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Market Conduct: A New Actuarial Frontier

Track: Product Development
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Summary: What impact will the Insurance Marketplace Standards Association and other recent market conduct developments have on:

- *Product development, product features, pricing*
- *Advertising, sales, and marketing materials*
- *Illustrations*
- *Targeted marketing (e.g., older ages)*
- *Agent compensation*
- *Agent training*

Panelists introduce attendees to these concepts and more. Attendees will gain a greater awareness of the impact that market conduct developments pose for their professions.

Mr. Marc-Andre Giguere: During my presentation, I'll cover some of the current market conduct complaints, recent regulatory fines and market conduct settlements, the media reaction and public perception to these settlements, and how they have affected our industry.

Most of today's market conduct complaints have come from misleading sales practices. There shouldn't be any surprises. I'm sure everybody is familiar with these complaints, but the most frequent ones are inappropriate policy replacements, vanishing premiums, life insurance sold as an investment, misleading sales illustrations, and agent fraud. However, not all of the complaints result from sales

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practices; some are due to factors outside of the company's control. You might say that some of these are actually more important than the sales practices, but a lot of the complaints were due to unreasonable policyholder expectations. Anytime you gave customers more than one illustration, they keep the most favorable, then take the other two and throw them out. They think that the most favorable illustration was at least the most likely, if not guaranteed.

General economic factors, such as interest rates and overall mortality, have greatly affected the performance of our products, and that has caused a lot of disgruntled policyholders. Overly complicated products have tainted the industry. A lot of our products are hard enough to explain to an agent; they're nearly impossible for the agent to explain to a customer. If we had better communication with our policyholders, both at the time of sale and during the life of the product, chances are we wouldn't have these problems.

Last but not least, it truly appears that the insurance industry is held up to a standard that is much higher than in any other industry. A good comparison would be car dealerships and airlines. If you go to a car dealership, you can buy the exact same car as your neighbor and your price may be a couple of thousand dollars more. Insurance companies have a hard time differentiating price based on underwriting factors. For the airline industry, how many people here have been stranded in a city because of weather? The airlines say, "We're not responsible for weather," while an insurance company that sells a universal life (UL) product is expected to be held responsible for declining interest rates.

Unfortunately, once companies started getting comfortable with some of the complaints we mentioned earlier, we started seeing new complaints coming in. Some of these new complaints include inappropriate investment advice provided by agents when selling variable products. It could have been just a simple question from the policyholder asking, "Which fund do you think I should put my money in," and the agent would answer, "Our small cap fund has done really well, so why don't you put your money there?" The customers follow the advice of their agent without really thinking about it, and when the fund's performance is under that of larger companies, they come back and complain about the agent.

Illustrated policy loan arbitrage is still an issue. When companies don't have direct recognition dividends, it can cause some serious problems. There are complaints about inconsistent commission structures and inappropriate or misleading policy loan cost information. Somehow policyholders got the impression that the policy loan was one cost, perhaps a 3% charge, but it was actually a lot more than that because their credited rates would go down and they actually had to repay the loans. We've also seen a lot of complaints about unsupportable crediting rate

programs. Plaintiffs' counsels are alleging that companies knew that the credited rates would be going down based on their portfolio, and they just kept illustrating at these higher rates. The difficult thing about these new complaints is that it truly seems that the plaintiffs' counsels are getting smarter in that they're going after allegations that are not as simple or as obvious as some of the early ones, like vanishing premium, replacements, and things like that. They're obviously starting to understand our business, and they're hiring some pretty good actuaries on the consulting side to help them.

As a result of all these problems, we have a large number of dissatisfied policyholders, for many reasons. Usually dissatisfaction involves things like vanishing premium. Customers get a notice saying that if they don't pay a premium their policy will lapse in two years. Or, worse than that, on a UL policy, they might get a notice saying if they don't pay a premium soon, their policy will lapse in 60 days. Because of these unsatisfied customers, we've seen a large increase in the number of complaints received by both insurance companies and regulators.

Over the last few years, scrutiny by the regulators seems to have increased significantly. Not surprisingly, the three states that are most active in the market conduct field are New York, Florida, and Texas. With the increased scrutiny, we've seen record-breaking fines. In 1986, the largest fine that had been levied against a company was $100,000 against Executive Life by the State of New York for inappropriate financial transactions. When that fine came out, it was highly criticized. Insurers thought it was unreasonable to charge $100,000.

Since then we've seen Prudential agree to a $35 million fine recommended by the Multi-State Task Force for market conduct issues. MetLife has paid up to $20 million in fines related to the sale of life insurance policies as investment products in Florida. And there are a lot of other companies like John Hancock, who paid $1 million in fines just for general market conduct issues. I should have mentioned that most fines have been for the normal churning or inappropriate replacements, misleading sales practices, unapproved policy forms, or inappropriate agent compensation.

Perhaps it's good news that many of the regulators don't seem to blame companies for what has happened; they tend to blame specific agents or agencies that have truly abused the process. They make them surrender their licenses and won't let them sell insurance. The regulators really don't seem to think that it is company policy to mislead policyholders. It wasn't that the company came up with this program and trained all its agents on how they could get the better of their customers. There are simply a few rogue agents out there. Some regulators do feel,

however, that management has not paid sufficient attention to market conduct issues, and that they haven't taken complaints very seriously.
If you stop and think about it, what does your company do when an agent has many complaints against him? Do you withhold any of his financial compensation, or does he just stay on and every once in a while you say, "These complaints aren't very good and you should stop doing this?" I think one of the things that has really hurt the industry is when regulators were able to show that some of the agents who were promoted to managers actually had many complaints against them. It appeared that you approved of what they were doing.

A potentially troubling development lately is that some companies are refusing the regulators access to their files. They're afraid some of these documents might become public and at some point be used against them in a lawsuit. This has made for sometimes tense relationships with the regulators. Most of the time things have been worked out, but it will be fun to see what happens if companies keep pushing it.

We'll move on to market conduct class-action lawsuits. Unfortunately, I keep adding new names to the list of companies that have been named in these lawsuits. Since my last presentation in June in Hawaii, I've had to add State Farm Life and even Manufacturer's Life. Most of the major North American life insurance companies are on my list of companies that have been sued, and the plaintiffs now seem to be going after what you might call the second level of insurance companies. It's not companies like Prudential, the Met, and New York Life anymore. They're coming after the smaller life companies like Nationwide, Pacific Life, and National Life of Vermont. It's fair to say that nobody is safe right now; they seem to go in order. They started with the biggest companies, from whom they thought they could get the most money, and keep going down.

Many of the past market conduct settlements have addressed the same complaints that we talked about earlier. Some that are a little different are things like financed life insurance, which is often grouped with internal replacements and deferred acquisition cost (DAC) product adjustments. We still see a lot of litigation around companies increasing their cost of insurance (COI) rates to recapture the DAC tax. Unfortunately, plaintiffs have caught on to this and whenever there's a settlement, they will want to address any DAC tax issues without even knowing if you have any. They figure that by posing the general question, if you do have anything, you'll agree to throw them in there, and that's more of a breach of contract. You can't argue much on a DAC tax case. Companies usually agree that all policyholders who were affected will get a reimbursement for the DAC tax charge.

To date, market product class-action settlements announced have involved both large sums of money and large numbers of policyholders. From the numbers, it's easy to see how market conduct has become so important. Keep in mind that all the numbers are estimates of customer value and do not represent actual cost to the company. I'm sure we all know that the actual cost to the company is sometimes very different from the value created for the customers. Just from these five companies I've discussed, we have over $3 billion of customer value created, and over 20 million policyholders.

Forget about the cost just for a second and look at the number of policyholders. It's easy to see how these settlements can affect, if not completely bog down, a company just because of the sheer volume. We've seen companies hire hundreds of temps to administer these deals because it's hard to find an insurance company that thinks it can administer it themselves. Actually, for many of the smaller companies, the administration charges and fees relating to the settlement are often a very significant percentage of the total settlement package.

From the Floor: The average settlement per policy varies from $50–200, and for one person the settlement amount seems almost pointless.

Mr. Giguere: That's the nature of class-action lawsuits. If you look at class-action lawsuits, it seems that public perception is changing because people are realizing that the only one who benefit from these lawsuits are the plaintiffs' counsels.

Mr. Paul V. Bruce: I have an additional comment. Not only do they vary a lot by company, but, if you looked inside, you'd find they vary a lot within companies. There are people getting zero and there are people getting thousands of dollars, depending on the type of relief and the type of situation; there's an extreme amount of variability there.

Mr. Giguere: I think the $50 is the State Farm settlement, which seemed out of whack compared to all the other settlements that we've seen lately because State Farm Life came out pretty recently. For 4.4 million policies, the amount is very low. I haven't read through the whole complaint for State Farm, so I'm not quite sure what the plaintiffs were alleging. But there has to be something different because there's no way that on a recently negotiated deal, especially against a firm like Milberg Weiss, you would get a $50 per person average. So it might be that the number of policies is somewhat inflated and that most of them aren't eligible for the big remedies.

What can we expect in the months and years to come? Unfortunately, we've noticed that plaintiffs' counsels are targeting smaller companies. They're going after

companies who had 200,000 policies issued during the class action period, and they've actually written letters to the companies who had less than that saying that they are investigating them. Some of the more famous plaintiffs' counsels have also mentioned that they will soon cycle through the industry again and go after companies who offer health and annuity products. If you look at the way a lot of companies have been adjudicating their claims on their health products, it's easy to see how plaintiffs' counsels are thinking that there's going to be a lot of money there.

Unfortunately, people look at the movie *The Rainmaker* and believe it. The concept was that the insurance company was turning down every claim on the first attempt, assuming that most people would just go away. And, unfortunately, movies like that and TV shows put out a very negative image of health insurance companies.

Mel Weiss has also stated that he expects a lot of losses to be generated from the demutualization restructurings that we're seeing. A couple of months ago in *Money* magazine, there was a big article about mutual holding companies. The article said people were not getting their fair share. The good news is that courts are looking at these settlements more closely right now. They're trying to make sure that the fee the plaintiffs' counsel will get is in line with the value that is actually created by the settlement, not the billions of dollars that we used to see for New York Life and Prudential. Because of that, some of the compensation seems to be coming in after the settlement is done, as opposed to right when it's agreed to. Hopefully, as part of that as well, the courts are paying closer attention, because they've realized that there's too much abuse going on and the only people profiting from this are the plaintiffs' counsels.

Media reaction seems to have diminished significantly over the last few months. How many of you saw articles on Pacific Life, Manufacturer's Life, or National Life of Vermont? Some of the articles I saw were not even on the front page of *The Wall Street Journal*, but on page 12 or 13. Some of these companies were pretty happy about that. Media reaction affects public perception; we don't want the public to think there are a lot of problems because we don't think there are a lot of problems.

The articles we have seen lately have had a lot less emphasis on abuse to the policyholders. The first few articles were always talking about how the policyholders were cheated. They'd give the example of an elderly person who had a whole life policy for 25 years, and the agent convinced him to change that into a variable life product. Those are the exceptions, but they were focusing too much on the exceptions. Recent articles have also had a lot less emphasis on the cost to the company. Some of the first articles on New York Life and Prudential gave you

the impression that there was no way the company would be able to pay for the settlement. People were starting to worry that the company would go bankrupt because of the settlement.
Despite the fact that media reaction has diminished, these class-action settlements can still have significant impact on your company. It's very important to look at the financial impact of a settlement on your company, but more important at how it will affect your existing policyholder relationships, your reputation, or the morale of your home office employees and sales force. If any of those go down, then your new sales will go down, and you're going to have a hard time getting over it. It's not thought about a lot, but when you're with these companies who start administering these deals, you realize that a lot of the employees in the sales force are actually embarrassed by the settlement and the news that it's generated. They think about how they are going to explain this to their next-door neighbor or family members who bought some of these policies. "I thought this was a good deal, and it turns out it's not. I'm not looking too smart and I feel bad for all these people." The reaction is usually that most companies truly feel bad for their policyholders.

The articles paint a very negative picture of the industry and unfortunately, our industry is one that is greatly affected by anything that happens in the industry. If any company gets a very bad article, your sales force then has to convince your policyholders, even if you're not at all like XYZ, that that's not the case at our company. It's always painted with a wide brush, and we always seem to think it affects the whole industry, but it really doesn't.

I hope we've learned something from this whole market conduct experience and the increased attention because I don't think anybody believes that this problem will go away any time soon. Some of the things that we have to do a better job with is developing products that meet our customers' needs and are easy to understand. We have to stop the process of developing products and convincing policyholders that this is what they need. Rather, we should be listening to what they want and develop the appropriate products. Policyholders usually don't want very complicated products.

We also need to find a way to improve communication with the policyholders both at the time of sale and during the lifetime of the policy. A lot of the complaints come from the fact that policyholders are surprised to find out their policies aren't performing. "I paid my seven premiums, I was told to only pay seven, and I'm surprised that I have to pay an eighth one." You wonder, if they had been warned ahead of time, would their reaction have been very different, and I think it would. It's usually that they're just surprised and they have to come up with the money now, and they weren't planning on it. Also, we need to keep better customer files.

Most companies can't tell you what illustration a particular policyholder was given. We can't even say if the policy was illustrated on a vanishing premium basis.

In closing, I just want to say that I think it's our responsibility as company actuaries to make sure we don't provide plaintiffs' counsels with their next meal ticket for 10 years. We have to look at the things we do, our product development, building our administration and financial reporting systems, and ask, how would a non-actuary look at this and understand this? Does it make sense to anybody else but actuaries?

Ms. Lisa DeBoss: We have had suits regarding vanishing premiums, and I don't want to get into the program that we took. But, we developed the Valued Customer Program, and went out as one of the few companies to take a proactive role and contact the policyholders. We have actually put money into specific contracts, but that's not why I am standing up here. I wanted to get some input on what people thought.

First of all, I think this is a good start, but we should also remember to focus a little more on agent training. I just moved into a new role a few months ago. I'm now managing the in-force illustrations area and I see a common practice, where agents will take our illustrations (and we're subject to the Canadian Life and Health Insurance Association guidelines regarding disclosure) and transfer the information you provide on your illustration to one of theirs. I saw one case where this agent came up with some very creative columns on a par policy. I want to find out if there are any regulations or practices in the U.S. for monitoring agent illustrations to make sure that, if they use the company name, they're also transferring all your disclaimers. How do you monitor something like this?

Mr. Giguere: There is a lot of regulation but, unfortunately, agents are very smart people. Selling insurance is a very hard thing to do, and they come up with their own spreadsheet, even official looking software, that will do things that your illustration system won't allow them to do. Policy loan arbitrage is a good example of this. Your illustration system might not have been able to maximize the loans out of this, but the agent will figure out how to do it.

Mr. Bruce: I spent a little time buying some life insurance from my agent within the last few months, and he complained to me about how thick the illustrations have gotten and all the extraneous disclosures, which he really thought detracted from the ability of the illustration to show what should be shown and was not user-friendly to the client. So there are a lot of opinions about what an illustration should show and whether it is useful, informative, or not. I'm going to talk a little bit about the illustration model regulation in no great detail, but I think it might answer some of your questions for the U.S. side.

Mr. Dana Rudmose: I have a comment. Regarding your company's compliance program or follow-up monitoring, whatever it is, when you're looking at agent's files, a lot of the illustrations are supposed to be signed by the policyholder or the customer. If you're not seeing company-approved illustrations in the files, signed by the policyholder, you've got a real cause for action against that agent.

Mr. Bruce: I'm going to talk about three main things, not in terms of their content, but rather their intent. I'll talk a bit about Insurance Marketplace Standards Association (IMSA) in terms of content because I happen to know more about that, having been personally involved, but I will touch on these other items.

The internal replacement model regulation is no longer a proposed model reg. At the time that the internal replacement model reg was being heatedly discussed last winter, the Montana legislature got antsy, perhaps prompted by the Montana Insurance Department, and said, "We're not waiting any longer; we're going to adopt this thing as the current proposal stands and be done with it." So there's a lot of impetus on the part of the regulators to get on top of this replacement issue. And I want to talk a lot about what's in the purpose section of these things.

The illustration model reg that's a couple years old now came out of the regulatory world, and it provides standards for life insurance policy illustrations. I want to emphasize the word "standards" because it's really something that other people felt they had to impose on the industry to make us do business the way we should be doing business and treat our clients the way we should be treating our clients. I think that does not reflect favorably on the industry, the companies in particular, and their agents.

This illustration model reg requires a designated responsible officer to certify annually that all the illustration formats meet the requirements of the regulations. Also, an illustration actuary, named by the board, has to certify annually that the policy values illustrated conform to the requirements of the regulation. So this is very, very heavy-handed regulation on this issue. The basic illustration must be provided. Just as Dana said, forms are supposed to be signed and an annual report has to go out. So there is a lot of regulation about what's in an illustration, how it's used, who gets it, when they get it, who signs it, and how official it becomes. And I would agree that most companies are less than stringent in terms of having a copy of any signed illustration in their home-office files, let alone in their field or agent files. This has had an impact on the sales process, a key focus on guaranteed and non-guaranteed elements, and of course delivery and retention, certification testing, redesign, annual certification, and administration systems implications for the annual reports and what they have to say.

The IMSA, in its own words, is a membership organization established to promote ethical market conduct practices in the life insurance and annuity industries. That is a huge undertaking. It's a two-step process: a self-assessment and an independent assessment. It was created to respond to all the things that Marc talked about, including public attitudes toward the insurance industry. The ACLI has produced some statistics that indicate that the public has more faith in and a higher perception of the nuclear power industry than it does the life insurance industry.

IMSA is not as broad as some people would like it, but it's plenty broad to those of us who had to try to work our way through it. Someone had raised a question earlier about agent training. What the agents know about their products, how well they present them, and how they use them is key to IMSA. We want to make sure not only that they're properly licensed and registered, but that you're recruiting to get the right people in front of your clients. IMSA covers the sales process from the first client meeting through policy delivery, with special attention to sales materials; illustrations including claims of product performance; replacements, which as you know has been a hot topic; advertising; service; and complaints. The thing they're looking for in the complaint aspect is a thorough, well-documented process for handling client complaints, including an easy means to register a complaint, such as a well-publicized 800 number. Really, IMSA is almost a Baldrige assessment in terms of making sure that your clients are part of the sales process with respect to their knowledge, their input, and getting what they want and need to make good decisions.

IMSA says you have to get to "yes" and if you're familiar at all with IMSA, you're thoroughly familiar with six principles. They contain a lot of words like high standards, active and fair competition, fair, expeditious supervision. Again, I'll just focus on some of the operative words. There are three aspects to IMSA, and as an organization, we found what I think most organizations would also find—that the farther down the list you go, the more difficult proving you're IMSA-certifiable becomes. If your company has policies and procedures, that's not too hard. If you don't have a given policy or procedure, it's not too tough to write one. Then you must make sure someone is responsible for establishing and maintaining, communicating, deploying, and monitoring that; and then, are the procedures communicated thoroughly? You can have a policy about something and if the field force has no idea it exists, you're probably not adequately communicating it. Finally, you have to be able to prove they're consistently used. Then, do you monitor for the use, the knowledge, and the application of those policies and procedures and take steps if they're not being used? That becomes quite difficult.

IMSA is proving costly to the companies that want to go through that assessment process. We not only had to retain an external assessor, but also had to put half a dozen people on it in the home office about half time on average. A couple of us were full time; some were quarter time. It also takes a lot of internal resources from people you ask for things, so it's a very expensive process to go through.

The other issue is, what if you find problems or outright illegalities? How do you end up without having that in some plaintiff's attorney's file? How do you get it fixed without raising all sorts of alarms? This is a concern if you're going to launch an IMSA effort. There's also an issue with the wide variety of approaches by independent assessors. We agreed with our assessors that we would change such and such a policy or tweak this or adjust that, and people with external contacts in the company would say their friend over at this other company said they didn't have to do that. The answer is, they probably had to do something different but they probably already had something in place, but this is where reasonable assurance comes into play, which was a keystone of IMSA.

It's not an audit. There's not a textbook approach, and various companies had to do different things to make themselves IMSA certifiable. But I think that is an issue that's going to get addressed as people continue to go after IMSA certification, and they will rework things when their three-year term is up.

A key membership issue right now is, what happens if a company violates the IMSA principles after its certification? I know the IMSA board has struggled with that for some time. For example, and this is just my opinion, if you see a violation of a reg in some state, that probably doesn't mean you're not worthy of being an IMSA company. But if you see systemic recurring violations of a regulation that should be covered under IMSA, then maybe there is some question. Customer complaints continually coming in on the same topic, or a given state is continually finding problems. That could be a key IMSA issue, and it will carry a lot of weight in terms of IMSA's usefulness and marketability going forward. And, I would guess that most of our agents don't know that much about IMSA. We talked to them about it, sent them a brochure, and did some training on it. I just don't think it's a big deal to them because it isn’t a big deal to the public yet, and I'm not sure how or when that will happen.

Let's move on to the National Association of Insurance Commissioners (NAIC). The NAIC is no longer proposing a replacement model regulation. It covers life insurance and annuities. I want to talk about its purpose. It indicates that the regulators believed that this was necessary to protect the interests of life insureds and annuity purchasers by establishing minimum standards of conduct, which clearly implies their belief that the companies were not doing the right thing by

their customers. It goes on to talk about the duties of the producers, agents, or direct marketers, and insurers. One of the scary things in this regulation, and I think the same is true of Regulation 60 in New York, are the duties placed on the replaced insurer, the company that's being replaced. Even if that company does not want to conserve that business, there are a lot of things it has to do to provide notice to its policyholders, so that it's helping these policyholders make the right decision.

New York Regulation 60 says, "to protect the interest of the public." It sounds like the Constitution or something. "Minimum standards of conduct, full and clear information reducing the opportunity for misrepresentation and incomplete comparison." As a long-term employee and member of this industry, I see that to be at least a slap on the hand if not a slap in the face, and maybe it's deserved. But I think it's clearly people stepping in and creating requirements that we apparently were unwilling or unable to generate for ourselves.

The other aspects of these model regulations are that they include a very broad interpretation of replacements. The NAIC model reg I think has a 13 month forward and backward look to see if you have replaced something. And I've seen a regulator interpretation that says, if you stop putting money into one annuity and start putting money into another flexible annuity, that is a replacement. I've seen that in writing from a regulator. How many regulators hold that view, I don't know, but that's a pretty broad interpretation of a replacement.

What does that mean to us as actuaries? Clearly companies are being held more accountable for their sales practices. I think a lot of what has led to this replacement binge has been the generational aspects of UL and variable universal life (VUL) products. The cycle for a product has gotten very short. At least some of us in the room can remember the very first UL, which was a front-loaded, expensive monster to buy. It was a nice attempt at unbundling a whole life policy. And very shortly on the heels of that followed a generation two or three, and not too long after that followed VUL. VUL seemed to jump on the stock market rise, and it's almost natural to show your clients that this next one is better. And in many cases it really was. It had better COIs because we were better at capturing mortality. It had interest rates that looked better. It did not have a front load, or it had a separate account opportunity that the original ULs didn't have.

Product design and management issues, setting and resetting COIs, setting and resetting interest rates, the use of bonus rates—IMSA says you need to give the policyholders every piece of information they can possibly get (more or less) to determine if it makes sense for them to do a replacement, and I'm not sure that the policyholder can actually make that determination given all kinds of information.

Mr. Rudmose: The future is the hard part. If we all knew that, it would be really easy, just like predicting the stock market. I'd like to spend a few minutes as our firm's student of the NAIC and impart a little of my practical background from being with the Ohio Insurance Department. I was the assistant director there for seven years, and about half that time I had market conduct responsibility. I'll try to give you my sense of how insurance departments operate, how that thinking works, and what some of that may mean for the issues that are before us with market conduct.

If you step back for a second and look at the NAIC, its role is really to try to define standards. And that becomes very important. What the NAIC tries to do is establish national standards for the individual states to adopt. Most insurance commissioners are appointed by their governors and, in some of the larger states, like California or Florida, commissioners are elected. And even though the insurance commissioners are part of the executive branch of government, they serve as an enforcement agency and execute the laws that have been enacted.

When you look at the NAIC, what you find is a kind of legislative process. Everything that happens there comes down to 50 votes (or 54 if you count D.C. and the three territories). Everybody gets one vote, and everything that moves through the NAIC and gets ultimate approval by the plenary comes down through that type of a process. Everything works with a lot of committees, public hearings, and input from consumer groups and the industry. Some of the things that the NAIC is doing today in the market conduct area include the *Market Conduct Examination Handbook*, which is an audit manual for state market conduct examiners to use to conduct an examination. It has been through several revisions over the last few years and it's still under study. The NAIC is looking at the HMO side of the industry and managed care, and that's a big project that's ongoing.

Paul talked about the life disclosure illustration regulation. It is now being widely adopted by the states. Another big issue is marketing through what I'll call nontraditional distribution channels. There was a big task force that looked at the Internet and what kinds of safeguards ought to be in place. Before the NAIC gets to a model reg or a model law, it tends to issue white papers. It's a way of floating an idea, running it up the flagpole and seeing what kind of reaction you get. It's a speedier process than trying to promulgate a full regulation or a rule. There was one last December that came out regarding the Internet.

Another key area is multistate market conduct examinations. This is one that the industry is pushing really hard. When you compare the operations of a financial exam to a market conduct exam, you tend to find a lot more cooperation on the solvency regulator's side. They have a zone system in place, where a state of domicile leads the examination, and then representatives from any other zone that

the company writes business in can participate. So for a typical, very large company, you'll probably have your state of domicile and then maybe three other examiners representing the other zones. It's a way to cut down on having 12, 14, or 15 state insurance departments in on a financial exam.

Unfortunately, nothing similar exists on the market conduct side. As you talk to people in your companies you might find that whoever spearheads the market conduct coordination for the company receives notices of examination on a weekly basis. Some states are famous for doing a lot of market conduct exams. Nevada, Missouri, and Georgia will send their examiners out anywhere, anytime, and anyplace. It's a big funding source for those states. There's been a big push from the industry to come up with something analogous to the financial exam where you get more representation on a national basis so you can see where it comes out. When you get into the market conduct area, the state regulation tends to be a little less standardized than it is on the solvency side. Each state tends to have its own nuances for things like taxation and premium tax, credits, and those sorts of things, that will figure into a market conduct exam.

I mentioned that agents' licensing is closely watched. Again, the industry is pushing hard on this to try to get some uniformity and reciprocity so it will be easier for agents to do business across state lines and get licenses in other states where they want to do business. There's been a big push there to free that up.

The last issue is suitability. If I were to make any bold prediction today of things coming up on the radar screen, it would be the issue of suitability as a new standards area. The plaintiffs' attorneys have essentially announced that they're going to go after suitability next in terms of the sales practices.

The market conduct guidelines are similar to a white paper that the NAIC adopted about 18 months ago. It originally started out as a proposal much like the financial accreditation program, where state insurance departments would be graded against these standards to get their accreditation. It went nowhere real fast. The industry will support strong solvency legislation, rules, and accreditation pretty readily, but something similar in the market conduct area met with a lot of resistance.

So the NAIC ended up adopting "guidelines," a section called Laws and Regulations. There are 21 model laws that a state insurance department ought to have to be effective in the market conduct arena. The big ones are unfair and deceptive trade practices, the agent continuing education model law, and rules governing advertising of life insurance. Then it gets into the operations of an insurance department, consumer services, and the kinds of things states ought to be looking for in those areas.

They should be looking at their complaint handling procedures, timeliness, and the information service that a state would be putting out, such as the consumer guides or buyers handbooks as on the property/casualty side. You'll see a lot of comparisons of homeowners and auto rates and the same sort of things for Medicare supplements as well as life insurance policy forms, rates and how a department approves rates and forms. The timeliness of that is a big issue. Producer licensing is seen as the key. It ensures that anybody who solicits, markets, or negotiates an insurance contract is licensed by the department; therefore, the regulator can take action against that person in cases of abuse, whether it's an agent's license, a TPA license, or a managing general agent license.

Investigations enforcement is another big area. Looking at the process that states use to conduct investigations, confidentiality is key. The NAIC looks at the staffing, personnel, continuing education, and hiring standards a department uses to support compliant department operations.

My final comment is on the guidelines and the impact they have. Ohio is a very good example of what I call a pretty solid state from an industry standpoint. The domestic industry there is very strong; you have companies as big as Nationwide, Great American, and Progressive to much smaller companies, including the farm mutuals. There is a good mix of stock, property and casualty, mutual, the whole gamut. If you look at Ohio for the last 10 years, the total head count of the insurance department has gone from about 240–260. That entire increase is in the market conduct area. There has been no increase in the rates or forms area, no increase in the financial exams area, and no increase in the liquidation bureau. It's all been completely on the consumer services and market conduct area. Every state department is funded differently, but these guidelines give the insurance commissioner something to take to the state legislature to show we need funding for this.

Guidelines may not be akin to an accreditation program—which actually became a dirty word in most of the legislatures because the legislators felt that the executive branch of government was passing laws when it's the role of the state's general assembly to do that—but they give us some weight and authority, a road map, and a goal to shoot for. Again, Ohio is a pretty good barometer of a state that doesn't like to fund its insurance department very well, particularly for non-solvency. It's a state where the insurance department, of 12 cabinet agencies is the smallest state agency. It has to fight for funding at least every two years. But using the guidelines, the commissioner has been very effective in getting funding for that program.

And, with government, once it gets there, it tends to stay there. It's a lot harder to get rid of a program than it is to build one, so I think you're going to see around the country that market conduct is here to stay. It's going to be a part of states' budgets and an area that they continue to focus on.

When I started at the department in 1989, the largest fine ever levied by the Ohio Insurance Department against a company was $2,500. The companies would look at their total fines paid in a year and say, "It's $40,000; who cares?" Now we've seen much different scenarios. There have been much bigger fines—in the $100,000 or $200,000 range—and it's become a big funding source for departments. Again, Ohio is a good example.

Technically, the fine is supposed to go into the general revenue fund, but the department negotiated as part of the settlement that, out of the $100,000, $60,000 of it will go to cover the department's costs. So $40,000 ends up in the general revenue fund, and $60,000 ends up coming back to the department. I think that's probably typical around the country. Insurance departments are building staff and budget.

In the future, I see continued focus by regulators. And there are two things that will get a commissioner's attention real quickly. One is the governor's office calling, and the other is the press. When articles appear on the front page of *The Wall Street Journal* or local papers regarding a domestic company, it's going to get a story and a follow-up story. And it's going to continue to be in the forefront, which always begs the question, what are *you* doing? So government officials tend to react by saying, "Here's what we're doing. We're going to kill this ant with a sledgehammer."

I can't overemphasize multi-state exams. I think Prudential set the model for what the regulators will do about large company problems with the Multi-State Task Force. It makes for good reading if you have an interest in the issue of market conduct in terms of how that company operated and the incentives, and it's really a well-written report and has a lot of useful information.

Policyholder suits—we've all been through the vanishing premium and the churning, and how the plaintiffs are talking about suitability as being the next subject area that needs more restrictive laws and regulations. The NAIC continues to have working groups focused full time on the market conduct issues. You can look through its roster of meetings and find 150–175 different meetings. Ten or fifteen years ago, 90% of those would have been on solvency, actuarial task forces, and number crunching-type issues. Now you see a lot more consumer activism-type issues in the market conduct area.

Recently, looking at Lloyd's for example, we've seen the Holocaust settlements. There's not an issue they're not taking on proactively. Market conduct is a due diligence issue. We're in this wave of merger mania. Clearly, the due diligence teams, looking at acquisitions are going to assess market conduct exposure because, as you buy companies or blocks of business, those issues are going to carry forward. And, while the events may have happened eight or nine years ago, the one who owns it now is going to pay the fines or settle the lawsuits.

Another issue is compliance programs. Market conduct has become an issue for A.M. Best. The company's analysts will tell you that assessing a company's compliance program is becoming one of the ratings components that they're looking at in terms of the companies exposures and risk management programs.

I thought we'd spend just a few minutes here at the end talking about the suitability issue. In its September meeting, the NAIC formed a new working group: the NAIC Suitability Working Group. The membership of the group is a carryover from the Replacements Group. It's chaired by Paul D'Angelo of New Jersey, a well-regarded market conduct regulator who headed up the multi-state task force on Prudential. The group's goal was to recommend standards for suitability, and what that means is it's going to do a white paper first and then, ultimately, if the momentum builds, end up with a model reg or a model law that addresses suitability.

What the group found, at least at this first meeting, was that there aren't many specific state statutes or laws that address suitability. Minnesota has a law on its books that was discussed, but beyond that you didn't hear of any particular state that's got a law actually on their books. The New York legislature has mandated that the insurance department recommend by this December whether there should be a regulation in New York on suitability. My guess is that it will probably agree that we need to study the issue, and we'll probably come up with something.

Finally, suitability issues had its genesis in the securities industry. When you look at the life insurance industry, where has all the growth and emphasis been? Recently, it's been driven by the demographics of the country, wealth transfer, and asset accumulation, so the variable market has exploded for a lot of companies. When we talk about suitability, it's about customer needs analysis. It's about digging into customer's profiles, assets, and income. The source of funds is going to be a key issue. Often, the seller of a variable annuity doesn't necessarily know where the funds are coming from.

Speaking from my IMSA experience, there's a lot of emphasis on internal replacements, replacement activity, trying to meet those definitions, and track that

activity, but beyond that, not much is captured in the applications. But at some companies that I've talked to, there's a real concern about funds coming from a lump sum paid out of a 401(k) plan. The concern is that these are qualified monies, and that somehow a broker/dealer/sales agent rolls them into a non-qualified variable annuity. That would really be ripe for some kind of abuse because you're probably not helping out that customer. So you have to go through a litany of questions with the customer, like: "Is this the right time to buy this annuity? Are you fully funding your 401(k)? Are you in your deferred comp plan at work?" We need to determine the right choice and order of priority for some of those kinds of issues. Regulators make a comparison with the existing insurance program to determine if a company is really looking at the customer's profile.

There are even more sophisticated issues, including tax implications and estate planning. None of it is easy, but these are areas companies are going to have to wrestle with when we talk about training, setting up some protocols, and creating some models for the sales force to use. Variable products are going to be the lightning rod because of their flexible premiums and non-guaranteed elements. Those things can be difficult to explain to consumers. I think companies are wrestling with a definition of replacements. I'm talking about the 13-month-free look before and after and those kinds of things, the compensation of agents, and how that's going to work. Again, many companies spend a lot of time ticketing the internal replacement area, addressing compensation issues, and making sure there's no reward for an inappropriate internal replacement.

My last point is about exchanges, and the issue of qualified versus non-qualified money and how that gets captured. This is food for thought in terms of where the insurance departments are. It's front and center at the NAIC, and I think it's front and center for most insurance commissioners. It's clearly out there for the plaintiffs' attorneys. They've been rewarded richly and are going to continue to see the industry as a ripe target, particularly in the next 15 years because of all the wealth transfer and asset accumulation going on.

Mr. Bruce: At our company, the Missouri examiners were with us for a while about a year ago. There are three or four examiners who do market conduct exams, and one of the things they explained to us is that they do not have any office anywhere at all. This becomes part of their motivation to keep looking at a company. They were at our company 100% of the time and when they left, they boxed everything up and told us where to ship it next. And before they got there, a box of stuff came from our company. So they're never going home. They're not going to sit in Missouri and wait for anything. They're doing market conduct exams 100% of the time. That's all they do.

Don't overlook this issue if you have any variable products at all. The SEC and the National Association of Securities Dealers (NASD) are also very active on the market conduct front right now. They have made it clear that they're going to look at a lot of companies as fast as they can, and they are very much in the market conduct exam arena these days. They want to make sure that they get in on the fines if there are any to be had.

From the Floor: The conversation today has surrounded individuals—customers and consumers. Has there been any activity bringing complaints against institutional products or institutional marketplaces?

Mr. Giguere: I haven't seen any yet. There will be probably some.

Mr. Bruce: I've heard some rumors that this is coming—that companies are going to be held accountable. It's something that I came across in *National Underwriter, The Wall Street Journal,* or somewhere. Some of the small employer markets have felt, for example, that the person responsible for picking out a 401(k) carrier for a small company isn't as sophisticated as a person who picks out that carrier for IBM, Amoco, or someplace like that. There are market conduct implications, especially in that small marketplace, for a single business with 6–100 employees. I've heard that this is an area that people will be thinking about in the near future as well.

From the Floor: The New York replacement regulation requires a projection of a current rate assumption, while the NASD prohibits it for variable annuities. How are companies dealing with this?

From the Floor: I've been involved with Regulation 60 for some time, including this issue, and I believe the NASD prohibits the projection of variable annuity future value. I think you'll find some companies are going to respond to Regulation 60 by stamping that particular section of the disclosure form with a disclosure that says, "We are unable to project these values because that is prohibited by the NASD."

This issue was brought up during the development of Regulation 60, and it's surprising that it didn't receive more attention. There were at least a dozen companies that brought up this issue during the commentary period. At that time, and I will not speak for the department but, what I did hear from one representative from the department was that they were talking with the SEC during the development of the regulation to see if they felt the SEC had a problem with this requirement. Unfortunately, it's not the SEC that has this problem with the requirement, it's the NASD. So there is some confusion there, and I do know some companies are taking the position that they will not permit their broker

dealer/registered rep to project variable annuity values. It's an open issue, and I think companies are having a hard time dealing with it.

Mr. Rudmose: I would not hold myself out to be an NASD expert, but I know if you think about the average prospectus for a mutual fund, all it gives is historical performance and then a whole bunch of disclaimers. So there's an obvious conflict between that and what the insurance regulators like to see, which is, a bunch of scenarios, so that's going to be an issue.

From the Floor: One important issue, especially with flexible premium life insurance, is that the contract can go down in flames if interest rates fall, and that is at least not likely in an annuity.

From the Floor: Other than the occasional IMSA logo that I've seen in the National Underwriter ads, can you tell us what other educational plans IMSA has?

Mr. Bruce: There was a promise that it would do some heavy-duty publicizing. Shortly before April 1, 1998 it went to a number of companies and said, "It's time to publicize and how much would you like to contribute to that?" Our answer was zero, and I didn't see much publicizing. Now, with Bob Googins stepping down and a new IMSA head coming in, we may have a hiatus in terms of carrying the ball forward. I know Bob has done great work and I think this may be an area that hasn't come to fruition. I know it wanted to get together with consumer groups and the press. I haven't seen much and don't even know what plans are in the works.