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POLICY AND RATE FILING COMPLIANCE

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- State insurance department viewpoint on successful filings.
- Insurance company viewpoint on successful filings.
  - Practical ideas on filing preparation
  - Ways to shorten the filing process and approval time
  - Successful correspondence with regulators
- The Life and Health Compliance Association
  - Who is this group?
  - How can they help you?
- Staffing and organization for compliance

MR. DAVID J. CHRISTIANSON: The product explosion of the 1980s has brought about many changes for the insurance industry. It has increased the need to act very quickly with a product to bring it from the idea stage to the point at which we can sell it. One of the significant "road blocks" or delays in this process is gaining state approval of these new products. It used to be that the period between filings back in the 60s and 70s was measured in years or even decades. Now, for our company at least, the period between new filings' being made is measured in weeks or months. At the same time, state laws and regulations are becoming increasingly complex and are also changing more rapidly. From the insurance department point of view, it has added very

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significantly to its workload. There has been an explosion in the number of new filings occurring at the same time that states are facing shrinking budgets. This climate has created a situation of tension. Out of all this emerges a quest for faster, more efficient filing procedures, better relations between insurance companies and regulators, and in general, more timely approvals.

This program will be geared towards practical solutions. We will give several practical examples and ideas of ways to shorten, improve and streamline the filing process by examining the process from all perspectives -- namely, the regulators, the insurance companies, and the consultants -- and also learn about a trade organization that some of you may already be familiar with, namely, the Life and Health Compliance Association. Our hope is that each one of you will pick up one, two or three ideas that will help you in the filing process, perhaps cutting days or weeks from the process for your company or consulting firm, and also help ease the regulatory burden.

Our first panelist is Dana Fulton. He is the life and health insurance actuary with the Pennsylvania Insurance Department. He has been there since 1976. Dana will present the filing process from the perspective of an insurance department. His purpose will be to walk you through the filing process and hope that you might better empathize with the Insurance Department and, through that and also through a better understanding of the process, may learn ways to improve your filing procedures to cut time off the filing process.

MR. DANA FULTON: My comments are intended to pertain to the filing of forms and rates in Pennsylvania. It is hoped that my remarks will generally also be relevant elsewhere.

I believe it would be informative to walk through a filing from the time it is received in the Department until final action is taken, pointing out the mechanics involved in the filing process and some of the common problems we encounter.

Each working day all mail received in the Department is distributed. It is important that a filing be directed to the proper person. In Pennsylvania, new

form and rate filings should be addressed to the Director, Bureau of Policy Examination. The Department often receives filings directed to the Commissioner. This may cause a delay as the filing is first routed to the Commissioner's office, then to the proper Bureau. A resubmission should be addressed to the attention of the person who reviewed the original filing. Otherwise it may be necessary to route the resubmission to a number of different people.

Each filing received in the Bureau of Policy Examination is stamped showing the date received. All filings will be reviewed and a response sent to the company within 60 days of this date, as required by statute. We occasionally receive a status request on a filing that had been sent to the Department months earlier. If the company does not receive a response within the 60 days, allowing for mail time, call the Department. Conversely, we receive a number of status requests within the 60 days, sometimes within the first week. While we appreciate the reason for the status request, this can be overdone. A company that has made prior filings should know generally what the turnaround time has been. I suggest that the company not call until at least a week beyond the normal review period. If a status request is made, we need the form number, whether it is a new filing or resubmission, the date submitted and, if a resubmission, the name of the person who reviewed the filing.

A filing of a new form is first assigned to one of the Policy Examiners. If the filing must also be reviewed by an actuary, the examiner will forward the filing to the appropriate person. A rate filing not involving new forms, such as a request for a rate change, is given directly to the actuary.

New filings are worked on in chronological order in accordance with the date stamped on the filing. This applies to both the examiner and the actuary. It is likely, though, that the turnaround time of the examiner and actuary will not coincide.

Anyone who has made filings in Pennsylvania probably knows that if actuarial review is required, turnaround time has generally been at least 6 weeks and sometimes as long as the full 60 days. We are hopeful that this review period will be shortened. Our goal is a turnaround time of no more than 3 weeks.

If there is a problem with the filing, the company will receive from the examiner and/or the actuary a letter disapproving the filing, listing the reasons for disapproval. If the company does not understand the content of the letter or is unsure what must be done to resolve the problems, we would be glad to discuss the filing over the telephone. We would prefer, though, that the company not call if the intent is to respond verbally to each item in the disapproval letter. This takes time away from reviewing filings with minimal positive results. Some companies have requested a meeting to discuss the disapproval letter. While a meeting may sometimes be necessary, we have generally found that the same can be accomplished over the telephone. A meeting cannot be used to advance the filing ahead of others previously received. If the company is to refile the disapproved form or rates, a written response to the disapproval letter must be submitted. It is important that the company respond to each reason for disapproval. I have received resubmissions that completely ignore some of the issues. This can only result in the filing's being disapproved again.

The company should remember that the person reviewing the filing is applying the Insurance Laws and Regulations and the guidelines of the Department. An unpleasant confrontation with the examiner or actuary is not productive.

The company should initially try to resolve any areas of disagreement with the person who reviewed the filing. If the company's position is that a law or regulation or guideline should be changed, this should be addressed outside the context of a filing. If an impasse is reached concerning interpretation and application, the company could request that the issues be discussed with the examiner's or actuary's supervisor. I believe courtesy would suggest that the company make such a request through the person reviewing the filing. The company also always has the right to request a hearing concerning the disapproved filing.

As with new filings, all resubmissions are worked on in chronological order according to the date stamped on the resubmission. The Pennsylvania Department does, though, give some priority to the resubmissions over new filings.

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A form is approved by the examiner, while rate filings are approved by the actuary. If a filing consists of a new form and rates, such as an individual health form, the form will not be approved until the rates are approved. A copy of the form and/or rate table, bearing the Insurance Department stamp of approval, is returned to the company, and the Department retains a copy. All forms and rates must then be submitted in duplicate. In addition, forms submitted for formal approval must be in final printed form intended for actual issue or actual field issue.

The Department does not grant formal approval to typed or photocopied forms. All filings in Pennsylvania from companies domiciled in states with a filing fee must also include the appropriate retaliatory filing fee. Approval of a number of filings is delayed because the companies do not follow these basic filing requirements.

I asked a number of people in the Pennsylvania Department who work on these filings what their advice would be to a company that is preparing to make a filing. Their response to this was adamant and unanimous. Foremost, the company should be aware of the applicable Insurance Laws and Regulations and the guidelines. While this may seem evident, I cannot overemphasize its importance. Filings are disapproved daily for reasons that a basic knowledge of our laws and guidelines should have prevented. While I understand and appreciate the effort needed to develop and maintain information on the various laws and guidelines, I believe the results in approved filings warrant the effort. A reduction in the number of disapproved filings would also improve the turnaround time within the Department.

An example is the definition of a preexisting condition in a health insurance policy. The theory of first manifested has not been allowed in Pennsylvania since 1978, when the Minimum Standards Regulation for health insurance was enacted. Forms are filed today with the first manifested language. The filing is disapproved, and the policy changed and refiled. The time lost is evident.

Another example is time period limitations on recovery of accidental death benefits. Pursuant to regulation adopted in 1978, no provision for accidental

death benefit may contain any requirement that death must occur within any specific time period. Here again policies are filed with a time limit.

With respect to rate filings, I consistently review filings requesting a rate increase that do not contain the required experience data needed to complete the review. When a rate filing is disapproved because additional data are needed, I always identify the data and information that must be included. Nevertheless, many of the rate increase filings are initially disapproved because the filing is incomplete.

If a company does not have copies of the Insurance Laws and Regulations, I suggest contacting the legal counsel within the Insurance Department. The Pennsylvania Department does not normally provide copies, but we do provide direction as to how copies can be obtained.

We have generally distributed guidelines either by mailing directly to each licensed company or requesting the assistance of the Insurance Federation of Pennsylvania. If you are uncertain as to what the current guidelines are, call the Department. A couple of examples in Pennsylvania are the guidelines for the review of universal life insurance and the guidelines for the review of variable life insurance. These were distributed in May 1984 and September 1985, respectively. There have also been some more recent additions to the universal life guidelines. In addition, we recently prepared a comprehensive package of the guidelines for all product lines. The package was mailed to each company in January of this year. The data and information required in an individual health rate increase filing are included in this package.

Prior disapproval letters are an excellent source of information about a state's requirements. If a filing is disapproved, make a record of why. It amazes me the number of times filings are submitted in a format that has been previously disapproved. I am almost able with some filings to prepare a disapproval letter before I review the filing. We have had situations where a form is approved after much effort and numerous revisions only to receive a similar filing shortly thereafter containing the same mistakes.

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Another important consideration in preparing a filing is to ensure that the Department is provided with sufficient background information and a description of unique or unusual new policy or rating designs. While we would be glad to discuss a new concept before the filing is made, this should not be used as a replacement for a complete filing letter. It would be helpful, though, if the letter referenced any prior discussions.

Consider the amount of effort required in designing and rating one new product. Then remember that while the policy design may have become very familiar to the company by the time a filing is made, the ideas may be new to us, and the filing is only one in a large stack of files. A discussion of new concepts in the filing letter is extremely helpful. Filings have been disapproved because additional explanatory information is needed to complete the review. In addition, the time needed to review a filing can be extended significantly if the filing letter is incomplete. This increases the turnaround time for all filings.

The filing letter should identify, describe and point out the purpose and use of any unique concepts. There is a regulation in Pennsylvania which lists other information that should be included in the letter of submission, such as the form number and a statement of the coverage provided.

On the other hand, companies sometimes file information with the Department which is unnecessary. This includes a notice of home state approval, the current interest rates for annuity or interest sensitive contracts, disclosure, replacement and annual report forms and the Flesch score. While the Flesch score need not be filed, the form of course must be readable. It is also not necessary to file a form when reprinted, such as by computer or laser printer, if the form was previously approved and the content and form number are not changed.

While this is not intended to be critical, I do want to mention the lack of care we sometimes observe in the policy design or preparation of the rate filing. I suspect much of this can be attributed to being rushed due to the pressure caused by today's competitive marketplace, which I can fully understand and appreciate. Nevertheless, this can be a problem.

Let me cite some examples. The terms "cash value," "cash surrender value," "surrender value," "account value," "accumulation value" and the like have been misused in universal life policies. In one policy, "cash value," "actual cash value" and "current cash value" were all used to refer to one and the same thing. In another policy the term "net cash value" was defined and used but then dropped halfway through the policy in preference for the undefined term "net cash surrender value," which meant exactly the same thing. You can imagine the frustration in trying to review something like this.

Sometimes there is also a general failure to explain or spell things out in policies when explanations are clearly necessary.

Another example is policies that contain inconsistencies and contradictions. This seems to come either from the "cut and paste" method of policy drafting or from writing without having situations where people in the Department who daily review these forms struggle to understand what was intended.

In resubmissions, previous revisions are sometimes not retained. Forms have been changed in response to a disapproval letter only to be changed back to the original wording in a subsequent resubmission.

With respect to the actuarial part of filings, I've reviewed actuarial memorandums that are not consistent with the policy, or filing letters that are not consistent with the memorandum. Particularly troublesome is when the experience data filed in support of a rate increase is not consistent with corresponding data submitted in a previous filing. I'm sure you can appreciate the concern I have when the reported premium and claim amounts supporting a rate increase for a form change from one filing to the next.

In conclusion, I want to summarize what in my opinion are the important points to remember in making a filing. First, the policy should be designed, the values in the policy determined and the rates calculated with attention paid to the applicable laws and regulations. The submission should conform with any appropriate guidelines. These guidelines may range from requirements relating to policy provisions to something simple like filing in duplicate. If there is something unique or different about the filing, provide an explanation in the

letter of submission. To the extent possible, avoid careless mistakes in the material submitted to the Department. If a filing is disapproved, the reasons for disapproval should be understood before a resubmission is made. If necessary, discuss the issues with the person who reviewed the filing. Finally, respond completely and directly to each reason for disapproval.

MR. CHRISTIANSON: From an insurance company's point-of-view, there are a lot of things we did in the 60s and 70s that were effective and efficient enough for those times, but now must be replaced by new procedures. As an example of that, one of the people in our compliance staff was visiting with someone from another insurance company who said that state Amendatory Agreements took four to eight weeks to get keylined and prepared and wondered what our experience was. Our reply was that it took approximately 45 minutes, and, not only that, we don't use Amendatory Agreements. Instead, we actually go in and change the text of the contract. While this seems almost an unbelievable leap from four to eight weeks down to 45 minutes, it happens because of new technology, namely, computer-prepared forms. These, along with many other ideas, will be shared with you by Karen Weiss. Karen is a Senior Actuary with the Northwestern Mutual Life Insurance Company, and her main area of responsibility is the compliance function.

MS. KAREN J. WEISS: Contract development, along with product specifications, is one of the keystones of the product development process. Regardless of what area of the company is directly responsible for filing, the involvement of the actuary is vital to the success of the state filing function. The actuary must convey company objectives, and how the new line of business and/or new plan will be in the best interest of the company and the consumer.

State filing is critical to the success of a new product. State approval -- or lack thereof -- is very visible. With such high visibility it is important that the state filing team effectively communicate with the product development actuary, the attorney, agency force and marketing areas of the company. If approval is not forthcoming on a timely basis, the reason must be conveyed to these areas.

The state filing process begins with drafting of the contract. The policy drafter works with the product development actuary to make sure that he completely understands the product and its purpose.

Next the policy drafter talks to fellow employees. Home Office committees participate in the drafting process. At our company, the policy drafting actuary prepares the initial draft based on the product specifications. Members of the Law, Information Systems, Insurance Operations, Marketing and Policy Issue Departments review the contract and help develop the final draft.

WHAT IS TO BE FILED?

A typical state filing requirement reads as follows:

> All policies, contracts, certificates, endorsements, riders, applications and related forms for life, accident and health insurance shall, prior to their use in this state, be submitted to and formally approved by the Department for filing or approval, unless specifically excepted under the Insurance Code.

We follow the guideline that all forms that will be attached to the policy must be submitted for state approval. We believe that if a form may be contested due to misstatements, then it should be filed. We occasionally submit some additional forms for information, although some states do not like informational filings. In some cases, where we submit a form for information, some states may respond that they would like the form filed for approval.

ROLE OF THE ACTUARY

The Policy Filing Actuary, along with the Product Development Actuary, is responsible for developing a policy that will be approvable. Along with the development of policy language for the contract, the Actuary develops any additional benefits such as disability waiver of premium, accidental death, inflation protection option, and guaranteed insurability option. Applications must be designed to accommodate the new products and corresponding supplemental benefits. When an application is taken by our agents, primary data is entered

in our processing systems by officer managers in the General Agency offices. Ease of usage by the agents and office managers is an important design consideration.

Readability standards must be met. Policy filings must include a certification of the Flesch Readability Score. A standard of 40 is required by states adopting the NAIC Model. A standard of 45 is required in Connecticut, Florida and New York, and 50 in Maine, Massachusetts and North Carolina. We test the Flesch Readability Score by computer, using software developed in our office with a dictionary of words commonly used in our contracts.

The design of the policy specifications page is another aspect of policy form development. An appropriate balance must be achieved considering appropriate disclosure, state regulatory requirements and space limitations. The work of the drafting team is not complete until they have designed policy specifications pages (including variations for policies with various combinations of additional benefits, and for substandard business). Since the policy schedule page is based on actual gross premiums to be charged, the pricing team must have completed its work before the policy is filed.

The format for the NAIC Policy Summary must be considered, including cost indices for 10 and 20 years. In addition to pricing for gross premiums, the dividend scale must be set so that illustrative data is ready to be submitted to those states which require this information, e.g., Connecticut and Florida.

For accident and health insurance, the Outline of Coverage must be submitted to several states. This outline is a summary of the policy provisions and includes a place for the premium to be given to the applicant/insured with a breakdown of the premium for the policy and for additional benefits.

Nonforfeiture benefits must be calculated for the basic policy, including cash values, paid-up insurance and the period of extended term insurance. These values, on a net basis, are indicated on the policy specifications page, on the assumption that there are no dividend additions and no indebtedness on the policy. In addition, the actuary must test the cash values and certify that

they are at least as great as those required under the nonforfeiture laws of the state in which the policy is filed.

HOW ARE FORMS FILED?

Preparation for filing takes a month to six weeks after the draft has been finalized by the drafting team. Forms must be in the final print. They must reflect state variations. All filing requirements must be met.

Each insurer is obligated to make certain that the policy, rider or endorsement has been drafted in compliance with the statutes of the state in which the approval is sought. Standard provisions may be included in the basic contract, but a corrective rider or endorsement may be necessary to modify the contract to comply with the particular state requirements.

We will always get approval of a filing in our home state of Wisconsin first, and then file in the other states (regardless of whether domiciliary approval is required for filing). We use this procedure because Wisconsin responds within a few weeks, and we can then make changes in advance so that we seldom, if ever, have any state variations in our home state. Some other companies will file in their home state and at the same time in states not requiring home state approval. We use the interim time when Wisconsin is reviewing our filing to prepare state variations and get ready for filing in all other states.

FILING OF RATES (HEALTH INSURANCE)

Accident and Health filings must include an actuarial memorandum. The content of this memorandum includes the formulas used, anticipated loss ratios, commission rates, assumptions for issue and maintenance expenses, morbidity and claim experience and termination rates. Based on this memorandum, the insurance department actuary should be able to derive the gross premium set by the company. A complete set of rates based on age, occupational class, sex and/or any other premium parameters must be included.

STATE FILING REQUIREMENTS

Keeping track of state filing requirements can be challenging. There is help -- the ACLI, HIAA and NILS (National Insurance Law Service) distribute quite a bit of information. One of the most helpful is the Life and Health Compliance Association. Missing a requirement may mean that the entire filing is returned to the company intact. The filing letter and transmittal requirements must be corrected and resubmitted.

Most states do not accept a filing for analyst review until all of the transmittal requirements are met. Second filings take time and are costly for both the Insurance Department and the company. The 30 or 60 day deemer period does not begin until the filing is accepted. The company cannot deem the form approved until the state has held the filing for 30 or 60 days (as specified by statutes). The importance of complete filing submissions in obtaining state approval cannot be overemphasized.

Incidentally, many companies send their filings by registered or certified mail, return receipt requested. The receipt is proof that can be used when exercising a deemer approval, since the 30 to 60 day period begins when the submission is received by the state Insurance Department. We typically inform a state before exercising a deemer provision. Some states will write to you that the filing has been received and can be assumed to be approved under the deemer provision. We do not exercise a deemer approval without some communication with the state.

WHEN SHOULD FORMS BE FILED? HOW MUCH LEAD TIME IS NEEDED BEFORE THE SCHEDULED INTRODUCTION DATE?

For life filings, schedules usually anticipate filings to be made 4 to 6 months prior to the anticipated introduction date; for Accident and Health filings, 6 to 8 months; for variable products, 9 to 12 months. Note also that company licensing can add additional time if the company has not previously been admitted to write that line of business. The times mentioned are averages. New and innovative products can require additional filing time.

The times above may be a little long, but we try to have all states approved before we introduce a product. Some companies might introduce a life filing, for example, in 2 to 3 months. It is possible to have 40 to 45 state approvals in that time period. However, there may be some administrative problems in introducing a product before you have all approvals. For example, agents in some states may have lost the marketing thrust and enthusiasm if they are not able to sell immediately. There also may be problems concerning the state of jurisdiction when agents write in more than one state, and one state is approved and the other is not.

ROLE OF TECHNOLOGY

Within the last five years, we have seen major breakthroughs in computer technology that have assisted in policy form development. For example, at our company the cover and all of the contract pages are prepared by computer. Contract language and headings are entered into the word processing system. The system produces a contract page according to our specifications. A second program assembles the various contract pages in order depending on the plan and state. Pages for optional additional benefits are also included. A third program collates the policy cover and the policy specifications page with the inside contract pages. A photocopy of the application is attached, and the policy is ready for mailing.

Computer prepared policies have produced major changes in our policy form development and state filing process, as well as major changes in the policy issue function. We no longer need to maintain an inventory of forms for issue in each state. State variations are placed within the contract pages. Amendments and endorsements are seldom used; the only exceptions are IRA and TDA endorsements.

When developing a new plan or when revising a current product, the current state variations are automatically included in the revised state variation. The filing team simply calls for two copies of the contracts for all 50 states, staples and binds them together along with a John Doe application, and the forms are ready for filing with the states. Negotiated changes and updated

language to reflect new statutory or regulatory requirements are readily accommodated.

Office automation also facilitates communication between the product development actuary and lawyers and the insurance departments represented on the drafting team. At Northwestern Mutual, this system is only partially in place, but already it has produced time savings. Messages and common libraries are available via desk terminals to policy drafting team members. This improves response time and convenience for the drafting team. Intermediate hard copies of various drafts need not be distributed.

When the policy filing team obtains a letter from a state insurance department, a message can be sent to the other team members along with a proposed response. Comments and corrections can be communicated back via terminal to the policy filing team. As state approvals are received, the approval date and other pertinent comments are entered in the terminal on a master list library and are provided to the policy drafting team and to the product development area. Everyone is then up to date on the current status of the project.

Most companies have master lists of states with names and addresses of insurance commissioners, with attention lines varying for the Life, Accident and Health and Variable product lines of business. Office automation is used to address the letters and produce labels for the envelopes. This system also produces state certificates and a reminder message about checks and duplicate copies.

Records retention is of growing concern as the number of filing submissions increases. The filing area may be asked to produce proof of approval many years after the original approval was received. Requests may come from state insurance departments or from insurance company attorneys or from counsel representing the policyowner. Usually the policy form approval area is the keeper of this historical documentation.

Our company has maintained complete hard copy files of stamped approval letters, even those that are 50 to 100 years old. Filing space is becoming a problem. I know of other companies that are developing retention standards,

e.g., all current issues and historical files for the last 10 to 20 years. Earlier approvals are available through microfiche documentation. Some others are changing to microfiche copy of all approvals. Conversion can be time consuming and costly; many administrative decisions must be made as to exactly what records should be retained.

As of July 1, 1986, the state of Vermont will be requiring all filings to include a microfiche copy of the filing letter and the policy form. The state of Utah is considering the same requirement.

SUCCESSFUL FILINGS

What constitutes a successful filing? From the company and agent viewpoint, a successful filing is measured by all state approvals in as short a time period as possible. There are several things that a company can do to ensure that filings are as successful as possible.

The more complete the original filing, the faster state approvals will come in. If the original mailing is incomplete, valuable time is lost. Some states return the entire filing, while others write for the missing item.

Try to anticipate questions from the states. To assist the state in its review, furnish complete explanations of the plan and how it will be used. If complete information is included in the original filing letter, follow-up correspondence is reduced or eliminated.

Correspondence from the state should be answered as completely and as quickly as possible. A prompt response from the company indicates that it is indeed sincere about timely approval.

If you have not heard from a state within 6 weeks to 2 months, a follow-up letter or phone call is in order. A follow-up will determine if the filing was received, and if received, just where it is in the review process.

Telephone calls can produce a more immediate response than written communications. We routinely include a statement that the Insurance Department can call

at company expense. A number of states take us up on that offer. We also initiate phone calls when we are uncertain about their questions or alleged deficiencies in our policy forms. However, telephone calls should be used with discretion. Some states prefer written correspondence, and it is best to follow their wishes. Also, do not call and ask for special handling on every filing. Your company will become a nuisance. Use your own judgment.

For innovative new products, a visit to a few state insurance departments might be in order. On a few occasions, our company has contacted Wisconsin, our state of domicile, and a few other states when the new product is still in the development stage. This allows us to discuss details prior to the final draft. When we submit for final approval, we have a greater chance for uniform approval from all states. This preliminary look by a few states allows both the company and Insurance Departments to identify key issues which can be worked on and researched over a 6 month or longer period of time, rather than in the last month or so before expected introduction.

Some states impose additional administrative requirements over and above those required by uniform statutes or model regulations. These may include special disclosure forms; forms to be signed by applicant/insured for election of various policy rights; and additional information on premium notices, specifications pages and/or annual policy statements. In order to minimize state differences and non-routine handling, special state requirements, if reasonable and in the policyowner's best interests, can become the standard version for use in all states.

If state variations are unavoidable, attempts should be made to consolidate them. Sometimes states have different comments or questions, yet they might accept the same solution as that used in another state. For example, special disclosure requirements serve a variety of purposes when they are included on the policy specifications page or on the policy summary.

NEGOTIATION PROCESS

The negotiation process can be of benefit to both the company and the State Insurance Department. Communication of new ideas and education as to the

intent of both parties can be discussed openly through visits to the state insurance department.

Hearings, either formal or informal, can be facilitated by an attitude of cooperation. Both insurance companies and regulators should be interested in the availability of products that are in the best interest of the consumer. If the laws and regulations of the state do not permit the Insurance Commissioner to approve a certain product that would fill a definite need for the residents of that state, the laws may have to be adapted to permit such an approval.

Our company has used hearings, both formal and informal. On some of our filing submissions, such as those for our various amendment programs, administrative hearings have been set up at the request of the Insurance Department. Such hearings are not adversary hearings, but rather informative proceedings made for the public record.

A company that exhibits a spirit of cooperation with the regulators and that has established trust and confidence in both its management and its agents can often negotiate a compromise. For example, the company might be allowed to continue to use its original contract language on the assurance that it will make the agreed-upon revisions at the next submission. Alternatively, the company may agree to a certain administrative procedure, although that procedure may not have to be stated as a contractual right. Or the company and the State Insurance Department may agree to a conditional approval, with reconsideration after a stated period of time based on consumer reaction. In the long run, such a spirit of cooperation will benefit the consumer and the insurance industry.

MR. CHRISTIANSON: Our next speaker is Don Edde. Don is a consultant in the compliance area. He has worked for 23 years in the insurance industry, both as a consultant and at three insurance companies. Don is a CLU, FLMI, and Registered Health Underwriter. He is the past chairman of the Executive Committee of the Life and Health Compliance Association and will share with you information about that association. This is a trade group that was created for some of the needs mentioned above, namely, the need to keep up with regulations

and laws and to learn how to deal better and more effectively with insurance regulators.

MR. DONALD Y. EDDE: If a time for an idea has come, it *will* happen. Such is the case of the Life and Health Compliance Association. In the fall of 1978, I was sitting at my desk in Chicago reviewing a new Wisconsin bill, when I received a call from a friend of mine at Benefit Trust. It seems he was trying to locate a copy of the very law I was working on. During our conversation, I learned that the search was further prompted by a call from Allstate to Washington National, who called Combined, who called Benefit Trust.

The idea struck me that why could not compliance people meet to discuss and compare problems. The president of my company agreed, so I sent out a mailing to regional life and health insurers. I was surprised that the first two companies to respond were *not* local -- but rather from Pennsylvania and Texas. One suggested an all day meeting, rather than just dinner, and asked that dues be kept under $1,500 a year. The rest is history. Our first meeting was held on January 18, 1979, in Chicago. In the week prior to the meeting, Chicago had snow, snow and more snow. We called the meeting off many times, but whenever the snow would stop, people would call to say "let's do it." There was lots of interest, so finally 36 people from 27 companies met for a day to discuss their questions.

The meeting went well, but no one volunteered to sponsor another one. I made such good contacts that we decided to go another time. The attendance more than doubled to 81, Federal Kemper volunteered to take the next meeting and we were off and running. I started talking to attendees, telling them how easy a meeting was to hold and urging them to take a meeting. Meetings are now scheduled through May of 1988. There were 245 companies represented at the last meeting in May this year.

Through the first nine meetings I virtually ran a one man show, but the organization had grown to where other input was due. We formed a committee of the nine companies that had sponsored meetings to date, and, as opposed to incorporating, a "Principles of Association" was drafted and adopted at Meeting X. Under the "Principles of Association," an executive committee made up of

members of past hosts coordinates the activities of the Association. We continue to hold three meetings per year run by a volunteer host company. It is the responsibility of the host company to obtain or provide legal counsel to preview the questions submitted for discussion and to monitor the meetings with regard to anti-trust concerns. There are no membership dues, but a registration fee is charged for each meeting attendee. The host company provides all needed staff and underwrites any profit or loss from the meeting. At each meeting, there is open discussion of compliance problems concerning life and health insurance products. Discussion questions are solicited in advance (at our last meeting, over 300 questions were addressed). There is no discussion of rates, concentrated efforts or lobbying.

In the past, various people have offered to share their research on given topics. There is now a volunteer committee which provides "handouts" on a formal basis. These handouts cover a number of different areas, including such topics as filing requirements, health minimum standards, life solicitation regulations, rate filing requirements, out-of-state group requirements, Medicare supplement regulations, readability -- there are 30 separate headings. These are updated for each meeting and at last printing numbered over 800 pages. This information is available only by attending a meeting. Any company that attends a meeting of the Association is added to our mailing list for future meetings and is considered a "member." Registration materials are sent to each company some two months prior to the next meeting. Questions are solicited at that time. Any company that does not attend a meeting for two years is removed from the list. Responses to questions at the meeting are not recorded or reproduced in any manner. Benefit is received only by attendance.

One of our members started a survey in 1982 of the location and size of compliance units. Table I shows the location of the compliance unit in responding companies.

Table I
Location of Compliance Unit

Department	1982	1983	1984	1985	1986
Actuarial	26%	26%	30%	39%	39%
Legal	21	30	30	30	16
Other Dept.	33	19	12	4	14
Separate	20	25	28	27	31

As you can see, the percentage of units found in the Actuarial Department has increased from 26% in 1982 to 39% in 1986. Actuarial-based units and "free standing" separate departments are the most common.

The size of the compliance unit, of course, varies with the size of the company. As shown in Table II, companies with under 250 employees have been fairly consistent in the range of 2 to 2.5 employees per unit. In the 250-500 employee size, units have generally included between 3 and 4 employees. For the larger size companies, we've had to exclude 2 or 3 companies each year because they have extraordinarily large units. Excluding those, larger companies have had 4 to 7 employees per compliance unit.

Table II
Size of Compliance Unit
(Average number of employees)

Company Size	1984	1985	1986
Under 250 employees	2.33	2.45	2.38
250 - 500 employees	3.12	3.18	3.89
Over 500 employees	5.57	6.80	4.17

The results in Tables I and II may be slightly skewed because the surveys are done only once each year and may be affected by the meetings' being held in different regions of the country. Nonetheless, I think they give a pretty accurate picture of compliance units.

Future meetings of the Life and Health Compliance Association are scheduled as follows:

Date	Location	Sponsoring Company
Sept. 10-12, 1986	Winston-Salem, NC	Integon Life
Jan. 28-30, 1987	Tampa, FL	Home Life Financial Assurance Corp.
May 27-29, 1987	Des Moines, IA	Bankers Life
Sept. 23-25, 1987	Denver, CO	Great West Life
Jan. 20-22, 1988	San Diego, CA	E. F. Hutton Life
May, 1988	Cedar Rapids, IA	Life Investors

I urge those of you involved in compliance work to attend one of these meetings to learn first-hand how the Association functions.

It's been pointed out to me by people attending both Society meetings and Compliance meetings that perhaps there should be more effort at interaction between these two groups. I think that's a great idea.

MR. CHRISTIANSON: I'd like to ask Karen and Donn Satrom, our recorder, what special equipment is needed to do computer-prepared forms. Donn heads up the Compliance unit at Lutheran Brotherhood, a large fraternal benefit society.

MS. WEISS: We have a laser printer along with XICS software that we have purchased to produce contract forms via the computer.

MR. DONN B. SATROM: We also have a laser printer, but we use Document Composition Facility (DCF) to format our contracts.

MR. ARNOLD A. DICKE: I heard that Northwestern Mutual Life had remarkable success with the filing of a very complicated series that you came out with. I heard that you were able to accomplish this in four months. I also heard that you had had some early meetings with some of the state insurance departments about this series, and I wondered how you arranged that.

MS. WEISS: We filed in Wisconsin in June and in all the other states in July for a January introduction. At introduction, we were missing two states. We did contact our home state about this product, and we also visited the New York Insurance Department in March. We met with four people from this Department, two actuaries and two lawyers. They knew what we intended this product to accomplish. By visiting with them early, we were able to identify issues so we had enough time to research them in advance. The New York Insurance Department wanted additional disclosure, and although it allowed us to sell immediately, we did not have to provide our systems disclosure items until April. This is the area I was talking about in my remarks on the negotiating process.

MR. DICKE: Is it fairly common that states are willing to meet with you that early, or do you think this was a special situation?

MS. WEISS: I think this was probably a special situation. I don't think they would want to devote that much time on a regular basis. Northwestern Mutual

does not have a universal life type product. We felt there were some differences in this product from universal life products, and we wanted to decide fairly early what disclosure might be appropriate, since we would need systems time to prepare for universal life type disclosure.

MR. STARR E. BABBITT: I am with the Tennessee Insurance Department. I was interested in Dana's comments about giving refilings preference over new filings. We work a little differently in that refilings fit in like any other submission except in one case. If we get behind and get close to the 30 day deemer, we go to new filings and catch up on them before we consider refilings. Karen's comments about notifying states regarding the use of the deemer were very good.

MS. WEISS: We seldom use the deemer in any state. We do try to allow the four to six month period, which means we expect to hear from all states in that period. There are a few exceptions in states where we are expected to use the deemer.