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Report of the 28th A2ii – IAIS Consultation Call

Supervisory Ratios and Cost Structures

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The Consultation Calls are organised as a partnership between the Access to Insurance Initiative (A2ii) and the International Association of Insurance Supervisors (IAIS) to provide supervisors with a platform to exchange experiences and lessons learnt in expanding access to insurance.

Introduction

When licensing and supervising insurance products, supervisors need to make judgements on the soundness, sustainability and ethics of the product proposed. This is particularly the case when products are designed as part of an initiative for increased financial inclusion, as those underserved segments often contain economically and socially vulnerable consumers with low familiarity with insurance products.

This call explored some of the approaches in evaluating this, the ratios involved (e.g. loss ratio, claims ratio, renewal ratio, and others) and some concrete examples of what considerations come into play. This call topic is a response to the discussions that took place in the IAIS Implementation Committee meetings in November 2017.

On the call, expert presenters **Clémence Tatin-Jaleran** and **Andrea Camargo** spoke about the use of key indicators and ratios in insurance supervision, with specific attention for how these would also be applied in an inclusive context. They were followed by **Michael Sicsic** of the UK's Financial Conduct Authority (FCA), who gave participants an overview of an FCA pilot project that has run for the past 2 years.

Presentation on Cost Structures and Ratios in Insurance Supervision

By Clémence Tatin-Jaleran

Rationale for Inclusive Insurance monitoring

To achieve risk-based supervision and apply the proportionality principle, supervisors must understand the market, assess the risks, and then adopt appropriate measures. This process starts fundamentally with understanding the market. The strongest tool in understanding the market is a robust and well-designed monitoring system.

Below is a table taken from the MI Landscape of Africa, which sets out a few snapshots of what stages a developing inclusive insurance market would reach over time: they differ by outreach, product types, channels used, and types of MI players.

The collection of a number of indicators could help supervisors get a better sense of how deep financial inclusion is in their markets, how much impact their current policies have, and what kind of trends are forming (allowing proactive steps, rather than reactive).

Typically, it is within the mandate of insurance supervisory authorities to protect more vulnerable customers and ensure that adequate client value is delivered to them. The treatment of vulnerable customers has an impact on future insurance market development, and as such on an aggregate scale the provision of low value insurance can have serious financial and social impact on low-income households.

Supervisors may look at key performance indicators from a client-centric perspective, and ask themselves:

- Is the experience from low-income households in line with good market conduct?
- Do products offer adequate value to low-income households, addressing needs at affordable premiums?
- Are market players' behaviours ethical toward the low-income segment?

An example of how the market failed is in Zimbabwe: A Zimbabwean MNO reached 1.6 million insureds in 12 months with life insurance product. However, services and insurance contracts were cancelled over royalties payment issues between IT service providers. Clients were no longer serviced, and the regulator had to intervene to get the insurer to still pay some claims. Overall, this led to 63% of users deciding never to use a similar product in the future, permanently harming overall confidence in the insurance system.

Challenges in some jurisdictions

A few jurisdictions undertake substantial compulsory data reporting requirements, either for all products or only for inclusive products. The frequency of such reporting is typically quarterly or annually, and is submitted electronically. Some typical key indicators that are collected are:

1 Operational Expense Ratio
2 Claims Ratio
3 Renewal Ratio
4 Turn-Around-Time
5 Rejection Ratio
6 Growth Ratio
7 Solvency Ratio
8 Liquidity Ratio
9 Covered risk and type of cover
10 Number of policies
11 Sum Insured
12 Written Premiums
13 Acquisition, Administration, costs

However, this process encounters a number of important challenges:

- Companies often resist any increase in their reporting requirements, as this adds resource-intensive internal processes, possible raises confidentiality issues, and sometimes also a lack of clarity over what constitutes inclusive insurance.
- The data that the supervisor receives may not be complete due to conflicting definitions (e.g. mass insurance vs inclusive insurance)
- Once the data is collected there is often no systematic analysis by the supervisor, possibly exacerbated by a lack of resources or lack of expertise with inclusive insurance.
- Even if data is collected and analysed, this does not smoothly lead to actions, and as such often the only outcome is limited or no action.

Four KPIs, from a supervisory perspective

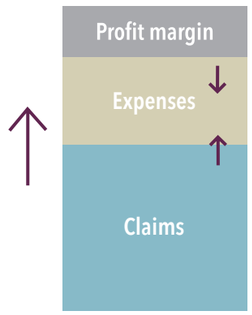
In this presentation, we explored four of the most prominent indicators.

Indicators 1 and 2: Claims Ratio & Operational Expenses Ratio

The claims ratio compares the monetary value of claims paid versus the premiums received for a particular product. The operational expenses ratio is the portion of the premiums that are costs for the insurer (salaries, operations, etc.). Once claims and operational expenses are deducted from the premiums received, the remainder is profit .

When interpreting the claims ratio and the expenses ratio, the supervisor may notice certain problems:
The claims ratio may be too high: this means the products is not financially sustainable and may put the insurer under pressure.
The claims ratio may be too low: this means the client is receiving little value for their products, and may be indicative of a number of serious problems.
The operational expenses ratio may be too high, putting negative pressure on client value due to issues with intermediaries or inefficient processes.

To illustrate where this is problematic, we can look at the overall microinsurance sector 2013 loss ratios in Colombia.

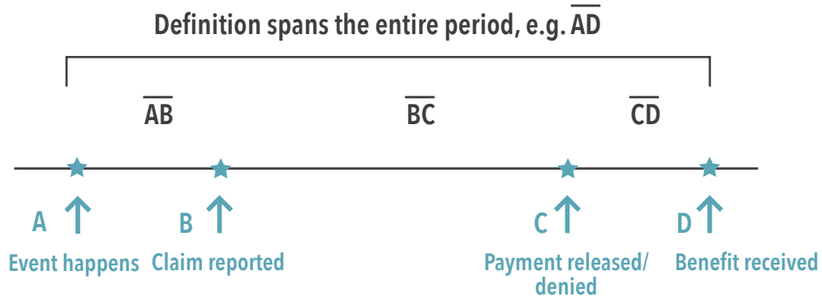


Ramo	Loss ratio 2013
Personal Accidents	18.5 %
Burial	21.9 %
Group life	31.1 %
Others	14.6 %
Excluding group credit life	23.3 %
Including group credit life	23.8 %

Source: A2ii Country Assessment – Colombia 2014

Indicator 3: Turn Around Time

Though this is often considered as the time between the insurance company receiving a claim and the insurance company authorizing a payout, this does not consider the client's experience. A better description is the time between the accident happening, and the customer effectively receiving the payout in their account. An analysis of the Turn Around Time also should not just look at average times, but at the frequency of outliers and extreme cases. (This can be done by requiring reporting in terms of % of claims up to 7 days, 30 days, or 90 days, giving a more detailed picture of where the majority of payments lie).



Focusing on low-income households, the need for speedy cash payouts is heightened (particularly for agriculture and health insurance), as they are more vulnerable. As such, this indicator will relate strongly to clients' experiences and trust in the industry.

Indicator 4: Renewal Ratio

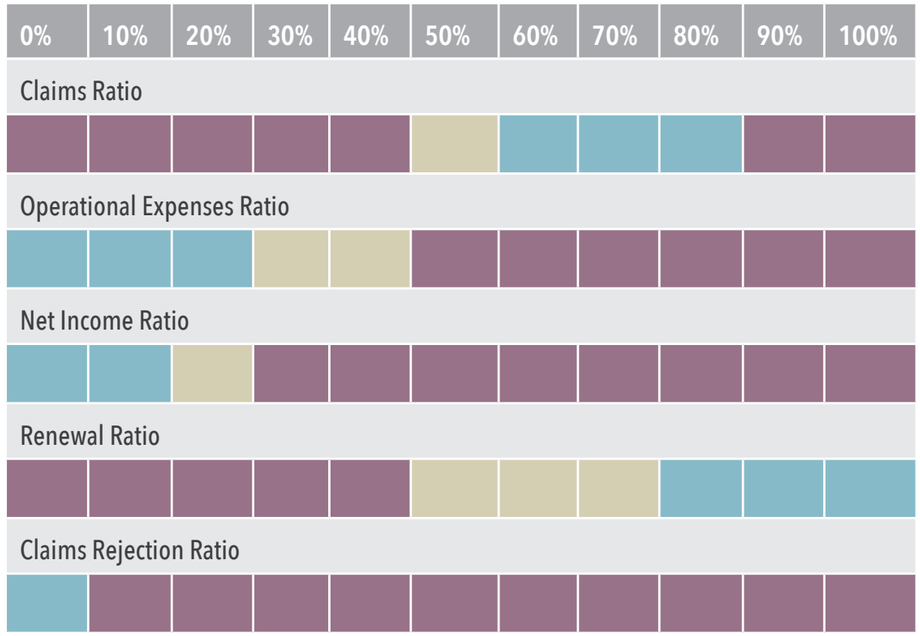
This is the percentage of clients that renew their policies once they have lapsed. There can be many potential reasons for a low renewal rate, and it is frequently observed that renewal ratio increases in more competitive and conventional insurance.

Some common reasons for a low renewal ratio are: low perceived value, distribution incentives may only stimulate new business, renewal times that don't match cash flows, too high premiums, or renewal process is too complex or inconvenient.

Adequate levels for KPIs and further monitoring options

When analysing ratios that the supervisor observes in their market, they will need to make judgements on the appropriateness of many of the ratios they observe. There is no universal one-size-fits all level that suits all situations, and many of the factors will vary by the risks insured, the maturity of the product, which segment is served, etc. Ultimately, the supervisor's goal is to strike a balance between sustainability for the insurer, and client value.

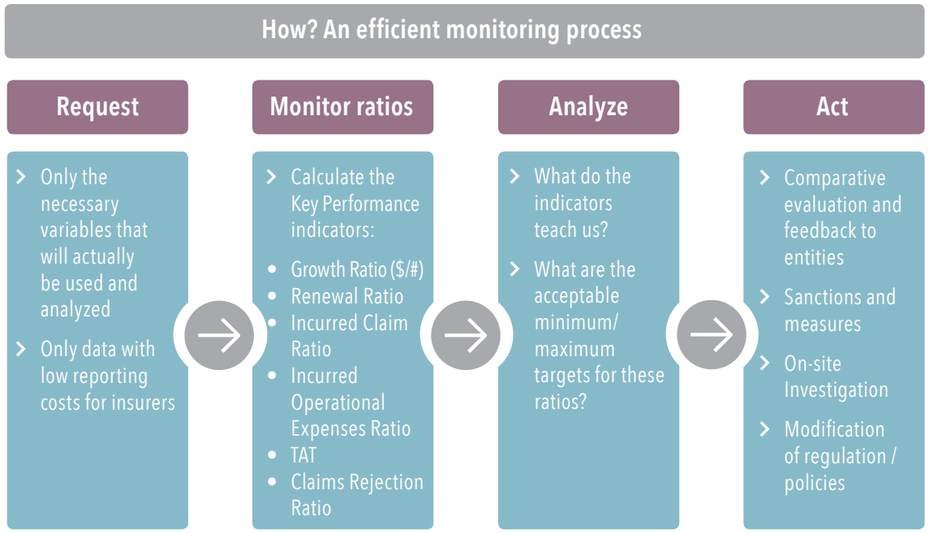
When analysing by entity, product type and per channel, the following ratios have been observed to lead to positive outcomes, and could be used as a starting point in an analysis.



Monitoring as a process

Monitoring is the first step in a process that leads to analysis and action. In addition to the monitoring of KPIs, there are a number of complementary measures which may be considered to complete the picture for supervisors, such as:

- Ad-hoc additional data requests for a specific entity or product
- On-site visits to consult documents and database
- "Mystery shopping", where the supervisor purchases products in the marketplace to better understand the customer journey
- Interviews with intermediaries and end-clients for feedback on inclusive insurance experiences
- Different frequency for different information requests



Case Study: United Kingdom

Michael Sicsic presented the experience of the UK's Financial Conduct Authority (FCA).

The FCA has recently concluded the second phase of their pilot project, which requires a range of general insurers to submit key performance indicators to the FCA. The FCA then makes these indicators publically available online. The goal of this transparent approach is to give insurers an incentive to improve their client value.

An in-depth look at the key indicators can be found in this FCA discussion paper titled **"DP15/4 – Developing General Insurance Add-ons Market Study – Remedies: Value Measures".** The discussion paper and the value measures datasets of the pilot study are available on the FCA website.

Design and conception of the pilot
The FCA was looking at ways of using data transparency drive positive change in the market. As a precursor to their pilot, the FCA performed a study in 2013 that looked into General Insurance (GI) add-ons[1] (2013). The study identified poor value in both add-on and stand-alone products, and found that there are no commonly available measures to assess the value for money of general insurance products. Competition was not working to improve the product offering, and consumers could not make meaningful, informed product choices at the time of purchase.

In response to the 2013 study, the FCA banned opt-out sales, enforced a deferred opt-in period for specific products, and improved the information provided to the customer. It lead to a further discussion paper, which took a closer look at a "value measures" as a more systematic way to address this kind of market deficiencies.

The discussion paper's conclusions were as follows:

1. The scope and granularity for a value measure should be explicitly defined.
2. Value measures could be evaluated as either an isolated quantitative measure (e.g. claims ratio), or they could be integrated more closely as a "scorecard".
3. The FCA could require the data to be part of customer information at the point of sale, or alternatively it could publish the market-wide data centrally.
4. Other pertinent information could be included, such as the cost of distribution, commission, customer satisfaction and retention rates, settlement times, and other data.

The FCA experiences strong resistance from the market on using claims ratio as an isolated measure, in favour or a scorecard approach. Industry was also concerned that transparency might negatively affect competition.

1 a product that is purchased in compliment to the main product

The pilot ran for a period of two years, producing 2 annual datasets which would give consumer groups and market commentators an overview of market practices. The reporting was mandatory for all firms operating in the UK, it focused on a range of general insurance products, and the FCA published the collected data on its website.

Lessons Learned
After the first publication, the following feedback was gathered:

- Using consistent definitions is crucial. After the first pilot, the FCA realized that the understanding of definitions was not consistent. Hence the need for further refinement, discussion with firms and agreeing on clear definitions to ensure that the data is comparable and consistent.
- The quality and granularity of the data varied. There may be a role for a benchmark between firms to identify gaps, as getting sufficiently granular data is necessary to make meaningful management decisions.
- Overall buy-in from the industry has been positive. There has been moderate pick-up by consumer groups and media.

After the second publication of data, some improvements were already visible in the data set. Some firms improved their products, reducing costs and making claims easier. Some firms put in place better processes to allow managers to assess the value of their products.

This approach has several positive functions for supervision. This data publication ensures that firms need to have processes in place to review and assess the value of their products, and this should be embedded in their market conduct risk framework. This should also be based on quantifiable metrics. Enhanced management information will assist firms to identify potential harm and to drive actions to resolve it, and it allows for appropriate oversight and challenge from senior management and board. Firms also now see the need to look closer at the drivers of the metrics: Are the products appropriately designed? Is the claims process accessible? Do people know what they are being sold? Does the distribution channel negatively impact the client value?

These are important questions, and the transparent disclosure of the reported data gives firms an incentive to improve, aligning their motives with supervisory objectives and client value. Some early observations:

In term of next steps, the FCA is currently considering to either do a third pilot or moving to consultation to implement value measures publication into their rules i.e. making it mandatory for all products in general insurance.

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Any questions about FCA's discussion paper and pilot studies including the datasets can be posted to Mr. Michael Sicsic at michael.sicsic@fca.org.uk

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Questions from the audience

- **Did all the companies report comprehensively during the FSC pilot?**
  Yes, as it was mandatory for companies that offered certain specific products. This is within the power of the FSC to require. The FSC then also published the data, to use transparency as a supervisory tool: it gives the insurers a vested interest in the quality of their indicators beyond just the commercial value (which they were usually already collecting).

- **What role does digitalisation have in reporting?**
  The digitalisation of insurance architecture also allows for newer firms to build this kind of granular reporting into the system from the very beginning, particularly for young companies who are not reliant on legacy systems. Industry and the supervisor should have a discussion to identify which metrics, with which frequency, and through which process, should be reported, so that the data published is not of crucial commercial sensitivity.

- **Can transparency be used as a supervisory tool?**
  The idea of using transparency as a tool to align insurers' interests with their customers is a powerful one, and has been demonstrated in Colombia and South Africa. It can be as simple as publishing the top three companies that are the subject of most complaints – an action that drives insurers to improve their service. Companies also start using their good ratios in marketing material, which creates further incentives.

- **Do any regional benchmarking initiatives exist?**
  It seems that the first regional comprehensive benchmarking system of indicators is currently being developed by the Mutual Exchange Forum on Inclusive Insurance (MEFIN). This regional forum amongst Asian countries is developing a system to benchmark and compare key indicators across the region, including market development, institutional development, client value, solvency efficiency, governance, product value, rate of growth, and outreach. Supervisors who are interested in knowing more about this can find more information on the MEFIN webpage (link), or can contact Shayne Rose (Bulos shayne.bulos@giz.de).

- **Were any of the companies already collecting this data before the FCA required them to report it?** Yes, mostly they were, with a commercial mindset, to see the profit margin (as the complement of loss ratio). They had a natural tension between the commercial and the client value perspective. The transparency of this data increased the importance of finding an appropriate balance between the two ratios.

- **Has the observation of low ratios frequently led to supervisory actions?**
  Yes, on a number of occasions, poor value products were identified and steps were taken to ameliorate the situation. For instance, an online retail purchase insurance was insuring based on the volume of the customer's purchase, including several items that are not insurable. After contacting them they agreed to compensate customers, because the claims ratio was only 2-3%. There were also other products, like home emergency products, where the design was not good, where the supervisor intervened to add more coverage to the contract, or to reduce the price, to get to a better value product.

In Colombia, a retail product was active with a 5% claims ratio. This was due to the sales process that included no explanation, leading to almost no claims. It was also sold to people who did not qualify for the product. The value was so low that the supervisor implemented market conduct rules for these kind of mass marketers – which is another actionable step that stemmed from the analysis of ratios.

- **During the FCA pilot some firms have made product improvements, or improved management information. Can you elaborate?**
  In terms of product improvement, firms can streamline the claims process, remove undue barriers to claims, or simply adjust the price to improve the value for money. Improvements to management information has concretely meant that the key indicators are now compiled and presented to the board, and subjected to an action-oriented review process. Often this leads to root-cause analysis, and actions that improve the situation. Sometimes this has meant withdrawing the product altogether.

  One of the factors that erodes value is also the commission in the distribution channels. The insurer might offer a good product, but the end cost for customer is driven by a lot of intermediaries and the complexity of the value chain. Having a clear view on these indicators may also lead to insurers rethinking their relationships with their intermediaries.

- **Can government subsidised insurance programmes be evaluated with the same indicators?**
  The ratios certainly still apply, and can be very useful in determining the health of government initiatives. For instance, if the claims ratio is unsustainably high, no insurer will want to cooperate with the government on projects.

To pose more questions to our experts, please contact:

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