Regulation of the non-life insurance industry:
Why is it so damn difficult?

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Regulation of the non-life insurance industry: Why is it so damn difficult?

By Shirley Beglinger

Preface

As this paper makes abundantly clear, insurance is an industry riddled with the kind of “Spanish practices” that banking dumped years ago. Even before the latest revelations, it was clear that it is opaque, inefficient and susceptible to all sorts of conflicts of interest – a combination that has (rightly) got regulators around the world concerned that they may well have been missing a trick in assuming that the bulk of their attention ought to be given to the banking and securities industries. Maybe (they are starting to realise), the bigger systemic threat comes from the incestuous world of insurance, reinsurance and broking.

As this is being written, New York State’s charismatic attorney-general, Eliot Spitzer, is getting his teeth deep into the insurance broking industry – suggesting that its independence is largely a myth, and that some of the biggest brokers are more interested in hidden commissions than in engineering the best insurance package for their clients. If his charges hold up, that would clearly be a massive blow for the industry. But there are lots more things to worry about – some of them even more deeply embedded in the way the various players in the global insurance industry comport themselves, and some of them (particularly the dependence of the industry on the broader investment climate, and the potentially suicidal nature of the reinsurance spiral) with profound systemic implications.

We know that financial regulators have become exceptionally concerned about insurance. And we know that they are frequently exasperated by the impenetrability of the insurance industry – its archaic practices, its apparent lack of professionalism, and (at least in the UK) its traditional, though possibly unfair, reputation as a dumping ground for less talented public-school types.

Their response – quite natural, really – has been to try to impose the same kind of more rigorous, quantitative, risk-based regulatory regime on insurance as they have already foisted on the banks. Hence the EU’s Solvency 2 regime, currently winding its way from Brussels to London – and the strong similarities that it holds with Basel 2 for banks.

Whatever one might think of Basel 2 (not much, in all honesty), one can understand why insurance regulators are attracted by its certainties. But, as this paper makes abundantly clear, they may be on the wrong track. Maybe insurance is so different from banking that the same rules cannot apply – and that, if regulators try to squeeze the square peg of insurance into the round hole of banking-type regulation, the result will be to increase, not decrease, the risk of a systemic threat.
That, at least, is one of the suggestions offered by Shirley Beglinger in this provocative paper.

Shirley has long been one of the most thoughtful of the senior practitioners in the London insurance market, with a particular knowledge of the interface between insurance and banking – and with Basel as her special subject. We don’t expect everyone to agree with her recommendations (though we find them persuasive); but we do believe that her analysis of why insurance is not just difficult, but different, is extremely convincing. Insurance’s problems are largely sui generis, and they require an approach that is both radical and idiosyncratic. We think Shirley offers that combination.

Andrew Hilton
Director, CSFI
Introduction

This is a paper about regulation – a subject that is normally as dull as ditchwater. Worse, it is a paper about insurance regulation - consensually regarded as even duller than ditchwater. (The old joke about accountants and actuaries may apply: insurance regulation is for regulators who find banking regulation too exciting.) But I hope it is not a dull read since the issues that it covers are ones that affect all of us every day.

The problem is that, as we shall see, insurance is a bitch to regulate – and, as a result it has traditionally been regulated both inadequately and badly. Even worse, regulators have all too often thrown up their hands and let the industry regulate itself. Even the Church of England has difficulty regulating itself, and the insurance industry certainly ain’t no CofE.

The inevitable result is a number of high-profile insurance company bankruptcies in the UK, the US and elsewhere, which have made regulator-bashing into an Olympic sport.

The current uproar concerning insurance brokers’ commissions and bid-rigging activities is a case in point. The New York State attorney-general may well bludgeon Marsh, Aon and Willis to their corporate knees. Hundreds of millions of dollars will certainly be knocked off their share prices, and management heads will roll. As the scandal widens, so will the spread on insurance industry bonds, and a tsunami of class action suits will almost certainly ensue. God bless America: in Eliot Spitzer we trust. Note, however, that, through all this, the relevant State insurance commissioners kept their heads down and their shoulders hunched – presenting the smallest possible target for when the debris currently being flung at the insurance industry is aimed at its purported regulators.

Meanwhile, on the European side of the Pond, many will smugly assert that ‘we don’t have that sort of problem here’. And when, in due course, it is proven that we do indeed have that sort of problem here, regulator-bashing will be not so much an Olympic sport as a blood sport. In vain, will regulators protest that they didn’t know about PSAs and MSAs (of which more later). In vain, they will point out that these “Spanish practices” are not within their regulatory remit – and anyway that they have been around since long before they came on watch. They will still be in for a bashing.

Insurance matters... All of this matters. Even before Hurricanes Charley, Frances, Ivan and Jeanne (which are reputed to have cost the global insurance industry over $15 billion), the industry was in something close to crisis. This is not new: insurance is a cyclical industry, and
every decade or so it seems about to commit collective suicide. But that is not to
deny the seriousness of the problem. In the non-life sector, the fall in equity prices
and competition from investment banks and specialised fund managers has had a big
impact. In the reinsurance sector, there are (apparently) well-founded stories that
several players are in big trouble. All of that is forcing financial regulators around the
world to take a much closer look at insurance regulation. This has been facilitated by
the establishment of new cooperative institutions, bringing together global insurance
regulators (as banking and securities regulators have been brought together for some
time), and by the decision in the UK to move insurance regulation from the DTI to
the FSA (via a brief and unhappy period of self-regulation). But it also reflects an
awareness that, in a world in which financial risk can be traded virtually
instantaneously (particularly through the credit derivatives market), regulators must
take the insurance sector much more seriously. There is a well-founded fear that
weaker insurers may have been accumulating much more risk on their balance sheets
than is healthy, simply to boost their bottom line by adding hefty premium income.

Unfortunately, insurance regulation is tricky. It is very different from bank regulation,
and the traditions of the industry are different as well. This paper is an attempt to
explain why insurance regulation is so tricky, and why the carry-over from bank
regulation will not be as easy as some regulators seem to assume.

How we do it now...

Regulators are perpetually under pressure – and, when they get it wrong, the mob
bays for their heads. Unfortunately, they do get it wrong from time to time, not least
because they have never really found a satisfactory way to regulate insurance.

Traditionally, the main approach that regulators have taken to keep insurers in line is
through so-called solvency measures (on the basis that, if they know there is lots of
wonga in the kitty, maybe it doesn’t matter too much if they don’t really understand
the business). A good example is the current EU regulatory regime, based on the so
called Solvency I Directive.

Under this clear-as-mud regime, an insurance company is required to hold capital
equal to the highest of the following:

- RSM = (18% of the first € 50 million GP + 16% of the remainder of
  GP) * RR;
- RSM = (26% of the first € 35 million average claims* + 23% of the remainder) * RR; or

- MGF = a flat amount of € 2-3 million, depending upon line of business.

(where:

RSM: Required Solvency Margin
GP: Gross Premium, written or earned – whichever is the larger
MGF: Minimum Guarantee Fund
RR: Retention Rate = the 3-year average of net claims divided by gross claims. Claims are normally averaged over three years; however claims arising out of natural perils are averaged over seven years. (Gross claims is the total payable to a company’s Insureds in respect of their insured losses. Net claims is the total payable after allowing for recoveries from reinsurance.)

Just to pile pelion on ossa, some lines of business are further penalised. For instance, a company writing marine, aviation or general third party liability must hold an additional 50%.

Since the capital generated by all this brouhaha was higher than under previous regulatory regimes, Solvency 1 was generally regarded as a step in the right direction. However, even its die-hard supporters concede that it has considerable limitations:

- It is formulaic and ‘one-size-fits-all’. An example: Company A specialises in fire insurance for munitions factories, petrol refineries and paper producers. Company B writes fire insurance only on private homes for the affluent middle classes. Although Company B’s portfolio is considerably less risky, both companies are required to hold the same relative amount of capital.

- Specific insurance company risk profiles are ignored. For instance, a number of insurance companies were established during the 1990s with the explicit goal of writing large lines on non-standard risks. There is nothing inherently wrong with this (well maybe not); but it will lead to more volatile results – and should therefore result in a higher capital requirement. It doesn’t.

- In some European countries, there are complex formulae which allow insurance companies to set aside ‘equalisation provisions’ – a sort of slush
fund which enables them to smooth results over time. The effect is to stabilise a company’s balance sheet. Much to the Germans’ chagrin, however, EU legislation ignores their existence.

- **Solvency 1 only gives 50% capital credit for reinsurance.** There may be good reasons for buying more reinsurance than 50% (after all, I sold it for years); but regulators still require primary insurers to hold capital as though extra reinsurance had not been purchased. Insurers tend to think that is jolly unfair. Anyone observing the current travails of certain reinsurers may be forgiven for thinking that even 50% credit is too much.

- **Solvency 1 completely ignores investment risk – which can very easily break a company.** Like banking, insurance is a huge generator of cash. One of the principles of insurance is that the cash generated by premiums is invested, and so generates additional returns which can be used to pay claims when they occur. This works well when stock markets are booming. Indeed, one UK firm claimed, a few years ago, that it could underwrite to a combined ratio of 117% and still produce an adequate return because of earnings from its investments. (A combined ratio, incidentally, is what one gets when one adds claims, management expenses and acquisition costs of a given year, then divides the result by the premiums of that year.) However, when stock markets reverse, insurance companies can easily see their capital erode. 117% Insurance Company plc is a case in point: stock markets reversed, and a grand old insurance name imploded almost overnight.

Another type of investment risk currently ignored by regulators is correlation between insurance investment portfolios. Consider the example of a company with a large portfolio of risks in California, which also invests a large chunk of its premium earnings in California. When an earthquake strikes, the company is faced with huge numbers of claims – and therefore needs to liquidate its investment portfolio. But that has also been hit by the catastrophe.
How are we going to do it...

With so many problems associated with Solvency 1, the EU Commission is now seeking to draft new rules – known as ‘Solvency 2’. This is a mammoth undertaking, which is supposed to deliver:

- better protection for policyholders – particularly for private buyers;
- further progress towards a single EU market for insurance;
- steps to prevent accounting arbitrage;
- greater transparency with regard to a company’s risk situation; and
- built-in flexibility, allowing supervisors to adapt to the latest market developments as they arise.

Over four years of often frustrating work on Solvency 2, the Commission has no doubt come to wish that it had picked an easier task.

One positive result of this frustration, however, is that the Commission has sought help from wherever it can find it. That has involved the commissioning of numerous studies, both internal and external. Two external studies are particularly interesting.

The first – written by a team led by Paul Sharma of the UK’s FSA - is fairly slim, but fascinating. It should be mandatory reading for insurance CEOs.

Sharma’s group undertook a detailed study of recent insurance insolvencies, asking itself:

- what caused them?
- were there warning signs that regulators might have picked up on? and
- what lessons could regulators learn from these failures?

Inevitably, the report’s main conclusion seems a bit banal: errors by management (whether strategic or operational) are the most frequent cause of insurance
insolvency. That said, Sharma’s analysis is surely sound. He points out, for instance, that some of the main risks that the insurance industry faces – eg the economic cycle and market competition - are exactly the same ones that face any corporate undertaking, and as such wouldn’t attract any comment if the bankrupted company manufactured widgets or sold pizzas instead of consumer financial products. Others are variations on themes identified by the Basel Committee on Banking Supervision, and can be lumped together under five headings (my words):

- **Strategic risk**: Management may have decided to expand business in directions which are ill-advised or ill-timed.

- **Operational risk**: Inadequate or failed processes, systems or people. In an industry as riddled with “Spanish practices” as insurance, this is perhaps the single biggest risk cluster. It includes:
  - management and staff competence risk – too often, “management” is by banking professionals with little or no experience of insurance (and that is getting worse as old-timers fall off their perches);
  - internal governance and risk control;
  - controller and group risk – which, in insurance, tends to mean control over the accumulation of risk on a group-wide basis (a prudent CEO may well have decided not to risk more than 1% of one firm’s capital on a single risk, but if an underwriter in London believes he is the only one on that particular risk and therefore risks 1%, and the underwriters in New York, Bermuda, Paris, Munich and Zurich do the same, then the company is exposed to 600% of the “prudent” risk); and
  - failed processes – business processes in insurance are often badly designed and poorly executed (badly designed because the process of concluding an insurance policy requires many manual steps, and poorly executed because administration is usually the first place an insurance company seeks to cut costs).

- **Business – or underwriting – risk**: The golden rule in insurance is that large events happen – and they can affect an insurer’s portfolio enormously. Combine this with the numerous pitfalls associated with the framing of an insurance contract (of which more later), and the potential for disaster is enormous.
- **Asset/liability risk**: This includes the counterparty risk posed by reinsurers. Not all reinsurers are able or willing to pay when disaster strikes. Although a reinsurance recoverable can look very pretty on a balance sheet, when thousands of flooded households are clamouring for their money, cash is king.

- **Stupidity risk**: This may be a bit unfair, but (as I discuss in greater detail below) insurance is a very peculiar industry with traditions and practices that seem designed to bring disaster in their wake. It is also an industry which seems very slow (indeed positively reluctant) to learn from its mistakes. Reflecting this, one of the greatest risks is that a claim will be recognised too late, and/or that the reserve posted for it will prove too low.

Sharma emphasises that no warning bells go off when any of these problems is about to manifest itself. Indeed, an insurance company may still look hale and hearty up until the very moment of disaster. The only way for a regulator to receive a timely warning of trouble would be to transact the business itself. So regulators just have to do their best to design a system of regulation which gives them some warning of when intervention might be needed.

In contrast to Sharma, the **KPMG report** is a vast and learned tome – though it also contains some useful insights. One is that there are so many similarities between insurance and banking that the regulatory framework for insurance should be similar to that adopted for banks by the Basel Committee on Banking Supervision – colloquially known as ‘Basel 2’.

I think that is broadly true. However, it is also true that it is too easy to fall into the trap of assuming that insurance and banking are essentially identical. As I try to explain below, at some length, the differences between the two may be as important (or more) for regulators to focus on as the similarities.

Whatever, under the (generally benign) influence of Sharma and the KPMG team, instead of reinventing the wheel, the EU Commission is now proposing that insurance should be subjected to an adapted version of the three-pillar “Basel 2” capital regime:

**An ersatz Basel 2 . . .**

  - **Pillar 1: Quantitative requirements**, including:
    - minimum capital requirements, to be set using a risk-based approach by reference to underwriting information, assets and liabilities;
- options for firms to graduate to scenario approaches for the calculation of their own capital requirements – based upon internal probabilistic models;

- group solvency requirements, taking account of additional risks at the group level; and

- other prudential rules relating to assets and liabilities.

- Pillar II: National supervisors should assess the effectiveness of internal risk management systems, including:

  - exposures (including reinsurance);

  - internal risk models;

  - stress-testing;

  - fitness of senior management; and

  - asset/liability mismatches.

- Pillar III: Insurance companies should provide greater public disclosure of information, enabling market participants to clearly understand their risks.

One major difference is that Basel 2 imposes on banks a Pillar I (ie capital) charge for operational risk. As drafted, insurance regulation appears to have no such intention – which seems odd since operational risk is one of the main culprits in the various bankruptcies reviewed by Sharma. Instead, the operational risk review is being entrusted to national regulators, with no specific guidance on sanctions if their findings are unsatisfactory. Some regulators will no doubt prefer to turn a blind eye to the shortcomings of their national champions. Others will be draconian. (And we can guess which regulators will fall into which category.)

In anticipation of new EU regulations (or, more realistically perhaps, to head them off), various national regulators in Europe have also put forward their own risk-based solvency models, which depend less on carry-over from the banking model:

- The Dutch PVK, for instance, has advanced a tripartite model, composed of a Minimum Test, a Solvency Test and a Continuity Test. The Minimum
Test is backward-looking, intended to ascertain whether an insurer has in the past created sufficient reserves for its proven needs. The Solvency Test is a standard scenario model test, designed to find out whether the company has sufficient capital to remain solvent in the coming year. The Continuity Test is intended to take a longer-term view of solvency – evaluating the impact of various adverse scenarios on an insurance company, while simultaneously giving credit for management measures. This, too, is intended to be regularly back-tested.

- **The British FSA** (which is only now gathering insurance regulation to its bosom) has also been galvanised – partly because some of the more publicised insolvencies have happened in the UK and partly because the IMF has made some uncomplimentary remarks about the manner in which British insurers balance risk and capital. Its response involves two Consultation Papers:

  - **CP 195** – ‘Enhanced capital requirements and individual capital assessments for life insurers’ – is a first step towards imposing risk-oriented capital requirements on life insurers; while

  - **CP 190** – ‘Enhanced Capital Requirements and individual capital assessments for non-life insurers’ – is intended to do the same for the non-life industry.

- **The German Gesamtverband der Deutschen Versicherungswirtschaft** has also weighed in. It proposes to adapt S&P’s Risk-Based Capital (RBC) model, giving credit for correlations between various categories of risk. The GDV proposes that each line of insurance business be given a specific weight and correlation factor, and that the correlation factors should be reviewed on the basis of a ten-year rolling average. A cynic might view this proposal as an attempt to safeguard at least part of the ‘equalisation reserve’ regime so beloved of German insurers.

All of this seems logical. However, it leaves open some fairly glaring questions, such as who is to design and/or approve the scenario models which will underpin this all-important regime. Nor is it quite clear (at least to me) how it is going to fit with the work the Commission is doing on Solvency 2.

Equally, transferring the concept of Value-at-Risk to an insurance company’s huge portfolio of investments seems reasonable. However, it is not clear that the implications have been truly thought through. After all, given the size of investments (i.e. the trading book) held by the insurance industry, it seems likely that the introduction of a VaR-based capital requirement calculation would greatly increase
the total amount of capital that insurance companies are required to hold – potentially putting some of them out of business.

Insurance ain’t like banking...

This brings up an important point – one of the most important points that I want to make. I am worried that the obvious similarities between banking and insurance (both parts of the same financial services industry, right?) can blind regulators to the differences between them – and those differences may be more important to successful regulation than the similarities. Unfortunately, they are less susceptible to the kind of formalistic/mechanistic regulatory mechanism epitomised by Basel.

Regulators – quite understandably – *like* the formalistic/mechanistic approach. It’s (reasonably) easy to understand, and the lack of banking bankruptcies proves that it works (doesn’t it?). Hence, they tend to pooh-pooh the all-important differences. Like a difficult teenager, the insurance industry is given a pat on the back and told not to worry its pretty head – it will grow out of its problems just as soon as it starts to be sensible (like the banks). Insurers are perfectly happy to be condescended to, since it obviates the need for reform (or at least puts off the evil day). Like dodgy Cousin Jasper, they will have flogged the family silver and bunked off with the proceeds to the races before Auntie Regulator ever realises what’s going on.

I have already covered some of the differences between insurance and banking. Let me give you a few more examples:

- **Premiums vs interest**: When a bank lends money, the interest rate charged reflects the opportunity cost of the money lent out, plus an additional charge – a risk premium – which reflects the likelihood that the loan will default. An insurance contract is very different. The risk premium is payable in advance, like the fee for a stand-by line of credit. This reflects the insurer’s understanding that if a loss occurs, what is effectively a stand-by line of credit will be drawn down in full or in part – and that part which is drawn down must be considered irrecoverable.

- **Data collection**: There is a huge body of credit default data floating around the global banking industry, at least compared with insurance. And ever since JP Morgan published CreditRisk Metrics on the internet in 1994, banks have been sharing data. Out of this pool of data, credit actuaries can now calculate the likelihood that a loan will default, and how much of the loan will be lost in the event of default. In many jurisdictions, they can even give an accurate forecast as to how long the recovery process will last, thus generating a
reliable net present value for recoveries. There is no such body of data in insurance. Most of the few attempts to create such pools over the years (the German auto pool, the French computer crime database, the US crime bond statistics) have collapsed. Whereas major disasters (such as earthquakes and windstorms) are tracked in great detail, most insurance companies regard ‘their’ loss data as a competitive advantage – and guard it jealously.

Regulators (who, in my view, tend to be over-impressed with the banking model) nevertheless seem to take it as given that comparable data is available in the insurance industry, has been collated over at least one economic cycle, and has been shared and counter-checked. They also assume that scenarios, stress-testing and predictive models are all substantially similar between companies. In fact, although every insurance company has scenarios and ‘a model’, they tend to be proprietary (a fancy word for primitive), and the inputs owe as much to art as to science.

- Reserving practices: We all assume that when we trash the Beemer and call our insurance company to report a claim, the insurer knows how much to reserve. We also resign ourselves to the notion that our insurance premiums are going to be considerably higher next year. But just how are those reserves and that higher premium set? I don’t want to make anyone unduly nervous, but they are generally set by insurance actuaries – the butt of unkind jokes throughout the insurance industry – whose expertise drives large parts of the industry and determines product pricing.

Let’s look at reserving in a bit more detail.

In reality, despite the jokes, there is a fair amount of mathematical science behind actuarial reserving. Notwithstanding this, however, things do go wrong. The Independent bankruptcy in 2001 was a case in point. The actuaries working at Independent Insurance used what they firmly believed was the best mathematical science. They calculated and trended and allowed for IBNR (incurred but not reported) and IBNeR (incurred but not enough reported) and peer-reviewed and double-checked. But the very best science is useless if predicated upon rubbish data. The Independent’s claims department was under-resourced and undermanaged; claims reports were bunged into drawers, reserves were not entered into the information systems. Whole swathes of files were consigned sight unseen to the archives. Thus, the actuaries were basing their reserving on a sample of numbers which bore little relation to the true liability of the company. In due time of course, the problems came to light; but by then it was too late to save anything and the company went spectacularly bankrupt. The Independent was a fairly crass case, but better companies can (and do) get it wrong.
Life insurance may be fairly straightforward – a person is clearly alive or not, and, when he dies, the value of his life policy falls due. Life actuaries ought, therefore, to be able to predict the probability of loss, and there ought to be no question about the value of the loss. Non-life insurance, however, is far more volatile. The randomness which is fundamental to insurance creates imponderables. A non-life insurer can never know which risk is going to be affected by what event, or how much it will cost when the event occurs. He can only know that something is going to happen somewhere. Earthquakes and windstorms are fairly easy. But what about asbestos? Tobacco? EMF? And what chance of some gullible European judge awarding US-style megabuck damages? After all, Spanish judges went on a megabuck awards spree during the 1990s – and very nearly wiped out their nation’s insurance industry.

In this environment of endemic uncertainty, how can an insurer hope to set reserves correctly?

If reserves are too low, the company’s capital and cash flow will sooner or later be impaired (remember the Independent). On the other hand, however, if reserves are set too high, shareholders will get jittery because the company appears not to be on top of its business. Auditors will also question its reserves – and the tax man is not far behind, claiming that the company is trying to hide its profits.

Plus, there is a big issue around what one might call “hidden complexity” and its impact on reserving – a problem that barely arises in the meat-and-potatoes world of retail banking (though some mortgage products may include fairly impenetrable bells and whistles).

Hands up anyone who’s ever even read the small print on his or her household insurance policy – let alone understood it. Even in a room full of expert financial analysts, there will seldom be more than a handful who know more than the annual premium and the deductible (and sometimes not even that). We take such simple “mass” insurance products for granted – and yet they can be immensely complex when one looks inside the box.

An example will illustrate what I mean:

Back in June 1987, Mrs Jones and her toddler, Tommy, visited the neighbour, Mrs Green. While the ladies were drinking coffee, Tommy crawled upstairs and out on to the balcony. Since Mrs Green was planning to glass in the balcony, she had not secured it. Tommy promptly fell off the balcony, head first on to the patio. He was rushed to hospital, where it was happily confirmed that he was uninjured. Or so it seemed. From then on, Tommy was prone to headaches, was
occasionally violent and sometimes simply fainted. At five, he was
diagnosed as a possible epileptic, and at 12 he suffered a violent seizure
which left him partially paralysed. Medical science having advanced
during the years since his fall, doctors were now able to show that his
epilepsy and the seizure were owing to an undiagnosed haemhorraghe.
At age 18, Tommy’s disabilities were reassessed and he was found to
be completely disabled.

Let’s view this sad little story through the eye of Mrs Green’s insurance company.

In 1987, Mrs Green’s policy was closed out showing a slight loss arising from legal
expenses. Then in 1990 – long after the 1987 accounts had been closed - the policy
had to be re-opened and a much larger reserve booked, because liability policies of
this nature always tie the loss back to the year in which the harm occurred (this is
called an “occurrence trigger”). When Tommy had his seizure in 1997 – 10 years
after the fact – the insurance company realised that taking care of him would cost a
lot more than hitherto assumed. And in 2003, when Tommy turned 18, the insurer
understood that he would never be able to support himself, and so some sort of
pension or annuity needed to be bought for him. Only when the annuity had been
bought could the insurance company say once and for all what its loss on Mrs
Green’s policy was. Fifteen years seems a long time to figure out whether you’ve
lost money (and if so how much), but it’s not unusual in the insurance industry.

It can get worse.

While all of this was going on, let’s imagine that Mrs Green bought a holiday home,
and made arrangements for the mail related to that house to be retained at the local
branch of the building society which financed her mortgage. She then instructed her
home bank to make quarterly transfers to that branch to pay the mortgage.
Unfortunately, owing to a clerical error, the standing order was not carried out.
However, the local branch of the building society did, of course, retain all the
increasingly strident correspondence related to Mrs Green’s defaulted mortgage.
Only when Mrs Green wanted to visit her holiday home more than a year later did
she discover that it had been foreclosed and force-sold. Not only had she lost her
holiday home and possessions, but the net sales proceeds were also less than she had
paid. Mrs Green therefore sought redress from the bank which had failed to execute
her standing order – which, in turn, referred the case to its professional indemnity
insurers. The facts were pretty clear, and Mrs Green finally received a cheque.

Note that the actual harm in this example occurred during 1987 and 1988. But let us
say that, at the end of 1988, the bank changed its PI insurer. Since the bank knew
nothing of Mrs Green’s loss at the end of 1988, the 1988 insurer was able to close his
books with no loss recorded. The new insurers – although no mistake had occurred
during 1989 – had to pay for the loss of previous years. This is because PI policies are written on the basis that they cover claims made during the currency of the policy, irrespective of when the actual loss occurred. This is known as a “claims-made trigger”.

What one needs to understand about the differing triggers – occurrence vs claims-made – is how they affect the emergence of losses. This has no parallel in the banking world. As we saw, policies written on an occurrence basis can have a very long latency period – it can take 20 years or more for losses to materialise and for those losses to be properly valued. In the case of large groups of claimants who were harmed over a period of several years – eg asbestos – courts have been dragged into determining when exactly the harm occurred, i.e. which year’s (or years’) policy should be liable for the loss? If the same proximate cause of loss applies, the courts must also decide whether there should be one policy limit and one policy deductible for all claimants, or whether there should be a limit and a deductible for each claimant. If the courts choose to interpret the policy wording so that there is one policy limit for each claimant, an insurer may find that what he thought was a policy limit of say £10 million in the aggregate suddenly turns out to be a policy limit of £10 million per claimant, equivalent to several hundred million pounds in the aggregate.

Or he may find that, since the harm in cases such as asbestos occurred over several years, each year’s insurance policy must respond to its fullest limit. Again, the insurer finds that the burden imposed upon him is several hundred percent of what he intended.

Policies written on a claims-made basis have no such tail. If the insurer receives no notification of loss before the end of the policy period, that policy period is closed off – there are no losses and all premium can be booked to profit. The drawback, of course, is that a new insurer may find himself paying for losses which occurred long before he went on risk – and that can also bring a firm to its knees.

The result of all this is that insurance reserving has become one of the most difficult tasks imaginable.

Stock analysts (and teen-aged scribblers in the financial press, who are highly susceptible to analysts’ blandishments) are another reason why setting reserves is so difficult – and indeed why running an insurance company is harder and less fun than it was in the good old days when we could hope to be on the golf course by four.

When a buy-side analyst announces that he expects a company to produce post-tax earnings of X per share, and is therefore setting a share price target of Y, it is a
brave (or possibly suicidal) CEO who ignores this in favour of setting the reserves his actuaries or his instinct tell him are necessary. After all, it may take anywhere between three and 30 years for claims to actually be paid out. By then, the CEO may well have moved on to a happy and gin-sozzled retirement. Much easier to under-reserve just a bit to keep the analysts happy – with the benefit going straight to the bottom line. In any case, stock markets may pick up enough to bail us all out.

The broader issue is that, to a stock analyst, money has no business just sitting on a company’s balance sheet waiting for a (very) “rainy day”. If it isn’t being actively invested, analysts insist that it should be given back to shareholders. In vain would a CEO argue that his company needs a fat security cushion for when a flood, a hurricane or an earthquake hits. If more capital is needed, the analyst would retort, it can be raised when it is needed. So, the browbeaten CEO capitulates, and gives his catastrophe reserve back to the shareholders. The truth is, however, that if a company tries to tap the market when it is known to have several hundred million dollars of claims to pay, it finds (surprise, surprise):

- that there is less cash available from the market; and

- that what cash can be found is much more expensive – quite likely, more expensive than the cost of keeping cash on the balance sheet.

As Converium, the struggling Swiss reinsurer, can no doubt attest, the downside of this is considerable. Indeed, if the company fails to raise the cash when it needs it, the weight of its liabilities may force it out of business - leaving widows and orphans with unpaid pensions, drivers with no insurance and the regulators looking for a scapegoat to save them from public evisceration. The net effect is that there are fewer and fewer companies in the non-life insurance market, because only the largest companies can survive the analysts’ attacks on their balance sheets.

“Rubber band” capital...

Having spent a considerable part of my professional career designing insurance products that could be sold to banks as a way of boosting their capital, I am under no illusions about the sanctity of capital in the banking sector. But, more than sometimes, I get the impression that insurance regulators are just a weeny bit naïve when they rest the bulk of their case on Pillar 1 capital.

Traditionally, capital had three defining characteristics. It was:
- permanent;
- risk bearing; and
- paid up

It isn’t any more; all three characteristics have been eroded by pressures on the industry. Back then, a shareholder bought shares in the expectation that he could sell them if the company’s business wasn’t doing so well. He understood that his downside was limited to the value of the shares in the event of insolvency. If the company had a pile of cash sitting around, he naturally felt that the likelihood of insolvency was more remote. And if the worst did happen, that pile of cash might even mean that, when the liquidators were finished, the investor might receive back a share of the value of the company’s assets.

The current fashion for giving cash back out of a going concern greatly exacerbates the volatility of a company’s performance and share price. Since there is every likelihood that cash won’t be available when it is needed, the probability of insolvency for any financial undertaking, especially insurance, is far greater. But most of all, the concept of permanent share capital is thereby destroyed.

The risk-bearing element of share capital does not involve only insolvency; traditionally, it also included the understanding that an annual profit distribution (the dividend) is discretionary. Today, however, a CFO who foregoes a dividend is committing professional suicide. In vain, he may point out that the dividend cover is insufficient because he’s already given cash back in the form of a share buy-back. Whether this is true or not, analysts will trash the stock. So the dividend continues to be paid, even, in the insurance industry, when commonsense says it is time to stuff money in the company’s bottom drawer. Exit, stage-left, the ‘risk-bearing’ element of share capital.

Paid-up is is also on the way out. Call me old-fashioned, but in my day, when a company was liquidated the traditional order of recipients for cash were:

1. the tax man;
2. the liquidator in respect of his fees (not formally but certainly in practice);
3. the policyholders;
4. short-term creditors;
5. bondholders; and finally

6. shareholders.

The understanding then was that, if your piece of paper wasn’t at the very back of the cash queue, it wasn’t share capital. Nowadays, with contingent capital, preferred shares, hybrid capital, subordinated debt etc etc, most of the new forms of “capital” look like loans in disguise.

Accountants don’t help either...

Whether an insurance firm follows International Financial Reporting Standards (IFRS) or US Generally-accepted Accounting Principles (GAAP), it sometimes seems that accountants are just there to make trouble for the hard-pressed insurer.

Let me give you three examples of what I see as the law of unintended consequences (since I have to believe that accountants are not of their essence malign):

- **Asset/liability management**: The IASB (International Accounting Standards Board) is currently working on a new set of accounting rules which call for a review of how insurance assets are matched with liabilities. While most attention seems to be focused on life and pensions assurance and on related savings products, the new rules as currently drafted would seem to affect both life and non-life insurance. Sounds fine – but, given the difficulty of even ascertaining insurance liabilities, the whole notion of ‘matching’ seems distinctly premature. Still, I suppose, one has to start somewhere – and the IASB proposal has certainly concentrated minds. The European Committee of Insurers, for instance, appears to favour a solution whereby consumer products (life and non-life) would be “ring-fenced”, with a specific pool of assets set aside to match them. Unfortunately, the IASB currently argues for something very different: that all liabilities must be properly valued and then everything suitably matched. Exactly how that valuation is to be carried out (or by whom) has not yet been revealed.

- **Contract valuation**: As part of a broader discussion of fair value accounting, the IASB is also working on a new rule designed to place a valuation on insurance contracts. This would supposedly enable the policyholder to show some kind of countervalue for his premium on the asset side of his balance.
sheet. The corollary is, presumably, that insurance companies will be required to show an equal and opposite liability on their already hard-pressed balance sheets. (At the moment liabilities are only shown on a company’s balance sheet once a loss has occurred and reserves have been posted.)

- **IFRS, GAAP and the rest:** Moves to establish international benchmarks for accounting are certainly a step forward, but national legislation always seems to be several paces behind. Indeed, what presently counts as capital in Italy, France or Japan would probably count as ‘creative accounting’ under IFRS or GAAP. It follows then that companies subject to IFRS or GAAP accounting are being held to a capital standard far higher than those of their competitors. An observer might find it hard to square this with the European Commission’s goal of creating a level playing field for insurers throughout the EU.

## Information issues

As noted, both accountants and regulators are, in my view, way too easily seduced by the parallels between insurance and banking – to the detriment (I would argue) of the insurance industry’s health.

Nowhere is that more evident than in the area of documentation and management information systems. Too often, accountants, auditors and regulators appear to believe that extracting ‘real’ liability numbers must be merely a matter of pushing a button to produce a number, then doublechecking that number against the contracts in question.

This may be true for standardised commodity insurances – householders’ policies and vehicle insurance policies, for instance. But such policies account for less than a third of total premium in the insurance market. Most other policies – ‘industrial’ policies covering fire, general liability, products liability, professional liability, marine, engineering, aviation, etc. – are not standard. And any insurance buyer with more than, say, $150,000 to spend on premiums expects as a matter of course to purchase a personalised insurance product. The result is that policies covering the same sort of risk for the same sort of industry may have many wildly different features – very different to mortgage lending or standardised credit agreements.

But that is far from the end of the matter.
Agreeing the price before the product . . .

What often appears bizarre to outsiders (and often seems to be ignored by regulators) is that negotiations on individual policy wordings may take several months, or even years, after the deal is supposedly closed and the insurer is ‘on risk’. Anyone who has followed the insurance wrangles following the World Trade Center attacks will be aware of this hitherto unquestioned practice – which has no parallel in the real world (or in banking). Yes, the price of insurance is generally agreed in advance. But negotiations over what, exactly, is being bought and sold may not be concluded for months after the fact. Moreover, the premium is usually billed 2-3 months after the start of the contract, and many industrial insureds do not pay up until a further 3-6 months after the invoice is received.

On top of that, it is not unheard of for an insurance broker – at his client’s behest - to come back to the insurer halfway through an insurance period and suggest fairly fundamental changes to the contract. Depending upon the state of the market, insurers are quite likely to agree – though the changes themselves may not be very well documented. A “back of an envelope” is often as good as it gets. Very rarely does the subject of additional premium come up.

All of this seems crazy. But it sort of works in a sort of way – and generations of long-suffering judges have established a body of case law that enables the industry to limp along in a half-assed way.

What it certainly does is make data management well-nigh impossible. True, management information systems at insurance companies are fairly easy to build when the products sold are standardised and the premiums are calculated automatically. But when the other two-thirds of the business needs to be tracked, it’s very different – and devilishly difficult. Many companies (not just basket-cases) figure that they have done well if they actually manage to keep a reasonably coherent paper trail of what they have sold. The upshot is often management information systems which need a lot of manual intervention, numbers dumped into spreadsheets and back on to mainframe systems, with all the scope this provides for operational failure.

Plus, when insurance companies do set out to build business databases, they tend to find that the priorities are driven by conflicting interests. Underwriters want underwriting information; claims specialists want claims information; the accountants want billing, cash-flow, taxation and expense information. On those rare occasions when one group doesn’t ride rough-shod over everyone else, management’s demands for information generally come as an additional bolt-on. The result tends to be an information system which leaves everyone equally frustrated. Unfortunately, management often doesn’t realise that the information coming from its management information system is unreliable. Thus, when strategic decisions are made, they may well be based upon a gut-feel rather than on hard numbers. A fortiori, the same
applies to regulators who rely on company data; everyone is blundering about in something close to total darkness.

The reinsurance issue

This is another area where, people seem too easily impressed by the parallels with banking – and where Basel 2-type solutions may not be as appropriate as everyone appears to think.

The point is that, under Basel 2, when a bank’s credit portfolio is being reviewed with the intention of setting aside the requisite regulatory capital, it is allowed to reduce its capital if there is an appropriate hedge – ie if the risk has been laid off. That is despite the fact that, as we know:

- legal certainty in hedging contracts is often lacking in cross-border situations;

- the hedge doesn’t always work; and

- the seller of credit protection may have understood the contract differently from the buyer – and may be unwilling (or unable) to pay up if called on.

Nonetheless, bankers seem broadly content with this approach.

The proposals currently being considered within the EU Commission as regards insurance appear unclear on whether or not credit will be given for reinsurance purchased. And if credit is to be given, how much credit will it be?

This is another area where the apparent similarity between banking and insurance may be misleading.

When banks buy and sell credit protection among themselves, they do so on a very clearly delineated basis. For instance, where protection is purchased on a portfolio basis, the portfolio itself is usually a clearly defined set of similar risks – ie credits of similar size to similar sorts of companies, with similar tenor. Where a ‘mega-loan’ is to be protected, the name of the borrower is disclosed between the buyer and the seller of protection. There is a clear understanding among participating banks:
that they can be both buyers and sellers of protection;

- that, as a result of this, they have to keep close track of their overall exposure to a specific name (particularly if a loan has been syndicated); and, most important,

- that, if there is a credit event, the seller(s) of protection will lose money and the buyer(s) will gain.

The credit roundabout

This may sound obvious – but, in fact, it is not. What is noteworthy is that banks have been so successful at establishing fairly stringent standards of disclosure, standardisation and documentation. What is also noteworthy is that they hold each other assiduously to those standards, and refuse to do business with those who don’t measure up.

Relations between insurers, reinsurers and intermediaries are far more primitive.

First, there is the matter of how business tends to be written at the front end. An insurer may have a solid portfolio of household and small office-based businesses. On the face of it, this is ideal – homogenous, generating steady income, fairly low loss ratios etc. But the fact is that, all too often in the insurance industry, a portfolio like this is subject to unexpected cluster events – windstorm, hailstorm, flood, earthquake – in which the profits of several years can be wiped out in a single night. There may be some parallels here with, say, specialist mortgage lenders in the banking industry, but it is a problem that is endemic in insurance while it is relatively rare in banking.

Recognising this (since not all of them are out to lunch with dodgy Cousin Jasper), many insurers seek to diversify their portfolio. They do this by two means:

- **Syndication**: Where an industrial undertaking has particularly high values to insure, the risk will rarely be placed with a single insurer. Instead, the industrialist usually hires an insurance broker to place the policy. His task covers both price and terms, usually on a “bespoke” basis. The broker canvasses the insurance market and selects a lead underwriter. But, unlike the lead manager on a conventional syndicated loan in the banking world, the insurance leader has no legally grounded duty of care to his co-syndicants – though certain leaders in specialised areas will establish a reputation for expertise and thorough due diligence. The leader will price 100% of the insured limit, but may himself only accept 10% of the risk. The broker must, therefore, find co-syndicants willing to accept the remaining shares. The leader’s reputation may well mean that these co-syndicants will waive all or
part of their own due diligence, and will follow the pricing and terms set by the leader. Thus, with a strong leader, the broker’s task of placing the risk is easier – but that is a reputational issue, not a legal one.

However, what is good for underwriters may not reflect the wishes of the client – or of his broker. If the broker selects an ‘established’ leader, that leader may well refuse to accept all the bells and whistles sought by the buyer. So the broker has to shop around and find someone willing to sell him bells and whistles – but that may make co-syndication difficult.

The point is that – unlike in banking – each syndicant fights his own battles. Each co-syndicant will accept a portion of the risk which fits his own underwriting capacity or risk appetite.

- **Reinsurance**: Let’s assume that the portion accepted by a particular syndicant corresponds to rather more than 1% of his capital. In order to reduce his risk back down to a prudent level, that underwriter may then cede a portion of his share to his reinsurance treaties. In other words, he may lay off part of his risk. At the same time, in order to further diversify his portfolio, this underwriter may also accept shares of the reinsurance treaties of other underwriters. It’s an easy way to increase income; it doesn’t take much administration, and it genuinely adds diversification.

But what does this really mean? A reinsurance treaty is an agreement between an insurer (the cedant) and a reinsurer, whereby the reinsurer agrees to accept a proportion of the premiums written by the insurer and to pay the corresponding proportion of the cedant’s losses when they occur. The simplest form of reinsurance is the quota share treaty. The quota share is an agreement whereby the cedant automatically cedes X% of the premium for every risk he writes to the reinsurer, up to a certain maximum limit of liability. The reinsurer in turn agrees to automatically pay X% of the cedant’s losses.

The reinsurance treaty almost never specifies the maximum sum insured of a risk which may be ceded – merely the maximum amount of his liability that the underwriter may cede. Even where there is a list of risks which may not be ceded, such restrictions are easily circumvented by re-categorising a risk. There are few exclusions, and only very rarely is there a requirement to identify in advance the risks ceded to the treaty. The whole thing is based upon *uberrima fides* – utmost good faith.
A banker would be stunned by this assumption that everyone else is a jolly good chap. But that is how insurance and reinsurance have worked for several centuries.

Let’s now say that our underwriter-cedant has a reinsurance treaty whereby he cedes 50% of all business written up to a maximum amount of US $100 million. He has five reinsurers, each writing 10% (of 100%). He in turn is reinsurer on five similar such treaties for other underwriters.

So the risk is spread widely and the underwriter’s portfolio is nicely diversified. Or is it?

One sunny day, an insured factory burns to the ground and the building’s broker trots around to present a claim for our underwriter’s US $20 million participation. Our underwriter writes out a cheque, then goes around to his reinsurers to collect his 50%. But it turns out that all of his reinsurers also had a share of this particular risk – so they’re not best pleased to be writing a cheque to the underwriter as well as to the insured. Two of them ask for a few days’ grace while they collect money from their own reinsurers. The underwriter then goes back to his office – only to find that all five of his reinsurance clients are waiting there, wanting a cheque from him for that portion of the same risk they had ceded to their treaties. And so on…

Rather than a virtuous circle of winners and losers, the mechanism of reinsurance can create a deadly inward spiral. In the end, it can turn out that our underwriter had written not his prudent 1% of capital on a particular risk, but a much larger percentage via opaque reinsurance treaties, the implications of which he had given little thought to. When the Piper Alpha oil platform blew up in 1988, the Lloyd’s insurance market found itself the victim of precisely such a vicious inward spiral. Everyone had reinsured everyone else on the same risk, and Lloyd’s only narrowly escaped bankruptcy. At the time, all market participants swore they would never again engage in such practices, and the Lloyd’s board did its best to write rules which would prevent it from happening again. Twenty years later, they’re at it again. It seems, indeed, that insurers do not learn. Attempts by the big professional reinsurers to restrict such ceding practices have been dismally unsuccessful.

All too often, it is only after a major disaster has struck that market participants realise too much risk is concentrated on frighteningly few balance sheets – usually reinsurance balance sheets. Inevitably, when disaster strikes, weaker balance sheets go to the wall, and larger companies become larger. And, willy nilly, the surviving reinsurers come to present a systemic risk – not only to the insurance industry, but potentially to the entire financial services industry.
Just when you thought it was safe to go back into the water ...

Implosion of the brokerages ...

Mr Spitzer’s expanding crusade against the financial services industry has (rather dramatically) called attention to another systemic risk few of us saw coming: brokers.

During the boom years of the 1990s, the number of major brokers in the industry contracted steadily. They went from being ‘the Big Eight’ to ‘the Big Six’ – and thence to ‘the Big Three and supporting cast’. The takeovers were expensive, but not dramatic; where a company was being taken over, the big egos were perfectly happy to accept lots of luverly doosh and step aside. The companies doing the taking over were unsentimentally acquiring control of vast premium volumes. In this equation, Premium volume = Brokerage revenue. But more importantly, Premium volume = Control – something every intermediary dreams of having.

Not a single takeover ever met resistance from competition authorities. Either they were asleep at the wheel, or they assumed (logically enough) that as long as there were lots of insurance companies, there would be lots of competition for business – and therefore that the insurance-buying client would get a fair deal.

At the same time as all of this industry concentration was going on, insurance and reinsurance brokers were discovering their own very special sharp end of the long latent claims issue discussed above. Namely, that, since the broker is the agent of the client, it is the broker’s responsibility to collect on those ancient insurance policies when the judge hands down his decision on asbestosis or tobacco or pollution or EMF.

... their very own “long tail” problem

Having done a good day’s legal work, the judge bustles off to molest the port decanter. The broker, however, stumbles down to the cellar to excavate insurance policies applicable 20 years ago when the asbestos was used or pollution was happening. Then he must identify the participating insurers on those policies and collect their share of the monies awarded by the judge. Many of those insurers are no longer trading under the same name. Or no longer trading at all. Or if they are still trading somewhere, the broker may well be stuck with collecting their relevant reinsurance for them – again, from reinsurers who may no longer be trading. Und so
welter. The broker’s task suddenly takes on Brobdignadian proportions. Vast armies of staff must be employed to handle it. And vast armies mean vast costs – in salaries, space and facilities.

Unfortunately, this run-off business has no associated brokerage income. So all of these costs must be financed out of ongoing revenue from other sources. Bankruptcy looms.

Enter the PSA, or ‘Placement Service Agreement’, which in due course metamorphosed into the MSA, or ‘Market Services Agreement’. The names were different, but the intent was substantially the same: an agreement whereby, in addition to the fee or brokerage paid up-front by the client to the broker – and known to the client at the outset – the insurer would pay an additional ‘overrider’. The overrider would amount to (say) 2 – 5% of the total premium volume placed by the broker with that insurer. A higher percentage might apply for renewal business, and an even higher percentage could be charged if certain revenue targets were achieved.

Some insurers saw nothing inherently wrong in the concept and signed up pretty quickly. Over time, others came to the view that this ‘double-dipping’ was probably all right as long as it was disclosed to the client. Still others thundered that it simply wasn’t right and refused to participate at all. Very soon, as a simple matter of survival in times of exploding costs and thin revenues, brokers started to concentrate business with those underwriters who participated in PSA arrangements.

Over the past half-decade or so, a new generation of brokers and underwriters has come up through the ranks. As this happened, the PSAs became subject to what the American military describes as ‘mission creep’. That is to say, the original purpose of ‘simple survival’ was transmogrified into ‘profit maximisation’. Business would be steered wherever the intermediary stood to profit best.

If everything in Spitzer’s complaint is proven (and, if there are no mitigating circumstances), then the conclusion must be that the brokers took each other over until they controlled enough of the buying market to also be able to control the selling market. Realising that insurance buyers were under pressure to obtain as much insurance cover and insurance advice as possible for as little money as possible, the brokers logically concluded that their only hope of increasing their revenues was to tap into the sellers. As the trusted agent of the buyer, the brokers controlled what was bought and from whom. It was they who decided whether an underwriter’s business expanded or shrank – who ate and who starved. If the broker chose to rig the bids, then participating insurers - having once agreed to the Devil’s deal (as epitomised by the PSAs) – saw no option other than to cooperate. Although some of Mr Spitzer’s allegations smack unpleasantly of the biggest kid on the block bullying
his gang into line, reality may have been that it was easy for everyone. The underwriter profited, the broker profited and the client … well, the client didn’t know the difference and therefore probably never felt the [financial] pain. As for non-participants: they gradually found themselves starving on the moral high ground.

If one looks back to the Sharma report, the entire story can be subsumed under some of the headings his group identified:

- **Strategic risk:** Without consciously thinking about it, management decided to fundamentally change the business model in a manner which will probably turn out to have been extremely ill-advised.

- **Operational risk – Internal governance and risk control:** There are two elements of outrage in this saga. One is the allegation of bid-rigging, which is almost certainly illegal and probably criminal. The other is the issue of non-disclosure. Several of the more squeamish PSA participants seem to have believed that Marsh had originally promised that the additional commission would be disclosed to the [paying] clients. They now say that Marsh failed to do so because it claimed (somewhat disingenuously) that the PSA/MSA payments could not be specifically attributed to any one client – and therefore could not be accurately disclosed. Surely, warning bells ought to have gone off somewhere on the senior management floor.

- **Stupidity risk:** Even the most foolish embezzler knows better than to document his intention of getting his hand as deeply into the cash-till as possible. And yet such documentation appears to be precisely what Mr Spitzer has discovered.

Conclusion: a lot of people in the industry must indeed have been out to lunch and off to the races with Dodgy Cousin Jasper.

**And over here?**

The British FSA has launched an investigation of its own into the PSA/MSA story. No doubt, it will find a few smoking guns, because America has a distressing habit of exporting some of its less savoury ideas. But it’s worth remembering that the FSA doesn’t go on official watch for insurance broking until 2005. And its regime will be very different from the *laissez-faire* old-boy network which has hitherto characterised the industry.

Notwithstanding this, regulator-bashing will no doubt be the order of the day in the UK as it is in the US.
Where do we go from here?

Shirley burns her bridges

From a regulator’s point of view, it must sometimes seem as though the insurance market is so badly broken as to be past repair. Maybe that’s true, but there are a few things – contentious and unpopular though they may be – that should be considered. At the risk of damaging my own career prospects within the industry I love, let me put a few thoughts on the table.

The first thing is to put aside the notion that, just because something has been done in a certain way since Biggles was in prep school, that is the way it must be. Spanish practices are rife in the insurance sector – and any regulator worth his salt has got to tackle them.

Recommendation one . . .

Perhaps the easiest win would be to segregate the assets and liabilities associated with consumer insurance. A regulator can look like a hero to Mr and Mrs Average-Homeowner simply by demanding that the assets associated with the retail insurance consumer should be ring-fenced.

. . . two

He could also start by specifying minimum standards of cover which must be extended to the retail insurance customer in the areas of:

- household insurance;
- vehicle insurance;
- third party liability; and
- accident insurance.

. . . three

Because this is the one area where claims statistics are reasonably reliable, the regulator could also require that reserves be set to a 99.9% confidence interval. In addition, each company might be required to maintain an escrow reserve of an extra 10%. Half of this could be used to cover catastrophic events. The other half would be set aside for the possibility that a fellow retail insurer might go bankrupt. In such a case, the survivor companies would be required to contribute cash out of escrow in proportion to their market share to cover retail losses.
Insurers will of course insist that it is uneconomic to segregate the portfolio, and that setting aside an extra 10% on top of very conservative reserves will unduly cut into their profit margins. Maybe, but retail insurance business is generally extremely profitable. So profitable in fact that it often cross-subsidises a company’s industrial portfolio. Therefore, segregating the retail portfolio should result in lower premiums for householders, while industry’s premiums would probably increase to reflect its true share of the overall risk pool.

This sounds reasonable (to me). But don’t underestimate how contentious it would be within the industry. Plus, there is a “joined-up thinking” issue; if these measures were pushed through, it would also be necessary to involve two other interested parties:

- **the Inland Revenue** (in the US, the IRS) – which must be told that these extra reserves are not profit (and therefore not taxable); and

- **the accountants** – who must be made to understand that there is a reason that the retail portion of the portfolio is segregated from the rest of the company, and that in the event of bankruptcy nobody has any claim on those monies until every single retail policy has run off and every single retail insurance claim has been settled.

**...four**

In light of Mr Spitzer’s allegations in the insurance/reinsurance broking area, a number of fairly draconian measures push themselves to the forefront:

- brokers should only accept fees or brokerage payments from the client – and where they receive any other compensation, they must be required to disclose it in writing to the client, stating the amounts received to the nearest penny;

- underwriters should be obliged to quote only net premiums to brokers, which net figures must be disclosed at all times to clients; and

- given that brokers are equally victimised by the long latency problems of the insurance industry, they too should be subject to a capital requirement – perhaps calculated in a manner similar to that proposed for Independent Financial Advisers under new EU rules.

**...five**

The ‘fit and proper’ regime currently operated by the FSA in relation to other financial services should be extended to both brokers and underwriters.

**What else can be done?**
In my opinion, the level of ignorance about insurance – even amongst financial
sophisticates – is astonishing. Worse – as I hope I have made clear – this ignorance
is compounded by a semi-rational gut-feel that anyone who knows anything about
banking knows enough to get by in the insurance area. After all, banking and
insurance are just two slices of the great financial services pie, aren’t they?

Well, not exactly. I am firmly convinced that the repeated analogies with banking are
taking insurance – and insurance regulation in particular – in the wrong direction.
What we have to do is make people understand insurance, qua insurance – not as a
pale imitation of banking. And to make it a more professional discipline – not a
dumping ground for not-so-bright public school types. (Though, to be fair, that image
was always a distortion of the truth; there are some very bright people in the
insurance industry.)

This starts with education. Non-university insurance diplomas are already on offer in
several countries around the world – some enjoying a greater degree of recognition
than others. Germany has its ‘Diplomierter Versicherungskaufmann’, France has its
‘Diplome d’Assurances’, etc. The British Chartered Insurance Institute offers a
comprehensive and very widely recognised diploma. So there is certainly plenty of
education on offer, but:

- there is still, to my knowledge, no university business diploma exclusively
devoted to insurance;

- there is no specific requirement for a senior executive in insurance to hold
any kind of relevant educational qualification; and

- there is no requirement for a senior executive to have any experience of
insurance ‘at the coal face’ – which means that the people who make
strategic decisions often do so in total disconnection from the reality of
their company.

I don’t want to sound like the sort of saddo who thinks that a university degree (or
degrees) is the answer to a real-world problem, or that bits of paper guarantee
managerial competence. But I do believe that, in an industry as important as
insurance, it is reasonable to insist that:

- any executive intending to take a position involving strategic, management
and/or underwriting responsibility should hold an insurance diploma
recognised in the country where his company has its headquarters; and
any executive going above middle management must have at least five years’ experience ‘at the business coal face’.

The challenge for regulators will then be:

- to set the minimum standards to be met for diploma recognition;
- to agree international “passporting” of diplomas; and
- to embed the experience requirement in the ‘Fit and Proper’ tests of the national prudential regime.

And of course to placate an industry lobby that will be outraged at the idea that the way it has been run for two hundred years maybe ought to change.

That brings me to what I am afraid is likely to be my most unpopular recommendation.

...seven

Much space has been devoted to the difficulties of claims handling and claims reserving. The fact is that no regulator can ever hope to judge the adequacy of a company’s reserves with any degree of confidence. Nor can a regulator easily develop a view of the speed with which claims develop, get paid and go away.

The only people who are really equipped to judge the adequacy of a company’s reserves are claims specialists and actuaries. But no regulator worthy of the name is going to ask an actuary to self-certify his own work. Claims specialists in turn tend to be held in relatively low regard by the industry. (A glance at the job ads in the industry will underline the point: a claims specialist with X years’ experience can expect to earn not more than 60% of the salary paid to an underwriter of comparable experience.) And yet between them, claims specialists and actuaries combine the expertise to fix a company’s claims reserves – and thereby indirectly decide its survival.

These then are the people who should be charged with ascertaining the adequacy of a company’s claims reserves. Not of their own company’s claims reserves, however. After all, the boss is still looming in the background.

Instead, I suggest that each company should be required to provide a team of actuaries and claims specialists. These teams would be charged with an annual peer review of a competing company’s claims reserves. They would be required to certify
the adequacy of those reserves. And that certification would form part of the ‘true and fair’ attestation in each company’s annual report.

I am aware that this proposal will go down like a lead balloon in parts of the industry. But I really cannot see an alternative. Certainly, this isn’t a task for consultants, whose Pavlovian response is to produce the “right” answer for whoever pays them. Plus, there is, I believe, a considerable upside.

Peer-reviewing the claims reserving of competitors will mean that:

- claims specialists and actuaries develop greater expertise to apply to their own claims;

- claims reserves over time should settle at a fairly uniform (and adequate) level across the industry; and

- greater transparency of statistical methods will prevail.

Insurers are going to hate this idea. Claims reserves are like a miser’s gold. As long as the miser is not actually forced to allow someone else to count the coins, he can claim to be richer (or poorer) than he is. Similarly, the CEO – struggling to keep analysts and rating agencies and accountants happy – would have them all believe that the company is just rich enough, but not too rich. When the definition of ‘rich enough’ becomes universally visible, the balancing act becomes more difficult.

The challenge for regulators will be

- to design a system of annually rotating peer reviews between teams from rival companies;

- to encourage the training of expert staff so as to create a sufficiently large ‘militia’ resource; and

- to convince the accountancy profession of the necessity for the true and fair attestation.

Here, and almost equally contentiously, I also believe that the insurance industry would benefit from creating the same kind of data bases that are now fairly common in the banking industry.
When JP Morgan first published RiskMetrics, the banking industry thought it was committing corporate suicide. After all, if information was (as everyone believed) a competitive advantage, who would possibly share it out freely? In fact, the publication of RiskMetrics was an act of enlightened self-interest. It forced other banks to raise their game, to analyse risk better and to recognise trends as they developed.

The insurance industry has not to date benefited from a similarly visionary step. Regulators would do well to encourage – forcefully if need be – national bodies to build shared databases. Make no mistake, this will be an uphill battle. First, all insurers tell each other that they have ‘great’ loss data. If they were forced to share, they know full well that they would reveal that the emperor has no clothes. Second, as we have seen above, clean loss data can take a long time to solidify. Unless someone (the regulator) puts his foot down, there would be endless actuarial wrangles as to which number is the real loss, crystallised at which point in time, entered into the databases when (and by whom). Third, the Competition Commissioners are always lurking in corners. Anywhere two or more insurance rivals gather to exchange information, the competition authorities smell collusion – which may carry criminal penalties for CEOs. This tends to keep insurers far away from each other. More joined-up thinking is needed here. After all, when there is adequate data available, the price and value of insurance will be more readily visible. Such transparency, I believe, can only be good for both buyers and sellers of insurance.

And that brings me to my last couple of points – ones that I know will also be contentious. We have got to do something about reinsurance.

Swiss Re has published studies over the years which indicate that 70% of the world’s reinsurance premiums sooner or later – directly or indirectly – wind up concentrated on six or seven balance sheets. (The remaining 30% is split among several dozen smaller firms.) The latest of these studies – sigma 5/2003 – makes for interesting (and sobering) reading.

Those six or seven balance sheets represent a huge systemic risk. In addition to other regulatory measures, it must, therefore, be sensible to require that:

- a company wishing to engage in reinsurance should be specially licensed to do so;

- no company or group of companies licensed to transact reinsurance should transact primary insurance;
- in addition to peer-review of claims reserves, reinsurers should be required to audit and certify the accumulations in each others’ treaties; and finally

- reinsurance companies (or groups) should be required to hold a much greater solvency reserve than primary insurance companies – perhaps two or three times as much to reflect the risks they are taking on.

Until such time as the opaque practices discussed above disappear altogether, the only way to ensure the solidity of reinsurers – and the viability of insurance – is to keep lots of wonga on hand. Much much more wonga than appears to be proposed in the latest EU draft.

Having made myself thoroughly unpopular within the industry, I may just as well conclude by making myself unpopular with regulators.

Most of the regulators currently being shoved willy nilly into the regulation of insurance come from a banking or a life insurance background. And that’s just not good enough. Whereas most people are generally honest, what keeps them honest is the fear of getting caught. As we’ve seen above, insurance has so many angles and blind alleys that only insurance insiders can be expected to separate harmless insurance idiosyncracies from genuinely inimical practices. The industry will never be successfully regulated until there are some real practitioners on the regulatory team. Perhaps they could be retired practitioners, or young turks on their way up the corporate ladder and ‘loaned out’ to the regulator as part of their career grooming. But, if at least a few poachers aren’t turned into gamekeepers, the insurance industry will continue as is – until it poaches itself to extinction.
Shirley Beglinger started her career at Credit Suisse in Zurich as a fixed income trader, before moving into private banking. In 1984, she joined GAM Global Asset Management – now part of UBS – in fund management. She joined Swiss Re in 1988, and gathered ample experience in both insurance and reinsurance practice. Since 1995, she has specialised in all types of financial institutions underwriting. Shirley spearheaded Swiss Re’s efforts to gain recognition in the Basel 2 process for insurance as a mitigant of operational risk. She recently resigned her post as a managing director of Swiss Re, and is currently on sabbatical.
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Internet and Financial Services: a CSFI report. In-depth analysis of the industry’s key sectors. Please order through City & Financial Publishing. Tel: 01483-720707 Fax: 01483 740603. £45/$75


“Sizing up the City - London’s ranking as a financial centre” An assessment of London’s competitiveness as a financial centre. By David Lascelles. June 2003. Published by the Corporation of London £25/$40/€40
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