Supervisors' use of key indicators to assess insurer conduct

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About the IAIS

The International Association of Insurance Supervisors (IAIS) is a voluntary membership organisation of insurance supervisors and regulators from more than 200 jurisdictions. The mission of the IAIS is to promote effective and globally consistent supervision of the insurance industry in order to develop and maintain fair, safe and stable insurance markets for the benefit and protection of policyholders and to contribute to global financial stability.

Established in 1994, the IAIS is the international standard-setting body responsible for developing principles, standards and other supporting material for the supervision of the insurance sector and assisting in their implementation. The IAIS also provides a forum for Members to share their experiences and understanding of insurance supervision and insurance markets.

The IAIS coordinates its work with other international financial policymakers and associations of supervisors or regulators, and assists in shaping financial systems globally. In particular, the IAIS is a member of the Financial Stability Board (FSB), member of the Standards Advisory Council of the International Accounting Standards Board (IASB), and partner in the Access to Insurance Initiative (A2ii). In recognition of its collective expertise, the IAIS also is routinely called upon by the G20 leaders and other international standard-setting bodies for input on insurance issues as well as on issues related to the regulation and supervision of the global financial sector.

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Content Overview

Executive Summary

The IAIS' 2020-2024 Strategic Plan identifies culture and conduct as a key focus area in insurance supervision. This calls for supervisors to adopt a more integrated approach to prudential and conduct risks, recognising that conduct risks can lead to financial soundness concerns for the sector and vice versa.

Traditional compliance-based approaches to conduct supervision make it difficult to ascertain the real value, and possible risks, to customers of the current and emerging insurance landscape. Supervisors are, therefore, increasingly looking to adopt more forward looking and outcomes-based approaches to conduct risks.

Between December 2020 and February 2021, the IAIS, through its Market Conduct Working Group (MCWG), surveyed members[1] to obtain a view of current supervisory approaches and challenges related to using data and key indicators to assess conduct-related outcomes.

The survey covered a total of 51 authorities across developed jurisdictions and emerging markets and developing economies. Annex 1 lists the survey respondents and summarises the supervisory scope and mandate of the respondent pool.

This short public report presents general findings from the survey.

Chapters 1 and 2 cover respondents' powers to collect conduct data, and their approaches to collecting, processing, validating and analysing such data. Most respondents have formalised powers and frameworks for collecting conduct data, and most commonly get that data from both insurers and third parties, or otherwise just insurers. No strong trends emerge regarding the tools being used for collection, processing, validation or analysis.

Chapter 3 describes the number and type of conduct indicators collected by supervisors. In total 201 unique indicators were reported by respondents; this large number reflects the slight variations in the indicators. Most supervisors reported collecting 20 or fewer indicators to assess insurer conduct. Key findings include that there is a concentration of indicators which focus upon claims, and which link to assessing appropriateness of the product or customer value. Also, complaints data is regarded by supervisors as a top source of information across all conduct outcomes.

Chapter 4 presents the purposes for which supervisors use the conduct data analysis, which was spread reasonably evenly across each of reactive, preventive and proactive supervision. Unsurprisingly, analysed conduct data is often used to identify potential misconduct and support formal enforcement measures, but the survey also revealed that about half of the respondents also use it to inform product interventions and consumer education initiatives.

Chapter 5 identifies the top five challenges encountered by supervisors, with number one being poor prioritisation of conduct-related issues by insurers, and second being a lack of resources on the part of the supervisor. It then describes the recurring themes reported as difficulties in interpreting and using conduct data collected from insurers and third parties. Amongst others, these include definitional issues, insurers inability to provide the requested data, and poor data quality.

Chapter 6 reports on the impact of Covid-19 on supervisors' collection of conduct data. Many supervisors initiated specific data collections relating to insurer conduct in response to the Covid-19

[1] See Annex 1 for further details on the survey respondents.

crisis, but most respondents reported having no plans to change their general approach to conduct supervision.

As the next step, the IAIS is also working on developing practical guidance for member supervisors on the use of key indicators to proactively monitor conduct risks to enable more timely responses to emerging conduct trends and risks. This is expected to be made available to members in Q1 2023.

Definitions

"Key indicators" in this paper refers to data used to measure the delivery of conduct-related outcomes by insurers, including data collected primarily for prudential or other purposes but which may provide supervisory insights on conduct-related outcomes.

"Conduct of business" and **"Conduct-related outcomes"** refer to insurers and intermediaries treating customers fairly by:

- "developing, marketing and selling products in a way that pays due regard to the interests and needs of customers;
- providing customers with information before, during and after the point of sale that is accurate, clear, and not misleading;
- minimising the risk of sales which are not appropriate to customers' interests and needs;
- ensuring that any advice given is of a high quality;
- dealing with customer claims, complaints, and disputes in a fair and timely manner; and
- protecting the privacy of information obtained from customers"[2].

[2] See ICP 19.0.2

1 Data gathering powers

1.1 Legal basis for collecting insurer conduct data

A significant majority of respondents (90%, or 46) have explicit direct powers for general data collection from insurers, entrenched in primary or subordinate legislation. In many cases, these powers do not specifically mention conduct-related data. Instead, the legal basis to collect conduct-related data is seen as part of the general power to collect insurer data for supervisory purposes.

1.2 Conduct data collection framework

Most respondents (80%, or 41), although not all 90% who report having a legal basis for collecting conduct data, have a formal framework in place for collecting conduct data relating to insurers. There is a large variance in practices, with formal arrangements ranging from requirements for insurers to submit periodic market conduct returns, surveys, or "statements", through to ongoing data collections in the form of general regulatory reporting and cyclical supervisory reviews of individual insurers. For respondents (20%, or 10) that do not have a formal data collection framework, conduct-related data appears to be collected largely on an ad hoc basis with some respondents currently in the process of formalising their data collection and reporting processes.

2 Collection and analysis of conduct-related data

2.1 Sources of conduct data

Over half (63% or 32) of respondents collect conduct-related data from both insurers and third parties, while just over a third (35% or 18) collect such data from insurers only. Only one supervisor collects conduct-related data exclusively from third parties. Third parties identified by respondents include:

- Industry associations
- Intermediaries and third-party administrators
- Ombudsmen and other external dispute resolution/consumer complaints forums
- Other regulatory authorities, including for example the prudential supervisor where there is a split in the conduct and prudential mandate
- Policyholders, eg through direct complaints
- Print and social media
- Professional firms, including auditors and licensed insurance managers

2.2 Collection, processing and validation of data

Most respondents rely on a combination of manual and automated processes for collecting, processing and validating insurer conduct data. Automated processes are based largely on Microsoft Suite tools, such as Excel spreadsheets and risk dashboards. Digitalised portals are used by several members mainly for collection purposes. However, often the analysis of that data is still being done

manually. Some exceptions were noted with regard to the analysis of purely quantitative data and complaints information.

Respondents appear to be at markedly different stages of maturity regarding the deployment of more sophisticated business intelligence (BI) and other technology-based tools to help identify potential conduct risks and trends. Based on the responses received, the uptake of supervisory technologies (SupTech) for conduct supervision is still in relatively early stages in most respondent jurisdictions.

2.3 Data analysis methodologies

Most respondents use a combination of quantitative and qualitative data methodologies for analysing data relating to insurer conduct, with the use of qualitative analysis techniques (used by 94%, or 48 respondents) being slightly more relied upon than quantitative analysis (used by 80%, or 41 respondents). Four respondents reported also using 'other' techniques, but no further information was provided as to what those techniques are.

3 Number and types of key indicators collected

3.1 Number of unique indicators

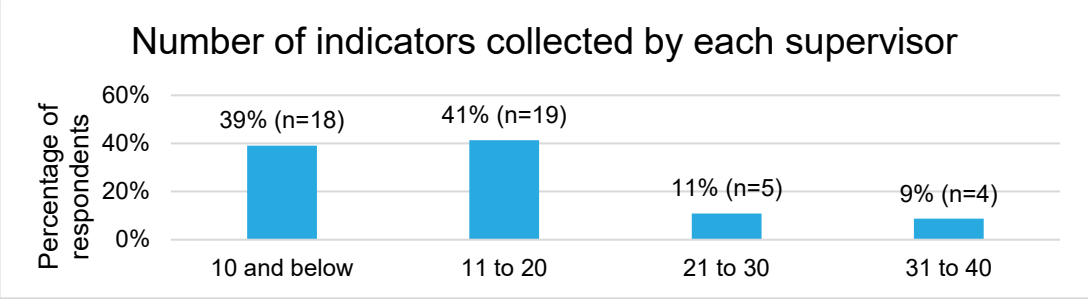
In total, 201 unique indicators were identified by survey respondents. Indicators were considered unique so long as they were calculated differently, even if aiming to measure the same aspect. For example, cancellation rates, cancellations by customers, and cancellations by insurer are counted as 3 unique indicators. As in this example, where broader indicators ('cancellation rates') are also split into subcategories (cancellations *by customers*, cancellations *by insurer*), the broad indicator itself, as well as the subcategory indicators, are separately counted.

3.2 Number of indicators collected by each supervisor

Most respondents (80% or 37) collect 20 or fewer indicators. 41% (19 respondents[3]) collect between 11 and 20 indicators, and 39% (18) collect 10 or fewer indicators.

At the other end of the scale, just 4 (9%) respondents collect more than 30 indicators, two of whom are jurisdictions with twin peak supervisors.[4]

Chart 1: The number of indicators being collected by each supervisor



[3] For this question, the total respondent count is 46, as 5 of the total 51 did not respond.

[4] 'Twin peaks' refers to there being two separate supervisory authorities, one for prudential issues and one for conduct issues.

3.3 Types of indicators: classified by focus area

For analysis, the 201 unique indicators can be clustered into 7 focus areas, plus a catch-all of 'Other'. The focus areas are presented in the following table with example indicators to illustrate the kinds of indicators classified to that focus area.

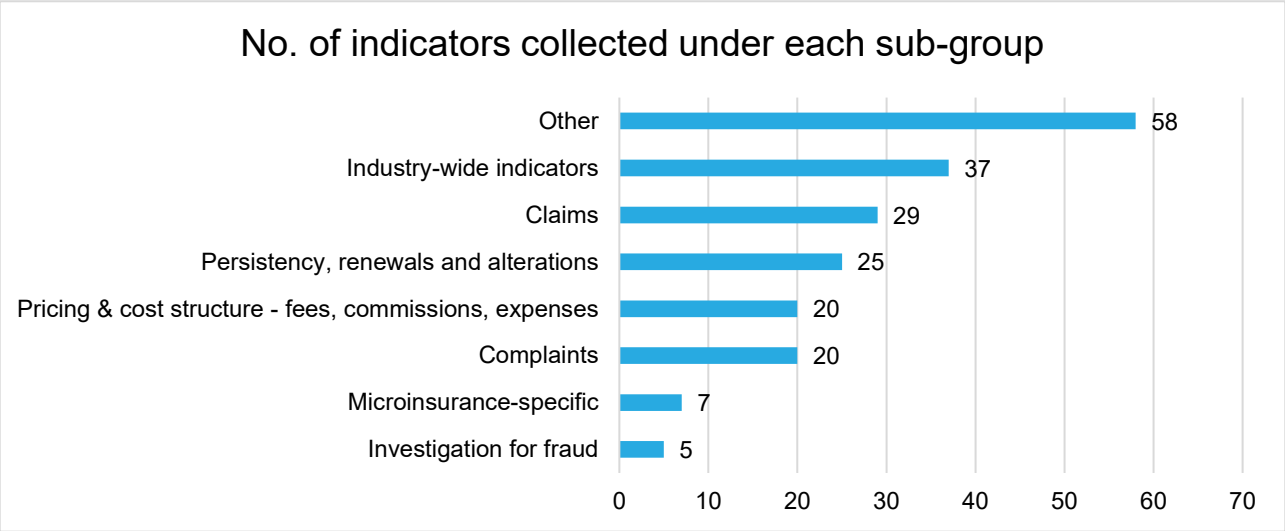
Table 1: Classification of the total pool of indicators into focus areas

	Focus area	Example indicators
1	**Claims**	• Claims volumes and amounts • Claims outcomes or status such as whether registered, pending, denied, accepted or withdrawn • Claims ratio* • Reasons for claims not being paid or delayed
2	**Persistency, renewals and alterations**	• Lapse and cancellation rates or persistency ratio* • Renewal ratio* • Reasons for poor persistency • Proportion of cancellations post a certain period eg free-look or time tranches, churn and replacement rates
3	**Complaints**	• Overall complaint volumes • Complaints broken down by issue, status/resolution outcome or by channel, insurer, and product line • Complaint rates* • Complaint reasons • Dispute numbers and rates*
4	**Pricing & cost structure - fees, commissions, expenses**	• Combined ratio* • Expense ratio* • Amount of commission and non-commission fees
5	**Microinsurance-specific**	• Take-up rate • Renewal ratio*
6	**Investigation for fraud**	• Number/proportion of claims flagged or investigated for fraud and the outcomes
7	**Industry-wide indicators**	• Includes areas such as distribution and product landscape, prudential data, business and policy growth
Other		• Includes areas such as product design and selling practices, product landscape, customer satisfaction, how information is given to consumers, advertising channels and practices, outsourcing, and insurers' internal policies and practices

*Indicator explained in Annex 2.

Aside from the catch-all groupings of 'Other' and 'Industry-wide indicators', the focus areas with the greatest number of indicators are 'Claims', and 'Persistency, renewals and alterations'. 29 of the 201 indicators are classified as indicators relating to 'Claims' and 25 of the 201 are classified as relating to 'Persistency, renewals and alterations'. That there are more indicators relating to these two focus areas may reflect the breadth or the maturity of these topics, especially where the indicators are common prudential indicators as well.

Chart 2: The total number of indicators collected, classified by the indicators' focus area

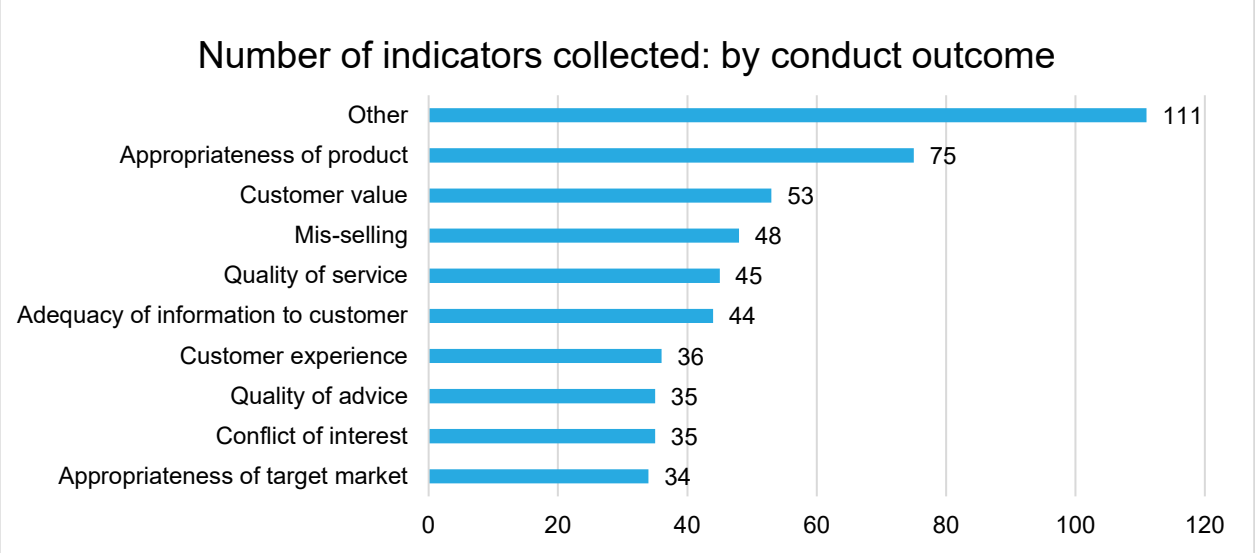


3.4 Types of indicators: classified by conduct outcome

Survey respondents were asked to link the indicators they use to certain conduct outcomes. A list of conduct outcomes was determined based on ICP 19 (Conduct of Business) and presented for respondents to select from, plus a catch-all option of 'Other'. It should be noted that because the options for conduct outcomes were fixed and determined by the design of the survey, it may not reflect how supervisors themselves classify the relevant conduct outcome for a given indicator. Also, a high number of supervisors selected 'Other', possibly reflecting that they do not currently embed outcomes into their analytical frameworks or they use other analytical approaches.

Excluding the catch-all grouping of 'Other', the outcome category with, by far, the highest number of indicators is 'Appropriateness of product' with 75 unique indicators reported as linked with assessing this outcome. The next highest was 'Customer value' with 53 unique indicators, followed by 'Mis-selling' with 48 unique indicators.

Chart 3: The total number of indicators collected, classified by the conduct outcome measured by the indicator



3.5 Indicators used for multiple purposes

Many indicators were identified as relevant to assessing multiple conduct-outcomes. The following table presents the most frequently reported indicators for each conduct-outcome category.

Complaints data was regarded by respondents as a top source of information for the majority of outcomes. Only when assessing for 'Customer value' was it not a frequently used indicator.

Table 2: The most frequently used indicators for each conduct outcome

Outcome	Indicators most frequently used[5]
Appropriateness of target market	1. Complaint volumes, issues and reasons 2. Insurer's customer segmentation and target market 3. Cancellation rates
Quality of advice	1. Complaint volumes, issues and reasons 2. Lapse rates and reasons for poor persistency 3. Claims outcomes
Conflict of interest	1. Remuneration and profit-sharing aspects eg amount of commission and non-commission fees, profit-sharing rates and agreements 2. Insurer policies and procedures 3. Complaint issues and reasons

[5] Measured by frequency of mention across survey responses.

Customer experience	1. Complaint volumes, issues and reasons 2. Claims turnaround times 3. Complaint handling turnaround times
Quality of service	1. Complaint volumes, issues and reasons 2. Claims turnaround times 3. Lapse rates
Mis-selling	1. Complaint volumes, issues and reasons 2. Lapse and cancellation rates 3. Complaints by channel/insurer/product
Customer value	1. Claims ratio, volumes and values 2. Rates and reasons for claim denied 3. Claims turnaround times
Appropriateness of product	1. Complaint volumes, issues and reasons 2. Complaints by channel/insurer/product 3. Lapse and cancellation rates 4. Advertising expenses

4 Supervisory uses of conduct data

4.1 Supervisory purpose

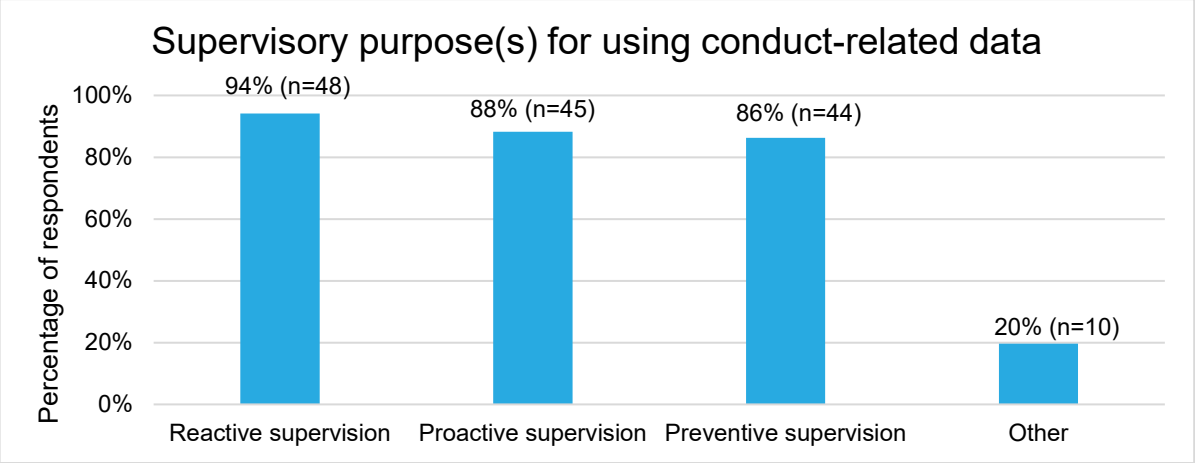
Most respondents reported using conduct data in a combination of ways: for reactive, preventive and proactive supervision purposes.

- **"Reactive supervision"** refers to measures in response to the emergence of issues such as performance lapses or regulatory breaches, eg as part of enforcement action.
- **"Preventive supervision"** refers to measures taken to discourage or deter behaviour, eg pre-emptive warnings, benchmarking, regulatory guidance, education etc.
- **"Proactive supervision"** refers to measures that seek to identify issues before they are apparent to the supervisor, eg thematic reviews.

Using conduct data for the purpose of reactive supervision was most common (94% or 48), followed by proactive supervision (88% or 45), then preventive supervision (86% or 44). Two respondents indicated using conduct data only for reactive supervision while one indicated using conduct data for both reactive supervision and "other" purposes.

Ten respondents in total reported using conduct data for other purposes. Other purposes cited by respondents include consumer education initiatives, information gathering to inform future regulatory changes, and for purposes of regulatory coordination with other supervisors.

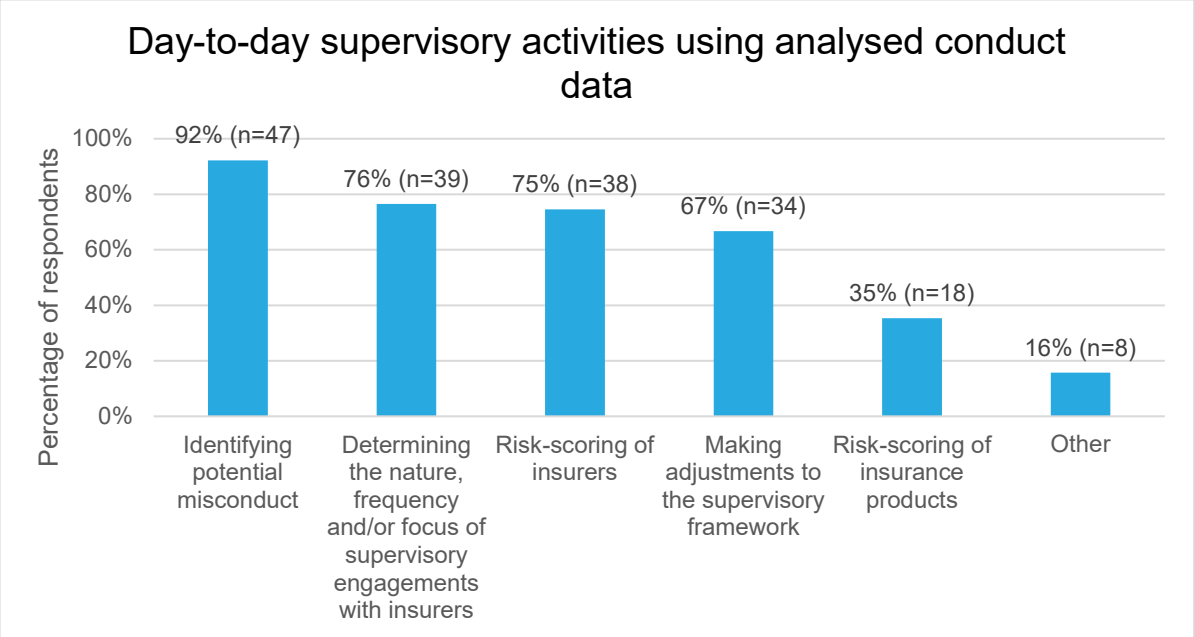
Chart 4: Supervisory purpose(s) for which conduct-related data is used



4.2 Usage of data analysis in day-to-day supervisory activities

Respondents overwhelmingly report using the results of analysis done on insurer conduct data to identify potential misconduct (92%, or 47). Other primary uses for analysis of the conduct data include determining the nature, frequency and focus of supervisory engagements with individual insurers, assessing the risk profile of insurers and informing adjustments to the overall supervisory framework. Additional or "Other" purposes highlighted by a minority of respondents (16%, or 8) include licensing/authorisation purposes, general information sharing and to help assess the overall performance of the insurance sector.

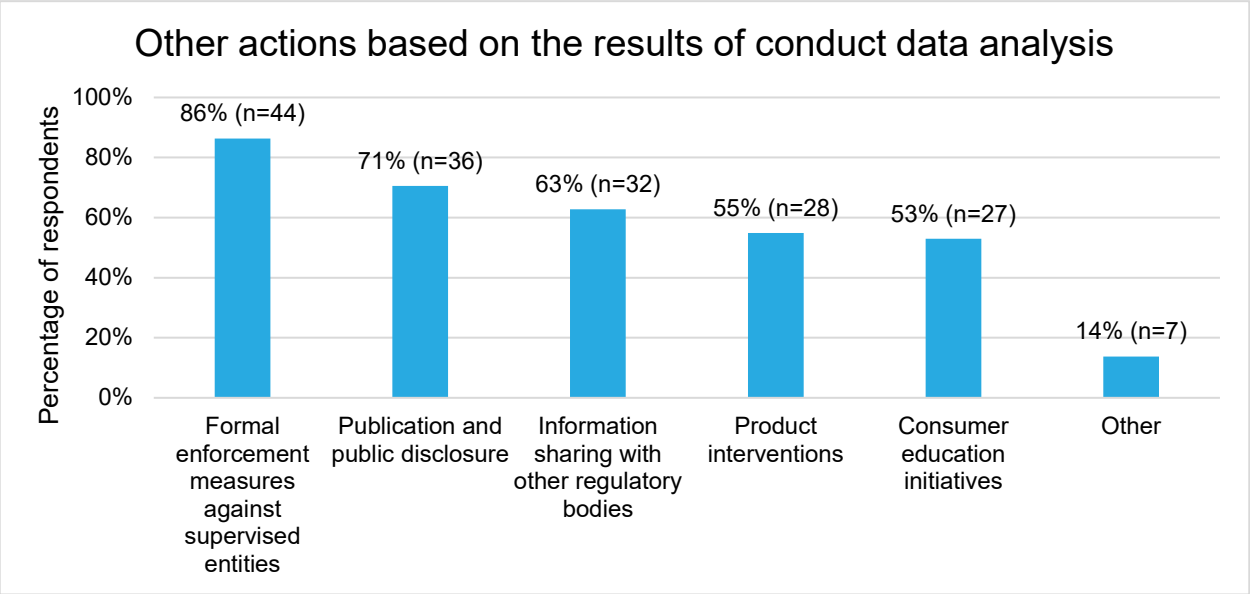
Chart 5: Use of analysed conduct data in day-to-day supervisory activities



4.3 Usage of data analysis for other actions or initiatives

In addition to the general supervisory activities described above, conduct data analysis results are also widely used to support formal enforcement and sanctions decisions against insurers (86%, or 44), public disclosure (71%, or 36) and regulatory collaboration purposes (63%, or 32). Over half of respondents indicated that they also use these results to help inform product interventions (55%, or 28) or consumer education initiatives (53%, or 27). Limited information was provided regarding the "Other" actions selected by just under 14% (7) of respondents.

Chart 6: Other uses of analysed conduct data



5 Supervisory challenges

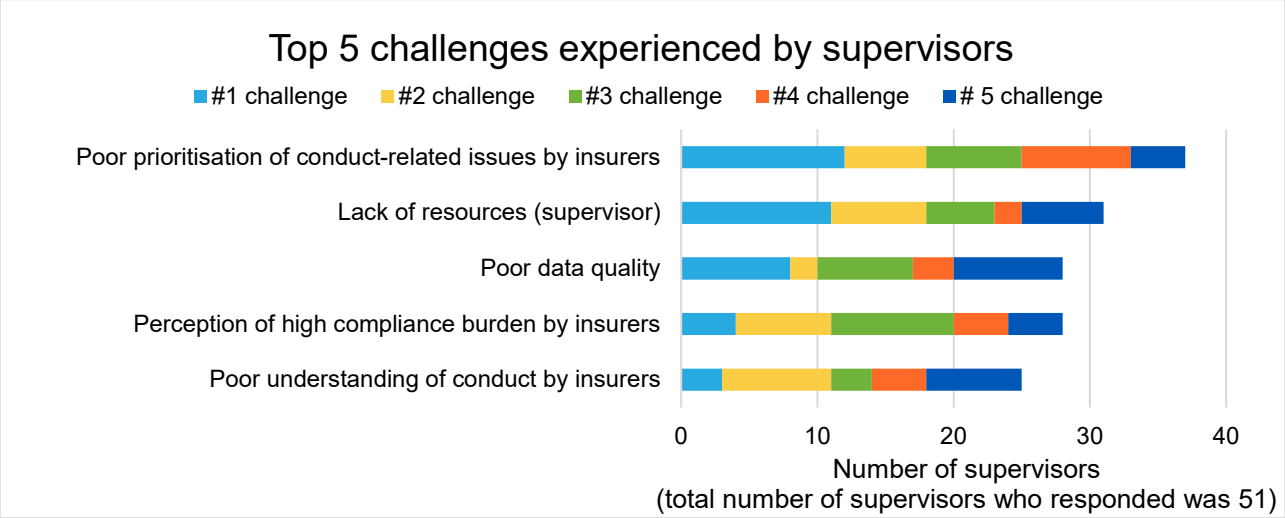
5.1 Snapshot of the top 5 challenges

The top five challenges highlighted by respondents in supervising insurer conduct are[6]:

1. Poor prioritisation of conduct-related issues by insurers
2. Lack of supervisory resources
3. Poor data quality
4. Perception of high compliance/administrative burden by insurers
5. Poor understanding of conduct by insurers

[6] See Annex 2 for the complete list of challenges surveyed, arranged by percentage of respondents that ranked each challenge from most challenging to least challenging.

Chart 7: Top 5 challenges



5.2 Difficulties interpreting and using conduct data

Respondents reported various difficulties interpreting and using conduct data received from insurers and third parties. Common themes raised were:

- Definitional issues: sometimes interpretational difficulties are encountered with insurers having a different understanding of the data requests. This reveals the necessity for exact definitions and a common understanding by supervisors and insurers of the terms used. Definitional issues arise more often with ad-hoc data requests than with ongoing periodic data submissions.
- Insurers need to make infrastructure investments: in some cases, insurers have many, often outdated, legacy systems and those systems may have limited or no capability to collect or report the requested data. Investment by the insurers is therefore required in their infrastructure to be able to provide accurate data. One respondent identified that the extent of conduct regulatory reforms in recent years has required insurers to make a number of system changes to comply with new regulatory reporting and data integration requirements.
- Mismatch between insurer's data and the supervisor's request: Some insurers are still in the process of refining their reporting processes to improve their data input and data collection processes. Sometimes how the insurer collects, stores and defines its data for its business purposes is different from what the supervisor wants to collect.
- Data limitations diminish the supervisory value of the data: If the insurer cannot provide data in the manner requested, there can be issues for the supervisor in analysing and comparing data across the industry. If a particular indicator can be provided but not related datapoints, the information may end up being too broad to be meaningful and/or actionable to the supervisor (eg complaints rate data without accompanying complaints reasons).
- Insurers do not collect certain data because they do not see the value: where the insurer's culture is not focused on customer centricity, and/or there is a lack of understanding and embedment of conduct risk management and mitigation in its risk framework and methodologies, the insurer may not collect and store relevant data.

- Insurers view data requests as a burden: insurers may hesitate to provide data viewing it as a burden and attribute delays in data provision to a lack of resources and cost implications.
- Poor data quality: data provided can be incomplete, of a poor quality, insufficiently granular, and/or incorrect making it insufficient to draw definitive conclusions. Data provided by third parties is sometimes merged with other data prior to submission. It was also reported that occasionally insurers provide data other than what was requested.
- Deliberately providing false data: one respondent identified that a lack of information provided and/or the poor quality of the information can be to conceal evidence of non-compliance. One respondent reported that some insurers inflate figures on quarterly returns because they want to use the data for marketing purposes.

6 Impact of Covid-19 on collection of conduct data

The Covid-19 pandemic has had a significant impact on financial customers and has also raised certain supervisory challenges for maintaining effective oversight of conduct risks that have potentially been heightened or highlighted by the crisis. To this end, the survey also requested information on whether and how the crisis has influenced or may influence the types of indicators required for conduct supervision purposes.

6.1 Covid-19 specific data collections

Many respondents (73%, or 35) initiated specific data collections relating to insurer conduct in response to the Covid-19 crisis. Most of these data collections commenced in the early stages of the crisis during the first half of 2020.

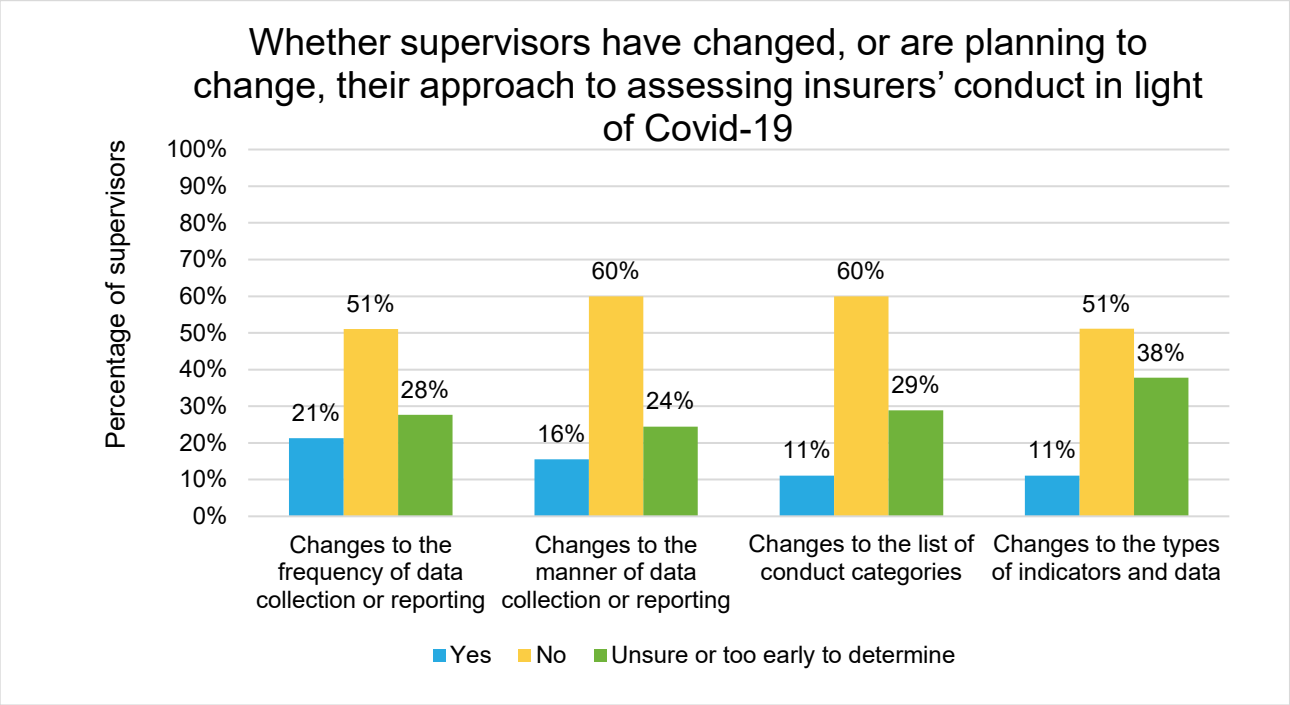
The focus of the conduct-related data collections related primarily to the impact of the crisis on premium payments, claims and complaints handling. Many of the respondents also requested specific information on policy terms and coverage exclusions for pandemic related losses, specifically in relation to business interruption, event cancellation, health and travel insurance. Additionally, in several instances supervisors required information pertaining to payment and other relief measures implemented by insurers, as well as arrangements to ensure ongoing servicing of policyholders through digital and non-face-to-face channels.

6.2 Changes to supervisory approaches resulting from Covid-19

At the time of the survey (December 2020 to February 2021), a significant majority of respondents indicated either that they have no plans to make changes to their general approach to conduct supervision, or that they were not yet in a position to determine whether such changes are in fact required, in response to the impact of Covid-19.

The main changes introduced by the minority of respondents who indicated otherwise relate to the frequency and manner of data collection and reporting for conduct supervision purposes. Previously planned changes to the manner of data collection have been accelerated by the crisis mainly to facilitate more streamlined and digitalised conduct reporting processes. One respondent also indicated that new product governance requirements would be introduced because of issues experienced during the crisis. Another respondent shared that regular collection of financial inclusion data from insurers would be introduced going forward, which had not been done prior to the crisis.

Chart 8: Influence of Covid-19 on supervisors' approach to assessing insurer conduct



Annex 1: Further details on the IAIS survey respondents

Respondents

Total survey responses: 51[7]

Responses from emerging market and developing economy (EMDE) members: 26 (51% of total survey responses)

The survey was distributed to: (i) Main representatives of all IAIS Members; (ii) Members of the MCWG; (iii) Members of the Financial Inclusion Forum (FIF); and (iv) Members of the A2ii Steering Committee: KPI Reporting Indicator Project.

Table 3: List of survey respondents grouped according to IAIS Member Regions

North America	Latin America	Western Europe	Central, Eastern Europe and Transcaucasia	Asia	Oceania	Middle East and North Africa	Offshore and Caribbean	Sub Saharan Africa
Canada, Ontario	Brazil	Austria	Albania	Chinese, Taipei	Australia	Qatar	Bahamas	Botswana
Canada, Quebec	Colombia	Belgium	Bulgaria	Japan		Tunisia	British Virgin Islands	CIMA[8]
USA, California	Costa Rica	France	Hungary	Malaysia			Cayman Islands	Eswatini
USA, Maryland	Uruguay	Germany	Poland	Philippines			Curacao and St Maarten	Malawi
USA, Missouri		Luxembourg	Republic of Croatia	Singapore			Gibraltar	Mauritius
USA, NAIC		Portugal	Republic of Serbia				Jamaica	South Africa
USA, Washington		Spain	Slovakia				Jersey	Uganda
		Switzerland	Slovenia					Zimbabwe

[7] Two further responses, from the UK and India, were received after the survey period. These inputs will be included in developing the members guidance but are excluded from this report.

[8] Conférence interafricaine des marchés d'assurances (CIMA) / Inter-African Conference on Insurance Markets covers 14 West and Central African countries, namely Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Republic of Congo, Equatorial Guinea, Gabon, Guinea-Bissau, Ivory Coast, Mail, Niger, Senegal and Togo.

Insurance sector coverage

All respondents indicated that they are responsible for supervising both the life and non-life insurance sectors. 84% of respondents (43) are also responsible for supervising the health insurance sector. 23% of respondents (12) indicated they also supervise "other" entities including:

- Health service providers related to auto insurance
- Mutual benefit associations and trusts for charitable users
- Special purpose entities, including alternative risk transfer companies and captive insurers

Entities supervised

92% of respondents (47) are responsible for supervising the conduct of both insurers and insurance intermediaries. 53% (27) indicated that their supervisory mandate extends to other entities, which include the following:

- Asset management companies
- Capital markets and related intermediaries
- Credit providers
- Foreign insurers and reinsurers
- Institutional investors
- Insurance advisory service providers
- Investments and investment intermediaries
- Loss adjustors
- Managing general agents
- Medical schemes and Health Maintenance Organisations (HMOs)
- Money transfer companies
- Mutual insurers and co-operative financial institutions
- Premium finance companies
- Retirement funds and retirement fund intermediaries
- Third party administrators

Split between conduct and prudential supervision

The overwhelming majority of respondents (94%, or 48) are integrated regulators, i.e. the same authority is responsible for both conduct and prudential supervision of insurers. Only three jurisdictions included in the survey analysis indicated the mandate for conduct and prudential supervision was split between different authorities.

Financial inclusion[9] mandate

More than half (55%, or 28) of respondents have an explicit supervisory mandate for financial inclusion[10]. Of the remaining 45% (23), three respondents indicated that while they do not have an explicit or direct mandate for financial inclusion, these matters are addressed indirectly through their ongoing supervisory activities.

Table 4: Survey respondents grouped according to financial inclusion (FI) mandate

Explicit/ Direct FI mandate			No FI mandate		Indirect FI mandate
Brazil	Jamaica	Uganda	Albania	Jersey	Australia
Botswana	Japan	USA, California	Austria	Luxembourg	Germany
Canada, Quebec	Malawi	USA, Maryland	Bahamas	Mauritius	Poland
Cayman Islands	Malaysia	USA, Missouri	Belgium	Portugal	Singapore
Chinese, Taipei	Philippines	USA, NAIC	British Virgin Islands	Qatar	
CIMA	Republic of Croatia	USA, Washington	Bulgaria	Republic of Serbia	
Colombia	Slovenia	Zimbabwe	Canada, Ontario	Slovakia	
Costa Rica	South Africa		Curacao and St Maarten	Switzerland	
Eswatini	Spain		Gibraltar	Turkey	
France	Tunisia		Hungary	Uruguay	

"Conduct of business" or "Fair treatment of customers" definitions and frameworks

Most respondents (90%, or 46) define or understand the concepts "conduct of business" and/or "fair treatment of customers" in the same way, or similar to, the IAIS definition[11]. A slightly lower

[9] "Financial inclusion" refers to "a state in which all working age adults have effective access to credit, savings, payments, and insurance from formal service providers. 'Effective access' involves convenient and responsible service delivery, at a cost affordable to the customer and sustainable for the provider, with the result that financially excluded customers use formal financial services rather than existing informal options" See Global Partnership for Financial Inclusion (GPFI), *Global Standard-Setting Bodies and Financial Inclusion for the Poor: Toward Proportionate Standards and Guidance*, October 2011. Also see IAIS *Application Paper on Regulation and Supervision Supporting Inclusive Insurance Markets* (2012).

[10] Annex 1 identifies which respondents have financial inclusion mandates.

[11] See Definition at page 4.

percentage (82%, or 42) have a formal framework in place defining what is meant by “conduct of business” or “fair treatment of customers” in their jurisdictions. Respondents who do not have the same definitions as the IAIS definition provided various reasons ranging from the supervisory authority’s definitions being still under development, to the definitions not necessarily covering all elements of the IAIS definition, eg product design, marketing or insurance intermediaries.

Annex 2: Indicators explained

Survey respondents were not required to provide definitions or formulas for the indicators that they reported using. There may be variations in how indicators are defined and calculated across jurisdictions, and in particular circumstances.

To be clear, this report does not intend to prescribe any fixed definitions for indicators. Simply to assist with general understanding, the following high-level explanations are offered:

Cancellation rate: measures the number of policies proactively cancelled (i.e., during the policy term) either by the insurer or the policyholder relative to the total number of policies. Sometimes cancellation rate is differentiated according to cancellation by the policyholder vs the insurer.

Claims ratio: measures how much the insurer is paying out in claims relative to the premium.

Combined ratio: shows the underwriting profit or loss before taking investment income into account.

Complaint rate: ICP 19.11.1 defines a complaint as an expression of dissatisfaction about the service or product provided by an insurer or intermediary. At its most straightforward, a complaint rate measures the number of complaints relative to the total number of policies in force. Complaint rates can be further disaggregated to provide more targeted insights, for example complaints that are still outstanding relative to the total number of complaints received, complaints resolved in favour of the consumer relative to the total number of closed complaints etc.

Dispute rate: 'dispute' can refer to the specific type of complaint when a consumer does not agree to the terms of a claim settlement that has been decided by the insurer and raises the disagreement through the appropriate dispute resolution system. The dispute rate then measures the number of claims disputed relative to the number of claims finalised.

Expense ratio: shows the insurer's cost of business relative to its revenue from gross written premiums.

Lapse rate: measures the number of policies discontinued due to non-payment of premiums by the policyholder relative to the total number of policies at the beginning of the period.

Persistency ratio: the ratio of policies that have not lapsed, been cancelled/surrendered, matured or terminated upon claim at the end of a given period relative to the total number of policies at the beginning of the period (minus those which have matured or terminated upon claim) which shows the business that the insurance company can retain.

Renewal ratio: measures the number of renewed policies in a period relative to the total number of policies at the beginning of the period.

Readers may also wish to consult the *A2ii Market Conduct KPI Handbook* which includes a list and explanation of indicators.

Annex 3: Full ranking of challenges faced by supervisors

The chart below lists the challenges faced by supervisors in assessing conduct and fair customers outcomes, where each challenge is mapped to the percentage of respondents split by their ranking of each listed challenge. Rankings are from 1 to 12, where 1 means the challenge is considered highest and 12 the lowest. The larger the blue-red zone is for each challenge (rankings 1 to 5), the more significant the challenge is considered to be.

"Other" includes the newness of supervisory authorities or conduct mandates, as well as the current lack of a structured conduct supervisory approach, and lack of automated SupTech solutions. One respondent also indicated that some insurers have security concerns about external sharing of confidential data, and another suggested that the large number of complex products could be a potential challenge.

Chart 9: Challenges faced by supervisors