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Market Conduct Issues for Product Development Actuaries

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Moderator: MARK A. MILTON
Panelists: BRUCE F. DEAL†
MARC-ANDRE GIGUERE
ROBERT SCHWAB‡

Summary: Market conduct issues are perhaps one of the most serious facing the life insurance industry today. How did we get to this point? And more importantly, what actions are companies taking to address these issues? This session explores the primary issues underlying market conduct concerns, as well as overview approaches to evaluating litigation from an actuarial and economists' perspective. Insurance Marketplace Standards Association will also be discussed.

Mr. Mark A. Milton: I'm an actuary with Kansas City Life, and I'm going to be your Moderator. And although I'm no expert on this topic, I think we have a panel that is, although I must admit, since the first of the year, my firm has been hit with two class-action lawsuits, so I have a feeling, by the end of the next year, I probably will be an expert on the topic. How many of you work for a firm who have had market conduct issues recently, or a class-action lawsuit? Please raise your hands. We obviously have lots of experts in the room. Recent public opinion polls indicate that 35–40% of the population feel that life insurance companies and their agents don't really care about the policyholders' needs. This will make it extremely difficult for us to compete in the financial services industry in the future, if we don't change this perception. So I think this is a very important topic.

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†Mr. Deal, not a member of the sponsoring organizations, is Vice President of Analysis Group Economics in Menlo Park, CA.

‡Mr. Schwab, not a member of the sponsoring organizations, is Compliance Consultant of Milliman & Robertson, Inc. in Chicago, IL.

Note: The chart referenced in the text can be found at the end of the manuscript.

Market conduct issues have created a tremendous amount of additional work for actuaries. If you think about illustration regulation compliance, training and marketing material analysis, complaint resolution, Insurance Marketplace Standards Association (IMSA) certification, all kinds of things have happened that probably created more work for you. Well, our panelists have ideas of a few more things you can be doing in the future with your spare time to help address these issues as well. Market conduct related lawsuits have become somewhat of a cottage industry. More and more, law firms are specializing in this area, and I know of at least four agents who have been asked by plaintiffs' attorneys to see if they could go into state insurance departments and help drum up future business by finding disgruntled policyholders. Insurers are being judged today based on their decisions from years ago. There's always a tendency to apply laws and policyholder perceptions from several years ago to today, and that's a very difficult environment to be in, but I guess it's due to the nature of our contracts, which are long term. Market conduct issues have had an ongoing impact in the industry. There are suits against new companies. There are new regulations and task forces, new allegations, and also settlements have been evolving. I guess the old excuse that "the computer made me do it" probably won't work going forward.

Well, suppose you were the actuary, and your chief counsel walked into your office and handed you a 178 page class-action lawsuit, which said that you deceived people and your crediting rates were not supportable. You encouraged churning and twisting. Your illustrations were misleading, and your agents were not properly trained. Well, what would you do? Fortunately, we've assembled a panel of experts to help you with those issues. We believe that every actuary should know about market conduct issues, what caused the problem, what's being done about it, industry and legal trends, and most importantly, what you can do going forward.

I'm now going to introduce our panel. We have three panelists who have worked in this area. The first, Marc Giguere, will be providing an actuarial perspective on the topic. Marc has worked in the Tillinghast Dallas office for the last three years. Bruce Deal is a senior economist and vice president of Analysis Group Economics, and serves as director of the Menlo Park, California, office. Bruce holds an undergraduate degree in Economics and a graduate degree from Harvard University. For most of the past three-and-a-half years Bruce has been managing the economic analysis involving sales practices litigation for several life insurance companies, and in addition to his insurance work, Bruce also manages other projects involving the use of economic and financial data from a variety of industries. From a compliance perspective, Robert Schwab is a compliance consultant in the Chicago office of Milliman & Robertson. He specializes in life and annuity product development and compliance issues. He works with insurers by assisting them with product filings and working through the various state insurance department and SEC requirements.

Rob has been active in life insurance and annuity compliance within the industry for more than nine years, previously with Allstate Life. Rob is going to give us a perspective on part of the solution, which is IMSA certification.

Mr. Marc-Andre Giguere: As Mark mentioned earlier, I have been working for Tillinghast in the Dallas office for three years now. Since joining Tillinghast, I've worked on approximately ten of the market conduct lawsuit settlements with companies of various sizes. My presentation today is entitled: "Market Conduct Litigation Settlements, Past, Present, and Future." This presentation was put together using public information on past settlements, as well as personal experience and discussions with lawyers as to where we are currently going, and what we can expect for the future.

My presentation will cover the following sections: The first section, Description of Past Settlements, will cover the allegations that have been addressed in past settlements, as well as the remedies that have been offered. The second section, Current Trends, covers some of the more recent allegations which plaintiffs' counsels have been raising, as well as changes on the settlements, to both the remedies offered and the administration of the settlement itself. The third section, Where Are We Heading, is a result of conversations with different defense counsels as to what they believe the potential areas for future claims are, as well as what companies can do differently in the future.

Description of Past Settlements

Let's start by talking about which companies have settled market conduct lawsuits to date. This list includes all of the companies whose settlements are now public. And as you can see, when you have companies like Prudential, Metropolitan Life, New York Life, John Hancock and CIGNA, just to name a few, most of the biggest life insurance companies in North America are on this list. Unfortunately, the list of companies continues to grow as we're speaking. Dozens of other companies are currently negotiating with plaintiffs' counsels on some market conduct settlements but have not yet gone public. This list of companies should probably more than double over the next 12–18 months. Past settlements have addressed the following main allegation, inappropriate internal and external policy replacements, where inappropriate is usually defined as a replacement that is not to the policyholder's advantage. One way of measuring this is by performing an internal rate of return calculation for both the old and the new policies from the policyholder's point of view; allegations of finance life insurance, where values from one policy is used to purchase another policy. One interesting note on finance life insurance is that the new NAIC model regulation on replacements has now expanded the definition of a replacement to include financing, and a notice must be sent to all policyholders any time a loan, withdrawal, or surrender is requested, even if no replacement is

indicated. Policies are issued on a vanishing premium basis, which can no longer vanish on the illustrated date. This is probably the most frequent allegation that we've seen so far. Also related to vanishing premium, we have underperforming policies, such as Universal Life policies, which can no longer mature despite paying the target premiums. Unfortunately, in many cases, these last two allegations are due to changes in the economic environment, as opposed to anything that the company has actually done, but we're still being held responsible for that. And usually what happens is, in those cases, the plaintiffs usually allege that they didn't really understand their policy and they weren't aware that the performance of the policy would be based on external factors. There have also been some allegations of life insurance sold as an investment, where policyholders thought they were purchasing an investment product or a pension fund, but were actually purchasing an insurance policy. One good example of that is the Met Life case involving nurses in Florida, from a couple of years ago. We've seen inappropriate sales illustrations, and allegations of inappropriate back-tax product adjustments. These usually involve insurance companies that increase the COI charges to recover the lost investment income.

THE LIST OF COMPANIES HIT WITH MARKET CONDUCT LAWSUITS CONTINUES TO GROW

- Metropolitan Life
- Prudential
- New York Life
- Crown Life
- Allianz Life
- Liberty National
- Great West Life and Annuity
- Transamerica Life
- Phoenix Home Life
- CIGNA
- John Hancock
- Equitable of Iowa
- Others

The obvious question is, What did we as an industry do to get into this situation? And there are several things. First of all, increased competitive pressure drove agents to push the limits as far as what they were willing to say and what they were willing to illustrate, just to make sure that they could get the sale. In addition, improved technology allowed agents the freedom to create their own, or modify the company's illustration systems, to either use more aggressive assumptions, or alter the actual output from the system. Decreasing interest rates, which although the companies should not be blamed for this, did create a problem since agents did not always do a good job of making sure that the policyholders understood their products. A lack of sales force supervision has allowed agents who were stretching the limits to keep doing so, while a better supervision system could have noticed these problems and addressed the situation. Lack of disclosure and communication at the point of sale, and during the lifetime of a policy, produced very dissatisfied policyholders. Many complaints that we've seen mentioned, that the policyholders

were actually surprised to find out that their policies would either not vanish when they were supposed to, or, unless the policyholder paid more premiums, the policy would lapse. And last but not least, volatile product design just made it more complicated for policyholders to understand their policies, especially with the change in assumptions that we've seen in the last ten years.

Settlements usually offer two types of remedies, general policy relief, and alternative dispute resolution. Because they are available to every class member, and usually without any evidence required, remedies offered under general policy relief must have a very low cost to the company. A key point to remember, as to what determines a good remedy versus a bad remedy, is companies want to have remedies that have a high customer value created to actual cost to the company ratio. So if you have something that will cost you $10 but will create perceived value of about a $100 to the policyholders, that's a remedy that you want to offer. Most past settlements have offered the following forms of general relief. Option premium loans allow policyholders to take a certain number of loans against the policy at a rate that is usually lower than the normal policy loan interest rate. The number of loans allowed usually varies based on the past performance of the policy, and changes by issue year. Class members may be given the option of purchasing an enhanced-value policy, annuity, or mutual fund, where the company will make a contribution to the policy at some later date. This contribution, paid by the company, is usually offset against sales force compensation, and therefore usually has very little cost, if any. These remedies, although, usually have a condition that says that to purchase one of these enhanced products, you cannot take any money out, either by a loan or through surrender of an existing product.

Another type of remedy usually offered is settlement contributions, which are basically company contributions paid to an existing policy. Because this remedy represents actual cash out the door for the company, some companies have limited who is eligible for that remedy to only a specified group of class members, such as those that were more harmed than others. As you can see, most of these remedies would have very low, if any, cost to the company, but would create significant value to the customer. And that's one of the main reasons why these were pretty much constant from all the past settlements.

The purpose of the alternative dispute resolution is to offer class members who feel they can prove they were harmed a process to show their evidence in the hope of getting a more generous remedy, such as remedies offered under the Alternative Dispute Resolution (ADR) by allegation and specific policy history. The most common remedies that we have seen to date are rescind and restore, where the policy is rescinded and the policyholder is restored to the position they would have

been in, had the policy never been issued. Rescission is usually offered for allegations of inappropriate replacements, financing, and life insurance sold as an investment. Some companies with financing allegations have offered to refund contested amounts which might have been used for financing another policy. These contested amounts can be in the form of loan withdrawals or dividends that were assigned to another policy. Class members whose policies need extra premiums to vanish are usually offered a full or shared vanish, where a shared vanish typically means that the company will share the cost of the extra premiums required with the policyholder. Class members who are in danger of having their policies lapse may be offered a no-lapse guarantee remedy, under which the company guarantees that for as long as the policyholder pays the illustrated premiums, the policy will not lapse. Also, a catch-all remedy that can be offered for any performance-related allegation is a cash-value adjustment, where a policy's actual cash value is either increased or set equal to what was illustrated at the point of sale.

All claims that go through the ADR process are first scored, based on the evidence presented by the policyholder as well as by the company. Claims may then receive different forms of the remedies that I've just mentioned. Many past market conduct settlements have had the following characteristics. As I said earlier, most of the settlements have affected most of the biggest companies. Settlements usually have two mailings to class members. The first mailing is to inform them of the class, and to tell them that they have to decide now if they want to be part of the class or if they want to try to opt out and go on their own; and the second mailing usually asks the class members to select a remedy. To date, settlements have been very difficult to administer, with administrative costs often representing a significant percentage of the total costs incurred by the company. Just to give you an idea on some of the companies that we saw listed, the administrative costs can easily go in excess of $100 million, just to administer the settlement over two or three years.

For both plaintiff and defense counsels, customer value created is the most important aspect of these settlements. Now, from reading past press clippings associated with these settlements, you've probably seen how all these settlements are supposed to generate billions of dollars in customer value, but unfortunately, past customer value calculations were often inflated due to the methodology used. People didn't really understand what the goal of customer value created was, they used to think that the bigger the number, the better, because it was easier to justify the plaintiffs' counsels' fee, and there was more public support. But actually, it can create some backlash where companies are afraid that you've spent too much, and that it might affect your financial stability, especially if you're a stock company. As a rule, most past settlements have had fixed plaintiffs' counsels' fees.

Current Trends

Plaintiffs' lawyers are now coming after companies with new allegations of wrongdoing; inappropriate product adjustments for DAC tax have now become part of what we could call the form letter that is automatically filed by plaintiffs' counsel. Basically, they work on a list, and after each case, they just add to that list and they keep filing that same list. With the increasing popularity of variable products, we are now seeing allegations of improper investment advice given at the point of sale. One example of this is when a policyholder comes back saying that the agent told him or her to put money in fund A, but that fund B has actually had better returns ever since the policyholder purchased the policy. Another example is commission inconsistencies, where different commissions were paid on the same products sold to different people. Inconsistent crediting rate programs, which were somewhat frequent with companies which actively tried to replace products from other companies. Another is misleading policy loan cost information. For example, how many companies have used a statement saying, the actual cost of a policy loan is only 2%, just because the difference between the policy loan interest rate and the credited rate was 2%? We're now starting to see performance allegations involving clone funds. It appears that policyholders have a hard time differentiating between a clone fund from an insurance company and the actual mutual fund that might be listed in the newspaper. And when they hear about how Vanguard might have returned 30% last year, they don't understand why their Vanguard fund in the insurance company didn't give them 30%.

Some of these new allegations require new remedies. Cash value adjustments are now much more common since many of the new allegations are not related to any specific promises which can't be kept, but are rather just general performance issues. Cash value adjustments also seem to be some of the most preferred remedies by class members, since they're so easy to understand, as opposed to a permanent vanish or a rescind. Because many of the inappropriate DAC tax product adjustments involved COI increases, the logical remedy is to reverse the inappropriate increases. Some companies are, however, offering these reduced COI charges as a general policy relief, since there is no evidence required from the class member to prove that this applies to them. If they have a certain product, it does apply, and the policy contract sometimes states that the COIs can only be changed based on your expected future mortality, so companies don't want to push their luck by putting these through the ADR. They feel that they're definitely wrong, so let's just offer it to everybody. Very similar to cash value adjustments, some companies offer to basically reimburse the excess commission that was charged to the policyholder. Although some companies may pay this out directly to the policyholder, most companies just pay it into the contract, and therefore it's a lot like the cash value adjustment.

The settlements themselves are also changing. There's been a change in the type of general policy relief offered, from remedies that require policyholder action, such as electing a remedy and maybe purchasing a new policy, to remedies that are automatically provided to the class members. Some examples of these new remedies could be free term insurance for three years or five years, or free accidental death benefit protection. Companies are moving to settlements that are easier to administer and are less costly. A couple ways of doing this are, you can reduce from two mailings to only one mailing, which would require the policyholder to decide if they still want to be in the class, and, as well, determine what it would want to do, general policy relief or ADR. Some companies are even considering eliminating the whole ADR process altogether, and are instead creating sub-classes and designing specific remedies for each sub-class, in the hope that, maybe they'll pay out more as benefits, but they'll have lower costs for the administration.

Customer value calculations are now more realistic and closer to the actual costs incurred by the company. Companies are no longer using excessive take-up rates on remedies such as an enhanced value policy, and are instead trying to determine the actual number of people that will truly elect this remedy. What used to happen is the experts would say, "Let's assume everybody will purchase one of these enhanced value policies. The cost to the company was zero, and the value created might be equal to 100% of the first-year premium." But it turns out that it's closer to 2% of the people are buying an enhanced value policy, even if they had chosen that as their remedy. They just choose it but they never want to do it. Sort of understandable, if you're mad at your company because they did something wrong. I think the last thing you want to do is go buy another policy from them. Plaintiffs' counsel fees are now related to customer value calculations. What's happening is a pretty good change, it makes you feel good and gives you hope that our judicial system is pretty good. Certain judges which were skeptical of the inflated customer value calculations have started tying the plaintiffs' counsel fees to the actual customer value created, and in these situations, the plaintiffs' counsel gets a portion of their fees up front, and they get the rest of it after the settlement is all done. So, it might take a couple years, and it's based on the actual customer value created, which is calculated throughout the process.

Where Are We Heading?

As we speak, plaintiffs' lawyers are now pushing companies even further. They're becoming more demanding. Every time a company pays more than what other companies have been paying in past settlements, the lawyers reset the bar and they use this as their new starting point. So as they're becoming more demanding, it seems that the average cost per policy seems to be going up as well. They are

demanding more guarantees, since their legal fees are sometimes directly attached to the customer value created, and they can be in two forms: (1) they'll guarantee an average cost per policy to an average cost per ADR policy, or (2) they'll actually want guarantees as far as what percentage of the people going through ADR will get a certain score, like maybe the highest score. They're looking for automatic remedy qualification, which is sort of what we talked about earlier on general policy relief, offering the free term insurance. And there's really two reasons for that. If everybody gets free term insurance, you're assured of at least a minimum level of customer value created, and it also eliminates the problem of people who never responded to one of your mailings, and who never got any benefit, coming back later and saying, I was automatically included in this class by not responding, but I never got the mailings or, it's not fair. So offering something, even if it's very little, to everybody is actually a pretty good idea. Since most of the big companies have already been hit or are currently in the process of settling, lawyers are now coming after some of the smaller life companies. And not surprisingly, smaller companies appear more likely to fight a class action than to automatically settle. The Mutual of New York case, where the class action was rejected by the courts, seems to give companies even more reasons to fight a class action.

Lawyers are now targeting health companies with regards to claims handling issues such as the denial of AIDS claims, or denial of claims because of preexisting conditions. Also, not many of the lawsuits settled today included annuities. This is however, changing, because Mel Weiss, who is probably the most well-known plaintiffs' lawyer, has now stated that once he's done with these life insurance products, he is going to go back to the exact same companies and say, Now let's look at your annuities, there have to be some issues there.

What do companies do in the future to insure that we do not get into this situation again? Companies need to develop and enhance tools to assist the sales force in identifying customer needs, and insuring that customers are sold products which best address their needs. One very simple thing that companies can do, and it might even be the most important one, is you've got to improve point of sale and post-sale communications with the policyowners to avoid the kind of surprises that created all these lawsuits in the first place. If a company knows that it has a certain amount of exposure to some of these claims, it might be a good idea to develop a company-sponsored remediation plan to address the issues before all the lawyers get involved. Most of the time, if you go to your policyholders and say, because of things that were outside of our control, we feel that you've been shortchanged and we'd like to give you something, they'll be pretty happy about that. And at the same time, as part of this remediation program, you get them to sign a release that waives their right for future litigation. Increased sales force supervision and

monitoring would allow a company to detect inappropriate sales force behavior, and take the appropriate action. And last but not least, becoming IMSA certified is also a very good idea, since this forces the company to make sure that they are keeping an eye on the situation. IMSA will be covered later on by Rob.

Mr. Bruce F. Deal: As Mark said in the introduction, I have a slightly different perspective, although I think very complimentary to the presentation that was just done. I'm an economist, not an actuary. I work for a consulting firm, and about 70% of what we do is litigation consulting. Lately, a pretty good chunk of that has been life insurance litigation, but we work with a lot of industries in a lot of different contexts, so have a slightly different perspective on these than people that are focused strictly on the life insurance industry. There are three things that I want to talk about complimentary to what Marc was just talking about. I'll talk a little bit about what some of the causes are of the current life insurance sales practices litigation. The second thing I want to discuss a bit is how companies think about estimating the potential ADR take rate. Again, this is where the real cost to the company is, at least in the kind of current state of the art on these settlements. Before companies settle, they want to try and get a sense of whether they are settling for a bread box or a bus. You need to have some sense of what that take rate is going to be, and what those scores are going to be, before you make that decision. And we've been involved in this process in a number of these settlements, so we'll talk a bit about how that's done. And then some lessons for the future, again, some of them sort of emphasizing points that have been made, and some newer points.

In terms of what caused the problems, there are many reasons, and we don't have time to go into all of them. But I want to highlight three major categories. The first cause is the macroeconomic factors, that really are beyond the company's control. You're not Allan Greenspan out there, you don't set interest rates, you didn't cause these macroeconomic problems. But there are some slight subtleties that are getting companies in trouble. I want to talk about that. Then there are a number of factors that are within companies' control, that were within companies' control, and we'll talk about some of those. Finally, I'll discuss some individual agent sales techniques out there as well.

In terms of the macroeconomic factors, I don't want to spend too much time focusing on the specifics, but essentially I've mapped out a few of the key rates and things that have driven a lot of these problems. In Chart 1, you can see that the line that ultimately ends up being the lowest is the inflation rate, the CPI rate. The scale goes from 1979 through 1995. As you may remember, back in the late 1970s and early 1980s, inflation was running at 10%, 11%, 12%, then plummeted by about

1983, 1984, down to 3% or 4%, and it's kind of bounced around since then. Ultimately, there's a fairly strong relationship between the inflation rate and interest rates.

What I've plotted on the top left line that then moves down, the ten-year U.S. Government bond, is a representative type of a bond, although most insurance companies don't necessarily hold government bonds. You can see, again, when inflation was very high in the late 1970s and early 1980s, interest rates on those ten-year U.S. Government bonds were 12, 13, 14, as high as 15%, in 1982. Then you can see, they sort of bounced around. By about 1985–86, they were back down to around 7% or 8%, kind of bounced around from there, and currently are somewhere around the 6% range. Well, of course, what actually happened, in terms of insurance companies' investments, is essentially you have this trailing average of bonds, you're sort of buying new bonds every year, and bonds are maturing and rolling out of the portfolio. So, effectively, you've got this average of the previous seven years here to illustrate it. But what you can see is, interest rates were extraordinarily high in the late 1970s, early 1980s. As interest rates are higher than what was sort of in the portfolio at that time and what was rolling out, the average of the portfolio was steadily increasing, to the point where it peaking in roughly 1985, 1986. At that point, of course, current interest rates were well below that average, so of course the average is being driven down over time. Then the stair-step line is a hypothetical dividend rate or interest crediting rate that would mirror what was happening to the overall portfolio of the company, so that it's increasing during the early 1980s. There it's stepping up, to 1984, 1985, you have very high dividend rates, in some cases, historically high dividend rates. That's sustained for some amount of time, but of course, ultimately, as the portfolio is not earning rates to sustain that, it's having to come down again.

Now, again, the overall drop in interest rates and the change in interest rates is not driven by the insurance company. It's arguably not even completely driven by Allan Greenspan, but it's sort of a macroeconomic factor. But what's happening in terms of the sales practices litigation, is the allegation is not so much that you have control over those interest rates, but that you should have known that you couldn't sustain those dividends. You should have known that you can't sustain those type of interest crediting rates, especially in the sort of 1985, 1986, 1987, 1988 time period. You knew that what was rolling out of your portfolio had significantly higher earnings rates than what was rolling into it, that it was virtually inevitable that you were going to have to decrease dividends and interest rates. That's the sort of crux of the issue, is how predictable was that. Interest rates in general are not very predictable. It's hard to know for sure what ten-year bonds are going to be three years from now. But in these circumstances, there was some amount of information

that the insurance company should have known, so when they were allowing current interest rates and current dividend rates to be illustrated, in the mid-1980s, late 1980s, when current rates were significantly lower than that, arguably it was virtually inevitable that those were not going to be sustainable. So that's the crux of the issue in terms of the economic factors that are beyond the company's control.

As to factors within company's control, as Marc mentioned, this was a time of fairly significant innovation in the life insurance industry. Many new products were introduced, Universal Life, some of the second-to-die estate planning kind of products. Variable Life was being introduced widely. Economists think choice is great, competition is wonderful, more choices are always better, which I think is generally true, but unfortunately, in the sales practices story here, many of these new products were much more sensitive than older products to some of the limited payment type programs that were being used to sell them, the vanishing premium, the limited payment on the Universal Life. So these new products were just much more sensitive than some of the old products out there. In addition, the introduction of computerized custom illustration systems, especially the PC-based systems, meant agents could generate these wonderful custom illustrations, which, again, are terrific in the sense of showing what might happen, but also generate what looks like a very precise, almost contract-like scenario for a policyholder. So a policyholder understands that if they pay exactly this amount for this period of time, this is the kind of value that they'll have out there. So you've got these sensitive products being illustrated on these customized systems, creating, at least in the policyholder's mind, argued by the plaintiffs, anyway, this perception of sort of certainty out there. Again, to emphasize a point made in the last presentation, there's very limited communication from the companies to the policyholders regarding dividends and interest rates. So, policyholders weren't necessarily notified along the way that dividends either are likely to change, or have changed, and that may have an impact on your policy in terms of how much you're going to have to pay out of pocket, or the type of program you had. Many of these policyholders, as Marc mentioned don't figure out that they've got a problem until they get to the end of what they thought was going to be their vanishing premium period. I thought I was paying for seven years, only to find out, sorry, you don't pay for seven years, now you pay for 15 years, or 20 years. So there's just not a lot of communication there. Now, part of the reason is that there's just very limited tracking of payment methods out there. The home office, in general, administers every policy the same, even the Universal Life policies, so they don't often really know how many policyholders intended to do some type of a limited payment scheme, or how many of them are using an old policy to fund a new policy. There's a lack of information out there, so arguably, even if they wanted to notify them, they just didn't have the systems to be able to do that.

Having worked on five or six of these cases now, the plaintiff's allegation is almost always, not so much that there were a couple of bad agents out there, but this was a centrally-planned conspiracy that actuaries at the home office knew that this was going to be about deceptive sales practices. I have not seen that sort of home office conspiracy out there. These problems happened, but I call it, life insurance companies accidental defendants. They just didn't see it coming, maybe should have seen it more than they did, and then there are a few agents out there that lend some credibility to these allegations. In terms of the specifics on the individual agents, my experience, working on these projects and going through complaint files and agent statements and so forth, is agents really had a very limited understanding of the product sensitivity themselves, to dividends and interest rates, so they really didn't understand what was going to happen to these products if dividends changed or if interest rates changed. They may have had some sense that it was going to have an impact. They didn't understand the magnitude of that impact, or exactly how that would affect a policyholder.

The second point, related to the macroeconomic one, just a real limited understanding of the dividend interest rate sustainability. I put it in quotes, "We've never cut dividends in our 100 year history." You can substitute your history, the number of years you've been in business, but you certainly have agents that were out there creating the perception, if not the reality for your company, that in fact, dividends were basically only going one way, and that was up, during this time. So they didn't really understand the sort of macroeconomic graph that we looked at before, that in fact, you couldn't sustain those kind of dividends, given what was happening to interest rates.

Related to that is this lag between the original sale and future problems, that the way commissions are structured for agents, typically, there's so much incentive to make that sale, given the front-loading nature of the commission, that even if you knew that there was potential for some of these problems, they typically don't show up for four or five years, in some cases, more than that, 10, 11, 12 years. If an agent didn't have the real long-term picture, if they didn't think that they were going to be around selling insurance for that same agency, and in the community, this was going to be someone else's problem. Unfortunately, it is someone else's problem, it's mostly your problem, and it becomes our problem when we get involved in these, too. So that lag creates some problems. There certainly were the occasional, but again, rare, purposeful misrepresentations. You all know that there are some bad agents out there. Unfortunately, sometimes they're on the list of the, top-selling agents in the company as well, or at least historically were on that list.

From my perspective as an economist and someone somewhat outside of the industry getting involved in it, one of the tasks that we get asked to help with is estimating these potential ADR take rates. Remember, there are really two take rates that are relevant here. One is the general policy relief take rate: Who's going to buy these enhanced products? That has relatively little cost to the company. The trend is towards a more realistic rate, but frankly, companies haven't really cared that much about that rate, other than, if it's higher, it may look better, at least in the past, it may look better to show how we're creating hundreds of millions of dollars of value. But it doesn't have a tremendous effect on the cost to the company, whether 1% takes it or whether 80% take it.

ADR, on the other hand, has a very direct effect on the cost to the company. So companies are typically very interested in trying to figure out what that take rate is. Let me, again, put a caveat here. This is not precise science, there is no magic methodology here. But there are some things that one can do, and I'm going to talk a little bit about some of the internal and external data that can help inform us about the take rate. Even if you haven't been sued, and don't have to do this yourself, these may be useful things that you can think about in terms of figuring out your own exposure.

There are really three main components to the ADR take rate that have to be estimated. The first one is the overall take rate. You issued x number of policies. What percentage of those policies are going to come back through ADR? Is it 1%, is it 2%, is it 5%, is it 10%? And the range is fairly broad, at this point. You at least see estimates up front, and many of these are in process, so we don't have a lot of real final numbers at this point, but some of them are 1% or even lower, up to 7%, 8%, 9%, 10%. Some of these numbers have at least potential ADR claimants. Now, what it will actually turn out to be remains to be seen, but you want to get that overall estimate.

Then you've got to think about how they're going to break down by claim. So, overall, 2% of the people, we think, are going to come through. But how many are going to come through and want a vanishing premium type solution? How many have a replacement type problem? How many say, "I bought insurance and I thought it was an IRA," or something like that? The costs vary for those different allegations, so you've got to have some sense of which are going to be the big categories that people fall into. Then you think, within each of those categories, what's the scoring distribution going to look like? The way this works, you fill out your form, send it in, and it gets scored. An independent scoring body says, what you've got here is a vanishing premium claim. They assign a score, anywhere from one to three or one to four, the scales differ depending on a settlement, but basically

the more evidence you've got, the higher your score, and the higher the relief cost. At the lower scores, depending on the policy size, cost may be a few hundred dollars to low thousands of dollars, to the company. At some of the highest scoring levels, and for a bigger policy, it can start adding up to real money, per policy, thousands of dollars, in some cases, even tens of thousands or more. So you really want to get some sense of what those scores are likely to be.

Let me just review, fairly quickly, and again, I want to emphasize, this is not precise science here, but there are at least some things that can help inform you as to what that take rate is likely to be. I've categorized these as both some internal data sources and some external data sources. In my experience, the complaint logs or databases, are probably your single best source of information out there. These are the people who have said, I've got a problem out here, you should do something about that. Arguably, these are the people who are most similar to the people that are going to come through an ADR process, so you want to really mine that data, understand what your complaint rate has been. Understand, people are complaining about products, when were those products sold, what kind of complaints are being received. Sometimes that involves a more detailed analysis of the complaint files. It's not often the case that companies, when they set up their complaint system, even five, six, seven years ago, said, "We're going to be sued, I know it. We've got to collect the following pieces of information to really understand what our ADR take rate is going to be." That just didn't happen. So not surprisingly, the databases are not perfectly set up. What we've done in some cases, is actually going back through, either a sample or, in some cases, a more comprehensive analysis of these complaint files, and really mined that data for the type of allegation, the type of evidence that the policyholder has, the type of solution that was provided by the company, a number of different factors.

This is also a useful source, particularly when combined with the complaint information. So once you realize people are complaining about these kinds of problems, going back to the policyholder database and asking, "How many of those kind of people are there? And when did they buy these products?" is a very useful thing. Of course, the big problem is, it's often what's not in the policyholder database that you really want to know. So particularly on some of these sort of rollover allegations, you don't have a field, I would venture to guess, in your policyholder database, that reads, "This policy was bought, and is being paid for, by an old policy, and the guy doesn't really understand that very well." My guess is you don't have a field like that. Some of you may have a field that reads, "This person bought this on a vanishing-premium basis. We know that." Unfortunately, my experience is that those are often incomplete, so there may be people out there that are doing everything they need to do, and look just like the people that bought

on the vanishing premium, they may think they bought a vanishing premium policy, but you have no idea at the home office, you don't know that they bought like that. When it fails for them, just like it fails for someone that you've got in your database, they're going to have the same problem, they're going to come back to you in the same way. So, the policyholder database by itself is often not sufficient for really getting a handle on what the exposure is here.

The sales materials and illustrations all really hinge on what was said to the policyholder at what time, and what the policyholder saw, in terms of written documentation. You want to have a good handle on what your illustrations looked like over time, what type of disclosures were in there, in what years do you have the serious problem, in terms of disclosures. Merge that with the data on complaints, in the policyholder database, to figure out, if we've got a real problem with these, these illustrations had very bad disclosures during these years, how many policies were sold, how many complaints are we receiving. Understanding that is key. If you have any experience from past mailings, and particularly I'm thinking of regulatory-type mailings, "You may have had experiences where insurance departments said, you've got a real replacement problem in x state, or y state, you need to do some type of a mailing, notify these policyholders, see if they want to come back." You may have some experience from that as to what those notification take rates are, that can be very useful information.

In terms of external data that you want to marry with this internal data, obviously, as I said, the take rates from other settlements provide a pretty good benchmark. Unfortunately, there are not very many final take rates out there. But nonetheless, getting some sense of, how do we stack up compared to Company X or Company Y, given what their take rate was, is a very useful thing to at least try to do. It'll give you some ballpark range. Then you want to look more closely at your settlement, and look at the particular provisions of your settlement. Is yours going to be seen to be more generous? If it's more generous, arguably, more people are likely to come through. If it's harder to get certain types of relief, or particularly if it's harder to get certain types of scores, it may be that you end up with a somewhat higher take rate, but a lower scoring breakdown, so the final cost may be less to you. Understanding those provisions and how they compare is critical. Marc made a reference here to understand what the lawyers' incentives are, too. It may be a very good thing for the American judicial system, for the lawyers' fees to be somehow tied to what value is being created. What it often means in practice, for companies, is that these plaintiffs' lawyers will have a real incentive to make sure that ADR take rates higher. So, before, it might have been a 1% take rate, but you can bet that if $20, $30, $40 million of these plaintiffs' lawyers' money is on the table if they don't get a take rate over x%, you're going to get a take rate over x%. They're going to be out there sort

of beating the bushes, trying to get that take rate higher. It's a big wild card factor, there's no precise way of figuring it out. And in fact, oftentimes, it's not even part of the original settlement, it's imposed by the judge when he approves it, but understanding what that implication is, is critical.

Let's move quickly into some of the lessons for the future. What can be learned from this? I've subtitled this, "How to Avoid Making the Plaintiffs' Lawyers Rich." There are four things I want to talk about: product design (which is directly applicable to many of you here, who are product design actuaries), some illustrations materials, customer disclosures, and the use of some internal data. I'll move quickly so that we have plenty of time for the IMSA presentation as well. In terms of product design, there are a few general lessons here that I think would be useful, and many of these are things that you've already thought of as well. But the first point is making products robust under various dividend interest-rate scenarios. You can't predict future interest rates, but you can predict that they're going to be different than they are now. You want to be careful to make sure that the products are fairly robust under a variety of different scenarios. And be careful about new money-rate products. Some of the products that were being introduced during this time gained their particular advantage from the fact that you re-started portfolios at different points in time. Those kinds of timing differences are very transitory in nature and can come back to bite you on the other end. Not to say that it shouldn't be done ever, but just to be careful about trying to play differences in current portfolio earnings versus what you might be able to get on some historical basis.

Knowing the product's weaknesses is probably even more important than making the product robust under various dividend interest-rate scenarios. Some of these new products are terrific, give people a lot of flexibility, but are extraordinarily sensitive to changes. That doesn't mean you shouldn't necessarily introduce them, but figuring out what the plaintiffs' lawyers will see as their meal ticket ten years from now is critical, to know those weaknesses. The third bullet is making sure that the sales, marketing, and disclosure materials address those product weaknesses. Making sure that those materials are in place to address those known product weaknesses is critical. Then finally, making sure that you've got the administrative systems in place prior to introducing new products is also very important. I'm sure this is a fight that many of you have had with your Information Services (IS) people and other folks, but understanding what people bought, the kind of policy and the kind of payment pattern that they think they've got up front is very critical.

In terms of the sales illustrations and disclosures out there, I know there are whole sessions on this, so I don't want to go into too much detail. Illustrations should be simple, clear, and complete. Showing the performance under various scenarios is

also critical, and these are issues that are being addressed, like being very careful about allowing above-current-rate scenarios. This is a lot of what's gotten companies in trouble now, especially during that period I was showing earlier where, arguably, we knew that dividend interest rates were coming down. Some companies still allowed agents to show above-current-rate scenarios out there. You can imagine, that doesn't look very good right now, in the litigation context, and that's something plaintiffs' lawyers are using to beat insurance companies over the head.

Related to that is, these boiler-plate disclosures aren't sufficient. Almost every illustration that I've seen has said something to the effect of, dividends are not guaranteed, interest rates are not guaranteed. That buys you pretty close to zero with the plaintiffs' lawyers. It's not to say that you don't need to have those in there, but it's just to say that it's just not sufficient out there, to avoid these kinds of problems. And particularly, the types of disclosures that would help prevent you from being in this circumstance today are disclosures that emphasize the impact on the out-of-pocket costs. So not only do you say, dividends aren't guaranteed, but you say, if you bought this on a vanishing-premium basis, and dividends change, you probably will have to pay more premiums, or you will have to pay less premiums if interest rates change the other way. That connection between what happens to dividends and interest rates and how much the policyholder is actually going to have to pay, that's the critical link that's often not made in illustrations, and that's what plaintiffs' lawyers are really focusing on. Similarly, the Universal Life illustrations, often show, under current interest rates, you'll have $1 million in cash value when you're 65, but, by the way, under the guarantees, the policy will be dead in 15 years. That's helpful, but in fact, what's really happening to people is they run out of cash value and they're starting to get these sort of term bills saying, you're out of cash value, but don't worry, you can keep it in force as long as you pay us $12,000 a year in insurance charges. That doesn't play very well either, in these scenarios. So that emphasis on the out-of-pocket costs is important.

Don't make it easy for agents to minimize disclosure, related to the, "If there's a way, agents will find a way of doing it." So, separating out pages, blanking off disclosures, you can't prevent an agent from altering an illustration in any conceivable way, but don't make it easy for them to do that. Simple things like numbering pages "x of x," those kinds of things, so that it's obvious when something's missing, is good. Also send out ongoing updates with disclosures on them. The ultimate form of that is sending in-force illustrations every year. That's probably not practical, but something that notifies people that, they might be off track, or that the interest rate or the dividend rate is different than when you bought it, would be a very useful thing.

Let's discuss the use of internal data. One of the things to remember is capture more detailed payment plan information up front. Many of these products have an infinite number of ways of paying for them and payment patterns, but at least capturing a little bit more basic information like that would be extraordinarily useful. A second point is to use the complaint-handling process as a business tool. There is a tremendous amount of information in complaints about problem agents, problem policy types or problem payment methodologies. Things like that, are often separated from the ongoing development of new products, and the ongoing monitoring of agents. Linking that much more closely, I think, would go a long way towards helping companies identify problems early on and avoid making the plaintiffs' lawyers rich.

Related to the payment plan point is tracking blocks of policies and payment plans, not necessarily tracking every single policy every single year, but at least understanding that people who bought vanishing premium policies in 1983 are likely this far off, or that far off, or people that put money into a Universal Life back in 1985, thinking it was enough, are they off a little bit or a lot? Some basic information like that would be extraordinarily useful, just to give you a sense of where the real problems are. So, taking some sample policies, running them through some sample payment schemes, and understanding where they are today, versus what the person may have thought they were buying at the time, would be extraordinarily useful. Also, all this monitoring data can be used to intervene early. There are statutes of limitations issues on these things, and if you notify someone early on that there may be a problem, if they don't do anything about it for several years, at least you've put them on notice. That can buy you a lot, in either individual lawsuits or class-action settlements, that you did your best, you did your part to notify the policyholder that things aren't exactly the same as when they bought the policy, and they may need to do something differently.

Finally, the complaint-handling process itself. What are you doing for policyholders that are complaining today? I think these basically mirror some of the points that were made before, that trying to essentially mimic an DR-type process is a useful starting place, establishing some fairly straightforward guidelines for providing relief. Many of you have these kind of guidelines, but it may be worth looking at them one more time. So, different kinds of evidence get you different scores, get you different kinds of relief. There's a little less room for the mood of the person that's handling the complaint to make a difference in what that person gets. In general, be generous with policyholders. I think this is an important lesson that I've seen: Regulators and plaintiffs' lawyers love to find examples of people that have had legitimate complaints and have been ignored. That does not play well. That's typically money that's very poorly spent, saving a buck on the complaint-handling

process will cost you many, many times that in these lawsuits. Again, using the complaints as an opportunity to learn, keeping the complaint tracking database simple and complete.

Keep track of which policy is being complained about, which agent is being complained about. What's the nature of the complaint, does it mirror any of these things that are in these sales practices litigations? Understanding some of that information can be very useful later on, both to track ongoing problems, and if you do get sued, understanding what your exposure is. Finally, let's discuss communication and cooperation with regulators to resolve problems, related to the generosity issue. My experience is, trying to fight the regulators and tell them that they're wrong, has cost companies dearly in class-action lawsuits. So with that, let me turn it over to Robert, and he'll talk a little about the IMSA certification.

Mr. Robert Schwab: Well, now that we've identified what's gone wrong, we can all jump to IMSA and we can all be satisfied that if you're IMSA members everything's right now, and you'll never have any more difficulty again. I don't think that's the case. And if you've been through an IMSA certification, you probably don't think that's the case either. One of the things that you'll figure out real quickly about what I'm going to speak about is that it may very well be the most subjective thing you're going to hear during your 2–3 days here. Some of what was spoken about today seems a little bit objective when we talk about numbers. But my experience with IMSA is that it is amazingly subjective. Because of the subjectivity, you're going to have to listen to a lot of my opinions, and what I think about it. But I think that any time that you listen to anybody speak about IMSA, that's what you're going to be faced with.

While there's little doubt that IMSA has come about in response to the market conduct concerns, no one really knows whether it's going to do any good or not. We can become IMSA members, but we really don't know what kind of impact it's going to have on the market conduct lawsuits that have flooded the industry recently. I think it's probably a safe guess that there are representatives here that are from IMSA member companies, representatives here from companies that are considering IMSA, and representatives here from companies that have no interest at all at this time. More companies are becoming interested in it. I think a year or so ago, there were a lot more companies standing on the sideline. Once IMSA membership became available April 1, 1988 and companies could advertise, and the numbers were advertised as to the amount of companies that had, in fact, gone through the assessment, there seems to be a lot more interest now, among those companies that were otherwise sitting on the side. I'll try to go through and give a quick overview of what the assessment is, how companies go about it, what they

need to do, and then talk a little bit about the future, and what will probably happen with IMSA.

Several years ago, the ACLI formed an executive committee of CEOs that decided, in response to the market conduct difficulties, what kinds of things needed to be done. Out of that grew the IMSA concept. IMSA is a voluntary organization open to every life insurance company that completes the membership assessments. Companies that want to become IMSA members are required to adopt and demonstrate compliance with the IMSA principles and code as part of the life insurance ethical market conduct program. Beginning April 1, 1998, companies could officially begin to advertise IMSA membership. They had actually been accepting membership applications for about a year before April 1, 1998. As of April 1, there were 155 companies. That represents 64% of the new life insurance business sold, 50% of the annuity business, and 54% of the new life insurance and annuity. The numbers probably surpassed anything that anybody thought would occur this soon. When you talked to Bob Goggin, Executive Director, and went through the training sessions, IMSA didn't expect quite as many companies. There was certainly a snowball effect after the beginning of the year, when several of the larger carriers who had initially said they weren't going to become members changed their mind, and for whatever reason, decided to go forward.

As I mentioned earlier, in order to become an IMSA member, a company must adopt and comply with the IMSA principles and code. The principles of ethical conduct, developed by IMSA, are as follows, and I can almost picture Bob Goggin, standing up at the training session saying these things. Each life insurance company subscribing to these principles commits itself, in all matters affecting the sale of individually sold life and annuity products:

1. Conduct business according to high standards of honesty and fairness, and render that service to its customers which, in the same circumstances, it would apply or demand of itself.
2. Provide competent and customer-focused sales and service.
3. Engage in active and fair competition.
4. Provide advertising and sales materials that are clear as to purpose, and honest and fair as to content.
5. Provide for fair and expeditious handling of customer complaints and disputes.
6. Maintain a system of supervision and review that is reasonably designed to achieve compliance with these principles of ethical market conduct.

Sounds kind of simple. We just do the right thing, we treat each other, we treat our customers as we would like to be treated, and maybe all of the bad things that have occurred in history go away.

In order to demonstrate that a company has adopted, and lives by, this ethical code, it must go through a two-step assessment, the self assessment and the independent assessment. The assessment requires that the company answer "yes" 162 times, and that an independent assessor must agree with all 162 "yes" answers. The IMSA questionnaire has 27 questions. Each question has three aspects, and each aspect has two components. And by my calculation, that's 162, and that's the only calculation I'll do today, and probably as detailed as I want to get with numbers. For each question, there is an approach aspect; in other words, has the company developed a way to comply with the question? Under the approach aspect, a company must demonstrate that there are policies and procedures in place to answer the question, and that the responsibility for communicating the policies and procedures has been communicated. For the deployment aspect, the company must demonstrate that the policies and procedures have been communicated, and that they are consistently used. Finally, the company must show the policies and procedures are routinely monitored, and that the insurer acts upon the information received. All 27 questions have to be answered "yes." There are no exceptions. Once the company has satisfied itself, through self-assessment, that all of the questions can be answered "yes," an independent assessor must verify the results with a separate assessment.

Each of the 27 questions are applicable in some way to the marketing and sale of a life insurance or annuity product. There aren't very many questions that are explicitly aimed at actuaries, and in my experience with the several assessments we've done, I would guess that, depending on the company, the actuaries directly participate in maybe four or five of the questions. It depends on how your company's set up and who you supervise. As an example, let's run through question 4.4 quickly. Question 4.4 asks whether a company has policies and procedures that provide a reasonable assurance that sales illustrations are accurate and complete and appropriately disclose guaranteed or nonguaranteed elements. So once you've read the question, you then go into the IMSA indicators, and there are seven indicators for each of the questions. IMSA would very much like for each company, when they answer each question, to use the indicators that they've listed. They went through great pains to make these indicators as broad as they could, and you have the ability to use an alternative indicator. If you use an alternative indicator more than three times, then all of your alternative indicators must be sent to the Executive Committee of IMSA, and they need to pass on whether or not they're valid. In the three assessments that we've done that were complete, we

used one alternative indicator in one of the assessments. In most cases, you can fit whatever you do into the indicators that are given. What IMSA would like for you to show is that your company has policies and procedures to insure that your sales illustrations are accurate. And again, in deployment, you can see that the indicators are just as broad. You can choose from among them. So we go to the monitoring indicators that you can choose. Again, you've got the choice of using these or going to an alternative one. You need to repeat this for each of the 27 questions. It takes a long time to get through the questionnaire. When you think about the time that it might take, just to do the sales illustration and to develop the documentation for your answers, and then you think about doing it 27 times, it's quite an exercise.

One of the things that IMSA did not attempt to do was create a process that everybody needs to follow. They set up guidelines, and you can go to training sessions, but no one sat down and said, here are the ten steps that each company needs to do in order to become accredited as an IMSA company. So each company, depending on its size, its distribution channels, needs to develop what it wants to do with the self-assessment. Now, IMSA has a handbook, and you can go to the training sessions, and you should. But as far as the self-assessment goes, companies go about it in various ways. Some have full-time staff that works on IMSA now, and conceivably will work on IMSA for years and years to come. Some people have a committee made up of members from Claims Administration and Actuarial, Legal, that come together and answer the questions during the self-assessment. One of the things that changed midway through the development stage of IMSA was that companies are allowed, and almost encouraged, to hire an independent assessor, during the self-assessment, in order to help them get through the self-assessment. When the ACLI held meetings two years ago, among those of us interested in becoming independent assessors, they envisioned a complete distinction between the self- and independent assessment. The assumption was that the self-assessment would be done, and then at some time, you would bring your independent assessor in to check the work. That changed, and frankly, it changed late. The decision was made that companies shouldn't have to invest all that time, resources, and money into going through their self-assessment without knowing, at least to some extent, what lay ahead in the independent assessment. So in almost every case, companies hire an independent assessor early in order to get their input, in order to ask questions as they go through the self-assessment. So in theory, at least, the independent assessment can go fairly quickly.

Among the most important decisions that your companies seeking IMSA membership or that already have IMSA membership, or need to do during the three-year time span where your IMSA membership is good, is try to decide who to hire as an independent assessor, IMSA has been a godsend to consultants. Companies

are required to spend thousands and thousands of dollars to hire us. They don't have any choice. And there are a lot of different entities, and a cottage industry has sprung up. There are auditing firms, (like Coopers & Lybrands, and Deloitte & Touche); law firms, actuarial firms like Milliman & Robertson, and other consulting firms that were doing compliance work beforehand. Some of them came from a quality consulting, and maybe decided to segue into this. But I think that those are the four major categories of the consultants out there you need to seek to hire.

Each potential assessor, and myself included, will be more than happy to explain to you why we are much more qualified than the others to do the work. And we constantly run up against that, and I'm certain that everyone has their own reasons for why they should be the one that you hire. But I think when you hire an independent assessor, there are three aspects that you should consider, and those are: knowledge of your business, the ability to perform the assessment, and the cost. Now, we all know that cost is going to play a major part. And these assessments are not inexpensive. And ranges go anywhere, I'll start at a low end that I know of, of $20,000, and they certainly go above $100,000. So what you get for that, and who you want to hire and the comfort level that you need to achieve with them are very serious considerations when you're doing this. But if I was hiring an assessor, I would want to make certain that he or she or they understood my company, how it works, who my customers are, and what I sell. I think if you need to educate your independent assessor on those things, you're using that time in an inefficient way, and people coming in the door ought to understand at least that about what you do.

What do you get for your money? I have no idea. You get to advertise IMSA membership for three years, we all know that, and then after three years you need to go through that again. Do you lessen the possibility of lawsuits as a result of market conduct activity? There are those that argue that maybe you increase them. There are those that argue that you uncover things through these assessments that you might not have uncovered, and maybe don't want to uncover. What I hope that companies get out of it, though, is that they look at their activities, that they look at how they sell life and annuities, and they learn and adjust things. They use this opportunity to do a sincere examination, and I know that's not the case, I know that when a company calls on February 1, and they say, what we need is IMSA membership by April 1, I know that they're going to take a limited amount of information out of this. Now, what I would hope your independent assessor leaves you with, will leave you with, or has left you with, is some insight on what they've learned, what you need to look at, and what you need to do in order to improve the way that you go about selling your business.

IMSA membership lasts for three years. The worst thing you can do is set this thing aside for two-and-a-half years, and six months before that expires, say, you know what, that's right, we've got to do this again. This ought to be an ongoing system where, in three years you're completely as confident today as you were three years ago with your ability to answer yes to all of the questions, you bring in your independent assessor, and they verify that.

One of the things that a lot of people are talking about now is where IMSA goes in the future. Bob Goggin, the Executive Director, has said that the title of the organization and its reference to insurance is not by accident, and that in fact, at some point, this may spread to the health side, to property and casualty. They intentionally used the insurance reference rather than life insurance to leave that possibility open. Another thing is that the initial focus of the 27 questions dealt with the sales of life insurance, and that certainly won't be the case. IMSA is undergoing the process right now of trying to decide whether to include items like Claims and Underwriting and Pricing in what they will do, and certainly, in the next three years, that questionnaire will change, and there will be different questions to answer. I think, in the end, the success of IMSA will depend on the industry's commitment to the association, but most importantly, whether consumers care. And if consumers don't care, or if your field doesn't care whether you're an IMSA member or not, and if it doesn't help you in market conduct exams, then it may be a success, but I don't think that those things will happen, and I think that the number of member companies that we have right now has shown that the association is strong, and it's probably here to stay.

Mr. James D. Atkins: I have a two-part question on Universal Life sales illustrations. The first question would be, What language is sufficient in an illustration so that we don't get sued in the future over the "I did not understand it wasn't guaranteed?" And the second part would be, Will the illustration regulation that's now adopted in about half the states be sufficient?

Mr. Giguere: It's not quite obvious that there's any wording that can just make sure that you won't get sued in the future for Universal Life, because a lot of times, the agent really didn't know the answers, and would just make up something. So I think your wording is something that's going to keep changing, maybe almost monthly, as you keep getting some of these complaints. And as far as the illustration regulation, I don't think that's going to stop anything. I think it's a good idea, but the thing is, even if every company does the same illustration with the same wording, plaintiffs' counsels will still come up and say, "Well, I have Policyholder XYZ here who didn't understand it," and the fact that it's the model regulation won't do anything.

When you're able to say, "I didn't understand it, despite the fact that I signed it, I just signed it because the agent told me to sign it," we have a serious problem.

Mr. Milton: Yes. The counsel we're working with said, that's nice, but it may not be sufficient. I guess my own personal view on that is that a good illustration, and I'm a firm believer in the illustration regulation, we've adopted it in all states, and maybe a quick show of hands, how many other companies have done that, adopted the illustration regulation in all states? About half the room, for the *Record*. So, I think they must believe it helps. But that, in conjunction with a follow up, where you are communicating annually with the policyholders and letting them know something about their funding may help, but I don't know if there are any answers that would really assure one.

Mr. Deal: Let me just make one quick comment on that. My experience has been, again, similar to this, that there is no single way to avoid it, but here a couple of simple suggestions. One is, to make sure that the illustration is complete, and it's fairly obvious when it's incomplete. So again, the page numbering types of things, and on pages where you're showing current rates, to always have the guarantee scenario shown on that same page, so that the agent can't separate it out and just show the current rates. This doesn't guarantee you everything, but it does do something. So, be real careful about illustrations that allow you to separate things out.

Mr. William C. Cutlip: I just want to underscore a couple of the things that Bruce said in terms of what can be done to make things better for the future. I've done some litigation consulting, and I have one example coming out of that, that speaks to a couple of the points that he made, and that was, three months before the policy lapsed, the policyholder got an annual report. One of the illustrations in the annual report was, if you continue to pay the target premium of $*x*, then here's how much cash value you'll have at the end of the next year. Along with that, she got a boilerplate, one-form sheet from the agent that had the checkmark that everything looks fine with your policy and there are no problems. The problem with it was that, first of all, the agent wasn't educated to read the annual report to know what was going on. The second thing was, she hadn't paid the target premium in five years. Nobody had figured that out, from the illustration. So the fact that it was a blanket thing was no help in that situation. And we look at this, when we, as actuaries, hear a presentation like this, if we're not working directly in that area, we may say to ourselves, that is a company responsibility, we don't have any responsibility for it. But I would exhort us to say that there are things that we can do as pricing actuaries, and the most important thing to do is pretend that we're a customer. Go to the other side of the desk. Sometimes we get so involved and so

focused on the technical aspects of the pricing, and the regulatory aspects of the illustrations, that we forget whether they really tell the customer anything or not. So the base question is, can you take the work that you have just done and explain it to your mother in such a way that she will understand it, assuming that your mother is not an actuary? So I think that's an approach that we, as actuaries, can take to not only help our company clients, but also to serve our responsibility and our duties to the public, to help the public understand. And one quick question, if I may, for Robert. Is membership in IMSA limited to ACLI member companies?

Mr. Schwab: No, it's not.

From the Floor: Question relative to IMSA. Do companies that are members of IMSA commonly correlate their complaint log against their answers to these 162 questions?

Mr. Schwab: Yes.

From the Floor: Because it would seem to me, if they don't, you're in big trouble.

Mr. Schwab: They have not, historically, because the questionnaire wasn't around five years ago. But certainly, as we've gone through the assessments, one of the things they've learned is to correlate the complaint log.

Mr. Milton: I might do that. Just another quick survey: How many companies in the room currently provide policyholders with an annual report that has a re-projection each year? About ten people out of a very full room may have raised their hand. I guess, to me, that's a very valuable benefit for a policyholder, if I were to, as Mr. Cutlip suggested, put myself in the policyholder mode, I would want that. I'd want it for my mother, as well.