To Be Argued By:
SETH ARD
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CTQ-2022-00002
U.S. Court of Appeals, Second Circuit Docket No. 21-1830

Court of Appeals

STATE OF NEW YORK

ANDREW NITKEWICZ, as Trustee of THE JOAN C. LUPE FAMILY TRUST on behalf of himself and all others similarly situated,

Plaintiff-Appellant,

—against—

LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK,

Defendant-Respondent.

REPLY BRIEF FOR PLAINTIFF-APPELLANT

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SUMMARY OF REPLY

Plaintiff paid "for any period," a full year in fact, when he timely paid his Annual Premium to Lincoln – an annual payment he made once per year, for 8 years, in the exact amount and exact annual interval that his Policy said. It is undisputed that the insured died five months later. Yet Lincoln claims it should keep *all* the money Plaintiff paid for the whole year. This Court will normally refuse to depart from the plain meaning of a statute, even when that meaning leads to a seemingly unjust result. Here, this Court should certainly not abandon plain meaning to help an insurance company pick a policyholder's pocket.

Lincoln strains to avoid the plain meaning of Insurance Law section 3203 (a) (2), which requires "a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred." Lincoln argues, without citation to authority, that "there can be no dispute that the statutory premium must pay for a period of coverage" and that the annual premium payment cannot be for a year of coverage because (a) it *might* not pay for the entire year (even though the Policy is designed for it to do so), and (b) there is no way to tell which portion of Plaintiff's annual premium was paid for coverage versus investment purposes or something else (Brief for Defendant-Respondent ["Resp. Br."] at 19-20).

This argument rests on several errors. *First*, it depends on inserting the words "for coverage" (or "for guaranteed coverage") into the Statute, inventing statutory language that adds the underlined words to say: "a refund of any premium actually paid <u>for coverage</u> for any period beyond the end of the policy month in which such death occurred." But that is not what the Statute requires; all it requires is that there was a premium actually paid for any period. And there was: an annual premium payment was paid for a year. *Second*, the Statute is agnostic as to whether the premium actually paid is for the purpose of coverage, for investment purposes, or for some other purpose, and the Statute is also agnostic as to whether the premium pays for coverage, other costs, or for Lincoln's bottom line. The Statue only asks whether the premium was "actually paid for any period beyond the end of the policy month" in which the insured's death occurred, and that is exactly what happened. *Third*, the Statute accounts for the impossibility of determining whether a premium payment was made for the purpose of providing coverage, or for investment purposes or something else, by not introducing any of those concepts into the statutory language: the Statue only asks whether the payment was actually paid for a period beyond the death of the insured, regardless of any estate planning or financial purposes the payment served.

Lincoln also argues that the premium was not "actually paid" when Plaintiff sent Lincoln a check and Lincoln cashed it, but instead only when Lincoln moved

the money between accounts, making a "monthly deduction" from the Policy's account value (Resp. Br. at 1). But Lincoln's internal application of funds has nothing to do with whether Plaintiff "actually paid" the premium. Plaintiff "actually paid" his premium when Plaintiff mailed the check and Lincoln accepted the payment. And Plaintiff did not pay "one month at a time," as Lincoln would have it (*id.*). He paid one year at a time, every year for eight years, by way of his "Annual" premium (Rec. 65). Plaintiff therefore paid for a period (seven months) beyond the death of the insured, and he is entitled to a prorated refund under the Statute.

Lincoln also tries to sidestep the plain meaning of the Statute by focusing on how Plaintiff's insurance policy is a universal life policy. Lincoln submits that it makes sense to "treat owners of term policies and owners of universal life policies differently" (Resp Br. at 44). But Plaintiff has emphasized how, under Lincoln's interpretation, the statutory refund requirement would ***never*** apply to a universal life insurance policy (Brief for Plaintiff-Appellant ["Opening Br."] at 16, 27-31). Lincoln has no answer for this. ***Its brief fails to identify even one example of how, under its interpretation, the refund requirement could apply to universal life insurance.*** That failure dooms Lincoln's argument because the Statute applies to "[a]ll life insurance policies, except as otherwise stated herein," and the exceptions "stated herein" do not include universal life policies. This Court may not "second-

guess the legislature's determination, or … disregard—or rewrite—its statutory text" (*Xiang Fu He v. Troon Mgmt., Inc.*, 34 NY3d 167, 172 [2019]).

The Legislature knew that it included universal life policies because in the immediately preceding subsection of the same Statute, the Legislature chose "to treat owners of term policies and owners of universal life policies differently." (Resp. Br. at 44; Ins. L. § 3203 [a] [1] [providing a longer grace period for policies "in which the amount and frequency of premiums may vary" (i.e., universal life insurance policies) and a shorter grace period "for all other policies"]). If the Legislature also meant to treat universal policyholders differently for the refund requirement within the very same Statute, "it could have easily" done so (*Walsh v. New York State Comptroller*, 34 NY3d 520, 526 [2019]). Instead, it exempted only "single premium" and "paid-up policies," not universal life (Ins. L. § 3203 [a] [2]).

In the least, under the terms of the CPGR rider at issue in this case, the answer to the certified question is yes. Plaintiff's annual premium *guaranteed* coverage for each year it was made. In factual circumstances such as these, where the policyowner paid the annual premium *exactly once per year* and that annual payment *guaranteed* coverage for each year, there is no possible interpretation of the Statute under which that premium payment was not a payment for a year. If the Court is concerned about limiting its determination, it may answer the question affirmatvely under "the facts presented" by this case (*Messner Vetere Berger*

McNamee Schmetterer Euro RSCG Inc. v. Aegis Grp. PLC, 93 NY2d 229, 236 [1999]).

ARGUMENT

I. The Premium Was "Actually Paid."

Plaintiff has stressed the simple and undisputed facts that Plaintiff sent Lincoln a check for the full amount of the last annual premium ($53,877.72), and Lincoln cashed the check. Under a plain-language approach, Plaintiff's premium was "actually" paid; it was paid "in fact; in reality" (*see* American Heritage Dictionary, *https://ahdictionary.com/word/search.html?q=actually* [Definition of "Actually"]; Opening Br. at 18).

Lincoln criticizes Plaintiff for "rely[ing] on lay dictionaries" to interpret the Statute (Resp. Br. at 20). But that is what this Court frequently does. "We construe words of ordinary import with their usual and commonly understood meaning, and in that connection have regarded ***dictionary definitions as useful guideposts*** in determining the meaning of a word or phrase" (*Walsh*, 34 NY3d at 524 [emphasis added]).

The Statute provides additional support for Plaintiff's interpretation of "actually." It distinguishes a premium that was "actually paid" from an "unpaid premium" that was due but not paid (Ins. L. § 3203 [a] [2]; Opening Br. at 17). Here, there was no "unpaid" premium. Plaintiff sent the check, Lincoln received

the money, and credited it to the policy account and administrative expenses. How would universal life policyholders not believe that they "actually paid" their premiums once their checks cleared?

Lincoln struggles to avoid this commonsense conclusion, arguing that only "the monthly deduction" is "what 'actually' pays" for insurance (Resp. Br. at 19). Yet Lincoln acknowledges that premium payments fund the Policy Value, which is the "source of funds" for the monthly deduction (*id.*). An insurer's internal accounting process cannot change the plain meaning of "actually paid." And the Statute does not limit refunds to the portion of premiums that pay for insurance; it requires a refund of "any premium" paid for any period beyond the insured's death.

Lincoln also contends that some portions of the premium "cover the risk of loss, while others relate to the investment component" of the Policy (Resp. Br. at 18). But whatever Lincoln contends premiums "cover" or "relate to" does not matter. The Statute does not distinguish between premiums paid for coverage nor premiums that relate to investment (or some other purpose). The Statute just refers to premiums. The Policy similarly does not allocate premiums between the savings and death benefit aspects. There is just one "annual" planned premium and a policyholder does not control Lincoln's internal allocations. Moreover, Lincoln does not seek to allocate; it wants to keep 100% of the premium – the death benefit

part as well as the investment part – for itself. Nowhere does the insurer explain how this is fair, nor permissible under the Statute.

Lincoln next argues that the monthly deduction is what "actually" pays because it "actually extends the coverage" and "continues the Policy from month to month" (Resp. Br. at 17, 19). But the words "actually extends the coverage" or "continues the Policy from month to month" are not in the Statute. The words "actually paid" are.

Continuing in its effort to amend the statutory language, Lincoln adds other words or phrases into the Statute, saying it is inapplicable because "a Planned Premium may not prevent the Policy from terminating" (Resp. Br. at 22). The lower federal court in this case made the same mistake, dismissing the Complaint because a planned premium "may not necessarily prevent" the Policy from lapsing (Rec. 335). The Statute does not say "prevent the Policy from terminating" nor "guaranteed coverage." It says "actually paid." The annual premium was actually paid, and it was paid for a year – the entire contract is designed so that the annual premium is paid exactly once per year (Opening Br. at 21-22 [citing numerous Policy provisions, including provisions that describe the planned premium as what the policyholder "intend[s]" to pay, and the premium frequency as "how often [y]ou intend to pay" it]). Whether that annual premium was paid for coverage or

investment purposes or a blend of the two, and whether it guaranteed coverage for a year, is irrelevant under the Statute.

To support its wish to add a "coverage" or "guaranteed coverage" requirement to the Statute, Lincoln points to the Statute's condition precedent: "if the death of the insured occurs during a period for which the premium has been paid" (Resp. Br. at 19). But that phrase supports Plaintiff because it acts to distinguish a case like this one – where the policyholder paid the policy's premium – from a case where "the death of the insured occurs within the grace period provided in the policy" such that the policyholder is not entitled to any refund (Ins. L. § 3203 [a] [2]).

When not inserting its own words into the Statute, Lincoln chides Plaintiff for "pointing to a single word" in the Policy – "premium" (Resp. Br. at 21). That criticism is misplaced because the Statute says "premium," and the Policy repeatedly uses the word "premium," which is why Plaintiff relies on those provisions (*see* Opening Br. at 21-22 [citing Rec. 65, 75]). In any event, Plaintiff has cited several Policy provisions to support his position, including provisions which refute an argument that Lincoln has made: that his premium was not "actually paid" because it can in the future hypothetically be withdrawn (Opening Br. at 19-21). Lincoln responds only with silence, tacitly withdrawing its "withdrawal" argument. Plaintiff also cited several Policy provisions to support his

argument that the premium was paid "for any period" (Opening Br. at 21-24 [citing Rec. 64-65, 75-76]; *see also infra* Section II).

Lincoln's reliance on *New York State Association of Life Underwriters, Inc. v. New York State Banking Department* is misplaced (Resp. Br. at 20-21 [citing 83 NY2d 353 [1994]) [*NYSALU*]]). Lincoln cites this case to argue that Plaintiff must do "more than look at the word 'premium'" (Resp. Br. at 20). But Lincoln again mischaracterizes Plaintiff's position, which does not focus on a single word, as noted above. Lincoln also mischaracterizes *NYSALU*. According to Lincoln, *NYSALU* ruled that "that annuities are not 'insurance' in the sense that mattered" even though "[t]he *NYSALU* statute called annuities 'insurance'—period" (Resp. Br. at 20). Lincoln omits a key point: *two* statutes were at issue in *NYSALU*. The question presented was whether banks were permitted by a banking statute to sell annuities. The petitioners argued "no," relying on the meaning given "annuities" in a separate insurance statute. The Court declined petitioners' invitation to interpret one statute by way of the other. The Insurance Law in this case poses no such similarity.

Lincoln goes so far as to wave away Plaintiff's analogies to buying groceries and prepaying mortgages (*compare* Opening Br. at 18-20, *with* Resp. Br. at 21). It claims these analogies are "not helpful," including because the Policy "is a sophisticated financial instrument" (Resp. Br. at 21). So are mortgages. Lincoln

also misses the point of the analogies, which is that people "actually pay" for all kinds of things regardless of how the recipient of the money internally accounts for the funds actually paid. As another example, if someone pays $1,000 at a charity auction for baseball tickets, she has "actually paid" $1,000 for the baseball tickets even if the charity only allocates $200 to reimburse itself for the tickets and the remaining $800 goes to other things. The "usual and commonly understood meaning" of "actually paid" encompasses scenarios where someone writes a check for something (as Plaintiff did) and the seller cashes that check (as Lincoln did) (*Walsh*, 34 NY3d at 524).

II. The Premium Was Actually Paid "For Any Period."

The premium was also "for any period"—one year. The Policy says the premium is for an "ANNUAL" period, and it was the eighth in a series of premiums paid annually, in identical amounts, as specified in the Policy (Opening Br. at 21-22; Rec. 65, 75, 100). The dictionary states the plain meaning of the word "for" is "[u]sed to indicate the object, aim, or purpose of an action" (*see* American Heritage Dictionary, https://www.ahdictionary.com/word/search.html?q=for; Opening Br. at 23). An "annual" premium is paid with the "object, aim, or purpose" of paying for a one-year period.

Without offering a competing definition of "for," Lincoln incorrectly states that Plaintiff "does not cite any Policy language" to support his interpretation

(Resp. Br. at 24). The key Policy language is the word "annual." As Lincoln concedes, "annual," as used throughout the Policy, signifies "how often the owner intended to pay" his premium (Resp. Br. at 23; *see also* Opening Br. at 21-22 [citing numerous Policy provisions, including provisions that describe the planned premium as what the policyholder "intend[s]" to pay, and the premium frequency as "how often you intend to pay" it]). Lincoln does not address *Cragg v. Allstate Indemnity Corp.*, 17 NY3d 118, 122 [2011]), which instructs that "[i]nsurance contracts must be interpreted according to common speech and consistent with the reasonable expectations of the average insured" (*see also* Opening Br. at 22). Here, an insured would reasonably understand an "annual" premium to pay for an annual period. Indeed, the entire Policy design, codified in the words of the Policy, was for the policyholder to pay this exact amount once per year, extending coverage each time for one year until the next payment is due. And "annual" on the facts of this case describes not only how often Plaintiff *intended* to pay the premium, but how often he *actually* paid it.

Lincoln urges that "Annual" as used in the Policy "refers to how often [Plaintiff] chose to receive payment notices that he was free to disregard" (Resp. Br. at 22). That misses the point. The fact that the policyholder could have disregarded the notices does not change the fact that when the annual premium was in fact paid, as it was here, it was paid for a year. The Policy design – written into

the Policy itself – is for the premium to be paid exactly once per year. If that is not a payment for a year, nothing is.

Other provisions further refute Lincoln's argument that, for Plaintiff's Policy, insurance can only be paid for "one month at a time" via the monthly deduction (Resp. Br. at 2, 6). The Policy itself refers to premium payments "sufficient to keep this policy in force for at least two (2) months" (Rec. 76). The Statute likewise has a 3-month grace provision, which explains that for policies "in which the amount and frequency of premiums may vary" (i.e., universal life insurance policies), the policyholder is entitled to a grace period "within which to ***pay sufficient premium to keep the policy in force for three months*** from the date the insufficiency was determined" (Ins. L. § 3203 [a] [1] [emphasis added]). These provisions demonstrate that universal life insurance need not always be paid for "one month at a time," as Lincoln claims. In response, Lincoln says that a payment "sufficient" to keep a policy in force for 3 months "does not . . . actually purchase[] three months of coverage" (Resp. Br. at 26), but the Statute contradicts that argument.

Subsection (a) provides:

> (1) [F]or policies in which the amount and frequency of premiums may vary, . . . the policyholder is entitled to a sixty-one day grace period . . . within which to pay sufficient premium to keep the policy in force for three months . . . .
>
> (2) [I]f the death of the insured occurs during a period for which the premium has been paid, the insurer shall add to the policy proceeds a refund of any premium actually paid for any period beyond the end of the policy month in which such death occurred.

Lincoln cannot credibly contend that a premium which meets the top provision somehow fails to meet the bottom provision. And if a universal life premium can be sufficient to pay for 3 months of coverage, it follows that universal life premiums can also be sufficient to keep a policy in force for 6 months, 9 months, or 1 year. As a result, Plaintiff prevails even under Lincoln's (incorrect) argument that the Statute contains a "for coverage" or "for guaranteed coverage" requirement. At the very least, it is a fact question, which cannot be resolved on the pleadings, whether Plaintiff's annual premium was sufficient to keep the policy in force for 1 year, as it was designed to do.

Finally, Lincoln raises public policy arguments, claiming that (1) calculating Plaintiff's refund "requires inventing rules" and (2) that a refund would upend "the benefit of [Plaintiff's] bargain" (Resp. Br. at 25). But there is no need to "invent rules." The refund here is easy to calculate under the Statute:

$53,877.72 (annual premium) X 7/12 (months after the insured's death) = a refund in the amount of $31,428.67.

To the extent relevant, public policy concerns cut in Plaintiff's favor. Lincoln has retained over $30,000 of a premium paid for the period after the insured was dead in exchange for a $125 deduction (at most) in monthly cost-of-insurance charges and for just five months (*see* Rec. at 288 n.5). Furthermore, there is no need to address "accrued interest" because Lincoln gets to keep that money under both parties' interpretation of the Statute (Resp. Br. at 25).[1]

III. If the Legislature Saw Fit to Exempt Universal Life Policies from the Statute, it Certainly Knew How to Expand the Statutory Exemptions.

A ruling for Lincoln would create a new statutory exemption that the Legislature did not include. The Statute applies to "[a]ll life insurance policies, except as otherwise stated herein," and the enumerated exceptions "stated herein" do not include universal life policies. Plaintiff has stressed that "[t]here is simply no way to rule for Lincoln without taking the position that the Statute does not

[1] Lincoln's retention of interest provides context for Lincoln's discussion of the Policy's Option II death benefit, which Lincoln confines to the "Facts" section of its brief (Resp. Br. at 13-15). Here, the prorated return of one premium payment provides less than the Option II death benefit, which includes the full death benefit plus the *entire* Policy Account value (*see* Rec. 77). Lincoln's concern that Plaintiff seeks part of the Option II death benefit despite choosing Option I overlooks the fact that the refund sought is implied as a matter of law into every insurance contract by Statute. Lincoln cannot escape this obligation simply because it ignored the statutory requirements when developing its policies.

apply to universal life insurance policies" (Opening Brief at 28). In response, Lincoln cannot identify even one example of how, under its interpretation, the Statute might apply to a universal life policy.

Lincoln instead proposes a new, judicially-crafted exemption for universal life policies. It argues it is "neither unfair nor irrational" to "treat owners of term policies and owners of universal life policies differently" (Resp Br. at 44). That is an argument, at best, for an amendment that should be made to the Legislature. This Court is "not at liberty to second-guess the legislature's determination, or to disregard—or rewrite—its statutory text" (*Xiang Fu He*, 34 NY3d at 172).

Xiang Fu He is instructive. This Court was deciding whether out-of-possession landlords can be liable under a New York City ordinance requiring property owners to maintain their land in a safe condition. This Court answered "yes" because the law "makes no distinction for those owners who are out of possession" (*id.* at 172). By contrast, the law "expressly exclude[d] certain owner-occupied properties from its reach," which demonstrated that "if the City Council meant to exclude a class of owners, it knew how to do so" (*id.*). That same analysis applies here. The Legislature chose to exclude "certain" types of policies from the refund requirement: single-premium and paid-up policies (*id.*) If the Legislature "meant to exclude a class of [life insurance policy] owners, it knew how to do so" (*id.*).

"[W]here the Legislature lists exceptions in a statute, items not specifically referenced are deemed to have been intentionally excluded" (*Weingarten v. Bd. of Trustees of New York City Teachers' Ret. Sys.*, 98 NY2d 575, 583 [2002]). Plaintiff relies on *Weingarten* (Opening Br. 28), and Lincoln ignores this important precedent, along with *Beck Chevrolet Co. v. General Motors LLC*, 27 NY3d 379, 389-90 [2016]), which also supports Plaintiff's position (Opening Br. at 30).

And Lincoln barely addresses Plaintiff's reliance on *Walsh*, burying its response in a footnote (34 NY3d at 524; *compare* Opening Br. at 23, 29-30; *with* Resp. Br. at 43 n. 6). *Walsh* counsels against rewriting statutes to add new exemptions: "If the legislature intended to exclude the injuries at issue here, it could have easily drafted the statutory language more restrictively, for example, by adding limitations to the word 'act'" (*id.* at 526-27). That reasoning applies with particular force where "the legislature did just that" in a different part "of the same statute" (*id.*).

Here, in crafting the 3-month grace period provision of the same Statute, the Legislature chose "to treat owners of term policies and owners of universal life policies differently" (Resp. Br. at 44; Ins. L. § 3203 [a] [1] [providing a longer grace period for policies "in which the amount and frequency of premiums may vary" (i.e., universal life insurance policies) and a shorter grace period "for all other policies"]). If the Legislature also meant to treat universal policyholders

differently for the refund requirement in the same Statute, "it could have easily" done so (*Walsh*, 34 NY3d at 526-27).

Lincoln's only response to *Walsh* is to say that the insurer "designed" this particular Policy to avoid triggering the statutory refund requirement (Resp. Br. at 43 n.6). But, as Plaintiff has demonstrated, the Policy on its face does trigger the refund requirement because it provides for what happened in this case – the actual payment of a full year's premium. Under the Statute, the insured's death within the year requires a partial refund. If Lincoln tried to "design" the Policy to avoid the Statute's refund requirement, it did not succeed.

Lincoln also says the Statute existed "before modern universal life insurance was created" (Resp. Br. 42) – implying that the Statute is antiquated and the Court should therefore rewrite it. But the Statute's 3-month grace period provision refutes that characterization: this provision was amended in 2008 to single out universal life policies for different treatment (2008 Sess. Law News of N.Y. Ch. 264 [S. 7765]). The Legislature could have amended the refund requirement to exclude universal life at the same time, but it did not.

Lincoln's case law is inapposite. In *Arbegast v. Board of Education of South New Berlin Central School*, this Court was interpreting an undefined statutory term by reference to case law, which is not the approach that Lincoln proposes here (65 NY2d 161, 16-70 [1985]; Resp. Br. at 43). Lincoln also repeatedly cites *Gaidon v.*

Guardian Life Insurance Co. of America, 94 NY2d 330 [1999], to suggest that universal life policies are more "complex" than term policies (Resp. Br. at 18). But *Gaidon* did not address a breach of contract claim, much less suggest that universal life policies should be carved out of statutes where they are covered by the plain meaning. The Legislature here decided to apply the refund requirement to universal life policies, and the relative complexity of these policies is not a reason to nullify the Legislature's decision.

Even if this Court revisits the Legislature's policy decisions (which it should not do), it should conclude that the Legislature's decision was the right one. Plaintiff's Opening Brief used an example to illustrate this point (at 30-31): Where two policyholders on the same day pay the same $12,000 annual premium for the same $100,000 death benefit, and die on the same day 32 days later, Lincoln's position results in the term policyholder recovering $110,000 while the universal policyholder gets $10,000 less.[2] Lincoln does not dispute that this example is accurate. The outcome Lincoln seeks is arbitrary and unfair.

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[2] For example, if the $12,000 annual premium is due and paid on January 1, and the insured dies 32 days later on February 2, then the owner is entitled to a ten-month refund (at $1,000 per month given the $12,000 annual premium). Because the refund is for the premium paid "for any period beyond the end of the policy month in which such death occurred," the refund is only for March-December, which is 10 months.

Lincoln offers an elaborate explanation for "why the Legislature acted reasonably in treating these owners differently" (which begs the question by ignoring, of course, the simple fact that the Legislature did no such thing) (Resp. Br. at 43-44). Its explanation focuses on the policyholder's option to pay premiums in different amounts and at different times (Resp. Br. at 44). But Lincoln fails to explain why the Legislature chose to penalize a policyholder like Plaintiff, who paid his premiums annually, by allowing an insurer like Lincoln to retain a premium for a period in which it provided no coverage.

IV. Lincoln's "Other Available Interpretive Principles and Tools of Statutory Construction" Support Plaintiff.

Lincoln invokes various "interpretive principles and tools of statutory construction" (Resp Br. at 28-37). But none enable the insurer to escape the plain meaning of the Statute and the Policy.

First, Lincoln claims that Plaintiff's interpretation of the Statute makes the word "actually" superfluous (Resp. Br. at 28). Lincoln does not explain why. It says that "[t]he term would be superfluous unless it distinguishes the actual transfer of funds in exchange for insurance coverage," and it confusingly ends the sentence there, leaving the reader to wonder: "the actual transfer of funds" is distinguished from what? Presumably, from premiums that are due but not "actually" paid – and Plaintiff's premium, which was actually paid, is therefore within the Statute.

In truth, it is Lincoln's interpretation that erases "actually" from the Statute. The transactions on which it relies are not actual payments, but internal bookkeeping entries – monthly deductions automatically taken from the policy value *by the insurer* (*see* Rec. 62, 327). Plaintiff relied on *Leader v. Maroney, Ponzini & Spencer*, 97 NY2d 95, 104 [2001] (Opening Br. at 26) to explain why Lincoln's interpretation of "for any period" makes "actually paid" superfluous; yet Lincoln ignores that case.

The two cases cited by Lincoln on this point support Plaintiff (Resp Br. at 28-29). In *Lemma v. Nassau County Police Officer Indemnification Board*, this Court "decline[d] . . . to replace the word selected by the legislature" (31 NY3d 523, 531 [2018]). And in *Kamhi v. Planning Board of Town of Yorktown*, this Court rejected the town's argument that a statute "implied" a power not expressly listed (59 NY2d 385, 390 [1983]). Here, the insurer wants to "replace" "for any period" with "for any period of coverage" or "guaranteed coverage" and it wants to "imply" an exemption for universal life which is not only missing from the Statute, but directly contradicted by it (*see supra* Section III).

Second, Lincoln faults Plaintiff for "placing all the weight on the word 'premium'" while "trivializ[ing] the 'actually paid for any period'" portion of the Statute (Resp. Br. at 29). But Plaintiff has devoted full sections of his Opening Brief to each portion of the Statute.

Third, Lincoln claims the Statute "must be narrowly construed" because it supposedly "contravenes the common-law rule" that no portion of any premium need ever be refunded (Resp Br. at 31). Lincoln then submits that its interpretation of the Statute is preferable because it is "narrow" insofar as it limits the refund requirement to payments that "maintain insurance coverage from period-to-period"—the monthly deduction (*id.* at 32).

There are two problems with this argument. First, the cases cited by Lincoln have nothing to do with *life* insurance. Second, even if there was such a presumption, the Legislature has abrogated it. And in so doing, the Legislature applied the refund requirement to "all" policies with exclusions that do not include universal policies. "[A]part from the express statutory reservations, there are to be no limitations" on a statute's scope (*Oden v. Chemung Cty. Indus. Dev. Agency*, 87 NY2d 81, 88 [1995]).

Fourth, Lincoln echoes the federal district court's concern that Plaintiff's interpretation would adversely affect hypothetical policyholders under another statutory provision. This other provision addresses scenarios where the insured dies during "the grace period provided in the policy": "if the death of the insured occurs within the grace period … the insurer may deduct from the policy proceeds the portion of any unpaid premium applicable to the period ending with the last day of the policy month in which such death occurred" (Ins. L. § 3203 [a] [2]). The lower

court worried that crediting Plaintiff's interpretation of the refund requirement would allow insurance companies, under this provision, to deduct an unpaid planned premium from policy proceeds, thus transforming an "optional statement [] of intent" into a "binding promise" (Rec. 338; *see also* Resp. Br. at 32). Lincoln likewise asserts that if a Planned Premium can be "actually paid" for purposes of the statutory refund provision (as Plaintiff argues) then any part of a Planned Premium that is not paid must be an "unpaid premium" within the meaning of the statutory three-month grace period provision.

But that is not so; the two parts of the Statute use different language. When the Statute deals with the 3-month grace period, it requires payment within that period of a specific premium – a premium "sufficient … to keep the policy in force for three months" (Ins. L. § 3203 [a] [1]). The "unpaid premium" which the insurer may later deduct is limited to that grace-period premium, and it is further limited to the "portion" that is "applicable to" the month of death (*id.* [a] [2]). For example, if (1) the grace-period premium owed (the premium sufficient to pay for 3 months) is $10,000, (2) the grace-period premium is not paid, and (3) the insured dies after 2 months, then the insurer would be permitted to deduct $6,666 from the death benefit payment, which is equal to the "unpaid" portion of the grace period. Even if the Statute were ambiguous, Lincoln offers no reason why it should not be

interpreted to produce the fair result described just above, rather than one that Lincoln correctly calls "unworkable and unfair" (Resp. Br. at 32).

In any event, this debate is academic because Plaintiff's Policy already addresses what happens if the insured dies during the grace period, and in Lincoln's words, this Policy is the "only [] specific Policy" "before the Court" (Resp. Br. at 41). In such a case, only "the amount needed to continue this policy to the end of the policy month of death will be deducted" (Rec. 76). This Policy provision obviates the lower federal court's speculative concern.

Fifth, Lincoln accuses Plaintiff of trying to "backdoor" in *contra proferentem*, which Lincoln claims "has no place in this case" (Resp. Br. at 35-36). It argues that the doctrine "do[es] not apply to legislative enactments" (Resp. Br. at 36). But Plaintiff is applying the doctrine to the *Policy*—not the Statute. The question here is whether, *under the Policy*, it is reasonable for an insured to believe that payment of the Planned "Annual" premium is a payment "for any period," *e.g.*, a year. Because Lincoln drafted the Policy, Plaintiff appropriately contends that any "ambiguity must be resolved in Plaintiff's favor" (Opening Br. at 27; *see also Westview Assocs. v. Guar. Nat'l Ins. Co.*, 95 NY2d 334, 340 [2000]). The cases cited by Lincoln (at 36) also support Plaintiff because this Policy is a "standard policy" and, to the extent it is deemed ambigious, it should be interpreted

in Plaintiffs's favor.[3] Finally, Lincoln's observation that *contra proferentem* is a doctrine of "last resort" also cuts in Plaintiff's favor (Resp Br. at 37). Plaintiff's case was dismissed at the pleadings stage before discovery, and thus before any extrinsic evidence could be discovered and presented that might be prioritized over *contra proferentem*. At a minimum, Plaintiff's claim should move forward to discovery to develop that evidence, particularly where, as is here, Plaintiff holds the tiebreaker.

V. The Department of Financial Services Product Outlines Do Not Help Lincoln.

Lincoln extensively relies on the New York Department of Financial Services Product Outlines (Resp. Br. at 37-41). There is no reason for this Court to consider these Outlines. Lincoln asked the lower court to take judicial notice of them (Rec. 111). Plaintiff opposed the request (Rec. 302), and the court denied it as moot, having decided the case without considering the Outlines. (Rec. 343). But if this Court does consider them, it will find, as the Second Circuit did, that they do not provide any useful guidance.

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[3] *See Morgan Stanley Group Inc. v. New England Ins. Co.*, 225 F3d 270, 280 [2d Cir 2000] [holding that *contra proferentem* applies even to disputes between sophisticated businesses, provided the policy is a "standard policy" that the insurer "didn't amend"]; *United States Fire Ins. Co. v. General Reins. Co.*, 949 F2d 569, 573 [2d Cir 1991] [explaining that "an ambiguous policy [should] be construed against the insurer," but declining to apply that rule to a dispute between two insurers].

Lincoln cites just one case in support of its request for the Court to consider these materials, *Albano v. Kirby*, but its reliance on that case is misplaced (*see* 36 NY2d 526, 532-535 [1975]; Resp Br. at 39). In *Kirby*, this Court relied on an agency memorandum that was interpreting agency *regulations*—not a statute. That distinction is critical because where, as here, "the question is one of pure statutory reading and analysis, . . . there is little basis to rely on any special competence or expertise of the administrative agency" (*Matter of Gruber*, 89 NY2d 225, 231 [1996]).

In any event, the Outlines do not support Lincoln's position. The Outline for universal life insurance says that if the insured dies "during a period for which the amount needed to continue the policy has been applied," then the insurer must refund "such amount applied for any period beyond the policy month in which the death occurred" (Rec 132).

But, as the Second Circuit found, this guidance is "not . . . helpful in interpreting [the Statute]" (Rec. 393 n.5). The Outline "does not explain what it means to 'appl[y]' the 'amount needed to continue the policy,'" nor "answer[] whether a planned premium made for the following year is 'applied for' an annual period" (Rec. 394). Indeed, Lincoln's interpretation—that only the monthly deduction is ever "applied" (Resp Br. at 38 n.4)—is inconsistent with the Product Outline. Under its interpretation, there could never be an "amount applied for any

period beyond the policy month in which the death occurred." Plaintiff's interpretation, on the other hand, makes more sense: A "period for which the amount needed to continue the policy has been applied" refers to a situation where the policyholder has paid a premium applicable to a specified period of time, as Plaintiff did. In any event, if "applied" means something other than "actually paid," then the Product Outline contradicts the Statute.

Finally, this Court should reject Lincoln's bizarre argument that it should win the case because the question presented has never before been litigated (*see* Resp. Br. at 38). Perhaps the issue has never been litigated because it is Lincoln's position, not Plaintiff's, which lacks merit. Insurers other than Lincoln may simply have complied with the plain meaning of the Statute, as Athene Life did for the same insured on an analogous universal policy (*see* Opening Br. at 12-13).

The Athene Life example also refutes Lincoln's unsupported assertion that agreeing with Plaintiff would undermine "settled expectations in the life insurance industry" (Resp. Br. at 3). That argument is also inappropriate at the pleadings stage where there has been no discovery into what is or isn't "settled." More fundamentally, as noted above, "[i]nsurance contracts must be interpreted . . . consistent with the reasonable expectations of the average insured"—not the "settled expectations in the life insurance industry" (*Cragg*, 17 NY3d at 122).

VI. The Facts of this Case Require an Affirmative Answer to the Certified Question.

For all the reasons argued, the answer to the certified question is an unqualified "yes." But if the Court is concerned about limiting its determination, it may still answer the question affirmatvely under "the facts presented" by this case (*Messner*, 93 NY2d at 236). The presence of the Coverage Protection Guarantee rider ("CPGR") renders Plaintiff's policy different from some other universal life policies (Opening Br. at 31-34). Plaintiff paid extra for the CPGR, and it transformed his annual premiums into the functional equivalent of a term life annual premium. His annual premiums ***guaranteed*** the Policy would remain in effect for the entire annual period.

Lincoln tries to persuade the Court not to address this issue. It says that "the Second Circuit rejected [Plaintiff's] argument regarding the CPGR" (Resp. Br. at 44). But the Second Circuit only said that, in its view, the CPGR could not enable Plaintiff to prevail "under *Lincoln Life's* interpretation of the statute" (Rec 392-93 n.4 [emphasis added]). That statement is true, but irrelevant. The question for this Court is not whether the CPGR leads Plaintiff to victory under *Lincoln's* interpretation of the Statute, but whether the CPGR helps answer the certified question. Plaintiff respectfully submits that, at a minimum, the answer to the certified question is "yes" where a policy has a CPGR.

Lincoln also offers the surprising suggestion that this Court may not consider the "facts presented" in this case, such as the CPGR (Resp. Br. at 46-47). Meanwhile, Lincoln elsewhere contradicts itself and insists that "only the specific Policy and its terms are before the Court" (Resp. Br. at 41). In any event, Lincoln's attempt to ignore the "facts presented" here is wrong. This Court has repeatedly answered certified questions based on the specific facts of a case, even where the certified question was more broadly worded. In *Messner*, 93 NY2d at 238, this Court answered relatively a broad question on the basis of "the facts presented," although those words did not appear in the question certified. Similarly, in *Madden v. Creative Services, Inc.*, 84 NY2d 738,741 [1995], this Court answered a certified question based "on the facts presented" even though the question did not expressly call for that approach. A certified question is not a straightjacket. The Second Circuit here, as is customary, invited this Court to "reformulate or expand the certified question as it deems appropriate" (Rec. 398).

Contrary to Lincoln's suggestion, Plaintiff here is not claiming that the CPGR "actually pay[s] for any period of coverage" (Resp. Br. at 47). The annual premium is what pays for the insurance. But the CPGR ensures that payment of that premium **guarantees coverage for the full annual period**. Indeed, **Lincoln never argues otherwise**. Rather, Lincoln criticizes Plaintiff for supposedly ignoring the Policy's definition of the CPGR. However, both parties rely on the

same Policy provisions addressing the CPGR (*see* Opening Br. at 31-34 [citing Rec. 64, 87, 89]; Response Br. at 48-49 [also citing Rec. 64, 87]).

Lincoln also submits that coverage is not "guaranteed" if the prerequisites for guaranteed coverage are not met – a self-evident and irrelevant proposition (Resp. Br. at 49). It is undisputed that none of the contingencies that could nullify the CPGR happened here. The CPGR provides a "Coverage Protection ***Guarantee***," as its name states.

Simply put, Plaintiff's annual premium, because of the CPGR, was set up to guarantee coverage for the full year. Plaintiff's premium was therefore the functional equivalent of a term life premium, and there is no dispute that the statutory refund requirement applies to term policies. Accordingly, the answer to the certified question is "yes" at least on these facts.

CONCLUSION

This Court should answer the certified question affirmatively.

Dated: July 11, 2023

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CERTIFICATION

I certify pursuant to Rule 500.13 [c] [1] that the total word count for all printed text in the body of the brief exclusive of the table of contents and the table of cases and authorities is 6,963 words.

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