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PANEL DISCUSSION

PROPERTY AND CASUALTY INSURANCE

Panel Members:

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The subject will be discussed broadly under the following subdivisions:

1. Rate-making
2. Claim Control
3. Marketing
4. Adequacy of Facilities

Emphasis will be placed on matters of special interest to actuaries or presenting a contrast to life insurance.

HAROLD R. LAWSON:

It is a new departure for the Society of Actuaries to have a discussion of the property and casualty insurance business. The three guests on the panel—Mr. Smith, Mr. Schloss, and Mr. Curry—are members of the Casualty Actuarial Society, of which Mr. Curry is the president.

I think that there is a wide general interest on the part of our membership in the subject of property and casualty insurance.

SEYMOUR E. SMITH:

I am a bit abashed at discussing the subject of rate-making before this audience. I think that it is somewhat of an open secret that our success in pricing our product in recent years has been a little less than spectacular.

I thought that it might be more helpful if, instead of attempting to discuss the technical aspects involved in rate-making in the casualty and property business, I would briefly and lightly mention some of the concepts and problems the rate-maker faces in our area of insurance which are quite different from those faced by the actuary and underwriter in life insurance.

One of the major differences is that in the casualty and property business the rate-maker works with a wide spectrum of rather disparate

insurance coverages. He has to cope with everything from fire insurance and extended coverage or windstorm insurance to that magnificently titled coverage "inland marine," which embraces such diverse risks as bridges, goods in transit, radio towers, contractors' equipment, jewelry—almost anything you can name.

He has to price burglary insurance, glass insurance, boiler and machinery insurance, fidelity bonds, surety bonds, and workmen's compensation coverages. Then there are general liability coverages, running the gamut from hazards of elevators to product liability on drugs, cosmetics, and almost any product that is manufactured. And, finally, he has to cope with the more well-known problem of automobile insurance.

Within this framework of wide and disparate coverages, we also are concerned with the particular size of the exposure. This ranges from the small individual risk, such as the individual householder or the individual automobile-owner, all the way up to the country's major manufacturing corporations.

Of particular difference, when compared with life insurance, are the short-term contracts with which we deal. The frequency of the relatively substantial changes in rates, and of changes in hazards, require that our business essentially be of a very short-term nature.

The losses that go into our rate-making are heavily influenced by external factors. Social, economic, and physical changes can all impinge upon our results and thus can change drastically and rapidly in a short period of time.

I realize that there are changes in mortality and morbidity, but I doubt very much that you would anticipate changes in the nature of 20, 30, 40, and 50 per cent within a one-, two-, or three-year period.

Our short-term contracts are also necessitated by the relatively frequently changing requirements for coverage, also quite different from life insurance. The coverage needs, limits of liability, amounts of insurance, and physical changes in the property of manufacturing processes which we ensure, often require very substantial changes in short periods of time.

We also have rather wide-ranging loss potentials when compared to the relatively fixed obligations that you gentlemen deal with in life insurance. In general liability insurance, for example, an event will occur. The cost of that event, if carried to litigation, can range from zero, in the event of a successful court verdict, to several hundreds of thousands of dollars, in the event of an adverse one.

In fire insurance, an event can occur which can result in a waste-

basket fire costing $5 or $10 or the destruction of an entire plant running into several millions of dollars.

While you gentlemen do have to consider the possibility of catastrophes in the nature of epidemics and so forth, those that we face are more frequent and their potential, in size, is rather dramatic. I would just mention Hurricane Betsy, which, as near as we can ascertain, cost the insurance industry $700 million.

In dealing with the insurance hazard, we have two measures affecting loss—the frequency with which an event occurs and the severity of the loss. These two measures are both subject to rather substantial changes within short periods of time and must be considered severally and jointly in evolving rates.

We have another situation which differs rather materially from life and accident insurance. I refer to the wide-ranging measurement of loss by geographic or political subdivision or by types of occupation. I realize that you have these differences also; but, as I understand it, mortality experience in Seattle, St. Louis, or Philadelphia is not particularly different, nor would you expect it to be, whereas in automobile insurance, for instance, a relatively few miles of distance between two towns will produce loss hazards in rates varying by several hundred per cent.

With this wide range of hazards and the disparity of loss potential broken down to so many small groupings, we have the problem of developing a solid statistical base from which to operate. The statistics required to meet our business needs are in such detail that in very few areas are we able to develop a data base similar to your mortality studies.

In workmen's compensation insurance, in private-passenger automobile insurance, and in the insurance of private residences, we have fairly good statistical data. There are enough units of exposure, and they are sufficiently uniform within a reasonable degree with regard to their size, that the statistical base from which we operate is reasonably good.

In most of the other areas of our insurance operation, however, the limitation on statistics is such that we must have a very large degree of underwriting judgment in the determination of our rates. This presents problems of judgment, and it presents competitive problems, too, since judgment and the market place cannot be separated. It also presents problems under our rate regulatory pattern.

We have another history in our business which reflects itself in the statistics available to us. For many years in the *casualty* coverages, the tendency was for an insurance company either to accept the risk in its entirety or to reject it in its entirety. As a result, to operate successfully,

companies had to develop statistics reflecting size of loss. As the limit of liability increased, data were accumulated which gave reasonable yardsticks for determining the price for each additional unit of liability.

The property business, historically, did not develop that way. With the exception of the small risk, property underwriting over the last hundred years evolved from the underwriter's determining how much of the total exposure he would accept. It was not at all uncommon on a warehouse or factory of any size for ten, fifteen, or twenty companies each to have a small percentage of the total hazard. This was not covered in layers of liability but on a pro rata basis, so that, for example, if there were ten companies on the risk and there was a $10,000 loss, each company contributed $1,000. Since each company treated this as a $1,000 loss, experience by size of loss, or $10,000 in this case, was not available. With marketing conditions changing so that the underwriting of property business more nearly approaches the historical casualty system, we find ourselves dealing with an inadequate statistical base.

In our liability coverages we have another statistical problem that is rather unique. In this area the statistical period with which we must deal very often reflects a very sizable amount of losses that are still not settled and for which reserves which have been established on a judgment basis may or may not turn out to be adequate with the passage of time. This situation contributes very drastically to the statistical problem of the rate-maker.

We have an additional problem in that, with our rapidly changing hazards, the time that it takes to accumulate statistics often makes rates out-of-date. Thus, they do not necessarily reflect the future impact of the external political, social, and physical changes which will influence the losses that we cover. There is a growing awareness among actuaries in the casualty and property business that we need substantial *external* statistical indicators to bring to bear upon this problem.

Historically, we have two types of rate-making in our business. One is rate-making in concert; the other is rate-making for the independent filing. Until approximately twenty years ago the great bulk of rate-making was done in concert through rating bureaus, in which a large number of companies pooled their experiences, their talents, and their judgment to determine rates. Within recent years, independent filings have become a very major part of our business, and the rate-making function has thus changed considerably.

Rates developed in concert must be as appropriate as possible for a large group of companies, even though they may have rather considerable differences in their individual operations.

Rates developed for independent filing are different, in that the rate-maker must be keenly aware of the underwriting policy and performance of *his* particular company. The loss hazard materially changes, depending upon the underwriting approach used, the degree of selectivity, and the engineering talent that is brought to bear in preventing losses.

Our rate-making, as I indicated before, covers the spectrum from *manual* rates, which are developed for individual risks by the averaging process for a great many similar hazards, to *individual risk rate-making* for the large industrial accounts.

Our experience has indicated—and I am sure that this is rather common in group insurance—that there is a wide range of hazards between individual risks reflecting management, processes, and a wide variety of rather nebulous factors.

In approaching this problem, we have what we call experience rating, retrospective rating, and schedule rating. Experience rating essentially measures the losses and the exposures of the recent past and assumes that the same relationship will continue into the immediate future. It is prospective rating. Retrospective rating is, as the name implies, the adjustment of the rate following the expiration of the contract, reflecting the risk's actual experience. Schedule rating falls into two classes. In the property business, it is an attempt to measure the physical hazards involved in building; in casualty insurance, it tends to reflect the judgment of the underwriter.

Finally, we differ from life insurance in that the rate regulatory problems with which we must deal are somewhat different from yours. We have a wide variety of rate regulatory laws around the country, ranging from the California type of law which, in effect, permits a company to develop and use its own rates to that existing in some states where the state actually makes rates for us.

In the great bulk of our business, we have what we call prior-approval laws, under which the rate-maker must file his proposed rate with the rate regulatory authority and *wait* upon approval before use. This presents some very practical problems in many areas. While the intent of this type of statute was sound, it did not work out in practice. The intent was to have the rate-maker prove his point. When he changed his rates, he was the one who had to bear the burden of proof. Unfortunately, in many states the reaction of the public, of the press, of the governor, and of the legislature to rate increases has so pressured the insurance commissioner to second-guess the rate-filer that needed increases have in many instances been very hard to come by.

It is intriguing, at times, to observe the degrees of ingenuity with

which a rate-regulator can justify disapproval of a rate-filing. In one state, not too many years ago, there was a request for a rather substantial increase in automobile rates. The regulatory authorities pointed out that at that point of time there was a certain degree of political unrest in Saudi Arabia, that it was at least conceivable that this unrest could get out of hand, and that this might have some impact upon the flow of oil. It was even conceivable that the people in that state might not be able to get as much gasoline as they had in the past and therefore the rate increase was unnecessary.

Basically, all the woes—if I may use that term—that our business has had in recent years reflect our greatest problem—price inflation. Inflation has forced us to increase our rates for almost all lines of insurance in almost all jurisdictions and at frequent intervals.

The statistical imperfections with which we must deal, the regulatory problems that we must face, the necessary judgment in trying to anticipate the impact of changing social and economic conditions—these have been rather less than perfect in actual performance.

There is one other aspect that I might mention. As I understand it, in life insurance and in health and accident insurance, the use of investment income in rate-making has always been an accepted practice. I am sure that those of you who look at the trade press are aware that in the casualty-property business, however, the role of investment income is a highly emotional issue, something akin to Viet-Nam or the Great Society. It is very easy to oversimplify, but just one individual's point of view might be helpful in understanding why this is such a hot issue.

Historically, in the casualty and property business within regulatory ranks, within rate-making ranks, levels of profit loading in rates have evolved which are considered acceptable. By and large, these have ranged from 2½ per cent on workmen's compensation to 5 or 6 per cent on the property lines. People were accustomed to this type of loading in the rates for profit, and it was considered generally acceptable under the rate regulatory laws. Yet, when one stops to think about it, this is an entirely inadequate return.

While individual companies *do* have substantial variations in the relationship of their premium volume to their surplus funds, as a general rule of thumb within our industry, it usually works out that companies should maintain a relationship of about 2 to 1, premiums to surplus.

If you take a 5 per cent profit margin as the maximum attainable, on an after-tax basis the return on stockholders' equity would be totally inadequate to produce the necessary funds for risk capital in our business. We *need* the additional amounts of investment income.

My own belief is that, if investment income were to be taken into account in our rate-making, it would require a substantial adjustment in our profit margin to produce a proper return, and, consequently, we would merely be going through a rather futile exercise.

HAROLD W. SCHLOSS:

One of the barriers to our two professions' getting to know one another is the difference in vocabulary. Some of the terms that we use are close enough to be recognized. For example, what we call a "pure premium," you know as a "net premium." We do not use the term "net premium," because that means something else to us.

However, by and large, there are a few common terms, and we have to get to know what we mean. An example of this is the title of this section of the panel, which is called "claims control." In view of the fact that we have just been through the most disastrous year in our history, a casualty actuary making up this program would have phrased it "claims out of control."

In order to appreciate the differences and similarities in the claim picture, you should first understand how our coverages differ from yours. We have some two dozen different lines of business, as defined in the NAIC convention blank. There are scores and scores of sublines and major types of coverages.

In the limited time that I have, I cannot give you even a bird's-eye view; that would be too detailed, and you do not need it. So I will just give you an astronaut's eye view.

From the point of view of claims, there are two types of coverages—first-party coverages and third-party coverages.

The first-party coverages are akin to life insurance. This is where the policyholder himself or his designee becomes the claimant or beneficiary under the policy. Examples of this among the lines that we write would be fire, marine, burglary, and automobile collision insurance.

One difference among our coverages, however, is that your insurance is a valued form. The amount of the benefit is the amount of the insurance. There is no doubt in your mind as to what that is. In the property lines, even though we write a first-party coverage, we do not have, except to a limited extent, the valued form. Thus the amount of the benefit is uncertain.

Most of our losses are partial losses. For example, if you had an automobile collision policy, which we had sold you for one year, and if you had a collision in April, it might cost $150 to pay the claim. If you were to crumple the fender in November, it might cost $160 to pay the claim.

Thus we have quite a range of possible claim payments, as Mr. Smith referred to before.

Historically, we have had two types of companies in the business—fire companies and casualty companies. At present, all of us are multiple-line companies and can write all kinds of insurance, but both these types of companies wrote first-party coverages. The fire companies wrote fire, extended coverage—the principal peril there is windstorm—marine insurance, and automobile physical damage. The casualty companies wrote—as first-party lines—burglary, boiler, machinery, glass, and fidelity insurance.

Another significant difference in our policies (and this applies to the third-party side) is that we write contracts of indemnity. This means that we reimburse our assured for any loss he may suffer. If he is held legally liable and is required to pay, technically we reimburse him. In practice we have gone far beyond the technical indemnity contract. We do not merely reimburse him, we step into his shoes and pay the claim on his behalf. Furthermore, a very important part of the coverage is defense. If he is sued by a third party, we provide him with legal defense.

Against this broad background, I might tell you something of the mechanics of the claim operation in the industry. First of all, it is very highly decentralized; we cannot settle claims from the home office. If a house catches fire, somebody must go out to look at it; it cannot be done remotely. It is necessary to have a man on the scene to ascertain the amount of the damage.

It is a characteristic of first-party insurance that the claim frequencies are relatively low. Companies have difficulty, therefore, in adequately staffing a decentralized operation in an economical fashion. So, except for the very largest companies, most companies will use independent adjusters out in the grass roots to take care of the claims which do arise in the first-party coverages, particularly fire and extended coverage.

The advantage of using independent adjusters also arises in another area. Particularly in the fire business, which started when the reinsurance market was rather rudimentary, there developed an extensive use of coinsurance. If we have a claim or a loss involving a number of companies on the risk, it facilitates matters if a single adjuster handles the claim on behalf of all the companies.

In addition, there can be very large and complex losses in the property field with which the employed staff adjuster might be unacquainted and we would want to use a specialist who is an independent adjuster.

On the other hand, in the third-party field, which covers automobile liability, general liability, and workmen's compensation, the claim fre-

quencies are much greater. There is a larger volume of claims, and companies can economically afford to staff their own offices.

If there is a suit involved, the company's practice is usually to retain a local attorney. In the large urban centers, such as New York, Chicago, or Boston, a large company might have a sufficient volume to have an employed, salaried attorney on the staff to handle these third-party suits.

You have a potential epidemic problem. We have actual epidemic problems, and we have perhaps ten to twenty each year. We call these catastrophes. We have various definitions for catastrophes in use in our rating approaches, but statistically we define a catastrophe as an event that creates an insured loss of $1 million or more. This will include single large losses, which are rather prevalent in the property field. I can recall one fire loss in excess of $30 million. But the epidemic analogy relates rather to the case where a single event calls for a multiplicity of losses.

Mr. Smith referred to Hurricane Betsy, which is a very conspicuous example of a large catastrophe. Less prominent are the minor catastrophes—that is an anomalous term—which might run a little in excess of $1 million. The most common of these are tornadoes in the Midwest and Southwest, which, because they have a very narrow path, very narrow length, and usually strike areas that are not heavily settled, may run to one, two, or three million dollars.

Most of our catastrophes occur in the extended-coverage line because they arise from the peril of wind. We are now running into situations arising out of the civil rights demonstrations, because we do provide coverage for riot and civil commotion. The Watts area riots in Los Angeles ranked as a catastrophe statistically—as well as by other criteria—because they caused insured losses in excess of $1 million.

Catastrophes strike us in other lines of business. They strike us in automobile physical damage because many automobiles are damaged in connection with a hurricane. Hurricanes are a major problem because they strike the heavily populated East Coast and Gulf Coast, and these run over $100 million, sometimes less but often more.

Hurricane Betsy, which generated more than 500,000 claims in the 48–72-hour period in which the wind blew, severely taxed our claim facilities. Since we have a widely decentralized operation, you might be interested in how the industry handled Hurricane Betsy.

The industry has what amounts to almost a paramilitary operation. As soon as the winds stopped blowing, there were staff adjusters and independent adjusters flying into New Orleans from all parts of the country. There was a tremendous amount of damage; a lot of work had to be done. When a claimant has some damage and he is insured, he

usually wants to be paid yesterday. Notwithstanding the fact that there were no building materials in New Orleans and there was not sufficient contracting labor, everybody wanted his claim paid. I think that it is rather remarkable that this backlog of half a million claims was cleaned up in about a three- or four-month period.

The claims which provide the greatest contrast with your own are the third-party claims; these are principally automobile, bodily injury, and general liability claims and are very difficult to evaluate.

I must repeat that we do not have valued forms. The problem is how to value a claim—a third-party claim—when there is not even a possibility of appraising property damage. For example, how do you value facial damage to a young girl who is hurt in an automobile accident? How do you value the damage to orphans when their parents are killed in an automobile accident? As difficult as it is, we must do exactly that, both for rating purposes and to establish our company's liabilities on our books.

Not only are they difficult to evaluate, but they also require an extremely long period of time to settle. They often involve litigation, and they are very strongly influenced by inflation. Litigation is a fact of life for us, but it must be strange to you. You pay your claims promptly and without too much trouble.

Against only the four companies represented here on the panel—Travelers, Glens Falls, Royal, and State Farm—there were pending, at the end of last year, 90,000 suits arising out of automobile accidents causing bodily injury liability. There were also other suits involving general liability and automobile property damage. You may think that this situation arises because we do not like to pay claims—and maybe you would think so even more if you had ever been a claimant. But the fact is that we do not control the suits. Since these claims are so difficult to evaluate and since there must be an element of negotiation between the claimant and the company, many suits are filed merely as a technical matter to give negotiating strength to the plaintiff's attorney.

Most suits are settled and do not actually go to court. Of those relatively few suits that go to court, many are settled in the course of the trial; there are very few that go to an ultimate judicial determination.

We have become almost immune to the litigation situation. You can see that the casualty insurance companies support a very considerable proportion of the American Bar.

Another interesting thing is that these suits tend to come in late; that is, they are reported rather late. It is not uncommon for a claim to be made on liability coverages one year after the accident has occurred, or

two or three years. This makes it rather difficult for us to settle these claims quickly, as we would like to do.

On an average, it takes a casualty company two years to settle an automobile bodily injury claim. I am talking of the average in the sense of dollars of claim; based on the number of cases, the average settlement time is much shorter. The small ones are settled very quickly, but it is the larger, more serious ones that may be involved in litigation that take a long time.

This is the reason that these cases are so susceptible to inflation. Every claim man must decide whether he should settle the case today for a thousand dollars or take his chances of settling it next year for eleven hundred dollars. The quickest way to the poorhouse is for a company to pay every claim demanded. The second quickest way is to fight every case all the way up to the Supreme Court. So every company must develop its own philosophy of claim-handling, must decide what degrees of stringency it will impose; with three or four exceptions, I think that every company that I know of does a fair job of balancing the interests and obligations of its policyholders. I say policyholders, because they pay the claims; we are just the conduit. It is not fair to the policyholders if we overpay claims.

We like to refer to some of these things that we do in our field as the practice of actuarial science. But one very important thing is the valuation of loss reserves, and I think a better term in reference to that would be "actuarial art," because nowhere is a broad background, experience, and sound judgment more vital.

Because we have the problem of cases being reported late, the actuary is often concerned with setting up reserves for incurred but unreported losses. I think that, because of the nature of our claims, this is proportionately heavier for us than it is for you. But by far the overwhelming bulk of our loss reserves is for cases in the course of settlement.

There are two broad methods for establishing these reserves. There is a host of statistical methods being used and now being developed, and the trend is in that direction. But, for most companies, in most cases there are individual case estimates made by claims examiners or claims people in the claims department to establish these. Even though the actuary does not establish these reserves, it is his responsibility to analyze them and to determine their position. They are only estimates. The odds are against the estimates or the reserves exactly matching the company's liability; they are either over or under. Unless an actuary does this, his management simply cannot appraise the underwriting results of the

company, nor can they appraise the surplus position of the company.

Let me give you a quick arithmetic example. If a company initially had a loss reserve position of $300 million with an equity of 5 per cent—by equity, I mean the margin between the company's reserves and its actual liabilities—and this equity slipped to 4 per cent, the company's reported statutory result would have been improved by $3 million.

In current underwriting conditions, where profit margins are nonexistent, it is obvious that this type of thing can mean the difference between profit and loss to a company. Every company must know what is happening to its loss reserves. I think that this fact is too little appreciated, even within the industry, and certainly without the industry.

Those of you who are with stock companies know that security analysts tend to make adjustments to your reported earnings and to your surplus. They make similar adjustments in the case of casualty companies, but I have never seen anyone refer to this concept of the equity in loss reserve or attempt to make any adjustment. Maybe they are not aware of it, or maybe, because it is so difficult, they do not get into it.

I will just cover one more topic at this time. I understand that there is a section in the New York law which frustrates some life actuaries and makes them unhappy. I think that it is called Section 213. We do not have expense-limitation restrictions, but we do have a provision in many state laws—over a dozen, I believe—which we call the Schedule P provision; it relates to loss reserves. We call it the Schedule P provision because the mechanics of accomplishing what the laws provide are set forth in Schedule P of our convention blank.

Essentially it is a minimum reserve law. It applies to automobile liability, general liability, and workmen's compensation. These are the lines of business in which it is most difficult to evaluate accurately a claim, particularly in the early stages. Casualty actuaries have long complained about this schedule, and we have talked much about it, but we have learned to live with it. It really does not do us any harm. Actuarially it is quite weak; it is very ineffective and does not do the job that it was designed to do.

Without going into detail, let me give you just one example. Essentially it provides that, on policies written in recent periods, enough loss reserve shall be carried so that the company shall report a loss ratio of 60 per cent for automobile bodily injury liability. Since experience has deteriorated sharply and many companies are reporting loss ratios in the 70's, it is quite apparent that Schedule P itself does not give a regulatory official any signal that a company is heading into trouble by under-reserving.

We have had our problems with this, and efforts that we have made to change it have been met by the response of the NAIC that, after all, these are statutory formulas. We even changed our approach and tried to get the statutes repealed, with regulatory powers given to the commissioner instead to formulate minimum reserve requirements. The response to this was that they could not support our efforts to repeal these laws unless we had an adequate substitute. We are still working on this. We still do not think that there should be a statutory formula in the law because it is too rigid and does not reflect the changing conditions of business. But, in any event, we have not yet been able to arrive at a substitute formula that satisfies the regulatory officials.

Last year I spoke about this to an NAIC Committee, reminding them that it was the fiftieth anniversary of actuarial criticism of Schedule P, which started back in 1915. Over the years we have done some tinkering with it. We had to tinker with it a few years ago, because there are other liability forms being written, such as homeowners' policies, which were never contemplated when the Schedule P statutes were written and yet certain losses have the same characteristics with which Schedule P is supposed to cope.

We have not given up, however, and we are hopeful that some day soon we may get some real reform in this area.

HAROLD E. CURRY:

Inasmuch as virtually all my insurance career has been spent in the area of rate-making, I think that my competence in the discussion of marketing can hardly be challenged. Obviously I will not be fettered by any numerous experiences in the sales field, and I can consider the matter with complete objectivity.

In one of his letters of instruction regarding preparation for this panel, Mr. Lawson suggested that I might present the position of the direct writers. I am not too sure just what a direct writer is. If you are referring to a direct writer as a company whose agents operate exclusively for them, might I suggest that there are life companies in this room which are also direct writers.

Judging from the record of the so-called direct writers in the property and casualty field, I do not think that I should take much time in defending their type of operation. I would merely refer you to the historical record of distribution of the companies in this category and let you draw your own conclusions as to whether or not direct writing is a method of distribution that is satisfactory and pleasing to the buying public.

Having referred to the direct writers, perhaps I should make a comment or two with respect to sales organizations in general.

I happen to be of the conviction that, as an industry, our ultimate objective is to attract as many policyholders as we can, serve them well, and through this service grow in prominence, as the years flow by, as a source of the peace of mind that sound insurance fosters. If this is a valid point of view, it seems to me that we waste a lot of energy debating about what type of distribution system is to be used. I cannot think of anything of less interest to a prospect for insurance coverage than the method for compensating the agent or whether he has an ownership in the renewals. The prospect is seeking sound coverage in a financially strong company that bears a reputation for treating its policyholders equitably and will render service when the need arises.

During my own experience of buying insurance of various kinds over my lifetime, I have purchased policies directly by mail, I have purchased them through agencies, and I have purchased them from representatives of so-called direct writers. During my lifetime, too, I have changed locations a number of times, and I can only report that there is one entity in the entire sequence of changes of location which has maintained a continuing interest in where I am located and that I continue to pay my premiums regularly—that is, the underwriting company.

In each instance, and in every communication that I have received, these communications emanate from the home office of the company and not from an agency or from an individual. To me this points up the necessity of a company's establishing and maintaining a direct line of communication with its insureds, regardless of what distribution system is used.

In determining the type of distribution system that a company intends to use, it must carefully evaluate its degree of interest in building and maintaining policyholder loyalty and control over the handling of its business. If it decides that it intends to make a minimum effort to build policyholder loyalty, less attention need be given to the type of distribution system used.

A company operating under the general-agency system relies to a considerable extent on the placing agent to give it an acceptable book of business, because it must compete within the agency for each risk. This is less true for the direct-writing company because of the tendency among such companies to operate on an exclusive agency basis. Under such an arrangement, a company has a better opportunity to acquire a book of business of uniform quality, but the agent may lack some breadth in the range of risks that he can write. I think that statement will perhaps

create some interesting discussion. At least, in preparing for this panel in a sort of dry run that we had, I found that there are some differences of view among the members of the panel. Fortunately, we live in a country where differences of view do not result in decapitation. Friendly debate, I think, is fine. I respect their right to be wrong in their opinions.

In recent years the agency limitation, insofar as the breadth of risks accepted is concerned, has somewhat diminished because of the fact that company groups have become more prevalent, with each member of a company group having its own acceptance standards. I am inclined to feel that this is having some influence on policyholder loyalty and that, as time flows on and as this development grows, risks will have a greater tendency to become attached to a company or company group and will be a little more inclined to resist being changed from one company to another. I cannot prove this point, and there are other factors that are involved—some of which are growing in influence—that may prompt a risk to stay with a specific carrier.

It must be borne in mind in the casualty business that policy contracts are issued for relatively short periods of time. That has been referred to by earlier panelists. In the majority of the lines of insurance, the risk is evaluated at each policy expiration. With the current emphasis on individual risk experience influencing the rate charged, there is some encouragement for the better risks to shop around for another carrier and at a better price. The risk with adverse experience is more apt to persist, because it realizes that some difficulty may be encountered in securing comparable coverage elsewhere in a voluntary market.

We find this happening very frequently in the automobile field at the present time. And, as Mr. Schloss and Mr. Smith have both mentioned, we have not been eminently successful in the last few years in showing underwriting profits. This has made it necessary for companies to select their risks with some care, and policyholders are a little inclined to stay with you, particularly if they feel that if they were to leave, having had a bad experience, they could not get insurance elsewhere.

So far as I am aware, there are no recent studies in depth of the relative influence of each of the factors that contribute to policyholder movement from company to company. There have been a number of studies made; I do not think that they are studies too much in depth. I think that it would be interesting if an impartial study could be made, but I do not know whether this is possible; every time that any trade group asks for a study of this sort, ordinarily the firm, if it engaged an outside firm to make the study, recognizes that its compensation may be somewhat influenced by the conclusions that it may reach. It is somewhat like the

lawyer who gets his convictions from the same place that he gets his income.

So any comment that I might make with respect to the factors that contribute to policyholder loyalty or movement from company to company is somewhat theoretical and based largely on casual observations over approximately the past 40 years.

The development of machine methods for processing policies at the time of issuance or at the time of renewal is awakening some consumer interest in the amount of compensation paid to writing agents and the method used in computing it.

In some of the recent rate hearings on automobile insurance filings, representatives of the public—and I use that term somewhat loosely because we wonder sometimes whether the protestants at these rate hearings actually represent the public or just have a personal ax to grind—have raised the question of why the agent's commission should be related to the premium charged on a percentage basis and why, when a rate increase is sought on a basis of adverse loss experience, the agent should receive more dollars of commission via a rate increase.

I do not know whether we have a really good answer to that problem. I think that it is one that we are going to be plagued with. There are ways, of course, that it could be handled, but it would really shake the traditions of our business if we were to cave in to that line of reasoning.

Similar questions have been asked with respect to variations in agents' compensation being based on risk classification. At this moment I think that it is a little difficult for us to predict what the final outcome will be to inquiries of this nature.

Just to clarify a little what I am referring to by risk classification, let us take an example in the automobile insurance field. Ordinarily, risks now, by most companies, are classified on the basis of several factors, such as the age, marital status, sex, the drivers, the type of use of the vehicle, and such things, with rates varying widely. For example, if you take the rate for an adult risk classification at the index of 100, the rate for a youthful, single, male driver who is a principal operator of the vehicle might run as much as $350, $400, or $450. So, there is some question raised of why the agent should get 3, 3½, or 4 times as much for writing insurance on a youthful risk, from which, from past experience, the companies know that they will have difficulty in returning an underwriting profit or even breaking even.

These are questions that are plaguing us now. We do not have the answers to them. We would appreciate suggestions and answers with regard to how these matters can be handled.

There are many, many methods of marketing that are now being used or explored in the casualty and property field. The consumer response to the homeowners' policies that were introduced just a few years ago has stimulated the interest from the market standpoint, and also from the management standpoint, in developing what we might refer to as one-stop insurance marketing centers.

I am inclined to feel that, with the deeper involvement of the life insurance companies in the property and casualty business through their affiliates, this interest has been heightened to some extent and will probably be emphasized still more in the future.

From the buyer's standpoint, I do not think that there is any question but what there is some attractiveness to the buyer, particularly in the personal lines of insurance, in being able to go to one source for all his insurance needs, particularly if those needs can be fulfilled with premium payments spaced to approximate the flow of his earned income.

We might as well recognize that, for the majority of people, income does not come in at one time during the year. It comes periodically from month to month, and they like to allot a fixed amount out of each pay check for the payment of their various obligations.

In one state that I visited some years back, I was impressed with the ads that I saw in the newspapers. None of the ads told how much a refrigerator or an automobile cost in total. Every one of the ads said that these items cost so much a month. If you asked individuals what a refrigerator cost, no one knew, but they did know that it was $4.82 a month.

To me this is a key point that we have to recognize in our insurance distribution and marketing systems, and we have to provide a means whereby the individual can pay his insurance costs as he earns his income.

If the current interest in companies' grouping together and expanding into other lines through affiliates, acquisitions, mergers, and so forth, persists and enlarges, I think that we are faced with the task of a substantial revision in several of our traditional forms of agency training and organization and changes in our policy forms, our premium-collection procedures, and even to some extent in our company affiliations.

I know that most of you are aware of these matters, and I think that, as you get around and visit with other companies, you know that most alert company managements are also deeply engrossed in various studies of them.

One of the subtopics that it was suggested I comment on briefly is the participation of government in insurance. In the casualty and property business, of course, from the standpoint of marketing, rate-making,

claim control, and so on, we have rather careful supervision now from regulatory authorities. You will notice that even on this panel we have authorities to regulate the panel; we cannot get away from regulation, so we might as well learn to live with it. It is not too bad, really.

Particularly in the last twenty years the property and casualty business has been extensively exposed to regulation by state authorities. In most instances this has not created great difficulty, but there are experiences, of course, that have not been too pleasant. Those experiences with regulatory authorities at the state or federal level have tended to make the property and casualty people a little gun-shy of any insurance program that would involve government participation.

In a way, I think that this is unfortunate, because it tends to block an objective consideration of some of the insurance problems in which government participation, if it could be properly contained, might be helpful. The net result is that in our business there are a widespread resistance to government participation in insurance programs and a hearty desire to handle insurance market problems through private channels.

I think that we all have a tendency or liking for running our own show. I think that we like to have as much liberty as possible. I noticed a definition of liberty the other day that is worthy of remembering: "Liberty is not the right to do what you choose; it is the responsibility to do what is right."

CHAIRMAN LAWSON: Mr. Humphrys is now going to talk to us about the ability of the insurance industry to take care of the needs of the insuring public, what we have called on the program, the adequacy of facilities.

RICHARD HUMPHRYS:

Adequacy of facilities really means the capacity of the insurance industry to provide the public with the insurance it wants and needs. Considering the staggering variety of these wants and needs and the variety of coverages that have been designed to meet them, as already outlined by previous speakers, you can see that this is no small task.

The financial resources needed to provide this coverage, particularly having in mind the enormous concentration of risks that is encountered frequently in this industry, are very large indeed.

Mr. Smith mentioned that a general rule of thumb in the industry is that premiums written are about twice the policyholder's equity. By a rapid calculation that is within the easy competence of any actuary, this brings one to the position that the capital and surplus reserve should be about equal to the policy reserves, which is regarded as a good target for

the property and casualty industry. This would be very startling in a life insurance company statement, except, of course, for a brand new company.

The extent of the financial resources that are available in this industry is somewhat obscured because so much of the strengeth is provided on a pooled basis through reinsurance. The vast and intricate network of reinsurance is a very interesting and peculiar feature of the fire and casualty industry. It may be that, if your career started and grew in this industry, you have become quite used to it. You would have cut your teeth on a small quota share treaty, then graduated to a surplus line, and then graduated to catastrophe coverage. But, coming at it fairly cold, I have been very much interested and intrigued by the complexity of the reinsurance network that spreads not only within a nation but over international boundaries. Sometimes I think that it becomes so complex that companies themselves are not too sure how it works out.

The problem of adequate financial resources to provide insurance coverage for insurance needs is quite serious for small countries and developing countries that do not have large amounts of capital available. Such capital as they do have is usually needed to develop their own resources and other facilities, and these do not usually provide good investment opportunities for fire and casualty companies.

Even if the insurance needs are filled or the attempt is made to fill them in the first instance by locally based companies, they cannot hope to provide the facilities without access to the international reinsurance market.

Even in a country such as the United States, with its vast financial resources, the fire and casualty insurance industry spreads coverage throughout the international market on these big risks. Hurricane Betsy was mentioned earlier, and the shock waves from those losses spread throughout the world reinsurance market.

In passing I might mention that this is one of the problems that gives great concern to insurance supervisors—the problem of international reinsurance and trying to see to it that resources are available within a country to meet the claims.

Where insurance facilities just are not available without access to the international market, there is no choice but to make some compromise with these principles. Fortunately, the reinsurance market is very strong and has served the public and the insurance needs in all countries very well. Failures are very rare indeed though they are not unknown.

One of the interesting features of this industry, too, is the very large number of companies, many of them quite small. It is quite possible for a small company to be successful in specialized lines if it limits its risks to

a moderate size compared with its resources and avoids catastrophe hazards. Other medium-sized companies can compete because of access to reinsurance. This sometimes leads, of course, to the consequence in which a company may be little more than an agency of a reinsurance organization. This has a number of problems.

In thinking about adequacy of facilities, I think that we have to go beyond insurance of the very large risks and think about providing coverage for individuals. This has given rise to two serious problems in Canada and the United States in recent years in two lines of insurance, automobile insurance and fire insurance.

In automobile insurance, as has been mentioned, the financial experience has been very bad in recent years, and the rigidity of the rate structure, particularly because of government control of rates, makes it difficult to adjust rates to meet the claims, even if statistics can be developed quickly enough.

Consequently, many companies have tried to improve their underwriting results by adopting more severe underwriting standards and by tending to reject applications that appear to be at all substandard. This has resulted in a number of people's having difficulty getting the insurance that they need which, in turn, gives rise to a number of problems usually voiced through the political representatives of the irate public.

This can produce some rather odd situations. I remember encountering one in which a new driver applied for insurance to a company that had a rule against accepting applications from new drivers. So the applicant turned to another company. The other company did not have a rule against accepting applications from new drivers, but it had a rule against accepting applications from anyone who had been rejected by any other company, so they turned him down, too.

I think this is quite a serious problem for the industry, and I do not believe that the answer is in rejecting the poor risk and trying to share the better risks among the companies. If the public does not get the insurance that it needs through the industry, it will get it some other way. The obvious other way, which seems to be raised from time to time, involves government participation.

The answer must lie in improved rating procedures and adequate adjustments of rates, so that the insurance can be provided on a satisfactory basis. Efforts have been made to solve this problem by assigned-risk plans. They do provide facilities for giving insurance, but these plans have their own problems, since companies sometimes try to push too much into the assigned-risk plan and the public seems to feel that there is some taint attached to that; an unfavorable reaction is the result.