don't have the cash available to continue to make the premium payments out of pocket, and they will surrender their policy or let it lapse. Those people would still be in the class.

What we're talking about now are the allegations. The typical case alleges that their policy illustrations were used that showed a vanish date or an offset date at a point in which the policy, in a sense, would pay its own premiums as of a particular date out in the future. The dividends were allegedly known to be unsustainable because of the unusually high interest rates at the time. The allegation is that there should have been more warning to the policyowner that the dividends were not guaranteed, that performance may not be at the level illustrated, and that the vanishing date might come later than it had been illustrated. Another common allegation is that they would persuade people to turn in their existing policy with either Wright Life or with another company. They would also surrender it and use the cash value to buy a new policy or to use dividends from an existing policy to pay premiums on a new policy or to take a loan against the existing policy to pay premiums on the new policy. In some cases, they might have done that to pay premiums in advance for the life of the policy on a discounted basis, but that would be based on a projected vanishing date at a point in which the new policy would pay for itself. So you would have a compound situation where they would be induced perhaps without fully disclosing the economic implications of taking the values of the existing policy. They would buy the new policy and be disappointed with the new policy. In a sense they would be disappointed in two respects.

Another typical allegation in these cases was to sell the policy without proper disclosure or emphasis on the fact that this is really life insurance. While it does

have a cash build up component, in the form of either a savings or retirement component, people would buy it thinking it was a savings vehicle and did not fully understand the life insurance implications of it. In that respect, allegations would be made that this conduct was misleading. So after making these basic allegations, which are supposedly common to the class, they would bring these allegations on the basis that these selling techniques with inadequate disclosure, improper training, or inadequate training was a top-down project. In other words, they were instigated by senior management.

There are various types of legal theories that can be pursued, and I don't want to go into detail on that. The easiest to understand is common-law fraud, negligent misrepresentation, or violation of state consumer fraud statutes in which the essence of the claim is a lack of disclosure. That is when the policyowner is not fully told or when the prospect is not told that these illustrations are not guarantees. They are based upon current rates of dividends that could change. They could go up or down. Another situation was the lack of full disclosure of the economic implications of replacing a policy. A typical replacement would be the person who has a $20,000 policy who has now reached a stage in life where maybe he or she needs $50,000 worth of coverage. Rather than buying an additional $30,000 of insurance, the agent might persuade him or her to turn in the $20,000 policy and buy a new $50,000 policy. That, of course, would be predicated upon the current age. Also, there might be additional commissions generated so that the agent would have an incentive to sell the $20,000 and then the $50,000 rather than the $20,000 and then the $30,000. There was inadequate disclosure of the economic implications of doing that.

The relief that's sought in these cases is essentially to fulfill the failed expectations of the class members, the people who are disappointed because the dividends did not reach the level that was illustrated and thus are not sufficient to pay the premiums. They want to have premiums made up in effect. They want to have the cash values or cash accumulations restored so they are sufficient to pay dividends that would reach the level that was illustrated. In other words, they want relief that would place the policyholder where he or she would have been if the illustrations had proven to be accurate. In some cases, particularly in the replacement area, the policyholders would ask for rescission of their insurance contract. It is an opportunity to turn in the replacement policy and to get back the old policy with the values restored to that. This is what is asked for in the complaint on behalf of all of these thousands and thousands of policyholders.

When you get the complaint filed, the first thing that you have to do is assemble a team to deal with it. These are very complex cases. We're talking about information data that goes back to 1984. As Steve said, many companies didn't

retain records of what illustrations were shown to which prospects. There may not be adequate records to show which ones were internal replacements or let alone which ones were external replacements. So when you assemble a team, you obviously have to have senior management to oversee a case of this significance that can have major potential economic consequences for the company. You need a legal team obviously because this is a lawsuit, and you have to do something to deal with it. You certainly would draw on your inside legal staff who would play a very significant role in coordinating things. However, in every single case that I'm familiar with, you have to bring in outside counsel. These are class actions, and as I've said, there's certainly a large body of law dealing with that.

While I only showed you four or five different causes of action, they all raised very sophisticated complex legal questions of whether those claims can be brought at all or indeed whether the case can proceed as a proper class action. I don't want to go into that in detail, but it simply means that you have to have a legal team with both inside and outside counsel working on it. The actuarial function is extremely important here as I will talk about later, and that's really why we're here. Other people are involved because facts have to be gathered as to what the practices were during the time covered by the class period (1984 through 1998). So you retain outside counsel, and you retain an outside consulting actuary. There are dozens of people who have had experience in these cases. Some have been litigated aggressively, but most have settled. In all instances there has been extensive involvement of outside counsel and consulting actuaries.

You review the complaint, you look at the facts, you evaluate the viability of the causes of action, and you see if there's some basis to bring an attack on the complaint, possibly to get it dismissed at an early stage. A key factor is to try to assess whether the claims can be maintained on the part of the class. Look at your marketing materials and your sales materials to see if there's legal vulnerability. This is when the lawyers and the actuaries along with management plan a pivotal role. They determine whether to settle or to fight. That's a decision that has to be re-evaluated continuously throughout the case. You may decide to fight to see if you can get the case dismissed or perhaps have the judge decide that it cannot go forward as a class action.

Let me say that even if you win the class action suit and a judge decides that it should not proceed as a class, that doesn't mean that you're home free because at that point you may have tens or hundreds or even thousands of individual claims or lawsuits by individual policyholders who will claim those same wrongs, even if they don't do it on behalf of a class. If you defeat the class you may find yourself inundated with individual lawsuits. So throughout you have to assess where you are and whether you should proceed with settlement. If you go the settlement

route, and that doesn't seem to be going well, then you can always walk out and go back to court and litigate. If the litigation is not going well, you can decide now is the time to consider settlement seriously.

I want to outline what the actuary does for the lawyer, and then Steve will return and talk in more detail about how the actuary does this. What is your dollar exposure to liability? In any lawsuit, you have a number of factors to consider in evaluating the wisdom of settlement. What will it cost to litigate the case? What do we save in terms of legal costs, management time, and so forth if we settle? On the other hand, what is our exposure if we do fight? What are the risks of fighting? What's the cost of fighting? You have to look at how the policies actually perform in relation to the illustrated performance. What is that shortfall that the policyholders have suffered? What are those three extra premiums costing them? How much money is necessary in order to cover the shortfall in this situation? What losses have the policyholders sustained as a result of surrendering the old policy and buying a new one or borrowing against the old policy and buying a new one in these replacement situations? What losses have the policyholders sustained because they bought policies that underperformed the illustration where they really purchased what they thought was an investment?

As Steve discussed, you were illustrating 9% or in the heyday 11%. Granted that was just an illustration, and you may or may not have had cautionary language alerting the policyholder that this isn't a guarantee. This is just where we are today. Maybe the guarantee is something like 4%, but these people who perhaps were mis-sold a policy by an aggressive agent thought that that 11% was going to be there forever. It's now 7%. What is it that they lost? Are they able to make a viable claim. What are the damages that the company is exposed to? As a lawyer, I can tick these off. I can list the questions, but I don't have the wherewithal to answer them. I need people at the company to put together the data on their policyholder census and try to get some idea of what illustrations were used. We need to know how many people might have been sold on the premium offset basis. With the help of both inside and outside actuarial help, we can find out what your exposure is.

The bottom line is you must put it in a nutshell. A single item here is what expectations are the policyholders exposed to as a result of the policyholder either not building up the death benefits that were illustrated or the other expectations that were not achieved based on the illustrations that they saw when they bought their policies. That's the first area that the actuary has to look at. Assess for me, the lawyer, what my damage exposure is. What's my worst-case scenario? If we fight, are we talking about wiping out the company if the court finds that people are allowed to rescind their policies or should be paid an amount of dividends sufficient to pay premiums up to the vanishing dates? Once the assessment is made, and if I

decide to settle, Steve might come up to me and say, "Well, if you fight and you lose, you're not going to be here tomorrow." You're going to have to find yourself somebody to deal with an insolvency problem. I'll talk about settling. What are the options available to me to settle? There are some things that have been done in the dozens of cases that have actually been settled.

Once again, you bring in the actuary to help you figure out what is it going to take to settle the case. What kind of dollars are we talking about? And if I look at various relief options or packages, what are those packages likely to cost? It's easy to talk in general conceptual terms. Steve is going to talk about how you go about assessing this. One possibility is simply to make contributions to the value of existing policies, such as increasing dividends or interest payments for some limited period of time. It is sort of a kicker to throw into the policy. This can be given to everybody in the class who still has a policy or it can be given to those who apply for it. There are innumerable combinations and permutations of these types of relief. Another is to give people a benefit that is calculated as a portion of the amount needed to bridge the gap between the illustrated value and the actual value of the policy in terms of the vanishing dates. Maybe you give them 50% of the amount needed to bridge the gap. In some cases it is 75% or 100% or even 150%.

You may do this simply as something that you offer anybody who makes a request or you may couple this with a claim process where people come in and they make claims. Depending upon how strong their claim is, you can give them a greater amount of relief to bridge this gap. But you need an actuary to come in and tell you what it takes to bridge this gap. What is the total cost going to be if we implement this kind of relief? Obviously you look at a horrendous exposure of liability. You don't want to turn around and settle the case so it pays the same amount as if you had lost. You want to try to work out something that's livable.

In the case of existing policies or comparable relief to those with terminated policies you can compensate them for losses when they replace the policy. You might even make rescission available in given situations depending upon what relief you need to grant. You have to assess what the performance of those original policies would have been. What relief would it take on a reasonable basis to restore people to the position they would have been in if they would not have bought the new policy and had stuck with their old policy?

In some cases, it's simply death benefits added to existing policies or no-cost term policies issued with a fixed limited period of duration. This is designed in the situation, in which people have allowed their policy to lapse because they didn't reach the vanishing date when they thought they would. They don't have the money to pay the remaining premiums. They let their policy lapse, and they're now

without life insurance coverage. Giving them a no-cost or low-cost term policy for a fixed duration replaces the insurance coverage that they lost because of the disappointed expectation with respect to the vanish. You can give them vouchers to purchase new Wright Life policies or possibly an annuity; in other words, it is credit toward purchasing a new policy. Or you can sell them a new policy or annuity with an enhancement. Obviously anybody can go to their Wright Life agent today and say, "I want to buy a new policy." Wright Life is still in business and they would be happy to sell to anybody who meets their underwriting standards.

What has happened in these settlement situations is that the company will sell you a new policy based on your current age, that is based on perhaps liberal underwriting standards. We may relax the underwriting criteria, but if you buy that policy at the end of the first year we'll put some more money in that policy. At the end of the first year we'll put in say 30% of the first years' premiums. If you stick with us after, let's say, three years we'll put in another 30%, and if you're with us at the end of the fifth year we'll put in another 30%. So after five years, we would have put in the equivalent of 90% of the first years' premium. That's the enhancement that makes it worthwhile for the class member to take this relief, even though it requires him or her to buy a new policy or pay some money out of pocket.

Now this points to one key feature, which again, the actuary can help you with; that is the cost to the company may not be as great as the benefit to the policyholder. If the company is selling this policy, but not paying a commission to its agent, obviously the company is not paying out of pocket. Let me put it this way: it's ahead of the game more than if it were selling a conventional policy, but of course that's transparent or irrelevant to the purchaser because his or her premium is the same whether the insurance company is paying a commission or not. The enhancement is a benefit to the policyholder, and it's something they wouldn't get under other circumstances. So the true cost to the insurance company might be offset. The enhancement might be offset by not paying a commission so the benefit to the policyholder might actually be greater than the cost to the company.

I have just a couple more examples of the kind of relief that you have in these situations. You have relief that may be granted automatically whether or not anybody applies for it, and the actuary here should be able to give you a pretty accurate calculation if you're going to make a certain level of contribution. It varies with the size of the policy or the size of the reserve for that policy. Some relief may be granted at the time of application by the class member. For example, there is buying a new product and then enhancing it with a contribution. This takes some initiative on the part of the class member, but then my actuary has to tell me how many people are going to do this. How many people are going to apply for this and what's it going to cost me? How big are their policies going to be when they buy it?

Based upon what my enhancement might be, the actuary must estimate these things and tell me, as the lawyer, what that settlement is going to cost me so I can advise my client whether that's the way to go.

Other relief might be granted only if you submit a claim and you achieve a certain score. Steve will talk about some of the developments that are occurring there in terms of this claim process, but the actuary has to come in and make some kind of educated guess. I hope it is well educated as to how many people will actually submit claims. Will 100% of the class submit claims? Will 1% submit claims? That makes a big difference in terms of the cost of this settlement. Somebody has to do that estimate and I, as a lawyer, don't have the tools to do that.

What does the actuary think the score distribution will be? Let him look at the illustrations we used; let him look at our census of class members and see our people. Let's say we have a one-to-five scoring range. Is that going to be a bell curve? Is it going to be at the high end? What kind of conduct are we finding in our review of the companies' files, and what's the scoring pattern likely to be? What will the score distribution produce in terms of the cost to Wright Life to pay out to settle this case? Should we then tailor how much we're willing to pay for a score of one, two, three, four, and five based on what we, as defense counsel, think that score distribution is going to be and based on what the actuary has told me?

There's a lot of back and forth in these negotiations as you do this assessment, because we have to know what the cost of these settlement options is going to be to Wright Life? How strong is the plaintiff's case? The stronger it is, of course, the more Wright should be willing to pay to settle. But it has to know what that cost is going to be. What's the value of that settlement package? In a class action, if you settle, the court must approve the settlement unlike a one-on-one lawsuit. If I sue you directly, you agree to take a certain amount of money. We sign a settlement agreement; tell the court the case is over, and walk away. The court doesn't care how much we've paid. In the class action, the settlement must be presented in every jurisdiction of federal court and state court. It must determine that it's fair, reasonable, and adequate.

The actuaries play a key role in this situation in demonstrating to the court what the value of the settlement package is. The value of the settlement may also be determinative of the plaintiff's attorney's fee because their fees will generally be based on the value of the settlement. However, those fees get paid out whether they're a part of the settlement, whether they come out of the amount paid to the class, or whether they're paid by Wright Life directly. The court wants to know how much the value of the settlement is so I can tell what benefit the plaintiff's attorneys have conferred. In almost all of these cases that benefit is going to be unknown

because the benefits don't get paid out until you find out how many people submit claims. What are their scores if it's a case that involves scoring of claims. The court doesn't know until way down the road and nobody knows until the end of the process what the actual payout has turned out to be. But at the stage where the court is approving the settlement and awarding attorneys fees, it generally is dealing with estimates. Those estimates are actuarial projections (if I'm using the proper actuarial terminology).

Other involvement of the actuary includes putting together the internal files and constantly evolving settlement options. Settlements are negotiated over a period of years. Sometimes, as different ideas are floated, they're then assessed by the actuaries and then the attorneys might come back to the bargaining table and counter proposals are made. They're not deals that are struck in a day or a week. The consulting actuaries will present evidence to the court regarding the terms of the settlement in support of finding that the settlement is fair, reasonable and adequate, including the value of the benefits to class members.

Finally, what if the case is not settled? If, for some reason, you've decided to try to settle, and it doesn't fly, the consulting actuary will be heavily involved in general support of the defense litigation effort and in defense of the company to try to show the reasonableness of the illustrations that were used and to show the propriety of the dividend setting policy. Sometimes plaintiffs will contend that dividends were maintained at an unreasonably high level in order to try to hold the line. To try to reach that vantage point they were paying dividends at a level that really wasn't sustainable or perhaps was in excess of what they should have paid. It was misleading prospective policyowners who then bought policies based on current illustrations when those illustrations were perhaps unreasonable. The consulting actuary will come in to show that the illustrations were reasonable and will play other roles in determining that the company's illustration procedures and other conduct was reasonable from an actuarial point of view.

I, as the lawyer, have a wide array of questions that I need answered before I advise the client on whether we should fight or settle. If we go into the settlement mode, what are the options we should consider in settling? We must evaluate the proposals that the plaintiff makes. What are they going to cost us in the long run? We'll assess and put together our own package of counter proposals that we can live with. Once again, the consulting actuary is essential in terms of advising counsel of what is acceptable and what might the cost of that package be so management can then decide what it can afford to pay. Perhaps we will want to go back to the court room and fight this one out. Having now asked the questions, Steve's job as a consulting actuary for the internal staff is to provide those answers.

Mr. Hildenbrand: As Allan mentioned, the lawyers and senior management of the company ask a lot of questions as things move along in either the settlement or the litigation process. I thought I'd run through some of the more specific things that we have done in dealing with these cases.

First, by way of background, for the last three-and-a-half years, I've personally been spending a lot of my time in this area particularly, the class action area on the defense side. I suspect that the principles are more or less the same working for the plaintiff side. I mean you still have to look at and address the same issues, the technicalities, and what expectations or estimations are, so I suspect the principles are fundamentally the same.

But some of the specific things that we need to address in working with the lawyers in these matters and helping them get an idea of what types of things they're talking about would include at least the following. When we start off on these things it's our job because of our particular background and education to educate the litigators and educate senior management. I usually do that at the beginning of these things. I spend a lot of time with the lawyers, especially the outside counsel, who may not have ever worked on a life insurance case or even an insurance case before. Now all of the sudden they're thrust into a technical, regulated industry and they may need some help in understanding the types of products involved and the features of those products.

We must also get senior management to really focus in on what the issues are, and more importantly, what the cost implications are to the company. What are the threats to the company in the event that things were to go a long way out and wind up in a negative fashion? At the outset, it's our responsibility, along with some of the internal people at the company, to explain what the issues are and how these things work. I might add, especially in Allan's case, litigators tend to be very quick studies. Allan was terrific in terms of understanding the nature of the products. He understood things such as how the life insurance policy works, and how the premiums work going back all the way to the era when these things were being sold. He understands what a cash value is and how dividends work. Allan even knows what the three-factor contribution method is.

Specifically we'll spend a lot of time going through the technical product features, the dividends and the interest rates. How is this all impacted? There are the whys and hows that the interest rates went up and then came back down. What is a vanish, and how does it work? What are paid up additions? What's an account value? We need to go through it all and get them up to speed so they can become conversant with the issues, with the company people, and with the people they're going to be ultimately sitting across the table from. That's really the first area that I

think we need to be able to explain in a fairly nontechnical way—what are these issues, and what are those implications?

Mr. Horwich: Maybe there is one point that I could add here. Some of the same plaintiff's lawyers are bringing all of these cases. There are a number of different defense lawyers. Some have pre-existing relationships with the insurance company, and some have been hired by a number of different insurance companies. The plaintiff's lawyers are not doing these on a one-shot basis. Some of them have handled dozens of cases, and they have their own consulting actuaries. As a defense lawyer, I might be sitting on one side of the table with Steve and the company people, and the people who are on the other side of the table are as educated about this industry as we are. They usually have the opportunity to get into the companies' documents. They will not talk settlement until they've taken at least some discovery of the company, no matter what stage you initiate settlement discussions. It's their ethical obligation, and they do in fact do this to take at least the basics of discovery to educate themselves about the company before they start the negotiating process.

While it's the job of somebody like Steve, who works mostly on the defense side, to educate defense counsel, you might be dealing with somebody on the other side who knows what they're talking about. They may not have a lot of the company-specific information to start with, because each company has it's own unique products, and it's own unique profile. They may not have gotten into that yet, but they know what they're talking about because they've been through many of these cases. As Steve will talk about in a few minutes, these settlements have evolved as new ideas have come up as plaintiff lawyers have gotten either smarter or more flexible and as defense lawyers have studied the prior cases and come up with new wrinkles or ways to resolve these cases.

Mr. Hildenbrand: That is a good point. The plaintiff side is a very closed group of lawyers, and they've become very good in terms of understanding our industry, especially from the standpoint of being able to look at many different companies' very technical documents and having a lot of help from their experts. They're basically coming in primed and already knowing a lot of this stuff. It's our job, on the defense side, to help get your litigators and your lawyers up to speed on this so they can be conversant on a relatively equal playing field with the other side. The lawyers will tell you, "This class is going to involve whole life or permanent life policyholders." In this example, from January 1, 1984 through current time, it would also include perhaps some universal life policies both active and terminated. We must build a model for the company.

Most companies nowadays have their liability models set up already with the asset/liability work. You need to just extract those policies that would be considered part of this class and take that out and analyze these policies independently. Basically what the lawyers will ask you is, "What is the potential range of exposure that we're really talking about here?" I mean, what is the difference between, for example, the cash values that were illustrated to be in effect today versus what they are today. So you really have to go back and make believe you were there back then, and take those that are in force right now, those that terminated at various points in time, and do those projections and come up with estimates of dollar differences. This is so the lawyers can get an understanding and a feel as to what type of damage the plaintiffs might be thinking about, because, quite frankly, they're doing the same type of calculations.

You also want to know what the difference is between what policyholders might have been shown in an illustration with respect to a vanishing period or premium offset period versus what it is now. It varies tremendously as most of you know by type of product, how heavy leveraged the product was, when the product was sold, which era it was sold in, the age that the policyholder is, and so on. They need to get a feel for what we are talking about. Has the vanishing period doubled? In some cases, it has more than doubled if it's a very heavily leveraged product. In other companies, with a very conservatively managed portfolio, and a very vanilla type product, it might only be a small difference.

The lawyers need to get a feel for that. They want to know what the extent of the total damage is, if in fact they thought what they saw on an illustration was really going to happen. In order to do that, the company has models in place so that you can start looking at analyses that enable you and the lawyers to get a grip on what we are really talking about here.

There are essentially two pieces to the settlements. The first piece that Allan alluded to earlier is general relief where benefits would be given automatically without showing cause or, I guess, making a claim. Lawyers and companies will want to know the difference between giving 10 basis points a year or 25 basis points a year for a specified period of time. What are the types of benefits, what are the types of costs to the company, and what are the earnings implications? We need to be able to, on the fly, work with the lawyers as negotiations take place or as discussions take place internally regarding what will be offered. If they're asking for this or they're asking for that, we need to know what we are really talking about in terms of benefits to the policyholders and costs to the company, which, as Allan mentioned, are not necessarily the same thing.

Another thing that Allan had mentioned is that when we get into the more detailed discussions on these, the second part of these settlements will have evolved into people making individual claims within some type of a formal structure. Companies need to know what this is going to cost. And there are at least two types of cost associated with this. The obvious one is the relief that policyholders would be granted if they could prove their case. The way these things are set up is policyholders will make a claim, they'll send in whatever evidence they may have, a company may have to look at its own files, and there will be some type of score, which is based on the evidence of the person's claim. A score might run anywhere from zero to three. Zero would indicate that you actually submitted something that was contradictory to your claim. One would be it's neutral or doesn't help or hurt your claim. A two might get you halfway to a full claim, and three gets you full relief or whatever has been negotiated. Companies obviously will need to know what is the cost of that relief. In order to estimate that cost you're going to need to know certain things like how many people are going to make a claim and how many people are going to successfully make a claim. What's the distribution going to be of those people making claims by score, and what are the demographics of those people making claims? We learn from experience what the tendencies are, what the take rates have been historically, and what the impact general relief may have. Typically, the way these things are set up, the general relief will be given if you don't file a claim. If you file a claim you forego general relief so policyholders will have to decide whether filing is worth it. Sometimes they'll just take what's in general relief because it's a lot easier. We need to sit down and estimate those things. If they ask me what the take rates are going to be, I say it's going to be somewhere between zero and 100%. They look at me like I'm crazy, but then I say it's going to be between zero and 100% because it's very, very contingent upon a whole host of things. In the end, we're able to narrow it down a little more specifically into a range of take rates and scoring distributions and demographic distributions that we can give senior management. We can give the lawyers some reasonable amount of comfort as to what the range of potential outcomes is going to be in terms of dollars on the claim relief.

Mr. Horwich: It's well known from the press that there have been dozens of settlements. The obvious thing to do for anybody wanting to assess the likelihood of claims being made is to go back to see what actually happened in these earlier cases. When the first one came along, people didn't know much; but now we've had some experience. Unfortunately, for better or worse, most of the information regarding the actual outcomes of these settlements is not public. Many of these companies of course are mutual companies, and there is no public disclosure of the actual outcome of the claim process. In some cases, it is confidential by agreement of the parties. In some cases, there is some public information because the court may have held back a part of the plaintiff's attorneys fee to wait to see what the

actual outcome of the claims process has been. In the vast majority of these situations, either because the process has taken so long and hasn't even been completed or because it's confidential or because there simply is no disclosure of it, you don't have a public way of going out and getting these data to find out what the take rate or the claim rate, or whatever you want to call it, has been in the actual cases that have been settled. Each case is somewhat different and the claim process may be a little different. Some cases may be cumbersome and some may be more user-friendly. Obviously the parameters and dynamics of a particular scheme of claim review will impact the extent to which people avail themselves of it. It's also influenced by the extent to which people feel aggrieved. If people generally feel that they were not misled by the company they may be less inclined to go through the effort of submitting a claim. If they feel they've really been hornswoggled, then they're more likely to file a claim; so you have only a limited amount of actual historical data on these procedures. What you do have is very case-specific, so it's very difficult to try to put together what little you have to come to a reasoned conclusion in what the actual experience in your situation under a particular design that you may be negotiating will be. For that reason, we need the expertise of people who perhaps had advised a variety of clients, even if they can't disclose to the lawyers or the principals what actually happened in a specific case. They're bound by some confidentiality or ethical prohibition about making a disclosure. They at least have the judgement that they can use when they're doing a general assessment for you.

Mr. Hildenbrand: I would add to that that each case is going to be unique because there are a tremendous number of circumstances that will influence what types of take rates you're going to have, and who's going to make the claims. Typically what we'll do, in terms of getting a hold of something like that, is look at the company's history with respect to complaints, claims, and settlements that they've made individually. For example, if it's a very extreme case of vanishing premium, what we would typically do is go back and run a correlation between the complaints file versus the profile of when policies were supposed to have vanished. So you look at the in force and you can tell pretty much by your projections when these policies should have come to that point. You can see if there's a correlation between the number of claims beginning to arise versus the point when they didn't think they were going to have to pay anymore premiums. Then you relate that to your other experiences. But those are some of the techniques that can be done either internally or externally to begin to get a feel as to what type of a claim take rate you're going to get, and what the nature and the demographics of those claims are going to be. Are they big claims, small claims, older people, younger people, and so on? It's extremely important to at least get a feel as to where those dollars are going to wind up coming from. In many cases, it can be a great deal of money with respect to the entire settlement.

The trend has been away from a very involved claims procedure. The early cases were very confrontational, user-unfriendly procedures in which both sides got involved. There was arbitration and expense, etc. This was something we were used to and that's how it was done. Companies have come to the realization that, in many cases, they might wind up spending more administratively than the relief they would give to the policyholders in the first place. Why have a procedure that's going to get the policyholder even madder because of all the hoops that you would have to make them jump through?

Some of the more recent settlements are automatic or a little bit more mechanical. They have streamlined the alternative dispute resolution (ADR) or the claims review process (CRP) down quite a bit, such that the companies are not spending a lot of time and the other side is not spending a lot of time watching over what's being done. In some cases, a third party arbitration process or a neutral type of valuation process has been used to review settlements. You don't have to deal with the extra arbitration or the extra review by the plaintiff side. I think both sides have found out that this method has been quite productive. Let's put the dollars towards the policyholders and take care of their claims as opposed to hiring more administrative people and TPAs.

Mr. Horwich: It's implicit in what Steve has said. I think it ought to be stated. I don't think I touched on this in most of these settlements. I don't want to make an unqualified statement because there have been so many settlements, and I have not read them all. The company ends up paying for almost everything. The company pays for the notice that is sent out to the class to comply with the class action procedures. It can be very expensive to print and mail if you're dealing with millions of class members, especially if there are one or two stages of notices. You set up a bank of trained telephone operators to answer questions because these settlements are complex. It's not as simple as somebody's just going to send you a check for $75 or $150 if you have a claim. They're complex; people are asked to make choices. We haven't gone into that in detail, but people have to make a choice from among those options and they need to be educated. That telephone bank is paid for by the company.

The size of that operation is obviously dictated by the size of the class. You then have the administrative cost of doing all of these things, including any claim review process. In virtually all the cases, the company has paid for that. You can cost that out and try to figure out what it would cost to process a claim. A Steve said, if you're going to devote dollars to resolving this matter, the company, whether it's a mutual or a stock company, would, as a matter of good policyholder relations, do it to keep policyholders happy. Instead of paying some administrator for a lot of time and expense, which makes that industry rich, they apply those costs to benefit

policyholders. So that's a cost component that the company has. In some cases, that has proven to be extremely cumbersome and extremely costly, and that is why there has been this move on the part of a number of companies to try to reduce those costs. But the plaintiffs then want to see at least some of those saved dollars moved over into the claim relief or the amounts that are actually paid out to the class members. The plaintiff's lawyers are not dummies. They know what's going on here, and when they see you saving dollars by streamlining the administration they want to see at least some of that go to the class members.

Finally, as I alluded to earlier, in the vast majority of cases the company has paid the legal fees. Now that has to be approved by the court in a class action, but the amount is negotiated. That's the last thing to be negotiated in the settlement. Everything else has to be resolved before that to be done in proper form, but the company pays those legal fees. So you have to add up all of those cost components as well as the parts that are going directly to the class when you assess what the cost of the settlement is going to be.

Mr. Hildenbrand: Allan spoke about the types of benefits or relief that have been provided and where the trends are going right now with respect to some of these settlements. Typically what you'll see in these are some type of a basis point enhancement to the policy or the credited rate or on the dividends usually for some relatively short period of time—two, three, four years. In addition you might see some cost of insurance discounts on universal life policies for a particular time. Many of these have some nice incentives that in order for the policyholder to get they have to stay in force. There are some very positive things about that. There are also some other types of settlements: enhanced value annuities (EVAs) or enhanced value policies (EVPs) in which the policyholder will get some type of a discount to the premium or additional coverage.

There's a very similar concept—for every dollar you put in we'll, for example, match it with a dollar. I've seen that in a few settlements. There have been some discounted policy loan rates. These are driven quite heavily by what the company can do administratively. Before I'd venture down that road, I'd really want to make sure to check with the people who administer the policies. When they find out about some of these things, they pass out. You have to make sure that the company can do this, and that it's not going to bring their administrative systems down.

Some of the other features that have been used recently are pools or funds, caps or ceilings, target amounts, or guaranteed amounts where it adds some certainty to the settlement amount. As with anything else, there's a cost associated with that. But those are some of the features that companies would like to have so that they have a

greater certainty in terms of what the dollar amount of their exposure and their cost is going to be.

And, of course, that leads into one of our favorite topics, which is financial reporting. How do you account for all this stuff? What types of liabilities do you put up? How are you going to deal with this on a GAAP basis? This has driven some considerations of my clients in terms of the types of remedies they're putting forth on vanishing premium claims. For example, the old way to fix these things was to say, "You're right. I promised I was only going to make you pay seven premiums. There is enough evidence. Don't pay anymore after your seventh premium and we'll check it every year to make sure that your dividends plus paid up additions are enough. And if they're not, we'll make sure we dump in the extra amount." That requires a company to monitor this every year going forward and that liability for that promise is going to bounce around as your dividend scale or as your credited rates go. So companies have moved away from that and said, based on today's current scale, here's the amount we think is necessary to make your policy vanish. We'll dump it into the policy, perhaps with some restrictions on usage of those funds. Then the company has quantified it's liability and they can be certain to be done with it. The movement is more towards certainty, ease of administration, and ease of reporting.

Mr. Horwich: Let me make one observation. This is not a good time for insurance companies to be upgrading their system in terms of accommodating the needs of a settlement. There are tremendous demands on most insurance companies, as there are on all financial institutions, to make sure that they are Y2K compliant. So to be designing settlement options that involve overlays on your existing systems is not something that insurance companies want to be doing today. They don't want to have to be adding new bells and whistles in the middle of 1999 when they're already trying to make everything work properly. So that has been something of a constraint in terms of the flexibility that these companies have in doing some of the things that they might otherwise want to do.

The companies that settled back in 1997 and 1998 either may not have foreseen the difficulty that that was going to create or were not able to address the systems constraints effectively in the context of their ultimate Y2K compliance. But somebody who's going through this today has to be very mindful of the system demands of implementing some of these things at the same time that they're trying to bring their system in to Y2K compliance. They might have a company-wide freeze, for example, on any new initiatives with respect to systems development.

Mr. Christopher H. Hause: Something that Allan said a while back kind of struck a chord with me in terms of propping up credited interest rates or dividend scales.

We have the certification on the annual statement as to whether the companies current nonguaranteed scales are supportable. I was just wondering if you ever ran into a case where that opinion was qualified or not or whether that particular statement by the actuary has been examined in regard to a lawsuit?

Mr. Horwich: As to the qualification and reporting requirements I would defer to Steve on that. It is a common allegation in these lawsuits that in fact companies were continuing dividends at a level that didn't comply with the certification that you referred to. Perhaps it was made by the plaintiffs who did not have access to all of the information they would need to make a sound judgement on that. Of course, if they were not in compliance, then the plaintiffs would be able to allege, perhaps successfully, that there was deception going on because the company wasn't making full disclosure with respect to their compliance with that standard.

Anybody who was looking at that would say, well, these dividends are good for at least two years or whatever the requirement is. They would have been misled and possibly would have bought a policy that resulted in unmet expectations. So that is a thing that the plaintiffs definitely focus on. And if the case goes far enough, they will get into all of the actuarial documents, all of the board, or committee documents that relate to the dividend-setting process. They would try to establish, along with their actuarial team, that the dividends that were being paid and that were used to illustrate on a current basis were not sustainable, and did not meet those criteria and thus were false and misleading. Again it was a technical issue, but the actuarial testimony of a consulting actuary can be crucial if you reach the defense stage of the case. You'll have the company people testifying historically as to what their analysis was, why they did what they did, and why they reached the judgements they did. Then the outside expert, the independent expert, will testify on the behalf of the defendant to prop up or support the reasonableness of the judgement that was made at that time. But that is definitely an inherent part of many of these cases.

Mr. Hildenbrand: I think, from the plaintiff's viewpoint, during discovery, they're looking for stuff like a memo from the chief actuary. You have to remember this goes back to the mid 1980s for the most part. You might have had a memo from the chief actuary that says to the president or marketing department, "We need to change our dividend scale; we can't support this anymore." Another correspondence would say, "That's great, but we need to hold out for another year or two so we can sell X more policies." I think that that just gives a lot of ammunition on the plaintiffs part, perhaps justifiably so, that the scale was artificially maintained. I think nowadays it's tougher and tougher to do that. I don't spend a lot of time in those particular areas, but there is supportability from the

model regulation on illustrations. I mean all that stuff needs to be really scrutinized. Ten or fifteen years ago, it was not quite as explicit as it is nowadays.

Mr. Hause: I was referring more to the annual statement exhibit 8 certification issue. Exhibit 8 carries a question that says, "Do you offer nonguaranteed elements in your policies? If so, you have to complete an actuarial opinion." Part of the actuarial opinion says that's attached to the annual statement, which I believe is a public document and the plaintiff should have access to it. The actuary says these are supportable based on the company's current or projected experience and so on. Have you ever ran across that situation where there are conduct issues involved in which the plaintiffs more or less proved that that actuary was stretching the truth?

Mr. Hildenbrand: In the cases I've worked on, the answer to both questions is no. It has not gotten to that point. I think most of these, if I'm not mistaken, have really gone to settlement so it never really gets that far. There have been some. A couple of companies have litigated and actually prevailed. I can think of two of them that have prevailed in certain instances on this and those issues have not at least come to the point that you mention there.

Mr. Horwich: Those allegations are made. There's no question about it. That is a focus of the discovery that the plaintiffs take, in order to find if the company bowed to internal marketing pressure. If the plaintiffs could find something like that, it would be a gold mine. They look for that, and they allege that in their initial complaint, which is usually filed at a time when they have access only to the public statements. I will defer to the plaintiffs as to what kind of investigation they do before they make those kinds of allegations. But that is, without question, a focus of their investigation when they do get into the company documents because if they can find support for that kind of an allegation, it's obviously very significant for their case.

Mr. Hildenbrand: Allan, do you have any comments you might want to make in terms of historical documents? I suspect many of the actuaries out here work for insurance companies.

Mr. Horwich: You can't redo history, and I would not counsel anybody ever to destroy documents. In the future, be careful what you write because a lot of people do a lot of what I would call musing memos or they put down their thoughts or their preliminary analysis. It's saved just because people don't clean out their files. Today litigators will tell you generally, and this has nothing to do with life insurance in particular, that e-mails are going to be the bane of any company's existence on the defense side because we write them so casually. Often they are in fact written in a casual fashion or in an off-handed way, using jargon and colloquialisms. When

we think they're disposed of, they're not. When you delete an e-mail on your machine, it's still buried somewhere in the network or in a backup tape and aggressive litigators will demand production of those kinds of documents. Back in the days when things were only hard copies, people just saved everything. You didn't worry about weeding out your files unless maybe you got a promotion or left the company or something and then you cleaned things out.

Plaintiffs are very adept, as one would expect, at blowing out of proportion some intermediate stage analysis or off-hand comment or exchange where there's a lot of open give-and-take. In an organization that encourages that kind of back and forth, you will find a lot of files in which people put down their preliminary thoughts that were ultimately not the final decision or not the basis for the final decision. It then has to be explained away if you ever get to the stage of litigation. You will find hundreds of thousands of documents at all sizes of insurance companies, and often there's not a good record of what they really are. It may not be clear who the author was, what the circulation of the document was, and what the disposition was. It becomes a nightmare.

There's nothing you can do about the past, once you're sued and you're served with a document request or are otherwise disabled from destroying anything. But my advice to all clients is to be very circumspect about what you put on paper. Once something is superseded, get rid of it. Make that an ordinary course. Don't selectively dispose of things, but keep the final documents. Keep the documentation of your decision so that six years down the road, when you have to defend why you set a dividend where you did, you can explain and demonstrate why you did it rather than having to deal from memory.

Even if there's not a class action, there can be a suit by one policyowner over his or her $50,000 policy. They may demand the same document production relating to dividend setting, illustration practice, or all of these range of documents that would be demanded in a class action involving hundreds of thousands of people. You may have to produce those same documents. Once they get them in one case, the lawyers may see if they're favorable to the plaintiffs side and try to determine whether there's some basis for bringing a broader lawsuit. So the fact that you may be hit with only a handful of individual suits doesn't mean that those unfortunate jottings of 15 years ago aren't going to see the light of day.

Mr. Carl A. Westman: You were describing the various forms of relief available to policyholders. I was curious about the case of a settlement of plaintiffs that do not seem to ask for any kind of cash settlement. All the forms of relief you described were in the form of higher benefits. It seemed to me that if they weren't spending

the money on a premium that did not vanish they would spend it on something else. I figured there must be a legal reason for it.

Mr. Horwich: I think it is a combination of factors. First of all, when you're giving relief to terminated policyholders, it often takes the form of a cash payment. It may be the ability to buy a new product that isn't a cash payment but in some cases it is cash. If there's a claim review procedure, they might have a cash award in that situation. Sometimes the policy values or the enhancement to the policy values can be structured in such a way that they may be immediately withdrawn by the policyholder. That again depends upon the negotiation of the deal and how it's set up and what the defendant company is willing to do.

Based on my study of numerous settlements and what I've personally been involved in, it doesn't seem to be the plaintiff's focus. I think one reason for that is the following. As I said earlier, the cost to the company is different from the value or benefit given to the policyholder, in which case you're putting values in a policy or selling a new policy. You also might not be doing it with a commission payment. The cost to the company may be less than the actual benefit to the policyowner. What the plaintiff wants to see is a high value. They're not so much interested in what it costs the company; they're interested in what the benefit to the policyholder is because that's what the legal fees will be based on.

In some cases, companies made low-cost loans available to policyowners and they would make the loan available at cost plus maybe an administrative cost of 10 basis points or whatever. That didn't cost the company anything, but it was probably an interest rate that was much lower than the man on the street could get if he wanted to go borrow some money. Being able to borrow money at the company's cost of money may have been a very significant benefit to a policyowner, but it cost the company nothing. The plaintiffs are looking at what benefits can be generated for the policyowners. What is the value of that? Can it show the court that this is a high-value settlement that is fair and reasonable under the circumstances and that it justified the substantial legal fee on our part? Now the companies might have business reasons as to why they would rather put values into a policy on the books rather than have it go out as cash. That is from the company's point of view rather than the plaintiff's point of view.

Mr. Hildenbrand: That's the correct thinking. You should put the settlement amounts into the policies and maybe structure it somehow so that the policies stay in force. I mean that's a good thing from the company's standpoint. Many of the points Allan made are very well taken. I mean that is what's driving a lot of this. There has been and there was one recent settlement within the last six months where essentially it was all cash. They were just going to write checks and be done

with it. From an administrative standpoint I think they just wanted to take care of it. There was pretty much a dollar figure specified that had to be spent. So the company knew what the amount was. From an administrative standpoint, they just wanted to spend the money and be done with it and not have to administer it or worry about it. It's easier to cut a check than it is to set up a system to track all this stuff going forward.

Mr. Horwich: One thing you should keep in mind in some of the settlement scenarios that we've described here is if you're putting values into policies over a three- or four-year period, you're administering the settlement for that period of time. You're still dealing with those situations for those policyholders that stick with you. One settlement for example has enhancements made all the way up to the fifth year of a new policy. So you're in effect in the settlement for five years. The claim review process may inherently drag out over a period of time because it's something that's going to take time to be done. You're going to be administering that by answering phone calls and questions from policyholders that have questions about their claims for a year or more. There is that infrastructure that is set up both at the company and any third-party vendors that you retain to administer this. There are systems that you have to have in place to make sure that these credits are made where they've been promised as long as the policy is still in force. Steve mentioned you might have to make estimates that may be difficult to deal with, particularly for a publicly held company. There have been some stock companies, but most of these have been mutuals. Some have been publicly held stock companies where they have financial reporting requirements for stockholders that are very significant. They have to try to put a number on these settlements. If it's all cash, you don't have to worry about that.

Mr. Bruce D. Sartain: When you were talking about the destruction of documents, you were careful about saying not to destroy documents once you're sued. What's the legality of destroying documents? This vanishing premium problem started to come into the press a couple years ago. Were companies legally allowed, before they are specifically sued, to go back and then start destroying documents to protect themselves?

Mr. Horwich: That question has a variety of answers to it. First of all, I can't speak to what the regulatory requirements are in any jurisdiction that might require you to maintain certain records for a certain period of time. Second, most companies today have record retention polices, and if you started disposing of documents earlier than the records retention policy generally provided for retention, that's not going to look very good to a judge or to a jury. Once the lawsuit starts, the plaintiff will do one of two things: they will either ask the judge to enter a blanket record-retention order, which will mute the question. You'll be under an obligation if the

judge enters such an order. Alternatively, they may serve a document request on you that is so broad that you would be at peril to destroy anything. You might find yourself inadvertently destroying something the plaintiff felt was within the scope of that request, even if your lawyers felt that it wasn't.

One example has become notorious. It was in the press, so I'm not giving away any confidential information. I was not involved in that case. Prudential did destroy some documents, but I don't remember the exact circumstances. I don't know whether they were under a specific order or retention or whether they were documents that had been called for in a document request. Maybe some rogue staff member or somebody else destroyed documents, and they paid a very dear price for that. It did not endear them to the judge. I believe they were sanctioned directly for having done that. It was settled at a very significant cost to Prudential. Juries would be heavily influenced by hearing that relevant information might have been destroyed. Once it's destroyed you can't be absolutely certain about what it was, but that obviously does not serve you well. My general instruction to a client who is sued in a situation like this is put a freeze on your documents. In a very large company that may be difficult to do or to enforce because you may have 10, 15, 20, or 30 regional offices. It depends on the nature of your agency force. Are they employees of the company? Are they independent contractors? You have a wide range of variation with respect to that, but the general instruction in situations like this is don't destroy documents. It may hurt us. Some of the documents in the files may hurt us, but it's a matter of the integrity of the judicial process. In the best interest of the company, the best thing to do is simply not to be destroying documents. But, as I say, very often events will mute that because plaintiffs don't want to see documents destroyed. They want to see the judge order you to retain everything. But those orders are hard to enforce rigorously simply because these companies have thousands and thousands of employees scattered all over the country.

Mr. Hildenbrand: I would echo on the records retention. You must keep good records, good documentation of decisions made, and things done. If you have extraneous stuff in your files, it's just something else that you have to explain. It may be taken totally out of context in a matter of several years down the road. I think you should be careful and be very diligent with your files and keep good files.

I've always been intrigued by this notion of class action. How can a set of lawyers and some judge in some little town, for example, bind everybody across the nation into some type of a settlement. What's the methodology? How does this stuff work?

Mr. Horwich: There was a Supreme Court case, *Handsary v. Lee,* back in the 1930s or 1940s. There are constitutional issues involved. The Federal courts since 1966 had a very broad class-action rule. It has been amended a few times and is still under review. There was a much looser rule in, I believe, 1938. It is a matter of due process. The courts have held, including the U.S. Supreme Court, that if people have adequate notice in these situations, they can be bound. A state court can do this as well, although the questions will relate to due process and fair notice, depending upon whether a state in some corner of the U.S. has jurisdiction over all people in the U.S. But if they get notice, which is one of the things I mentioned earlier about class actions, you have to give the best notice practicable under the circumstances. And in the case of insurance companies, you can identify who all your customers are. You certainly know who has a current in force policy. There's no excuse not to be able to mail to them. In many cases, you will have a last known address for a terminated policyholder, even going back to somebody that bought in 1984 and terminated in 1985. You may have an archived tape done at year end that will show you that person's address at that last point. You might dig that up and it might get sent back by the post office as undeliverable, but you give it a shot. You also can put a notice in the newspaper to try to pick up those people who don't get the individual notice, but as a matter of constitutional law, the U.S. Supreme Court has held that you can bind these people. In exchange for these settlement benefits, which flow to the class members, the court grants the defendant a release so that any claims that are encompassed by that lawsuit are released by every single member of the class as it's defined by the court in exchange for those benefits. The benefit may be $10 in one case, or it maybe $10,000 in another, but the defendant wants to buy peace. Settling the class action is useless unless you get peace. You don't want to be sued by the people you've just settled with. So you get a release that the court enforces, and if somebody who is in that class sues you somewhere else, you walk into that other court with a court order that says, "Your honor, I got a release from this person because this person was in that class. I've got a list that shows they were in the class. They settled; they're bound by that settlement; they have relinquished the right to sue me in connection with their purchase of their policy. Throw them out." If that judge in that other court does what he's supposed to do, he will dismiss that case. You buy peace by following the constitutional requirements of due process. Steve can help you figure out how much it will cost.