GENERAL INSURANCE and THE PUBLIC INTEREST

Working party membership

Derek Newton (Chairman)	Steven Fisher
Richard Bland	Peter Hinton
Kathy Byrne	Julian Leigh
Ian Clark	Matthew Maguire
Martin Cross	Richard Winter

Summary

The actuarial profession has assumed for itself a public interest role. It is promoting this fact widely. So, before actuaries working in general insurance end up on *Today* explaining to John Humphrys precisely how, for example, recommending premium rate increases relates to the public interest, they ought to think carefully about what that role means to them.

This report is intended to stimulate those thoughts. It is far from being comprehensive, not all of the situations identified are applicable to all general insurance actuaries, and it does not have all of the right answers. In fact, it contains very few answers, as we on the Working Party have carefully avoided making specific recommendations of that nature. It is one of our conclusions that few situations are black and white, that most are different shades of grey and that, in each situation where an actuary is involved, it is down to him/her to decide what is and is not a matter of public concern, and how it relates to the actuary's duty to his/her employer or client.

Those actuaries who believe that GIRO working party reports should be crammed full of formulae and data will loathe this report. It contains virtually no numbers, and certainly none that can be analysed. On the other hand, this leaves more room for qualitative issues to be highlighted and explored, and we have taken great advantage of that fact.

As mentioned above, one of our conclusions was that this remains an area of great uncertainty. It is also an area where, in the long term, the public interest is best served by all parties concerned behaving responsibly. Because of the uncertainty, there is a major public interest role for those, such as actuaries, who profess to understanding the industry and the market, to ensure that those others less well informed have an adequate understanding to enable them to undertake continually responsible actions.

There is more to be done to investigate this topic further. We intend to continue our work until the start of the 1999 Convention.

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1. Introduction

1.1 **Where we started**

At the inaugural meeting of the working party it quickly became apparent that this subject means different things to different people. What the public interest comprises, how far the public interest extends, how general insurance relates to the public interest, how the public interest relates to general insurance - indeed how, if at all, actuaries should get involved in resolving such issues - all of these considerations elicited a range of views from the ten working party members.

With consensus regarding the fundamental questions appearing a forlorn hope, we in the working party settled on the following as our objectives:

- To highlight issues within general insurance that might be considered by some to be of public interest.

- To provide informed opinion/argument regarding those supposed issues

  - to further debate
  - to influence decision makers
  - to influence opinion formers

  by exploring how they have come about, by considering their impact and, indeed, whether some are really issues at all, and by setting out some of the possible courses of action for the industry, for industry bodies or for the government. Where possible we have discussed the pros and cons of these courses of action.

Unless an action is clearly desirable or undesirable we have restricted our conclusions to setting out the possible consequences of different actions and have thus avoided setting out definitive recommendations.

We concentrated on the UK personal lines market, in part as that is where the majority of the experience within the working party lay, in part because personal lines seemed more easily related to the public interest than did other types of insurance, and in part because we perceived that personal lines generates the most interest amongst the general public (we feel that there is far more PR potential, and potential risk, in personal lines than in commercial lines or in reinsurance).

That said, we have also covered some issues with specific reference to commercial insurance and, in a few cases, reinsurance. We believe that many of the issues raised in connection with personal lines apply equally in other areas of insurance.

1.2 **Where we finished**

Where we finished was only part way to where we wanted to go. We have identified many issues and we have at least provided a commentary on each of these, in some cases also providing potential courses of action. But we are well aware that there are many more issues that we have not covered, and, of those that we have, we do not claim to have identified the full range of potential actions.

So what does this report contain? For the benefit of the casual browser, we set out below what is included in each section.

- *Section 2 - Some basic questions*: the equivalent of this section in an actuarial report would be the part in which the terminology used within the report was defined. Here we ponder over the questions:

  - what is "general insurance"?
  - what is "the public interest"?
  - what is the profession's true responsibility to the public interest?
  - what is an individual actuary's role in respect of the public interest? and
  - how is all of this affected by the economic and ethical environment in which we operate.

  The answers to these questions are fundamental to how we approach the perceived public interest issues that we subsequently highlight. As a result our meetings were regularly side-tracked as we explored the philosophical depths that these queries uncovered. In preparing this report we have tried to summarise our conclusions - such as they were - without pursuing matters to quite the same depth. We suspect that we have still been too philosophical for some tastes and yet have been too superficial for others. We are ourselves philosophical about that!

- *Section 3 - Public interest issues in product design*: here we start highlighting some issues, focusing at this point on product design. We explore policyholders' understanding of what they had bought or been sold (an important distinction) - both what it is and what it should be - and consider an alternative product structure that might resolve some of the issues arising. We also consider the effectiveness of the industry in reacting to social changes and changing risks.

- *Section 4 - Public interest issues in product pricing and underwriting*: in this section we look at pricing differences in three main areas - between insurers, between risks and between renewals. Those wishing to learn our views on "red-lining" by price should look at this section. We have spent some time and many pages exploring various options to improve the availability of affordable insurance. We feel that some of the options have distinct possibilities.

- *Section 5 - Public interest issues in product distribution*: we start this section by revisiting some earlier research regarding product availability before turning to the rights and wrongs of payments to brokers and other intermediaries. There were strong views on all sides and so the discussion is lengthy, although the conclusions are limited. We conclude the section by considering whether the industry has a problem with mis-selling, if so then how big is the problem, and if it is big enough to warrant action then what action could be taken.

- *Section 6 - Public interest issues in claims management*: we now look at how insurers handle claims (including their exclusion, the insurers' relationship with claimants and cost reduction techniques). We also touch on the level of claim amounts and whether, in their efforts to keep down claims costs and hence premium levels, insurers are fully providing the level of cover contractually undertaken.

- *Section 7 - Public interest issues in the regulation of the general insurance industry*: this section acts mostly as a useful reminder to readers of the supervisory framework in place for the industry, and of the other controls, both statutory and voluntary, imposed upon it.

- *Section 8 - Public interest issues and other interested parties*: our work concentrated on the main technical aspects of insurance (product design, pricing, distribution, claims handling). Here we note some of the aspects that we did not cover, at least not in any depth, and make some passing observations. The other interested parties to whom we refer are employees, shareholders (and financial analysts), the media and consumer lobby groups.

- *Section 9 - Conclusions*: the preceding sections are long, involved and, despite heavy editing, rather rambling. In this section we attempt to pull together the various lines of thought and to summarise our views.

We recognise that there will be parts of this report that some people will object to. We hope that its readers will appreciate that it has been written with positive intentions, rather than to be controversial, and that it should be used as a springboard for constructive debate.

We would like to make it clear that the comments made in this report reflect the collective range of personal opinions of the members of the working party, augmented on occasions by those of their contacts outside of the working party. They do not necessarily reflect the views of the Institute or Faculty of Actuaries, nor those of any of the employers of the members of the working party.

We would also like to thank Knight Features for its kind permission to reprint the Scott Adams' cartoon at the start of Section 5.

2. Some basic questions

2.1 What is meant by "general insurance"?

This is a straightforward question with a reasonably straightforward answer but one that is worth stating here for clarification. It is indemnity business, providing compensation if defined events occur, and is set out in detail in its 18 component classes within the Insurance Companies Act 1982 and its subsequent amendments. These classes are:

- Accident
- Sickness
- Land vehicles
- Railway rolling stock
- Aircraft
- Ships
- Goods in transit
- Fire and natural forces
- Damage to property
- Motor vehicle liability
- Aircraft liability
- Liability for ships
- General liability
- Credit
- Suretyship
- Miscellaneous financial loss
- Legal expenses
- Assistance

Apart from the above classifications, general insurance is often split between that providing cover to, or for, the individual (personal lines) and that providing cover to, or for, commercial, corporate or grouped entities (commercial lines).

When considering the public interest these classifications are of limited use. In this context a classification that defines the relationship between insurer, insured and any other parties would be more helpful. One such split would be as follows:

1. Insurance protecting the insured against entirely natural events (e.g. weather, ill-health). No other parties are involved.

2. Insurance protecting the insured against own accidental actions (e.g. motor own damage). No other parties are involved.

3. Insurance protecting the insured against liability to others arising from the insured's own actions. Here it is often the third party that is being protected against financial loss. The insured purchases insurance out of duty to the third party (assuming the potential loss is beyond the means of the insured). This duty is recognised in law in the case of employers' liability and third party liability cover in connection with motor, riding stables and nuclear establishments.

4. Insurance protecting the insured against the actions of another party (e.g. burglary).

Under this classification structure the public interest issues for each group are likely to be different.

A final way of looking at general insurance business might be to remember simply that it is not long term business. This is grossly unsatisfactory as a definition but is important, because it highlights that general insurance products are fundamentally different from the retail investment products that comprise much of the long term business segment. As such there are aspects of their respective regulation and operation that are of necessity different.

2.2 **Is insurance a discretionary purchase or a social right?**

A useful reference point for any discussion of rights is The Declaration of Independence of the United States of America:

> "We hold these truths to be self-evident: that all men are created equal… [and] that they are endowed by their Creator with certain unalienable rights; and that among these are Life, Liberty and the pursuit of Happiness."

If a case is to be made that insurance is an inalienable right, then it must be as a pre-requisite for the pursuit of happiness. We cannot find any arguments for this that stand up to serious scrutiny.

The Universal Declaration of Human Rights ("UDHR") and the European Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") were similarly examined. The rights encapsulated within the Convention and the declarations are essentially about freedoms to perform certain activities and to not have goods and personal conditions taken away or violated, rather than about having things provided. However, Article 25 of the UDHR says that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including…necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." This implies a right to some form of insurance, covering certain circumstances, whether it is provided by the state or by private means.

In the UK, the state provides cover against all of those events, as part of the National Insurance scheme. The National Insurance scheme does not cover all of the population (e.g. those paid below the National Insurance threshold and those who have failed to "pay their stamps"). Those outside the National Insurance scheme would still be

entitled to basic social security support, although some of the bureaucratic hoops that they have to jump through appear to be beyond the capabilities of a few unfortunates.

Further exploration of political philosophy and then of social economics proved an interesting diversion for the working party but a diversion nevertheless. We could find some arguments for insurance against ill-health, unemployment, etc., being a fundamental right but absolutely none that supported the view that, say, property insurance is a fundamental right. Therefore, for the remainder of this report, we have assumed that the state in the UK provides an adequate level of "fundamental right insurance" and that insurance provided privately is a discretionary purchase, albeit one that in many cases is socially desirable for the benefits that it brings to individuals and to communities. In these cases it could be said that, whilst the provision of insurance is not a right, it is in the public interest. We will discuss this in more detail when we look at situations where insurance is not available to all.

We have henceforward ignored the National Insurance scheme and all state-provided insurance covers.

One area that we were not able to explore but that we feel would be interesting is the media's view of the public's right to insurance. After all, media groupings such as the press and broadcasters are extremely powerful influences on decision makers - whilst we might argue from a position of pure logic that insurance is not a right, these groupings or important elements within them might hold different views which need consideration. Similarly, we would like to have been able to explore the views of consumer lobbyists.

2.3 **What is meant by "the public interest"?**

Who or what is the public? What is their interest or in their interest?

The public would appear by definition to be a communal grouping and hence the interests of such a grouping might be at odds with the interest of some of its individual members, for example in respect of individual freedoms. The conflict between the individual and the majority is not a new one. This is an area which could produce great swathes of text, but is almost certain to conclude that neither the individual nor the majority should completely dominate, rather that some balance must be found. Where the exact balancing point lies would appear to be a question that is impossible for an individual to answer. Perhaps it is for society as a whole to decide how much collective benefit it wishes to concede to certain disadvantaged individuals. In other words, if the majority holds the view that it is unacceptable, say, to charge a high contents premium in a high crime area, then it is in the "public interest" to introduce cross-subsidies, even though this increases the cost for the majority.

Of course, “the public” in respect of the insurance industry comprises many different groups (shareholders, policyholders, employees, consumer affairs journalists, politicians, etc.). There is overlap between some of these groupings. Each of these groupings has its own interests. Some of them are particularly voluble in presenting their case (for example lobby groups - after all, that is their role) and are therefore influential in the determination of public opinion, although they might not necessarily reflect the overall public interest.

Some of these interests would appear to be at odds with each other although, as has already been mentioned, there is a view that, in a capitalist society, over the long term, the interests of all involved groups are likely to coincide (but see 8.2). This brings us neatly to the next basic question.

2.4 **Within what framework (ethical and economic) are we operating?**

The UK is a capitalist society with a largely free market economy. Various political and social commentators may well pick arguments with that bold statement but we will assume for the purposes of this report that it is essentially true and will discuss here its implications.

The normal assumption of a capitalist economy is that it is in the overall public interest for companies and producers to act in their own best interests. In the long term, their own best interests are best served by acting in the best interest of their customers who usually comprise, directly or indirectly, the public. However, we should be clear that actuaries who act for insurers are not there in the first instance to act as policemen supervising the operation. We do not expect professional people such as cost accountants working for, say, W H Smith to denounce the company for charging what they might think is an excessive price for pencils or for not opening a branch in a particular, socially deprived area. Similarly, we should not expect actuaries to do such things as try to control the prices charged by insurers for their products, at least not for non-commercial reasons.

The UK is also a democracy. Again, there will be those who quibble about the degree to which the public can exercise democratic rights but the essential truth is that the government regime and the economic environment which it promotes is an expression of the will of the majority. The public interest is therefore fluid. It is not changed by the government, but changes in government reflect a shift in society’s view of the public interest.

2.5 **What is the role of actuaries when it comes to the public interest?**

In the Professional Conduct Standards ("PCS"), which were adopted by the profession in the UK on 1st July 1999, the role of the actuarial profession in respect of the public interest is encapsulated in Section 2.1. This states that, "the actuarial profession has an obligation to serve the public interest. Collectively it seeks to do so by informed contribution to debate on matters of public interest and by influencing those with the power to protect and enhance the public interest."

It is noticeable that the profession is not restricted in the areas in which it might serve the public interest, merely that its means of so doing will be via informed contribution to debate and by influencing those with power. In other words, the profession should steer clear of subjects where the knowledge, training and experience of its members is insufficient for them to provide informed comment but it is entitled, indeed it has a duty, to comment on matters that its members know something about.

The PCS is less clear on the public interest role of actuaries as individuals as opposed to a professional body. This is perhaps because there is still an active debate within the Councils on the matter. Section 6.1 suggests that actuaries giving actuarial advice "must consider the implications of that actuarial advice for third parties", which might in part explain the role, although it is vague on what action the actuary should take after considering the implications. However, it is worth noting that, in his Presidential Address[1], Paul Thornton stated "I am in no doubt that the profession must retain as its raison d'être the service of the public interest. We need….to be prepared to take on responsibility, to see duties laid upon ourselves in legislation and to deliver the high standards, the professionalism and the competence that Governments will expect from us." If that is what the profession must do then is that what its members must also do? It would appear to be so.

So on that basis we have identified that the profession has assumed a well-defined responsibility to serve the public interest, and has assumed on behalf of its members an obligation for them also to serve the public interest, albeit in a far less well defined manner.

Insofar as there is an understanding of how individual actuaries would serve the public interest, there seems to be an assumption made by many that this obligation is primarily one of "whistle-blowing", of highlighting instances where the public interest is not being served. We on the working party believe that our brief as actuaries to serve the public interest is wider than that and indeed far more positive. We agree that actuaries should assist the move away from current practices when they are contrary to the public interest but we consider one of the most valuable roles of the actuary to be to defend

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[1] *Lessons from History* - an address by Paul N Thornton, the incoming President of the Institute of Actuaries, delivered 14th October 1998

existing or proposed practices that are already in the public interest but which have come under attack from ill-informed commentators or from bodies with vested interests in alternative procedures.

This means that actuaries may well get involved in matters that in themselves do not appear to be strictly actuarial. We do not have a problem with that. Actuaries' knowledge and understanding of insurance extends far beyond actuarial techniques and practices. Where possible, actuaries should use that knowledge and understanding to contribute constructively to industry debates.

Having said all of that, there may well be instances where an actuary perceives one or more of an insurer's practices to be against the public interest. How should he or she behave? What if the insurer is the actuary's employer or client? Do considerations of the public interest override the actuary's responsibilities to act in the best commercial interests of the employer/client and therefore affect the performance of his/her duties?

The PCS outlines the actuary's duty to his/her client in Section 4, in particular in Section 4.1 which states that "an actuary has a duty to the profession and responsibility to any client must be consistent with that duty." On face value that would appear to imply that serving the public interest takes precedence over serving the client. Yet, "unless disclosure is required under statutory or judicial authority or Guidance Notes, the actuary must make no disclosure of the client's affairs unless authorised by the client". As very few of the public interest issues highlighted in later parts of this report are matters that require disclosure under statutory or judicial authority or Guidance Notes, one must conclude that whistle-blowing on these matters is out of the question.

Moreover, as Section 5.1 of the PCS states, "advice to a client must be unaffected by interests other than those of the client, taking account of any identifiable professional or legal duty of care of the client in respect of a third party." One of the concerns raised during the exposure process was that this section seemed to be at odds with the obligation to serve the public interest (ironically it is part of a section headed "Conflict of Interest"!). This apparent conflict may be resolved if one believes that the best interests of a business are, in the long term, best served by meeting the interests of its customers in general, who, in the case of insurance, are, directly or indirectly, the public. This is discussed in more detail in earlier sections of this report. It should also be noted that current insurance legislation places a duty on insurers "to conduct their business with due regard to the interests of policyholders and potential policyholders".

Of course, this does not mean that the actuary should not blow the whistle if he/she finds that the Finance Director is stealing the company's assets, or is employing heavies to frighten off hostile witnesses in litigation in which it is involved - the actuary still has a duty to report instances of malfeasance that he/she discovers. In this respect the actuary is no different from any other responsible person. The Public Interest Disclosure Act, which came into force in July 1999, supports the reporting by individuals in the work place (including actuaries) of malpractice that threatens the

public interest. It does this by providing protection to the individual against subsequent victimisation, providing the whistle-blower follows the procedures set out in the Act. It is interesting to note that the Act covers only threats to the public interest stemming from:

- crime or breach of regulatory, administrative or common law;
- miscarriage of justice;
- danger to health and safety;
- damage to the environment; or
- the cover-up of one or more of the above.

This is a narrower definition of "public interest matters" than many casual observers might have expected. However, it is clearly viewed as legally enforceable.

All of this is most interesting and we are sure that the philosophical debate could be extended for several more pages. However, we will stop it there with the conclusion that, for the purpose of this report at least, we are going to stick our noses into as much within the general insurance industry as we can.

3. Public interest issues in product design

3.1 The ideal product

In order to understand better the background to some of the public interest issues in product design we start this section by setting out the principal characteristics that would define the ideal general insurance product:

- *Consumer requirements* : the coverage offered by the product should match as closely as possible the needs of the intended purchasers.

- *Intermediary requirements* : the product should meet as closely as possible the needs of the intended sellers of the product. This might include the level of remuneration (commission or fees) relative to the sales effort required.

- *Insurer requirements* : the coverage that the insurer is prepared to offer should be commensurate with the limitations of its processes, systems and abilities, particularly regarding policy administration and claims handling.

- *Regulatory requirements* : the product must satisfy all appropriate legislation. This would include "voluntary" codes imposed by trade and/or consumer bodies.

- *Method of sale* : the complexity of the product should be appropriate for the chosen method of distribution.

- *Saleability* : the product should have a clearly defined market and be appropriate in all respects to the needs of that market.

- *Simplicity* : the product should be simple enough to be easily understood by both prospective purchasers and sellers.

- *Fraud prevention* : the product design should minimise or remove the potential for fraudulent claims. This will help to keep down both claims costs and premium rates.

- *Pricing* : the product should be capable of being rated accurately and appropriately. This should not be expensive to carry out relative to the anticipated expense loadings. The resulting price should be acceptable to the target market which would consider that the product offers value for money.

- *Cost reduction* : where the price is too great for certain target customers, coverage should be scaled back in order to reduce the price (for example comprehensive motor insurance being scaled back to third party only cover).

- *Evolution* : the product should be able to be developed further over time, to meet changes in demand, environment, etc.

- *Product differentiation* : some products are 'tweaked' to differentiate them from those of competitors. This is another form of evolution.

Of course, the ideal product remains just that, an ideal. All existing products fail to meet the exacting standards of at least one of the above characteristics. Most of these characteristics are linked in some way, and many will conflict with others. Some simply might not be achievable, for example an insurer starting a new product line might have no basis for pricing other than inspired guesswork. It is these flaws and deviations away from the ideal that give rise to the many different product offerings in the market. It is also these flaws and deviations that give rise to many of the potential public interest issues in product design (and indeed in product pricing and product distribution).

3.2 **What does each policy cover?**

Concerns have been raised over many years regarding the detail of policy wordings, particularly around the fringes of the product cover. The policy document is a legal document which therefore must specify in legally unambiguous terms precisely the obligations of both the insurer and the policyholder. Despite the efforts of various Plain English campaigns, legally unambiguous policy wordings remain both very lengthy and difficult for the average reader (i.e. one without legal training) to comprehend. As a result, few policyholders read the small print of their policy at its issuance and therefore few have more than a general idea of the terms of the policy throughout its lifetime.

This is compounded by different insurers having differing approaches to these fringe areas, which themselves might be extensive. For example, a member of the public who buys insurance cover for his home contents might believe that his bicycle is included in that policy. But is it? And if it is, then when is it? Can he legitimately make a claim if the bicycle is stolen from the hallway of his house? What happens if it was stolen from his locked garden shed? Or if the shed was unlocked? Or if he had left the bicycle in his garden? Or chained up outside Tescos? There are some policies that will cover the bicycle in all of those circumstances and there are others that will cover it in none. Yet to the casual purchaser these policies may well look identical and might be marketed using similar phrases such as "Peace of mind for your possessions".

This is a simple example. Others that easily come to mind concern policy excesses, waiting periods, occupancy clauses, policy exclusions, etc. The policyholder tends only to realise that he is not covered under particular circumstances when he makes such a claim. The claim is then rejected, with the policyholder being referred to an obscure sub-paragraph of a sub-section in the middle of several pages of small print. In such cases one questions whether the policyholder has actually bought (or been sold - we

will come on to the subject of distribution a little later) what he wants, needs, or thinks that he has bought.

The converse of this situation is when an incident occurs and the policyholder is unaware that he/she is covered under the terms of the insurance. This is particularly common under extended warranty cover and may well be under other policy types too.

One of the causes of this confusion is the tweaking of the product to ensure product differentiation as noted in 3.1. Arguably this tweaking is not in the public interest as it results in more complex products and makes it harder to compare two companies' offerings. It is also very hard for consumers to value these "bells and whistles" and some distributors are keen to use them to "muddy the waters". One member of the working party cited an example from his past involvement in creditor insurance where the salesmen were always demanding further product add-ons, one salesman being particularly and rather gruesomely fond of including large dismemberment benefits. Many of these add-ons were, he recalled, of little intrinsic value to the consumer, certainly less than the premium being charged for them, yet the salesmen were convinced that their existence boosted sales (perhaps because they increased the "headline" maximum benefit available).

However, not to permit this freedom to differentiate products would impair innovation. If the form of a policy were laid down by law or regulation or industry code, then new features (including those to the policyholders' advantage) would never be added, and there would be no possibility of, for example, a cut-down product being launched to serve a poorer sector of the market.

Another cause of the complexity of policy wording is the need for insurers to protect themselves against those deliberately selecting against them and against fraudsters. One wonders whether the damage that is being prevented outweighs the damage caused to the industry by the confusion that the prevention methods create.

The apparent 'pigeon-holing' of products into defined categories causes further confusion, so that some losses will be covered under one policy in some circumstances but a different policy under other circumstances. It might also mean that a loss is covered twice, or not covered at all. This is particularly noticeable in the area of household goods and personal belongings, where, for example, a loss might be covered under a motor policy, a contents policy, a buildings policy and/or an extended warranty insurance depending on the circumstances. This may in part be due to the flaw inherent in all legal documents, in that circumstances occur that the legal draftsmen had not, indeed could not have, anticipated. However, much of this confusion is not necessary and is most certainly not in the public interest - such situations must lead to gaps appearing in the cover where it is not intended.

A policyholder's understanding of the cover bought is clearly affected by the amount of information provided at the point of sale. Most distributors try to convey the key

product information but find it difficult to provide detail, unless the purchaser requests it, without taking the sale meeting/telephone call to excessive lengths. They rely on the policy document providing all of the detailed information. However, to what extent is it reasonable to expect the policyholder to read and understand all of the policy document, particularly when in many cases he/she will only receive the full policy details after buying the policy? The Insurance Ombudsman appears to think it to be not very reasonable at all - in recent relevant cases he has based his decisions on what the policyholder was or was not told at the point of sale, rather than what was written in the policy document.

There are other related issues. For example, do insurers apply the policy terms accurately or consistently? The answer to this is almost certainly "no", although instances where there has been deliberate inconsistency or inaccuracy have all been (as far as we can recall) to the benefit of the claimants. However, we can recall many instances where there has been accidental inconsistency or inaccuracy, at times to the policyholder's detriment. At such times it would appear that the affected insurer's staff and/or training and/or systems are unable to cope with the complexities within the policy terms. As long as the systems are administered by human beings complete consistency is not possible, but the minimisation of such errors is clearly in the public interest.

The ABI has recently launched a campaign called *Putting the Customer First*. It is intended to promote good selling practice but may well have some impact on product design and product awareness amongst consumers. As part of it, the ABI has prepared and made available to the public leaflets covering the main types of general insurance policy - holiday, motor, mortgage repayments protection, private medical, buildings, extended warranty/mechanical breakdown, and home contents. The leaflets set out some basic explanations of the generic products and features for prospective policyholders to look out for and questions for them to ask. Not only will it encourage better selling but it should promote better buying.

It is worth mentioning that the Council of Mortgage Lenders has specified a baseline creditor product with the intention that all such cover provided across the mortgage market meets or exceeds this baseline. The baseline specification encompasses both benefits offered and exclusions. The baseline product came into effect on 1st July 1999 so it has not been possible to comment on its impact within this report. We hope to comment at the Convention on how it has been received by the industry, by lenders, by consumers and by the media.

In general the old saying *caveat emptor* continues to hold sway. Insurers cannot be expected to ensure that every policyholder understands fully what he/she has bought, rather that responsibility must reside with the purchasers themselves. However, there is a need for insurers to continue to strive to make their policies easier to understand - this will be to the immediate benefit of the public and, in the avoidance of bad publicity

through policyholders' confusion regarding the terms, it will be to the long term benefit of the industry and of its individual members.

3.3 **An alternative approach**

Perhaps it is time to move away from the current strict categorisation of insurance products (i.e. motor, household, medical, etc.) and to move to an insurance "product" that gives consumers the exact cover that they require for their circumstances. One way of achieving this would be to produce modular products in an insurance "supermarket", allowing the consumer to choose the coverage they require by buying the different units separately (with possibly a choice between different providers as well) to match their needs. This would fit comfortably with the concept of simplicity since smaller blocks of insurance can more easily be explained individually, and the emphasis of choice is put back on the consumer. "Shop assistants" could be on hand to explain the different products on offer, as well as offering general advice.

The "supermarket" could be a physical location, akin to a high street broker, or a virtual location, via the telephone, television or Internet. The "shop assistants" would need to be well informed about the available blocks of insurance (so perhaps the supermarket analogy is not very appropriate!).

To an extent this modular approach is already developing, with household insurance often having a central core and a number of subsidiary parts that may be taken from the menu or left on the shelf, for example legal protection as an add-on, bicycles as an add-on, etc. But it does make buying a product rather more complicated. Most people perceive insurance as a boring necessity, not something on which they would like to spend a great deal of time. The added complications in the sales process might also increase the costs of the insurers or distributors, increases that would then be passed through to the policyholders in the form of higher premiums. The policyholders would thus be paying more for greater product transparency and flexibility, rather than for additional cover.

3.4 **Social changes**

It is apparent that some aspects of the design of, and policy terms within, general insurance products have struggled to keep pace with the changes in society. For example, some motor policies allow a discount to the standard rate for a second named driver if it is the spouse of the first named driver. However, far fewer provide a similar discount if the second named driver is not the spouse but is a co-habitee and even fewer if it is a same-sex co-habitee. Whatever the reasons behind the original discount (probably a combination of marketing spin and better claims experience arising from

those in a stable relationship) there is likely to be similar justification for extending the discount to the non-married co-habitees, especially as this social grouping has expanded rapidly over the past three decades. Yet the industry seems slow to react.

There is in this last point an overtone of discrimination. This will be dealt with in more detail further on.

Having said that, the industry has been quick to react to other social developments, for example the increased propensity for people to take more than one holiday each year has resulted in annual travel policies; similarly home contents insurers have responded to the major boom in the domestic use of computing equipment. In general, if a member of the industry perceives that there is a potentially profitable part of the market that has not yet been penetrated, be that serial holidaymakers, PC buffs, or co-habiting drivers, then it will try to exploit it and, if it is successful, it will soon be joined by the rest of the industry.

3.5 **Changing risks**

How well does the industry react to changing risks?

It is hard to be precise - there is an huge range of risks for which the industry provides cover and they are continually evolving - but from what we have seen the answer is probably something like the proverbial curate's egg.

In essence, the industry is cautious. It has every right to be - after all, its members will suffer much more than their policyholders should they get their overall policies wrong. Hence, when new risks emerge or old ones mutate, the industry will look closely at the developments before acting. When one or more insurer feels that there is a demand for cover and that it has enough information to be able to price the risk properly then it will start up the market.

An example of this would be in the mortgage indemnity guarantee business. When the property market nose-dived in 1990/1991 and the recession began to bite home many insurers found to their cost that their mortgage guarantee business, far from being the goose that laid the golden egg that they had thought it was during the preceding boom years, was in fact rather more like a turkey. Many insurers promptly withdrew from the market whilst others withdrew on a temporary basis, re-entering shortly afterwards with a much altered product that limited the insurer's exposure and introduced an element of coinsurance with the lender.

In the end, if there is a market that is prepared to pay what an insurer believes to be an economic premium, then cover is generally available. If no insurer has a view on what an economic premium level is, then cover is generally not available.

4. Public interest issues in product pricing and underwriting

4.1 **Price variation between insurers**

Prices for covering identical risks can vary by large margins between insurers. Is this in the public interest?

The answer to that is probably "no" but that is not to say that it is against the public interest. It is worth considering here why such margins occur and what the consequences of them are.

Some price differentiation is a manifestation of the free market economy (or at least a manifestation of imperfections in the free market economy that prevent achievement of price/demand equilibrium throughout the market) - producers charge the price at which they wish to sell their wares and consumers pay the price that they feel represents fair exchange for the wares. This situation is corrupted if there is a cartel in operation or if there is any element of compulsion. However, it does not explain the size of margin that can exist in general insurance prices which can be due to several things: different rating structures (for example, Insurer A uses a rating factor ignored by Insurer B, Insurer C allocates postcodes between 20 postcode groups whereas Insurer D has only 5 postcode groups), different in-house experience leading to different weightings being given to the rating factors, different judgements being applied to similar experience by management, different profit targets, different expense experience or expense allocation methods, deliberate cross subsidies between products, etc. In short, despite the advances made in the use of statistical analysis, the science of general insurance pricing is sufficiently an art form for the output of the various pricing "artists" to look strikingly different.

So the reasons for it happening are, in general, innocent enough. The consequences, whilst at times irritating, are also largely benign. The main consequence is that a policyholder, having bought cover from an insurer at one price, finds out that another insurer would have provided cover at a much lower price. This can result in feelings of annoyance and resentment, but, assuming that the policyholder was a willing buyer of the cover, that resentment is really at a bargain missed. It is akin to someone buying, say, a washing machine in one shop only to walk into another shop to find the same machine on sale for a lower price.

Another consequence, and a more worrying one, is the adverse press coverage that large differentials might engender. High premium rates relative to those available elsewhere in the market tend to generate reports in the personal finance columns about "rip-offs" which damage the reputation of the relevant insurer and indeed of the industry as a whole. Unfortunately, the obverse of this situation - that many of those insurers not "ripping off" their customers might instead be incurring losses - is equally

likely to attract adverse publicity, this time in the business pages. The industry could get caught between accusations of sharp practice and accusations of incompetence. It needs to steer its PR between these two.

4.2 **Price variations between risks**

The cost of obtaining seemingly identical cover can differ hugely between putative policyholders. Are these differences in price between risks acceptable? Indeed, is it socially desirable that "risk prices" are charged for inner-city home insurance risks when this can mean that the cover becomes unaffordable to those who need the product most?

The underlying principle of the free market economy is that of "willing buyer, willing seller", with the seller under no obligation to sell for less than he/she perceives to be his/her economic cost. The average cost and frequency of claims varies considerably between different risk groups which provides at least some reason for the wide disparity between insurance premiums. It is likely that these differences will increase in magnitude as the better risks exploit developments in the management of safety/security/etc. and the poorer risks continue to fail to exploit them, either through ignorance, poor management or physical inability.

That is the explanation of why these variations have developed. The question remains whether they are in the public interest.

Household insurance

The issue of the high cost of contents insurance for inner city dwellers was covered to some extent by the Household Working Party that reported to GIRO in 1998. One of its conclusions was that household cover is currently available to virtually everyone and that the cost is not excessive. However, for various reasons, a significant percentage of the population (about 20%) are not buying it.

This was backed up in a recent survey[1] which noted that those households without cover tended to fall into certain groups:

- 94% of home owners (including mortgagors) had this cover, while just over half of those in rented accommodation did not (the proportion of renters without cover hardly varied depending on whether or not the tenancy was private or with a local authority or housing association)

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[1] *Paying for Peace of Mind* by Claire Whyley, James McCormick and Elaine Kempson, Policy Studies Institute Report no 852, 1998.

- 40% of those with a net weekly household income under £100 were uninsured
- 96% of those with a weekly income in excess of £400 had contents cover. This implies that some well-off households are not insured so a lack of insurance cannot due purely to poverty, although it is clearly either a contributory factor or a strong indicator.

The reasons for not having insurance were varied. The authors of the report categorised the uninsured as

- *delayers* - those who had never got round to it;
- *unawares* - those who had never thought about it;
- *objectors* - those who had an unfavourable attitude to it, although it included those who thought insurance was a "rip-off", who might therefore to a certain extent also be included as price/condition excluded;
- *evaluators* - those who were still trying to make up their mind;
- *price/condition excluded* - those who felt they could not afford it; and
- *access excluded* - those who had tried to get insurance but failed.

By far the largest category was price/condition excluded, amounting to half the sample; the smallest, accounting for only 2% of uninsured, was access excluded, while objectors amounted to only 4% of the sample.

The same report did not conclude that formal "red-lining" - the intentional exclusion of certain risks - was a serious problem. Non-insurance tended to arise from a number of factors. Those in high-risk neighbourhoods could generally get insurance if they tried hard and could pay for it, although they found it harder to get a quotation. Again, this backed up the work of the 1998 Household Working Party, as did another recent report, published by the Joseph Rowntree Foundation[2], and a study by the University of Bristol's Personal Finance Research Centre.

Some of the price/condition excluded suffer through living in an area or property deemed to be high risk, with consequentially high levels of insurance premiums. Neighbourhoods differ greatly in the degree of expected loss that arises for household contents insurance. Principally this is a matter of differential rates of burglary, and burglary-related vandalism. The improvements in risk analysis made possible in recent years by better statistical techniques have facilitated greater price differentiation. The better these techniques become, the more differentiated prices will become.

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[2] *Kept out or opted out? Understanding and combating financial exclusion* by Elaine Kempson and Claire Whyley (for the Joseph Rowntree Foundation): published March 1999

Other price/condition excluded people suffer through budgeting on a weekly basis. Many do not have bank accounts. Many insurers insist on either the payment of the annual amount of the premium in full once a year in advance or a monthly payment by standing order or direct debit. The former course is prohibitively expensive for poorer households whose budgeting skills may be poor; the latter course is not open to those who do not have bank accounts and, as the insurer will normally charge for the loss of interest and the expense of operating the direct debit, it will add to the cost[3]. Home service companies could provide a partial answer, but their representatives form networks that are expensive to maintain, and might in any case be more directed these days to sales rather than premium collection.

It is normally to be expected that poor people will buy less of everything than rich people, inferior goods excepted. Whether there is any public policy issue at stake depends, therefore, on whether or not insurance is considered to be such an exceptional product that intervention is needed in the market to improve the access of poorer households to it. The absence of formal red-lining suggests that this is not actually a problem that needs addressing *per se*. A more likely strategy would be price reduction. However, if prices were required to be held down below profitable levels, formal red-lining might become more of an issue, and it would be reasonable to expect limits on companies' freedom to refuse coverage as well as on their freedom to price.

We have identified the following broadly defined policy options for government and the insurance industry in dealing directly with this situation:

- do nothing;
- subsidise cover for poorer households;
- do more within the current system;
- introduce limits of insurers' freedom to price and decline proposals;
- "baseline insurance"; and
- introduce government-funded insurance schemes of last resort.

These we discuss in detail below.

- **Doing nothing** would obviously not address the situation. Yet the other options require measures that do not exist in any other market. If it were considered that the situation was not serious enough to justify these then doing nothing would be

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[3] The Joseph Rowntree study was very concerned that services in general - not just insurance related services - were increasingly assuming that customers had existing relations with financial services providers, and that it was becoming increasingly hard for those outside the system to break in - a classic Catch-22 situation. This left them exposed to higher costs, an inability to buy services that they might need, and vulnerable to unregulated and shady local "financial services" suppliers.

acceptable. This is by no means an indefensible position. The interviews with the uninsured in the both the PSI and Joseph Rowntree reports showed that a significant proportion were unconcerned about not being insured. Even among those who were concerned, it was by no means clear that they were so concerned that insurance would be among their top priorities for spending if they received a modest boost in income, sufficient to cover the premium. A modest proportion were actively hostile to insurance and would be unlikely to want it in any circumstances.[4]

- **Subsidising insurance** is essentially the approach taken in other areas of providing essentials for the poor. The most obvious example is the provision of Housing Benefit. A mechanism to do the same for insurance might be similar, but this is not necessarily so. An advantage of this approach is that it will address the problem without the commercial distortions of intervening in commercial decisions. Also, it may be argued that it is appropriate, if the government wishes to take action to cure a perceived wrong, that the cost should come out of the public purse. Providing something for somebody who could not otherwise afford it is a social welfare cost, and therefore one that should be borne publicly. It is generally considered inappropriate that low income families should go hungry, but the remedy is not to require supermarkets to provide food below cost, but to provide an income from the public purse from which food may be bought.

  Against this approach there are several objections. The public purse is strained, and this would be an unwelcome burden on it. The level of public expenditure is about 40% of GDP; there are disagreements over whether this is too high, too low or about right. These are questions of political philosophy rather than of right and wrong, or even of economic theory. Even if the amount were to be found, it is far from certain that subsidising insurance for poorer people would be the most appropriate priority for its spending.

  Moreover, a subsidy is likely indirectly to raise the cost of insurance[5]. All other things being equal, it would therefore put extra profit into the coffers of insurance companies. This could be politically an unacceptable consequence, although it would be hard to prove definitively.

  Such an approach would therefore carry a significant PR risk. Actuaries, through understanding and hence being able to explain the levels of premiums, could help manage this risk, thus acting in the public interest as defined in Section 2.5.

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[4] The attitude of the PSI report, it should be noted, is contrary to this. In it the authors' attitude appears to be that everybody should have insurance, even if at present they think that they do not want it. Although the opinions to support this option were drawn from the PSI report, it would be misrepresenting that report to suggest in any way that this option was consistent with the report's conclusions.

[5] This is an economic argument. It is a standard piece of microeconomic theory that a subsidy on a good raises both the amount produced and the price.

- **Doing more within the current system** is possible. The PSI report identifies a number of schemes set up by local authorities to allow their tenants to buy insurance. These are placed commercially with insurance companies. They provide insurance at a flat rate to tenants of the local authority, and have apparently proved to be commercially successful. It would be interesting to know how companies can provide this insurance profitably to local tenants in a group scheme when they could not do so on an individual basis. To a certain extent the better areas will be subsidising the worst, but this is unlikely to be to an egregious extent, or tenants in the better areas would take their custom to the market individually. At least part of the answer is that the cost burden on insurers is reduced, as many of the local authorities concerned run an insurance-with-rent scheme, under which the premium is collected with the rent and passed in bulk to the insurer. This also obviates the problems with weekly budgeting and the lack of mechanisms to make regular payments that poorer households may face.

  Other advantages are that no distortion of the market is required. A disadvantage might be that the poorest households could still not afford cover. Insurers might do more by marketing more actively to local authorities and housing associations.

  The problem may be more on the other side of the relationship. Not all local authorities appear to want to operate such a scheme, finding it administratively fairly cumbersome, even though those that accept a commission generally find it is profitable to them to do so. The PSI report suggests that local authorities with housing stocks (generally District Councils, London Boroughs, Unitary Authorities and Metropolitan Boroughs) should be required to operate such a scheme. Housing Associations are sometimes too small to manage the administration, but it is sometimes possible for them to join together for this purpose to attain critical mass, or to piggy-back on a local authority's scheme. The PSI report notes that the local authorities that do not have schemes are by no means those in the highest-risk areas. This seems to suggest that, at least to a certain extent, local authorities that do not have schemes have not sought them because their tenants have few problems getting cover on the commercial market. Whether or not it should be made a statutory duty of local authorities to initiate a scheme depends on how important access to insurance is considered, and whether or not tenants in those areas that do not have schemes currently lack access in the commercial market. It should also be noted that it is possible that some local authorities would not be able to find willing insurers if they did try to initiate a scheme.

  Another way in which insurers could do more within the current system is to boost sales efforts in the high-risk areas. This is unlikely to be very successful. It has already been observed that these areas are likely to have high premiums, and poor households, who may find the mechanisms of payment difficult. It is, presumably, not without reason that insurers' operations in these areas are currently modest.

Within the existing household market, more could be done to design products that would meet the needs of low income and high risk families. The option of spreading the cost of cover across the year is frequently cited as something that will be attractive to low income families who do not have the wherewithal to make lump sum payments. But this is unlikely to be a practical solution, with the demise within the industry of the direct sales forces and with a significant proportion of the uninsured also making no use of other financial services such as banks. This approach does not lend itself to a cash society.

Another popular suggestion is to design cheaper products for high risk areas, such as indemnity only cover with high excesses or catastrophe only cover. This would not meet all of the insurance needs of families in these areas but would provide at least a basic level of cover at an affordable price.

- **The Introduction of Limits to the Freedom of Insurers to Transact Business** would be a major change in the business environment. There are many ways that limits could be brought in. For example, insurers could be forbidden to use certain rating factors such as area. Proxies for the forbidden factors would also have to be forbidden. These could be accompanied by prohibitions on declining proposals. Similar restrictions to these are in force in a number of American states, although these exist mostly on the motor side and are aimed primarily at preventing insurers underwriting on race.

  One objection to this would be that it would not in fact bring insurance within the reach of every household, as the non-underwritten premium could still be too high for the poorest households. Absolute limits on the premium rates charged, and a prohibition of minimum sums insured and minimum premiums would meet this objection.

  The obvious point to make in favour of a proposal such as this is that it overcomes the problem identified of households having very restricted access to insurance. A secondary advantage is that it does so without recourse to the public purse.

  The fundamental objection to this type of proposal is that it forces a subsidy from low-risk households to high-risk households. This is a form of social welfare transfer. It might be thought that this should more properly be done through the public purse. No other commercial operation is expected to act as a re-distributive social welfare mechanism.

  Other practical objections may be made. Such arrangements might discourage insurance buying among low-risk households whose premium rates are increased. They are likely to discourage innovation among insurers. They might also discourage risk management such as policyholders taking steps to reduce their risks. Finally, they might encourage certain undesirable practices, for example developers building on river flood plains, secure in the knowledge that, despite the expected

propensity of the newly constructed properties to flood, it will be possible for them to be insured.

- **Baseline Insurance** involves regulatory intervention without excessive interference with the existing system. We have already touched upon an example in the creditor insurance market for mortgages. In California, the authorities have adopted a similar approach in tackling the problem of high rates of non-insurance in specific zip-code areas. The resultant "low cost insurance policy" is just a standard policy with all the extraneous bits cut out, and is aimed at making the price of insurance more accessible. A risk is that it might result in people purchasing insurance which does not provide the full cover that they need and believe that they now have. The cost of the product in very high-risk areas is still likely to be prohibitive, regardless of how baseline it becomes. Nonetheless, it is an idea that we could see being popular, albeit with some adjustment, with the current UK Government, who would probably term it a "stakeholder insurance policy".

  The stakeholder policy would not be written by the Government - the Government would merely specify certain constraints which must be satisfied for the policy to be called "stakeholder" - and insurers would still be free to sell non-stakeholder policies, so the approach falls short of imposing regulation on the industry (although it would inevitably distort the market). It is probably analogous to the ISA CAT standards.

  An obvious difficulty is determining what the required standards would be (low cost, no undesirable exclusions, limited commission, etc.). The idea clearly requires a lot of thought before being put into practice but it would appear to be worth pursuing further.

- **An Insurer of the Last Resort Scheme** would be similar to a subsidy. It would also affect the commercial market in an unpredictable way. It would, however, meet the problem it is intended to address.

These are direct actions (or inactions) to deal with non-insurance. In high-risk areas some indirect actions could be taken to make the cost of insurance more affordable, by tackling the drivers of the risks. Insurance initiative could be part of this, for example subsidies put in place along with better policing, environmental improvements, subsidies for businesses considering moving into the area and other urban regeneration measures. Similarly, action could be taken to address the causes of poverty, rather than just to provide cheap insurance to the poor. These ideas are outside the scope of this report but they do seem to be better targets for Government intervention, to treat the ailments rather than the symptoms.

In conclusion, there is a significant proportion of the population who have not bought household contents cover. For the majority such cover is available but not at prices that these people regard as affordable. The industry and Government could both take some action that would improve the availability of insurance for these people but it is questionable whether, with it being a discretionary purchase, any more insurance would be bought. There is here an element of leading horses to water but not being able to make them drink. As one of the authors of the Joseph Rowntree report concluded, "Knowledge about financial services is remarkably low amongst households that are without them."

Other insurance

The issues raised above do not all transfer easily to, say, creditor cover, employers' liability insurance or facultative insurance, and so the preceding section is a poor representation of general insurance issues in general. However, there are parallels with other forms of insurance - for example, insurance for small commercial businesses operating in high risk areas, either geographically or commercially - and many of the points raised here in connection with household insurance are equally applicable to these other forms of insurance too.

Another area of concern is the availability of motor insurance for young drivers, particularly young males. It has been said that the industry has acted in the public interest by charging high rates and thus keeping 17 year old boys from driving around in Sierra Cosworths and their like, and there is some truth in that. However, premiums are now so high for young males that many cannot afford cover for driving even basic models such as Fiestas and Minis. Is this desirable?

As the social environment currently stands the answer is probably "no". Public transport, particularly in rural areas, is often infrequent and unreliable; many people need to be able to use a car to buy basic essentials or to get to any form of work. With insurance premiums rising to levels that young drivers deem unaffordable, many are simply opting not to have insurance and thus to break the law.

Of course, this is not really the fault of the insurers, although it is they who will get the blame for the increase in uninsured drivers. Rates are increasing as claims costs are increasing. Claims costs are rising as the roads are more crowded, cars are more powerful, the number of miles driven by each driver is rising, etc.

Again, many of the actions suggested for household insurance could be applied to this issue. An alternative approach might be to encourage young drivers (and also those other drivers deemed to be of high risk) to use other forms of transport, on which they would pose no threat to the public, for example by subsidising their use of taxis. The costs of this particular example would be horrendous but the best solution to this issue is likely to arise from such lateral thinking, rather than from interventionist action within the insurance market.

4.3 **Limited price variations between risks**

The above is all about products where the rating structure allows significant differentiation between policyholders. Products such as creditor, legal services, extended warranty, etc. are rated on a cruder basis than their cousins in the household and motor markets. Inevitably, crude pricing leads to more cross subsidies from the good risks to the bad risks. This is consistent with the principles of insurance although trends within insurance have been towards greater segmentation of risks.

One suspects that the public would view these cruder product designs as beneficial if it saw as a consequence that no one was being discriminated against when they tried to buy cover. However, the public would feel less sanguine towards the designs if it thought that as a result large groups of policyholders were paying excessively for cover, even though others were getting a good deal. After all, it has been the public, as demonstrated indirectly by market demand, that has led the way to greater market segmentation and more complex rating structures. The public's view depends on the "spin" placed on the issue. Those members of the public who feel that they are among the groups of policyholders paying excessively tend to be considerably more vocal than those who feel that they are benefiting through cross subsidies keeping down their premiums. This would appear to be an area where actuaries might stimulate, or at least inform, public debate by delineating what the choices really are.

It is interesting to note the recent history of travel insurance. The rating of this product is becoming more sophisticated, with older travellers paying more (due to the likelihood of the occurrence of a costly medical complaint increasing with age). The trend is in the same direction, if not so far advanced, as motor/household. A television programme recently criticised this trend and the rates that insurers were now charging the elderly. It avoided the issue of the lower rates now charged to younger travellers.

4.4 **Price variation at renewal**

Most general insurance is on an annual basis, with a two way option to renew the cover at the end of 12 months for another year. From one year to the next prices can vary, up or down, by significant amounts. This may be for well understood reasons (for example, a loyalty discount, a change in no-claims discount, or a change notified by the policyholder in the underlying condition of the risk). Often, however, the reason for this change is not obvious to the policyholder, for example, in household insurance if the change is due to the policyholder's postcode being re-rated from risk group X to risk group X+1/X-1.

Grouping of risks is one of the principles of insurance. Market and marketing pressures

have resulted in some degree of segmentation of risks. The wide range of expected experience between the different risk groups means that the prices charged for each vary significantly. Those risks on the edge of each group are therefore likely to experience significant price changes if an insurer decides that they have been incorrectly grouped. Ironically, the greater the degree of segmentation, the less the likely maximum variation at policy renewal as the differentials between the various groupings will be less.

This is one of the reasons behind the issue and as such is entirely innocent. However, it is not clear what explanation customers are given for such changes nor what sort of explanation they should expect.

There is another potential reason, that of an insurer increasing rates above what is considered to be an economic level, simply to increase profits. Is this in the public interest? If the insurer is not currently loss-making then the initial reaction is "no", the public (in this case represented by the policyholders) having to pay more for no further benefit (unless they are also shareholders of the insurer, or otherwise beneficiaries through cross subsidy of another product). However, we are back to the "willing buyer, willing seller" argument that underlies the free market economy. Policyholders in general appear increasingly willing to shop around. If the insurer prices its cover too highly most policyholders will show their displeasure by buying their cover elsewhere. Moreover, no other UK industry (except, possibly, housing and those recently privatised industries that are considered to be public utilities) is constrained from making price rises because it would like more profit.

This argument falls down if there is a concerted effort by the industry in general to raise the level of profits by all insurers increasing their rates or if there are mitigating reasons why the customer does not shop around. The latter is covered in Section 5 of this report, and the former is supposedly outlawed as it is a manifestation of a cartel. However, it is worth remaining on this issue for a little longer. Within the insurance market, groups of professionals from insurers transacting the same type of business (such as private motor underwriters, composite insurance actuaries, etc.) meet informally from time to time. Their conversations inevitably touch on matters of mutual interest. Aside from market and social gossip, these matters of mutual interest chiefly appear to be issues where any individual company's experience is limited (large claims, subsidence and new initiatives such as CUE spring readily to mind) and where pooled knowledge enables more efficient management within the industry. Therefore, as they currently occur, meetings of these groups are not a manifestation of anti-competitive practices. However, at the moment the UK market is sufficiently fragmented that those attending these meetings do not represent a dominant share of the market. Should the market continue to contract through mergers and acquisitions then it is possible that these groups would begin to represent a dominant market share and hence their operation would questionably not be in the public interest.

Some insurers have determined that the propensity of their policyholders to shop around at renewal for the best deal has some correlation with other easily measurable characteristics. They are then using these characteristics to segment their existing policy bases and are offering those that they believe are more likely to shop around better deals on renewal than they are offering the others (effectively cross subsidising between passive and active policyholders). Some insurers are applying this in a very sophisticated fashion. The consequence is that risks with an apparently equal expectation of future claims experience might be charged very different premiums, and that these differentials might be increased at each renewal. Is this in the public interest?

We have considered this at length, yet were unable to conclude definitively whether or not the practice is or is not in the public interest. We agreed that we would all individually be displeased if we were among the policyholders affected and realised that seemingly identical policyholders were being charged much less for cover. Such realisations could result in very negative publicity for the insurers involved and we sincerely hope that they have appropriate PR plans to mitigate the issue.

One concern raised was more emotional than logical, but was no less relevant for that. To some it simply felt wrong to charge someone more (or less) because of a judgement made regarding that person's nature, be it considered to be passivity, naivety or complacency, rather than regarding the underlying risk being covered. Furthermore, to charge additional amounts to those who might be considered naïve smacks of sharp practice.

The publicity issue, if and when it breaks, will become much harder to manage if the scale of the differentials continues to increase. If the insurers concerned are unable to manage fully the potential adverse publicity then it will affect the entire industry which is, after all, founded on the basis of trust between insurer and insured.

On the other hand, from a disinterested stance this is just another example of willing buyer/willing seller. Moreover, as retaining business is in general cheaper for insurers than replacing lost business, such measures keep down costs and allow better profits and/or lower premiums for the overall benefit of more than just the policyholders who received affirmative action. Unless it is actually outlawed, those insurers who can operate this practice will be seriously disadvantaged if they do not.

We also considered in passing the practice of some insurers, mainly direct writers, to test matters such as the price sensitivity of the market by experimenting with rate changes for short periods for small groups of prospective and/or existing policyholders. Again there was an emotional reaction, that it did not feel right to use (or "exploit" if we were to be really emotional about it) people in these experiments. Then again, it is still "willing buyer/willing seller". It also does not feel as wrong as offering differential rates at renewal in that the selection of policyholders for these tests is based more on general groupings rather than on personal characteristics such as lifestyle. In other words, as it is more random it seems more legitimate.

4.5 **Price variation and the insurance cycle**

For most of the market there is a pronounced pattern of variability in emerging profits. This pattern can equally be seen, albeit slightly earlier and without the overlay of claims fluctuations, in the premium rates being charged. The pattern is more pronounced for certain lines of business than for others.

In the UK, the pattern has been seen particularly clearly in recent years in motor premiums and profits. Premium rates gradually fall as insurers chase or seek to retain market share (by being more competitive), consequently profit margins are eroded, emerging profits become emerging losses, until, at some point, the bulk of the market decides that it cannot sustain such losses for any longer and the premium rates go back up again, usually to levels at which the accumulated losses can be recovered. Once those losses have been recovered the desire for market share becomes predominant once again, rates are cut and the pattern is repeated. In other markets similar patterns have been seen.

The extent to which this is a cycle is questionable - certainly, the shape of the premium rates over time resembles more a saw tooth pattern than a traditional sinusoidal wave pattern (the fall in rates being gentle, the increase in rates being very rapid), and the distance between the peaks and troughs is not consistent, nor is the depth of the troughs/height of the peaks. However, the pattern is generally referred to as a cycle, albeit one that is not yet clearly understood and upon the development of which a legion of factors impinge, for example experience, technology/techniques, management strategy and activity, and management ignorance and inactivity. The cycle is in effect a manifestation of imperfections within the insurance part of the free market economy.

The principal consequences of the insurance cycle are as follows:

- *Fluctuations in prices and underlying profits* : as previously discussed
- *Fluctuations in the availability of insurance (and reinsurance)* : when the cycle has passed through its trough and until after it has peaked there tends to be a shortage of capital in the market and hence the demand for insurance may not be satisfied.
- *Barriers to market entry* : the best time to enter the market is when the cycle has just "troughed" and existing capital has been battered. Ironically, the psychological barrier to entry is at its greatest at this time, and at its weakest some time after the cycle has peaked, when there is evidence of a period of sustained profit in the market (despite the downward trends).
- *Image of the industry* : it is a matter of some surprise that the industry has not received a worse press for its "boom and bust" pricing approach over the past 10/20/30 years in personal lines. The steep variations that customers see in their

rates from year to year (clouded admittedly by rating reviews and changes from time to time in the underlying risk factors) cannot be good for the industry's image. It may be that, with the emergence of alternative risk transfer vehicles, the pricing of which might be more stable, greater use will be made of alternative risk transfer ("ART") products at the expense of insurance, although clearly the potential for personal lines policyholders to use ART products is limited.

- *Insolvency (and more image problems)* : in the current business environment a likely consequence of the cycle is that some insurers will go bust. When this happens it is bad for the industry's image, despite the existence of the Policyholders Protection Board (and despite the possibility of bankruptcy being a key discipline in a free market economy).

Overall, the insurance cycle means uncertainty for everyone involved - management, policyholders and shareholders. In theory this is not in the public interest but let us not forget that uncertainty often promotes positive and innovative thinking, which often is in the public interest.

The question of whether it was possible to control or eradicate the insurance cycle was discussed at last year's Convention during one of the workshops ("Riding the Insurance Cycle"). The consensus view was that it is not possible to control the cycle as its drivers are still too unpredictable to model and as it is still heavily influenced by human actions, which themselves may be irrational. Eradication might not be in the public interest anyway - as has been discussed, although the cycle can lead insurance premiums on a roller coaster ride that policyholders find uncomfortable, it also periodically makes entry to the market much easier for new players and it accelerates the shake-out of the poorest performers, to the overall benefit of the general public.

4.6 **Premiums and the use of data**

We wondered whether there were any issues regarding the use of data. This prompted a detailed consideration of the various pieces of data protection legislation. We concluded that, with the present usage of data within the industry, there were no significant issues. We therefore relegated the results of the research into the legislation to Appendix A.

5. Public interest issues in product distribution

Satire is a caricature of grim reality. It only works with those people who recognise that reality through their own experiences. Readers who regard the above as amusing should consider which of their experiences lead them to that conclusion - do those embrace not only Dilbert's IT industry but also the general insurance industry? Those who do not find it amusing may well struggle with this section, indeed with life itself.

5.1 **Product availability**

It is widely believed certain insurers make their products unavailable to particular risk segments, by judicious use of distribution networks or through explicit red-lining. True or false? And if true, then acceptable or otherwise?

As mentioned earlier, various surveys have found no evidence that large numbers of potential personal lines policyholders are being excluded deliberately by the industry in general, although individual insurers might be red-lining particular risk groups (for example, publicans for motor insurance - such groups find obtaining insurance difficult from many of the high street names and tend to rely on specialist insurers and insurance brokers). Insurers may also red-line areas where they have already written much business and now wish to avoid further accumulation of risk, to a level beyond what they consider to be acceptable, in that area. This is an important part of the prudent management of insurers and it is therefore clearly in the public interest that they are allowed to do this.

Whilst insurers might not be trying to exclude any groups of potential personal lines customers there are some who find it difficult to gain access to insurance. This in part reflects the general tendency for much personal lines insurance cover to be sold rather

than bought. For mortgagors, the mortgage sale is a point at which they will be offered house contents insurance, even if the mortgagee cannot make it compulsory. Once a first sale is made, the mortgagor will be likely to view insurance premiums as a normal part of household expenditure and to keep a policy active. Those who remain tenants throughout their lives may never have had an opportunity of being sold insurance in this way. Much of insurance sales promotion, across all product lines, tends to be directed towards those who already have the product, or at least are already familiar with it, rather than those who do not. Finally, because the poor and those living in high-risk areas find insurance to be expensive, high-street brokers may conclude that it is not worthwhile to set up branches in areas where this is likely to be a problem.

Direct sales forces, particularly those with an industrial business focus, used to be able to address these issues to some extent. However, the decline in the numbers and sizes of such sales forces (only a few of which ever sold general insurance products) has reduced their capability. Moreover, such sales forces cost a lot to run and so their focus has been switched to selling high premium products such as savings and pensions policies that contain sufficient margins to cover the costs.

Even those home service agents who are encouraged to sell general insurance may be reluctant to sell in poorer areas. Not only do agents view these areas as worse prospects (and hence likely to earn the agents less commission for effort expended) than more affluent environs but they are also more concerned for their physical safety in some run-down areas and hence are inclined not to visit.

The more financially naïve find insurers and insurance brokers to be intimidating. For them to actively buy insurance it has to be available through bodies that they already trust and with whom they feel comfortable. The Post Office is often suggested as one such body.

Stepping away from household insurance, are there problems elsewhere? Certainly young drivers and those with poor driving records and/or convictions may well find difficulty finding insurers willing to provide cover, although there is almost certainly someone willing to accept the risk. Whether or not the premium charged is acceptable to the customer is another matter. The same is true for virtually any sort of insurance.

One area where availability may be an issue is that of insurance sold in conjunction with other products (usually non-insurance related), such as creditor insurance on the back of personal loans and extended warranty on the back of, say, a DVD player. In these cases there is clearly product availability but there is little or no choice regarding supplier and hence only a very limited chance to shop around for the best deal in terms of price and cover.

5.2 **Brokers' commissions and volume-related commissions**

Do differential commission rates inappropriately influence the advice given to policyholders by brokers or other independent intermediaries? Is it appropriate that brokers or other independent intermediaries tend to look only at a limited panel of insurers? Should there be full disclosure to the policyholder of the commission payments being received by the broker? And do volume-related commissions also inappropriately influence the recommendations of brokers?

First of all, there is nothing wrong in principle with payments to intermediaries. Intermediaries perform work in order to sell products and, in the case of brokers and other independent intermediaries, to provide consumers with choice. They also take some of the administrative burden from the insurer. It is right that they are remunerated for their efforts. However, some people do not like paying explicitly for services or advice, so commission is a way of compensating the intermediary for marrying up products and buyers. Whether or not it is the best way, and certainly whether it is the best way in all circumstances, is open to question.

In order to consider this subject it is worth considering at this point some of the trends that are taking place in the distribution of personal lines and commercial insurance.

- Brokers and other independent intermediaries account for more than 45% of personal lines distribution. Previously this percentage was much higher. In recent years there has been a significant growth in the volume of business distributed by direct channels, although this now seems to have plateaued. The personal lines marketplace has become extremely competitive and both motor and household business are in the middle of a soft market. This has forced a degree of consolidation amongst insurers and there are also signs of a significant consolidation amongst the broking community.

- A strong view exists in some parts that within five years few regional and local brokers will transact significant volumes of personal lines business. In addition, a number of insurers are expected to pull out of the personal lines market and concentrate on commercial business in order to make what they consider to be an adequate return. Those brokers and other independent intermediaries who continue to conduct personal lines business will be dealing with an ever dwindling number of insurers as the industry consolidates, with the result that partnership arrangements are likely to become more common. Such partnership arrangements generally include not only profit commissions paid by the insurer but also sliding scale commissions based upon the volume of business introduced to the insurer.

- Within the commercial lines market, brokers and other independent agents control over 80% of the market distribution. This is highly concentrated amongst the international and top 200 provincial brokers. For small and medium size

commercial business the insurers are increasingly focusing on a small segment of the provincial broker market. Targeted brokers are thus placing the bulk of their business with fewer and fewer insurers. The pace of this panel consolidation appears to be increasing. Datamonitor Research, which was commissioned by Ernst & Young, indicated that the average panel size for a provincial broker has now fallen to 46 insurers. Within this it is not uncommon for 90% of the business to be placed with fewer than 10 insurers.

- A number of insurers, most notably Norwich Union, Eagle Star and CGU, have launched "club" and "preferred" strategies in an attempt to reinforce this behaviour by working in partnerships with the brokers. As brokers struggle to meet profit share criteria for participating schemes and the insurers look to lock them into partnerships, many such brokers will become tied or multi-tied agents.

- Where insurers have a broker "club", they are generally made up of a select bank of intermediaries who are offered unique products or services. These are usually brokers who, in return for producing substantial business for an insurer, receive rewards in the form of increased commission.

- A number of major insurers own brokers or intermediaries, e.g. Royal & Sun Alliance and Swintons, Norwich Union and Hill House Hammond. This gives rise to an obvious conflict of interest, which may not be communicated to the client. Regulations restrict the amount of business that wholly owned brokers may place with their parent companies but there appear to be no formal restrictions that apply to other types of intermediaries owned by insurers.

- There has been an increasing trend for certain insurers to make net-rated products available to brokers for sale to their clients. The insurer seeks an agreed level of premium for the policy, the broker sells the policy for what is can get from the customer. The same broker can therefore sell the same product to two different clients at different prices. This is another manifestation of the differential pricing that we have discussed at length in section 4 of this report.

The scope and range of these market trends was a concern to the Insurance Brokers Registration Council ("IBRC"), the statutory body for broker regulation in the UK. When the Government issued its consultative paper on broker regulation in the summer of 1998, the independent Council Members of the IBRC (i.e. those appointed by the Government and not from the broking fraternity) decided that it would be appropriate for them to issue an independent response. Within this response they brought a number of their concerns to the Government's attention:

- The broking industry has been developing in such a way that there is a continual need to reinforce the law of agency. It was recognised that brokers and independent intermediaries operate under a conflict of interest in that they act on

behalf of a client, but are usually remunerated on a commission basis by the insurer. A broker's personal financial rewards are often directly linked to the amount of money extracted from the client, although it is recognised that fee-based remuneration for advisers is now increasingly common, particularly in the commercial and London markets. In addition, since most insurers who sell their products via intermediary channels now offer special deals to brokers and intermediaries based on agreed business volumes, there was a need to reiterate to the broking community the law of agency and for them to identify their client. In theory the law of agency tells the intermediary where its loyalty should lie and so provides the insured with adequate protection. However, intermediaries frequently misunderstand their legal obligations and fail to manage properly the principal/ agent relationship. For this reason a recommendation was made to the Government that the assistance of potential additional remuneration by way of volume commissions paid by insurers should be fully disclosed to the client.

- The trend for brokers to deal with increasingly small panels of insurers was also concerning the independent IBRC Council Members. The regulatory submission for IBRC brokers requires them to identify where any insurer accounts for more than 15% of the risks placed. The establishment in recent years of club and preferred strategies by the provincial insurers has been forcing a number of brokers to consolidate the placement of their business. Many of these arrangements are geared to the profitability of the account and, in the current soft market where profits are few and far between, many brokers are under severe financial pressure. The inevitable outcome is that these brokers will get ever closer to one or two insurers, and ultimately are likely to become tied agents.

- There is no requirement for general insurance brokers to disclose to policyholders the level of commissions that they receive. The recommendation was to introduce disclosure of fees and commissions to give transparency. A secondary concern was that a level playing field should exist between disclosure of commission for financial services and general insurance business. This met with resistance from the broker community who felt that the current economic climate meant that their businesses were already suffering without an increased focus on the cost of doing such business. Their view was that it would put them in a poor light when compared with the direct underwriters, although they were offering a valued additional service, being that of choice.

- The overall view was that the basis of broker remuneration should be disclosed if not the quantum. The problem is one of commissions being hidden from the client such that the broker's objectivity is brought into question. At all times objectivity should be clear and transparency of remuneration assists in this regard.

The views of the independent members of the IBRC Council, as expressed above, are not universally accepted. In particular a robust defence can be mounted against the

disclosure of commission on general insurance business on more than just the grounds that such a focus would be detrimental to brokers vis à vis direct writers :

- The concern that there should be a level playing field across all financial services, including general insurance, is spurious due to the differing natures of the products. General insurance usually comprises an indemnity benefit or pre-determined benefit that is paid when a claim occurs. Customers decide whether to buy based on price, cover and service. They know what they are getting for the premium they have paid (notwithstanding comments made elsewhere in this paper). This is a very different situation from that of investment products for which commission is disclosed, the rationale being that the overall level of charges taken from a policy will affect the return a customer gets back.

- It is questionable whether compulsory commission disclosure has improved the lot of the investor in other financial services. In the past investors compared prospective returns, usually based upon past performance (and occasionally on some overly optimistic forecast returns, until that practice was rightly outlawed), and the reliability of the investment house/insurer when deciding which investment to make. Now their decisions are often clouded by resentment about the sums that are instantly being deducted in commission from their initial investment. Any decline in the charges levied since the change in legislation are probably more a reflection of a competitive market where being seen to maximise return is the key to success, rather than of commission disclosure. Indeed, in the investment market, when the LAUTRO maximum commission agreement was stopped as being anti-competitive, the result was that commissions increased. Everyone had expected commission to fall when commission disclosure was brought in but this did not happen. If commission disclosure were to be introduced for general insurance would it reduce overall levels of commission? If the life market is anything to go by it would not, so are the interests of consumers served at all by commission disclosure?

- The provision of services or goods in other markets involves some form of commission (for example, in the form of retailers' mark-up). Yet in very few is there a requirement for this commission to be disclosed. Many of these goods and services are of vital importance to the public (such as food and clothing) and/or involve over the year far greater cost than do insurance products. Why, then, is disclosure so necessary for insurance products? Having said that, according to the law of agency, the brokers should be acting specifically on behalf of the policyholder. Few other providers of services or goods have this legal obligation, so the comparison is not wholly valid. Of course, not all intermediaries are brokers - some would be better described as insurance retailers. The distinction is rarely clear to consumers who therefore can be disappointed with the level of service that they receive. This could be resolved were the intermediaries to make additional efforts to clarify their roles to the consumers at the beginning of any transaction.

- Is there an underlying desire from customers to know about commission anyway? One suspects not, although disclosure would undoubtedly result in some heated comments from policyholders and from industry commentators, via "Moneybox" and the Personal Finance sections of the weekend newspapers.

However, the position for large commercial risks is now a lot clearer. The whole debate hit the press in the early part of this year with announcements by Aon Risk Services in the UK and J&H Marsh & McLennan in the US that they had come to agreements with the Association of Insurance and Risk Managers in Industry and Commerce ("AIRMIC") and the Risk and Insurance Management Society ("RIMS") respectively, on the disclosure to their clients of incentive payments such as over-riders and profit commissions. Aon in particular has pledged to phase out volume over-riders and incentive commissions that it received from insurers for placing business with them. Where such payments remain it has agreed that these should be disclosed to its corporate clients.

Whilst on the face of it these seem to be generous offerings by Aon and Marsh, they have arisen following pressure applied by AIRMIC and RIMS who were concerned as to the extent of consolidation within the insurance markets and the increasing power of the major brokers. Clearly there was a desire for commission disclosure here.

We are aware of some personal lines brokers that expect a similar push for disclosure of commission on their business. We believe that this is still a long way down the track, even if it is coming this way at all. In the personal lines market intermediaries are competing with direct writers and other distribution networks which would not be forced to make full disclosure of their distribution costs. Even were they to do so such comparison would not be meaningful, the pace at which costs were incurred and commissions earned often being out of step. So disclosure of commission for personal lines business would probably provide little benefit to the consumer.

That said, if, as a result of the procedures and practices described above, the law of agency is being broken then there is potential for a very large number of claims for restitution from clients. This could result in considerable adverse publicity for the industry ("another mis-selling scandal rocks insurance industry", etc.). The issue of mis-selling is covered in more depth later in this report.

5.3 **High commissions**

For some products the level of commission levied by the distributor is disproportionate to the amount of work undertaken to distribute the product. Indeed, over half of the premium might be absorbed in this way. Can such commissions be justified? Do they bring the industry into disrepute? Does the involvement of actuaries in pricing such products bring the profession into disrepute?

The areas of the insurance market where commissions tend to be highest are those where insurance is offered as an add-on by retailers of other services, such as warranties on brown and white goods and on cars, creditor insurance on personal loans and car loans, and household insurance at the point of taking out a mortgage. Here 30-50% levels are not uncommon.

The level of commission included will affect the price at which a product is offered. To an extent the customer can shop around for the best price within the market. This comes back to the old argument that we have covered several times already, that if the market price allows high levels of commission to be paid then in a free market economy it merely reflects the level at which there are willing buyers and willing sellers.

This argument is dented if the customer does not have the opportunity to shop around. A retailer will offer only one scheme of extended warranty; a lender will offer only one creditor cover - in both cases, consumers can shop around between retailers or lenders for the best overall package, but it is not straightforward. Moreover, they may well be offered the insurance cover part of the way through the transaction, on a "take-it-or-leave-it" basis. Psychologically, many people find it both hard to back out of a transaction that is partially completed and to evaluate the merits of the overall package. Perhaps this has less to do with commission rates and more to do with the sales techniques used.

Looking at other markets such as retail, the typical mark up can be 3 or 4 times the cost of the goods. This is true for things such as food, clothes, etc. In comparison the amounts of commission charged on general insurance products seem relatively modest.

When it comes down to it, the agent is only going to sell a product if it is financially worthwhile for him/her to do so. For low premium products a substantial (relative to the premium) commission/ fee payment is required if only to cover the cost of the work involved in selling. However, the fact that the highest commissions are found where there is a captive or semi-captive market suggests that there is a market imperfection.

5.4 "**Mis-selling"**

The pensions "scandal" has raised public awareness that mis-selling by erstwhile reputable institutions of financial service products can occur. As a result personal finance journalists tend to explore this possibility with most insurance issues that arise. Yet is there mis-selling? If so, then how widespread is it? What is it, in the context of general insurance? What are the causes? What actions should be taken to minimise the risk of future mis-selling?

Using the broadest definition of mis-selling it has to be accepted that there have been instances of mis-selling within the general insurance market as indeed there must have been within all markets. Moreover, there will continue to be instances. Let us consider these instances first by circumstance and then we will consider the extent to which they occur and possible actions to minimise the risk of reoccurrence:

(i) *The customer does not understand what he is buying*

There is an obligation under the ABI Code of Conduct for the selling of general insurance for the agent to explain the main benefits and exclusions to the customer before the contract is concluded. However, it is obvious that some people do not know what they are insured for. This usually becomes apparent at claim stage when claims are declined because they were not covered by the policy.

The causes of this problem could be the policy design and documentation, as described in Section 4.2, policyholder ignorance or misinterpretation (beyond that which could reasonably be expected, bearing in mind the documentation), or misrepresentation by the intermediary, either deliberate or accidental.

Ignorance and misinterpretation certainly do exist and are impossible to legislate against, although better documentation and sales procedures will mitigate the problem. Accidental misrepresentation also certainly occurs and again is impossible to avoid completely. The effects of improved training are often offset by increased staff turnover within sales teams and by increasingly complex and difficult to understand or explain products.

Deliberate misrepresentation should have been eradicated by the ABI Code. However, there are examples where the Code has been broken, although whether deliberately or through systemic error is a moot point. On reflection, the situation whereby some mortgage lenders used to charge borrowers an increased amount "to cover the MIG premium" without making it clear to the borrower that it was the lender, not the borrower, that was insured, was probably an example of misrepresentation. Whether the lenders regarded it as such at the time is debatable.

(ii) *The product sold is not appropriate for the customer's needs*

In many instances personal lines cover is bought by the policyholder. However, there are circumstances where the product is sold to rather than bought by the consumer. As there is no legal requirement for a fact find before such a sale (as there is when selling life assurance or investment products), it is not possible to establish whether the product being proffered covers the needs, and if it does whether it does so excessively.

Is this a public interest issue? For many people insurance is a major financial outlay and is potentially as important to them as their savings. However, there is a difference. A savings policy may be wholly inappropriate – opted out pensions for example. On the other hand a general insurance policy, whilst it might be a poor fit to a person's needs, it is unlikely to be wholly inappropriate (a motor policy sold to a person with no car would be a good example). Moreover, the contract is shorter term and the policyholder can break it, or replace it with a more suitable one at expiry, with less financial loss. Therefore, the possibility of being sold inappropriate cover is an issue but a less extreme issue than that faced in other areas of financial services. Certainly, being sold a policy that covers more than is needed is potentially a much less serious issue than one that covers less than is needed.

So what can be done about it? Is a fact-find along the lines of the Financial Reviews carried out by life and investment intermediaries a viable proposition? Would the cost of such an exercise be acceptable to the public? Could a hierarchy of personal lines insurance needs be established? And would such an exercise give the public the reassurance that it sought, bearing in mind the mis-selling difficulties faced by the life, pensions and investment markets even since the introduction of such fact-finds?

There are several features of the medium to long term savings market that have driven the move towards disclosure that are not replicated in the general insurance field. The contracts are designed to stay in force for many years, and are generally sold with a minimum recommended term of five years. The penalty to customers who stop their contracts early has historically been extremely high (although this is changing). The future performance of the company is reflected in the returns given to customers, and so high expenses or poor investment performance will have major effects on the return that customers gets. Finally, in many cases, customers will have a fixed sum that they wish to invest and obtain the maximum return they can on it. For all of these reasons, in the medium/long term savings ("MLTS") market, the risk of making a poor decision is largely borne by the consumer, and hence there has been a drive to give the consumer sufficient information to make an informed decision.

Many of the features in the above paragraph do not apply to general insurance products. As has already been pointed out, they are normally short-term products, often with a contract period of just one year. Customers are therefore able to switch between providers regularly, and indeed for contracts paid by monthly direct debit there are virtually no restrictions on a consumer's freedom of movement. The price of the contract is agreed at the outset, and so the effect of poor control of expenses by a company, or indeed obtaining poor investment return, will be to reduce the profits that company makes. While consumers may be indirectly affected by future price increases as a result of poor performance,

they are under no obligation to continue insuring with the same company.

The key difference is that the insurance contract has a fixed price at the outset. It is therefore relatively easy for consumers to get information about the prices at which they can obtain the cover that they want, and to choose the company that offers them the best value. How the contract in question is priced is not relevant to customers – their decision will be based on the deal that offers them the level of cover and service that they desire at the best price they can find. The decision process is far more transparent.

For the process to be truly transparent, consumers need to be given sufficient information that they can establish that the level of cover they are being offered meets their minimum requirements. The role of individuals in the sales process also needs to be clearly stated, so that the consumers know whether the people that they are dealing with are purely providing information and prices for products, or are undertaking to search the market for a deal that best meets the consumers' requirements. In the latter case, if there were a danger that the adviser's remuneration would bias their advice, the arguments for introducing commission disclosure become stronger.

The closest that the personal lines insurance industry comes to a fact find at present are questions asked for underwriting purposes. These are almost invariably aimed more at excluding poor risks, rather than at identifying ones that are so good that they really shouldn't be buying the cover in the first place (as they have virtually no exposure to the risk to be covered).

(iii) *The product duplicates cover already given*

An obvious example of this is travel cover, which may replicate much that is in a household policy (especially where protection has been taken out for household goods outside the home) or medical expenses cover. Stand-alone policies to provide cover for things such as bicycles and mobile phones and multi-appliance extended warranty products suffer similarly.

If consumers understood better the extent of cover provided by their existing policies then the likelihood of this issue occurring would be reduced. But with packaged products such as travel insurance there is always the risk of partial duplication. And travel companies often require proof of valid travel insurance before commencement of a holiday - some might not take kindly to holidaymakers producing not a single, easy to check insurance document but copies of several documents, with or without the relevant paragraphs highlighted and an accompanying explanation of how the sum of the parts comprises the required insurance cover.

Is it a major issue? "Yes", if it is the result of inappropriate selling. But it is not

uncommon in other markets such as retail where many people regularly experience the frustration of finding that the only way to replace a broken or missing item from a set of several is by buying again the whole set (i.e. including several duplicate pieces). It is annoying but it is generally accepted.

(iv) *There is no obligation on companies or intermediaries to offer the most appropriate product (apart from the law of agency, in the case of brokers)*

This is related to (ii) above. However, it can also apply in circumstances where an insurer has launched a revised and renamed version of an existing product but keeps renewing existing business on the old version. If, say, the product were household insurance and if the old version were sum insured rated and the new version were bedroom rated then it is likely, all other things being equal, that some existing policyholders - those with below average sums insured for the size of property - would be better off staying with the old version whilst others would benefit from rate reductions were they to move to the new version of the product. In such circumstances is the insurer morally bound to inform the policyholder about the new product?

In theory the existing policyholder is no worse off than he/she had been before the new product launch - the new product does not affect the performance of the old one - in which case there probably is no obligation on the insurer. Yet with regular changes to premium rates this is hard to demonstrate.

Is it therefore in the public interest that insurers should offer the most appropriate product? Certainly the adverse publicity that insurers could attract were it discovered that they had been charging higher than necessary premiums to "loyal" policyholders would damage the reputation of the industry and that would not be in the public interest. The industry needs to be able to avoid such adverse publicity, either by eliminating the risk of such incidents or by managing the public relations issues.

This is not quite the same as "old building society account" problem, whereby building societies, having attracted customers to invest in accounts with high interest rates then deliberately lower the rates on these accounts, without explicitly notifying investors, whilst offering high rates to investors in new accounts. This practice has attracted reams of adverse publicity but still continues.

(v) *The product provides no cover at all*

There have been some well-publicised instances of policyholders buying cover for which they should have been declined at the outset. This has usually only come to light when they have made a claim that has subsequently been rejected due to the policyholder being excluded by the terms of the cover. An example would be

travel insurance, which has occasionally been sold to elderly holidaymakers who have then had a claim declined on the grounds of their age.

It is notable that travel insurance has historically been sold in many cases via a simple tick-box on a holiday application form. Age restrictions on elements of the cover are not highlighted for the benefit of the putative policyholder, nor is the applicant's age highlighted for the benefit of the underwriter.

Are these well-publicised instances a large proportion of incidents occurring or merely the tip of the iceberg? The following example implies the former: a year or so ago there was a problem with DSS officials deducting creditor insurance benefit payments from a claimant's unemployment benefit. This resulted in a lot of headlines in the newspapers at the time and accusations of mis-selling. In fact the whole market (even with encouragement from journalists for affected claimants to come forward) could only come up with a handful of cases where this was the case. In the end a compromise was reached with the DSS whereby they would not deduct creditor benefits from unemployment benefit where the creditor benefit was earmarked to pay a mortgage or loan.

(vi) *The product appears to be compulsory*

This is often the situation when a product is sold in conjunction with another service, such as travel insurance with a holiday or household cover with a mortgage. Whilst both the holiday provider and lender are entitled to require holidaymakers/borrowers to have and to be able to demonstrate that they have adequate insurance, they do not have to take out the insurance offered to them by the holiday provider/lender. Yet that might appear to be the case.

It is also questionable whether the administrative charges imposed by mortgage providers for changing the insurance details on its borrowers' records represents some restraint on trade, which would not be in the public interest.

Despite a widely held belief to the contrary, the practice whereby borrowers had specifically to opt out (often via a hard to see tick box located towards the end of a long, complicated loan application form) if they did not want creditor insurance to support their loan repayments has been banned for some years. Now borrowers have to positively opt in and lenders have actively to sell the benefits of the cover that they are offering.

(vii) *The industry manufactures needs that are artificial*

The insurance industry claims to sell peace of mind. However, its marketing is such that it often disturbs existing peace of mind by highlighting various unpleasant possible future events. Jogging people out of complacency and making them think realistically about their future and their needs in different

scenarios is a public service. Playing on people's fears and worrying people excessively about negligible risks is anything but a public service. There is a thin line between the two (this is also true for the marketing of products well beyond the boundaries of general insurance).

(viii) *Deliberate misrepresentation by the intermediary*

Whilst this may well occur it is clearly outlawed by the ABI Code of Conduct (and doubtless by other means too, depending on the circumstances). It is clearly not in the public interest and would be condemned by all right-minded actuaries.

None of the issues noted above have specifically actuarial angles. Nor do we think that any of them are major. The existing legislation and codes of conduct outlaw malpractice and guide insurers and distributors regarding best selling practice. To strengthen the codes through additional legislation and controls would be costly, both to the Government and to the industry and would probably not be justifiable, economically. The underlying issue is that potential policyholders need to understand what they need and want, and to recognise it when they see or hear it. In essence they need to be informed buyers. Sadly, too few are. The insurance industry and its constituent parts need to improve this. The ABI is taking a lead with its *Putting the Customer First* campaign.

6. Public interest issues in claims management

6.1 **Exclusion of claims**

We have already touched upon the issue of policyholders finding out specific details of their insurance cover at the point of claim rather than at the point of sale through their claim being refuted. In many cases a careful look at the policy terms makes it quite clear why the insurer is not accepting the claim. In some other cases, however, policyholders are left feeling that insurers are not acting in the spirit of the cover, and are reverting to legalese to refute or reduce claims. An example of that appeared to be the recent case where an elderly couple's claim against the considerable damage caused by a squirrel that got into their house was initially rejected as the terms of the policy excluded damage through rodent infestation. Based on those details of the situation that were set out in the newspapers, this appeared to onlookers as a case of the insurer (or officials within the insurer) taking a rather broad view of the term regarding "infestation" and ignoring the general nature of the cover and hence what the policyholders had thought that they had bought.

Of course, in this particular example it may well be that the public read an unbalanced account and hence gained a false perception of the situation. The reaction of the insurer, which not only reconsidered and then allowed the claim but also changed all of its relevant policy terms to ensure that such incidents would in future be covered, implies that the overall perception was correct. In this case the insurer acted honourably and allowed what it appears should have been a legitimate claim, save for a flaw in the policy wording. There is a suspicion that not all insurers would have acted in the same way.

It is worth remembering that some policyholders opt for the cheapest cover available, regardless of how far that cover extends, and then make a fuss when claims that are explicitly excluded within the policy terms are denied. Policyholders who opt in this manner should ask themselves why a particular insurer is able to offer cover at rates cheaper than those on offer elsewhere in the market. It may be because the insurer is grouping its risk factors differently from the rest of the market, or because it is more efficient in its cost management, or maybe because it is the most vigorous in managing claims.

It is also worth remembering that the policyholder should always be notified explicitly of key exclusions, particularly any introduced at or between policy renewals. One area that is particularly pertinent at present is that of excluding claims related to the "millennium bug" (the "Y2K exclusions"). With so little still known about the impact that the "bug" will have on the industry, its members are rightly being cautious and are applying Y2K exclusions where they feel them to be appropriate. To what degree they

will be applicable in practice may well depend upon how the policyholder was notified about them.

There is, of course, a view that, as the "millennium bug" was a foreseeable event, it is not possible to insure against the consequences and hence that all "bug" related claims should be excluded. In some circumstances, this might not be considered to be a reasonable attitude by the public.

6.2 **Treatment of claimants**

Many claimants feel that they are distrusted by their insurers and treated as probable fraudsters.

This certainly used to be the attitude of the industry, which did not allow making a claim to be an easy or very satisfying experience. In recent years this attitude has started to change. Customer service is now the key, and tele-claims centres have made the notification of claims a simple process that often results in an almost instant response. However, many longer serving industry staff still look suspiciously at claims being made.

In many ways they are correct to do so. The incidence of insurance fraud is still very high - anecdotal evidence suggests that 10% of claims relate to events that have been deliberately incurred or that simply did not happen, and many more claims are for amounts that have been inflated beyond the correct value. It is right for insurers to try to weed out the cheats, and to reduce artificially-inflated claims to realistic amounts - this is in the public interest as it ensures that insurance premiums can both be kept to low levels and be adequate to meet legitimate claims. But it is not right that in so doing honest policyholders are treated roughly. A balance has to be struck. Where that balance lies is unclear. This leads us to the management of claims costs.

6.3 **Managing claims costs**

Most insurers are in a constant quest to reduce the legitimate cost of claims. In a competitive environment lower claims costs should lead to lower premium rates. The end is therefore in the public interest - but are the means likewise in the public interest?

Active claims management can take many forms. Examples in property insurance include preferred suppliers of replacement goods and services (bulk buys result in discounts) and the provision of emergency helplines (prompt action to mend items such as burst pipes can greatly reduce the ultimate claims cost); in injury cases expert medical care can reduce the ultimate suffering and loss; and in unemployment insurance

providing claimants with assistance in finding new work can cut back the final claim (although some observers suspect that this saving is outweighed by the cost of achieving it), as well as leaving the policyholder with positive feelings about the insurer. All of these initiatives are admirable, at least in principle, in that they are aimed at reducing costs whilst not diminishing the cover provided, and, in cases where they are seen to be contributing positively to society, they enhance the reputation of the industry.

We also considered other, far less laudable methods of cost effective claims management. These included claims departments leaving unanswered, sometimes even unopened, claims-related mail and large claims being contested up to a court hearing, at which point, immediately before the hearing is due to start, the insurer offers the plaintiff a relatively low settlement. Pleasingly, although we had all heard that this sort of practice occurs, we were unable to find any specific examples, at least none that implied that the occurrences were systematic rather than random examples of incompetence, misunderstanding, etc. We suspect that that such incidents will become much rarer following the reforms instigated earlier this year by Lord Woolf.

6.4 **Claims prevention**

In many cases, rather than manage incurred claims, the industry would like to prevent the claim being incurred in the first place. With this aim in mind the industry tries to educate policyholders regarding the nature of the risks that they face and how these risks can be mitigated (for example, fire prevention, security locks and alarms, health and safety policy). It also commissions research into the causes of certain types of claims (for example, catastrophes such as earthquakes and hurricanes). Finally, individual insurers encourage better risk management amongst policyholders by offering discounts to those who have taken specified steps aimed at claim prevention (for example, specific quality of locks, frequency of fire drills, etc.).

All of these things are beneficial to the industry, in that it reduces costs, to policyholders, as these cost reductions are often eventually passed through to them as premium rate reductions, and to society as a whole, in that they promote more responsible behaviour.

An issue with claims prevention methods is how the policyholder who inadvertently fails to comply with them is treated. For example, where cover is conditional upon (or a discount is applied to the premium because) a burglar alarm is fitted it is common for the insurer to insist that it is switched on if the insured property is left empty. But this leaves the property uninsured should the alarm not be set properly. Some insurers take a very hard-nosed approach, whilst others appear more understanding of human foibles and will not reject outright any claim made in such circumstances.

6.5 **Claim amounts**

For some insurance claims, the claim amount is relatively certain. It is the cost of repairing a car, of reimbursing a merchant for cargo lost on a sunk ship, of the claims paid in a certain period over a specified limit by another insurer, or one of the other thousands of examples. For other claims the claim amount is uncertain and is often the subject of considerable debate. A good example would be somebody claiming under a liability policy for injuries suffered. In this example the claim amount would be to cover the cost of treatment and care already undergone, the cost of any future treatment and care, past and future loss of earnings, and compensation for stress, suffering, inconvenience, etc. The past costs might or might not be know, but the future costs and the appropriate levels of compensation are matters of judgement.

At this point the report could sink into a treatise on the development of liability claims costs around the world, with the usual gasps of disbelief at the magnitude of recent awards in the USA, similar gasps at the apparent inadequacy of awards in other parts of the world, and gloomy warnings that the UK awards tend to follow those in the USA but with several years' delay. That would be boring and predictable. It would also take the members of the working party alarmingly out of their professional depth. We shall leave it by saying that insurers who provide cover against certain events should also provide that cover to the appropriate level (unless they have explicitly capped cover in the policy terms). There is a suspicion that the industry's resistance to the widespread use by the Courts of the Ogden Tables and in particular of an interest rate based on a index-linked gilt yield was motivated more by a desire to minimise claims costs than by a deep-seated belief that the previous case law provided more appropriate levels of claims settlements. The debate on the use of structured settlements may be similarly tainted.

The use of structured settlements rather than one-off cash payments for liability claims is being championed by elements of the profession (indeed, we understand that another GIRO Working Party will be reporting on the matter in October 1999). This is a good example of how the profession can act in the public interest (or as it perceives it) and influence the operation of the general insurance business in the UK.

7. Public interest issues in the regulation of general insurance

There is a considerable volume of legislation that applies to insurance. Much legislation, not primarily aimed at insurance, has implications for insurance companies and how they conduct their business. None of the working party members are familiar with the detail of this legislation, and therefore the remarks within this report regarding such legislation are based on the working party's collective general knowledge and understanding.

7.1 **Financial supervision**

General insurance companies are subject to financial supervision and prudential controls beyond those applicable to the generality of companies. This is for two main reasons:

- insurance companies accept moneys in advance for a service to be provided at a future date. In effect (but not, of course, in law) they are trustees for the premiums until they are earned and for the claims reserves until claims are met; and

- failure of an insurance company can be especially hard on an insured who has an outstanding claim. The purpose of insurance is often to provide financial protection against misfortune, which would otherwise cause hardship. In such a case, failure of the insurer will cause suffering to the insured (and to third party claimants in the case of liability insurance). Indirectly, others might suffer (for example the insurer's or insureds' employees, customers, suppliers, shareholders) so failure of an insurer can cause more general economic dislocation.

Under the Policyholders Protection Act ("PPA"), which became law in 1975, in the event of an insurer's failure 100% of compulsory insurance benefits and 90% of other personal lines benefits will be met by the Policyholders Protection Board, itself funded via levies on the industry. Despite the existence of the PPA, there is still a need for supervision. Firstly, much insurance is not covered by the PPA, and the protection is not complete; secondly, much inconvenience and worry is caused to insureds by a failure; thirdly, it is desirable to minimise the costs of meeting payments under the PPA, as these fall directly on the insurance industry members and indirectly on their customers.

The current structure of insurance supervision in the UK largely dates from the late 1960s and early 1970s. Previously, the main control was "freedom with publicity", with minimal supervision. Insurance company accounts were supposed to provide insureds and their advisors with sufficient information to determine whether a company was sound.

The legislation was influenced by the high-profile failure of two companies (Fire, Auto & Marine and Vehicle & General) as a result of fraud and mismanagement (under-reserving, leading to underpricing, and over-trading) respectively. Since then the system has been refined in the light of experience and minor modifications have been introduced to meet the requirements of EU Directives.

The main features of the supervisory regime are that:

- those controlling the insurer must be fit and proper (in other words that they are honest, responsible and mindful of their obligations to policyholders, and that those running the company also have adequate experience, qualifications and ability);

- all insurers must maintain at least a minimum margin of free assets over and above their liabilities (other than to shareholders);

- the supervisor has extensive intervention powers if he/she believes there to be a risk that liabilities to policyholders will not be met, or in certain specified circumstances (which experience or common sense suggest are likely to put policyholders at risk) or if a company breaches requirements laid on it by the Act or the supervisor; and

- the supervisor has the power to remove a company's licence if allowing it to continue in business puts policyholders or potential policyholders at risk. Part of the object of supervision is to put companies which are inadequately capitalised or not managed soundly and prudently out of business before they become insolvent and while there is still a high probability that claims to policyholders can be met in full.

In practice the supervisor requires insurers to maintain a solvency margin well in excess of the statutory minimum, normally at least double. Insurers writing risky lines of business or otherwise subject to greater risks than the norm will be expected to have a greater solvency margin than this.

Underpinning this is a requirement for detailed annual returns to the supervisor. These annual returns are public documents that have been subject to audit scrutiny, and provide much detailed information on the insurer's business and affairs. They contain information on matters such as reinsurance arrangements and the run-off of claims payments as well a much more detailed breakdown of the business than shown in Company Act accounts. If necessary, the supervisor can require a company to provide additional information on a confidential basis or more frequently, for example quarterly. The supervisor may also have informal discussions with the insurer to learn more about the nature of the insurer's business, its plans and how it is run. This is to help the supervisor identify the main threats to the insurers and likely developments.

Like Company Act accounts, the annual returns are subject to accounting rules for insurers as laid down in Schedule 9A of the Companies Act 1985. There are also detailed rules for valuation of assets in the Insurance Company Regulations. In

practice, however, companies have considerable discretion when valuing general insurance liabilities. It is difficult to see how it could be otherwise in that the magnitude of general insurance liabilities is so uncertain, particularly for some classes. Estimating the magnitude of the liabilities requires skill and judgement. Different people will make different judgements, each of which may be quite justifiable, but which will result in quite different estimations of the magnitude of the liabilities. Thus the provisions held in respect of these liabilities might legitimately appear anywhere within a wide range.

Insurers can, and do, set provisions at levels which are towards the bottom of what most observers would consider to be a reasonable range of estimates, through making optimistic assumptions. Auditors will generally accept this provided the assumptions are not unreasonable. Insurers can also set provisions towards the top end of the reasonable range of estimates but this is less of a worry for the supervisor than for the Inland Revenue in that high levels of reserves slow the emergence of taxable profit.

We are not suggesting that it is other than exceptional for insurance companies deliberately to understate their general insurance reserves. However, it is human nature to be slow to recognise losses in a situation of uncertainty, and insurance company directors are only human. Furthermore, it might be thought odd that the directors, whose performance is being measured, should have this degree of control over the measurement.

Many insurance companies routinely use actuaries to value part or all of their insurance liabilities, or to test the valuation of these liabilities for reasonableness. Very often the actuaries' reports are made available to the regulator, who can also require a company about which he/she has concerns to commission an actuarial report. It would not be a major departure to require all companies to commission an actuary (or other suitably qualified person subject to a professional code) to set, independently, insurance provisions or to report publicly, and again independently, on the provisions set by a company.

Such a requirement would increase the confidence of the regulator and others that the reserves were likely to be adequate and that relevant information had not been overlooked. It would not ensure that the provisions were correct - that could only be ascertained with hindsight - but the independent nature of their estimation would provide some comfort. As an aside, for land owned by a company, the valuation has to be performed by a qualified valuer - the directors may, for prudential reasons, substitute in their accounts a lower value, but may not substitute a higher value than the last proper valuation. It is perhaps surprising that the general insurance reserves, which comprise for most insurers far and away the largest component on their balance sheet and the valuation of which is so uncertain, are not subject to at least as stringent regulations.

Further to this, an actuary could prepare a financial condition report demonstrating the ability (or otherwise) of a company to continue writing business and to withstand

adverse shocks and identifying the main dangers it faces. We believe this already to be the practice in Canada. The advantages to the regulator and to the public of such a report are obvious, providing reliance can be placed upon it. Indeed, any company should routinely identify its main risks and strategies to deal with them as part of sound and prudent management. It is worth noting that actuaries are already involved in planning, as well as capital management and allocation, in many UK general insurance companies. By contributing to the sound management of companies, they are serving the public interest. The possibility of introducing financial condition reports in the UK is currently under consideration.

Having said all of the above, we recognise that there are several obvious situations where independent review would add negligible value, just cost, for example in estimating the outstanding claims reserves for lines of business where the uncertainty is relatively small. Moreover, the working party thought it best to leave reaching a conclusion on the topic of the statutory role of the actuary in general insurance to another working party.

7.2 **Discrimination and unfair terms**

- *Race relations*

  Insurers cannot use race or ethnic background as a rating factor, nor as a factor in deciding whether to issue a contract.

  "Indirect discrimination", in the sense of action that has different effects on different ethnic groups, is permitted. This is banned for employment - for instance employers (including insurers) are not permitted to advertise job openings to relatives of employees, if this (as it usually does) leads to a disproportionate ethnic mix.

  An insurer that used another factor as a deliberate proxy for race would be in breach of the law. As in most English (and Scottish) law, the criterion is intent. Thus it would be in order to charge higher rates for inner city areas because they had higher crime rates, but not because they had higher proportions of ethnic minorities. This may be contrasted with the situation in the USA, where indirect discrimination, in the sense noted above, has been banned in some jurisdictions.[6]

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[6] In October 1998, Nationwide Mutual was fined $100m and ordered to pay $500,000 compensation to African-American homeowners who claimed that the insurer had red-lined them. The case initially appeared to the working party members to be one of indirect discrimination although there has subsequently been some suggestion that the discrimination was direct, with agents overcharging or turning down African-American homeowners for insurance whilst accepting their European-American neighbours.

There are two conflicting public interests. There is a strong public interest in avoiding action that can be labelled as indirect discrimination, to avoid social exclusion. There is also a strong public interest in charging premiums which properly reflect the expected claims, to prevent insurers being selected against, and to make insurance as widely available as possible. Where the balance lies depends on the degree of discrimination, direct and indirect, to which minorities are subjected, as well as to the strength of the data justifying differential rates, etc.

Insurers should look out for actions (rating, selection criteria, targeting of sales campaigns, etc.) that have the effect of indirect discrimination, and ensure that they are properly justified on criteria other than race. Individual insurers who fail to do this may be targets of investigations by the Race Relations Board, who can, if they wish, indulge in "fishing trips". A number of failures, or a single large failure, increases the risk that the law might be amended to ban indirect discrimination. As has been made clear, this would not be in the interests of the general public.

- *Religion*

  In Northern Ireland there are similar restrictions on the use of religion as a rating factor. There are similar public policy interests as for race, and there is a movement to bring religion within the scope of the Race Relations Act. It would be inappropriate for insurers to discriminate on grounds of religious affiliation in the absence of hard statistical evidence.

- *Sex equality*

  The insurance industry is in an unusually privileged position, in that it is permitted, under certain conditions, to discriminate on grounds of sex. Differential rates or policy conditions must be justified by statistical evidence.

  Public interest demands that this privilege is not abused.

  Interestingly, creditor insurers cannot now refuse to provide unemployment cover to women over age 60. This is despite such women being unable to sign on as they are past state pension age. Here it is apparently acceptable for the Government to discriminate but not for insurers

  Following intervention by the Equal Opportunities Commission, creditor insurers now also have to provide cover for complications of pregnancy. There appears to be a developing trend that expects insurers to provide cover for social as well as insurance reasons. This will have rating implications.

- *Disability*

  The main effect of the Disability Discrimination Act upon creditor and health

insurers has been to prevent insurers using a “good health declaration”. This has resulted in the tightening up of pre-existing condition exclusion clauses. This has had both positive and negative results for consumers

- *Unfair Terms*

  Under the Consumer Contracts Regulations 1994 insurance policies are now subject to unfair contract terms legislation. However, the "core provisions" (those terms which define the main subject matter of the contract and the adequacy of the price or remuneration as opposed to the goods or services supplied) are excluded from being assessed for fairness provided that they are in plain, intelligible language.

  Having said that, terms which are concerned with the process by which claims may be brought do fall within the scope of the Regulations. This allows the Courts to control the fairness of the procedures for making claims.

  What is deemed to be “fair” and “unfair”? The European Directive, upon which the Regulations were based, states

  > "A contractual term which has not been individually negotiated shall be regarded as unfair if, contrary to the requirement of good faith, it causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer".

  It is hard to be specific about what this means in practice. However, it appears clear that it is only those contractual terms which create a significant imbalance in the parties' rights and obligations and which are contrary to the requirement of good faith which are to be considered unfair. If a term satisfies the requirement of good faith then that is enough for it to be relied upon.

  The Regulations only apply to personal lines contracts.

  A recent example of the Regulations being applied occurred when the Insurance Ombudsman decided that, for single premium creditor insurance contracts, it is unfair not to give a refund of premium if the loan is settled early. Most companies will normally give a refund anyway, but some do not and keep the cover in place.

7.3 **Other regulatory controls**

- *Anti-competitive practices*

  There is legislation, both UK and European, preventing anti-competitive practices, cartels, etc. This prevents insurers colluding on rates, and restricts their ability to

make market agreements (market agreements may be subject to approval by Brussels, for example the P&I clubs had to modify their agreement because of intervention by Brussels).

As has been mentioned before, informal groups exist between insurers in which the members share experiences. It is likely that these groups have some impact, however indirectly, on premium rating and it is therefore questionable whether or not they are in contravention of these restrictions on co-operation on rating, although we doubt that the legislation was intended to outlaw such groups.

- *Office of Fair Trading*

  The Office of Fair Trading occasionally intervenes in insurance matters. Recently it banned the practice followed by some travel firms of making discounts conditional on purchasing a particular travel insurance. Although some practitioners were outraged at the time and foresaw the consumers suffering as a result, it appears that the market has absorbed the changes with no detrimental effects on holidaymakers.

- *The Insurance Ombudsman*

  The Ombudsmen scheme is a Government sponsored initiative to encourage better management within specific industries by providing a single powerful agency to which consumers can bring any complaints about that industry or its members. The Ombudsmen often provide arbitration in unresolved disputes between consumers and industry members. The insurance industry is a beneficiary of the scheme.

  Membership of the Insurance Ombudsman scheme is currently limited to underwriters. It is not compulsory. However, pressure is placed upon all members of the industry to comply with the rulings of the Ombudsman.

  In general, in cases of ambiguity, both Courts and the Insurance Ombudsman tend to interpret insurance contracts against the insurers (who drafted them and should have ensured that there was no ambiguity in the first place).

- *Monopolies and Mergers Commission*

  In general mergers and acquisitions of insurance operations or of their component parts are subject to the same regulations as they would be for other industries. This means that the Monopolies and Mergers Commission ("MMC") would be asked to opine on the desirability of a merger or acquisition if it were thought likely that the resultant operation would be in such a dominant position that it could effectively exert too great an influence on the market. Such an outcome is clearly not in the public interest.

  Few if any UK insurance deals have generated much excitement at the MMC but,

with the current pace of market consolidation and with several of the major players in the market being linked in merger speculation, it is probably only a matter of time before a mega-deal is referred to the MMC.

What is not clear is the attitude of the MMC on the domination by one or more players of specific lines of business. Were one insurer to dominate, say, the motor insurance market or to write a very large proportion of the UK employers' liability business then the MMC could be expected to intervene. Whether the same would happen were an insurer to dominate, say, the white goods warranty market or a particular segment of a larger class, such as male drivers under 21, is uncertain.

- *General Insurance Standards Council ("GISC")*

Currently there are three different regimes in the UK that between them regulate the sale of general insurance products and those responsible for selling and giving advice on general insurance products:

- the Insurance Brokers (Regulations) Act 1977 (under which the IBRC was set up as a statutory regulating body)
- the ABI Code of Practice for Sales of General Insurance; and
- Lloyd's regulation of Lloyd's brokers.

Further to the legislative programme to bring into being the Financial Services Authority, which will be the single statutory regulator in the financial services sector, the Insurance Brokers (Regulations) Act will be repealed and the IBRC disbanded. In its place a new self-regulatory body will be established, through the collaboration of the ABI, the Association of Insurance Intermediaries and Brokers ("AIIB"), Lloyd's, the Lloyd's Insurance Brokers Committee ("LIBC"), and the International Underwriters Association/London Insurance and Reinsurance Market Association ("IUA/LIRMA"). This body is the GISC.

The GISC is intended to protect all general insurance customers, both individuals and corporates. It currently proposes that the following principles will apply to all types of insurance:

- high standards of integrity, financial soundness, fair dealing and competence will be established and maintained within all those regulated by the GISC (which will be all GISC members which in turn is expected to be the vast majority of the UK industry, including insurers, brokers and intermediaries)
- policies that are proposed are suitable to the needs and resources of customers and that the customers are informed about the product that they are buying and its price
- adequate systems will be in place to deal with any customers' complaints and for

ensuring that appropriate redress is available.

It intends to secure these principles by promoting appropriate behaviour, rather than by introducing prescriptive processes and procedures.

One of the criticisms in the past about the ABI and IBRC regimes was that neither had much in the way of teeth and hence were unable to take effective action in the face of non-compliance. The GISC, in contrast, intends to have the power to impose sanctions upon any of its members that stray from its established principles.

What those sanctions will be and indeed what the detailed principles will be remains to be seen - currently the GISC is still shaping its rule book via a wide ranging consultation exercise (although that should have been completed by the time that this report is published). It is expected that the GISC will begin operations at the beginning of 2000, assuming that all of the linked legislation and related actions run according to plan.

- *Compulsory insurance*

Some classes of insurance are compulsory, notably those that provide cover against third party motor claims and for employers' liability to employees for work-related injuries, where the employer is responsible. Nuclear installations must have liability insurance (or equivalent arrangements), and riding establishments must have third party cover. Solicitors must have professional indemnity (through their mutual fund), estate agents must have insurance cover for clients' money, and merchant shipping must have pollution cover. Third party liability cover may also be required[7] for such things as activity in outer space, the operation of railways, osteopaths, or for vessels on inland waterways.

The public interest in providing coverage for the main ones is obvious. The justification for making it compulsory to insure against some liabilities and not against others that might be thought equally important is unclear. Where to draw the dividing line is a matter of judgement. We have not considered the issue, but it is worth noting that, in other countries and at other times, different types of insurance have been made compulsory, for example fire insurance in cities and schemes that substitute for national insurance.

Where third party insurance is compulsory, it might be considered that it is in the public interest for the innocent third party to be compensated promptly and fully, without having to negotiate too many obstacles. It is perhaps worth noting that judges have apparently stretched the law to ensure that third parties get

[7] In these cases, the power to require insurance is delegated to third parties.

compensation and have sometimes explicitly used the existence of insurance as justification.

It might also be considered to be in the public interest that all those requiring compulsory cover are able to buy it at affordable rates. As we have seen in the case of third party motor insurance that is not always the case. Looking at employers' liability, an inability to afford the compulsory insurance cover might force out of business an employer, with consequential job losses and other adverse social results. This is, on the face of it, undesirable. But if an employer is unable to obtain affordable cover then it has such thin trading margins that its eventual failure is extremely likely anyway, it has a poor claims record or it has in place certain conditions, practices or procedures that all insurers regard as placing a high risk of injury upon the employer's staff. The high premiums offered therefore encourage the employer to improve its health and safety record, an outcome that is in the public interest.

8. Public interest issues and other interested parties

This report has largely focused on the policyholder (or prospective policyholder), the insurer and the distributor. We have also touched on the regulators. But there are many more people with an interest in general insurance who we have so far not referred to.

8.1 **Employees**

We considered public interest issues as they related to employees only briefly. Our initial conclusion was that the issues regarding employees in general insurance were not significantly different from those of employees working in any other industry. In practice, the interests of an insurer's employees (and for that matter of agents and Directors) may differ from those of the insurer. As a result, or because of a misinterpretation of the insurer's interests, the decisions and actions that employees take might also not be in the insurer's interests. For example, employees may consider it is in the insurer's interests to deny or to delay legitimate claims, rather than to pay them promptly. Such behaviour might be further encouraged by unwittingly inappropriate performance targets. Aside from the regulations and codes of practice already in place, better quality and more accountable management is the answer to this.

8.2 **Shareholders and senior management**

The attitude of shareholders varies considerably. Some invest for the long term and are prepared to weather the ups and downs of the stock market and of particular industries' trading conditions. Others are much more focused on short term performance. For example, it might be in the short term interests of shareholders to have high declared profits, leading to a take-over at an inflated price, rather than for the company to be run soundly for the long-term. Whilst the latter group might be smaller than the former, they tend to be more vocal and to gain more media attention.

This can encourage short termism amongst the senior managers. Key investments are curtailed as they are a drain on the profit & loss account in the immediate future and only pay back fully some years hence; sales (often taken as a proxy for future profits) are driven forward through price undercutting, thus fuelling future losses, rather than profits, and general market instability; and corners are cut in an attempt to cut immediate costs. This can lead to enhanced profits today but an overall decrease in the real value of the insurer's business.

We believe that the public interest is best served within the industry by the practitioners (and the shareholders who may drive the practitioners' actions) taking a long term view and managing effectively in line with that view. There may be a role for regulation (in the broad sense) of the insurance industry's behaviour towards its customers and the public, although this needs to be applied with a light hand, so as not to stifle imaginative but constructive behaviour.

8.3 **The media**

As was said earlier, we would have liked in this report to have taken into account the views of the media but we ran out of time. That is a pity as the media are extremely influential. In many respects that influence is exercised extremely well, with the public being well informed of insurance issues, constructive advice and explanations being offered and examples of sluggish service and questionable practices rightly being highlighted, with the result that the relevant service providers have been forced to clean up their acts.

On the other hand the working party members had all seen instances where a situation was presented in a one sided manner, using unnecessarily emotive language. We recognise that the ultimate goal of, say, newspaper journalists is to write attractive copy that will help their newspaper to be sold. We also recognise that even-handed accounts on most things, but particularly insurance related matters, rarely make riveting copy. But the result of one sided reporting is that the public will be misled. This might not be by much but it can be such to turn people wholly away from particular insurers, particular insurance products or indeed the entire industry. As has become clear over the rest of this report, insurance is too important to people's lives for its integrity to be casually denigrated.

In part this is a criticism of sections of the media. But it is easy to criticise the media for misrepresentation when in fact the problem might be that the issues were inadequately explained by the industry to the media. The media should not be blamed for failures within the insurance industry to get its messages across effectively

Looking forward we would like the financial media to continue to inform, to probe, to highlight poor performance and to entertain, but we would like those involved in the media to consider the potential consequences of their investigations and to exercise appropriate balance and judgement in their reporting. The industry should seek to support this by being candid and clear in its dealings with the media.

We would make similar appeals to consumer lobby groups for them to exercise responsibility and not to be unnecessarily alarmist, although we recognise that their representations need not be entirely balanced.

9. Conclusions

There is a very wide range of potential public interest issues in general insurance, of which we have identified only some. That they are all matters of public interest is not in doubt; what is in doubt is the extent to which they are issues. Depending on one's perspective, be it policyholder, insurer, shareholder, intermediary, financial analyst, personal finance journalist, consumer lobbyist, interventionist or free marketeer, the view of what is a key issue and what is a minor irrelevance can be markedly different.

With a limited range of perspectives on the working party, we were able to reach some consensus. We concluded that, although many of the issues raised were not positively in the public interest, they were not against the public interest either. Most we considered to be largely neutral or to have, in practice, such a negligible impact that to take responsive action would appear unnecessary. Unless they should discover some particular individual case of dishonest dealing, there is nothing that requires working actuaries to deviate from their normal duties of working in the best interests of their employers or clients.

However, we did identify a number of areas where industry practice can be questioned, and it might be in the industry's interest to address these questions before they become controversial issues. There are also areas that might become politically controversial, and the profession should prepare to take a lead in providing informed and balanced comment in the discussion of public policy choices. Places where the industry is particularly vulnerable to such questions are as follows:

- *Product "mis-selling"*: we believe that this occurs, albeit largely unwittingly. As such, it presents a big public relations issue for the industry, probably disproportionate to the size of the underlying problem. The main manifestation of product "mis-selling" is policyholders buying insurance that does not provide the cover required. The causes of this are partially confusion on the part of policyholders (and sometimes the product distributors) regarding the precise terms of the policies in question, and partially the policyholders not being clear regarding their needs. Insurers should continue to improve the clarity of their sales and policy literature (ensuring that they are consistent with one another) and more initiatives such as the ABI's *Putting the Customer First* campaign that aim (in this case as a secondary benefit) to improve the consumers' understanding of insurance products should be undertaken by the industry. The media could also play a very useful role here.

- *Availability of insurance*: we concluded that insurance is available, somewhere, for virtually all risks. However, for some the proposed premium rates may be considered to be unaffordable. This applies particularly to domestic contents

insurance, motor insurance for young drivers and other high risk motorists, and commercial insurance for small businesses. It has potentially adverse social consequences. There are a variety of measures that could be taken in response to this, by the industry or by the Government. All have their pros and cons. We concluded that none was clearly ideal but that some merited further investigation.

At the same time, insurers should also be responsible in their pricing. We believe that they need to be able to price as they see fit, to enable them to charge an economic rate for each risk underwritten yet still make an adequate return on their capital. However, if and when a consequence of economic rating for each risk is that insurance is pushed beyond the means of particular people or businesses, then the relevant insurers need to have firm evidence to support their decision, otherwise they leave themselves open to the charge that they are playing with people's lives (or at least an important aspect of their lives). The adverse publicity aspects of that charge are potentially disastrous, for the insurers in particular and for the insurance industry in general. It could also adversely affect public opinion of the insurers' professional advisors (internal and external) such as actuaries.

- *Differential premiums based on perceived propensity to shop around*: several members of the working party felt uneasy about this practice and, should the magnitude of the differentials reach high levels and the practice then be highlighted, it is likely to discredit the industry. We recommend that insurers demonstrate restraint in this area and that they ensure that they have prepared a good defence in case of adverse publicity.

- *The role of brokers*: brokers act *de facto* as the agents of insurers when they are *de jure* the agents of the insured. Application of the law of agency is being prejudiced by this conflict of interest. This needs either to be reaffirmed or the nature of the relationship to be changed. Moreover, greater clarity is needed for the benefit of the consumer regarding the relationships maintained by the intermediary (broker or otherwise) with the consumer and with the insurers.

- *Claims management*: there is a thin line between minimising claims costs and failing to provide the agreed level of cover. Policyholders who are badly treated might well take their business elsewhere, in which case the insurer ultimately suffers, but third party claimants have no such sanction. The Woolf reforms will partially alleviate this issue but the real solution lies with the attitude of insurers.

- *Public relations*: the industry does not get a good press. Some of the adverse publicity that it attracts is undoubtedly deserved and should lead to improvements in industry practices; some is more attributable to lazy or unbalanced journalism; and some is due to poor quality or incomplete information provided by the industry and its members. The media cannot be expected to present the facts if they are not given them, or if they are given them in a confusing or ambiguous way. This is clearly

where actuaries, with their knowledge and understanding of the industry, especially its technical aspects, could play a key role, although they themselves are not renowned for their communication skills!

Our final conclusion is more of a plea, that all of those parties involved in insurance fulfil their role responsibly. In particular, customers should assume responsibility for understanding their own needs, and insurers should make customers more aware of what their products cover and should then deliver the cover provided in as painless a manner as possible.

Appendix A

General insurance and the Data Protection Act

A revised Data Protection Act came in to effect in the UK on 24th October 1998. It has largely been drafted by the European Council and is further reaching than its predecessor. At present there is little consensus as to how it will work. This appendix outlines aspects of the Act relevant to insurers and attempts some sort of interpretation.

The purpose of the Data Protection Act is broadly to force data controllers to

(a) disclose the fact that they have data,

(b) not hold any data which they do not have a reason for holding, and

(c) offer various methods of redress to the subjects of the data when inappropriate data is held.

The insurance industry contains many data controllers and normal compliance is required for the operation of the databases that underlie the vast majority of personal policies. What is particularly interesting is the large number of possible loopholes in the Act that may have an impact on the conduct of insurance business.

The wording of the Act is vague and non-specific, which complicates its interpretation. Furthermore, nowhere does it say in definite terms what data can and cannot be held and for how long: everything is defined using words like "reasonable", "necessary" and "appropriate". It would appear that a judge's discretion could mean everything in the interpretation of this Act.

There are obvious exemptions: detecting crime, apprehending offenders and taxing people are all primary areas in which the Act does not apply. But there are more interesting exemptions:

1. 28 (2) includes an exemption where "Personal data ... are processed for the purpose of discharging statutory functions ...". This would appear to include statutory reserving and reporting requirements.

2. 29 – pretty much all health and social work seems to be excluded, subject to the approval of the Secretary of State.

3. Interestingly, 30 (2) includes "... for protecting members of the public against financial loss due to dishonesty, malpractice or other improper conduct ... in the provision of banking, insurance, investment, or other financial services ...",

which reinforces the idea that an exemption could be gained if the purpose was involved in the protection of the consumer.

4. 31 – "... journalistic, literary or artistic material ...", "... public interest ...", etc. In other words, to facilitate whistle-blowing could be a valid reason for non-compliance with the Act.

5. Section 32 is all about "research purposes", defined as including "statistical and historical purposes". Presumably this covers the operation of, for example, the Continuous Mortality Investigation Bureau and would permit actuaries to undertake some of the more rigorous GIRO investigations that have required some data pooling in recent years.

The exemptions to the Data Protection Act granted under clause 30, and generally described as "regulatory activity", appear to be sufficient to allow an insurance company to retain indefinitely as much data as it likes, providing that it can show that this is necessary for the purpose of calculating reserves as statutorily required.

The use of personal data for rating purposes falls into a much greyer area. The use of the "statistical research" clause in Section 32 is stretching it a bit, because this is clearly aimed at academic research rather than a company's individual commercial research. This then means that we have to worry about data being retained: Schedule 1 principle 5 states that "Personal data processed for any purpose or purposes shall not be retained any longer than is necessary for that purpose or those purposes", and that means that retaining data purely for the purposes of rating investigations might not be possible. Of course, the same data might be retained for the purposes of statutory reserving or in case of late notified claims, both of which are exempt, so would that mean that you could retain data legally for one purpose and then use it for another as well?

In practice it is probably (although not certainly) legitimate to retain depersonalised data (with name and address removed, and probably any identification numbers also deleted) that could be used for rating investigations. Data mining the records to identify some rating factors not previously considered is more of a grey area.

The most telling statement in the Act is Schedule 2 (conditions relevant for purposes of the first principle: processing of any personal data), clause 4:

(1) The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.

(2) The Secretary of State may by order specify particular circumstances in which this condition is, or is not, to be taken to be satisfied.

In other words, the Act means whatever the Government wants it to mean.

Appendix B

Position paper on the availability of personal lines general insurance

The Public Relations Committee, in association with the profession's Practice Boards, produces from time to time various position statements to enable its officers, members of its Council and senior members of staff to respond to questions from the profession, the public and the media about important topical issues and developments.

These statements may be used as a background for public pronouncements. They are not formal guidance, neither are they a definitive expression of the views of the profession as a whole on the subject.

There is a contact name for enquiries at the end of each statement. Please feel free to speak to this person if you would like more information.

Introduction

There is an increasing public perception that certain personal lines general insurance products will not be available at an affordable price to a minority of the UK population who are considered to be subject to higher than average risk of loss. Many of those most likely to be adversely affected come from the poorer sections of society, which may make the issue more politically sensitive.

Background

By using computers, insurers - usually with the assistance of actuaries - have been developing increasingly sophisticated premium rating tables for the main classes of personal lines insurance. One consequence is that some individuals belonging to categories that have been identified as representing exceptionally high levels of risk may be unable to obtain the insurance cover they desire at a price they can afford.

Such problems can arise in any class of general insurance (and indeed in long term insurance also). The effect of greater sophistication in the premium rating of motor insurance is generally seen as acting in the public interest - for example by discouraging young people from driving high-powered cars and by charging high premiums to people with a bad accident record. Despite occasional references in the press to alleged cases of undue discrimination in travel insurance (a type of business that can be regarded as being associated with a luxury rather than a necessity), this is not considered to give rise

to a material problem.

This leaves household insurance, both buildings and contents cover, as being the class of business most exposed to allegations of the creation of an insurance underclass. Individual properties may be subject to such a high risk from such perils as burglary, flood or subsidence as to put insurance of such properties beyond the means of their owners or occupiers. The issue then is whether the availability of the relevant insurance cover should be regarded as so important a human right, and so important a feature of an orderly society, as to require that arrangements be made to ensure that at least some minimum level of cover will always be obtainable at what can be regarded as a reasonable and affordable price.

Research

A GIRO working party carried out some research into the issue of the availability of household insurance during 1998, building on previous research carried out a year earlier. They suggested that with a few exceptions it was in the interests of society for affordable cover to be available. One exception related to prospective policyholders with a history of dishonesty, who form a significant proportion of the population, perhaps especially in the areas identified as having a high risk of theft. Another concerned property which was clearly subject to regular flooding or coastal erosion, where the price paid for the property could be expected to have had regard to that fact.

The working party investigated the premium rates quoted by 13 major companies for a "typical" semi-detached house. They concluded that whilst there was a far greater diversity of prices than had previously been the case, there did not seem to be a significant problem in terms of the availability and affordability of buildings insurance, particularly when taken in the context of the costs of home ownership as a whole. They concluded, however, that there was a much more serious problem with regard to contents insurance in high risk areas, particularly for householders who were tenants rather than owner occupiers.

Some data on the penetration of household insurance are provided in the Family Expenditure Survey published annually by the Association of British Insurers. The latest edition, published in April 1998, indicates that approximately 90% of households in owner occupied properties have expenditure on buildings insurance. A similar proportion of households in owner occupied properties have expenditure on contents insurance, but a much smaller proportion of properties subject to other types of tenure have contents insurance expenditure. In addition, penetration of both buildings and contents cover is highly correlated with the income of the household. The relatively low penetration in the low-income households is no doubt due to some extent to a perceived lack of affordability.

Conclusions

The information currently available does not indicate any material lack of availability of the standard forms of personal lines general insurance product, but there is some evidence that affordability is an issue and may be an increasing one.

With regard to buildings insurance, insurers operate an informal agreement which ensures that cover for subsidence is maintained following the sale of a property. So long as this voluntary agreement works satisfactorily there would appear to be no need to put it on a more formal footing, but the matter should be kept under review.

One possible solution to any future problem of the lack of affordable personal lines general insurance coverage is the institution of involuntary pools for risks considered undesirable by the insurance industry. As in the USA, where such pools exist, these could be supported by the active insurers in the particular market, in proportion to their voluntary writings.

It appears desirable to avoid the extreme situation which sometimes arises in the USA where the authorities attempt to address the issue of non-affordability by severely limiting the degree to which insurers can discriminate between different risks in their premium rates. Such restrictions, as well as being contrary to the culture of the UK insurance industry, would probably be in breach of the European non-life directive.

The General Insurance Board proposes to ensure that the GIRO Committee regularly appoints working parties with the responsibility of monitoring the availability and affordability of the various types of personal lines general insurance. Such a working party has already been formed for reporting to the General Insurance Convention in October 1999. It is proposed that they should consider, as part of their research, the nature and scope of appropriate pooling arrangements which may be required in the UK at some time in the future.

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