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Compliance, Product Filing Efficiencies, Insurance Marketplace Standards Association: What is the Advice of the Regulators and Other Inside Experts?

Track: Product Development
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Summary: All of us are faced with regulatory and compliance issues that we need to understand and manage. If we had more insight into the intent and concerns of the regulators and other inside experts, our companies could deal effectively and efficiently with these issues. A panel of experts from the state regulatory environment and from Insurance Marketplace Standards Association provides us with a comprehensive overview and unique insight into various regulatory and compliance issues. Topics include:

- *Insurance Marketplace Standards Association*
- *Compliance Issues*
- *Recognition and use of new regulations*
- *New product filings*
- *Filing of rates and other product revisions*
- *Effective communication procedures—mailings, face-to-face visits*

Mr. John A. Tak: I'm a product actuary with Security Life Reinsurance, and I will be your moderator for this session. Our industry is changing very rapidly and, as a result, is becoming much more complicated.

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Note: The charts referred to in the text can be found at the end of the manuscript.

For example, economic globalization is expanding the focus of our companies internationally. With financial services modernization, traditional insurers are faced with new competition from nontraditional sources. Continued industry consolidation is changing the competitive landscape. Customers are more sophisticated than ever before and are not afraid to hire legal counsel to challenge perceived insurer mistakes. Recent well-known litigation has hurt the industry's reputation.

The shelf life of products continues to decrease, while products become more complicated. Sales illustrations are much more tightly regulated to address disclosure issues. Unprecedented technological advances are providing new avenues for companies to offer their products for sale. Because of the complexity of our product environment, we know this clearly impacts the regulatory environment. Because interaction with the regulators is a significant part of the product development process, it's incumbent upon us to better understand the regulatory environment and its impact on our operation.

We have a distinguished panel of experts to help us to improve our understanding of the regulatory process. Our first speaker is Don Walters. Don is currently the deputy director of the Insurance Marketplace Standards Association (IMSA), and is senior counsel in the State Relations Department of the American Council of Life Insurance (ACLI) where he provides primary staff support on matters pertaining to market conduct issues and the ACLI compliance section. Don also has legislative responsibility for the state of Arizona and, as well, has subject matter responsibility for advertising regulation, agent qualifications and licensing, blue sky laws, financial planners, and variable products. Before joining the ACLI, Don worked with the F&G Life as compliance officer for its broker-dealer. He has also been a staff attorney with the Pension Benefits Guaranty Corporation.

Our next speaker will be Fred Bodner. Fred has been with the New York State Insurance Department for many years, and currently holds the position of chief of the Health Bureau. After a period of private practice, Fred joined the insurance department and, following periodic promotions, was appointed to be chief of the Life and Health Bureau in 1983. Fred also was named the assistant deputy superintendent of the department in 1992 and held the position of a special deputy superintendent in 1995.

As part of the reorganization of the department in 1997, Fred was named chief of the newly formed Health Bureau. The Health Bureau is staffed with attorneys, actuaries, accountants, and field examiners. The bureau is responsible for the regulation of health insurers and HMOs in New York State, including the premium and product review and approval, market conduct, triennial exams and financial

solvency. Fred establishes the department's initial policy in many areas relating to health insurance sold in New York State. He's a frequent contributor to various New York government groups addressing issues of statewide importance related to health coverage and health care financing.

Our final speaker is Leslie Jones. Leslie is a member of the Society of Actuaries and is currently the deputy director for the Office of Actuarial Services of the South Carolina Department of Insurance. She is responsible for managing the activities of the life, accident and health division and the property and casualty division as well. She has been with the department since January of 1996 and also serves as the department's chief life and health actuary. Before joining the department, Leslie taught at the business school at the College of Charleston. She has also worked as an actuary with an insurance company and with a benefits consulting firm.

Don will discuss IMSA.

Mr. Donald J. Walters: On behalf of the Insurance Marketplace Standards Association, I appreciate the opportunity to provide you with some updated information about our organization. As many of you know, we kicked off our organization on April 1, 1998, and we're pleased to report that we've had substantial progress in terms of our growing membership. We'll review some of the issues that IMSA has confronted in the past and continues to address. We'll also take a brief look at some of the issues that we might be examining in the future.

As many of you know, IMSA was created as a byproduct of the market conduct difficulties that many insurance companies encountered in the early 1990s and late 1980s. The ACLI convened a CEO task force on market conduct. These CEOs developed several possible alternatives to address these problems, and one of the concerns was that perhaps a regulatory program that would be mandatory would be imposed upon the insurance industry. There was growing concern over a director and officer liability with respect to class action lawsuits that were being filed against life insurance companies; as a result, the CEO task force took a look at a number of different alternatives.

The CEOs examined the creation of a self-regulating organization as a first step. They also looked at creating a producer's database to monitor the activities of agents. They finally looked at establishing a code of conduct. They examined the self-regulating organization alternative, but, for a variety of different reasons, including antitrust concerns and the bureaucracy that might be associated with establishing such a procedure, they elected not to pursue such an organization. They did examine the producer database, which has led to the producer information

network (PIN) program some of you may be familiar with. They did act upon establishing a set of principles and code of conduct that led to the Insurance Marketplace Standards Association we know today.

IMSA has several constituencies. We first focus upon consumers because, frankly, this is one of the primary reasons why IMSA has been established. Our purpose is to establish and enhance consumer trust and competence in the marketplace for life insurance products. We also have constituencies within the industry. We serve as a liaison to answer questions that might be posed by our member companies concerning matters that pertain to market conduct practices. We also have an ongoing relationship with the regulatory community of which we are proud.

We have taken great steps to try to communicate well with the insurance industry and the regulatory community. By doing so, we hope that IMSA provides benefits to all and really establishes a win because we think what we're doing is in the best interest of consumers, in the best interest of the industry, and in the best interest of the regulatory community, which has limited resources.

As I mentioned, IMSA has tried to serve as an open book. We certainly have no secrets. We have sent all regulatory departments in the United States a copy of our 191-page assessment handbook. They are aware of the procedures that a company must undertake in order to become a member of our association. We have invited all insurance departments to send representatives to our training session. Specifically, we invited regulators to attend our early 1997 training session. We had about a half-dozen regulators at that session.

We're holding another session in Kansas City on November 9–11th, and we're holding it in Kansas City with the specific goal of making it easy for regulators to attend these sessions. We want to make sure that the regulatory departments in the United States have a thorough understanding of our program.

Our executive director encourages disclosure. We have often had phone calls from our member companies that ask, "We're undergoing a market conduct examination at this point. What would you advise when the regulator is now asking to see the documentation that we have put together relative to IMSA?" Our standard answer has been, "That's good news." The documentation that is required by IMSA should report findings of positive instances of compliance with your company, and you should be encouraged to provide that information to the regulator.

IMSA is not a program about creating a litany of sins that creates a road map to the plaintiff's bar. It's a program that is designed to ferret out weaknesses in policies and procedures, and to institute policies and procedures that will provide effective

compliance. Throughout this process, we have encouraged disclosure to regulators. We'll talk about this in a bit more detail later on.

We have a policy with respect to self-critical analysis that we'll also review. This dovetails nicely with this notion of disclosure to regulators. Some of you may be aware that the ACLI has explored the possible enactment of a self-critical analysis privilege in various states. When reviewing this issue, the ACLI board determined that it would want to enact the strongest self-critical analysis privilege possible, recognizing all current common law and statutory privileges available to a company. However, at the same time, it would not limit regulators' current access to documentation, provided the fact that appropriate safeguards are instituted to disallow the further dissemination of that documentation to a third party (namely, the plaintiff's bar).

There is currently a proposal before the IMSA board to expand its membership beyond merely the life insurance industry, and we have found this to be an encouraging development. We have always envisioned that IMSA would be something more than just an industry program. At our most recent meeting in September 1998, the board voted to expand our board membership from 13 members to 18 members. This will permit a naming of a member to the board, perhaps, from academia. Perhaps we could even have somebody, at some point, from the regulatory community so that we could have a diversity of viewpoints with respect to creating a policy for IMSA.

As many of you may know, IMSA had its first presentation before the National Association of Insurance Commissioners at the summer national meeting in Chicago last year. We presented information to the market conduct examination task force, and they sent us several follow-up questions following that presentation. We responded to them in writing.

At the fall meeting in Washington D.C., the market conduct committee examined a range of seven possible alternatives ranging from creating a full-blown NAIC mandatory compliance program to doing absolutely nothing. The committee came out in the middle, and they elected to monitor the progress of IMSA over the next 12-month period of time and to receive current update reports regarding IMSA.

And at the recent fall meeting in New York City, our executive director, Bob Googins, provided a presentation to the NAIC in which he gave information regarding where the program is today and where we see it heading in the future.

As I mentioned at the outset, IMSA launched itself as a membership organization officially on April 1, 1998. It is significant to note that IMSA has been in creation

for probably five-and-a-half to six years (since the inception of the CEO task force). The program was put into place in November 1996 and companies were allowed to undergo the self-assessment process. It wasn't until April 1, 1998 that they were permitted to advertise their status as IMSA members.

When we launched the program on April 1, we had 155 member companies. They represented a combined market share of approximately 55% overall market share for individually sold life insurance and annuity products. We have a diverse membership as well. There were some concerns at the outset of the program that perhaps this would be geared toward the large mutual companies on the East Coast, and geared solely towards captive distribution systems. That has not been the case. We have a rather wide array of companies and distribution systems, and we are rather geographically disbursed.

Where is IMSA today? I'm pleased to report that we now have 199 member companies. We're right on the doorstep of our 200-member-company goal that we want to meet by year-end 1998. What's most important is that number represents in excess of two-thirds of the overall market share for individually sold life insurance and annuities.

A group of us were speaking during breakfast, and we were talking about the number of IMSA member companies. I pointed out the fact that there are estimated to be 1,600 life insurance companies in the United States. Two hundred member-companies doesn't seem like a significant figure, but I think it does have credibility as you start to look at those market share statistics. We anticipate that that will be growing over the next several months as well.

Let's discuss some demographic data regarding IMSA today. We have 21 members of IMSA who are not ACLI members. You may recall membership in the ACLI is not a criterion for membership in IMSA, which is why we have 21 non-ACLI member companies. We also have 27 Forum 500 companies. These are the smaller companies within the ACLI, and that group is called the Forum 500. You can see that a percentage of our association members do have smaller insurers.

As for company type, we have 158 stock companies, 36 mutual companies, four stock subsidiaries of mutuals, and one fraternal company. With respect to geographical dispersion, IMSA member companies are represented across 38 different states and Canada and, again, in that instance, of course, it would pertain solely to their U.S. operations.

The distribution system is rather diverse. Let me share with you just a few statistics. We have 166 members who use more than one type of distribution system; 33

members who use only one type; 46 who distribute through personal-producing general agents (PPGAs); 76 who use independent agents; and 131 distribute through broker-dealers. So you can see we have a rather broad spectrum that is not limited exclusively to those companies that are relegated to captive agents or that are distributing through a single distribution channel.

What is our projected growth for year-end 1998? We took a look at the list on April 1, and we developed projections. It looks like we will have a very good chance of meeting them. We are nearly at our 200-member-company goal. We're projecting 77% overall market share for individually sold life insurance, 69% with respect to individually sold annuities, and in excess of 71% overall market share by the end of the year. And this projection is based upon a survey that we conducted of independent assessors and member companies that may be aware of other companies that are going to be applying for IMSA membership. We surveyed the top 40 non-IMSA member insurers to get some indication of what their intentions are, and that is what is underlying these figures. I think we'll probably be at about 210 companies by year-end 1998. We're off to what one would consider to be a good start.

In order to become an IMSA member, a company conducts a self assessment, and then they engage a third party independent assessor. I thought you might find it interesting to note the types of independent assessors based upon category. Approximately 43% of our membership had independent assessments done by those affiliated with accounting firms. This might have been done by the consulting arm of an accounting firm. Thirty-eight percent is done by consultants. We were surprised to note that only 16% were developed by lawyers. When the program was initially developed, it was suggested that the majority of the independent assessment work would be done by lawyers, and that has not appeared to be the case thus far. Approximately 5% were done by others, which may include those affiliated with actuarial consulting firms and the like.

There are several different issues that IMSA has before the NAIC, and I wanted to bring you up to date on how we are attempting to address some of them. The first issue is with respect to IMSA scope. Its scope is limited to individually sold life insurance and annuity products. Will that change? How is that scope identified in advertising?

These are issues that have been raised by the NAIC. Another issue is the effectiveness of IMSA. This program is nice. It's a great set of platitudes. One could argue that IMSA adheres to the form of its principles and code, but where does the rubber meet the road? Is this program effective? How is that determined? It's a difficult question for us.

Another issue is conflict of interest and independence. Can we truly say that a company is undergoing a "independent" assessment if, indeed, the independent assessor has had some previous relationship with a company? Is this a substantive problem, or is this merely a perception problem?

A fourth issue is the subjectivity and perceived lack of homogeneity among independent assessments. There might be inconsistencies among the practices exercised by various independent assessors.

A significant issue for IMSA is postmembership market conduct problems. Once the program was announced on April 1st, it wasn't long thereafter that those interested in the program began to ask, "What happens if a company is an IMSA member and then becomes involved in a market conduct violation? What will IMSA do?" We don't have a credible answer to that question, or we didn't at that time because there are significant antitrust concerns associated with a membership organization. One could be kicking out one of its members.

We have developed a tiered set of responses to this issue, and I'll review them as we go through this presentation. They have been reviewed by our board of directors at a meeting in September 1998. Elements of this proposal have been put forward to all IMSA member companies who had an opportunity to review and comment upon it, and it will be subject to a vote of IMSA membership at our annual meeting in November.

The other issue that has come up is independent assessor access to insurer records. Can the independent assessor, when conducting this analysis have unfettered access to insurer documentation?

The last issue that we've addressed has been with respect to mergers and acquisitions. If a company acquires a block of business, how will that be treated for IMSA purposes? Let's address each of these individually.

The first issue pertains to scope. As you know, we are currently limited to individually sold life insurance and annuity products. There are certain group products that fall within the rubric of IMSA, because they are sold on an individual basis. One that comes to mind would be a 403 type of plan that is sold on an individual basis to those affiliated with school districts. The program is currently limited to individually sold life insurance and annuity products.

One of the issues that the NAIC presented to us was that if a company uses the IMSA logo and advertises in the marketplace, that suggests that code of approval, if you will, pertains to all of the functions that are associated with the market conduct

examination. We can create an argument that suggests that that's misleading. That's because there are elements of the market conduct examination that are not currently within the scope of IMSA, and the program itself is limited exclusively to life insurance and annuity products; however, many life insurers sell other products as well. So IMSA had to confront how to address that problem.

We've developed specific advertising materials that are designed to show IMSA's limited scope so that these could be used at the point of sale and, hopefully avert this notion of a misleading sales practice that would be contrary to the principles of our program. The issue that IMSA is limited in its current scope is underscored in our training sessions with company personnel, for independent assessors, and for members of the regulatory community.

As I mentioned, the consumer brochure was developed as well and, hopefully, this provides the same type of information to consumers so we don't have an instance of mis-selling. Any time that the IMSA logo is used in a company brochure that promotes a broad product line beyond the scope of just simply life insurance and annuities, there's a tag line that must be used. This tag line notes that membership promotes ethical market conduct for life insurance and annuities.

As far as the scope of products, we're limited to life insurance and annuities individually sold. We are exploring expansion of the program on two different levels. The first pertains to product lines. The first product line that we will expand to will be disability income insurance. The next product might be long-term-care insurance. Thereafter we'll start exploring other products typically sold by life insurance companies. We're often called regarding this issue, and the question is, "When will that take place?" I don't have a clear answer for you at this point in time. IMSA is in a bit of a transition period at this point. Some of you may know that Bob Googins, our executive director, will fulfill the remainder of his appointed term through calendar year 1998, and we will have a new executive director at work on January 1, 1999. The current plan would call for an exploration of this issue so that we may begin to develop subsets of our Assessment Handbook to address inclusion of these new product lines.

Let's discuss the scope of company functions. As I noted a moment ago, IMSA does not cover functional areas that are normally within the ambit of a market conduct examination. That would include claims, underwriting, and product development. These are areas that IMSA believes we will move into, perhaps on a more rapid basis than the development of other product lines. We'll be convening a group of interested parties to begin drafting those subsets of the assessment handbook.

With respect to effectiveness, the issue has often risen regarding whether or not IMSA can provide objective measurements of the effectiveness of this program at the point of sale. It's a very difficult issue for us to work with and, frankly, on a short-term basis, we believe it's too soon to determine. IMSA has only been in place since April 1, 1998. We're looking at a six-month time horizon, and we really don't have objective data available to us at this point to make a reasonable determination as to whether or not IMSA has been effective. We have reports that it has been effective. In other words, our summit meetings held throughout the year have been attended by company personnel and independent assessors. They have reported an overall upgrading in market conduct practices at IMSA member companies.

We have explored the issue of possibly instituting an American Institute of Certified Public Accountants (AICPA) type of effectiveness testing, but that's not currently required within the program. We don't anticipate that it will be part of any effectiveness analysis that we will be doing as we move forward. We have been in contact with the NAIC to explore accessing its complaint database. This is an issue for which we've received a good reception from the NAIC. We have talked about the idea of possibly identifying industry benchmarks with respect to complaints. We would then compare the data that are on the NAIC complaint database to the industry benchmarks to determine whether we have an analysis that would show how the pre-IMSA complaint activity took place versus the post-IMSA complaint activity that took place. Then we can make a comparison of the two and that might provide us with some objective data. At the NAIC presentation in New York, Bob Googins asked the Market Conduct Subcommittee to get permission from its senior committee to permit IMSA have to access to the database, which is confidential at this time.

One other possible means we might pursue to conduct this analysis will be the Life Insurance Marketing and Research Association (LIMRA) Customer Assurance Program (CAP) survey results. This is used by many IMSA member companies. What we may be able to do in conjunction with LIMRA is to take a look at the type of CAP data that were received prior to April 1 and compare them to post-April 1 data to see if we have a determinable effect.

Also, one of the issues that is raised when we start to explore the effectiveness of IMSA is Principle Six. Principle Six requires companies to monitor their compliance policies and procedures. IMSA has often been referred to as a snapshot in time, which is true, but one of the key elements of the program is that it will be reviewed over time so that it has an ongoing life of its own. It's not simply an analysis that is done once every three years and then nothing takes place in between. So we want to encourage that type of an analysis to take place at your companies as well

because these will be ways in which you may be able to determine various indicia of the program's effectiveness.

Principle 6 requires companies to conduct what we refer to as a root cause analysis with respect to complaints. It is not sufficient to simply respond to a complaint; the requirement of the IMSA program is to go further and actually examine what led to this complaint. Are there infrastructure weaknesses within the company that need to be examined, upgraded, and enhanced in some way so we can avoid this type of complaint from occurring in the future? As I mentioned, this is an ongoing program. We do require continual review over time.

The next issue we addressed with the NAIC was conflict of interest and the independence of independent assessors. This issue was raised at the outset of the program and during its creation. Our board reviewed this issue, and their determination was that it would be appropriate for all IMSA members to submit on their application form whether or not they have had any relationship with an independent assessor during the two years prior to submitting the application for IMSA membership. Frankly, several of our companies had that relationship, as we had anticipated.

But we held summit meetings in Chicago and in Washington D.C. this year, specifically geared to company people and independent assessors, and we asked them to react to this specific issue. They did not perceive this as a problem. We have tried to communicate that to the NAIC, and we'll continue to monitor this issue as well because we think it does have the potential to become an external problem even though it may not have an issue in substance.

Of those companies that are current IMSA members, under that disclosure requirement, approximately two-thirds reported that they did have some type of prior relationship. As you might anticipate, most of these arose through relationships with those accounting firms that had audit responsibility for companies.

With respect to the relationship by type, the accounting firms were dominant followed by individual consultants, lawyers, and then a smaller segment comprised of other professionals.

On this conflict of interest issue, we think that over time we'll continue to monitor this through additional summit meetings. As I mentioned, we think it's an issue of perception, not a substantive problem. Many independent assessors worked as consultants prior to conducting the independent assessment analysis, and many companies found this to be very helpful in preparing the type of data that would be

necessary in order to achieve yes answers that would allow them to become IMSA members.

On the subject of perceived lack of homogeneity among independent assessors, we pointed out to the NAIC that, although the principles and code are designed to have certain levels of subjectivity associated with them, they have very broad standards. As you start to examine the program more closely, you then start to move what we call various objective indicia that are identifiable indicators of whether or not a company has indeed changed a particular policy or procedure. As you start to ferret down from six principles to 23 code provisions, and I believe there are 193 different indicators of whether or not a company has met these compliance standards, you start to see that there's a great level of objectivity at IMSA's para-middle approach.

We also pointed out some objective actions that have been taken by member companies that certainly can be identified. Many companies instituted new policies and procedures to become IMSA members. Virtually all companies revised their existing policies and procedures in some manner in order to comply with IMSA's principles and code. Homogeneity of independent assessments is continually under review. I don't anticipate that we will move to the AICPA type of standard with respect to independent assessments, but it is an issue that we'll continue to monitor. One way we're going to improve homogeneity is through revision of the Assessment Handbook. We will go back and try to upgrade those so that we can have consistency and homogeneity among the type of independent assessments being conducted.

I think postmembership market conduct problems is probably the most significant issue that IMSA will address in 1998. As I mentioned earlier, it is a work in progress at this point. We have examined a variety of different alternatives that we could employ to address these issues. What we have determined is that IMSA should not serve as an intermediary for complaints. I will qualify that. IMSA should not be in the complaint handling business.

That is not to say that IMSA would not receive complaints and then, perhaps, pass them along to a member company. That has already started to occur. IMSA has received complaints from consumers, agents, and other life insurance companies; both IMSA members and non-IMSA members are "tattling" on other insurance companies. Our current position is that we will simply pass that information along to the named life insurer and allow the life insurer to address the problem.

Routine complaints that are offered to IMSA for resolution will be forwarded. As I mentioned, if the complaint itself comes from a member of the consumer community, that, of course, will be passed to the company and they can respond to

it. IMSA is not going to request a response from the company in turn. However, if a complaint comes from a regulator or an insurance company, then IMSA will require the insurer to whom we forward the complaint to respond to IMSA to verify resolution of the complaint as part of this procedure.

Repetitive complaints may require an additional review by an independent assessor, and this judgement will be made by the executive director. If we start to see a consistent pattern of complaints, or that the volume of complaints has grown, or that the nature of complaints is consistent, we then may ask the company to engage an independent assessor to come in and take a look at their policies and procedures and see if he or she can identify any infrastructure weaknesses.

If a company fails to respond to IMSA's request for information, or for appropriate modifications or strengthening of their procedures, this may lead to suspension or possibly expulsion from IMSA. These are the issues that raise antitrust concerns, and we are going to try to identify some of those issues over the next few months. In addition, IMSA will require a company to notify it of the conclusion of any formal regulatory proceeding and to provide the accompanying public records for possible further action by IMSA. We're trying to step up to the plate and be proactive with respect to how we will respond to instances of market conduct abuse.

As I mentioned, these issues raised significant antitrust concerns. One of the issues associated with antitrust is that the company would have a proper due process available to it if it feels aggrieved by IMSA. The current proposal does have those safeguards within it. A company can respond to IMSA and will have an opportunity to present its side of the case before any type of action is taken.

As I mentioned, the proposal will be subject to approval at our annual meeting in November 1998, and we are also going to submit the proposal for outside antitrust council review, and also review by the Federal Trade Commission (FTC). We recently received the analysis from the antitrust council, and they said they do not find a problem with this current proposal under the antitrust laws. We will be meeting with the FTC next week to get their reaction to the proposal as well.

Access to records is a very big issue for IMSA and member companies. Obviously, with the onslaught of class action lawsuits against insurers, we recognize there's a need to protect sensitive, confidential information, and we do not question that right of insurers.

But the question has arisen in another context, and that is independent assessors have complained that they have not had access to insurer records within the producer realm. They have not had the opportunity to meet with a particular agent

group or marketing organization in order to be able to determine whether or not they're complying with IMSA standards. This has been an issue, and we recognize that it is prevented by some agent agreements at various insurers. We are examining the possibility of instituting a requirement that an independent assessor would have access to that producer group, and that may require modifications of agent agreements in some instances.

This is an outcome of our summit meetings that we held, and we think it's an issue that we need to explore. By early in the first quarter of 1999, we might develop a policy on outside contacts from the independent assessor.

In addition, the issue of regulator access to insurer documentation is a very hot-button issue at the NAIC at this time. This is an issue that IMSA has established a policy position with respect to self-critical analysis. However, regulator access to insurer documentation is a much broader issue than that, and it involves principles of attorney-client privilege and work product doctrine, and also trade secret protection as well.

The NAIC has an Access to Information Working Group that is currently exploring this issue. As I said, the ACLI established a position with respect to self-critical analysis. IMSA's position is consistent with the ACLI on that matter. As I said, we do not want to limit current access rights of regulators to documentation if appropriate safeguards can be put into place that would limit further dissemination as well.

Regarding mergers and acquisitions, we are looking at several different ways to approach this issue. The acquisition of new lines of business is an issue that we confront. What will happen to a new line as it becomes a member of IMSA? We will explore whether or not that company has policies and procedures in place. If not, it must upgrade and develop policies and procedures that would meet IMSA standards. A company will be given 180 days to conduct that analysis, and it can apply for an extension with the executive director over that time period as well. During that period, there will also be a limitation on using IMSA's logo concerning any new products developed by that line of business.

What lies in IMSAs future? I talked about our membership goals. I think we're close to achieving those. We are in the process of establishing a Web page that will also provide public access so members of the regulatory community will have access to information about IMSA as well. We hope to have that in place by November 15, 1998. We'll continue our NAIC relationship.

There's currently a suitability working group that has been established at the NAIC, and we see an opportunity to play a role in talking about how IMSA sees the issue of product suitability for consumers. We will be working with that particular group. We'll also continue to review and ask questions regarding IMSA because we think ongoing critical scrutiny by the regulatory community is very important and is, in fact, appropriate for IMSA if it's going to be a successful program.

Mr. Fredric L. Bodner: I'm with the New York State Insurance Department. I'm going to talk to you about compliance and filing efficiencies and ways that you and your companies can get products approved quicker in New York.

I'll just very briefly go through an organization chart of the insurance department. It can give you a little bit of a handle on the structure of the New York State Insurance Department, and tell you just very briefly what bureaus we have.

The department has three major bureaus: the Property Bureau, the Life Bureau, and the Health Bureau. We also have an office of General Counsel. We have a Consumer Services Bureau that's staffed by a number of examiners, and they handle somewhere in the realm of 40,000 to 50,000 complaints every year on all types of insurance. We have a Licensing Bureau that's responsible for approval of licenses as well as renewals for agents and brokers. We have an Office of Legislative Affairs, which, as I'm sure you can figure out, is responsible for all of the legislative activity that the department gets involved in. We have a Research Bureau and a Systems Bureau.

Superintendent Neil Levin is the current head of the department. He has made a lot of positive changes. Greg Serio is the first deputy superintendent. Greg and Neil are the two top people running the insurance department at this time.

The three major bureaus that are responsible for regulation in the New York Department today are the Property Bureau, the Life Bureau, and the Health Bureau. And this is a result of a reorganization that was implemented by Superintendent Levin in December of 1997. The reorganization is intended to increase effectiveness and efficiencies. These three bureaus are responsible for any and all regulation of the companies that fall under each of them.

Let's discuss the Property Bureau. This is the largest regulatory bureau in the New York Department. There are about 250 people in this bureau, which mainly comprises examiners. The Property Bureau is responsible for regulating the financial condition and corporate conduct of property and casualty insurers. These include title insurers, financial guaranty insurers, mortgage guaranty insurers, cooperative fire insurers, risk retention groups, and insurance exchange matters.

We'll discuss the types of form filings that were submitted to the Property Bureau in 1997 (Chart 1). Chart 1 shows the number of filings. The Property Bureau reviews all property and casualty filings involving rates, rating rules, policy forms, rate classifications, and rating territories. The types of filings are indicated at the bottom of the chart. The two largest type submissions are other liability and motor vehicle.

The type of entities that fall under the Life Bureau are: fraternal benefit societies, accredited reinsurers, private and public retirement systems, charitable annuity society's welfare funds, viatical settlement companies, and life insurance departments of savings banks.

Chart 2 gives an indication of the number of policy form submissions that were made to the Life Bureau by product line. The top one is individual life insurance. We received 2,160 submissions in 1997. The second largest is variable life and annuity. There were 1,600 of those submissions. And the third highest form submission on the chart is group annuity, which had 1,301 submissions. The Life Bureau is responsible for reviewing and approving all of these product filings. There is no filing fee in New York for life or health insurance, but there is a statute that requires prior approval before any of these products can be sold in New York State.

The product responsibility of the Life Bureau is located in Albany where we have an office of about 230 or 240 people. The main office of the New York Department is located here in New York City where there are 500–600 people.

I am responsible for the Health Bureau. We regulate financial condition, corporate conduct, and we conduct periodic financial and market conduct examinations of our companies. As you can see, they include accident and health insurance companies, nonprofit health service corporations, medical expense indemnity corporations, dental expense indemnity corporations, and health maintenance organizations.

I'll give a very brief description of the Albany office of the Health Bureau. The Albany office of the Bureau is the area that's responsible for prior review and approval of all health products as well as review and approval of initial premium rates. The health rating section comprises actuaries. We also have a legal section, which includes a number of different attorneys.

The legal section is split into a contract unit which, is primarily responsible for review and approval of the different products that we receive. That unit is split into a managed care section, a commercial insurer section, and an Article 43 corporation section, which includes not-for-profit corporations in New York,

including Blue Cross/Blue Shield and the HMOs. They fall under either the 43 corporation or the managed care area. We recently established a program and policy unit that includes some attorneys whose primary responsibility it is to deal with all the public policy issues and legislative issues in which we get involved at the Health Bureau.

The New York City office of the health bureau is broken down into three major units. We have a field examination unit that comprises examiners who travel primarily around the state and do the statutory triennial examinations of our domestic companies. We have a market conduct unit that is designed to quickly address somewhat limited problems on an expeditious basis. We also have a corporate structure and solvency unit responsible for, as you might guess, financial plan and operation of our companies that fall under the Health Bureau's responsibility.

Chart 3 shows the number of health insurance policy form submissions that were sent to the Health Bureau in 1997. The largest number of submissions was received for group accident and health insurance. We received 4,234 submissions in 1997 in that area. The second largest was HMO submissions at 1,355. The third largest was individual accident and health submissions at 851. The product regulation area is located in our Albany office where attorneys review all the policy language, and actuaries look at the premium rates.

Some of the responsibility for premium rate revisions falls under our New York City office under the financial and corporate solvency section. Those people are responsible for the rate hearings that are required by New York law for rate increases that are requested by HMOs and Article 43 corporation not-for-profit entities such as Blue Cross/Blue Shield.

The Insurance Department sent out a circular letter last year to all of our interested licensees. A circular letter is really just an information piece. It doesn't have the force of a statute or regulation. This was really designed to expedite the approval of the large number of health and life policy forms that are submitted each year to the health and life bureaus. In this letter, we have set forth some procedural changes in the approval process. The letter indicates to companies that we are going to return submissions unreviewed if they are submitted to us in an incomplete fashion, or if they fail to comply with the department's submission rules.

Unfortunately, we have received our share of submissions of this nature in the past, and they have accounted for needless delays and an inefficient use of the resources of the Health and Life Bureaus. I'm happy to say that since this letter went out, the number of these types of submissions has decreased significantly.

We also are going to return submissions that clearly don't conform to New York law or regulation, or are clearly inconsistent with other applicable state or federal laws. When we do return a submission, we are providing advice on why the submission was returned. If the submission is incomplete, we indicate this. And if the submission does not conform in general to a statute or regulation, we are identifying that statute or regulation.

There are other scenarios in which the department may return a submission. These are complete submissions; however, they're poorly organized and they are difficult to understand, or may contain several substantive omissions or provisions that are not in compliance with Insurance Department law or regulation. We have, in the past, received submissions from companies that are identical to submissions that they've sent in to other states. We have found that, in many instances, there hasn't been a whole lot of attention paid to the New York law and regulations. These are being returned, and we are giving the reason for the action. If we have gotten somewhat through the submission, we're returning the form with preliminary comments, and other appropriate guidance is also being furnished.

The circular letter also advised companies that we do expect a complete written response to one of our comment letters or to other material that needs to be submitted to us within 30 business days of the date of our letter or request. At the same time, I assure you that this is not a one-way street. The insurance department has, over the last year, very closely examined and reviewed its operations, and we believe that we've made a lot of internal improvements and that we'll also do our fair share of making this process easier and quicker. If a response is received after the 30-day time frame, the department will reopen and file under a new control number, but that will likely result in a longer period of time going by before approval is ultimately received.

There are people you can contact at the department. This is intended to facilitate the approval process. We are encouraging insurers to contact the department personnel prior to making the submission if they would like to. If you have questions that you want to ask, if you're looking for guidance regarding the rules or regulations, these are the people to start with. We will participate in conference calls or meetings.

Austin Rinella, within the Health Bureau, is the attorney located in Albany to contact. If you want to talk about accident and health insurance legal issues, then Austin may need to refer you to someone who has a little bit more special expertise in the particular area that you're asking about, but this is the place to start.
Jim Gutterman is an FSA, and is the contact in Albany initially for the rating issues.

I think that the department has changed in terms of not being in a position to extend a significant amount of resources in helping companies do what we believe is their job. In the past, we have written comment letters that have included 50, 75, or 100 comments. That has taken a long time, and it has really made us unable to get to the submissions that are better prepared because those sit and wait while we do the work on those other submissions. This is a fairly significant change in the department, and it isn't intended to be anything negative. I merely intend to share the work here. I'm very positive about the response because I think that the companies really have done an excellent job of cleaning up some of the problem submissions that we did receive. I think the whole process is now a quicker one.

The Department's Web site address is *www.in.state.ny.us*. We do have a fairly significant and improving Web site that contains useful information for the insurance industry. It includes our press releases, our circular letters, our department regulations, and various publications and bulletins. The Web site includes information on how to submit a rate or form filing for both life and health insurance and property and casualty insurance. For life and health insurance, the Web site provides information on what forms must be approved, on prefiled group insurance coverage, on the forms approval process, where to make forms or rate submissions, and requirements for accident and health form submissions. There's also information on requirements for life insurance form submissions, which includes information on annuities and funding agreements, and there's also rate and nonforfeiture value submission information.

Let's discuss file-and-use rates for commercial health insurance. There's a statute in the insurance law—Section 3231e—that authorizes commercial insurers to file and use rates without having to wait for prior approval. This is a statute that took effect on October 1, 1994. A submission can be made only if the anticipated minimum loss ratio is at least 75%, and if there is an actuarial certification included with the submission stating that the insurer is in compliance with rate filing requirements contained in applicable statutes and regulations.

This statute does include language that requires the insurance company to submit a report to the insurance department by May 1 of each year advising us of the loss ratio on any policy form that was submitted via the file-and-use basis. If the loss ratio was not actually 75%, there must be a dividend or a credit against future premiums issued by the company by September 30 of that subsequent year that is issued to policies that were in effect at the end of the prior year, and that remain in effect at the time that the dividend or premium credit is granted.

A file-and-use statute in the New York Insurance Law for nonprofit health insurers and HMOs is found in 4308g of the insurance law. This took effect January 1,

1996. It's similar to the commercial section. The minimum anticipated loss ratio has to be at least 80% for individual direct pay products, or 75% for small group products; a loss ratio cannot be more than a 105%. There also is an actuarial certification that is required from a member of the Academy indicating that he or she has reviewed the submission and the development of rates, and that he or she finds it to be in compliance with applicable statutes and regulations.

There is also a 10% cap through December 31, 1999 on file-and-use increases or decreases in any continuous 12-month period. Again, this cap will disappear on January 1, 2000. It's going to be interesting to see whether the legislature lets that cap disappear because that has been an issue that a number of different advocacy groups have focused on. I think this will be one of a number of health issues that are addressed during the upcoming legislative session in New York. There are similar provisions in this statute to assure that the anticipated loss ratios are actually met. If they're not, corrective action has to be taken.

Let's discuss deemer legislation. This is a policy form approval deemer as opposed to a file-and-use rate. There is a pretty significant change in New York where prior approval for life and health insurance is held near and dear to a number of different people's hearts. This took effect January 1,1998.

If legislation allows companies to make a submission, it needs to be complete to the insurance department, and the form will be deemed approved if the department doesn't take certain actions within given time frames. I think the key here is not only does the submission have to be complete, but it must include a certification by an officer of the insurer stating that he or she has reviewed the product and believes it to be in compliance with the applicable statute and regulation.

There are some time frame issues that pertain to the deemer legislation. The insurance department has 90 days from receipt of the submission to take action. Either we approve it or disapprove it, which really, to me, means a comment letter. We are not anticipating very long comment letters because of the certification that the company officer is obligated to provide. Or we request additional information.

Once that information is received within the 90-day time frame the form is deemed approved. If it is, that begins a 45-day time frame that really runs back and forth with the onus being either on the submitting company or the insurance department to respond to a comment or information requested or received. If those 45-day times aren't met, either the form is deemed approved or the filing is closed.

There are a number of initiatives in the insurance department to make the process of prior approval a little bit friendlier and a little bit easier in New York. I could just

run through these quickly. These result from a number of meetings with industry representatives from the health, life, and property and casualty area. They are instituted by Superintendent Levin, and we think we've had some pretty positive results.

You can see, we're going to be implementing a public viewing station, both at our New York City and Albany office, so that people can come in and look at previously approved forms that are public information. These will be much easier to access. The public viewing will be expanded to include certain aspects of rate increase applications that are deemed to be public information. We're also going to draft a circular letter with current information on the necessary content and proper procedures for making a form or a rate filing, and we're going to supplement our existing web page material.

The department has some additional initiatives. We're now faxing acknowledgement letters if a filing company provides us with a fax number. We also are working on a list of mandated benefits as well as benefits that must be made available in New York State, and that will be published on our Web site. We're working on a pilot project with diskette submissions. We've utilized some selected submissions in order to determine the best way to speed the process. Our plan is to expand diskette submissions, and implement electronic submission programs initially through e-mail with attachments. The Health Bureau has also just recently hired ten new attorney examiners. I'm thrilled to say that a number of those people will be reviewing the various types of contract submissions that we receive.

In addition, we are going to be setting up regional meetings between insurers and bureau representatives on a periodic basis to discuss current issues and problems. We're going to try to set the first one up before the year is out. We're also developing a questionnaire and an evaluation form to be sent quarterly to those who submit products to us so that you can give us feedback and suggestions on the prior approval process. We're working on a permissible group checklist that will be included on the Web site, which some companies have asked us for.

We definitely encourage you to contact us. We're available for meetings and to provide whatever assistance we can. Now Leslie Jones from the South Carolina Department will speak.

Ms. Leslie M. Jones: I'd like to expand on what Fred has said with respect to compliance issues and focus specifically on new product filings, filings of rate and other product provisions in the System for Electronic Rate and Form Filing (SERFF) project that's going on at the NAIC level.

With respect to new product filings, there are three things that I'd like to get across. The most important thing that I think you should do when you're filing a new product is review the state filing requirements. I know that that's difficult for a variety of reasons, but that's very important for you to do. Another thing you need to think about is including all required information and fees. It's important to make the submission user friendly.

With respect to reviewing state filing requirements, one of the most important things to look at is whether or not a state is a file-and-use state or a prior approval state. The amount of information that's going to be required is going to vary significantly depending on whether or not the state is looking at your filing.

The NAIC has prepared a summary of form filing requirements for each state and a summary of state filing requirements for health insurance rates. These were compiled by the NAIC, but they have not yet been reviewed, so there may be some errors.

It's going to vary by state depending on whether or not the state is a file-and-use state or a prior approval state. It will certainly vary by product type and method of distribution. For example, in South Carolina, group health insurance filings are exempt from prior approval; however, if the form is mass marketed, we're going to review it. It's very important to look at those by distinction.

With respect to reviewing applicable state statutes and regulations, I think Fred made an excellent point. We often see filings where it's apparent that the company has not attempted to review South Carolina law and take into account any variations that we may have. That filing is going to get kicked back to you. So you may as well take your time, do your homework and review the state statute, if you want to get the filing through the first time. Many statutes are going to be uniform across all states, but there are going to be some variations.

I'm sure you have a compliance department that picks up on those variations. It's very easy to formulate your filing so that you comply with those variations rather than having it sit on an analyst's desk for 90 days after you submit it and then having the analyst kick it back to you. It has to sit on your desk for a period of time and then go back to the bottom of the pile when it comes back in the door. I would say that it's very important to review state statutes and do your homework up front in order to expedite your filings.

Include all required information and fees. Fred talked about incomplete filings, which will be popped right back to you. One thing that I consider the most important thing in your filing is your cover letter. If it is a new product filing,

describe what the product is. The analysts are going to read those cover letters in fair detail, so list the type of policy and describe unusual aspects of the form. I know that many of you think less is more and that they are not going to look at it; however, in a prior approval state, the analysts are going to be looking. If there's an unusual aspect of your form that you haven't justified in some manner, chances are you're going to get questioned about it. I would say that if you have something, with the new equity-indexed products, that you know is unusual, get it out up front, describe it, and sell the regulator on why it's a valuable feature in the product. That will surely avoid the back-and-forth contact between the regulator and the company.

How and to whom will the form be marketed? That's very important because the laws will vary. Mass marketed, group life policies follow different sets of laws than regular group life policies; potentially franchise small group health and large group health. The laws may vary. If it is individual health, it is very important to talk about who's going to be getting the form eventually because the laws will vary.

Another thing that we look for is whether or not the form has been previously filed and approved or disapproved in other states. If it has been disapproved, why? I know you don't want to tell us that, but that's something we're going to end up asking for eventually. You may as well get it out. If it wasn't a justified reason for being disapproved, chances are the department is not going to disapprove it on that basis.

In addition, your cover letter should indicate if the form has been approved in the state of domicile. In South Carolina, we don't require domiciliary state approval, but there are many states that do before they'll either review or approve your filing. You may as well go ahead and include it, and have that question answered in case there is some issue.

Include all required certifications. Fred talked about how , if you're going to follow their deemer provision, you must certify compliance with all the statutes of the state. The same thing applies for South Carolina. There's also a required certificate of readability. I'm sure most states have the readability regulation on the books. That has to be signed by an officer. Go ahead and include it in your filing. There is also reserve certification. We're going to talk about Guideline *ZZZ* in just a minute.

If you're filing an equity-indexed product in South Carolina, we want to know up front that you understand the new regulation for equity-indexed products and that you're going to comply with it. So we're going to require reserve certification. If the state has passed the Life Illustration Model Regulation, then, of course, the illustration actuary has to have a certification, and that should be included.

Let's discuss forms. This is what you all want approved. So make sure you get in the application and the contract. There are some things that we find missing every now and then. If it's a life policy and the state has life disclosure on the books, you must include the policy summary. If the state has life illustrations and you are illustrating the policy, then you might have to include only the basic illustrations and not the policy summary.

But that's important to find out because that was a correction that came after life illustrations were adopted. Some states have not yet changed their laws. If they required a policy summary and then they passed life illustrations, you still have to do the policy summary if you're illustrating. Be sure that you understand the state laws. If you're filing an annuity product, in general, you have to have a contract if the state has an annuity disclosure model on the books. For individual health insurance products, an outline of coverage is needed.

I didn't say advertising because South Carolina, in general, does not review advertising unless it's a new product, and we think it has unusual features that need to be adequately disclosed. Again, that's something to check. Does the state review and approve advertising? If so, include it up front because that's going to save you the back-and-forth interaction at the department, which typically has a 180-day time lag.

The actuarial memorandum is my favorite, and I am going to talk more specifically about it when we get to product revision without rates. The only thing I want to say about rates is that most states have an unfair discrimination provision on the books. Your rates may not discriminate. Rates will vary by class, so you may not discriminate. In some states, they're going to ask up front for actuarial justification for your rate classification. That's just something to think about.

For health products, of course, there must be a reasonable relation to benefits, and for most prior approval states that are looking at health products there's going to be a certification required that the rates comply with the laws of the state, and they're reasonable in relation to the benefits.

I think about reserves when I'm talking to product development actuaries. Reserves are fundamentally important to what you're doing in product development, and they are fundamentally important in the actuarial memorandum that you're going to be submitting with the new product filing. If the reserve methodology is not included in the policy form in South Carolina, then the actuarial memorandum has to have a completely detailed description of that methodology. I'm sure South Carolina is not the only state that has that requirement.

So it's important for you to keep up with what's happening with respect to reserve regulations. There are two current and very important reserve regulations in the works at the NAIC level. One of those, of course, is the dreaded *XXX*, Valuation of Life Insurance Policies Model Regulation. There is an industry group that's pushing very hard to get the NAIC Life and Health Actuarial Task Force (LHATF) to adopt *XXX* in December, which would mean adoption by the full NAIC in March with an anticipated implementation date in the major states of January 1, 2000.

So the best way to put it is the industry is on a very fast track. So if you're selling term products or whole life products that are likely to be affected by this model, I would encourage you to review the model. It's in a draft stage and it's still in a comment period. You would have an opportunity to be heard. Once *XXX* (if the industry gets what they want) is adopted in December and it's adopted by the states, there will (hopefully) be uniform adoption of the regulation. At any rate, it's important for you to keep up with what's happening at the reserve level, because when that next filing comes in and you're describing your reserve methodology, it needs to be consistent with the laws that are on the books.

Another reserve guideline is Guideline *ZZZ*. Any of you who are selling equity-indexed products are probably familiar with this regulation by now. Guideline *ZZZ* was adopted by the LHATF and subsequently adopted by the A committee at the NAIC meeting in New York. It's unlikely that this will change before it goes to the full body in December. At that point, it will become an official guideline of the NAIC.

For example, if you submit an equity-indexed annuity in South Carolina for review, we're going to ask you to certify that you're complying with one of the reserve methods that's recognized in Draft Regulation *ZZZ*. Of course, there are certifications within *ZZZ* that are required to be submitted quarterly that may not be the product actuary's responsibility after that. With the initial product filing, we're going to be looking for that certification.

Let's discuss innovative products. As a result of what happened with the equity-indexed product, the LHATF has decided that it is going to draft language that will say: If a company is developing an innovative product, it needs to discuss the reserve requirements with the regulator in the state of domicile. That actually came out of the work that was done on draft regulations *ZZZ*. That's something you should keep your eyes on.

If you're developing an innovative product and you're not sure whether the standard reserve methods that we know of will really fit, it's good to go ahead and

have that conversation with your domiciliary state regulator and start working out some of the bugs. That may end up in the form of a guideline very quickly.

Another issue that pertains to the Actuarial Memorandum is nonforfeiture. Of course, for a life product, you must demonstrate compliance with both the retrospective and the prospective test and provide a certification. Another newer element of the actuarial memorandum is your investment strategy, particularly with the emphasis on asset/liability management and the new products that contain investment elements. People at the state insurance departments are more and more looking to make sure that the individuals at the company have sophisticated staff to make sure that their assets are going to match their liabilities. So that's another element that you may consider adding to your actuarial memorandum that you've not necessarily thought about in the past.

The amount of paper that comes into an insurance department is overwhelming. Put yourself in the regulator's place and think about if you had to deal with that much paper and that many filings every single day. It includes stamped self-addressed envelopes. We like one letter size for correspondence (and we get that specific) and one big enough to return your filings because if we approve it, we're going to stamp it approved and send it back to you. Make clear reference to the form number. You should also reference whether the department gives the filing a phone tracking number that corresponds with your filing. Reference their tracking number so that everybody can keep track of what's going on. Order forms in a logical manner.

With respect to signatures, you have to have certification that the filing complies with state laws. We say it needs to be under oath of an officer of the company. Under oath means it has to be notarized. You can't just say sign under oath and then have the signature. It has to be an original signature by an officer of the company that has been notarized. These are important details to that analyst who's reviewing thousands of filings in a year.

Most of you who are dealing with individual health insurance and who are filing for rate increases are probably definitely familiar with the 1989 NAIC Rate Filing Guidelines. You should be sure to have them. I should point out that there are variations in those guidelines, and this is the problem that we have in South Carolina. In the "new" 1989 guidelines, there's a formula for low-premium products that develop the required loss ratio. We did not ever adopt that formula in South Carolina so we often get products that are targeting a lower loss ratio than we are allowing. Be aware that not all states necessarily moved to the 1989 model.

There's also recent NAIC activity with respect to rate filings, and I've included the model that they're working on that's very near adoption because I think that this context is going to be important going forward. There are several regulators who, for a variety of reasons, are unhappy with loss ratios as a measure of value to policyholders. One of those is that it creates perverse incentives for companies. For example, the higher your claims, the more of a rate increase you can justify. There's the potential incentive to not necessarily practice good claims handling practices, or to close off blocks of business, or to underprice your product.

So the loss ratio can create some incentives that don't work to the policyholder's advantage. This new model is an attempt to address some of those issues. It essentially eliminates loss ratios as a measure of value, and it tries to encourage companies to price their product appropriately in the beginning and disclose anticipated rate increases. To the extent that the rate increases you had anticipated had been disclosed, and the rate increases that you implement are consistent with that, then there's no need to file those rates with the regulators.

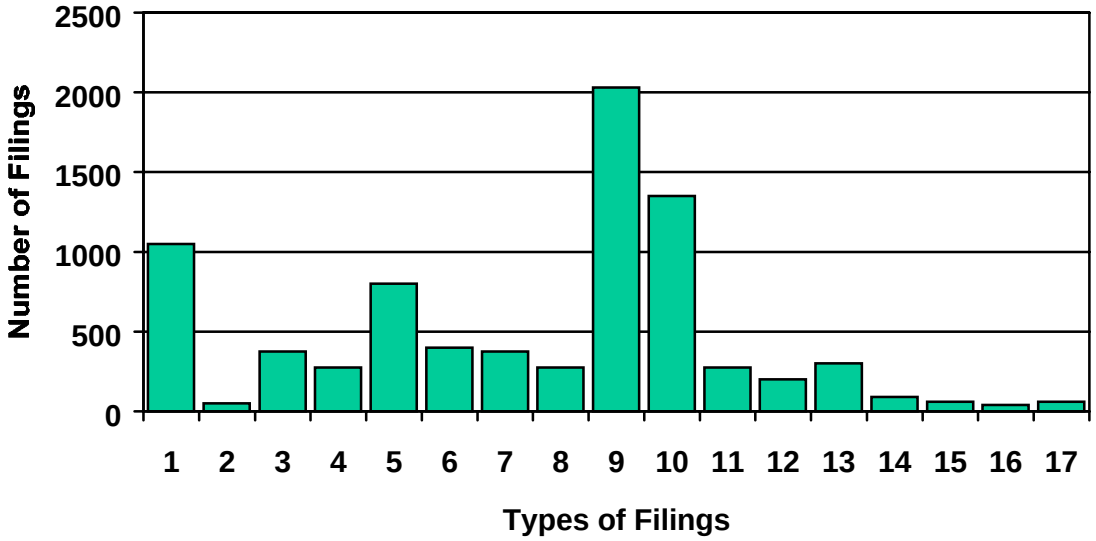
But if you need to file for a rate increase that was more than what you originally disclosed, then there may be significant penalties. So that's the concept behind this model. Right now, this model is limited to limited benefit type policies, such as hospital indemnity. They're looking at that concept at the NAIC level with respect to long-term care and disability insurance (DI) to see if it's appropriate for those types of products. If you're interested, it would be well worth your while to peruse this model and give any comments that you have to the NAIC.

With respect to product revisions, you need to think about whether the rates need to be revised. We often have two different analysts: a forms analyst and a rates analyst. The forms analyst will say, "We don't allow this benefit," or "You must include this benefit." The product will be revised. The rates haven't changed. That may or may not be appropriate. So that's always something to think about. If you're revising a product, follow the revision all the way through and see what other things should be changed.

Finally, I'd like to discuss the System for Electronic Rate and Form Filing and filing efficiencies. The NAIC started the SERFF project back in the 1990s with the goal of expediting the form filing method. There are two applications that they've developed so far. One is an industry application. The industry application essentially allows companies to submit their filings electronically to states and track those filings electronically. The company can go online and see what the status of the filing is.

The state application allows the state to set up an edit so that when the filing comes through, it can kick back an incomplete filing. Maybe there's some simple edit for a different rule that they're always going to be looking for. If those are not contained within the filing, it will kick them back, and then it will track things for the state. It also allows the state to put all of its requirements, laws, and checklists online.

CHART 1
NY STATE INSURANCE DEPARTMENT - PROPERTY BUREAU
TYPES AND NO. OF FORM FILINGS, 1997



KEY

1	Fire & Allied Lines	10	Motor Vehicle
2	Farmowners	11	Fidelity and Surety
3	Homeowners	12	Glass
4	Multiple Line	13	Burglary and Theft
5	Commercial	14	Boiler and Machinery
6	Inland Marine	15	Mortgage Guaranty
7	Medical Malpractice	16	Financial Guaranty
8	Workers' Compensation	17	Other
9	Other Liability		

CHART 2
NY STATE INSURANCE DEPARTMENT - LIFE BUREAU
TYPES AND NO. OF FORM FILINGS, 1997

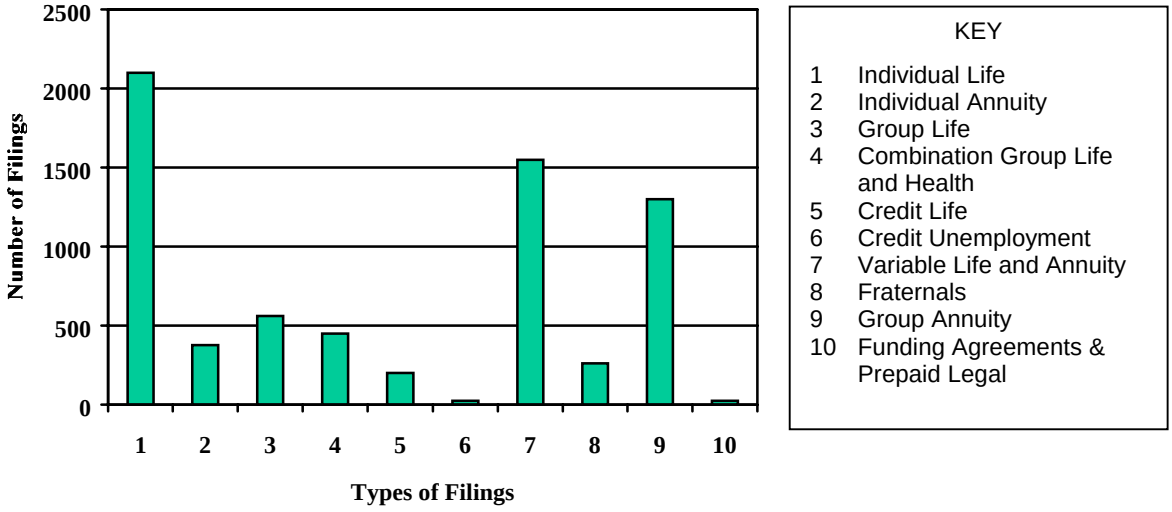


CHART 3
NY STATE INSURANCE DEPARTMENT - HEALTH BUREAU
TYPES AND NO. OF FORM FILINGS, 1997