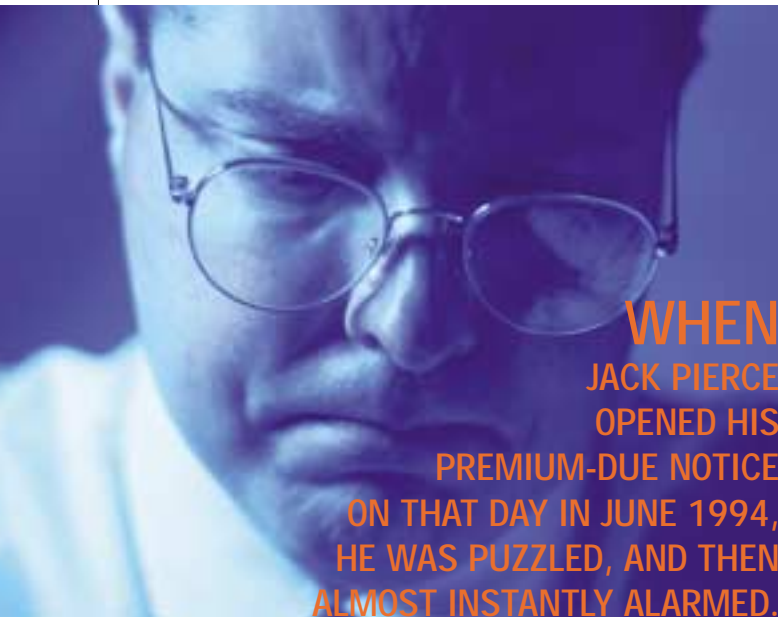


*Market conduct problems and bad publicity plagued the insurance industry in the 1980s and early 1990s, but insurers took pains to clean up their act. How successful have they been? And are state regulators buying it?*

# Self.

## IMSA



**WHEN JACK PIERCE OPENED HIS PREMIUM-DUE NOTICE ON THAT DAY IN JUNE 1994, HE WAS PUZZLED, AND THEN ALMOST INSTANTLY ALARMED.**

THE NOTICE FROM the Empire State Life Insurance Company was for a whole life contract he had bought in the summer of 1985 from an agent, Tim Collins, who had been referred to him by a friend. Jack had bought the policy, a \$100,000 “Estate Accumulator,” as death protection for his wife Margaret and a fund to cover college costs for their two preteenage kids. The premium was substantial—\$1,800 a year—but what sold Jack was a ledger statement Tim supplied showing that, based on an expected stream of dividends and excess interest earnings, the policy premium would “vanish” in seven years. In other words, the policy would become fully paid up without further premium outlay.

Jack had paid his premiums regularly. It hadn't always been easy, but each year he managed to scrape the money together and beamed with satisfaction each subsequent year as his annual notice arrived and showed a healthy growth in cash val-

ues and dividends. When the 1992 notice arrived, Jack calculated that this would be his last premium payment. It was an event worth celebrating. He wrote the check, and took Margaret out to dinner.

On June 7, 1993, an envelope from Empire State Life containing the customary notice of premium due of \$1,800 arrived at the Pierce home. Jack was confused. He called Collins, who promised to look into it and said it probably was “just a mistake, you know, computer error. Don't worry about it.”

But Jack did worry. And three weeks later, hearing nothing from Collins, Jack called his office and was told by Collins' assistant that everything had “been taken care of.”

In spite of their misgivings, the Pierces didn't pursue the matter further. They received no overdue notices. There was no reason to contact the company. Maybe everything was fine after all.

The notice Jack held in his hands on June 8, 1994, again asked for an annual premium of \$1,800. But this time the notice also contained a new item, a bill for \$162 representing interest on a loan. And on top of that, the cash value that had been growing so nicely was now essentially flat.

When Jack tried to reach Tim Collins, he was told Collins had left the company, and no, the company had no forwarding information. Would Jack like to speak to his new assigned service agent?

Jack hung up, called Empire State Life, was referred back to the sales agency, and was told no, they couldn't help him. He wrote a letter to Empire State, copied his state insurance commissioner, and waited.

On Oct. 5, 1994, he saw a notice in his local paper about a class action suit against Empire State Life concerning “vanishing premiums.” He picked up the phone.

# Control

## and the Image of the Insurance Business

### Class Action Hero

Although the names are fictitious, the circumstances, and others like them, were all too familiar to thousands of insurance purchasers in the 1980s and early 1990s. State insurance regulators were inundated by a flood of complaints over premiums that did not “vanish” as they had been promised, policies financed by cannibalizing older policies, and contracts that people were told were investments or retirement funds when, in reality, they were nothing more than life insurance policies.

The class action bar happily began compiling lists of potential plaintiffs. State regulators, sensitive to charges they’d been asleep at the switch, launched a series of multistate examinations of several large insurers.

Perhaps most damaging, the national press and the TV tabloids commenced a drumbeat of “investigative reports” that were grounded on the proposition that insurance companies and their agents were, at best, incompetent and untrustworthy; at worst, dishonest and predatory. What made matters even worse were the highly publicized investigations involving two of the most recognized and trusted names in the business, Prudential and Metropolitan.

In short, what was happening could not be dismissed as merely the sensationalized misadventures of a few marginal players. This was as close to motherhood and apple pie as you could get, and bells went off in the executive suites of life insurers across the nation.

Dick Schweiker, a former U.S. senator and Reagan cabinet member, was the head of the big Washington, D.C., life insurer trade association, the American Council of Life Insurance (ACLI), at the time. A veteran of the stock-mutual tax wars and the solvency crisis of the late 1980s and early 1990s, Dick was looking forward to retiring after nearly two full careers as a public servant and private lobbyist. But the growing wave of publicity about the Jack Pierces who were sold life insurance policies they either didn’t want or didn’t understand was becoming

a serious worry to his membership of nearly 500 companies. Calls from members of his board of directors were becoming more shrill and frequent. Dick was urged to “do something.”

To be sure, not everyone shared the same sense of urgency. There was quiet gloating in some quarters over the great embarrassment being suffered by the lordly Pru and Met, and some company execs were heard to grumble privately over the public black eye those worthies were giving the industry. Others, however, acknowledging that “there but for the grace of God go I,” looked inward and discerned that they easily could be next in the spotlight.

For his part, Schweiker sensed correctly that whatever the economic consequences of fines and class action settlements and knee-jerk over-regulation, the real danger to the industry lay in the loss of public confidence in an institution founded on trust. ACLI surveys had tracked a steady decline in the public’s opinion of life insurers and agents over a 25-year period, itself cause for serious worry. Schweiker was concerned that with market conduct rapidly approaching a crisis, the floor could fall out—with unthinkable consequences for the industry.

A “CEO Task Force” of the ACLI board was appointed to hammer out an industry strategy. Chaired by Steve Brown, then CEO of John Hancock, the group was composed of 14 CEOs representing a cross section of the life industry. The task before it: to address the problem of restoring public faith in life insurance companies.

The task force looked at self-regulatory models such as the National Association of Securities Dealers and the New York Stock Exchange. It also reviewed the regulatory experiences of several foreign countries. Amid calls for more aggressive state regulation, or even federal oversight, the task force fashioned the outline for a not-quite-self-regulatory organization (SRO) that would be centered on a rigorous self-examination and a third-party expert’s objective assessment of that examination.

If the devil is in the details, the details in this case were par-

ticularly diabolical. Months were spent resolving the issues that would separate large companies and small ones, career agency and brokerage companies, term writers and whole life writers, and fixed and variable product issuers.

The whole effort nearly foundered on whether the results of the required self-examinations would be available to regulators and other third parties. Insurers feared that such records would produce a road map for the trial bar, and some were sturdily opposed to providing such records even to the insurance commissioner. There were heated discussions over the question of whether such information should be protected through legislation, a statutory privilege that would attach to the products of a self-evaluation, or self-critical analysis.

Doubts were voiced over whether such a privilege could be sold politically, in view of the continuing bad press about the industry, and whether it would be effective against a court challenge. Not insignificantly, some worried that the insurance com-

missioner might find ways to retaliate if his request for the records were refused.

Still, the task force labored on, and resolved most of the issues that divided the membership through the determined work of a number of deputies groups. Dick Schweiker retired as planned, and his successor, Carroll Campbell, former congressman and governor of South Carolina, continued the high priority accorded the project by ACLI.

### Taking the Pledge

Finally, after almost three years of effort, the Insurance Marketplace Standards Association (IMSA) was born. It was led by Robert Googins, law professor, former Connecticut insurance commissioner, and retired insurance executive as its first director.

IMSA was founded on the following, simple concepts: It is a voluntary association consisting of life insurer members that qualify for membership by subjecting themselves to a rigorous

## A REGULATOR'S PERSPECTIVE ON IMSA

BY STEVEN B. LARSEN

WHILE THE RANGE of state insurance departments' regulatory activities is broad—agent and company licensing, fraud prevention, rate and form approval—most regulators agree that market conduct surveillance is second in importance only to financial solvency regulation. State laws designed to ensure that rates aren't discriminatory, advertisements aren't misleading, and claims are handled fairly are of limited value unless there are mechanisms in place to measure compliance with these market conduct standards.

The mechanism state insurance regulators have historically relied on to enforce these laws has been the market conduct examination, a system in which a team of state examiners scours an insurer's books and records, looking for evidence of compliance or misconduct.

The efficiency, and efficacy, of this system is currently being evaluated by the National Association of Insurance Commissioners (NAIC) as part of its broader, post-Gramm-Leach-Bliley (GLB) exercise in critical self-analysis and introspection. Many believe that rather than merely serving as a wakeup call for state regulators to modernize or face possible extinction through preemption, GLB is more ominously the camel's nose already under the tent—the camel being federal oversight of insurance and the tent being state regulation.

While GLB doesn't directly address state regulators' market conduct functions any more than it addresses rate and form review, the NAIC is actively modernizing all these functions. Regulators want to avoid the same fate as 50-state agent licensing, a function that GLB conditionally preempts for being too arcane and user-unfriendly.

One important market reform effort the NAIC is studying is the role an insurer's membership in a self-assessment organization such as the Insurance Marketplace Standards Association (IMSA) should play in the market conduct examination process.

It's unquestionably consistent with the regulator's perspective to encourage insurers to comply with market conduct regulations and

to create incentives for them to conduct meaningful self-assessments. Given the vast number of insurers in the marketplace, it's impossible for regulators to survey or examine them all. But even if regulators encourage membership in an organization such as IMSA, should IMSA self-assessments supplement (some would argue even replace) state examinations?

Insurers are pushing this idea for at least two reasons. First, the current 50-state system of market conduct review can be costly and time consuming for insurers. Formal state recognition and credit for IMSA membership would reduce or eliminate duplication.

Second, formal state recognition of IMSA membership would make the time and effort companies spend on IMSA membership that much more valuable.

There are, however, a few sticking points that need to be worked out before this view of IMSA's potential can be reached. First, it's critical that the criteria against which IMSA members are measured are compatible with the criteria state regulators apply in their traditional market conduct examination. This is not to say that IMSA membership lacks value if the self-assessments aren't as complete as a state exam or cover different subjects. Some IMSA criteria may even be more valuable or relevant than some state criteria, which should result in a rewrite of state standards.

But if the assessment is to serve as a surrogate or substitute for the state exam, it must be comparable to state reviews. Comparability also dictates that independent assessors should be able to measure actual compliance and not simply assess whether the insurer has a process in place designed to achieve compliance.

Second, the regulator must be satisfied that the independent assessor is indeed independent. There should be safeguards to prevent assessors from conducting "friendly assessments" for the sole prospect of repeat business with a "satisfied" client.

Third, regulators must be able to review and, if need be, validate the results of the IMSA assessment. Insurers are reluctant to

and independent self-assessment. The assessment process, a structured self-examination, is based on a set of six core principles of market conduct, amplified by a code that expresses in actual terms how the principles should be manifested.

The IMSA Principles of Ethical Market Conduct consist of a pledge by each member:

- To conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would apply to or demand for itself.
- To provide competent and customer-focused sales and service.
- To engage in active and fair competition.
- To provide advertising and sales materials that are clear as to purpose and honest and fair as to content.
- To provide for fair and expeditious handling of customer complaints and disputes.

provide self-assessments to regulators for two reasons.

First, information filed with insurance departments is often open to public inspection under state public information laws. According to many carriers, insurer self-assessments made available for public inspection give trial lawyers a free road map for class action litigation.

Second, insurers complain that in some states, regulators will issue fines or violations to insurers that report past noncompliance, even if the offending behavior has been corrected. Not much of a reward for honesty.

Both of these fears have some merit, and states must allay them if they want to encourage self-assessments and membership in groups such as IMSA. They should enact a meaningful privilege that prohibits the release of self-audits submitted to state regulators. Unfortunately, many consumer groups are wary of self-audit privilege and of limiting public access to self-audit reports. However, precedent exists today in the NAIC model examination law, which keeps working papers obtained in the course of either a financial or market conduct examination confidential. The NAIC is currently examining this issue in its Market Conduct Issues Working Group.

In addition, there should be a presumption that a carrier won't be penalized for reporting violations that have since been corrected or that were not committed willfully or knowingly. Such a presumption, however, should not mean that proper restitution can be avoided, and exceptions to the presumption should be allowed.

All these issues can, and should be, worked out as long as both IMSA and state regulators are willing to make changes. Under the right circumstances, IMSA can be a "win-win" for carriers and regulators. Regulators can achieve a greater level of market conduct surveillance than is currently available by having access to the audits of IMSA members. In turn, IMSA members should get some relief from duplicative review by state regulators. ●

**STEVEN B. LARSEN** IS MARYLAND INSURANCE COMMISSIONER AND CHAIR OF NAIC'S MARKET CONDUCT ISSUES WORKING GROUP.

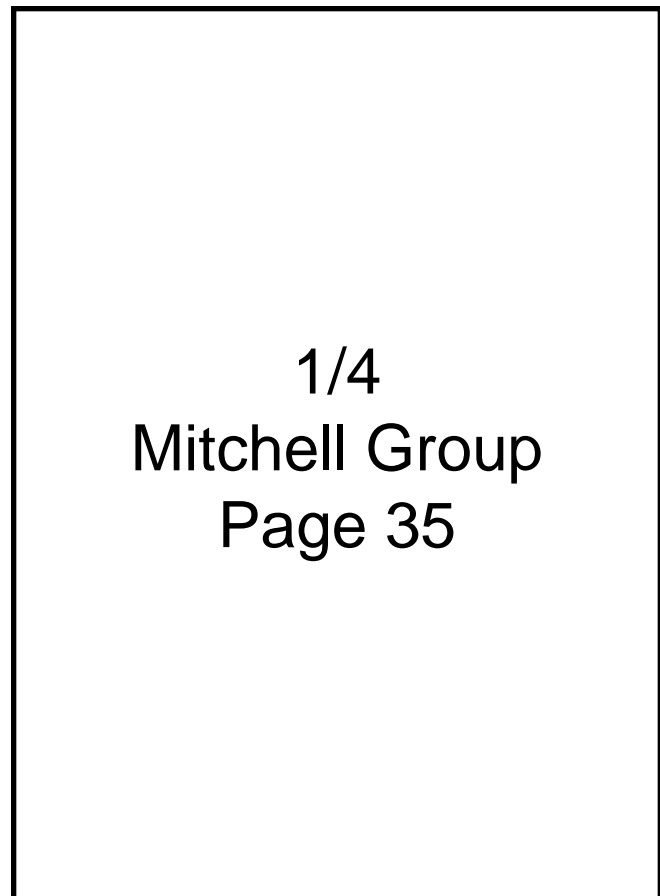
■ To maintain a system of supervision and review that is reasonably designed to achieve compliance with these principles of ethical market conduct.

The principles are weighted heavily toward marketing and sales functions, and don't address underwriting, claims, or policy service to any great extent. The lines of business subject to review are individually sold life insurance and annuities, because these products and functions have typically been the subjects of most of the market conduct difficulties experienced by the industry. Long-term care was added this past October. There are plans to eventually expand to cover other functions such as policy services and claims.

The process of "getting to yes" on a series of 24 specific questions designed to elicit whether a company measures up to the six principles is exacting and involves a significant dedication of resources. In effect, it's a self-imposed market conduct examination that determines:

- Whether a company has policies and procedures in place for the subjects addressed as well as a responsible resource;
- Whether those policies and procedures are communicated and used consistently;
- Whether the company monitors the operation of those policies and acts on information received through that monitoring.

This, the first phase of the self-evaluation, is sometimes done by the company using its own employees. Most com-



panies have sought the services of consultants (usually accounting firms, sometimes the company's own auditors) to assist with the self-evaluation. The results are then turned over to an "independent assessor," whose credentials have been accepted by IMSA, for an opinion as to whether the results are borne out by the facts.

The latter process has evoked controversy in that the "independence" of the independent assessor is regarded as less than ideal when the company's own auditors are used. It's especially so in the case where the consultant in the self-evaluation also later serves as the independent assessor.

Having completed the assessment required, the company applies and is admitted to membership in IMSA. This entitles the company to use the IMSA name and logo in its advertising and other materials, the idea being that this will serve as a "Good Housekeeping" or "Underwriters Laboratories" type of seal of approval that distinguishes the company for probity in the marketplace.

The "seal" is not permanent, and it must be tested through another round of self-assessment every three years so the company may maintain its IMSA membership. Needless to say, this can be a costly proposition.

The response to IMSA by state insurance regulators, until recently, has ranged from diffidence to guarded interest. Regulators have observed that while any voluntary effort by companies to improve practices in the marketplace should be applauded, IMSA can't begin to substitute for the state's own market conduct examination program because it lacks the breadth of the state's exam and because IMSA itself "lacks teeth," i.e., as an organization it has no enforcement or disciplinary powers over its membership.

Admittedly, part of the reaction is based on professional jealousy and the regulators' natural reluctance to surrender turf. This is further aggravated by any suggestion that regulators might not be entitled to the records of a company's own self-evaluation.

Because both the initial and ongoing costs for IMSA members remain significant, IMSA was urged early on to investigate whether membership might entitle a company to some recognition by state insurance commissioners. The reasoning was that since the self-evaluation overlaps to a great extent with the matter reviewed in market conduct exams, perhaps the examination in those areas covered by IMSA should be less rigorous. Or IMSA membership might serve as a mitigating factor in fines or forfeitures related to market conduct exams based on a presumption of good practice or fair dealing.

Regulators regarded such suggestions as premature, asserting that since IMSA had only just come into being with actual members in 1998, there had been no time to judge its effectiveness. They suggested much more experience was needed.

In other words, forget about it.

Other voices were heard. The Consumer Federation of America gave IMSA a faint endorsement, suggesting that the industry faces a challenge in proving itself trustworthy, and express-

ing doubts over the industry's capability to police itself without regulatory input and enforcement. Companies themselves, sensing that the market conduct crisis may have peaked, quietly began asking whether it was really necessary to spend resources and "keep doing this."

### Benefit of the Doubt

On balance, much remains to be seen as far as IMSA's future is concerned. While actual evidence of tangible benefit remains in short supply, companies, apparently wanting to put the best face on a costly and arduous effort, have indicated that the exercise has been valuable in turning up systemic concerns and has allowed them to better spot problems in replacement and agent training. They tout the better documentation of policies and practices, and a higher degree of accountability as additional benefits. Some companies even claim to have experienced quicker market conduct exams.

For its part, IMSA prides itself on a record that has not suffered an embarrassment, but fully realizes that it has yet to face the problem of a member company that misbehaves in the public eye. Will it suspend or expel such a member?

Deputy Director Don Walters is optimistic that a tangible benefit will emerge in the form of special credit to IMSA members by rating agencies, and (finally) an acceptance and recognition by regulators that IMSA membership means something in the market conduct context.

In fact, the frenzy of current NAIC defensive activities, driven by enactment of Gramm-Leach-Bliley, may unwittingly serve as a boost to the latter objective. A proposal currently being considered by the Market Conduct Issues Working Group would "enhance market conduct surveillance through insurer self-critical analysis." A possible outcome: Insurers reporting the adverse results of a voluntary self-audit to the regulator would be entitled to a "presumption in law that no financial penalty would be imposed for the self-reporting of adverse (noncompliant) self-audit results."

One might be forgiven a degree of skepticism concerning the latter. And, at a more fundamental level, the question of IMSA's viability may well depend on its ability to achieve prominence as an effective compliance mechanism in a changing financial world where insurance is merely a roommate to banks, and where the entire structure of regulation may undergo substantial change, at the expense of state regulation.

For IMSA to survive, it must remain relevant. It needs cachet—a higher public profile. It must also expand its range of products and functions, and position itself as a flexible and effective mechanism for dealing with whatever regulatory regime emerges.

A very tall order. ●

---

INSURANCE ATTORNEY **AL DAWSON** IS A PARTNER WITH THE LAW FIRM OF BAKER & DANIELS' WASHINGTON, D.C., OFFICE. PREVIOUSLY, WHILE AT THE AMERICAN COUNCIL OF LIFE INSURERS, DAWSON WORKED ON A PROJECT THAT RESULTED IN IMSA.