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GI AND THE PUBLIC INTEREST WORKING PARTY

GENERAL INSURANCE and THE PUBLIC INTEREST

Working Party membership

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Summary

The actuarial profession has a duty to serve the public interest, a duty that it intends to fulfil. What it does in pursuit of that duty could affect all actuaries, including those working in general insurance.

This report starts by considering and challenging how the profession attempts to fulfil its public interest role. It looks in particular at the establishment of position statements. The report calls for greater acknowledgement in the formation of the profession's stance on public interest matters of the views of rank and file members.

The rest of the report looks at various – but far from all - public interest issues in general insurance. It considers these from a variety of viewpoints, highlights some that warrant further research and makes various suggestions regarding others. Some of these suggestions will be eminently acceptable to most readers and others will cause near apoplexy. That is fine, most are suggestions not recommendations, and they are intended primarily to stimulate active thinking. Providing that those who have extreme reactions to this paper are consequently prepared to air their views in open and coherent debate then the report will have served a useful purpose.

In order to whet readers' appetites the following sets out what we have done. We have crawled all over compulsory insurance, commission disclosure, the mis-selling/mis-buying of insurance products, and access to insurance. We have looked at ways of making private motor cover more affordable for youngsters, at the desirability or otherwise of there being restrictions imposed on premium rating, and at how the rules regarding claims are set. We have investigated whether the existence of captives and of the reinsurance market is in the public interest. Finally, we have considered whether actuaries need to be more intuitive in their communications with the public.

Start thinking now!

Contents

1. Introduction
2. Actuaries and the public interest
 - 2.1 Visions, values and the public interest
 - 2.2 Position statements
 - 2.3 Public relations
3. Buying and selling insurance products
 - 3.1 Inappropriate purchasing and how to avoid it
 - 3.2 Intermediaries' remuneration
 - 3.2.1 "Normal" commission
 - 3.2.2 Volume related commission
 - 3.2.3 The law of agency
 - 3.2.4 Should insurers be allowed to own brokers?
 - 3.3 Availability of insurance
 - 3.3.1 Private motor insurance
 - 3.3.2 Household insurance
 - 3.3.3 Other insurance
 - 3.3.4 Access to insurance
 - 3.4 Market consolidation
4. Insurance and society
 - 4.1 Compulsory insurance
 - 4.1.1 Why should insurance be compulsory?
 - 4.1.2 What should be compulsorily insured?

- 4.1.3 What are the effects of compulsory insurance?
 - 4.2 Restrictions on premium rating
 - 4.2.1 Profit margins
 - 4.2.2 Rating factors
 - 4.2.3 Price differentiation between distribution channels
 - 4.2.4 Price differentiation between otherwise identical risks
 - 4.2.5 Summary
- 5. Claims management
 - 5.1 Rules and regulation underlying claims assessment and handling
 - 5.2 Claims management
 - 5.3 Looking forward
- 6. Captives
- 7. Reinsurance
- 8. Conclusions

Appendices

- A Summary of last year's Working Party Report
- B Potential issues in the selling of general insurance products
- C Compulsory insurance covers in England and Wales

1. Introduction

The work of this year's Working Party has been to extend the work of the previous Working Party, which had culminated in a gargantuan report presented at the 1999 GIRO Convention. We have included an easily digestible summary of that report as Appendix A.

We have revisited only those old debates for which we have new material or fresh insight. We have considered some areas missed out last year due to time constraints, such as reinsurance and the use of captives. Finally, we have considered aspects of the wider roles of insurance, for example its role in society.

Although lengthy, our report still only scratches the surface. We have commented on just a few aspects of insurance where we feel we can contribute. There remains much on which we have not commented. Also, whilst we believe the arguments contained in this report to be properly balanced, other industry practitioners, regulators, consumer lobbyists, etc. might well be able to produce further arguments that would change our conclusions. In short, this is very far from the end of the debate.

There is still criticism from within the profession about actuaries' public interest role. Most of that suggests that we are meddling where we should not meddle. There is also criticism from without the profession, mostly that we have tended to look away whilst scandals have been developing that have rocked the industry and the public's faith in the industry. We talk in Section 2 about the ways that the profession can demonstrate its commitment to the public interest. However, it is worth just reminding ourselves what we could do within the general insurance field specifically.

Actuaries in general insurance do not have the same influence as in life assurance or pensions. That is partially an accident of history and partially due to differences between the three industries. There is a risk of an adverse backlash should we in the general insurance field attempt to assume the same level of influence as enjoyed by our life and pensions colleagues. Nevertheless, over the last ten years or so, we have helped, both as individuals and as a profession, to improve significantly the level of financial control within the industry. Better financial control of insurers and within insurers has led, directly and indirectly, to the public being served better. We can also use our influence similarly to improve product design, claims settlement processes, sales-related practices, price levels, and pricing structures, making them more understandable. These would all be results in the public interest.

Finally, a disclaimer: references are made throughout this report to various legal points. Please note that the members of the Working Party are not legal experts and this report has not been subject to scrutiny by experts in insurance law, the law of agency, etc.

Therefore, anybody acting upon comments contained within this report does so entirely at their own risk.

2. Actuaries and the public interest

2.1 Visions, values and the public interest

In last year's report we established that the actuarial profession has a duty to serve the public interest and that it intends to fulfil that duty. We will not revisit that debate. Instead we will look here at the ways in which the profession is fulfilling its duty.

In the pamphlet entitled *Vision and Values of the Actuarial Profession* the Institute and Faculty explain that the profession serves the public interest in a variety of ways, including providing "authoritative and objective input to public debate".

The document then goes on to explain that the profession will serve the public interest as follows:

- *"We will be increasingly proactive on public interest issues so that we demonstrate, and the public understands, that we have accepted our responsibilities. We will:*
 - *continue to develop Position Statements*
 - *strengthen Professional Guidance*
 - *encourage Continuing Professional Development*
 - *continuously review and update the concept of Practising Certificates*
 - *raise public interest issues which are clearly within our accepted province.*
- *We will play our part in improving the education of present and future financial consumers.*
- *We will help the public by assessing the financial soundness of the businesses we advise. We will seek further agreed or statutory roles for the actuary - in particular in General Insurance and in due course the management of risk in financial services groups."*

The detail of professional guidance and development may well be contentious amongst actuaries but the principle of them is not. The idea of actuaries helping to educate financial consumers is also widely considered as acceptable. Statutory roles for actuaries and the concept of practising certificates are more controversial but are, as far as general insurance is concerned, being looked at elsewhere, and so are not considered further in this report.

We considered at some length in last year's report the question of whether it is appropriate for actuaries to raise potential public interest issues, at least within the

general insurance area. We concluded that it was, which thankfully gives us a remit for the rest of this report. But the question of Position Statements was not covered then and has, in recent months, generated some heated debate. The rest of this section of the report is devoted to Position Statements, in particular to how they are formulated and promulgated.

2.2 Position statements

Background

The Working Party last year raised several issues of which the Joint Institute and Faculty General Insurance Board ("GI Board") regarded three as worthy of wider debate. These concerned the remuneration of brokers, inappropriate buying/selling of insurance products, and utility pricing. The approach to be taken by the GI Board was threefold: to host a lunch for members of the trade press, at which they would be briefed about these issues, to commission Position Statements on each, and, in respect of brokers' commissions, for the profession to lobby the General Insurance Standards Council ("GISC").

Following the press lunch, the profession's stance regarding commission – calling for the abolition of volume-related commissions and the full disclosure to the policyholder of all other broker commissions – was reported prominently in *Post Magazine*, along with various broker groups' rather scathing responses. Several consulting actuaries felt severely embarrassed about this – the profession had not warned them that it had made these press comments (let alone that they intended making them), they fundamentally disagreed with the position taken, and their clients or employers were annoyed.

How are these positions agreed?

In the UK the profession is run jointly by the Institute and the Faculty. They also act as the spokespersons of the profession. In some respects they could be regarded as the profession's government, with the Institute and Faculty staff acting as the civil service, the members of the Councils being the MPs, and the Finance and Investment Management Committee ("FIMC") the equivalent of the Cabinet. This analogy can be extended as, like a government, the Institute and Faculty take actions on behalf of their members – the electorate – but without necessarily conducting a full consultation process beforehand.

Turning to matters of public interest, the choice of public interest issues is in general left to the practice boards, although occasionally FIMC itself suggests issues to consider. The practice boards then form a view on each issue, effectively a position statement. The draft position statement is scrutinised by FIMC and, if approved, made available for appropriate distribution. Should the issue be so pressing that it cannot

wait for full FIMC review then the scrutinising role can be delegated to a sub-group of FIMC, the sub-group comprising at least the current Presidents.

In general we, the Working Party members, do not have a problem with that. For many matters it would be impossible to hold a full debate involving the entire membership. But we do have some concerns:

- The range of topics on which position statements could be produced is vast. The ultimate choice of topics is something of a political act. Indeed, should the profession be empowered to issue position statements relating to areas where it does not have special knowledge or expertise, or where the interests of its members or the profession are not directly at stake?
- Are those pronouncing on these matters all qualified to do so? What about those reviewing or scrutinising the statements? How have the views of the wider membership been taken into account?
- Having established a position, is a public utterance the best way of encouraging the actions that the profession seeks? Behind the scenes lobbying might be a more effective way to achieve changes. The profession's role in obtaining improvement could be recognised retrospectively. Of course, this might already be going on – if it is “behind the scenes” then we would not know about it. But the profession has been accused in the past of political naivety and for it to charge about, firing off position statements at every public interest issue that it sees, would only perpetuate that impression.
- What, ultimately, is the accountability of those who set the profession's public opinions? It should be noted that the practice boards, especially the GI Board, include co-opted members, i.e. actuaries who have not run the gauntlet of the ballot box and thus gained the approbation of their peers. Reverting to the parliamentary analogy, are the practice boards the equivalent of government departments or quangos?
- Are they going to be used responsibly? Is there some quota for the number of Position Statements issued by each practice board or any degree of competition – however well meaning or light-hearted – between them? And are they being used more as publicity for the profession, rather than as heavy-hitting contributions to the public interest debate? If so then this strikes us as an unnecessarily risky way of gaining that publicity.

Whatever the answers to the above questions we conclude that the real weakness of the current structure for developing position statements is that the Councils and practice boards need to hear more of the opinions of rank and file actuaries. At last year's GIRO Kathryn Morgan appealed for volunteers to help prepare these statements. Just one person stepped forward. Unless the members of the profession express more

volubly their views on public interest issues – starting with what those issues are – then the public utterances of the profession can only reflect the personal views of members of the Councils.

The debate that will take place at the GIRO meeting on this report will contribute to this. However, something needs to be done to “fast-track” the profession’s stance on important public interest issues, to ensure that they have been tested against the views of all right-thinking actuaries, that their implications have been fully considered and that they really do advance the public debate.

Having raised the issue and declared that “something must be done”, we are neither volunteering to do that something nor even suggesting what that something might be, other than we might learn something from the process to develop guidance notes. However, we are certain that it is an important issue. The consequences to our professional reputation of making ill-considered statements on matters of public interest could be disastrous. But so too could be the results of us sitting on the fence, too concerned with saying the wrong thing to be able to say anything at all. “Damned if we do and damned if we don’t”!

As a postscript, we note that just one of the three Position Statements commissioned by the GI Board have so far been formally aired. That on broker remuneration was rather overtaken by the above events, although as originally drafted it suggested action less radical than that recommended by the Institute and Faculty to the GISC. The paper on utility pricing is still being redrafted. And the statement on inappropriate buying/selling of insurance products was finally issued at the end of June, whilst this report was in the final stages of preparation. We understand that this statement, whilst in final draft form, was posted in the “Members Only” part of the profession’s web-site and the resulting comments were taken into account in the published version. So perhaps some of our criticisms are being dealt with.

2.3 Public relations

The insurance industry – and on occasion that includes actuaries, individually and collectively – has often failed to get its message across to the public. In many people’s minds, that is due to poor communication and that what is needed to correct that is careful explanation of the important issues. But is that what is really needed?

“Careful explanation” means to many a watertight case, and for many actuaries (and probably some other insurance professionals too) a watertight case is usually one that is based on logic. But not everyone thinks in an entirely logical fashion. Money in particular, despite the numerical basis of finance, is a subject upon which perceptions and expectations often appear to defy logic. As a result discussions regarding personal money are often based largely on emotion.

"Careful explanations" based on logic are still required, and indeed are essential in helping the industry and its component parts to get their messages across to the public. But to ensure that the messages are appropriately understood requires them to be carefully tailored to the emotional responses of the audience. At its extreme this can result in "spin-doctoring", by which we mean the avoidance of proper debate, possibly to hide inadequacies in the argument. More responsibly applied it is really all about putting matters in a positive light, perhaps as a constructive counterweight to a destructive emotional outburst (e.g. as a riposte to accusations of "rip-off insurance"). In essence it is about establishing an understanding and rapport with those with whom the industry wishes to communicate, and practising two way communication, i.e. listening as well as broadcasting.

Actuaries have an important role to play in getting the message across. After all, we profess to understand the complexities of finances, of the products, of customer needs and of the industry in general. We must also ensure that what we do, and, to the extent that we can, that what others in the industry do, is explainable in simple, easy to understand language. If we do not, then, however logical our position or the industry's position, we will not be able to get our message across and will be deemed to be wrong. This would be very unsatisfactory.

3. Buying and selling insurance products

3.1 Inappropriate purchasing and how to avoid it

There are many forms of general insurance cover, many means and circumstances of buying these covers, and an extremely broad range of customers in terms of needs and ability to make a well-informed purchase decision. It is perhaps inevitable that there are occasions when consumers purchase, or are persuaded to purchase, general insurance products that are inappropriate, unnecessary, misunderstood or poor value.

We considered this last year and concluded that it is not a significant issue. This would appear to be supported by a report by the Insurance Ombudsman in which he noted that in 1998 he logged only 19 selling complaint cases (out of a total of 3,444 insurance-related complaints). Nevertheless, such cases attract public attention, particularly bearing in mind recent selling scandals in other parts of the insurance industry, and consumer pressures continue to grow for the protection of the unwary consumer and for the elimination of unreasonable selling practices. Therefore the industry should strive to establish and to maintain best practices as a means of minimising the risk. It needs to improve, and to be seen to be improving, continually its products and its sales practices.

Unsuitable purchasing includes:

- buying duplicate cover unintentionally or unknowingly
- buying cover that does not provide what is needed
- buying cover that is not needed
- misunderstanding or making ill-informed comparisons because of varying exclusions, excesses and policy limits
- feeling obliged to purchase cover as part of another purchase transaction
- buying product at a price significantly higher than available elsewhere.

Appendix B sets out some of the potential issues that underlie unsuitable purchasing.

To these issues the following are possible solutions, although whether the cost, complexity and consequences of some of these solutions are appropriate to the underlying complaint is a moot point. So too is how they would fit in with the style of systems and controls espoused by the FSA, etc. But they are all worthy of consideration, for some product types more than others.

- *“Plain English” all documentation and sales literature.* Many insurers have already done much in this direction but it is easy to find examples where they could

do more. However, there are a lot of mitigating factors. The technicalities and complications inherent in many policies are not easily explainable in brief and simple phrases. This situation is further complicated as insurance terms are largely defined by precedent and by common law, which can be inconsistent and changed without warning. The cost of reissuing all policy documents in this form would be high, as would the cost of keeping them up to date as policies are endorsed. Also, it is not possible to force people to understand the documentation if they are not prepared to read it.

- *Standardise basic policy covers.* The baseline product recently introduced by the Council of Mortgage Lenders in respect of mortgage payment protection has received, on balance, a favourable response. Although this sets out just minimum levels of cover, we feel that well structured standard terms for the more troublesome classes of business would elicit a similar response. On the other hand, such an approach would reproduce one aspect of the tariff system and thus might be considered to be anti-competitive. Nevertheless, we believe that this idea warrants further investigation.
- *Make transparent all exclusions (i.e. avoid them being hidden in the detail).* If making them transparent is difficult then it implies that the cover will not be easily understood by policyholders and hence is inappropriate for the market.
- *Introduce a cooling-off period.* In practice this is unlikely to work unless insurers were not immediately on risk, but were only on risk after the close of the cooling-off period. For certain classes of business this might have other benefits for insurers who otherwise can suffer badly from "Not Taken Up" policies, but it would have marketing consequences. Some aspects of this have already been built into European Directives, e.g. those relating to distance selling.
- *Require the intermediaries to understand fully their products.* There is already a requirement under the ABI code that intermediaries properly explain the main benefits and exclusions of any product that they are selling. The GISC draft rulebook adds to this competence and training requirements for intermediaries. However, we are not sure how these rules (will) apply to the likes of those selling travel insurance in holiday companies or warranties on electrical goods, few of whom are members of the ABI and few of whom, one suspects, will sign up with the GISC either. Many such retailers' staff members appear not to understand fully the mainline products that they sell, let alone the insurance that they sell as a follow-on transaction. Therefore we suspect that the training costs for such retailers would be prohibitive, particularly in the context of what are often small premiums. This cost would then be passed on to the customer or else the retailer would no longer offer insurance. Would the public regard this as an acceptable penalty for reducing the risk of mis-selling of such products?
- *Outlaw the practice of requiring cover to be bought from a specific organisation as part of another transaction.* This is already happening but is easier said than done.

In effect it is being tackled on a case by case basis. For example, at the end of 1999, the Government announced legislation to outlaw the compulsory tying-in of mortgages and insurance products. Lenders would still be able to require insurance to be taken out on the mortgaged property as a condition of the loan, but would no longer be able to compel borrowers to buy that cover from a particular insurer.

- *Introduce some form of independent/standard published indicators.* These could cover, for example, the scope of cover, service standards, and the insurer's attitude to claims payments. This would not work like a *Which?* survey as frequent price changes would preclude a recommendation of "Best Buy". But it could work like the *AA Hotel Ratings* in that policyholders would be able to see whether they were being offered a 5 star policy or a 1 star policy and would therefore be better placed to judge whether they were getting it for a fair price. They would also have some idea what sort of service to expect from their insurers thereafter. This is an intriguing idea but one, we suspect, that is fraught with difficulties – who, for example, would prepare the indicators? – and potentially a legal minefield.
- *Introduce "Policyholders' Reasonable Expectations".* This is an interesting idea but the experience of the life industry in getting to grips with the practicalities of this concept is not encouraging, nor are the costs that it has borne. In a low premium, thin margin business such as general insurance, particularly personal lines insurance, this seems to be a sledgehammer to crack a nut. Nevertheless, in its dictionary definition this appears to us to be a fine ideal and one that implicitly underlies much of what we talk about throughout this report.
- *Disclose intermediaries' remuneration structure and commission received.* We discuss this further in the following paragraphs.

3.2 Intermediaries' remuneration

There are two issues. One is normal commission – if brokers' and other intermediaries' remuneration is proportional to premium then they have an incentive to recommend the costliest product. The second is volume-related over-riders and similar arrangements that pay supposedly independent brokers to send their clients to a particular insurer.

3.2.1 "Normal" commission

Most people would agree that intermediaries need recompense for their work. What that recompense should comprise is less easily agreed. Nor is it easily agreed the extent to which policyholders should know what payment the intermediary has received as recompense for selling cover to the policyholder.

In the case of brokers, the purchaser is, as the principal, entitled to know this information. In the case of other intermediaries (e.g. tied agents), the purchaser does not have any such right.

To disclose or not to disclose?

Would routine commission disclosure improve matters? Would it reduce the incidence of mis-selling/mis-buying? Would it improve consumer choice?

Commission disclosure might prompt policyholders to look elsewhere other than the intermediaries whom they have already approached. Either they will thus achieve a worthwhile saving or enhancement to their service quality, in which case the disclosure has been useful, or they will not, in which case disclosure demonstrates that the intermediary has been doing a reasonable job. If policyholders misuse the information or take wrong decisions based upon it then that is their prerogative.

On the other hand, money is an emotive subject that can provoke irrational behaviours and responses. Even logical and unemotional people could easily get resentful were someone to tell them that when they handed over £100 for insurance cover the intermediary was immediately taking something like £25 of it for what they saw as simply facilitating the deal. Few currently realise how big a percentage of general insurance premiums the commission payments are (although they are not substantial in absolute terms). Continuing in the emotive vein, policyholders may well consider that to be a rip-off, regardless of whether £100 for the cover was a good deal.

The logical argument that, were one to do it oneself, it would take some time to ring around the various companies to get quotes and that this time saving might be worth £25, would be forgotten. So too would the other services that the intermediary might provide, such as proposal preparation, advice on security (one's own as well as that of the insurers' finances), claims handling, what are the policyholder's actual needs, etc. This might not be the case in all countries – for example in the United States service such as that provided by brokers is more widely appreciated and understood – but in Britain there is a more fundamental distrust of salespeople and an underlying attitude that good service should cost nothing.

On this basis disclosure might make many policyholders feel more dissatisfied than satisfied. One suspects that, were shoppers to understand the “mark-up” on other retail products such as clothing, they would be equally dissatisfied, seeing that the retailers' margins on such items are usually far greater than those charged by insurance intermediaries.

In passing, the intermediary is saving not just prospective policyholders time and money but also that of the insurers that they would otherwise contact directly. Often, intermediaries also key-in policyholders' data and issue policies on behalf of the

insurer. Therefore, part of the commission is really payment by the insurer in respect of these services. Would disclosure recognise this?

We are still not unanimous in our conviction that the Institute and Faculty are correct in calling for the routine disclosure of the commission earned. A system that works adequately might be best dealt with by saying "if it isn't broken, don't fix it."

An alternative to commission

If it considered that the payment of a commission linked to the premium amount represents an unacceptable moral hazard, then an option would be to outlaw commissions as such and instead to remunerate intermediaries by a fee for every policy sold. That still would not stop non-tied intermediaries being paid different amounts by different insurers, unless there were a standard fixed fee (or fee per mille sum insured) laid down by the regulator, or unless the fee were actually paid by the policyholders. Either option would remove some of the moral hazard. The latter would also be appropriate were the intermediary awarded a fee for arranging insurance cover, rather than for specifically selling an insurance policy. However, as has already been noted, the current commission-based system has generated few complaints, at least not to the Insurance Ombudsman, and does seem to work reasonably well. Therefore, whatever doubts we might have from a theoretical perspective, we see no justification for fundamental change.

3.2.2 Volume-related commission

By volume-related commission we refer to a system under which the average or marginal rate of commission paid by a particular insurer to an intermediary increases with the total amount of business that the intermediary places with that insurer.

The major areas where volume-based commission is paid is in the commercial markets. It is amongst the big ticket risks where expert buyers are involved that volume-based commissions are coming under the closest scrutiny. In last year's paper we commented on both the Association of Insurance and Risk Managers in Industry and Commerce ("AIRMIC") and the Risk and Insurance Management Society ("RIMS") positions which have become more entrenched since then. Both Aon and Marsh have now agreed to disclose volume-based commission to their clients.

It also appears that Aon, Marsh and Willis (i.e. the world's three biggest brokers) are being sued by a Californian attorney for failing to disclose contingency fees. This has prompted AIRMIC to reiterate its earlier calls for transparency of deals in the UK insurance industry. In the particular circumstances of this case the brokers were alleged to have made arrangements with insurers where they earned commissions based on the volumes of business placed. AIRMIC has indicated that it has submitted a proposed code of conduct for brokers to the Treasury and that a continuing dialogue is taking place.

Our position last year was much the same as AIRMIC's in that we called for the full disclosure of volume-related commissions. The Institute and Faculty went further and approached the GISC, in its role as the new intermediary regulator, to call for the complete outlawing of volume-related commissions. We understand, however, that the GISC does not intend the issue of volume commissions to be covered at all within its book as it does not regard it as a priority issue. In any event, we understand that the GISC will deal mostly with personal lines matters and will not get much involved in commercial lines issues.

As regards non-independent intermediaries the considerations are rather different, providing that the prospective policyholder is clear that they are not independent. However, volume-related commission where the rate of commission on all the business sold increases when a threshold is reached is still questionable. The point is that there is an additional and substantial incentive to sell an extra policy when the threshold is about to be reached. This might represent an irresistible temptation to unethical or even illegal behaviour. The point is not specific to insurance, but applies to any salesman or sales organisation remunerated in this way.

3.2.3 The law of agency

There is an interesting legal point within all of this, concerning the law of agency. Agents will normally be paid by their principals, and it is unusual in non-insurance contexts for the agents to be paid by the other party to any transaction. For agents to be remunerated by the insurers with whom they place business casts immediate doubt on their status as agents (as might the fact that some also perform administration services for those insurers). It might invalidate the contract itself, especially if the supposed principal does not know about the commission.

That said, payment of commission in the insurance context is a well-understood commercial practice that has stood the test of time. It is highly unlikely that a judge would invalidate an insurance contract simply because commission was paid by the insurer. In passing it is worth noting that a member of the Working Party did once discuss this matter with a non-insurance lawyer. The lawyer took some convincing that commission payable by the insurer was compatible with the broker being the agent of the insured, with his initial view being that there was a danger that the insurance contract was invalid. With the mental agility characteristic of his profession, he changed this view when assured that this was, within the insurance industry, normal commercial practice.

3.2.5 Should insurers be allowed to own brokers

In recent years several firms of high street brokers have been bought by insurance companies. A good example is Hill House Hammond, which is currently owned by CGNU. Is the ownership of brokers by insurers in the public interest?

It is not clear to what extent the public differentiates between brokers, who are supposedly providing potential policyholders with impartial advice, and other intermediaries such as tied agents. Therefore it is not clear to what extent they expect those providing impartial advice to be fully independent.

Ownership presents an obvious moral hazard. There is no reason to suppose that those insurers and brokers currently linked do not manage appropriately the conflicts of interest and maintain between them the necessary Chinese walls. However, there is a need for both parties to be scrupulously open regarding their relationship, to minimise unwarranted suspicion. Aside from that, given the melee that we know as the insurance market, we doubt there is currently any real public interest concern about this particular issue.

3.3 Availability of insurance

The Working Party discussed at length in its report last year the availability of household insurance. It concluded that there was no red-lining but that some people found it hard to afford cover, because of high risk premiums associated with particular locations or because of low levels of disposable income. It then discussed ways in which these causes could be addressed.

This year the Working Party considered other aspects of the issue.

3.3.1 Private motor insurance

What is the issue?

Young drivers complain that the insurance premiums that they are charged are excessive. This has meant that, for many, running certain types of cars (legally) is unaffordable. That is not a problem if the types of cars are purely those with high performance and hence high risk. Indeed, it could be argued that it is in the public interest to discourage youngsters driving such cars. However, if insurance is unaffordable for many, whatever the type of motor vehicle, then there might well be a problem. Society today expects adults to be mobile over a significantly wide area – for work, for leisure and for shopping. Moreover, in rural areas (and in many urban areas outside “normal” hours) public transport systems tend to be thinly spread and to operate variable levels of service. Although car insurance is but one of the costs of owning and running a car, for young people with low value, low performance cars it can be a high proportion of those costs and hence a major inhibitor of car ownership.

Are these high costs justified by young drivers’ claims (and expense) experience? It would appear that, overall, the answer is “yes”. Many industry practitioners have commented that the rates for younger drivers have, over the last few years, not been

sufficient to meet the increasing cost of their claims experience. This might be a function of the fact that a high proportion of increasing costs for insurers has come from bodily injury, etc. and younger drivers tend to have bigger than average claims that will take time to develop. Moreover, the risk is not restricted to the likelihood of accidents. It also includes the likelihood of expenses not being recovered. With lower and more uncertain incomes than the rest of the population, youngsters are more prone to chopping and changing their insurers, or even of cancelling mid-term, leaving insurers with high levels of unrecoverable sales, marketing and administration costs.

Those unfamiliar with the UK personal lines motor insurance market should be aware that the industry has, overall, experienced several successive years of losses on this class of business. Whilst individual insurers have made profits, through selective targeting or through careful cost management, the majority have suffered through charging inadequate premiums, the consequence of intense competition for market share. In this context any suggestion that motor insurers have been excessively charging segments of their customers are likely to be met with a justified raspberry.

What are the possible solutions?

As the rates charged to young drivers appear broadly justified by the costs involved, and hence are unlikely to be reduced significantly, what options are there to make mobility more practicable or affordable to youngsters? In answering this we will leave the potential solution of an integrated transport policy for Britain to one side – it has already defeated better minds than ours – and will deal similarly with e-Commerce, home working and virtual social lives. Instead we will concentrate on potential insurance solutions.

If the risks make the costs prohibitive, regardless of the type of car, then can we reduce the inherent risks? The answer is “yes”. Not only can costs be reduced by increasing driving skills (as demonstrated by, for example, the Pass Plus scheme and the Advanced Driving Test, passing either of which can reduce insurance premiums) but they can also be reduced by limiting the scope of cover. For example, it would be possible to restrict the driver to having no more than one other person under 25 in the car, thus reducing the likelihood of poor driving through “showing off” and other distractions, and the scope for large injury claims. Alternatively, a driving “curfew” could be placed upon the driver so that, by way of illustration, he/she would not be covered for incidents whilst driving the car between 10pm and 6am (clearly this option would not suit those who needed to use a car to travel to shift work). Earned NCD could then be used either to reduce further the premiums or to build back up the levels of cover.

¹ Readers are referred to Chapter 18 of *The Cabinet Diaries of Rt Hon James Hacker MP*

In many ways limiting to some degree the scope of the cover would be preferable to offering high excesses which youngsters could ill afford in the event of a claim. Were the youngsters to drive outside the terms of their insurance cover then they would be in effect driving whilst uninsured. Any claim that resulted in such circumstances would have to be picked up by the MIB. This might not be an additional burden on the MIB as the act of making insurance more affordable might reduce the number of people driving without any form of cover.

We are mindful that we have not run these suggestions past the various law enforcement bodies, some of which are still bristling after the suggestion that they frog-march drunks and hooligans to cash points in order to extract on-the-spot fines. We have also not verified that these suggestions comply with the various human rights and civil liberties regulations applicable in the UK.

Such product innovations need not be restricted to young drivers, although it is for them that the effect on the premium of these exclusions would be greatest. Some more mature drivers might appreciate a range of higher excesses, so that in effect they can self-insure for "normal" accident claims and just buy catastrophe cover. Currently it is difficult for any driver, other than a youngster, to obtain excesses of over £500.

It has been suggested that the product could be cut down to its most basic form. However, many insurers have withdrawn third party only insurance as they found their risk rates for the cover, when based purely on their own experience, were higher than those for third party fire and theft cover. This implies inadequacies in the rating structure in that some self-selection factor is not being taken into account. But the withdrawal of insurers from this cover is also partially due to there not being a loud clamour for cut-down cover. For youngsters, their car might represent a significant proportion of their material assets. They are therefore likely to want insurance cover to provide against the car being stolen or burnt out and hence would consider cut-down products to be unattractive.

Subsidised pools

Another way around the cost of cover being unaffordable might be the use of a subsidised pool. This could be appropriate for high-risk drivers as well as young ones. The pool could be set up and run as part of a government department, or as an extension to the current work of the PPB or the MIB. Drivers who could not get insurance would, presumably, pay a premium to this body. The premium might be based on what it was thought reasonable that drivers should be asked to pay. It would not be self-funding on this basis, as if it were then presumably commercial cover would be available for a similar price. The balance would have to be funded from somewhere: a mechanism similar to the PPB or the MIB is the obvious solution. There would be no barrier to the cost of this appearing as an explicit item on policyholders' renewal notices, so that the cost would be transparent.

In this case, the subsidy would be explicitly from the bulk of motor policyholders to the high-risk drivers. Alternative arrangements are possible, including subsidy from general taxation, although we consider it unlikely that governments will consider the subsidy of insurance a priority call on the public purse.

The subsidised pool approach has its disadvantages. What determines eligibility? Would it be some combination of age/driving record/vehicle type? If so, with the exception of the age criterion, it hardly encourages responsible motoring. And would it be means tested? Affordability starts at different levels for different people. It depends as much on one's financial priorities as upon one's disposable income. Again, this approach might not encourage socially responsible behaviour. And if the subsidy were not tiered then those who just missed out on a subsidy would be at a significant disadvantage to those who did not. Indeed, they could be doubly disadvantaged as they might well be paying for the subsidy themselves. No one is likely to be keen on this sort of arrangement, these marginal cases least of all.

All in all, the pooled approach does not appear a very attractive solution to the unaffordable insurance issue.

3.3.2 Household insurance

We concluded last year that relative affordability was not the main reason why some people did not insure their homes. However, several of the options discussed above for motor insurance could be equally applicable for household insurance. For example, a wider range of excess levels that enabled potential policyholders to make the decision between being fully insured and self-insured, or somewhere in between, would be attractive to some. So too would be allowing policyholders some form of co-insurance - in effect allowing them to be underinsured deliberately. Indeed, wittingly co-insuring would encourage greater responsibility and risk management on the part of policyholders. There is limited availability of these options through Lloyd's.

3.3.3 Other insurance

Other groups now find insurance to be unaffordable, at least for the level of cover that they previously enjoyed. For example, many churches can no longer afford to insure their property. Therefore church relics are stored away out of sight and buildings are no longer left open outside normal service times. This is inappropriate for places of worship. Also, many church buildings are listed and a parish too impoverished to be able to afford the insurance premiums could scarcely afford to restore a church badly damaged by fire or storm. Therefore, one presumes, unaffordable premiums are not socially desirable.

Professionals are also struggling with the increasing cost of professional indemnity insurance, caused by spiralling litigation. The costs of the indemnity cover are indirectly passed through to clients via higher fees but this only makes clients feel that

they are receiving less value for money. The alternative is that professionals cut corners to keep down their costs and the fees charged to clients, which is likely in itself to fuel the rising cost of cover.

None of the solutions noted for motor or household products are really suitable for small businesses in some inner city areas that find their insurance costs increasing beyond their means. In this case government action is needed, preferably to address the causes of those increasing costs, i.e. cracking down on crime and the causes of crime, and demonstrating to insurers how these actions will reduce their costs.

3.3.4 Access to insurance

With the move towards IT and centralisation of services, are some people falling away from having easy access to financial services? This is a concern of the Government, fuelled by the gradual demise of walk-in, high street offices and agency networks. Our conclusion is in general “no”, although some people will be adversely affected. Whilst some providers have cut some of their distribution outlets they have, in general, replaced them with several others. Customer choice is the current driver of distribution. Modern outlets are no longer restricted to standard working hours (Monday - Friday, 9am – 5pm or even less) but now can be accessed up to 24 hours a day, every day of the year. Not everyone has access to all of the methods (e.g. the Internet, iTV) for all providers but everyone has access to some. The industry should avoid complacency. However, it can take pride in this aspect of how it has developed in recent years to meet the needs of the public.

More of an access issue is the increasing requirement of financial service providers that customers buy their services using just credit cards or a retail banking service. Thus those who do not have a bank account and who wish to pay for services using cash are excluded. This is compounded by the use of credit rating techniques that assess as poor risks not only those who have a history of abusing credit services but also those who have not used such services.

It is not immediately clear what is the solution to this problem. Financial service providers such as insurers need to find a low cost means of collecting cash payments from those who still prefer to do business in that way. This might be through using a remaining high street presence (such as the Post Office, although these too are disappearing) or through co-ordinating cash collections with other services, such as electricity suppliers, gas suppliers, rental agencies or even the milkman.

3.4 Market consolidation

Recent market consolidation has resulted in just five insurers providing over 50% (by premium income) of the general insurance covers sold in the UK. Those same five

insurers tend to dominate most of the individual product classes. Is this in the public interest?

The reasons for consolidation are usually that greater size brings economies of scale and hence greater profits and/or lower charges to customers. The downside is that it can also reduce market competition, thus negating the need to pass on cost savings to consumers, and can restrict consumer choice.

With the market structure as it is there does not appear to be an overall lack of competition nor of available product. One would have expected the Monopolies and Mergers Commission to have stepped in on the recent CGU/Norwich Union merger had they had serious concerns.

Another concern would be how regulators treat the mega-insurers that emerge from this consolidation. Such insurers have such a dominant market position that many think that they cannot be allowed to fail, otherwise the market itself will be destabilised.

There are many other issues associated with market consolidation, such as the closure of offices, which can have a severe impact on the local economy, and job losses. We note these in passing but feel that these are too far outside our field of expertise for us to comment further.

4. Insurance and society

Last year the Working Party debated the impact of the “free economy” on the insurance industry and its operations. This year we consider, in the context of insurance in the UK, some of the ways in which the “free economy” is distorted by the imposition of politically or socially motivated constraints, over and above regulatory disclosure. We further consider the extent to which the public interest would be better served were those constraints to be relaxed or extended.

4.1 Compulsory insurance

The most obvious constraint within the insurance market is the requirement, in certain circumstances, for individuals and corporate bodies to take out prescribed forms of insurance. In the following paragraphs we discuss why this might be, whether or not the specified circumstances should be amended, and some of the consequences of making insurance compulsory.

4.1.1 Why should insurance be compulsory?

There are two reasons commonly advanced to justify compulsory insurance. The first is to ensure that the individual concerned does not suffer some loss that induces penury and, possibly, dependence on the public purse. The second is to ensure that in the event of the individual causing damage to some other person then there will be sufficient funds to pay compensation, even if the person responsible cannot afford the amount. In the UK the latter reason is more normal.

Appendix C lists the insurance covers that are compulsory in England and Wales. Most of these examples are of fairly limited application, but two pieces of legislation – those relating to third party liability for motorists and to employers’ liability - generate millions of policies every year.

It is not a peculiarly British practice to require these types of insurance by law. Motor third party liability is compulsory in almost all developed countries (although South Africa is an exception, and the extent to which the state social security system pays disability costs also varies from country to country). Most countries also have a requirement that employers will take out cover so that their employees may be compensated in the event of injury, either through employers’ liability or workmen’s compensation schemes.

In a society based on a mainly capitalist economic system, it is normal to allow consumers to decide whether or not they should buy any particular thing, with them

offsetting the value and utility that they expect to gain against the price that they expect to pay. A requirement to buy insurance is contrary to this principle. However, as far as the Working Party is aware, the current requirements to buy third party insurance are not the subject of any political controversy, certainly not in the UK.

The reason for this, presumably, is that the vast majority of compulsory insurance is regarded as protection for the victims of a tortfeasor, rather than for the insured himself. People do not choose to be victims of accidents caused by other people, and it is for the victims' protection that the relevant laws exist. In a serious accident the damages may be well beyond the means of even rich people, and extracting even modest damages from individuals may be difficult. By requiring compulsory insurance, society ensures that victims can be compensated. The need may be less obvious in the case of large corporations, whose capital often exceeds many-fold even the largest amounts of damages readily conceivable, but even large companies can go bankrupt, sometimes with surprising speed, and the necessary processes to establish subsequently amounts of damages may take several years. Moreover, the tail on liability cover due to latent claims mean that claims are often notified many years after the causal event and in some cases many years after the relevant employer ceased trading, was restructured, was taken over or was merged.

Compulsion may also be imposed by contract. A common example is in the conditions of a mortgage loan, which usually require a borrower to keep the mortgaged property insured against fire and other perils. In order to impose compulsion, the party imposing it will normally need to have some interest in the insurance being maintained. In the case of the mortgage this is that the value of the security taken by the mortgagee should not be reduced by the destruction of the property.

4.1.2 What should be compulsorily insured?

Whilst the desirability of some compulsory covers does not seem to be a matter of debate, the list of compulsory insurances could be considered somewhat eclectic. Motor accidents are common, and the need for this insurance is obvious, if the principle that victims of accident should get redress with reasonable certainty is to be upheld. Accidents at work are also relatively common and employees rightly are protected. But accidents commonly occur elsewhere or involve people other than employees. Why are not all people and businesses required to hold public liability insurance against any accidents that they might cause? Why are riding stables but not, say, amusement parks required to have liability insurance? Why should only certain breeds of dog be required to be insured? It is presumably less common to be mauled by a poodle than by a pit bull terrier, but a poodle can still do significant damage, and there are more poodles in this country than pit bull terriers. Also, a dog may do damage or cause injury for reasons other than uncontrolled ferocity – a car swerving to avoid a dog and thus hitting a pedestrian is the classic example.

The answer, presumably, is that the legislation was not developed in its entirety as the result of a philosophy about insurance and the public interest, but rather as responses to particular perceived needs for protection. For example, the Dangerous Dogs Act 1986 came into effect following a concerted media campaign that highlighted attacks by animals such as pit bull terriers, particularly on children. The media ignored as not newsworthy attacks by other dogs, such as poodles. Hence compulsory insurance cover was restricted to the only dogs that popular belief considered dangerous, rather than extended to all dogs or even pets. On this basis one must be grateful that the list of compulsory covers is no more eclectic than it already is. However, we believe that it would be in the public interest were the list to be tidied up and clear anomalies corrected.

4.1.3 What are the effects of compulsory insurance?

Non-motor

The effect of legal compulsion may not be straightforward. What happens if the individual or employer cannot afford the insurance? Consider first the non-motor cases. It seems unlikely that the cost of compulsory liability insurance could make the difference between solvency and insolvency for many companies. In cases where it did, the initial reaction might be that the laws caused the destruction of economic activity, thus a reduction of general prosperity, and loss of employment, and were therefore to be deplored. However, so long as the premium that would be charged reflected appropriately the level of risk, it might be argued that the spur to economic activity arising from the continuation of the enterprise was more than offset by the damage likely to be caused to others. In such a case, the overall effect on society of closing such businesses down would actually be beneficial.

Another way of looking at this is that if an employers' liability premium takes a company from solvency to insolvency then it is already in very poor financial shape and that has nothing to do with the insurance premium.

Motor

Turning our attention to motor, similar arguments apply about the effects of compulsion. For most drivers, the cost of insurance is likely to amount to less than 15% of the cost of running a car. For poorer people it is possible that this could make the difference between being able to run a car and not being able to. One may argue that this is no more likely than the cost of petrol being the straw that breaks the camel's back. Since a substantial proportion of the cost of petrol is taxation, the Government, which supposedly reflects society's concerns, presumably views this prospect with equanimity. Those who live in the countryside, where the lack of a car is most likely to present serious difficulties, are those who will tend to be able to get insurance relatively cheaply. Hence they are also those for whom the probability of insurance making the difference between being able to run a car and not doing so is lowest.

Availability of compulsory cover

When Parliament enacts laws that make insurance compulsory for a certain activity, it is reasonable to assume that it intends that the insurance to cover the activity should be taken out, not that the activity should cease. If the insurance industry does not want to cover the risk at an appropriate premium because of a general distaste for a particular sector then the use of compulsory insurance to achieve the policy goal is brought into question. It might also suggest that the freedom of insurers to set rates and to decline proposals should be restricted in compulsory sectors. We will come back to this later on. However, as has already been noted, we have not found evidence that those who require these compulsory covers cannot obtain them, although we note that for some market segments the choice of available products is restricted.

Enforcement

As with all laws, there must be sanctions against those who do not obey them. At present the maximum penalty for driving a car without insurance is a £5,000 fine (although the scope for Courts to fine those receiving income support is severely curtailed). The most recent year for which the Home Office has published information on convictions is 1997; in that year there were 257,689 convictions in England or Wales for driving a motor vehicle without the required insurance. This represents about 16% of UK licensed drivers. Some of these will be habitual offenders but, even so, bearing in mind that only those uninsured drivers involved in accidents or suspected of motoring offences will be detected, this is a surprisingly high percentage. It is estimated that between 5% and 10% of UK motorists are unlicensed.²

About 185,000 of those convicted were fined, the average fine for the offence being £212. In many cases the offence was committed in parallel with another offence such as stealing the car (obviously one does not take out insurance for driving cars that one steals). In these circumstances it is likely that a penalty for the whole set of offences would have been given on the most important one – presumably this accounts for the 73,000 who were convicted but not fined. Eleven offenders were also given community service for this crime in 1997. However, the average fine actually imposed is clearly trivial in relation to the maximum available. It is also not significantly higher than the cost of the insurance foregone – indeed, it is probably much lower. This only goes to confirm the generally held impression that driving without insurance is hardly a crime. This public perception is not, we believe, in the public interest.

Is there a way of making the compulsion easier to enforce? In France, cars must carry stickers showing that they are insured, in a similar fashion to the UK's tax discs that

² In 1998 the MIB paid out claims totalling £227m. This represents about 5% of the total value of claims paid during the year. Some of these claims costs relate to untraceable drivers (not all of whom will be uninsured).

show that the road fund has been paid. Several years ago, it was thought likely that a similar requirement was likely to be introduced in this country. At the time this appeared to be a simple measure that could well reduce non-compliance, and could be made at minimal cost to the public purse or to insurers. In a sense, it would have been equivalent to the requirement under the employers' liability legislation that employers must post certificates from their insurer on notice boards at their places of work.

The main objections to this proposal were that it would have been possible to take out insurance, obtain the sticker, cancel the insurance but retain the sticker. Hence it would still not have been obvious who was and who was not insured. Moreover, in the UK, unlike in France, third party liability cover is attached to the driver, not to the car. Maybe in the UK the drivers would have had to wear the stickers! The debate finally collapsed when the industry decided to build the Motor Insurers' Database, which is due to go live next year under the auspices of the MIB. This database will list all drivers currently insured in the UK. All insurers writing motor cover will be required by law to make submissions to the database.

The new database is intended to streamline the process of verifying cover by allowing the police to identify immediately if a given driver has cover or not. If a driver does not appear on the list then his cover will be verified in the usual way. The ease of checking for insurance cover will greatly encourage the police to check such details and hence will enable them to catch more uninsured. This should discourage others from driving whilst uninsured. It will also meet another need, for those overseas visitors who are involved in accidents to learn almost immediately the identities of the relevant insurers, in accordance with an EC Directive.

What effect does compulsory insurance have upon the insureds' behaviour?

It has been suggested that the existence of employers' liability insurance has a deleterious effect on health and safety standards in the workplace. A company that insures this risk, so it is argued, suffers no penalty when accidents happen, and therefore has no incentive to protect its workers. Money spent on workplace safety standards when there is employers' liability insurance in place is therefore money wasted. This may be true if the premium is unrelated to the riskiness of the employer, and there may be some truth in it if the relationship between premium and risk is less than proportional. However, it is standard practice for insurers to survey risks in detail at the underwriting stage, and many policies, especially those of larger employers, are experience-rated. Therefore, a contrary possibility is that employers may be spurred to better health and safety measures if there is a possibility of lowering their employers' liability premium.

The same applies to most of the other forms of compulsory covers, although for motor it is not clear whether fear of losing NCD markedly improves people's driving.

4.2 Restrictions on premium rating

We mentioned above that we would return to the question of restrictions on insurers in their ability to rate for compulsory insurance. This is where that discussion starts, with the topic widened beyond just that of compulsory covers.

The freedom that insurers currently enjoy to price general insurance products as they see fit, with no limitations, ties in with the current debate over the self-regulation of the industry. In lobbying against statutory regulation, the ABI argued that general insurance products differ from life insurance products and as such should not necessarily be subject to the same constraints. The main differences were that general insurance products:

- are purchased frequently;
- are products of indemnity; and
- have generally transparent pricing.

Industry and the general public view general insurance products as simpler than life insurance products and expect the pricing to be reasonably intuitive. The public will accept price differentials if they are supported by some easily understandable explanation. This is probably also the attitude of underwriters and marketing personnel of insurance companies who generally adhere to reasonable principles in pricing. On the other hand, many actuaries working in, or as consultants to, insurance companies have tended to take a more detached view. They consider the pricing and selling of general insurance products as a simple “willing buyer/winning seller” scenario, within which the existence of competition and the ease of switching insurers provide a large element of protection for the customer. As mentioned in Section 2, actuaries in such situations need to be mindful of how they try to get their messages across and to appreciate the more intuitive approach of others.

Although the industry would prefer there to be no restrictions on premium rating it is worth considering to what degree such limitations might be in the public interest. We will consider four aspects:

- profit margins;
- rating factors;
- price differentiation between distribution channels; and
- price differentiation between otherwise identical risks.

4.2.1 Profit margins

Is there such a thing as too high a profit margin? The free market argument says “no”. Insurers should be allowed to charge what they like. Should one be demanding an

excessive margin then it presents opportunities for others to undercut that provider through taking lower margins, which might be a better way for those insurers to maximise their profits.

On the other hand, the public usually takes a dim view of any organisation that complains of thin margins and hence increases its prices, at the same time posting apparently healthy profits. Insurers are not exempt from such disapproval. Indeed, insurers can suffer badly from this in that the inherent volatility of claims experience from year to year can lead to under-priced business generating big profits. We could digress for next few pages to talk about fair value accounting, claims equalisation reserves and reserving techniques but, as we are supposed to be talking in this section about pricing, we will resist the temptation. Instead we will merely note that it is a presentational issue for the industry. It is also one that insurers can use to their advantage when volatility has resulted in a bad year and prices are hence increased.

The profitability of insurance contracts is clouded by the potential for several separate companies, each requiring at least an adequate profit margin, to be involved in an insurance transaction (e.g. distributor, manufacturer, third party administrator). This can appear to dilute the apparent profitability of the "insurer" to the public. On the other hand, a financial services organisation that sells insurance could be under-pricing its general insurance products and making losses in that area, but making hefty profits from its other services. In these circumstances would the public accept it increasing its general insurance premium rates?

The situation becomes further complicated when the various lines within a general insurance operation are priced with different margins. Are these margins justified by the degree of underlying risk of the particular lines? What about the offsetting diversity risk? And what about the impact of cross sales (a lower margin could be justified for a particular product line if it generated further sales in a higher margin line)? This stuff is difficult enough to work out and explain internally, amongst insurance professionals, so insurers would appear to have little hope of getting the general public to understand these statistical gymnastics. Is there a role for actuaries here?

Some countries have attempted to restrict excessive margins by defining a fair profit. For example, in the USA, fair profit is defined in terms of risk based capital. However, to enforce this requires regulatory rate filing and justification, a move strongly opposed by many of the UK actuaries and other insurance professionals with whom we have spoken.

It is worth remembering that, when insurers are accused of charging excessively, it might not be that they are simply perceived as providing poor value *per se*, rather that someone is providing ostensibly similar cover that is cheaper. This could be due to excessive margins, or indeed to ineffective risk or expense control, within the accused insurer, or it could be simply that someone else is pricing at suicidal rates.

4.2.2 Rating factors

There are thousands of factors that could be used for insurance rating. Many are proxies for other, less easily quantifiable or measurable factors, and some are more indicative of the underlying risks than others. In practice only a few pieces of information can be gathered about each risk and so the underwriters have to choose the combination of factors that they believe will best indicate the underlying risks. What freedom do they have in that and what freedom should they have?

In the UK it is generally accepted that there should be certain factors whose use is not permitted in premium rating. Indeed, the use of ethnic origin or of spent convictions is specifically prohibited by law. However, other factors are used that would appear to be discriminatory. For example, gender is a primary factor in determining motor insurance rates. Why is this allowable? In practice it is taken more as a proxy for mileage driven, men being statistically likely to drive greater aggregate distances in any given period and hence more likely to have accidents. As a result, women tend to be charged lower insurance premiums than men of similar ages. Cynical males would question whether this discrimination would be so readily accepted had it been women that were charged the higher premiums.

Age is another major factor in motor, household and medical expense premium rates. There is a strong correlation between the cost of claims and a person's age for those classes of insurance. Whilst age is still a proxy for other factors (e.g. driving experience, time and effort spent on property upkeep, health) most people accept it for rating purposes. But it is a form of ageism that would not be acceptable in many other circumstances. Why is it in this?

At first sight anti-discrimination rules would appear to be largely based on the desire to prevent someone being consciously disadvantaged by others due to factors within that person but not within his/her control. This seems intuitively fair, and therefore covers gender and ethnic origin. But it would also cover age – being seventeen is bad news if one wants motor insurance, and there is nothing that one can do about it. It would also cover family medical history³, if not one's own, which would rather curtail private medical insurers' abilities to decline cover. And it could cover other things such as disabilities that are also occasionally used in general insurance pricing.

Based on this philosophy of anti-discrimination, there is an argument for restricting the use of rating factors to those within a potential policyholder's control (e.g. vehicle

³ UK disability discrimination legislation prohibits the use of medical history as a basis for premium rating (or declination) without the insurer having sufficient supporting statistical evidence. The insurer has to produce this evidence if so requested by an affected customer. In this respect the use in insurance underwriting of medical history differs from most other factors such as age for which no requirement regarding statistical evidence exists.

driven, home security and maintenance, exercise programmes). Thus they will be able to take action, if they so choose, to reduce the cost of their insurance.

However, on reflection, anti-discrimination rules in the UK are based more on the desire to prevent someone being consciously disadvantaged by others' unjustifiable prejudice. For example, it would be ageist to suggest that someone is too old or too young to fill a particular job, if that person has all of the required qualifications and experience, as that suggestion would be based on prejudice. However, it would not be ageist to suggest that a youngster is more likely to be a poorer driver than someone older, as that would be based on statistical evidence. Therefore it would appear that the sets of rating factors currently in use are not contrary to the UK's anti-discriminatory rules and philosophy.

Would consumers be better served were there to be more restrictions on the use of factors? Clearly it would mean that for some rates would increase but for others they would be lower. On average they would, in theory, be unchanged. Indeed, it would represent a greater pooling of risk and hence might be more easily priced by insurers that are currently struggling with the ever increasing granularity of their data.

In practice the elimination of, say, age and gender from motor premium rating would make motoring more affordable for young drivers (an issue discussed at length in Section 3). Costs would rise to a lesser extent for the much larger middle-aged group. Men would see rate falls and women premium increases. For household insurance differentials by age are smaller and the impact would be less marked.

For medical expense insurance the effect could be very significant. Rates are extremely sensitive to age and the elderly, whose income has declined, often find premiums to be unaffordable. Intuitively one would think that removing the age discriminator (if not the health record discriminator) would make the insurance more affordable. But it is likely that, if contracts remain annual, the cover would not be seen as good value by many young people who otherwise would have taken it up. They will drop out (denying themselves the benefits of insurance) and the average cost for those remaining will go up. The effect on the private medical market could be very significant and this would have a similarly adverse spin-off in the state health service.

Of course, unless agreed through some form of voluntary code, to enforce such restrictions requires monitoring, and monitoring involves bureaucracy and cost. These costs would be ultimately carried by the policyholders.

In the USA regulations vary from state to state. Some outlaw the use of age in rating, some gender, some both and some neither. However, virtually all states require the justification of premium rates to the state insurance commissioner prior to filing. Whilst the teams from the insurer and the state at such representations often include actuaries, the commissioners themselves are rarely actuaries. By accepting the rates for

filing they are in effect opining that they are fair and can be seen to be fair. They are not easily swayed by actuarial gobbledegook.

US actuaries work within the CAS's statement of principles regarding property & casualty insurance rate-making, which state that a rate:

- is an estimate of the expected value of future costs
- provides for all costs associated with the transfer of risk
- provides for the costs associated with an individual risk transfer
- is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarial sound estimate of the expected value of all future costs associated with an individual risk transfer.

This all sounds very reasonable and many UK pricing actuaries would doubtless also claim that they abide with these principles. The difference is that the US actuaries have to demonstrate that they have. We suspect that some UK pricing actuaries would not find this aspect to be easy.

Moving on from the issue of discrimination, insurers are increasingly considering the use of lifestyle factors in determining insurance premiums. Are these factors acceptable? And can underwriters use other information not explicitly provided by the policyholder to determine the premium (e.g. if it is thought that the portal one uses to access internet insurance services is a good indicator of likely insurance experience then can that be used in premium rating)? Currently there is no UK legislation that prevents this (providing that it does not contravene regulations that are not specific to insurance) and so the answer to both questions is "in theory, yes". But in practice if it is not clear why rates cost what they do and if premium differentials are not intuitively obvious then the answer probably becomes "no".

4.2.3 Differential pricing for differential distribution

Should there be one price for each risk, and one price for each product irrespective of channel? We do not believe that there should be. From the point of view of the insurer, different channels might give rise to different costs. They might have to underwrite differently, notwithstanding the apparent similarity between products. They may also have net price agreements with independent distributors and thus have limited control over the gross price actually charged for their product.

From the public's perspective they see, for other products, both financial and non-financial, differential prices from different distribution channels everyday. This is particularly true with the recent publicity attaching to Internet sales. It is widely accepted that other financial insurance products, such as bank accounts, can be priced differentially depending on the retail outlet so presumably the pricing of insurance products is viewed in much the same way.

We understand that several brokers have collectively lodged a complaint with the Office of Fair Trading against a large UK insurer. Their complaint is that they have been unfairly treated in that the insurer has provided cover through its direct arm at cheaper rates than it makes available to brokers such as them. The view of the OFT is not known at the time of writing

4.2.4 Differential pricing for otherwise identical risks

As highlighted in last year's report, some insurers base their premium rates on factors other than those related purely to the underlying insurable risk. In particular, some attempt to assess which of their policyholders are most likely to shop around at renewal and then charge those lower renewal premiums, so as to retain the business. A consequence of this is that those customers whom they believe to be unlikely to shop around are charged higher premiums than those considered likely to shop around. Thus, far from being rewarded, customer loyalty appears to be penalised relatively speaking. It could also be said that the insurers are taking advantage of customer inertia.

The justification for this is that retaining business at anything above a break-even premium improves overall profit and reduces industry costs to the general benefit. Hence it is better for all that the insurer retains the person likely to shop around at a lower premium rather than the insurer sticking to its fixed rate and losing the policyholder to another insurer.

However, that is a detached actuarial view. The ins and outs of expense recoverables and marginal costings are not intuitively obvious to the man in the street. The insurance industry relies on trust and is based upon "utmost good faith". It can ill-afford to indulge in practices that are thought to be unfair. Therefore, by pursuing this practice, whilst it might be ultimately to everyone's advantage, insurers may be failing to meet the public's reasonable expectations. If so then either insurers need to change their practice or the public need to change its reasonable expectations. Otherwise we could end up in an almighty row with very bad publicity and the industry's reputation further undermined.

In the recent past the Office of the Insurance Ombudsman has been looking at this practice with some distaste, owing to its lack of transparency. Whilst it had no jurisdiction on the pricing of insurance products, a case has been made for the new Financial Services Ombudsman to include insurance pricing within his jurisdiction.

4.2.5 Summary

Insurers, in common with other providers of services, need to be able to charge rates that discriminate between customers for a variety of reasons, including:

- the expected costs, including claims costs, of the services provided, so that they and (indirectly) their other customers do not subsidise high risk groups. Costs will reflect the precise nature of the contract and the circumstances of the insured that affect the nature of the risk. The process of rate setting will be partly objective, based on solid data, and partly subjective, where the data is insufficient or a change in circumstances is anticipated;
- to be competitive. As a result, some rates might not fully cover costs, let alone provide a reasonable profit; or
- other marketing considerations (e.g. deliberate loss-leaders or introductory discounts).

These practices are generally accepted as being reasonable.

Any interference by legislation (or otherwise) in the freedom of insurers to set rates imposes additional costs on insurers, and therefore on its customers. As well as the direct costs of compliance there are indirect costs aimed at demonstrating that the insurer is complying. These additional costs may also make it more difficult for insurers to develop new contracts and thereby restrict innovation. The costs of compliance would have to be recouped from premiums as a whole. Before deciding to interfere society needs to be clear that the benefits of interference outweigh the costs.

However, there are several areas, such as the acceptability of certain rating factors, where society could consider that some interference would be beneficial.

Actuaries need to take care in advising on the rating process. Prudence is needed to ensure that the self-regulation regime of the general insurance industry is seen to be working. Rating structures and the resultant rates should be fair and should be easily seen to be fair.

5. Claims

5.1 Rules and regulation underlying claims assessment and handling

In last year's report we looked at claims management. In particular we considered how insurers seek to minimise their claims costs and the extent to which that impinged upon the public interest. This year we have considered the rules under which claims must be assessed or handled. Recently, there have been several changes to these, the most notable of these have been

- the introduction of Ogden Tables and the choice of interest rates to be used;
- the change to the scale of recoveries to be made by the NHS against the cost of treating road traffic accident victims;
- the introduction of the Compensation Recovery Unit;
- the Law Commission proposals regarding non-pecuniary loss in personal injury cases; and
- the Woolf reforms.

These generally have had the effect of increasing the cost of claims for insurers.

Many of these changes seem intuitively sensible. Indeed, none have resulted in public outcry and most have been broadly welcomed by media commentators. Any concerns regarding the effect of these changes on the issue of affordability of insurance has been overshadowed by the general "fairness" of the changes.

Insurers themselves do not object to well reasoned changes that have been well trailed and impact only those claims related to future incidents, as they can be allowed for, albeit with a significant degree of judgement, within the insurers' pricing. However, it is more normal for any alteration to practice or procedure to apply to all cases settled after the date of the change. This would obviously include those cases incurred but not settled at the time of the alteration. Moreover, in the case of a judicial decision rather than changes as a result of the law reform process, the effect is immediate, with no warning period. For these cases the additional cost for the existing outstanding claims or for those that will happen under current policies falls squarely on the insurers, as the premiums that they charged were based on the assumption that the previous, lower cost regime would continue.

In such circumstances it is hardly surprising that the ABI has often objected to many of the mooted changes. The ABI rightly contests any flaws that it perceives in suggested rules and regulations. However, its opposition to the proposals has often been less to do with the principle of the suggested amendments and rather more to do with the

means of introduction, which the ABI believes damages its members, hence the industry and ultimately the market.

We should bear in mind that the purpose of the civil courts is to compensate victims appropriately for wrongs suffered. The system is not set up with insurance companies in mind. Victims of identical incidents a short time apart, settled on the same day for widely differing amounts, could reasonably feel dissatisfied, particularly were the reason for the difference that, in the time between the two accidents, a law reform had taken place that had not been backdated out of consideration for insurance companies.

How the system itself views the public interest is not entirely clear. In this context, the judgement on the eight test cases that recently came before the panel of judges, chaired by Lord Woolf, and which led to the increase in non-pecuniary loss claims in personal injury cases, was particularly interesting. It stated that the Law Commission Report, which had promoted the question of non-pecuniary loss claim amounts, had not taken sufficient notice of the impact of increases in "the level of insurance premiums" on "the public as a whole" that would result from increasing personal injury claim amounts. With this in mind the judges decided to scale back significantly the additional awards from the levels proposed in Law Commission Report 257.

It was not clear from this wording whether the judges believed that all policyholders would bear the additional cost equally or whether they understood that the policyholders perceived to be worst risks would bear the lion's share of the increases but still felt the additional amounts to be unacceptable. One would hope that it was the latter. Nevertheless, this was clearly a ruling that they made with the public interest in mind. But was the same public interest in the minds of the judges and Law Lords who rules in favour of use of the Ogden Tables and the 3% discount factor? The additional cost of insurance to the general public as a result of that ruling did not appear to be a major factor in their decision making.

When all has been said and done, the judiciary is really only ensuring that society's views on claim amounts are reflected in common law. The actuarial profession has a role in helping determine such societal views, by providing and/or challenging evidence supportive of changes or, where appropriate, of the status quo. The Working Party has heard criticism by actuaries of the judgement and also of the original Law Commission Report. This would therefore appear to be an area where actuarial input, to support or challenge as appropriate the statistical arguments of the various parties, might have helped. We understand that there was some actuarial involvement – perhaps there should have been more.

The personal injury non-pecuniary loss compensation issue has not yet gone away. The Law Commission's original recommendation was that, if the Courts did not implement its suggestions regarding compensation levels within two years, then legislation should be considered. The Law Commission has no executive power but is an influential advisor to the Lord Chancellor. In principle the question is still open as

to whether the Law Commission considers the Courts' actions so far as implementing their recommendations or not.

In passing we also note that the Law Commission had investigated movements in historic levels of compensation by reference to GDP per head. Presumably this was to ensure that there was a relationship between compensation for the claimant's impaired quality of life and earnings levels. However, the judges also commented that "as to the GDP, we do not consider that the index should be treated as a substitute for the RPI. The RPI provides a simple straight-forward measure of the value of money. It is readily understood."

This would appear to be another example of the intuitive overcoming what to others might be a more theoretically correct solution.

5.2 Claims management

Although we looked at this area last year there are a couple of aspects to bring up this year. The first concerns deceit on the part of the policyholder. For some reason "minor" incidents of defrauding insurers, such as by inflating claims amounts to cover an excess, appear not to be considered anti-social behaviour. The amounts involved are not considered to be significant when compared with premiums paid and there is no thought that the impact is higher premiums for all, including the honest policyholders. Whilst this is a worrying situation, far more alarming is the apparent rise in the incidence of faked claims – arson by the insured, manufactured car claims, etc. These not only defraud insurers, and hence other policyholders, but also risk the life and limb of innocent third parties and tie up the hard-pressed resources of the emergency services. Insurers have a duty to their policyholders to investigate suspicious claims thoroughly, but have also to avoid antagonising honest policyholders whose claims are delayed by such investigations.

The more that frauds are perpetrated against the insurance industry the more that the value of insurance as a public good is reduced. The ultimate extension of this trend would be that insurance is banned as a practice that encourages dishonest behaviour.

Before leaving the area of claims, the Working Party notes the imminent ABI General Insurance Claims Code. This will be launched later this year and seeks to introduce minimum standards for claims handlers and for policyholders, covering all aspects of the claims process from notification to settlement, and including, if necessary, complaints procedures. The ABI will be backing this up by introducing a benchmarking service, to enable those involved in the industry to compare their service levels with market norms. This would appear to be most laudable.

5.3 Looking forward

In the preceding paragraphs we have touched, all too briefly due to time pressures, on a few aspects of insurance claims assessment, management and payment, in addition to those we considered last year. The payment of claims is for most people the “moment of truth”, the point at which they can determine whether taking out insurance was a good idea and whether they feel fairly treated by the industry. It is a key public interest area. Therefore, this topic warrants significant further investigation.

6. Captives

Captives initially flourished during the 1980s. There were two principal reasons behind their establishment. The first was that they could be a recipient of risk transferred from the parent company's balance sheet (or from those of other companies within the group), without commissions and profit margins leaving the group. The second was that they could be established off-shore, in tax advantageous locations. Subsequently, captives have also been used to provide insurance not otherwise available to the parent or to the group in the conventional market.

Companies that established captives were thus trying to reduce their net costs and hence retain more net profit. Insofar as this resulted in lower prices and more financially sound organisations (and this assumes that the accumulation of retained risk was suitably managed to prevent it becoming excessive), this would be considered in general to be a good thing, i.e. in the public interest. The only doubt would be in the use of an off-shore domicile in that the additional profits and benefits thus generated would ultimately place a greater burden upon the taxpayer. However, changes in taxation rules during the 1990s have largely eliminated the tax advantages of captives.

The term "captive" is also used to describe an insurer that provides cover exclusively to customers of its parent, normally in conjunction with sales of non-insurance products by the parent company. A good example of this would be a retailer of, say, motor cars that set up an insurer to provide motor insurance to purchasers of its cars. Extended warranty and creditor insurance are other typical products for captives but in theory they could provide a very wide range of covers.

Is this type of captive in the public interest?

In general there seems to be little material difference between the price of cover as sold by a captive and as sold by a mainstream insurer (although this is hard to establish definitively as, for extended warranty at least, the product is not freely available in the market).

The sale of the product is more questionable. Many retailers have admitted that much of their income is through the sale of such insurance products rather than through the sale of their primary product, and hence there is an incentive to push the sale of the insurance, which could lead to an inappropriate sale. Moreover, as discussed in Section 3, many of the salesmen appear not to fully understand the insurance products that they are selling. This is clearly unsatisfactory but, as explained before, proper training would probably be costly relative to the premiums charged and would lead to a very large increase in premiums. Regarding the issue of the "hard sell", where this occurs it is probably a reflection of the ethic of the particular retailer. Whether such an

ethic could be constrained by regulation and hence the retailer encouraged to sell insurance appropriately is doubtful.

In less mainstream cases, where insurance arrangements are unique or unusual, there is clearly scope for parent companies to abuse the captive system, to the detriment of the policyholders. For example, the captive might pass hefty commissions and underwriting profits back to the parent. The high commissions and profits could be partially obscured by profit commission arrangements or through further inter-group transfers.

Off-shore captives are not members of the ABI (due to their domicile) but if they are UK authorised then they will have agreed, as a condition of authorisation, to abide by the ABI Code of Conduct for selling general insurance. However, it would appear possible that they could be EC authorised yet able to write business in the UK under the Freedom of Services legislation. If so then they would not have had to agree by the ABI Code of Conduct.

With the introduction of Insurance Premium Tax the efficiency of some captives is questionable. This is particularly true in the warranty and travel insurance areas, where IPT is levied at the higher rate of 17.5%. In the case of warranties this has forced many parents to withdraw from insurance and turn the contract into a maintenance agreement, subject to VAT which can, in turn, be offset against the cost of VAT on repairs.

Our overall conclusion therefore is that the use of captives has no significant public interest issues but that the operation of captives is open to limited abuse.

A minor issue concerns the contribution of captives to the PPB. Those operating as a UK authorised insurer will pay a PPB levy in the usual manner. In the case of off-shore captives operating via a UK authorised insurer (which effectively "fronts" the operation) it is the UK authorised insurer that is responsible for the levy. But again it appears that an EC authorised insurer selling directly into the UK has not such responsibility, unless so required by its domestic regulations. This would leave their policyholders unprotected in the event of their failure. Whilst the parent company might step in, to prevent damage to its reputation, this is not the same as protection through the PPB. We further suspect that few policyholders so affected are aware of the fact. We would like to investigate this further.

7. Reinsurance

In principle, the availability of reinsurance is in the public interest in that it enables insurers to offer wider covers, to withstand catastrophes and to spread risks. In practice there are some features within the reinsurance market that reduce its effectiveness or efficiency and hence are not in the public interest. Some of these we discuss below.

The capacity for some risks is rightly limited. Cover against earthquakes in Southern California and against terrorism in political hotspots is understandably in short supply. But the insurance cycle can lead to unnecessary capacity constraints. If these constraints are allied to overreaction by reinsurers to one or more insured catastrophes then the availability of reinsurance at sensible prices can be very restricted. Those direct writers thus unable to gain the reinsurance cover that they seek will either have to risk greater exposure than they wish to undertake or to reduce the cover that they provide to their policyholders. Neither of these are attractive outcomes. However, for a market driven so much by feeling we were unable to come up with a remedy.

The market is often rocked by catastrophes. That is hardly surprising as it reflects the nature of the business. However, it is also periodically rocked by unexpected judicial decisions, for example the decision some years back of a US Court regarding the liability of insurers for the costs of cleaning up pollution. There are usually three possible reasons cited for these decisions:

- the policy wordings were flawed;
- the insurers (and their counsels) had an imperfect understanding of the law; and
- the judge has effectively made new law (this can be interchangeable with the above, depending on one's own position).

Whatever the cause, this is not good news, for very much the same reasons as explained in Section 5.

Reinsurance can be a complex business and as such the market suffers from a lack of transparency. Nowhere is this better illustrated than in the emergence of various reinsurance spirals during the 1990s. These spirals were created by reinsurers retroceding cover to other reinsurers and then unwittingly accepting it back again as part of a package of cover retroceded by another reinsurer. This situation was exacerbated then by over-capacity in the market. Not only does this mess take a long time and much cost to unravel but, as it unravels, individual reinsurers find that they have been dangerously and unknowingly exposed to concentrations of risk. It is more than possible that they could find themselves significantly under-reserved as a consequence.

The above has all been about reinsurance itself. What about the providers of reinsurance, the reinsurers themselves – do they act in the public interest? In general, the answer is “yes”. Many reinsurers, with their wider market experience, are willing to act as consultants to direct writers, assisting them in developing covers, in premium rating, in setting up claims controls, etc. Thus they can facilitate greater consumer choice and deter unsound underwriting, although if unwilling to consider new ideas they might also discourage greater consumer choice.

Most reinsurance in the UK is written through Lloyd’s or the London Market. These have their own approaches to placing risks. Business in these markets could be broadly divided into two categories, “good” and “bad”. “Good” business has low expected claims and “bad” has high expected claims. Instead of differentiating by premium and hence turning it all into “okay” business, brokers operating in Lloyd’s or the London Market expect each underwriter to help them place some of the bad business. In exchange the underwriters expect the brokers to pass them sufficient good business to compensate for the dross that they have accepted. On the face of it this is bizarre, and provides no incentive to bad risks to take action to improve their quality. On the other hand, in these markets it is difficult to be precise as to what is or isn’t a good risk, the experience for many lines being very volatile. Moreover, the market writes a lot of long tail business, where the results (and so the information needed to identify bad business) will not become apparent for many years. There has to be some pooling of risk, and acceptance of other people’s poor risks may be part of the price paid for reinsuring one’s own liabilities. Without such pooling, individual insurers would be at risk and the London Market could not survive.

8. Conclusions

There is a very wide range of potential public interest issues in the UK general insurance market. Some of these we identified last year. This year we have identified some more. Our list is still far from complete.

Were we designing an insurance system from scratch it would differ in various ways from the current UK system. However, the flaws in the current UK system are not causing significant grief and the costs of most improvements that we could suggest would greatly outweigh the benefits, at least as currently perceived. Of course, as public perception of what is and is not acceptable changes then so to will the industry, as indeed it has already demonstrated through such things as developments in product distribution.

Whilst our overall view would be that the current system works satisfactorily, we also believe that there are several areas where industry practice could be questioned, because of insufficient transparency, because of the existence of moral hazards or because of changing public perceptions regarding “fairness”.

Places where the industry is particularly vulnerable to such questions are as follows:

- *Inappropriate buying/selling of insurance:* we believe that this is a minor issue in terms of incidence but a major issue for the industry in terms of potential adverse publicity. In this report we have made various suggestions aimed at reducing that risk. Some of these are familiar (for example, greater clarity in policy documentation) and some are more imaginative (for example, independent published indicators setting out the scope of cover, service standards, etc. of insurance products). The more imaginative ones require further development.
- *The remuneration of intermediaries:* whilst we appreciate that there is some moral hazard in the current commission based remuneration systems we do not believe that they warrant wholesale dismantling. Nor are we convinced that enforced disclosure of intermediaries’ remuneration would improve the standards of selling or buying. We continue to call for the routine disclosure of volume-related commissions, in line with similar calls made by AIRMIC and RIMS.
- *Availability of insurance:* access to private motoring is becoming increasingly a social necessity but one that is also becoming increasingly costly for young drivers and other motorists perceived as poor risks. We have suggested various ways in which motor insurance products could be developed to provide more affordable driving for such motorists. We have also investigated the subsidised pooling of poor risks. We considered how, if at all, some of these ideas could be extended to other insurance areas where particular customer segments found affordable

insurance hard to come by. We also looked briefly on access to insurance, concluding that, for the majority, longer opening hours and more means of distribution have improved access but, for the minority, particularly those who prefer to deal in cash, access has been reduced. Finally, we looked at the impact on the availability of insurance of recent market consolidation.

All of the ideas here (and there are some areas where we were unable to come up with any potential solutions) require further work to evaluate their practicalities.

- *Compulsory insurance*: this is an appropriate way for society to use insurance for the greater public good. Whilst we have no quibbles with the subjects covered by compulsory insurance we feel that there are other areas where enforcement of cover could sensibly be applied. We have recommended that the current list of compulsory covers is reviewed. Looking at motor insurance we note that a small but significant proportion of drivers do not buy insurance, despite the legal requirement. We also note with some alarm the limited sanctions that appear to be taken against offenders and suggest that these do little to discourage such law-breaking. We considered how compulsion could be enforced.
- *Restrictions on premium rating*: UK insurers currently have significant freedom, more than their counterparts in many other countries, in determining how to set premium rates. As this currently seems to work pretty well, there would appear to be little reason to impinge on that freedom. However, there are some aspects that insurers should bear in mind, particularly as public sentiment gradually alters.
- The public likes general insurance rates (particularly those that apply to them directly) to be intuitively understandable. Practices such as insurers increasing their rates when posting large profits or charging differentially at renewal based on the perceived likelihood of policyholders shopping around might be justifiable on pure financial grounds but they are not intuitively obvious. In such circumstances insurers need to manage their messages very carefully.
- It is already widely acknowledged in the UK that certain characteristics, such as racial origin, are unacceptable as factors for use in premium rating. In some US states age and/or gender are also considered to be unacceptable as rating factors. Will the UK follow the US model? We have neatly side-stepped that question, pausing only to review the basis for anti-discrimination rules, but have looked at some of the possible consequences were it to do so. We have also questioned whether the public will accept the future use of factors such as lifestyle characteristics that are not overtly linked to the incidence and severity of claims.
- *Claims*: we considered the current trend of increasing average claim amounts through judicial review and the fact that this was usually applied with an element of retrospection. We concluded that this is bad news for insurers but is understandable

in the circumstances and probably, overall, in the public interest. We note with enthusiasm the forthcoming ABI General Insurance Claims Code and with great distaste the growing incidence of faked claims. The latter not only attempt to defraud insurers and hence honest policyholders, but also can endanger lives and tie up unnecessarily the limited resources of the emergency services. We strongly support efforts directed at eliminating such claims.

- *Captives*: these have, in principal, a neutral public interest impact. However, their existence provides potential for abuse. This seems to apply particularly to EC (but not specifically UK) authorised captives selling directly into the UK. We are uncertain of the extent to which this potential is exploited.
- *Reinsurance*: the availability of reinsurance is certainly a matter of public interest, although ironically it is a subject of which the public know little. Yet there are many issues in the market, such the effect of the insurance cycle on the availability of cover, the lack of transparency, the complex terms and the potential for ruinously different legal interpretations thereof. These, indirectly, are matters of public interest. We have highlighted them and suggest that further work is carried out to assess possible solutions.

The actuarial profession has set out its stall regarding its public interest role. In particular it intends to raise public interest issues and to continue to develop Position Statements. This approach might not be to everyone's tastes but that argument has now passed. The question now is how best can the profession fulfil its intentions.

We have highlighted some concerns about the profession's current arrangements, in particular regarding the formulation of Position Statements. However, our main concern is that the views of rank and file members are not being properly taken into account. Part of that is because the processes for the profession to listen to the views of members need enhancement, part is because too few people articulate their views, and part is because what some of those people do say does not come across clearly. We must improve our ability, individually and as a profession, to communicate competently - to listen effectively and to broadcast understandably.

Whilst few of the areas highlighted in this report are purely actuarial we believe that, in fulfilling its public interest role, the profession should provide informed and balanced comment in any discussion of public policy choices in these areas. If necessary it should be prepared to lead that discussion.

Summary of last year's Working Party Report

The actuarial profession has assumed for itself a public interest role. It is promoting this fact widely. Actuaries working in general insurance ought to think carefully about what that role means to them and to their profession. The Working Party's aim in preparing its report was to stimulate those thoughts.

The report is far from being comprehensive and it contains very few specific recommendations. Most situations are shades of grey rather than black and white and, in each situation where an actuary is involved, it is largely 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.

There are, however, some issues that are more substantial or which generate more heated debate. These issues, which are summarised below, are ones on which the Working Party believes that the profession should act, or encourage others to act.

In conclusion, what constitutes "the public interest" in respect of general insurance is an area of uncertainty. The Working Party felt that, in the long term, the public interest is best served by all parties concerned behaving responsibly. It also felt that, 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 responsible actions continually.

There is a very wide range of potential public interest issues in general insurance. Some - by no means all - have been identified by the Working Party. 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.

The Working Party concluded that, although many of the issues identified were not positively in the public interest, they were not against the public interest either. Most it considered to be largely neutral or to have, in practice, such a negligible impact that to take responsive action was 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, the Working Party did identify a number of areas where industry practice could be questioned or which could easily become politically controversial, and concluded that it would be in the industry's interest to address these questions, with or without actuarial assistance, before they became controversial issues. Regarding the political dimension, the actuarial profession should 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"*: this occurs, albeit, in the opinion of the Working Party, largely without malice aforethought. Regardless of intent, it still 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 twofold:
 - confusion on the part of policyholders (and sometimes the product distributors) regarding the precise terms of the policies in question; and
 - policyholders not being clear regarding their needs.
- The Working Party recommended that insurers continue to improve the clarity of their sales and policy literature (ensuring that they are consistent with one another). It suggested that the industry undertakes 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. Furthermore the Working Party felt that the media could also play a very useful role here.
- *Availability of insurance*: it was clear to the Working Party that insurance is available, somewhere, at some price, for virtually all risks. However, for some potential policyholders the proposed premium rates might 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, most of which feature some degree of government or regulatory intervention. All have their pros and cons (as described in full in the report). The Working Party concluded that none was clearly ideal but that several merited further investigation.
- At the same time, the Working Party also recommended that insurers be responsible in their pricing. It recognised that insurers should 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, as a

consequence of economic rating for each risk, insurance is pushed beyond the means of particular groups of people or businesses, then the Working Party felt that the relevant insurers should have firm evidence to support their decision. Otherwise, insurers 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 be detrimental to public opinion of the insurers' professional advisors (internal and external) such as actuaries.

- *Differential premiums based on perceived propensity to shop around:* this situation occurs primarily on renewal, where otherwise identical risks are charged different rates by the same insurer for the same cover. There are various ways of justifying this practice and indeed it can be argued that it can result in lower premiums for all policyholders, not just those with a perceived propensity to shop around. However, not all members of the Working Party accepted the justifications and all felt that this practice represented a sitting duck for adverse and very damaging publicity (along the lines of "*insurers repay customer loyalty by ripping-off their policyholders*"), particularly should the magnitude of the differentials reach high levels. Therefore, the Working Party recommended that insurers demonstrate restraint in this area. They should also ensure that their justification for this practice is easily understood and robust.
- *The role of brokers:* brokers act *de facto* as the agents of insurers when they are *de jure* the agents of the insured. It appeared to the Working Party that the application of the law of agency is being prejudiced by this conflict of interest. The Working Party felt that either the law of agency needs to be reaffirmed or the nature of the relationship between brokers, insurers and insureds should be changed. Moreover, it also felt that 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. The Working Party felt that disclosure of the mechanics behind the scheme of remuneration for the intermediary (not necessarily of the amounts involved) would go a long way to meeting that need. Whilst it recognised that certain features of the various commission arrangements currently operating within the market (such as commission scales that escalate according to the volume of business placed with a particular insurer) might compound the current confusion regarding the law of agency, it did not feel that moving to other arrangements, for example replacing commissions with fees, would necessarily improve the overall standard of service received by insurer and insured.
- *Claims management:* there is a thin line between minimising claims costs and failing to provide the agreed level of cover. The Working Party were aware of anecdotal evidence of instances when insurers had overstepped that line. 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. This is a matter of social responsibility. The Woolf reforms will partially alleviate this issue but the real solution lies with the attitude of insurers.

- *Public relations*: the insurance industry - and this applies to life assurance as well as to the general insurance parts - 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 imbalanced 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. It was clear to the Working Party that this is where actuaries, with their knowledge and understanding of the industry, especially its technical aspects, could and should play a key role, although they themselves are not renowned for their communication skills!

The above comments highlight some specific areas within the insurance industry where there are emerging or unresolved issues. There are not many of them - in general, despite the recent poor publicity that it has attracted, the industry carries out its duties well and thus plays an important role in facilitating personal and commercial life. But, as mentioned earlier, there are also a lot of other areas where there are minor but still nagging issues, at least as far as some people are concerned. It would be possible for these to be blown up disproportionately with the risk that this escalation could damage, maybe even beyond repair, the already fragile reputation of the industry. The industry's ability to play that facilitation role would thus be lost. Therefore, the Working Party's final recommendation is something of a catch-all 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 B

Potential issues in the buying and selling of general insurance products

The following is a list of potential sales issues. We do not profess it to be a complete list, nor have we evidence that all of the issues listed are currently present in the UK market. However, if anyone wishes to research this field further then this list would be a good starting point:

- Product is inappropriate for the buyer's needs as defined
- Product is appropriate for the buyer's needs as defined but that definition is flawed
- Product bought is inferior to others available
- Product is expensive compared to risk covered
- Buyer encouraged to switch to a less appropriate product
- Buyer purchases an unnecessary product
- Duplicate cover is bought (e.g. travel insurance when cover already provided through home insurance/private medical insurance)
- Cover is bought under duress
- Cover is marketed with implication of compulsion (e.g. travel in conjunction with a holiday)
- Cover is bought as a result of other misleading advertising
- Advice received by the buyer is wrong or misdirected
- The buyer has misunderstood the intent behind the cover/product (e.g. private medical insurance, mortgage indemnity)
- The policy contains unexplained and/or unexpected exclusions so that particular claims are not covered as anticipated
- The policy contains unexplained and/or unexpected excesses and limits
- Gaps in the law and practice of insurance leave a "reasonable" claim uncovered
- The buyer's reasonable expectations of the policy are not fulfilled at time of claim
- The insurer imposes unreasonable terms upon the policyholder

- The risk is mis-classified for underwriting and pricing purposes, with the consequential risk that the policy will be void or subsequent claims will be turned down
- Pricing variability within the insurer for the same product, or over time (e.g. at renewal)
- NCD issues (e.g. “earned” versus “real” for company car drivers)
- Internet underwriting – who is responsible for information given in good intent, but “wrong”?
- Products and detailed policy wordings (e.g. peril definition) that differ, perhaps significantly so in legal meaning, but which might reasonably be perceived as the same by the general public
- The insurer’s insolvency and consequential inability to pay claims
- Buyers being unable to find “affordable” insurance and thus being forced to pay over the odds
- The distributor misquoting prices to “bait the hook”
- Potential policyholders being enticed into buying by special/free offers
- A lack of clarity concerning the role of agents/brokers/other intermediaries – for the customer, for the insurer or for themselves
- Underwriting discontinuities (e.g. moratoria and pre-existing conditions).

Similarly there are several potential buying issues (and again this is not a complete list):

- Misrepresentation by the buyer of details of the risk to be covered
- The buyer’s lack of awareness of type of cover required
- The buyer’s lack of awareness of level of cover required (e.g. under-insurance of personal contents, over-insurance of home structural value)
- The buyer’s lack of interest in the detail of insurance
- The buyer will have some assumptions regarding service standards that might be disconnected with the actual cost of providing such service standards.

In many circumstances some of the above are not issues at all but are noted for completeness.

The following is a list of things to consider when reviewing possible buying and selling issues:

- Customers all vary, according to
 - their needs and propensity to accept risk;
 - their capability, their time available and their expertise to make their own decision; and
 - their degree of independence.
- Short term products have different characteristics from long term/investment products:
 - they are less dependant on investment performance and expense bases;
 - policyholders are not locked in for a long period of time; and
 - claims arising from them are less predictable (by frequency and amount).
- The concept of *uberima fides* exists:
 - what behaviour/trustworthiness should be reasonably expected of an “average” purchaser?
 - should “experts” (i.e. insurers and intermediaries) be expected to show higher standards of behaviour than purchasers do?
- The consequences of inappropriate selling/buying have different magnitudes:
 - they can be serious if a major claim is turned down; but
 - if no claim is involved then they can be limited as the premiums are (usually) relatively small and, for most policies, policyholders can withdraw/lapse the policy at any stage.
- Various rights of redress and regulation exist to protect consumers:
 - the Insurance Ombudsman (to be replaced by the FSOS)
 - the ABI and going forward the GISC (via their selling guidelines)
 - the FSA (via prudential monitoring and regulation)
 - the OFT
 - the Advertising Standards Bureau (as well as the bodies that regulate the media that might carry advertising)
 - the Consumer Association
 - various media
 - the PPB.
- The following considerations might be relevant to behaviours:
 - the impact of high and/or volume related commissions;

- competitive pressures and free market environment;
- *caveat emptor* and “you get what you pay for”.

Compulsory insurance covers in England and Wales

The following insurance covers are compulsory by law in England and Wales. In some cases the same laws apply in Scotland and in Northern Ireland; in other cases there is generally similar legislation applying to those countries. In each case the relevant legislation is noted in italics at the end of the section.

- Motor vehicle users must be insured for third party liability. The sum insured must be at least £250,000 in respect of property damage and unlimited in respect of bodily injury. Emergency treatment costs must also be covered.
Road Traffic Act 1988.
- Employers must be insured for liability for personal injury and death sustained by their employees arising out of and in the course of their employment. This includes mental injury, but does not include liability for loss of employees' property. The minimum sum insured is £5 million in respect of any single incident.
Employers' Liability (Compulsory Insurance) Act 1969.
- Keepers of riding establishments must be insured against liability for injury to those hiring horses, receiving riding lessons, or third parties injured by those activities.
Riding Establishments Act 1970.
- Keepers of wild animals are required to be insured against liability for injury to third parties caused by their animals.
Dangerous Wild Animals Act 1976.
- Keepers of certain breeds of dog that have been bred for fighting are required to be insured against liability for injury to third parties caused by their animals.
Dangerous Dogs Act 1991 (although the actual requirement for insurance is in an order made by the Secretary of State under the powers granted to him by the Act).
- Licensees of nuclear sites must be insured against liability for death or injury to persons, or loss of or damage to their property, caused by nuclear materials or the emission of ionising radiation.
Nuclear Installations Act 1965.

- Shipowners must be insured against liability for oil pollution so as to comply with the International Convention on Civil Liability for Oil Pollution and Damage.
Merchant Shipping (Oil Pollution) Act 1971.
- Credit Unions are required to be insured against losses suffered, including some property damage, and liabilities incurred by reason of the fraud or dishonesty of any of their officers or employees.
Credit Unions Act.
- Insurance brokers are required to have insurance against liabilities arising in the course of their business.
Financial Services Act 1986.
- Licensed conveyancers are required to have insurance against liabilities arising in the course of their business.
Administration of Justice Act 1985.
- Estate agents are required to have insurance against liabilities arising in the course of their business.
Estate Agents Act 1979.
- Those involved in outer space are required to be insured against liability for loss or damage suffered by third parties as a result. The activities covered are launching a space object, operating a space object and any activity in outer space.
Outer Space Act 1986.
- The Solicitors Act 1974 allows rules to be imposed requiring solicitors to have insurance against civil liabilities incurred in the course of practice or while acting as a trustee. No such rules have ever been enacted, and the requirement is met by the Law Society's own rules. However, the same requirements are imposed by legislation in Northern Ireland and Scotland.
- Certain farm buildings must be insured against fire.
Improvement of Land Act 1870, Settled Land Act 1925 and Small Holdings and Allotments Act 1926.

There is provision in the Road Traffic Act to allow motorists to opt out of their duty to insure under the legislation. To do so, they must deposit £500,000 into court to cover at least the first part of any damages that may be awarded against them. This was raised from £15,000 in 1991. The number of people who have taken this option is not publicly available information.

There is no legal possibility of employers opting out of their obligation to take out employers' liability insurance. Indeed it is illegal to have an excess or deductible on such cover, presumably since this would erode employees' protection in the event of

the employer's bankruptcy. The Working Party is aware of one arrangement under which the insured issued a side letter to the insurer promising to pay the first part of the losses, thus achieving the same effect as an excess. If the employer became insolvent and unable to fulfil its obligations under the side letter then the insurer would have been an unsecured creditor for any amount owing under the side letter, but the policy would still have been in place, paying the full amount of compensation to injured workers. However, we have no reason to believe that such arrangements are common.

It should be noted that, although it is not a statutory requirement that practising professionals take out suitable professional indemnity cover, compulsion is applied in many cases by the relevant professional body.