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REGULATION OF DIRECT-RESPONSE MARKETING

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- o Expenses in direct-response marketing
- o Advertising compliance
- o Risk selection techniques -- unfair discrimination
- o Agent supported regulation
- o Use of telephone solicitors
- o Direct-response product design

MR. WILLIAM F. BLUHM: Our two panelists are Johan Vandervelde, from the New York Insurance Department, and Brad Smith, now with Milliman & Robertson. Johan is from the Netherlands originally. He started becoming an actuary in 1977 and has since worked at Mass. Mutual, Security Connecticut and Union Mutual, providing him quite a background, generally in product development. He now works in Albany for the New York Insurance Department monitoring the actuarial memorandum and opinions that New York requires. He serves on task forces for the department, currently on the new annuity rate legislation. Brad Smith is an alumnus of the University of Illinois. He was Vice President and Chief Actuary at J.C. Penney Life. I don't think you can get much more of a rounded and detailed background on direct response marketing than that. His responsibilities included the marketing function for direct response. Brad has recently opened up the Life and Health consulting practice for M&R in Dallas.

MR. JOHAN G. VANDERVELDE: I am one of the newer and younger members of the New York Insurance Department. In preparing for this panel discussion, I have familiarized myself as much as possible with New York Insurance Law

Regulation and Circular Letters appropriate to this topic and have read recent publications and advertisements. I also have discussed this topic with Bob Callahan, Jim Devine, Tom Hartman -- all actuaries in the Albany Office -- and with Rick Morse, a lawyer and a policy examiner in the Policy Bureau and Bob Nuding, Chief of Accident and Health Rating. I also spoke with some insurance company representatives, namely Robert A. Canfield from the Direct Marketing Corporation of America and Maria Thomson from John Hancock. What I have to say represents my personal observations and is not to be attributed to either anyone in the Department nor to the Department itself.

For various reasons, products sold by means of mass solicitation have not been an overwhelming success. (There are a few companies which have been very successful.) Some illustrations of this are as follows: LIMRA (Life Insurance Marketing Research Association) told me that in 1983 (the last year for which LIMRA has such statistics) only 2% of the total premium sold was obtained through mass solicitation.

The 1984 Life Insurance Fact Book (1983 data) shows that 0.5% of the total in force (ordinary, group, industrial, credit) was obtained through mass solicitation. Out of the 14 groups listed, 32% are employer/employee groups, 33.4% are credit card holders, and 15.2% are mortgage holders for a total of over 80% for these 3 types of groups. Groups of 500 or more account for 80% of the in force.

One of the reasons for these low numbers was, and to a certain extent still is, restrictive and inconsistent State Regulations. New York State feels that certain mass marketing serves a very legitimate purpose. It reaches markets that otherwise would not be reached and where definite needs for modest insurance programs exists.

For this reason, history shows that the New York regulations with respect to mass solicitation have become ever less restrictive. I will spare you most of the details of this history and instead will concentrate on where we are today and where we may be tomorrow.

The major reasons we have regulations at all are to:

a. Prohibit unfair discrimination.
b. Ensure that policyholders get a fair benefit for their insurance dollars.
c. Ensure company solvency.
d. Promote fair advertising.

The two major forms of both life insurance and accident and health insurance are individual contracts and group contracts. If there were no restrictions on the use of individual contracts, and an insurer were free to tailormake the risk selection and premium structure for different situations, then there would be no need of any group laws. However, Section 4224(a)(1) (LI&ANN) and 4224(a)(2)(b) plus 113(a)(3) (acc & HI) of the New York Insurance Law basically prohibits unfair discrimination for both life insurance and for accident and health insurance between members of the same class. (In the case of life insurance, there is the qualification as to equal expectation of life.) While this unfair discrimination section applies to both individual and group contracts, its application has been somewhat different.

Let me cover individual contracts first. As you will see, the central issues are unfair discrimination and the definition of a class. Each insurer is free to determine its rating classes. Prudence, good judgment and competition may force an insurer to use valid distinctions. Legal, social, and practical considerations may require insurers to either make or not make certain distinctions. For example, some jurisdictions require sex distinct life insurance rates; another has considered prohibiting sex distinct rates; and some, such as New York, permit an insurer to make its own determination for individual policies, at least those not involving employer/employee benefit programs. Most, if not all, of you are aware of the 1983 Supreme Court decision in *Arizona* vs. *Norris* which prohibited any distinction in sex in either employee contributions or employee benefits, and some states including New York, have taken the position that life insurance and accident and health insurance are affected by the Norris decision.

One interpretation of the "unfair discrimination" section is that unless a distinct class can be justified, an insurer must offer its products to the general public without any distinction in rates, benefits, or underwriting. This interpretation appears to be held in theory. If an insurer did only

direct response marketing via newspaper, magazines, radio, and television to the general public, and made no distinction in underwriting, premiums or benefits for any special group, but applied its rules generally across the board, then there would be no problem with the statute on unfair discrimination. However, the insurer might find its ability to acquire business very limited. Perhaps one answer may be for a parent group to use several insurers, each designated for a limited market as to active solicitation.

Over the years, the interpretation of class for individual policies has evolved such that today, there are at least the following classes recognized for differences in premiums, benefits, and underwriting:

(1) individual solicitation of individuals in the general public,

(2) mass merchandising of individual policies on a franchise (health) or wholesale basis (LI) generally to certain associations meeting certain criteria, but until recently, not qualifying as eligible groups under the group insurance laws, and to some employer/employee units and generally with certain collective renewal provisions (i.e., group nonrenewal rather than individual nonrenewal). In 1965, some limits were placed on the existing situation and formalized in Circular Letter guideline 4 (1965) amended in 1966 and 1969, and later, in the case of accident and health, incorporated into regulation 62,

(3) pension trust policies,

(4) graded death benefit guaranteed issue for generally limited amounts of insurance,

(5) payroll deduction employer/employee situations,

(6) senior citizen policies because benefits are small, and

(7) student term.

Another example of liberalized regulation is that New York approved as a class an employer funding a nonqualified employee fringe benefit in 1985. The key is that justifiable economies must exist, such as savings in marketing, underwriting and administration. So try us, you might like us. The fact that smaller groups were recognized as groups has somewhat eroded the necessity for franchise and wholesale rules. The franchise and wholesale rules were limited to term insurance. Interpretation was made to recognize all of the factors including the solicitation costs, underwriting, and lapses and recognizing permanent as well as term.

Yet, even if an insurer did not distinguish between such classes, but applied the same premiums, benefits and underwriting generally to the public, a given agent could still apply his own direct response techniques. The burden of proof is with the insurance company to justify a particular class as being nondiscriminatory. This was pointed out as early as 1955 by former Deputy Superintendent Harris.

Next is group mass solicitation. As noted, the application of the nondiscrimination statute has been interpreted differently for group insurance. While the same premiums, underwriting and benefits should be offered to groups having the same characteristics, the method of assessing contributions against individual insureds may vary from group to group. Where there is a subsidy by the policyholder (for example, by the employer) contributions assessed against individuals may be averaged by age, sex, and smoker/nonsmoker status. Where there is no subsidy, contributions may be distinguished by individual ages or by age groupings by smoker/nonsmoker status, by size and, in non-Norris situations, by sex. In turn, for the larger groups, the rate for a given group may be adjusted based on the experience of that group.

Group regulations used to be quite restrictive in that initially only groups where individuals had the same occupation were recognized.

Last year, after five years of study and based on the Model Group Insurance Laws adopted by the NAIC in 1980, the New York Insurance Law Section 4216 was liberalized to remove many of the restrictions on employer/employee cases and to recognize multiple employer trust of more than one industry,

associations and organizations meeting certain criteria -- 13 different types of groups in all. There is also a discretionary section permitting the Superintendent to approve other groups. Approval is given if:

(a) There is a common enterprise or economic or social affinity or relationship,

(b) The premiums are reasonable in relation to the benefits, and

(c) The issuance of the policy would result in economies of acquisition or administration, would be actuarially sound, and would not be contrary to the best interest of the public.

The Superintendent shall promulgate regulations setting forth any such groups that have been accepted as qualifying.

This section is very new (January 1, 1986) and interpretations are in the evolutionary process. Early indications are that approval will favor the sponsored groups.

The NAIC Model Laws require approval of the group policy and the certificates only by the state in which the policy is delivered. However, for these newly recognized groups, certificates on New York residents under group policies issued outside New York must comply substantially (i.e., compliance with New York law, except that reasonable deviation may be permitted in benefit levels, conversion privileges, preexisting condition and Flesch score test standards) with the requirements for certificates under group policies issued in New York. Also, solicitation was limited to that by licensed insurers (unlicensed insurers are not permitted to mail certificates for these new groups). In addition, any certificate on a New York resident under a group policy delivered in another state and not meeting the definition of an eligible group in New York must comply with the more stringent of the group or individual standards.

Although loss ratios have been well established in the accident and health area, based on the 1980 NAIC Model, the New York Insurance Law incorporated a requirement that benefits be reasonable in relation to the premium for these

newly recognized groups (except for the newly recognized non-occupational multiple employer trusts issued in New York) and the New York residents under these newly recognized groups as well as any non-recognized group where the group policy is delivered in another state. This has been interpreted by the department as requiring minimum benefit ratios as set forth in Regulation 123, effective January 1, 1986. These new requirements also apply to new certificates under group policies issued prior to January 1, 1986. The benefit ratios for life insurance are new. We did not want mass marketing insurance to be advertised as a cheap economic form of insurance if this were not so due to inordinate amount of expense of advertising, marketing, and soliciting insurance.

Direct response marketing can be by radio, television, and newspaper. The response may be greater where some special consideration is given to individuals who are members of a particular group even though the trust to whom the group policy is issued may have been set up by the insurance company strictly for marketing purposes. Where the group is one formed by the insurance company, care must be taken in the advertising to avoid misleading advertisements. Within the past year, the New York Insurance Department fined at least one insurer for misleading advertisements.

The unfair discrimination statute prohibits rebating of commissions within a given class. However, different classes may have different commission and fee schedules. One might expect direct response marketing to have either no or low commissions. Yet, the cost of advertising and marketing can be such that the overall unit expense cost of putting business on the books could be greater than for individually solicited insurance with the payment of fairly high commissions. To reduce the expense, an insurer may be inclined to either not underwrite and use a graded death benefit or to use simplified underwriting. However, the extra mortality along with the marketing expense may drive gross premiums higher than that for individuals who would qualify as standard for policies subject to regular individual underwriting standards. In some cases where this is so, the Department has required the insurer to advise the applicant of other less expensive forms. In any event, the insurer must be careful not to advertise low cost insurance if such is not in fact so. Regulations 34 (HI) and 34A(1980-LI&Ann) state the rules governing advertisements.

New York has a section 4228 (formerly Section 213) which places limits on commissions, total field expense, and total expenses for individual insurance. This section has been applied extraterritorially which is the reason why some insurers have chosen not to be licensed in New York. Expense of direct response marketing of individual policies must stay within such limits.

To date, most group insurance has been term insurance. The benefit ratio concept is easier to apply for term insurance than for permanent insurance. While consideration was given to directly controlling service fees, in particular those payable to the policyholder, the law and regulation rely on protecting insureds mainly through minimum benefit ratios. For these newly recognized groups (except for the newly recognized non-occupational multiple employer trust), dividends are first used to decrease the cost to the employer. The dividends in excess of the policyholders' contributions and expenses has to be paid in cash or reduce the premium for the insured (Section 4216 (h) (1)). Since the insurance law requires that policies be self-supporting on reasonable assumptions as to interest, mortality, and expense, the minimum benefit requirements have the effect of limiting the margin for expenses. This limitation may be more theoretical if an insurer spends more in marketing and does not get the response assumed in the self-supporting study. In such situation, the insurer might incur operating losses.

Finally, where do we go from here? It is obvious to anyone who has been involved with mass solicitation that non-uniformity with respect to the regulatory aspects among the states exists and is a problem. Some states do not allow billing by means of a credit card. Some states have loss ratios, some do not. The loss ratios vary. Some states do not allow mass solicitation at all. Some states are very concerned about selling to people over age 65. However, considering the modern printing techniques, a bigger problem is the variation in time of the approval process. Also, NAIC guidelines are not generally adopted across the board by all states. Thus, the regulatory environment is somewhat difficult to deal with.

Just let me point out that legislation is only one of the problems associated with the less than successful mass solicitation experience. Many companies themselves still have a lot to learn. Some companies such as USAA, which

sells Universal Life through mass solicitation to retired military officers, have been quite successful. The key ingredients appear to be control of expenses and commissions, and finding a particular niche of sponsored groups and a successful way to approach this niche with products that are needed, unique, and provide value.

MR. BRADLEY M. SMITH: We are going to talk about the regulation of insurance, specifically life and health insurance, offered through direct response methods. Direct response methods in this context will refer to insurance offered through the mail and/or over the telephone. We will address some of the opportunities as well as the limitations that such regulation represents. Our discussion will be split into six major sections. The regulation of group insurance versus individual insurance offered through direct response will be discussed initially. A discussion of Limited Time Offers (LTOs) will follow. The NAIC advertising regulations will be examined next, followed by a few observations on the regulation of credit card billing, the regulation of telephone solicitations, and agent countersigning requirements.

GROUP INSURANCE VERSUS INDIVIDUAL INSURANCE

Generally, the offers you receive in the mail today are split as to whether they are group insurance offers or whether they are individual insurance offers. There are few substantive differences between the insurance offered. The advantages and disadvantages of each approach will be summarized in this section.

A direct response group insurance offer is not "true" group insurance as we tend to think of it, where a minimum percentage of the group population (such as 75% in employee contributory plans) is required. Generally, the direct response offer was made on a group basis for one of the following reasons:

(1) The perception by consumers that group insurance implies a more competitive rate and therefore, a group insurance offer should draw a larger response than an individual offer. Although this seems reasonable to most of us, I know of one company that has done extensive research on this and has concluded that, although there is a perception among consumers that

group insurance will have a lower rate than individual insurance, the response rates (and issued and paid rates) are not significantly different between the two types of offers. Still, their emphasis has shifted to offering group insurance while their advertising copy emphasizes "low group rates."

(2) Group insurance coverages that are filed and approved in one state will not require filing in each state as is the case with individual insurance. For example, Exhibit I shows that group insurance offers approved in Illinois may be solicited in Illinois and thirty-four other jurisdictions (33 states and the District of Columbia) without further contact with the regulatory authorities, assuming that the company soliciting the insurance is properly licensed to do business in all jurisdictions in which coverage will be offered.

Further filing requirements exist in four states, other than these 34 states. Arizona requires the filing (but not approval) of all policy forms and advertising material. This requirement is pursuant to a relatively new statute and interpretative guide and, therefore, has little practical administrative history to guide insurers. At this time, the filing should be treated as a file-and-use situation with no acknowledgment or filing stamp being required from the insurance department.

Exhibit I

Illinois Group States

Alabama	Kentucky	Rhode Island
Alaska	Louisiana	South Dakota
Arkansas	Massachusetts	Tennessee
California	Minnesota	Utah
Colorado	Mississippi	Virginia
Delaware	Montana	Washington
Georgia	Nebraska	Washington, D.C.
Idaho	Nevada	West Virginia
Illinois	New Mexico	Wisconsin
Indiana	North Dakota	Wyoming
Iowa	Oklahoma	
Kansas	Pennsylvania	

Florida requires the filing of out-of-state contracts for informational purposes with the certificate being endorsed to recite that the contract is not governed by the Florida insurance laws. Whether to file advertising material is problematical. At times Florida insists on it as part of the filing package and, at other times, takes the position that the material need be submitted only if requested by the Department. While not required, it is prudent to wait 30 days after filing.

Michigan requires the filing of advertising material only. No approval is given. It may be treated as a file and use requirement.

Maine, being a modified model bill state which does not give automatic full faith and credit to an Illinois approval, requires a copy of the Illinois filing.

In four other states it is suggested that individual policies be used. These states are Maryland, Oregon, Texas, and Vermont. All these states will approve the use of individual contracts offered through direct response methods but normally reject the group contract approach. Maryland and Texas have discretionary group filing procedures but historically have seldom ruled favorably on a submission. Maryland, however, has approved some bank credit card group programs, and it might be worthwhile to try such a filing if there is an impediment to issuing individual policies.

Five states have special requirements which must be adhered to in any solicitation within these states. The states are: Connecticut, Hawaii, Mississippi, New York, and Ohio. The situation in Connecticut is not entirely clear, but it appears that with respect to group health insurance only AD&D may be solicited. Life coverage appears to be acceptable. Due to the lack of clarity in Connecticut, contact with the Department should be made to discuss each particular program. The problem is that the rules seem to vary case by case.

Hawaii requires that all mail solicitations be direct mailings from the insurer. In other words, no "insert" or "piggyback" solicitation can be made.

Mississippi, in effect, is similar to Hawaii in that it prohibits solicitations from the policyholder to prospective insureds. We will see how this comes into play when we review the set up of the trust involved in a group solicitation.

New York requires adherence to the Goldstein Memorandum, which in effect says: (1) the insurer must be licensed in New York; (2) mail must emanate outside of New York; (3) there can be no face-to-face solicitation in New York; (4) all return mail (applications, etc.) must go to an address outside of New York; (5) there can be no references in the material which might create the impression that the program is approved for sale in New York; and (6) the offer must be in substantial compliance with New York law.

Ohio requires fairly strict adherence to anti-selection rules. The program cannot allow (particularly with respect to life coverages) a wide choice of amounts of coverage by individual insureds. Experience indicates that the Insurance Department will allow for selection among multiple plans, but it is suggested that the number of plans available under each coverage be limited to no more than four choices.

Obviously, the environment with regard to applicable regulation changes constantly, and this summary is meant only to give you a flavor for what can be anticipated when you embark on a direct response group insurance program. Additionally, any prior agreements made by the company with individual states as far as filing requirements will alter this summary for that particular company.

The administrative advantage of group insurance offers allows a company to make test mailings of new products much easier and much faster than it could do if the products were individual offers requiring filing and approval in each state where they were to be solicited. Additionally, should the need for a premium rate change arise, the filing and approval of this rate change in the state of original approval (Illinois in our example) should suffice in most states. Thus, the implementation of premium rate changes is made less burdensome.

Generally, when filing a group policy with a state, only a maximum premium rate is filed with the understanding that different rates may be charged to

different groups depending upon the characteristics of the particular group. This rate flexibility is meaningful when offering the same product to different groups through direct response methods. This flexibility is not available when offering either individual life or individual accident and health policies.

A potential barrier to offering group Medicare Supplement policies is the 70% (75 in some states) loss ratio requirement for group Medicare Supplement coverages. However, the loss ratio requirement for group Medicare Supplement policies offered through direct response is generally the same as individual Medicare Supplement policies (60% in most states).

One benefit of offering a group life product instead of an individual life product is that group life insurance products are exempt from the Standard Nonforfeiture Law. This adds flexibility to the product design and enables the product development actuary to better match the equity that a policyholder has built up at the time of his withdrawal. This flexibility can be abused, however, and care must be taken not to create an inequitable or tontine environment.

Additionally, companies using agents as their primary distribution system have found less resistance to offers of group insurance being made through direct response than they have had with the individual insurance counterparts.

When picking the state in which to file your group policy, the following items should be considered:

- It should have adopted the NAIC Group Model Bill.
- It should be a respected jurisdiction.
- It should honor the principle of comity (reciprocity).
- It should be comfortable with trust groups.
- The company should have a solid relationship with that state.

The structure and legal relationships between the different parties involved in a group insurance trust are shown in Exhibit II.

Exhibit II

Legal Structure of Trust Group

- Master Policy
  - -- Filed with state of situs insurance department
  - -- Between master policy holder (i.e., XYZ Group Insurance Trust) and insurance company

- Certificate
  - -- Filed with state of situs insurance department
  - -- Issued to members of group that purchase insurance

- Trust

- Establishes group master policyholder

- Given situs in state of approval of policy

- Held by bank (Trustee) which acts as Trustee, but has no discretionary powers

- Board of Directors appointed (by Trustor) to direct Trustee

- Subscription Agreement
  - -- Not filed with state insurance department

- Third parties join or subscribe to trust to allow their members to be eligible

- Insurer can be the Administrator (pays annual fee to Trustee)
  - -- Separate post office box and bank account is set up

- Trustor is usually the parent or affiliated company of the insurer

LIMITED TIME OFFERS

The marketing results of a direct response marketing effort are generally improved if the potential purchaser is somehow forced to act, that is consciously decide to purchase or not. One method of accomplishing this is the use of limited time offers (LTOs). LTOs can involve real limitations prescribed by the solicitor of the insurance, or they can be artificial such as an increase in a person's age due to a forthcoming birthday. A birthday is an artificial LTO because of the possibility of backdating the policy. Generally, only real LTOs are regulated. The perceived need for such regulation exists presumably because the LTO should have some meaning. A continuously offered LTO is meaningless. Various states have prescribed the length of time required between LTOs as shown in Exhibit III.

Exhibit III

Minimum Length of Time Required Between LTOs

State	Period	Maximum No. of Offers Per Year
Alabama	6 months	
Arkansas	3 months	
California	3 months	
Florida	6 months	
Illinois	6 months	
Kansas	3 months	
Michigan	3 months	2
Missouri	3 months	
New Hampshire	90 days	
North Carolina	3 months	2
Pennsylvania	90 days for riders (prohibited for policies)	
Tennessee	3 months	
Texas	4 months	
Virginia	4 months	
Washington	3 months	

Except for Texas, the space is defined as the length of time between the close of one offer and the beginning of the next offer. The Texas period is from mail date to mail date. The LTO for all states must be available for a period of not less than 10 days nor more than 40 days.

Interpretation of these regulations limiting the periods between LTOs is unclear. Does the LTO limitation refer to offers made to the same group? Can you make an LTO to one group and then follow this LTO with another LTO to another group within the restricted period? What if the same person is a member of both groups and receives two back-to-back LTOs of the same product? Certainly the intent of these regulations is clear, and a company should be guided by this when deciding on the timing of its LTOs. Additionally, the administrative burden associated with LTOs must be considered when deciding whether or not to use a real LTO in the solicitation material. It is not at all clear in any given marketing effort whether an LTO actually adds to the response and ultimate profitability of the program. As in all direct response marketing, testing is the answer. LTOs have been used historically and continue to be used with guaranteed issue products for underwriting reasons, and any analysis of the incremental profitability of an LTO should consider the resultant savings in mortality/morbidity due to the LTO.

NAIC MODEL ADVERTISING REGULATIONS

The NAIC has adopted model regulations governing the advertising of both life insurance and accident and sickness insurance. The model regulations or similar legislation has been adopted in many states although the rules governing the regulation of life insurance advertising have not been as widely adopted as have the rules governing the regulation of accident and sickness insurance advertising.

Although there are many specific requirements detailed in each of these model regulations, I will leave review of such details with you and your legal staffs. Now I will recite passages from each regulation which should give you a feel for the purpose and general intent of these regulations. The regulations are very detailed. However, as long as an insurance company understands and makes every effort to comply with the intent and fulfill the purpose of these regulations, the company should not find itself in too much trouble.

The accident and sickness model states:

> The purpose of these rules is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance. This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident and sickness insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media.

The importance of precise categorization of what legally a solicitation is, is illustrated by this passage:

> "Institutional Advertisement" for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.
>
> "Invitation to Inquire" for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, which may contain:
>
> A. The dollar amount of benefit payable, and/or
>
> B. The period of time during which the benefit is payable; provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:
>
> > "For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."
>
> "Invitation to Contract" for the purpose of these rules shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement."

The phrase, "the information shall not be minimized, rendered obscure or otherwise made to appear unimportant" is used throughout both model regulations.

Other passages include:

> The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive.

Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed. . . .

Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used. . . .

No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. . . .

No advertisement shall contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will help fill some of the gaps that Medicare and your present insurance leave out," "this policy will help to replace your income," (when used to express loss of time benefits), or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy. . . .

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in, prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY." . . .

When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

> Do you understand that this policy will not pay benefits during the first (insert number) year(s) after the issue date for a disease or physical condition which you now have or have had in the past? YES

Or substantially the following statement:

> I understand that the policy applied for will not pay benefits for any loss incurred during the first (insert number) year(s)

> after the issue date on account of disease or physical condition which I now have or have had in the past. . . .

Testimonials used in advertising must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules. . . .

If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer. . . .

An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer, such fact shall be disclosed in the advertisement. . . .

The source of any statistics used in an advertisement shall be identified in such advertisement. . . .

No advertisement shall use any combination of words, symbols, or physical material which by their content, phraseology, shape, color or other characteristics are so similar to combination or words, symbols, or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of such a nature that it ends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

Additionally, the life insurance model includes phrases such as:

> Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. . . .

> No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life. . . .
>
> The information required to be disclosed by these rules shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading. . . .
>
> In the event an advertisement uses "Non-Medical," "No Medical Examination Required," or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions. . . .
>
> An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no agent or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the Insurance Commissioner prior to use. . . .
>
> An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed. . . .
>
> > An advertisement shall not contain statements, pictures, or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial conditions, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

As stated previously, these passages give you a feel for what the regulations are attempting to accomplish. However, the importance of thoroughly reviewing these regulations prior to the conception of any advertising material cannot be overstated if false starts and compliance hassles are to be avoided.

State approval of advertising material varies not only from state to state but, within a given state, may vary from company to company. Each company can,

over time, work out understandings with state insurance departments as to exactly what must be filed (if anything) prior to use and further, what must be approved prior to use. A past performance of strict compliance with a given state's advertising regulations as well as lack of complaints filed with the state insurance department and the company's reputation within the industry will affect the approval/filing requirements (or lack thereof) agreed to by the state. Obviously a shorter file/approval time line will allow a marketing effort to hit the streets that much faster and provides a competitive advantage to those companies that enjoy relaxed requirements.

CREDIT CARD BILLING OF PREMIUMS

Another aspect of insurance offers made through direct response methods is the ability to bill the premiums using a credit card. This capability is particularly appealing for offers made to retail and gas company lists. Billing through a credit card generally improves the affinity the insured feels toward the insurer which in turn results in higher persistency and more profit for the insurer.

Three states do not allow billing through a credit card. They are:

(1) New Hampshire
(2) North Carolina
(3) Florida

Four states allow credit card billing of premiums if a direct bill option is offered to the policyholder. These states are:

(1) Texas
(2) Arkansas
(3) Pennsylvania
(4) Minnesota

Additionally, the District of Columbia requires a direct bill option to be offered. My experience has indicated that when both the credit card billing option is offered along with the direct bill option, the policyholder will

elect the credit card option particularly if he understands that credit card interest is not being charged on his premium.

This brings up the issue of charging interest on premiums charged to a credit card. Some states allow this while other states do not. Some nationwide companies have decided not to charge interest on premiums charged to a credit card in all states while some have decided to charge interest on premiums charged to a credit card where this is allowed. The difficulty of implementing interest charges on premiums on a state by state basis has been a primary consideration of those companies that have decided not to charge interest in any states. Certainly, I would not let the time required to make such changes to a credit card billing system delay the implementation of a marketing program or test.

TELEPHONE SOLICITATIONS

A number of regulatory issues arise when insurance is sold over the telephone, not the least of which is whether the person on the telephone representing the company needs to be a licensed insurance agent. This is a sticky issue. On the one hand, it is obvious that when you call an 800 number in response to a television commercial, the operator on the other end of the line is generally not a licensed insurance agent and does not need to be one. In fact, if the operator is working for a Watts line service, the next call the operator answers could be in response to an ad selling Elvis Presley's Greatest Hits (the collector's edition) or a lady's organizing handbag. The operator is strictly an order taker, generally used in a two-step approach that creates a list from which a solicitation package will be sent out.

The issue becomes less clear if the operator asks any medical/underwriting type questions and is actually taking an application for insurance. Even less clear is the situation where the operator is calling you, an apparent cold call which has probably emanated from some type of list. Many companies take the opportunity to sell another coverage to an existing policyholder who has called the company requesting customer service on an existing policy. Is the customer service representative a licensed insurance agent? Probably not. All of these situations fall into a gray area. The issue of legal offer and acceptance

becomes an issue. Is the operator making an offer or making an invitation to make an offer? Is the potential policyholder making an offer to the operator? As was said before, this is a very sticky, unclear area into which an investment of some legal research by a company contemplating using this distribution system is worthwhile. Certainly, in any case, a licensed insurance agent available to assist the telephone operators should be on the premises.

AGENT COUNTERSIGNING REQUIREMENTS

We are all aware of the power the life insurance agent lobby has today. We have seen this lobby be influential in the adoption and retention of laws providing life insurance policies preferential tax treatment. We have also seen the negative influence this lobby has had on the regulation of insurance offers made through direct response methods.

Generally, these efforts are viewed as protecting the agents' turf. Deviating from the topic at hand briefly, I believe and it has been shown in some companies that direct response offers, when used as a supplement to agent sales efforts, do not intrude upon the efforts and results produced by these agents but actually increase their productivity. Awareness of the need for insurance is generally increased. Additionally, segments of the market that cannot economically be prospected by the agent, can become profitable when the prospect contacts the agent directly concerning the prospect's insurance portfolio in response to a direct response solicitation. These anti-direct response lobbying efforts within and outside a company are unnecessary and unproductive.

One result of agent lobbying efforts are countersigning requirements adopted in some states. These laws generally require that an agent sign and/or deliver to the policyholder policies issued through direct response methods. The company pays the agent a commission or an expense allowance for providing this unnecessary service. The advantage of offering insurance through direct response methods is somewhat mitigated with these requirements as the additional cost of providing this service is passed on directly to the policyholder.

The states listed below have adopted some form of countersigning requirement:

FLORIDA	Applications must be routed through an agent for his signature. Policies must be mailed to an agent for delivery to the Insureds.
GEORGIA	Policies must be mailed to a Resident Agent for delivery to the Insureds.
HAWAII	Accident and Hospital policies must be signed by a resident agent.
ILLINOIS	Accident, Hospital and Life policies must be signed by a Licensed Resident Agent.
KANSAS	Accident and Hospital policies must be signed by a Licensed Resident Agent.
MAINE	Accident and Hospital policies must be signed by a Licensed Resident Agent.
MASSACHUSETTS	Accident and Hospital policies must be signed by a Licensed Resident Agent. Life policies must be forwarded to a Licensed Resident Agent for delivery to the Insureds.
MICHIGAN	All applications must be countersigned with an Agent's rubber stamp.
MISSISSIPPI	Accident and Hospital policies must be signed by a Licensed Resident Agent.
NORTH DAKOTA	Accident and Hospital policies must be signed by a Licensed Resident Agent.
PENNSYLVANIA	Accident and Hospital policies must be signed by a Licensed Resident Agent.
RHODE ISLAND	Policies must be mailed to a Resident Agent for delivery to the Insureds.
SOUTH CAROLINA	Accident, Hospital and Life policies must be countersigned with an Agent's Rubber Stamp.
WEST VIRGINIA	All policies must be countersigned by a Licensed Resident Agent.
WYOMING	Accident and Hospital policies must be signed by a Licensed Resident Agent.

SUMMARY

In conclusion, it is obvious that offers made through direct response methods are highly regulated. However, this regulation is not prohibitive and should not deter a company with a well-defined market from entering this business.

Offers using direct response can be highly profitable if the company knows what it is doing. The potential for very costly mistakes also exists if the company is not experienced in this area. The necessary expertise can be acquired or rented. This should not be a deterrent from using this distribution system. The key element to success continues to be a well-defined market that has some affinity with the offerer of the product.

MR. ROY GOLDMAN: In regard to the LTOs, limited time offers, does that apply only when the products you are marketing are substantially the same product?

MR. SMITH: Yes, it's LTOs of the same product.

MR. GOLDMAN: Are there any general guidelines regarding the telephone solicitations and whether the individual has to be licensed? Is the judgment that one has to make whether the individual is making an offer or not?

MR. SMITH: That's basically it. You get into a lot of legal technicalities. I think if the telephone representative is taking an application, you are on very thin ice. I've seen that skirted essentially by representatives doing everything but completing the application and then bringing a resident licensed agent who is in the area servicing 32 telephone representatives to complete, essentially sign, the application, but I think you are on very thin ice. Now obviously, in television-type solicitations where you are calling a WATTS service, there is no resident agent and the telephone representative is not taking an application. The representative is creating a list.

MR. GOLDMAN: What about the situation where the telephone service is initiating the phone calls and describing the product and then saying, may I send you an application for the individual to sign?

MR. SMITH: I've seen companies not have licensed agents to do that. Again, I would just make sure your company is comfortable with the position that you are taking. I think that's the critical aspect. It's so ill-defined that it enters the realm of business risk as opposed to legal definition.

MR. JEFFREY A. BECKLEY: Brad, you talked earlier in your speech about the differences, or the advantages/disadvantages of group versus individual. Do the countersignature laws vary between group and individual?

MR. SMITH: That's a good question. I'm not sure of this, but I don't think that there are countersigning requirements on group certificates, but I may be wrong. Some states may require it. Certainly the list that I gave you was individual.

MR. BLUHM: I have a question. Back in the beginning, Brad, you indicated that there were 34 jurisdictions in which a single filing in Illinois would be recognized. Have you, or has anyone here, ever optimized how many filings it takes in order to cover all jurisdictions?

MR. SMITH: That's what I attempted to do with my explanation of what you would do. Incidentally, Illinois is not necessarily the state to do it in, just the state our particular company chose. Our company got Illinois, plus 33 others, plus the District of Columbia. The company opted for 4 individual filings of that product in those states that I had mentioned, Maryland, Oregon, Texas and Vermont. That's five, and basically what the company did was file group policies for the rest of the states or the rest of the jurisdictions within those states. So, you are talking about Illinois plus 34, that's 35 states being caught with 1. So, to cover the whole spectrum, you are talking about 17 filings -- 4 being individual, 1 being the group filing that takes care of Illinois, 33 states, and the District of Columbia and the rest being group filings in the remaining individual states.

MR. KWASI OSEI: I would like to pick up on Mr. Bluhm's question. In your experience, have you identified the states where the group filings would allow you to cover the most states? For example, I know that when you file in North Dakota you cover only 24 or 25 and, as you said, when you file in Illinois you cover 33 states. So it varies depending upon which states you file the group trust in. Have you identified which states will allow you to cover the most states?

MR. SMITH: Until you have actually done it, it's hard to say. Illinois seemed to maximize the number of states you can cover.

MR. BLUHM: I have a question for Johan. Under the new group law in New York, do you know whether a typical Illinois filing would now be acceptable in New York?

MR. VANDERVELDE: I think it would still have to comply with the new New York law. There are some special requirements in New York that I don't think Illinois requires. The extent of the additional requirements I'm not entirely sure about, but New York is one of those special cases not included in those 34 states that Brad mentioned.

I have a question for Brad. Is it indeed a problem in terms of the timing of the approval process for companies, state by state, some states might take a month, some states might take 6 months to approve a typical filing?

MR. SMITH: Yes, I think it's an overwhelming problem, particularly in direct response. Five years ago everybody probably thought direct response was a low-volume, high-profit business that didn't have much competition. Those of us that are in that business know that it's very competitive, particularly as far as new product development goes, and the last thing you want is to develop a product and not be able to get to the streets with it on a roll-out type basis or on a test basis before somebody else has hit the market with it. Or you might roll-out to 3 states, your competitors get a hold of it and they are rolling out to 33 states. So I would definitely say it's a problem. It's an impediment to swings in the marketplace.

Certainly, administratively, filing in one state makes the process simpler. This goes for rate filings, also. You file your Medicare supplement plan, for instance a group Medicare supplement rating increase. You get it approved in your group state, and you've bought into basically all of your group states. Now, I will say, there are some special requirements where a few of the 33 states that I mentioned require rate filings just for information purposes to be made before you can use them.

MR. OSEI: In addition to being able to cover so many states with one filing with group trusts, do you see any other advantage rather than using individual policies?

MR. SMITH: I think there's two that I probably didn't emphasize enough. I think the ability, if you are going to market life products, to be exempted from the standard non-forfeiture requirement is important because, in direct response marketing, you do not just have the major risk of nobody taking the product or nobody purchasing the product, or your solicitation expenses per dollar of annualized premiums skyrocketing. There also is the lapse risk which every company has, but it's particularly evident in this because the policyholder will get another offer in the mail. It might be accident only and it will be $5 versus the $13 per thousand the policyholder is paying, and he will get confused and drop your policy. It's critical in a life policy to be able to reflect an asset share type cash value or an equity built up by that policyholder for that particular policy in your pricing and not be constrained by standard nonforfeiture requirements.

Although I mentioned the instance where extensive marketing research was done and really showed no significant difference between group insurance offers and individual insurance offers, I think from a business standpoint, you just have the overwhelming market research that says the population as a whole views group insurance as cheaper and somehow that's going to be translated into better response and better persistency results. I think that's very similar to when you make an offer and there is very little significant difference between your test mailing and your basic product, but you still have to make a business judgment as to which one you are going to mail next, or you are going to re-test. I just feel that the group is probably the way to go on that even though the marketing research would show no difference. It certainly doesn't hurt.