*CCIR*

Canadian
Council of
Insurance
Regulators

Conseil
canadien
des responsables
de la
réglementation
d'assurance

# Risk-Based Market Conduct Regulation

## A Survey of Approaches

A report prepared by the
Canadian Council of Insurance Regulators (CCIR)
Risk-Based Regulation Committee

July 2004

## Table of Contents

Page

Executive Summary ..... i

Market Conduct Regulation ..... 1

Risk-based Market Conduct Regulation ..... 1

Risk Assessment ..... 2

Compliance and Enforcement ..... 3

Risk-based Market Conduct Models ..... 3

Insurance Regulators

- United States ..... 5
- Australia ..... 9
- New Zealand ..... 12
- European Union ..... 14
- France ..... 18
- Germany ..... 20
- Italy ..... 22
- Spain ..... 24
- Sweden ..... 26
- United Kingdom ..... 29

Securities Regulators

- IOSCO ..... 34
- Canada ..... 37
- United States ..... 41

Annexes

- Summary of Risk-based Market Conduct Models ..... 45
- Market Analysis Risk Assessment - U.S. State Experience ..... 47
- APRA's Risk-Rating ..... 53
- FSA's Risk Assessment ..... 56
- Australian General Insurance Code Of Practice ..... 58
- Australian Life Insurance Code Of Practice ..... 67
- New Zealand Fair Insurance Code ..... 83
- New Zealand Manual Of Practice Standards (Life Insurance) ..... 86
- United Kingdom Private Customer Code (General Insurance) ..... 87
- United Kingdom Code Of Market Conduct (Life Insurance) ..... 97
- References ..... 98

**Please note that the proposed directions in this paper should not be construed as the official position of any provincial, territorial or federal government or agency.**

In all modern economies insurance is subject to regulation and supervision. The nature of intervention varies considerably from country to country and is influenced by several factors, including public policy objectives and the structure of the financial system. Provincial and territory regulators are responsible for prudential and market conduct regulation and legislative compliance of insurers authorized in their province or territory.

These regulators oversee a wide range of company practices, including transparency and disclosure requirements, marketing of insurance products, the rating and underwriting of insurance products and claims processing and payment. The tools used to help protect the public from unfair market practices include licensing, consumer education, responding to consumer complaints, on-site examinations and in auto insurance, reviewing rates and policy wordings.

In February 2004, members of CCIR established a committee to review risk-based regulatory models. This review was initiated to address the following concerns:

1. Supervisory resources are finite and there is a need for regulators to target scarce regulatory resources toward higher risk areas.
2. The recognition that enhanced supervisory capacity and flexibility in responding to market conduct issues would better promote and ensure confidence in the insurance industry.
3. Regulatory practices have a significant impact on the performance of insurers. Industry representatives have expressed concerns about the complexity and cost of regulation in Canada.

*Overview and System Architecture*

Among the jurisdictions surveyed legislatures ultimately have the responsibility for insurance issues and policy and market conduct regulation is the responsibility of insurance departments or agencies. In multi-jurisdictional environments, the United States and the European Union, there is a body or mechanism for coordination and harmonization of approaches. Regulators police insurers and agents sales, underwriting and market activities in order to ensure that they adhere to certain standards and that claims are handled according to the provisions of the insurance contract.

In general, in jurisdictions that utilize a risk-based approach to market conduct, market conduct rules are often not codified in law but rather outlined in codes of practice. These codes of practice are “living codes” in that they are more flexible than statutory requirements, allowing regulators and industry to adapt to changing environments. Such codes of practice are generally developed jointly by regulators and stakeholders. As a result, jurisdictions that have moved toward a more risk-based approach with a greater reliance on corporate governance and outcomes have eliminated or reduced the number of prescriptive rules. In the European Union, prescriptive rules and regulations around the regulation of tariffs (rates) and drafting of products were largely removed in the mid 1990’s. Similarly, New Zealand and Australia have adopted less prescriptive approaches that use codes of practice.

All jurisdictions contain some form of independent consumer redress mechanism. Jurisdictions without guarantee schemes are more likely to have integrated market conduct and solvency supervision and focus more market conduct regulatory attention and resources on claims practices.

*Public Policy Objectives and Regulatory Principles*

Regulation provides a degree of protection and stability that leads to confidence in the institutions and in the financial system more generally. Insurance represents a tool of prime importance in modern economies: it enables economic agents to reduce and better manage their risk exposures. The basic feature of an insurance contract is that the insured buys a future promise of payment contingent upon the occurrence of specified events.

The long-term reliability and confidence that the terms of an insurance contract will be honoured must be beyond a doubt. The regulatory framework engenders a degree of public trust in insurance, from which consumers and institutions benefit. In response to these considerations, regulatory intervention among the jurisdictions surveyed is typically oriented around achieving some variation of the following public policy objectives:

- *Level playing field*: so that different types of insurers are not advantaged or disadvantaged relative to others by the regulatory framework;
- *Competitive markets:* the fostering of contestable, competitive and efficient insurance industries and the combating of excessive market dominance and restrictive trading practices;
- *Market confidence:* the promotion of the integrity and reputation of the insurance industry;
- *Financial sector stability:* the ability to respond to financial distress events such as the failure of an institution; and
- *Informed consumers*: providing policyholders with a disclosure environment conducive to making well-informed insurance decisions.

However, while these objectives comprised the principal public policy objectives among the surveyed jurisdictions, this list is not necessarily exhaustive or the list that individual provinces would necessarily wish to adopt, as there may be other objectives that may also be applicable to Canadian jurisdictions but not fully captured in the approach of another jurisdiction.

For example, important public policy issues in Canadian jurisdictions such as affordability and availability of insurance in most lines of business were not high on the list of public policy issues among the surveyed jurisdictions. This was particularly true for personal lines. A key exception was in liability insurance where international factors such as reinsurance rates have been important. In general, jurisdictions with risk-based approaches indicated that competitive markets and a level playing field generally ensured that there was enough capacity in the market to address availability issues. In addition, jurisdictions with a system-wide risk assessment process suggested that systemic issues such as these would be identified and addressed as they arose.

*Risk Assessment*

How risks are evaluated across jurisdictions is highly dependent upon the public policy objectives and regulatory principles of any particular jurisdiction. There is no standard definition of risk across jurisdictions. In some cases, risk is defined according to statutory objectives and in others, it is defined in response to consumer concerns. In all cases, it is related to securing confidence in the financial sector and ensuring that the terms of the insurance contract are honoured. As many jurisdictions do not have guarantee schemes in place, market confidence becomes a key public policy objective for many insurance supervisory authorities. Consumer complaints, as an expression of

consumer dissatisfaction, are a starting point for all the risk-based market conduct approaches that were reviewed.

Risk-based regulation is well established in the prudential regulation field. The prudential approach relies heavily on corporate governance to ensure that there are adequate systems and control procedures in place to prevent problems from arising and a reliance on third party oversight through auditors. Risk-based market conduct approaches in other jurisdictions build upon this approach and in many jurisdictions are integrated with the solvency risk assessment. Increasingly risk-based market conduct supervision employs forms of market surveillance and analysis by regulatory authorities and coordination between relevant supervisory jurisdictions.

Risk-based approaches to market conduct insurance supervision in other international jurisdictions are comprised of a structured approach that identifies the key risks to which the industry and individual companies are exposed. Generally this involves assessing the overall impact and likelihood of occurrence involved with a market conduct risk. Supervisors then focus supervisory effort on the most significant risk exposures. A supervisor ranks institutions by risk and allocates off-site monitoring and in some cases, on-site inspections for riskier institutions. By establishing a disciplined supervisory process for considering the key risks and focusing supervisory resources on those issues, the process can be made more effective and efficient for consumers and insurers.

As part of this review, the risk-based supervisory models of insurance supervisors in nine jurisdictions (United States, Australia, New Zealand, France, Germany, Italy, Spain, Sweden & United Kingdom) and of securities regulators in Canada and the United States were analyzed. The review finds a wide range of approaches and risk assessment techniques used by supervisory authorities. Trends identified by this review include:

1. The same or parallel regulatory approaches are used for life and health insurance and property and casualty insurance. Recognizing that there are differences between types of insurance, most models are flexible.
2. Those jurisdictions with clearly defined objectives (either in statute or defined by the relevant Ministry) tended to assess risk at an institutional and systemic level. Jurisdictions without clearly such defined objectives were likely to focus on institutional risk and less likely to monitor systemic risk.
3. Qualitative models have generally been in place longer and are utilized by a majority of jurisdictions. These types of models are most likely to occur in jurisdictions where insurance (in so far as market conduct) is considered just another service and market conduct regulation is part of a general consumer protection mandate for all goods and services.
4. Quantitative models with transparent decision trees or supervisory ladders have more recently been introduced in the United Kingdom and some U.S. states. Such models are more likely to be utilized in jurisdiction where risk has been clearly defined.

*Compliance and Enforcement*

The ultimate purpose of all regulation is to influence the behaviour of the system participants and so reduce the incidence of non-compliance. The purpose of risk-based regulation is to effectively channel supervisory resources in a timely and effective way in instances where market conduct risk or non-compliance behaviour is identified. Once a potential risk has been identified, supervisory authorities generally have a range of

proportionate response options available to them for encouraging compliance. Companies with a higher degree of voluntary compliance experience less intervention.

In all risk-based approaches, the primary incentive utilized for influencing the behaviour of the system participants and encouraging voluntary compliance, is that the nature and intensity of the supervisory authority's relationship with an institution is dependent upon an overall assessment of risk. In addition, some jurisdictions, where the supervisory activity is funded by an assessment on the industry, may incorporate some form of risk-based or risk-weighted assessment as an additional incentive. To date other incentives have not been developed although most jurisdictions assess financial and other penalties for non-compliance.

*Next Steps*

This paper is a review of the supervision of insurance and securities markets in a number of jurisdictions is the first phase in the review of risk-based supervisory approaches. Additional areas of research and consideration include the details and areas of focus for market conduct examinations in other jurisdictions and possible incentives for compliance that can be included within a risk-based approach.

## Market Conduct Regulation

In all modern economies, insurance is subject to regulation and supervision. The nature of intervention varies considerably from country to country and is influenced by several factors, including public policy objectives and the structure of the financial system.

Market conduct regulation in the insurance industry is justified on a number of grounds. One of these centers on the importance of the insurance industry to the wider economy and the consequences arising from any significant part and prolonged disruption of the system. Market misconduct can also lead to the deterioration of market confidence, reducing liquidity and risk-sharing and ultimately having a negative effect on growth in the economy.

There is also the recognition by legislators and supervisors that many small policyholders are not well placed to protect their interests when dealing with insurers, given policyholders' limited understanding of financial risk and the trade-off between risk and return inherent in every insurance product. Many regulatory interventions are therefore aimed at assisting policyholders to protect their interests in ways that do not insulate them from the consequences of their insurance decisions and do not pass on excessive risks to the taxpayer. Such interventions include disclosure requirements and requirements in relation to fair trading practices. Regulation may also be considered necessary to prevent improper market practices and promote market fairness. In some jurisdictions the objective of avoiding excessive market dominance by any single institution and combating restrictive trading or sales practices provides further rationale for some forms of regulator intervention.

Regulation provides a degree of protection and stability that leads to confidence in the institutions and in the financial system more generally. The regulatory framework engenders a degree of public trust in insurance, from which consumers and institutions benefit. In response to these considerations, regulatory intervention in most countries seeks to meet a number of public policy objectives in the insurance industry. These typically include some subset or variation of:

- *Level playing field*: so that different types of insurers are not advantaged or disadvantaged relative to others by the regulatory framework;
- *Competitive markets:* the fostering of contestable, competitive and efficient insurance industries and the combating of excessive market dominance and restrictive trading practices;
- *Market confidence:* the promotion of the integrity and reputation of the insurance industry;
- *Financial sector stability:* the ability to respond to financial distress events such as the failure of an institution; and
- *Informed consumers*: providing policyholders with a disclosure environment conducive to making well-informed insurance decisions.

## Risk-based Market Conduct Regulation

Risk-based regulation is well established in the prudential regulation field. It has been at the heart of the activities of regulatory authorities since the establishment of the first Basel Committee on Bank Supervision in 1974. The prudential approach has as component parts, a heavy reliance on corporate governance to ensure that there are adequate systems and control procedures in place to prevent problems from arising and a reliance on third party

oversight through auditors. Increasingly, it employs forms of market surveillance and analysis by regulatory authorities supported by transparency and disclosure.

A risk-based approach to market conduct insurance supervision is generally a structured approach that identifies the key risks to which the industry and individual companies are exposed. Supervisors then focus supervisory effort on the most significant risk exposures. A supervisor ranks institutions by risk and allocates off-site monitoring and in some cases, on-site inspections for riskier institutions. By establishing a disciplined supervisory process for considering the key risks and focusing supervisory resources on those issues, the process can be made more effective and efficient for consumers and insurers.

**Risk Assessment**

Because supervisory resources are finite, one of the most critical aspects of risk-based supervision is risk assessment. The purpose of risk assessment is to assess how well individual institutions and the market as a whole are meeting consumers' needs and then to take appropriate action where issues are identified. As supervisory authorities evaluate market conditions and assess risk, they have five basic mechanisms for gathering information:

- examinations,
- investigations of individual institutions,
- surveys and periodic reporting requirements designed to gather market conduct data,
- complaints data and
- the analysis of existing financial information collected for solvency purposes.

Risk assessment can be conducted at a variety of levels, using a variety of techniques, ranging from rigorous statistical modeling to more informal discussion and information sharing. Distinctions are drawn between quantitative (data-driven) and qualitative (event-driven) techniques and between macro (entire markets) and micro (specific institutions or issues) techniques.

Macro risk assessment, with the analysis of general market conditions, is considered important in fast-changing markets and markets with unique characteristics. Systemic risk assessment enables supervisory authorities to identify important market conduct problems, prioritize and coordinate supervisory functions and to establish an integrated system of proportional response to arising issues at an early stage: before they develop into more significant problems.

Micro risk assessment of individual institutions involves the utilization of quantitative or qualitative data and a decision tree of intervention, often called a supervisory ladder. Risk assessments may include impact and probability factors. The impact of an event could be assessed by reference to its systemic significance, the perceived importance of the firm (public perception/market confidence), retail customer base (number/nature of customers) and the availability of compensation or redress for consumer loss. Probability factors are assessed through business (external environment), control (internal systems, management and compliance culture) and consumer relationship (practices, nature of consumers, volume of consumer complaints) risks.

How risks are evaluated across jurisdictions is highly dependent upon the public policy objectives and regulatory principles of any particular jurisdiction. Consumer complaints, as an expression of consumer dissatisfaction, are a starting point for all risk-based market conduct approaches. Some jurisdictions also conduct desk audits utilizing already available information (financial, past examinations, investigations etc) in their risk assessment process. Where a potential higher risk institution has been identified, a supervisory authority would conduct a targeted on-site examination for more information about the issue. This information would assist the supervisor in identifying the appropriate corrective action.

**Compliance and Enforcement**

The nature and intensity of the supervisory authority's relationship with an institution is dependent upon an overall assessment of risk.

The ultimate purpose of risk assessment is to provide regulators with the basis for timely, appropriate and effective action. Once a potential risk has been identified, supervisory authorities generally have a range of proportionate response options available to them in order to address potential market conduct issues. The nature and extent of these response options depends on their statutory and regulatory authority.

**Risk-based Market Conduct Models**

A supervisory model is defined as a distinctive set of structures and processes for risk assessment and intervention that are logically consistent with one another. The structure or architecture of the system refers to the parameters for determining and implementing a jurisdiction's public policy objectives for the oversight of market conduct in the insurance industry. This architecture of the system is also an important element in defining market conduct risk. Processes (practices) refer to how risk assessment is conducted and how supervisory intervention to ensure compliance is exercised. Risk-based supervisory models vary according to public policy objectives, the definition of risk and in the practices of risk assessment and intervention.

This paper reviews the risk-based supervisory models of insurance supervisors in nine jurisdictions:

1. **United States** – a heterogeneity of approaches among the fifty states with a broader base of what falls within the scope of market conduct than most other jurisdictions.
2. **Australia** – an industry managed model with regulatory oversight.
3. **New Zealand** – a self-regulatory model
4. **European Union**
    a. **France** – complaint triggered risk assessment. Insurance market conduct risks addressed through the broader general business practice framework.
    b. **Germany** – an integrated solvency/market conduct approach that utilizes qualitative macro and micro risk assessment.
    c. **Italy** – focus on informed consumers utilizing qualitative macro and micro risk assessment.
    d. **Spain** – focus on informed consumers utilizing qualitative macro and micro risk assessment.
    e. **Sweden** – an integrated solvency/market conduct risk assessment approach.

f. **United Kingdom** – an integrated solvency/market conduct risk assessment approach utilizing impact and probability analysis on a supervisory ladder.

In addition, this paper reviews the supervision of securities markets in Canada and the United States. See Annex A for a summary of the models reviews.

In evaluating these models the paper describes the architecture of the system (supervisory authority, consumer redress mechanisms) and reviews key characteristics of the models including, the public policy objectives, how risk is assessed and the compliance and enforcement mechanisms available.

## United States

*Overview and System Architecture*

State legislatures ultimately have responsibility for insurance issues and policy and market conduct regulation is the responsibility of state insurance departments. State insurance regulators are responsible for regulating the financial solvency of insurers and their market behaviour. Regulators police insurers' and agents' sales, underwriting and rating activities in order to ensure that they adhere to certain standards and that claims are handled according to the provisions of the insurance contract.

The National Association of Insurance Commissioners (NAIC) coordinates the supervision of multi-state insurance companies within a state regulatory framework. The NAIC functions mainly in an advisory capacity and as a service corporation for state insurance departments. The NAIC supports state regulatory efforts by maintaining an extensive insurance database, providing technical expertise to insurance departments, developing model laws and coordinating regulatory policy. The NAIC Market Analysis Working Group (MAWG) is the national forum for states to share and coordinate the results of their market conduct surveillance and analysis programs.

The National Conference of Insurance Legislators (NCOIL) is an organization of state legislators concerned with insurance legislation and regulation. The NCOIL provides a forum for discussion among legislators and has adopted several model laws and resolutions for consideration by state legislatures in the United States. In March 2004 the NCOIL adopted a market conduct surveillance model law and a flex-rating regulatory improvement model law for property and casualty lines of business.

The United States does not have a national insurance ombudservice for consumer redress. Instead, each state insurance department monitors and handles consumer complaints.

*Public Policy Objectives and Regulatory Principles*

Market conduct regulation is designed to ensure that insurance companies are fair and non-discriminatory in their dealings with consumers, do not renege on the terms of the contract and write policies that offer what state laws require. Many state insurance departments and legislators have also generally recognized that competitive markets are the best regulator of insurance related activity.

*Risk Assessment*

The definition of market conduct risk has not been strongly formulated by most state insurance departments. In general, state insurance legislation prescribes unfair and discriminatory practices in industry's dealings with consumers. Commonly, state regulators look to ensure that insurance companies do not engage in unfair or discriminatory practices and do not renege on their terms of contract. At the state wide or systemic level, risk is often defined in practice by the level of rate increases, competition and size of the residual market.

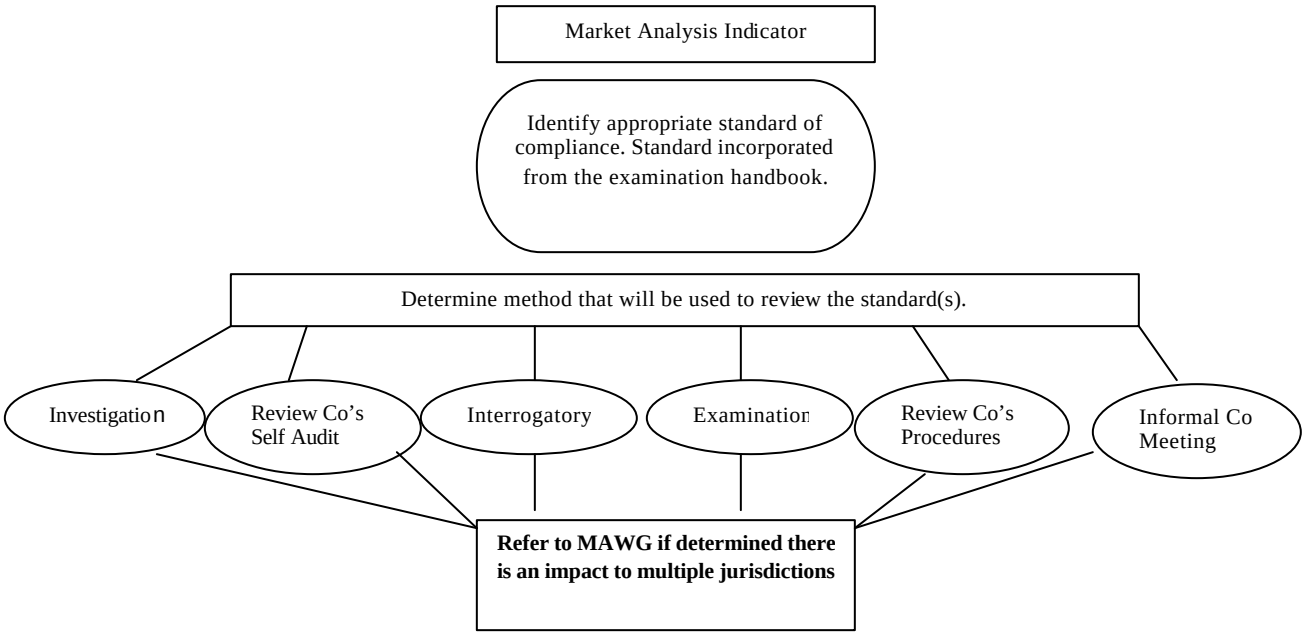
The NAIC Market Conduct Analysis Handbook approach to risk assessment incorporates information from both desk audits and on-site examinations. The approach combines impact thresholds and probability related data for state insurance departments to monitor. The NAIC identifies market share and national significance as important impact factors. Complaints and other data provide probability data. As some lines of insurance are considered more prone to market conduct problems, line of business may influence regulatory expectations regarding the potential for market conduct concern. In particular, the NAIC indicates that market conduct risks may be higher in some personal and small business markets than large commercial.

The NAIC maintains a database system (I-Site) containing complaints data, an examination tracking system, an investigations database and an enforcement actions database supported by data supplied by state insurance departments. I-Site also contains quarterly and annual financial statements. State insurance regulators access this database as part of their risk assessment of insurance companies that operate in multiple states. Coordination between state insurance regulators is considered essential to make market conduct regulation more effective and efficient. A company's compliance or non-compliance is considered to be largely the systemic result of decisions made at a national or regional level. U.S. regulators have noted that a life insurer's operations tend to be relatively consistent nationally while property and casualty companies tend to be regionally structured. A company that has an outstanding or outrageous record of market conduct in one market will likely have a comparable record in other markets where it does business. In the past, the I-Site database has suffered from under or inconsistent reporting by state insurance departments, reducing its effectiveness.

The MAWG reviews and coordinates state market analysis programs and also monitors nationally significant insurers.[1] If concerns with a nationally significant insurer are identified, the domiciliary regulator is notified and it develops a response plan in consultation with the working group. The MAWG is currently developing an automated tracking system for standardized market conduct regulatory profiles for nationally significant insurers. The profiles will contain five year trend information on state specific premium volume, a modified financial summary, complaints index report, regulatory actions report, investigations report, closed complaints report, exam tracking report, modified IRIS (solvency) ratio's and other information (reserves etc).

[1] The nationally significant threshold for a life insurer is $50 million (USD) in gross premium and did business in at least five states. For a P&C company the threshold is $30 million (USD) and it did business in 17 states.

**Risk Assessment & Compliance Process Flow**




*Source: NAIC Concept Illustration Integration of Examination Handbook into Market Analysis Handbook*

A number of states have introduced a Market Conduct Annual Statement for life insurers.[2] The participating states are Illinois, Maryland, Missouri, Nebraska, Ohio, Oregon, Pennsylvania and Wisconsin. The annual statement includes data claims paid exceeding certain threshold dates (30 days, 60 days), claims denied, claims received, replacements, number of polices in issued/in force and premium/value data by class of insurance. The annual statement is expected to provide an analysis tool for certain key market performance issues that will help regulators allocate market analysis resources where they can be most effective. The states intend to review their markets and share the results of their respective analyses and work to coordinate any needed responses or examinations.

The United States General Accounting Office (GAO) in its September 2003 review of market conduct insurance regulation found that formal and rigorous market conduct risk assessment was used inconsistently. The GAO report found that twenty-four states fully or predominantly conducted targeted on-site market conduct exams based on some form of risk assessment. Twelve states conducted routine on-site exams on a subset of companies. The remaining states either maintained a balance between routine or target on-site examinations or combined their market conduct examinations with solvency examinations. Annex B provides a more detailed overview of several risk based approaches in some states.

While it found that all states do some market analysis and risk assessment, the GAO also found that there was little consistency in how the surveillance and analysis was conducted. The GAO survey of states found that the most common triggers for a market conduct exam were a combination of complaints, market share and time since the last examination. The GAO review also found that state coordination of market conduct on-

[2] Developed in consultation with the industry. A P&C version is currently being developed.

site examinations was inconsistent and infrequent. It noted that even in states where coordination did occur, other states' examination results generally were not considered in determining examinations. As a result, the GAO reported that many insurance companies, particularly larger ones, reported that they underwent frequent and sometimes simultaneous on-site market conduct examinations. The GAO report noted that out of a sample of twenty-five companies, nineteen reported being examined 130 times by multiple regulators over a three-year period. It was noted that this occurred because of under or inconsistent reporting by state insurance departments, reducing the NAIC's examination tracking system's (included in I-site) effectiveness.

Responding to complaints is the primary way in which insurance departments assess market conduct risk. Complaint and financial statement data form the core data set of state market conduct risk assessment programs. Complaint data used for market conduct analysis in many states is screened for confirmed or justified complaints. Criteria for justified complaint status vary from state to state and may include for example, whether an insurer violated a law, whether the complaint was resolved in favour of the consumer or whether the complaint analyst determined that the complaint was valid. However many state insurance departments use unscreened complaint data.[3]

However, as state insurance departments evaluate market conduct risk, in addition to complaint data, they have three additional mechanisms for gathering information: examinations and investigations of specific companies, surveys and periodic reporting requirements designed to gather market conduct data and analysis of existing financial information collected for solvency purposes.

*Compliance and Enforcement*

Compliance and enforcement is the responsibility of individual state insurance departments. State insurance departments maintain complaint resolution programs and work with consumers and insurers to address consumer complaints. State insurance departments monitor non-compliance with the state legislation on market conduct and work with insurers to correct issues of non-compliance.

Insurance supervisors have a range of powers and enforcement mechanisms to address instances of market conduct risk or non-compliance. They have extensive inquiry and examination powers in which an insurance department can request information to better evaluate a risk. Further, supervisors have the authority to intervene and work with a company to address the specific issue of concern or develop a risk management strategy. State insurance departments may also deliver administrative penalties (financial) and have the authority to pursue enforceable undertakings through the courts and support criminal action leading to imprisonment. Where necessary, the regulator may withdraw an individual or company's license to operate.

State insurance departments maintain investigative departments dedicated to addressing issues of market conduct in financial services, particularly with regards to fraud or improper market practices. These units are responsible for protecting the integrity of the financial system.

[3] The justification for this is that a complaint is a measure of consumer dissatisfaction and all expressions of dissatisfaction should be counted equally.

## Australia

*Overview and System Architecture*

The Australian Securities and Investments Commission (ASIC) enforces and regulates company and financial services laws for investments, life and general insurance, superannuation and banking (except lending) to protect consumers, investors and creditors. An independent Australian government body, ASIC has regulated financial markets, securities, futures and corporations since January 1991. Since 1998, ASIC has been responsible for consumer protection in superannuation, insurance and deposit taking.

ASIC is responsible for compliance, monitoring and licensing of participants in the financial system to protect consumer interests and ensure market integrity; it also takes action to give effect to the laws administered by ASIC. In addition, ASIC works with the insurance industry on dispute resolution and industry codes of practice, which must be approved by ASIC. All insurers are required to ascribe to a code of practice.

The General Insurance Code of Practice is the only code approved by ASIC for general insurance. The General Insurance Code of Practice includes provisions on the supervision and training of insurance agents; training of employees; content and availability of policy documentation; procedures for claims handling; supervision of investigators, assessors and loss adjusters; and internal and external dispute resolution. This code was developed by the industry's Insurance Council of Australia. The Life Insurance Code of Practice includes provisions on same day sales; disclosure of capacity; fact-finding and needs analysis; customer advice records; training and competency of employees and agents; and inquiries, complaints and disputes. This code was developed by the ASIC's predecessor organization. There is also a general insurance agents code of practice for general insurance.

The Australian Prudential Regulation Authority is the financial supervisor responsible for prudentially regulating the banking, other deposit-taking, insurance and superannuation industries. Outputs aim to enhance public confidence in Australia's financial institutions through a framework of prudential regulation which balances financial safety and efficiency, competition, contestability and competitive neutrality.

All financial services firms are required to belong to an independent complaints scheme. The General Insurance Enquiries and Complaints Scheme (IEC) is an industry-run national program for consumers aimed at resolving disputes between insureds and their insurance companies or claimants who have a dispute with another person's insurance company in relation to motor vehicle property (ie third party claim). The IEC also provides free advice and information about any general insurance matter.

The Financial Industry Complaints Service (the Service) provides free advice and assistance to consumers to help them in resolving complaints relating to members of the financial services industry, including life insurance, superannuation, funds management, financial advice, stock broking, investment advice and sales of financial or investment products. There is also an Insurance Brokers Dispute Limited (IBD), which deals with complaints about general insurance brokers and some life insurance brokers.

All dispute resolution services must be approved by ASIC. The decision of the dispute resolution service is binding upon member insurers but consumers retain access to the courts if they do not accept the decision.

*Public Policy Objectives and Regulatory Principles*

ASIC's role, as the market conduct regulator in the financial sector, is to promote fair and efficient financial market characterized by integrity and transparency and supporting confident and informed participation of investors and consumers.

The legislative objectives of ASIC to promote the confident and informed participation of consumers in the financial system is detailed in the *Australian Securities and Investments Commission Act 2001* which requires ASIC to:

- uphold the law uniformly, effectively and quickly;
- promote confident and informed participation by investors and consumers in the financial system;
- make information about companies and other bodies available to the public, and
- improve the performance of the financial system and the entities within it.

In practice, ASIC seeks accomplish these policy objectives through supervisory approaches that ensure consumers receive adequate and appropriate information to make informed decisions about financial products and services and through oversight of the marketplace to proactively identify, stop and deter misleading and fraudulent conduct. In addition, ASIC seeks to adopt a flexible approach to regulation to ensure that unnecessary impediments to business are removed, where consumer protection goals are not compromised, and promote consumer education.

*Risk Assessment*

ASIC's definition of risk at an institutional level has been weakly formulated in terms of market conduct and generally defined through complaints and other issues identified in the strategic planning process. At the systemic level, risk is defined as any sequence of events or issues that will affect ASIC's statutory objectives.

In order achieve these statutory objectives, ASIC has developed an integrated risk based approach to compliance. The approach focuses on identifying and responding to emerging regulatory problems, patterns of conduct and financial services sector issues. ASIC's risk based approach involves systemic identification of important regulatory risks and then putting in place regulatory responses designed to address the specific regulatory concern

At an institutional level, ASIC's surveillance program monitors compliance by insurers (and other financial sector participants). The goal of the program is to influence the behaviour of the system participants and so reduce the incidence of non-compliance. ASIC's market conduct monitoring and surveillance activities can be broadly categorized as responses to notifications of breaches, detailed reviews of disclosure documents and targeted compliance visits and campaigns.

In addition to utilizing data from complaints, licensing disclosures and discussions with industry participants, ASIC has agreements with prudential regulators for access to

prudential risk ratings of institutions.[4] This prudential risk rating, particularly as it incorporates an assessment of corporate governance and internal controls, is a component of ASIC's institutional risk assessment. An outline of APRA's risk rating process (including impact and probability assessments) is included in Annex C.
In addition to institutional risk assessment, ASIC monitors and prioritizes issues in the external environment that impact the insurance industries. ASIC considers such external issues as economic pressures, global developments (reinsurance, litigation etc), competition, jurisdictional gaps, new product innovations, demographic changes and business cycles. This information and risk analysis, using impact and probability estimations, is used in ASIC's planning process to set priorities and allocate regulatory resources.[5] A result of this analysis may be theme inspections/sweeps by ASIC in order to generate more information for supervisors and policymakers.

*Compliance and Enforcement*

Responsibility for compliance and enforcement is shared by ASIC and industry bodies. Industry codes of practice are administered by the approved dispute resolution services in conjunction with ASIC. The consumer redress schemes monitor non-compliance with the codes of practice and the approved dispute resolution agencies work with insurers to correct issues of non-compliance. Compliance with the codes are enforced through sanctions against the insurer such as required in accordance with a specified timetable; a requirement that a compliance audit be undertaken; corrective advertising; and public censure. The consumer redress scheme may also refer the issue to the ASIC for enforcement.

ASIC utilizes its regulatory tools to influence the behaviour of financial institutions toward appropriate market conduct behaviour, with disciplinary mechanisms for transgressions. ASIC has a range of powers and enforcement mechanisms to address instances of market conduct risk or non-compliance. It has extensive inquiry and examination powers in which it can request information to better evaluate a risk. Further, it has the authority to intervene and work with a company to address the specific issue of concern or develop a risk management strategy. ASIC has the authority to pursue enforceable undertakings through the court and support criminal action leading to imprisonment.

ASIC places an emphasis on corporate governance and the responsibility of the company for compliance. Where necessary the supervisory authority may issue stop orders, subject a license to certain conditions, ban individuals or withdraw a company's license to operate.

[4] ASIC is in the process of implementing an new single licence that risk rates a company by requiring the reporting of the number of compliance staff, complaints history etc.
[5] While ASIC maintains staff in core functions, the broad system risk analysis is an important part in the allocation of staff into priority areas.

## New Zealand

*Overview and System Architecture*

New Zealand has one of the least regulated insurance markets in the world. Overall responsibility for policy development and review of the insurance industry lies with the Ministry of Economic Development. The Insurance and Superannuation Unit ensures insurance companies comply with the statutory obligations (primarily solvency related) under the *Life Insurance Act 1908* and *Insurance Companies' Deposits Act 1953*, and administers *the Insurance Companies (Ratings and Inspections) Act 1994.*

Consumer protection law, both statutory and common law, provides protections to consumers of insurance services. The *Fair Trading Act 1986* generally provides that no person may engage in business conduct that is misleading or deceptive or that is likely to mislead or deceive. The *Consumer Guarantees Act 1993* codifies common law principles relating to the basic guarantees in respect of the provision of goods and services to consumers, such as the need for a good or service to be fit for the intended purpose and to be provided with due care and skill. The Registrar of Companies has the authority to investigate companies and initiate statutory management in the enforcement of these Acts.

New Zealand has adopted a formal self-regulatory approach to insurance supervision of market conduct. The Insurance Council of New Zealand (ICNZ) works with the Ministry of Economic Development to oversee the general insurance industry. The Investment Savings and Insurance Association (ISI) is the industry self-regulatory body for life and health insurers. These self-regulatory bodies impose rules relating to financial market integrity and consumer protection, such as codes dealing with sales and disclosure of information. All members of the ICNZ and ISI are required to participate in the Insurance and Savings Ombudsman (ISO) Scheme.

The ISO is an independent body that assists consumers in resolving complaints against participating insurance and savings companies. The service is free to consumers. The ISO's jurisdiction is determined by its terms of reference. Insurers participating in the ISO scheme are obliged to have internal complaints processes. Decisions by the ISO are binding on insurers. Consumers may take the issue before the courts if they disagree with the decision.

*Public Policy Objectives and Regulatory Principles*

The Ministry of Economic Development has identified a number of public policy objectives for New Zealand's financial services sector. These include the promotion of a sound financial system, a level playing field, contestable, competitive and efficient financial markets, market confidence and prudent risk management.

New Zealand's financial services supervision is based on three principles: self-discipline, market discipline and regulatory discipline. Self-discipline involves reinforcing incentives to financial institutions to maintain internal systems of risk management. Generally this means promoting disclosure and accountability of boards of directors. Market discipline creates an efficient market through the incentives created by competition. Regulatory discipline is related to the limited use of regulatory and supervisory mechanisms to reinforce incentives for financial institutions. Higher risk institutions generate increased levels of supervisory attention.

To meet these objectives, the focus of New Zealand's market conduct regulation in insurance is on providing consumers with reliable and timely information to assist them to make well-informed decisions, and to require financial institutions and intermediaries to comply with general consumer protection law. Reflecting this, insurance and financial services law and regulations are principally disclosure based.

*Risk Assessment*

New Zealand's definition of risk at an institutional level has been weakly formulated in terms of market conduct and is generally defined through complaints. At an institutional level, these complaints are generally around business and claims practices.

The New Zealand self-regulatory authority utilizes complaints data in order to monitor market conduct risk. The Ministry of Economic Development may require further information where it is deemed warranted. In addition, the Registrar of Companies may investigate companies, give directions or initiate statutory management where warranted. New Zealand does not conduct desk audits or on-site examinations and generally relies on complaints to trigger market conduct action. In general, business practices of insurance companies are subject to the same rules and oversight as any other business.

*Compliance and Enforcement*

Compliance and enforcement is shared by the Ministry of Economic Development and industry self-regulatory bodies. Industry codes of practice are administered by the approved dispute resolution services in conjunction with the Ministry. The consumer redress scheme monitors non-compliance with the codes of practice and works with the self-regulatory bodies insurers to correct issues of non-compliance. Compliance with the codes is enforced through sanctions such as penalties and public censure.

While the Ministry of Economic Development relies on self-regulatory bodies and informed consumers in a competitive market to influence the behaviour of financial institutions, the Registrar of Companies does have the authority to investigate companies, give directions and initiate statutory management in the enforcement consumer protection legislation. The Ministry of Economic Development places an emphasis on corporate governance and the responsibility of the company for compliance. New Zealand is in a unique situation where the majority of its insurers are Australian companies. As a result, New Zealand relies on Australia's registration of directors.

## The European Union

*Overview and System Architecture*

Each European Union (EU) member country is free to regulate as it wishes subject to full implementation of EU directives. Historically, EU regulatory philosophies have varied enormously among EU states. Ireland, the Netherlands and the U.K. have always exercised regulatory authority with a minimum level of intrusion, placing emphasis on prudential regulation while allowing consumers to choose among an array of policy terms, conditions and prices. In contrast, most other EU countries had historically exercised strict regulation, focusing not only on prudential issues but also on the detailed oversight of policy terms and conditions, pricing and market conduct.

A report of the Organisation for Economic Co-operation and Development on insurance regulation among member countries notes that since 1992, insurance markets in EU countries have been transformed as the EU has moved toward an integrated insurance market that is more risk-based and less interventionist regulatory approach. EU framework directives have created a basis for home country control and mutual regulatory recognition built on minimum harmonization. These directives create the broad rules and policy direction of market conduct regulation within the European Union. Each Member State is responsible for the monitoring, compliance and enforcement of these rules and any additional local regulation. In addition, a European consumer redress service (FIN-NET) complements national ombudservices by providing cross-national services.

In most areas of regulation, the European Union has dealt with life assurance and non-life insurance separately in order to take account of their specific characteristics and the important role which life assurance plays in long-term savings and provident schemes. While the insurance framework directives have primarily focused on prudential regulation, they have also made fundamental changes to European insurance market conduct regulation. They have created a framework that requires financial institutions to provide their clients with appropriate information; strengthens consumer legal protection when something goes wrong; and provides for systems of redress.

The central concept to the insurance framework (for both life and general insurance) is a single European Union-wide authorization or “passport” and a primary (home member state) jurisdiction approach for all cross-border business.

On June 17, 2003, the EU Commission presented a **proposal for a directive on unfair commercial practices in the internal market.** The future directive is expected to harmonize the rules for market conduct, which differ from one Member State to another. It will establish a single, common and general ban on unfair commercial practices which distort consumers’ economic behaviour. The proposal lays down rules for determining whether a commercial practice is unfair and provides a short list of misleading practices which are prohibited throughout the European Union. The two criteria used to determine whether a practice is unfair are: if the practice is contrary to the requirements of professional diligence, and if it materially distorts the economic behaviour of consumers. The proposal makes a distinction between two types of unfair practice: those, which are misleading, and those, which are aggressive.

In general, market conduct regulation of insurance services in the European Union is generally not distinguished from the oversight of market conduct of other business services.[6] Nevertheless, the European Union has also developed proposal for the regulation of insurance intermediaries.

Since January 2001, FIN-NET, a complaints network for out-of-court settlement in the financial services sector, has helped consumers dissatisfied with a service to find an amicable solution to a problem where the supplier is established in a Member State. This initiative, intended to strengthen customer confidence, is consistent with the Financial Services Action Plan (FSAP) and the communication on a new strategy for the services sector in the wake of the Lisbon European Council.

*Public Policy Objectives and Regulatory Principles*

The creation of a single market in insurance has been one of the European Community's priorities for a long time.

**Public Policy Objectives for European Insurance Regulators**

| | Public Policy Objectives/Principles | Integrated supervision | Regulatory Authority |
|---|---|---|---|
| France | Financial sector stability<br>Informed consumer<br>Competitive markets | No | Ministère de l'Économie, des Finances et de l'Industrie;Commission de contrôle des assurances, des mutuelles et des institutions de prévoyance, |
| Germany | Financial sector stability<br>Market confidence | Yes | Federal Financial Supervisory Agency (BAFin), self-regulatory organizations |
| Italy | Financial sector stability<br>Informed consumer | No | Istituto per la Vigilanza sulle Assicurazioni Private e di Interesse Collettivo (ISVAP) |
| Spain | Competitive markets<br>Informed consumers | No | Dirección General de Seguros y Fondos de Pensiones |
| Sweden | Financial sector stability<br>Informed consumers<br>Good insurance (business conduct) practice<br>Cost/benefit analysis of regulatory measures | Yes | Finansinspektionen (Swedish Financial Supervisory Authority) |
| United Kingdom | Maintaining market confidence<br>Promoting public awareness<br>Protecting consumers, and<br>Reducing financial crime. | Yes | Financial Services Authority, General Insurance Standards Council (self-regulatory body for intermediaries) |

*Source: European regulatory authorities*

Over the last decade, the insurance market has been characterized in all Member States by a steady increase in turnover, reflecting growing demand for this type of product and the increasingly important part played by the insurance sector in the development of

[6] Note: As a result of this general trend toward regulating insurance through more general consumer protection legislation/regulation, some forms of market conduct regulation around the nature of the products (ex. tariff (rate) and drafting of products regulation) have largely been deregulated in order to enhance competition and innovation and facilitate healthy, solvent insurance markets. Such countries included France, Germany and Sweden.

economic activity in general. In accordance with Treaty, the internal market in insurance activities comprises an area without internal frontiers in which insurance undertakings are free to carry out their activities.

The objective of the European activity is to provide all European Community citizens with access to the widest possible range of insurance products on offer in the Community, while at the same time guaranteeing them the legal and financial protection required for an insurance transaction; the second objective is to guarantee that an insurance company authorized to operate in any of the Member States can pursue its activities throughout the Community as regards to both the right of establishment and the right to supply services.

These European Community measures, and in particular the third life and non-life Directives, provide the legislative framework for completing the internal market in the insurance sector through the establishment of freedom to provide services to potential policyholders, who will thus benefit from a wider choice of products at the lowest possible prices thanks to increased competition.

Overall the public policy objective of the European Community insurance framework directives around market conduct and consumer protection is to seek to establish legislation fostering a stable, reliable sector and to extend the range of products and to reduce the price and improve the quality of the services offered.[7]

*Risk Assessment*

Each Member State regulator is solely responsible for the regulation of an insurance company. As part of its supervisory activities, the home state regulator must require that insurers which it supervises have sound administrative and accounting procedures and adequate internal control mechanisms.

| | **Risk assessment methodology** | |
|---|---|---|
| France | Complaints data<br>Regular prudential/internal controls examinations | |
| Germany | Complaints data<br>Impact assessment (financial conglomerates) | Monitoring of system trends |
| Italy | Complaints data<br>Regular prudential/internal controls examinations | |
| Spain | Complaints and mediation data<br>Monitoring of system trends | Targeted desk/onsite examinations |
| Sweden | Complaints data<br>Impact assessment (size of institution)<br>Monitoring of system trends | Desk audits<br>Targeted on-site examinations |
| United Kingdom | Risk-based ladder of supervisory intervention based on impact (size of institution) & the probability (likelihood of a problem) risk of market conduct issues.<br>Complaints<br>Desk audits<br>Monitoring of system trends<br>Targeted on-site examinations | |

*Source: European regulatory authorities*

[7] Also to apply minimum prudential rules.

The authorities of the home Member State are given extended powers including the right to carry out on-site examinations of branches in other Member States.[8]

*Compliance and Enforcement*

Home Member State regulators are responsible for compliance and enforcement in the event of non-compliance with host state regulations.

EU regulatory authorities place an emphasis on corporate governance and the responsibility of senior management for compliance. Compliance is monitored through the ongoing firm-specific risk assessment process and firm-specific triggers such as complaints. EU regulators uses a mix of enforcement mechanisms that include private warnings, administrative penalties (fines etc), public censure, intervention (risk mitigation plans etc) and prosecution.

[8] Although host Member State authorities are entitled to be involved in such examinations.

## France

*Overview and System Architecture*

The Ministère de l'Économie, des Finances et de l'Industrie (Ministry of Finance, Economy and Industry) oversees the institutional framework for the regulation of insurance, including public policy relating to insurance companies, intermediaries and regulatory bodies. In addition the Ministry is responsible for the approval of new insurers, the transfer of portfolios and the approval of certain documentation, for example, with respect to advertising.

The French supervisory and regulatory mechanisms (primarily prudential) set up in 1989 to provide oversight to the insurance industry, recently underwent a restructuring. In August 2003, the organization of the supervisory structures were reorganized with the merger of the Commission de contrôle des assurances (CCA) and the Commission de contrôle des mutuelles et des institutions de prévoyance (supervisor for mutual companies) into the Commission de contrôle des assurances, des mutuelles et des institutions de prévoyances (CCAMIP). While the French system is in transition, the CCAMIP when operational, will be an independent public authority equipped with enhanced enforcement and compliance capacities.

The French Insurance Code and the EU directives establish minimum standards and information and advice to consumers, and in particular require that intermediaries disclose their financial and contractual ties to insurance companies. Under changes being contemplated for adoption by January 15, 2005, intermediaries will also be obliged to specify in writing, prior to conclusion of the contract, their reasons for recommending a specific product to a consumer. Policyholders are also protected under the Consumer Code from some marketing practices.

La Direction générale de la Concurrence, de la Consommation et de la Répression des Fraudes (DGCCRF) oversees market conduct operation of the insurers (and other sectors of the economy).[9] The role of the DGCCRF is to guarantee the conditions of a balanced and transparent market, for the benefit of all economic operators. The DGCCRF promotes consumer education and awareness and will also provide assistance to consumers in disputes with insurers. The DGCCRF also works with the CCAMIP.

The Comité consultatif du secteur financier (CCSF) is a high level body consisting of stakeholders that study questions and issues related to the financial sector and provide relevant policy recommendations.

*Public Policy Objectives and Regulatory Principles*

The French insurance supervisory framework is based around consumers, competative markets and ensuring that the insurance companies are able to keep their contractual commitments. The principle policy objective of the French supervisory system is to prevent problems from arising. The focus of French insurance regulation is prudential and has generally been more interventionist than the U.K. approach.

[9] DGCCRF - Directorate-General of Competition, the Consumption and the Repression of Frauds

*Risk Assessment*

Market conduct risk for insurance is not clearly defined, as insurance risks are not considered different from the market conduct risks of other services and products. In practice, market conduct risk in insurance is variable and defined through complaints trends. At an institutional level, these complaints are generally around business and claims practices.

The French regulatory authority utilizes complaints data in order to monitor market conduct risk. It regularly conducts prudential desk audits and on-site examinations and generally relies on complaints to trigger market conduct action. Where prudential on-site examinations identify problems with internal controls that would have implications for market conduct, these are usually addressed within the scope of solvency supervision. French regulatory authorities do not conduct market conduct specific examinations. In general business practices of insurance companies are subject to the same rules and oversight as any other business.

*Compliance and Enforcement*

In the event that non-compliance is identified, the Ministry has authority for investigation and enforcement. In addition to extended powers to carry out investigations, regulatory authorities may also issue injunctions and sanctions and as outlined in insurance code (law). In some cases these are subject to publication in the Official Journal in the form of opinion or to official statements (bond documents opinion and official statements).

The DGCCRF works with the CCA/CCAMIP on issues of misleading advertising and fraud.

**Germany**

*Overview and System Architecture*

Responsibility for the supervision of insurance is divided between the federal and state governments. The federal agency**,** Bundesanstalt für Finanzdienstleistungsaufsicht **(**BaFin), supervises private insurance companies active in Germany, which are large and of national scope, publicly listed, provide cross national insurance services.[10] State (länder) governments regulate smaller (generally mutual) insurance companies. The BaFin combines the three former federal supervisory boards for the credit system (BAKred) for insurance (BAV) and for the securities trading (BAWe).

The Versicherungsombudsmann is an industry run private arbitration board that is free for consumers. It assists consumers in resolving complaints against its insurance companies. Member insurers accept the rulings of the ombudservice as binding.

In addition, a network of private consumer centers (Verbraucherzentrale Bundesverband e.V.) provides consumers with information on their rights and obligations and will assist (legal advice, dispute resolution, prosecute illegal activity) consumers in the pursuit of their rights. There is generally a fee associated with this service. The network is a non-governmental organization acting as an umbrella for 38 German consumer associations. Government funding for specific projects supports the network.

*Public Policy Objectives and Regulatory Principles*

The principal objective of the German financial sector public policy is to ensure the long term stability and integrity of the entire German financial system. While solvency is the major focus of the regulatory system, a further goal of the BaFin is to protect customers and investors by overseeing business practice standards. Supervision of these standards protect the confidence of investors in the financial markets.

BaFin's underlying regulatory principle in the supervision of insurance is ensuring market confidence. The focus of BaFin's supervision of insurance is centered around protecting the interests of the insured (business practices) and to guarantee that the obligations from the insurance contracts are at any time fulfillable (claims practices and solvency).

*Risk Assessment*

Market conduct risk for insurance is not clearly defined. Insurance market conduct risks are not considered different from the market conduct risks of other services and products. In practice, market conduct risk is variable and defined through complaints trends. At an institutional level, business and claims practices are the primary identified risks.

At the institutional level, the BaFin primarily utilizes complaints data in order to monitor market conduct risk and non-compliance with business practice standards. The trigger further for examination or intervention at an institution is generally based on the experience of supervisory staff. There is no formal threshold or supervisory ladder that triggers supervisory investigation or intervention. In addition, supervised institutions are

[10] BaFin also supervises banks and securities.

required to report material facts, such as the appointment of new managers and structural changes.

Financial reporting by insurance companies provides the basis for analysis and checks. The BaFin regularly conducts prudential desk audits and where warranted, on-site examinations. Where prudential on-site examinations identify problems with internal controls that would have implications for market conduct, these are usually addressed within the scope of solvency supervision. On-site inspections require a judicial warrant from the district court.

In addition, Germany employs an impact assessment of risk whereby larger institutions and financial conglomerates are given priority in supervision. Generally, business practices of insurance companies are subject to the same rules and oversight as any other business.

At a systemic level, the BaFin identifies and analyzes financial and business practice trends, domestically and internationally. The BaFin's Financial Market and International Department monitors the system and develops strategy and responses to new challenges in the system as they arise.

*Compliance and Enforcement*

The BaFin utilizes its regulatory tools to influence the behaviour of financial institutions toward appropriate market conduct behaviour, with disciplinary mechanisms for transgressions. The BaFin has a range of powers and enforcement mechanisms to address instances of market conduct risk or non-compliance. It has extensive inquiry powers in which it can request information to better evaluate a risk. Further, it has the authority to intervene and work with a troubled company to address the specific issue of concern or develop a risk management strategy. The BaFin may also deliver administrative penalties (fines) and has the authority to pursue criminal action leading to imprisonment.

The BaFin places an emphasis on corporate governance and the responsibility of the company for compliance. Where necessary, the supervisory authority may participate in the executive committee, board of directors or other organs of the institution through a representative. In addition, the BaFin may withdraw a company's license to operate.

The BaFin maintains an investigative department dedicated to addressing issues of market conduct in financial services, particularly with regards to fraud or improper market practices. This department is responsible for protecting the integrity of the financial system.

## Italy

*Overview and System Architecture*

The Istituto per la Vigilanza sulle Assicurazioni Private e di Interesse Collettivo (ISVAP) was established in 1982 for the purpose of supervising insurance and reinsurance undertakings and other areas of private insurance, including insurance agents and brokers. In its supervision of insurers, ISVAP ensures that the technical, financial, asset and accounting management complies with the laws, regulations and administrative provisions in force. ISVAP also supervises insurance intermediaries in order to guarantee fair play and transparency, factors that it considers fundamental to the development of the insurance market. ISVAP carries out its functions under the policy direction of the Ministry of Industry. ISVAP's legislative mandate does provide the supervisory authority some responsibility in ensuring transparency and disclosure of information to the consumer. There are no specific regulations relating to the marketing of insurance although the general consumer protection laws apply.

Currently, ISVAP is organized into a number of departments including consumer protection (with claims and policies units), market surveillance and corporate governance.

Unlike many other European markets, Italy does not have an independent insurance ombudservice. As part of its consumer protection mandate, ISVAP collects complaints made by interested parties against supervised institutions. ISVAP works to facilitate the prompt and exact execution of contracts, clarifications from insurers and to facilitate a solution of a dispute. As of 2003, insurers operating in Italy are required to establish consumer redress mechanisms.

The Ministry for Industry is responsible for the revocation of the authorization to carry on insurance activities and for the commencement of the compulsory administrative liquidation procedures, both of which are ordered by ministerial decree.

*Public Policy Objectives and Regulatory Principles*

The public policy objective of Italian insurance supervision is to ensure the stability of the market (focusing on solvency and efficient/competitive markets) and to protect of the interests of informed consumers.

*Risk Assessment*

Market conduct risk for insurance is not clearly defined although transparency and informed consumers is a key market conduct supervisory goal. In practice, ISVAP through its complaints services, identifies claims and business practice risks by identifying issues and non-compliance with the rights and obligations derived from a contract of insurance.

ISVAP's market surveillance staff for market conduct and corporate governance practices monitors insurers and intermediaries for transparency and compliance with business practices legislation. At the institutional level, the ISVAP primarily utilizes complaints data in order to monitor market conduct risk and non-compliance with business and claims practice standards. In addition, it will monitor third party commentary on the industry (rating agencies etc) and consult with stakeholder groups in

order to identify and assess market conduct risks. Where a potential systemic issue for an institution is identified through the complaints data the ISVAP may request more information for a desk audit or perform an on-site inspection. The trigger for an examination is generally based on the experience of supervisory staff. There is no formal threshold or supervisory ladder that triggers an examination or investigation. The DGSFP does not systemically review and monitor industry marketing practices, but it does retain the right to investigate and take action should a problem arise.

In addition, ISVAP maintains a unit for monitoring corporate governance of insurance institutions, ensuring that internal controls are in place and that management fufils conditions of personal standing and professional qualification or experience.

Further, ISVAP monitors system-wide risk through the monitoring of international insurance issues and through research on insurance issues.

*Compliance and Enforcement*

In performing its duties, ISVAP has the authority to intervene and work with a troubled company to address the specific issue of concern or develop a risk management strategy. ISVAP may require the supervised institutions to communicate data, facts and information; it may conduct on-site investigations and any other type of investigation; it may summon the legal representatives, the director general and the chairman of the board of auditors and, where necessary, the representatives of the auditing firm assigned to certify the balance-sheet.

Within its statutory powers, ISVAP plays a disciplinary role on the insurance market. Not only does it supervise insurance operators' compliance with the laws and regulations but it also issues directives and introduces risk management programs and rules of conduct to address instances of market conduct risk or non-compliance.

Additionally, ISVAP places an emphasis on corporate governance and the responsibility of senior management for compliance. The ISVAP regulates the conditions of access (authorization and licensing of individuals) and exercise of the distribution of insurance products. Senior managers are required to fufil conditions of personal standing and professional qualification or experience.

The ISVAP maintains an investigative department dedicated to addressing issues of concern and non-compliance (in both solvency and market conduct) in insurance services.

## Spain

*Overview and System Architecture*

Statutory and regulatory provisions from very diverse areas converge in the regulation of insurance in Spain. Administrative laws apply to the control and supervision of insurers by public bodies. Commercial law regulates insurance contracts, providing certain policyholders and beneficiaries special protection.

The Ministry of the Economy is the administrative body which oversees the functioning and development of the insurance market in Spain, exercising its powers in the field through the Dirección General de Seguros y Fondos de Pensiones (DGS), which forms part of the state secretariat for the Ministry. The DGS consists of four directorates: insurance and legislative policy, the arrangement of the insurance market, inspections and pensions. In addition, some autonomous regions have full responsibility and power for legislative development and supervision of insurance. The DGS does have the power to pass technical rules with respect to solvency issues (investment etc) but scope is limited in market conduct. Nevertheless, in general, the DGS tends to issue general instructions rather than issue detailed written guidance.

Marketing and advertising by insurance companies must comply with the provisions of the General Act 34/1988 of November 11 on Advertising. Marketing and advertising by insurers must be truthful, effective and provide sufficient information to consumers.

Spain has recently established a new administrative body attached to the DGS in order to improve consumer protection. This Commission for Financial Services Consumer Protection monitors and assists consumer with complaints and mediation services. Spain also recently required insurers to establish consumer redress mechanisms.

*Public Policy Objectives and Regulatory Principles*

The principal objectives of public policy is to ensure a competitive insurance market, the financial stability of the Spanish insurance system and the protection of insureds. More recently the public policy objective of innovative insurance services sector has also been adopted.

The DGS seeks to protect customers by supervising consumer redress and overseeing business practices. The focus of the DGS's market conduct supervision of insurance is centered around protecting the interests of the insured (business practices) and resolving disputes (consumer redress).

*Risk Assessment*

Market conduct risk for insurance is not clearly defined. In practice, the DGS through its consumer redress and mediation activities, identifies claims and business practice risks by focusing on issues and non-compliance with the rights and obligations derived from a contract of insurance.

At the institutional level, the DGS primarily utilizes complaints and mediation data in order to monitor market conduct risk and non-compliance with business and claims practice standards. In addition, it will consult with stakeholder groups in order to identify and assess risks.

Where a potential systemic issue for an institution is identified through the complaints and mediation data, the DGS may request more information for a desk audit or perform an on-site inspection. The decision for triggering an examination is generally based on the experience of supervisory staff. There is no formal threshold or supervisory ladder that triggers an examination or investigation. The DGS does not systemically review and monitor industry marketing practices, but it does retain the right to investigate and take action should a problem arise.

In addition, the DGS monitors system-wide risk by monitoring domestic and international insurance issues and through studies on the private sector insurance.

*Compliance and Enforcement*

The DGS places an emphasis on corporate governance and the responsibility of trustees or senior management for compliance. The DGS regulates the conditions of access (authorization and licensing of individuals) and exercise of the distribution of insurance products. Senior managers are required to fufil conditions of personal standing and professional qualification or experience. The DGS also maintains a register of managers and intermediaries and such individuals must provide the DGS with necessary information to update the registers periodically. It must keep confidential any documents or information obtained in the exercise of its activity.

The DGS has a range of powers and intervention mechanisms to address instances of market conduct risk or non-compliance. It has extensive inquiry powers in which it can request information to better evaluate a risk. Further, it has the authority to intervene and work with a troubled company to address the specific issue of concern or develop a risk management strategy. The DGS may prohibit certain management activities or temporarily suspend management bodies for up to five years. It may also withdraw authorization to hold a post for an affected individual for up to ten years. The DGS may also restrict a company's operations to specific activities or revoke its authorization to engage in insurance services.

The DGS also possesses disciplinary tools including the cancellation of a company's administrative authorization, fines, and public/private reprimands. The DGS maintains an investigative department dedicated to addressing issues of concern and non-compliance (in both solvency and market conduct) in insurance services and pension funds.

## Sweden

*Overview and System Architecture*

Finansinspektionen (the Swedish Financial Supervisory Authority) is the public authority which supervises and monitors companies operating in the financial sector. Finansinspektionen possesses clearly defined powers to examine the accounts and documents of insurers. It can also publish guidance separately or integrated with regulations under the *Insurance Business Act*. Financial sector institutions are required to have permits issued by Finansinspektionen.

Finansinspektionen was recently reorganized into two main supervision departments, one for Stability and one for Market Conduct. Within the Market Conduct Department, the regulatory model for insurance still needs to be fully developed. In addition, there is new legislation in the pipeline respectfully financial advice to consumers, including insurance customers.

The National Board for Consumer Complaints and the Swedish Consumer Agency/Consumer Ombudsman are independent arrangements for resolving complaints against firms. The National Board for Consumer Complaints provides consumers with an impartial review of a financial claim against an insurer. The Swedish Consumer Agency is responsible for the protection of consumer interests and can take action to stop unreasonable terms of contract and misleading advertising.

*Public Policy Objectives and Regulatory Principles*

The Swedish Parliament and the Swedish Government have stipulated that Finansinspektionen should contribute to the stability and efficiency of the financial sector, and promote satisfactory consumer protection. The principle policy objective of the Swedish supervisory system is to prevent problems from arising.

Public policy objectives specific to insurance have been weakly formulated to date, but the Swedish government is contemplating future legislation, including a new Insurance Contract Law, which may be expected to clarify the public policy objectives of insurance regulation, as well as the distribution of roles among the authorities involved.

Three regulatory and public policy principles underlay the legislation on the operation and supervision of the financial sector in Sweden. These principles are:

- *Principle of stability:* which states that insurance business must be conducted so that solvency, liquidity, and the control over business risks, investment risks and business risks are sufficient with respect to the volume and nature of the business.
- *Principle of transparency:* which states that information to policyholders and presumptive customers shall be adapted to the nature of the policy and show in a clear way the policy conditions and value of the policy.
- *Principle of good insurance standard:* which requires insurance business to be conducted in an appropriate manner, including having mechanisms for handling complaints and other consumer issues.

In applying these regulatory principles to the supervision of insurance companies in Sweden, Finansinspektionen is expected to not unnecessarily hinder sound growth in

the financial sector by over-regulating. The focus of insurance legislation and supervision in Sweden has been oriented more and more toward information and disclosure as a means to the public policy objectives.

*Risk Assessment*

Finansinspektionen's definition of risk has been weakly formulated in terms of market conduct it is generally focused on claims practices risk and business practice risk such as the distribution/sale of insurance products and compliance with filing/reporting requirements.

Finansinspektionen is commissioned to monitor risks and risk management developments in the financial sector. A key measure in its market conduct risk assessment of an insurance company, Finansinspektionen utilizes complaints data in order to monitor whether there are any systemic issues in the way a company handles the settlement of claims.

In addition, desk-audits and regular financial reports and other reporting from insurance companies constitute, together with targeted on-site examinations, the mechanism for ascertaining whether insurance companies conduct their business in accordance with the laws and regulations of Sweden. Finansinspektionen is currently developing a software system for better analyzing the financial and other reported data to better refine its risk assessment of insurance companies. Further, Sweden employs an impact assessment of risk whereby larger institutions are given priority in supervision.

Finansinspektionen identifies and analyzes financial and business practice trends. Extensive periodic reporting by insurance companies provides the basis for analysis and checks. Information relating to corporate business operations is subject to statutory confidentiality rules in order to ensure that companies are able to compete on equal terms. The supervision of licensed insurance companies involves the examination of financial returns and notifications of all major changes to policy conditions in the main classes of insurance.[11]

Insurers are not required to submit any marketing materials to supervisors. Finansinspektionen as a rule does not intervene in such areas of market conduct. However, should company marketing practices be improper or misleading then Finansinspektionen may pursue action against the company as it considers justified. Complaints are the primary risk-based trigger for further investigation or intervention of an insurer.

*Compliance and Enforcement*

Finansinspektionen's effective and proportionate use of its enforcement powers to enforce the requirements of the *Insurance Business Act*, the regulations, supervisory guidelines and other relevant legislation (for example on competition or intermediaries) play an important role in the pursuit of its regulatory objectives.

Finansinspektionen utilizes its regulatory tools to influence the behaviour of consumers and financial institutions toward appropriate market conduct behaviour, with disciplinary mechanisms for transgressions. It also places an emphasis on corporate governance

[11] Note: Finansinspektionen does not have the authority to prescribe policy conditions but may pursue administrative or civil actions if policy conditions are not consistent with the statute.

and the responsibility of senior management for compliance. In issuing its annual permits, Finansinspektionen reviews the suitability of owners and senior managers.

Enforcement options generally range from informal measures to administrative fines. While Finansinspektionen has the power to issue admonitions, administrative penalties or injunctions, it may also call a special Board meeting on the market conduct issue and send a representative to that meeting.

## The United Kingdom

*Overview and System Architecture*

The Financial Services Authority (FSA) is an independent non-governmental body, given statutory powers by the *Financial Services and Markets Act 2000* (the Act). The FSA is an integrated regulator that supervises banks, insurance companies, mortgage lending, pensions, securities, investment firms, exchanges, clearing and settlement houses, and other market infrastructure providers. The FSA supervises the prudential soundness and conduct of business (excluding banks and the sale of general insurance) of its regulated sectors.

The General Insurance Standards Council (GISC) is an independent, non-statutory organisation that regulates the sales, advice and service standards of its members. GISC members may be insurers or intermediaries or others involved in general insurance such as claims handlers. The GISC is a self-regulatory body.

The Financial Ombudsman Service (FOS) and the Financial Services Compensation Scheme (FSCS) are independent arrangements for resolving complaints against firms and for paying compensation in the event of a firm's insolvency.

*Public Policy Objectives and Regulatory Principles*

The FSA's public policy objectives are described in the four statutory objectives established in the *Financial Services and Markets Act 2000*:

- Maintaining market confidence
- Promoting public awareness
- Protecting consumers,
- Reducing financial crime.

In pursuing these objectives, the FSA is required to take into account principles of good regulation. These principles provide the FSA with guidance on its supervisory approach and represent the ideals that the FSA keeps in focus when setting new rules and guidance. These principles are:

- *Efficiency and economy* – relates to how the FSA will allocate and deploy its resources.
- *Role of management* – a firm's senior management is responsible for its activities and for ensuring its business is in compliance with regulatory requirements.
- *Proportionality* – restrictions should be in proportion to expected benefits for consumers and the industry.
- *Innovation* – supervision should facilitate innovation by avoiding unnecessary barriers to entry or restrictions on launching new financial products and services.
- *International character of financial services* – the FSA must take into account the international aspect of financial services and must avoid damaging the competitive position of the U.K.
- *Competition* – the FSA must avoid unnecessarily distorting or impeding competition.

The Act applies these objectives and the principles of good regulation directly to the FSA's supervisory activities. The FSA risk assessment process principally assesses the

risk (in terms of both impact and probability) that an institution poses to the achievement of those objectives.

Self-regulatory bodies such as the General Insurance Standards Council have generally adopted these principles as well.

*Risk Assessment*

The FSA defines risk as a sequence of events or set of issues that would adversely affect the FSA's statutory objectives.

The first stage in the FSA's operating framework is to identify the risks to the statutory objectives. In doing this the FSA draws upon a wide range of sources including intelligence- gathering while supervising firms, contacting consumers directly, and monitoring industry trends and the economy. In addition, the FSA also conducts regular focused reviews of the industry and consumers using tools such as market research, discussions with industry and insurers, and mystery shopping. The FSA regularly consults a wide range of stakeholders, including market participants and consumer groups, and uses information supplied by the Ombudsman on industry trends and problems revealed through complaints.

The next stage is to assess and prioritise the risks. The FSA uses a standard risk assessment process that involves scoring a risk against several probability and impact factors. The probability factors relate to the likelihood of the event happening, and the impact factors indicate the scale and significance of the problem if it were to happen. Combining the probability and impact factors gives a measure of the overall risk posed to the FSA's statutory objectives. This assessment is used to prioritise the risks, determine the regulatory response and, together with an assessment of the costs and benefits of using alternative regulatory tools, help determine resource allocation.

The FSA has developed a single risk model whose architecture is built around its four statutory objectives. Using that model (called ARROW) the FSA assesses and prioritizes its regulated institutions according to the risks they pose to those statutory objectives. Following the risk assessment, institutions are placed into one of four categories on a supervisory ladder.

It is important to note that the FSA is both a solvency and market conduct regulator. Its risk assessment process therefore assesses both solvency and market conduct risks.[12]

The nature and intensity of the FSA's relationship with a firm is dependent upon its assessment of the impact of the firm on consumers and market participants. The impact of an event is assessed by reference to its systemic significance, the perceived importance of the firm (public perception/market confidence), retail customer base (number/nature of customers) and the availability of compensation or redress for consumer loss. At one end of the spectrum the FSA maintains a continuous relationship with certain firms that have a high impact rating. The FSA maintains a regular working relationship with the senior management of such firms in order to be aware of potential risks.

[12] Only the market conduct relevant risk assessment factors are discussed here, unless otherwise noted.

At the other end of the spectrum are firms assessed as low impact. The FSA uses a remote monitoring approach combined with visits, as necessary, in relation to specific issues. The ongoing risk assessment is a high level review, not an audit or process involving detailed testing for compliance. Firms in this category would not have a regular relationship with the regulator but would be monitored through regular required reporting. Where a firm within a particular supervisory category experiences heightened risk, the intensity of the supervisory relationship is adjusted accordingly, for a temporary period until the events prompting the adjustment have been addressed.

For firms not identified as low impact, the FSA conducts a more detailed risk assessment. The level of detail of this risk assessment depends on the impact score and key probability factors. The FSA clearly defines and publishes the impact thresholds for financial institutions.

**Financial Services Authority Risk Assessment Impact Thresholds**

| Thresholds | Life and health insurers (£ millions) | Life and health insurers ($CDN million) | General insurers (£ millions) | General insurers ($ CDN million) |
|---|---|---|---|---|
| | Total assets/liabilities | | Gross premium income | |
| High/Medium | 36,000 | 86,897 | 2,000 | 4,828 |
| High | | | | |
| Medium | 3,600 | 8,690 | 200 | 483 |
| High/Medium Low | | | | |
| Medium low/Low | 180 | 434 | 10 | 24 |

*Source: Financial Services Authority, currency conversion from Bank of Canada using exchange rate of March 16, 2004.*

Probability factors are assessed through business (external environment), control (internal systems, management and compliance culture) and consumer relationship (practices, nature of consumers, volume of consumer complaints) risks. The probability assessment involves desk-based work utilizing available information and additional information supplied by the firm. When necessary, supervisory staff carries out on-site work. The probability assessment is utilized to further assess risk and to provide a base for developing a risk mitigation program.

The intensity of the FSA's supervisory relationship is also influenced by its assessment of the firm's risk management procedures and practice. Well-managed firms with effective controls and risk management receive less supervisory attention than a similar firm with weaker internal controls. Consumer complaints are an important indicator for increasing the probability factor and changing a firm's risk assessment. The approach is designed to create incentives for senior management to manage the firm's risk effectively and so reduce compliance costs.

Overall the FSA maintains four risk categories in its supervisory risk assessment:

A firms (high risk/impact) – Systemically important firms with sufficient size that there could potentially be major impacts from financial failure or market misconduct.

B firms (medium high) – Important risk: moderate/high-risk assessment as a result of impact and/or probability factors. Regulator likely conducts regular examinations.

C firms (medium low) – Flagged risk: low/moderate risk assessment from impact or probability factors. Intervention is optional

| | |
|---|---|
| | and insurer receives a low level of regulatory attention. |
| D firms (low risk/impact) – | Default score: generally supervised on a remote basis,<br>Monitoring and regular reporting but not visiting insurer's in any systemic way. |

Risk assessments are sent to the full Board, and FSA supervisors often make a presentation to the Board, as the FSA believes that Boards should know how the regulators see them.

In addition, the FSA monitors broader economic and industry trends for risks to particular markets or categories of consumers or products. Following the identification of an industry trend of concern the FSA seeks to coordinate its regulatory activities to investigate, understand and address the potential risk. This analysis may result in theme inspections/sweeps in order to generate more information. The nature of the trend or issue determines the form of the response.[13]

A sample of the FSA risk assessment is included in Annex D.

*Compliance and Enforcement*

The FSA's effective and proportionate use of its enforcement powers to enforce the requirements of the Act, the rules, the Statements of Principle and other relevant legislation (for example, the *Criminal Justice Act 1993*, the *Money Laundering Regulations 1993* and *the Unfair Terms Regulations)* play an important role in the pursuit of its regulatory objectives.

The FSA utilizes its regulatory tools to influence the behaviour of consumers and financial institutions toward appropriate market conduct behaviour, with disciplinary mechanisms for transgressions.

The FSA places an emphasis on corporate governance and the responsibility of senior management for compliance. The FSA maintains an authorized firm and approval of individual's regime that is used to ensure accountability and enforce compliance. A firm may not carry on a regulated activity unless it is authorised by the FSA or is exempt. Firms must satisfy the necessary criteria (in relation to status, location, close links, adequacy of resources and suitability) before authorization to carry on a regulated activity is granted.[14] Similarly the FSA must be satisfied that persons applying to carry on controlled functions are fit and proper: that is, they meet honesty, competence and financial soundness criteria.[15]

[13] Another statutory objective of the FSA is to promote public awareness. As such the FSA also establishes and oversees the disclosure regimes of its regulated sectors. In addition it allocates resources to consumer education and public awareness building, oversight of the ombudservice and the guarantee fund.
[14] This is similar to the business authorization process of provincial/territorial regulators.
[15] Controlled functions are those jobs or responsibilities within a business that have a particular regulatory significance. Some examples are overseeing the firm's systems and controls and being responsible for regulatory compliance.

Approved persons, intermediaries and others involved in general insurance such as claims handlers are required to adhere to codes of practice.[16] These codes of practice set the minimum standards of good practice including marketing, the sale of insurance products, disclosures, ethics guidelines, redress and procedures for claims.

Compliance is monitored through the ongoing firm-specific risk assessment process and firm-specific triggers such as complaints. The FSA uses a mix of enforcement mechanisms that include private warnings, administrative penalties (fines etc), public censure, intervention (risk mitigation plans etc) and removal an individual or firm from of the approved person/firm list.

The FSA also establishes the training and competence regime in order to raise standards and improve compliance within an industry.

[16] Oversight of the code of practice for approved persons is performed by the FSA. The GISC oversees the codes of practice for intermediaries and claims professionals.

**International Organization of Securities Commissions (IOSCO)**

*Overview and System Architecture*

IOSCO is an organization of securities commissioners and administrators from more than sixty countries. Its primary mandate is to facilitate and coordinate international securities regulation and to promote consistency in regulation across borders.

The member agencies cooperate together to promote high standards of regulation in order to maintain just, efficient and sound markets; to exchange information on their respective experiences in order to promote the development of domestic markets; to unite their efforts to establish standards and an effective surveillance of international securities transactions and to provide mutual assistance to promote the integrity of the markets by a rigorous application of the standards and by effective enforcement against offenses.

IOSCO maintains two specialized working committees. The Technical Committee's objective is to review major regulatory issues related to international securities and futures transactions and to coordinate practical responses to these concerns. The work of the Technical Committee is divided into the following five major functional subject areas:

- Multinational Disclosure and Accounting;
- Regulation of Secondary Markets;
- Regulation of Market Intermediaries;
- Enforcement and the Exchange of Information; and
- Investment Management.

The second specialized committee, the Emerging Markets Committee, endeavors to promote the development and improvement of efficiency of emerging securities and futures markets by establishing principles and minimum standards, preparing training programs for the staff of members and facilitating the exchange of information and transfer of technology and expertise. It has set up working groups to address the following functional areas:

- Disclosure and Accounting;
- Regulation of Secondary Markets;
- Regulation of Market Intermediaries;
- Enforcement and the Exchange of Information;
- Investment Management

Self-regulatory organizations (SROs), that are affiliate members of the IOSCO, are members of the SRO Consultative Committee. The SRO Consultative Committee has designated contact persons with the Technical Committee Working Groups and is therefore able to provide substantive input related to their regulatory initiatives

Self-regulatory bodies in member jurisdictions are generally responsible for developing and enforcing codes of conduct.

*Public Policy Objectives and Regulatory Principles*

In its May 2003 paper, Objectives and Principles of Securities Regulation, IOSCO identifies three primary public policy objectives upon which securities regulation is based:

- The protection of consumers of financial services;
- Ensuring that markets are fair, efficient and transparent; and
- The reduction of systemic risk

Thorough surveillance and compliance programs, effective enforcement and close cooperation with other regulators are necessary to give effect to all three objectives. In all, IOSCO outlines thirty principles that are required to be practically implemented in order to achieve those public policy objectives. These principles fall into the following:

- Principles Relating to the Regulator
- Principles for Self Regulation
- Principles for the Enforcement of Securities Regulation
- Principles for Cooperation in Regulation
- Principles for Issuers
- Principles for Collective Investment Schemes
- Principles for Market Intermediaries
- Principles for the Secondary Market.

Underlying these principles, is the concept that sound and effective regulation that protects consumers, will reduce systemic risk. This brings confidence in financial markets' which is important for the integrity, growth and development of securities markets.

*Risk Assessment*

IOSCO's definition of risk is broken down into two overall types of risk: risks arising from the type and nature of the business being undertaken (business risk) and the risk of management's control systems not identifying and correcting deficiencies.

Supervision of market intermediaries' conduct, through inspection and surveillance, helps ensure the maintenance of high standards and protects consumers. Risk assessment programs are a necessary complement to investigation and enforcement programs. Inspection visits among member organizations may be rotational or driven by risk assessment or complaint.

IOSCO has issued a number of papers outlining methodology for risk assessment in different business areas. Risk assessment is generally focused on identifying non-compliance, predominately with marketing and sales. While complaints are a key indicator, securities regulators also monitor other indicators and conduct remote monitoring of advertising in trade and broadcast media, product literature and other relevant materials. Most risk assessment factors are qualitative. IOSCO has also developed checklists for on-site inspections.

IOSCO surveyed member organizations for their use of risk assessment methodology. The survey found that nearly all jurisdictions surveyed used some form of risk assessment. While most do not, a few jurisdictions use modeling techniques with weights on different risk factors to create an overall risk indicator. Risk assessment models attempt to view the relative riskiness of one institution to another (or a standard) in the context of the regulator's objective of consumer protection. They incorporate

detail from market risks (volatility in markets), operational risks (such as IT systems) and control risks. IOSCO notes that models should be dynamic, altering in reaction to new information or changes in the underlying market.

The survey found that risk assessments were used by securities regulators to focus supervision and prioritize on-site activity. The frequency of updates to the risk assessment differed greatly by jurisdiction.

*Compliance and Enforcement*

IOSCO notes that instances of operational breach may occur despite the existence of internal procedures and controls. It is not practical for supervisory authorities to oversee adherence to those internal procedures on a day-to-day basis. IOSCO's approach is based on a reliance on corporate governance, where senior management must ensure that they are able to oversee the day-to-day operations and address issues that arise.

## Canada

*Overview and System Architecture*

The Canadian Securities Administrators (CSA) is a forum for the 13 securities regulators of Canada's provinces and territories to coordinate and harmonize regulation of the Canadian capital markets.

Provincial securities regulators administer and enforce securities legislation. They regulators mandate disclosure requirements of information material for investment decisions, promote consumer and investor education about the risks and responsibilities of investing and authorizes persons who provide investment services to the public and supervise market intermediaries. In addition, the provincial securities regulators monitor and enforce a fair trading environment.

Provincial securities regulators delegate some authority to self-regulatory organizations (SROs). The well-recognized SROs are the Toronto Stock Exchange (TSX), Market Regulation Services Inc., which is owned jointly by the TSX and the Investment Dealers Association of Canada (IDA), and the IDA itself. Market Regulation Services Inc. is the independent regulation services provider for Canadian equity markets. The IDA monitors the activities of investment dealers across the country in terms of their capital adequacy and business conduct. The Mutual Fund Dealers Association of Canada (MFDA) is the SRO for the distribution side of the mutual fund industry. Generally SROs operate nationally. Quebec has its own government developed regime of regulating mutual fund dealers, insurance agents and financial planning.

The Ombudsman for Banking Services and Investments (OBSI) is an independent organization that investigates customer complaints against financial services providers, including banks and other deposit-taking organizations, investment dealers, mutual fund dealers and mutual fund companies.

*Public Policy Objectives and Regulatory Principles*

The public policy objective of securities regulation in Canada is to protect investors from unfair, improper or fraudulent practices and foster fair, efficient and vibrant capital markets. In addition, the provincial securities regulators seek to maintain public and investor confidence in the integrity of financial markets.

The annual reports and statement of priorities by provincial securities regulators generally state that the regulator's approach will be proactive, innovative and cost effective, fair and rigorous in applying the rules to the marketplace, and timely, flexible and sensible in applying regulatory powers to a rapidly changing marketplace.

*Risk Assessment*

Provincial securities regulators generally define several types of risk that they attempt to mitigate through focused regulatory attention, including[17]:

[17] Provincial securities regulators may formulate these risks in modestly different language and order. In some cases they are not explicitly defined at the provincial level but fall within the accepted CSA objectives.

- Non-compliance with regulatory filings and public disclosure;
- Inadequate management or control of the risks particular to its business; and
- Material breach securities laws.

In recent years, provincial securities regulators have generally sought to utilize risk assessment techniques to focus regulatory resources. Generally securities regulators in most provinces utilize qualitative risk assessment techniques, relying on the experience and skill of the analysis and enforcement staff. Exceeding thresholds for portfolio values, volume of trades, commissions or other indicators may trigger a supervisory review. Complaints are an important trigger for regulatory attention.

Ontario however, has developed a structured risk assessment model to complement its qualitative risk assessment for allocating regulatory resources. The Ontario Securities Commission (OSC) has developed a risk assessment model (risk model) for investment counsel/portfolio managers and fund managers (market participants). The primary purpose of the risk model is to assist in focusing compliance field review efforts in the most effective and efficient manner by directing compliance resources to high-risk market participants and the high-risk areas of their operations. The risk model begins with an analysis of major risk factors affecting the business operations of both fund managers and advisers. In determining the risk score of a market participant, the risk factors affecting a market participant's business operations and its ability to identify and mitigate these risks by establishing appropriate internal control procedures are considered.

A risk ranking is assigned to each market participant based on the overall risk score. The risk ranking is defined as High, Medium or Low. The risk ranking determines the extent and frequency of compliance field reviews. For example, a market participant who receives a low risk ranking may be subject to less frequent field reviews than a market participant with a high-risk ranking.

The OSC applies the appropriate indicators or criteria to the market participant or activity in question during an initial review. If the initial review demonstrates that few criteria are triggered, then it is unlikely that the OSC will pursue the review further. If enough indicators are present, the OSC will proceed to review or investigate the matter in more detail.

The OSC applies a standard set of risk-based criteria to each case to determine which ones may pose the greatest threat to the integrity of Ontario's capital markets. The OSC uses both impact factors and indicators of potential risk for individual market participants in its risk assessment. It targets is resources on areas using the following impact-related criteria where:

- the number of investors affected and the value of their losses are significant;
- the activity appears pervasive;
- improper activity is ongoing;
- resolution of the case would likely have precedent value for future cases;
- and the activity has received sufficient public profile to affect public confidence in the integrity of capital markets.

The OSC monitors the following indicators/criteria of risk for individual market participants:

- Prospectus indicators – an issuer of securities in Ontario must obtain a receipt from the OSC for its prospectus. The OSC reviews the corporate structure and underlying business, the issuer's financial condition or results, the nature of the offering, and the corporate governance of the offering.
- Continuous disclosure indicators – stock trading activity, financial condition or results, accounting methods and practices, auditor related issues, prior regulatory scrutiny and other factors that may arise.
- Compliance indicators – inherent risk (type and mix of business activity, strategic management and financial condition), regulatory risk, internal risk (quality of management & staff, adequacy of systems, marketing practices, adequacy of operational procedures and susceptibility to fraud or unethical behaviour) and risk control (board oversight, risk management practices).

In addition to risk-based reviews, the OSC conducts reviews on a random basis. Random reviews help ensure that all market participants are subject to market scrutiny at some point in time, even though they may not have triggered a risk-based review. The OSC may also perform detailed reviews based on its discretion or judgment.

Self-regulatory organizations also utilize risk-based models. Market Regulation Services Inc. monitors every single equities trade made during trading hours, as it occurs, to ensure compliance with the securities trading rules. If a rule breach is detected, it can reverse the trade immediately. In addition, Market Regulation Services Inc continuously monitors company news, stock charts, chat room activity and other sources to identify potential trading violations. It maintains a dedicated surveillance facility with systems and software that utilize mathematical algorithms to detect even the subtlest price or volume anomalies in any stock's trading pattern. These changes trigger alerts, which direct surveillance officers to assess the situation.

The IDA conducts reviews and audits of members during the course of a year to ensure that members are complying with financial and other regulations of the industry. This review includes receipt of all monthly financial reports and Joint Regulatory Financial Questionnaires (JRFQs). The IDA conducts targeted field audits when a complaint triggers a response and routinely audits approximately ten percent of member firms on an annual basis. Minimum standards covered in the review cover areas such as books and records, capital requirements, internal controls, insurance coverage requirements, segregation of clients' fully paid and excess margin securities, client documentation , credit practices and regulatory reporting requirements.

The MFDA conducts compliance reviews on a regular basis and when triggered by complaints. These reviews include both a financial and a sales practices component. The head office is included in these reviews.

*Compliance and Enforcement*

Provincial securities regulators' effective and proportionate use of enforcement powers play an important role in the pursuit of their regulatory objectives. Securities regulators state that they utilize their regulatory tools to influence the behaviour of consumers and

financial institutions toward appropriate market conduct behaviour, with disciplinary mechanisms for transgressions.

Provincial securities regulators place an emphasis on corporate governance and the responsibility of senior management for compliance. Some regulators have authority to oversee the design of corporate audit committees. In addition, regulators generally have broad powers to support disclosure and transparency. Compliance is monitored through the ongoing firm-specific risk assessment process and firm-specific triggers such as complaints. Provincial securities regulators use a mix of enforcement mechanisms that include working with self-regulatory organizations, issuing warnings, administrative action (fines etc), public censure and civil action to address issues of non-compliance.

Market Regulation Services Inc. regularly reviews trading firms' trade-desk procedures. The reviews are intended to assess whether trade desk procedures comply with the market integrity rules and appropriate provincial securities requirements. Compliance staff also assist in the development, introduction and education of users on new rules and policies that require all applicable market participants to proactively monitor their compliance by completing internal reviews and addressing deficiencies. A compliance officer will examine the results of these reviews when a field review is conducted at the trading firm's office.

In addition, Market Regulation Services Inc. will monitor and ensure the timely disclosure of material information. Companies need to notify Market Regulation Services Inc. prior to the issuance of material news releases as well as supply a written copy for review. Market Regulation Services Inc. will request that companies revise any releases that are unclear or overly promotional. All significant announcements must be made immediately after a surveillance officer has reviewed the release. If necessary, Market Regulation Services Inc. may determine that trading in any of the company's securities should be temporarily halted pending a news release, to allow the market to properly absorb the information.

As the national self-regulatory organization of the Canadian investment dealers, the IDA enforces rules and regulations regarding the sales, business and financial practices of member firms and takes registered employees. The IDA investigates complaints of regulatory violations and conducts disciplinary action in cases where violations have been substantiated. The IDA may conduct an investigation of a member firm or a registered employee as a result of an investor complaint or where it is necessary to enforce compliance with IDA by-laws, regulations or policies. The IDA has the power to reprimand, impose fines (up to $1 million), order suspension of or termination from employment with an IDA member. In addition, the IDA utilizes public censure through the publication of the penalty in its disciplinary bulletin, which is widely distributed to the media and within the securities industry.

Similarly the MFDA enforces rules through a transparent disciplinary process that can result in fines, suspension or termination of membership.

**United States – Securities and Exchange Commission**

*Overview and System Architecture*

The primary mission of the U.S. Securities and Exchange Commission (SEC) is to protect investors and maintain the integrity of the securities markets. Since 1996, when Congress passed the *National Securities Markets Improvement Act (NSMIA)*, regulatory responsibility for advisers has been shared between the SEC and state regulators. The SEC is responsible for examining only the largest advisers, with more than $25 million in assets under management.

The SEC oversees participants in the securities world, including stock exchanges, broker-dealers, investment advisors, mutual funds, and public utility holding companies. The SEC requires public companies to disclose meaningful financial and other information to the public. This provides a common pool of knowledge for all investors to use to judge for themselves whether a company's securities are a good investment.

The SEC's Division of Market Regulation establishes and maintains standards for fair, orderly, and efficient markets. It does this primarily by regulating the major securities market participants: broker-dealer firms, self-regulatory organizations (SROs)[18], which include the stock exchanges and the National Association of Securities Dealers (NASD), Municipal Securities Rulemaking Board (MSRB), and clearing agencies (SROs that help facilitate trade settlement); transfer agents (parties that maintain records of stock and bond owners); and securities information processors. Market Regulation's responsibilities include carrying out the SEC financial integrity program for broker-dealers; reviewing and approving proposed new rules and proposed changes to existing rules filed by the SROs; establishing rules and issuing interpretations on matters affecting the operation of the securities markets; and surveilling the markets.

Though it is the primary overseer and regulator of the U.S. securities markets, the SEC works closely with many other institutions, including Congress, other federal departments and agencies, the self-regulatory organizations (e.g. the stock exchanges), state securities regulators, and various private sector organizations. The SEC also receives and investigates customer complaints against financial market participants.

*Public Policy Objectives and Regulatory Principles*

The laws and rules that govern the securities industry in the United States derive from the concept that all investors, whether large institutions or private individuals, should have access to certain basic facts about an investment prior to buying it. The SEC regulates the capital market under the principle that only through the steady flow of timely, comprehensive and accurate information can people make sound investment decisions. As a result, the SEC is concerned primarily with promoting disclosure of important information, enforcing the securities laws, and protecting investors who interact with these various organizations and individuals.

[18] There are a dozen securities exchanges and associations that are registered as self-regulatory bodies. There are also six self-regulating clearing agencies. Self-regulatory bodies oversee financial, operational and sales-practice compliance of member firms.

*Risk Assessment*

In its budget hearings for 2004 – 2005, the SEC requested funding to initiate a new risk management program and create an Office of Risk Assessment and Strategic Planning. The first phase has been to organize internal risk teams for each major program area. The new office, working in coordination with the internal risk teams, would identify potential problem areas, focusing on early identification of new or resurgent forms of fraudulent, illegal, or questionable activities. In addition to fostering better communication and coordination between Divisions and Offices within the SEC, the risk assessment initiative would help to ensure a process whereby senior managers at the SEC have the information necessary to make better, more informed decisions and to adjust operations and resources to address challenges.

The SEC envisions that the implementation of a new, risk-based approach to selecting registrants for inspection will result in a different inspection frequency for firms with different risk profiles. The SEC model would correlate both examination frequency and examination scope with risk. The SEC model would consider impact factors and give enhanced focus to the largest firms. The top twenty of the 100-largest advisory firms and affiliated fund groups are to be placed on a two-year inspection cycle. For the remaining 80 firms, the SEC will assess each firm and determine how often it should be examined based on criteria indicating risk. Those firms with a higher risk will be examined every other year while those with lower risk will be examined at least once every four years. Similarly, the remaining 7,600 advisory firms and affiliated fund groups will be inspected on a two or four year cycle, again depending on the firm's risk profile. In addition, the SEC will evaluate the profile of each new firm that becomes registered with the SEC, and those new firms that appear to have the highest risk will be examined within twelve months of the time their registrations become effective. However, the SEC would also continue to complement routine inspections with cause exams, and with special purpose exam sweeps, from time to time.

The criteria indicating risk are still being developed but are expected to include quantitative measures derived from information reported in company filings with the SEC, and qualitative information such as the results of their last examination. Currently broker-dealers are required to complete risk assessment forms which collect organizational, policy, legal and financial information. The new model is expected to result in a “risk score” for an organization based on an overall assessment of the culture of compliance of the organization being reviewed. A good score will result in less frequent and more focused (complaint or issue driven) examinations. A poor score will initiate a more general and frequent examination process.

Currently, the SEC uses a systems approach to focus inspections on those activities that presented the greatest potential risk to investors. A systems approach focuses inspections on complexes, which are groups of financial products that generally have the same adviser or underwriter, and examines the compliance systems used by all entities in the complex. The SEC seeks to inspect each investment adviser, fund complex, and transfer agent affiliated with a fund group at least once within a five-year cycle. In practice, the large market participants receive greater supervisory attention than smaller market participants. More frequent inspections of these firms are conducted if circumstances warrant and resources allow.

In order to assess risk, the SEC relies on two primary types of on-site examinations. An SEC risk management examination begins with a system overview. An SEC internal controls examination begins with an overview of a firm's risk management system. Supervisory staff review the organizational structure and the process by which managers identify, assess, monitor and control all risks within the broker-dealer. These exams are conducted in conjunction with a review of the firm's compliance with the SEC financial responsibility rules, including capital rules. If a firm is not vigilant in a particular area and lacks controls, it will very likely have related deficiencies and violations in the area. During the examinations, the SEC is not looking for one particular set of policies and procedures.

SEC internal control examinations include reviews of the following areas:

- Senior management, to look for establishment of overall policies and active involvement in the process of risk management and the oversight of risk parameters and controls.
- Adequacy of resources and systems used for risk management, and compensation incentives that may adversely impact independence.
- Internal audit, to ensure that comprehensive and independent assessments get to management and that deficiencies are addressed in a timely manner.
- Market risk in trading activities and firm inventory, including VAR (value at risk), economic models, scenario analyses, stress testing, and back testing; follow trades from the trading desk through the entire risk management system.
- Funding, liquidity and credit risks, including counter party credit risk across all products and businesses, credit limits, pricing models, guarantees, collateral, margin, and settlement and legal risks.
- Operational risks, including segregation of duties, checks and balances, protection of customer funds and securities, operating systems, management information systems, management reporting, front and back office operations, security, contingency planning and disaster recovery.
- New products and activities are assimilated into the risk management system in a timely and appropriate manner.

The second type of examination that the SEC conducts in order to develop an overview of how well a firm is self-policing its activities, is the comprehensive compliance examination. While the SEC conducts many examinations focused on compliance with particular laws - such as the net capital rule or the Patriot Act, - this examination covers compliance with all relevant securities laws and regulations. Some of the functional areas the SEC assesses in these examinations include:

- senior management oversight and involvement;
- written supervisory procedures and implementation;
- independence and experience of compliance personnel;
- business and branch supervision;
- handling customer funds;
- surveillance and exception reports;
- reviews of correspondence;
- employee supervision, including heightened supervision;
- tracking and resolution of compliance concerns; and

- complaints, arbitrations, litigation, and investigations.

In addition, some key areas that are generally covered by a compliance program include: record keeping, including financial reports and capital computations; suitability and unauthorized trading; disclosures to customers; best execution and reviews for excessive markups; reviews for insider trading and market manipulation; information barriers, including restricted and watch lists; managing conflicts between investment banking and research analysts and anti-money laundering.

In addition to market participant specific risk assessment, the Office of Economic Analysis is the chief advisor to the SEC and its staff on all economic and empirical issues associated with the SEC's regulatory activities. The Office analyzes the impacts and benefits of proposed regulations, conducts studies on specific rules, and engages in long-term research and policy planning. The Office of Economic Analysis also analyzes potentially significant developments in the marketplace. Economic studies are designed in anticipation of and in response to developments in the securities markets, in prevailing financial practices among issuer firms, and in SEC policy.

The various SROs overseen by the SEC also conduct market surveillance and utilize risk-based approaches. SRO surveillance units use sophisticated computer technology to detect, real-time, any unusual or violative trading patterns, and generally surveillance staff maintains a presence on the exchange floor. In addition, SROs generally utilize electronic data-mining and pattern-detection systems, links to news and research, as well as public databases of officers, directors and other insiders to detect possible insider trading. Added to ongoing examinations, investigations and enforcement may be initiated by referral based on an indication of risk.

*Compliance and Enforcement*

The Division of Enforcement investigates possible violations of securities laws, recommends Commission action when appropriate and negotiates settlements on behalf of the Commission. While the SEC has civil enforcement authority only, it works closely with various criminal law enforcement agencies throughout the country to develop and bring criminal cases when the misconduct warrants more severe action. The Division obtains evidence of possible violations of the securities laws from many sources, including its own surveillance activities, other Divisions of the SEC, the self-regulatory organizations and other securities industry sources, press reports, and investor complaints.

Under the securities laws, the Commission can bring enforcement actions either in the federal courts or internally before an administrative law judge. The factors considered by the Commission in deciding how to proceed include: the seriousness of the wrongdoing, the technical nature of the matter, tactical considerations, and the type of sanction or relief to obtain.

SROs enforce rules through a disciplinary process that can result in informal discipline by an education or admonition letter or more formal disciplinary action in the form of fines, censure and suspension or termination of membership.

# ANNEX A
# SUMMARY OF RISK-BASED MARKET CONDUCT MODELS

| | U.S./NAIC | New Zealand | Australia | Canadian Securities Regulators | U.S. SEC |
|---|---|---|---|---|---|
| Regulatory Model | Regulator Managed | Self-Regulatory | Industry Managed | Intermediaries: Self-Regulatory<br>Institutions: Regulator managed | Intermediaries: Self-Regulatory<br>Institutions: Regulator managed |
| Principles of the model | Informed consumers<br>Non-discriminatory<br>Consumer redress<br>Competitive markets<br>Corporate governance | Informed consumers<br>Consumer redress<br>Corporate governance<br>Competitive markets | Informed consumers<br>Consumer redress<br>Corporate governance<br>Competitive markets | Informed consumers<br>Market confidence<br>Efficient & competitive capital markets<br>Reduction of systemic risk | Informed consumers<br>Market confidence<br>Efficient & competitive capital markets<br>Reduction of systemic risk |
| Architecture | State Regulator<br>- monitoring<br>- compliance<br>- corporate governance<br>- enforcement | Insurance Council of New Zealand<br>- compliance &enforcement<br>Insurance & Savings Ombudsman Scheme – consumer redress<br>Ministry of Economic Development –<br>- corporate governance | Australian Securities and Investment Commission (ASIC)<br>- licensing, education requirements, complaints<br>Insurance Enquiries and Complaints Ltd.<br>- enforcement, consumer redress | Provincial securities regulators<br>- licensing, oversight<br>Canadian Securities Association (policy coordination function)<br>Self-regulatory organizations<br>- intermediaries<br>Ombudsman for Banking Services and Investments (consumer redress) | National securities regulator<br>- licensing, oversight, consumer redress.<br>Self-regulatory organizations<br>- intermediaries |
| *Risk assessment methodology* | Complaints data<br>Impact assessment (size of institution)<br>Desk audits<br>Targeted on-site examinations<br>Monitoring of system trends (some states) | Complaints data | Complaints data<br>Targeted on-site examinations<br>Impact assessments<br>Prudential risk model – impact/probability<br>Monitoring of system trends | Complaints data<br>Targeted on-site examinations<br>Impact assessments<br>Risk model: impact/probability (OSC)<br>Real-time monitoring of trades – risk-based triggers<br>Monitoring of system trends | Impact assessment (size of institution)<br>Routine on-site examinations<br>Impact assessments<br>Real-time monitoring of trades – risk-based triggers<br>Monitoring of system trends |
| *Corporate governance* | Regulatory guidelines<br>- state regulators<br>- SEC requirements | Statutory requirements<br>Primary jurisdiction approach | Regulatory guidelines (prudential regulator), Australian Stock Exchange guidelines | TSX guidelines<br>Regulatory guidelines | SEC guidelines<br>Exchange guidelines |
| *Self-assessment program* | Under discussion. No action to date | No | No | | |
| *Consumer redress mechanisms* | Complaints departments of regulator<br>Courts | Investigation, assessment and dispute resolution (voluntary scheme) | referee/adjudication services | Ombudservice | Complaints department of regulators |
| Enforcement | Investigation<br>Corrective orders<br>Administrative action<br>Criminal action | Investigation<br>Dispute resolution by Insurance & Savings Ombudsman<br>Education/Penalties | Publish/advertise companies who are not in compliance.<br>Civil, criminal and administrative action | Investigation<br>Corrective orders<br>Administrative action<br>Civil action | Investigation<br>Corrective orders<br>Administrative action<br>Civil action |
| Guarantee scheme | State guarantee schemes | No | No | Yes, for some products | No |

# ANNEX A
# SUMMARY OF RISK-BASED MARKET CONDUCT MODELS

| | Germany | Italy | Spain | Sweden | United Kingdom |
|---|---|---|---|---|---|
| Regulatory Model | Regulator managed | Regulator managed | Regulator managed | Regulator managed | Intermediaries: Self-Regulatory Institutions: Regulator managed |
| Principles of the model | Financial sector stability<br>Market confidence | Financial sector stability<br>Informed consumer | Competitive markets<br>Informed consumers | Financial sector stability<br>Informed consumers<br>Good insurance (business conduct) practice<br>Cost/benefit analysis of regulatory measures | Maintaining market confidence<br>Promoting public awareness<br>Protecting consumers, and<br>Reducing financial crime. |
| Architecture | Federal Financial Supervisory Agency (BAFin),<br>self-regulatory organizations | Istituto per la Vigilanza sulle Assicurazioni Private e di Interesse Collettivo (ISVAP) | Dirección General de Seguros y Fondos de Pensiones | Finansinspektionen (Swedish Financial Supervisory Authority) | Financial Services Authority,<br>General Insurance Standards Council (self-regulatory body for intermediaries) |
| *Risk assessment methodology* | Complaints data<br>Monitoring of system trends<br>Impact assessment (financial conglomerates) | Complaints data<br>Regular prudential/internal controls examinations | Complaints and mediation data<br>Targeted desk/onsite examinations<br>Monitoring of system trends | Complaints data<br>Desk audits<br>Impact assessment (size of institution)<br>Targeted on-site examinations<br>Monitoring of system trends | Risk-based ladder of supervisory intervention based on impact (size of institution) & the probability (likelihood of a problem) risk of market conduct issues.<br>Complaints<br>Desk audits<br>Monitoring of system trends<br>Targeted on-site examinations |
| *Corporate governance* | Supervisory power to participate<br>Statutory/regulatory requirements<br>Exchange requirements | Approval of individual's regime<br>Statutory/regulatory requirements<br>Exchange requirements | Approval of individual's regime<br>Statutory/regulatory requirements<br>Exchange requirements | Approval of individual's regime<br>Statutory/regulatory requirements<br>Exchange requirements | Approval of individual's regime<br>Statutory/regulatory requirements<br>Exchange requirements |
| *Self-assessment program* | No | No | No | No | No |
| *Consumer redress mechanisms* | Industry ombudservice<br>Pan-European (FIN-NET) | Regulator facilitated redress<br>Pan-European (FIN-NET) | Government ombudservice<br>Pan-European (FIN-NET) | Government run ombudservices<br>Pan-European (FIN-NET) | Industry run ombudservice<br>Independent arbitration scheme<br>Pan-European (FIN-NET) |
| Enforcement | Investigation<br>Corrective orders/Intervention<br>Administrative action<br>Criminal action | Investigation<br>Corrective orders/intervention<br>Administrative action<br>Revoke approved person license | Investigation<br>Corrective orders<br>Administrative action<br>Revoke approved person license<br>Censure | Investigation<br>Corrective orders<br>Administrative action<br>Revoke approved person license<br>Censure | Investigation<br>Corrective orders<br>Administrative action<br>Revoke approved person license<br>Criminal action |
| Guarantee scheme | No | No | Yes | No | Yes |

**Missouri**

One example of what state market analysts can produce is the following set of reports compiled and published by the Missouri Department of Insurance, both in print form and on the Department web site, http://www.insurance.state.mo.us:

1. **Complaint Index Report:** Company performance is compared to the state's industry average. Companies are categorized by line of business and type of complaint.
2. **Market Share Report:** Market data for the top 35 insurance carriers and groups, including historical trends, for each line of business.
3. **Homeowners and Private Passenger Automobile Insurance Reports:** ZIP code level premium and loss data for each line of insurance, presented by demographic groups and geographic regions for the past ten years.
4. **HMO Report:** HMO data from the annual financial statements, such as premiums earned and costs incurred for health related services. This report also includes enrollment data, by ZIP code, including enrollment for specified regions of the state.
5. **Medical Malpractice Report:** Aggregate claims for the three years prior to the report. Includes information on claim frequency, loss ratios by company and by type of insured, average dollar settlements, litigated claims, average time to close claims, and other trends in medical malpractice.
6. **Real Estate Malpractice Report:** A ten-year summary by area of practice for filed claims, major activity responsible for alleged error or omission, most significant reasons for claims, years of real estate experience for the insured, and relationship of insured to claimant.
7. **Legal Malpractice Report:** Ten years of data presented by area of law for the insured, major activity responsible for alleged error or omission, most significant reasons for claims, legal disposition of claims, number of years in practice by insured, and relationship of insured to claimant.
8. **Product Liability Report:** Aggregate claims analysis incorporating three years of data. Included are indemnity paid per claim, average loss expense, average initial reserve, average time to close claims, business classification loss experience, product indemnity analysis and resolution and expense of litigated claims.
9. **Mortgage Guaranty Insurance Report:** Reports data from the most recent year and for more than two decades for both residential and commercial lines of mortgage guaranty insurance. The data includes earned premium by company, losses paid, outstanding claim reserves, IBNR reserves, contingency reserves, loaded loss ratios, and true loss ratios.
10. **Life, Accident & Health Supplement Data Report:** Information on all life and non-HMO health insurers, health service corporations, and fraternal companies licensed to operate in the state. The information includes detailed financial and premium information by company, by line of business, market share, life insurance in force and health benefits ratios. Companies file a Missouri supplement form which collects additional data beyond what is reported on the State Page; in particular, the lines of business are broken up into greater detail.
11. **Property & Casualty Supplement Data Report:** Data on written premium, loss ratios, and other information for all property and casualty insurers licensed in Missouri for all major lines of business.

**Pennsylvania**

The Insurance Department's first priority is to protect consumers through fair and efficient regulation of the insurance industry. Critical to fulfilling this mission are the investigative and monitoring activities conducted by the Bureau of Enforcement.

As the insurance industry becomes increasingly competitive and dynamic, the Bureau continues to endeavor to meet the challenges of the evolving marketplace. Developments such as increased deregulation, the emergency and growth of managed care, and the use of the Internet as a sales and marketing tool made it necessary for the Bureau of become more proactive. As a result, the Bureau formed a new division, the Market Surveillance Division. The division is made up of three team members who have experience in insurance investigations; consumer services, and market conduct examinations.

The Market Surveillance Division takes a proactive approach to enforcement by monitoring the insurance industry and identifying problems before they rise to the level of an enforcement action. Educating both the insurance industry regarding compliance and the Insurance Department about marketplace trends is a key part of the Division's types of compliance reviews. The Department's surveillance initiatives may be issue-driven or product-centered. A review can involve interviewing agents or companies regarding their knowledge of a new law or regulation or about their business activities and practices. Reviews also can involve sampling an agent or company's files to determine if they comply with a particular law or provision of a law.

Passages of new legislation or regulations, indications of non-compliance or a misunderstanding of the law, and media reports, can trigger market surveillance reviews. Agents or companies can be chosen for the review in several ways. In some cases, companies are chosen based on the products they sell. In other cases, companies are selected based on their market share, or companies may be chosen randomly.

Upon selecting a company for review, the Division mails each agent or company an announcement letter informing them of the review. Announcement letters are directed to the attention of the President/CEO and request that the company designate a company representative. The representative's responsibilities vary depending upon the review. In reviews that involve surveying the agent or company, the representative is usually the individual designated to respond to the survey. In reviews that involve sampling agents' or companies' files, the contact person is usually the person responsible for ensuring the information provided to the Department is accurate and reported in a timely manner.

Following the selection of a coordinator, the Division begins collecting information. In many cases, the Division obtains information through telephone interviews. In other instances, the Division requests the agent or company assemble the data and mail the information to the Market Surveillance Division. After compiling information from each agent or company, the Division sends the agent or company a letter and a summary of the findings to confirm the information collected is accurate and gives the agent or company the opportunity to clarify the findings. Once the Division confirms the information is accurate, the Division uses a software program to aggregate the information and conduct statistical analysis.

After analyzing the information, the Division's examiners draft a report summarizing their findings. Because the Division is responsible for monitoring the industry and reporting marketplace trends, the Market Surveillance Division's reports include aggregate information rather than information pertaining to a specific company. This allows agents and companies to be

more forthcoming, therefore providing a better indication of what is occurring in the marketplace. Upon completing the report, the Division presents its finding to the Director, the Deputy Commissioner, and in many cases to the Insurance Commissioner.

Depending on the purpose and type of the review, the Division may pursue one of several education initiatives. If the review was intended to identify misunderstandings of the law or areas of non-compliance, the Division may develop a PowerPoint presentation, which is available to consumers and the industry. The Division uses the PowerPoint presentation to present its findings to the industry, to educate it so it can better understand new laws or regulations, and correct any non-compliance issues discovered during the Division's review. In an effort to reach a broader audience, the Division has recently begun converting the presentations to fact sheets, which are posted on the Department's Internet site. Links to the series of fact sheets can be found at the Market Surveillance Division page, http://www.ins.state.pa.us/ins/cwp/view.asp?a=1281&q=528741.

In cases where a review was initiated by the Insurance Commissioner to obtain information to make a policy decision on a particular issue, the Division drafts a report and distributes it to appropriate staff within the Department. If the review was conducted to answer questions or address issues raised by the General Assembly, the Division drafts a report and distributes it to the General Assembly and other interested parties. Public reports are also posted on the Department's Internet site.

As Commissioner Koken noted upon the Division's creation, "Recent regulatory reforms have benefited both the industry and the consumer by making it easier for new products to get to the marketplace, but it also increases the importance of industry compliance." The Market Surveillance Division sends a clear and direct signal to the industry that we are diligently monitoring activity in the marketplace.

**Arizona**

The Market Oversight Analysis Section generates four complaint ratios: Personal Lines Complaint, Life & Health, HMO, and P&C w/ Disability. The Ratios are developed using a) data obtained from our annual Market Analysis surveys of all active direct writers in Arizona and b) the Department's complaint data obtained from Consumer Affairs Division. By dividing a company's consumer complaints by the number of exposures (and multiplying by 1,000), we arrive at the ratio of complaints, by company, per 1,000 Arizona policyholders.

As an example, the following outline of the Personal Lines In Force (PLIF) survey describes the procedures for a) disseminating the surveys to the insurance industry, b) retrieving, compiling, analyzing the data, c) transmitting the data to the Public Information Office in the Director's Office for publication, and d) getting the final brochures printed and available to the public.

1. In November of each year, the Analysis Section creates a list of entities to survey. The list is generated by querying the AS-400 using SQL and includes insurers licensed to write property and casualty insurance (excluding reinsurers). Narrow the list by identifying only those insurers with written premium as reported in their annual statement for the previous year in the following lines of business, as identified by the Annual Statement State Page Lines 4, 19.2, and 21.1. Also include any new P&C insurers admitted in Arizona during the current year. For each insurer identified as having any written premium in any of these lines, provide the following additional data:

   (a) Company NAIC number
   (b) Company name

(c) Company contact (VP or Actuary contact)
(d) Company mailing address (address, city, state, zip code)

2. The PLIF survey is created in either MS Word or Excel, and the cover letter is created in Word.

3. The company information is then mail-merged into the cover letter and printed.

4. Make a request to the Administrative Assistant for the number of window envelopes needed to mail surveys.

5. The letters are mailed to all the companies along with the PLIF.

6. In November of each year, send memo to Consumer Affairs Division requesting the year-end complaints by the end of February.

7. During this time, before surveys are returned by the insurers, an "entry form" should be designed on the existing Microsoft Access database from the table and the following fields should be added:

(a) NAIC

(b) Company Name

(c) Fname (Individual who completed form)

(d) Lname (Individual who completed form)

(e) Add1 (Individual who completed form)

(f) Add2 (Individual who completed form)

(g) City (Individual who completed form)

(h) State (Individual who completed form)

(i) Zip (Individual who completed form)

(j) Phone (Individual who completed form)

(k) Email (Individual who completed form)

***These fields are added to track the individual who completed the survey and may be used as a reference for future inquiries regarding the data submitted.***

(l) "Multiple vehicles": indicate "yes/no" if a company writes multiple vehicles per policy or just one vehicle per policy.

(m) "Vehicle exposures": the total number of vehicles insured under private passenger policies in force for that year submitted by the companies

(n) "Auto": the number of personal auto policies in force for that year submitted by the companies

(o) "Home": the number of homeowners policies in force that year submitted by the companies

(p) "Other": the number of other personal lines policies in force, reported by the companies.

8. Once Consumer Affairs indicates that the complaint data has been audited and verified, the complaint data is obtained electronically by querying the AS-400 complaint records and limiting the query to complaints received for the specific year, excluding miscellaneous complaints and producer complaints, and grouping the complaints by license type (i.e. P=Personal, L=Life, D=Disability, and C=Commercial). The list should contain the company's Cocode and name.

9. Once all the policy/exposure information has been entered into the database and complaint data gathered, develop a query from the table containing the data described in section (7) above and the complaint data described in section (8) for the final reports and include the fields specified in section (7) above and include the following fields:

(a) "Complaints": The number of complaints recorded by Consumer Affairs and Investigations. For purposes of the personal lines reports, the complaints should be limited to the P=Personal complaints.

(b) "Ratio" { should be written as follows –

Ratio: ([Complaints]/[Total])*1000 }

(c) "Total" { should be written as follows –

Total: IIf([Vehicle Exposures]>[Auto],

([Vehicle Exposures]+[Home]+[Other]), ],([Auto]+[Home]+[Other]) }

10. Add a criteria expression under the "Total" field section limiting the query to companies which wrote more than 4500 policies within the calendar year or have more than 4500 exposures. (>4500)

11. Run the query and generate a report and "format" into the final document that will become the published Personal Lines Complaint Ratio Brochure.

12. Double check figures for accuracy. Cross-check data reported by company against the following:

(a) Premium Written as reported on company's Annual Statement State Page. Calculate the approximate amount a policy would cost by dividing the reported amount of private passenger written premium, by the number of auto policies reported; if the resulting figure is unusually high or low, question the policy count by contacting the company, or check with Financial Affairs about the accuracy of the premium reported.
(b) Prior years data reported and prior years premium. Check for significant increase or decrease that appears out of the ordinary. Contact the company to question any unusual results.
(c) DOI Annual Motor Vehicle Liability Report (Compiled by Property and Casualty Division). Check to see that all companies reporting premium in MV Liability Report responded to the complaint ratio survey. Send a survey to any company that was not in the original mailing but reported premium to P&C. Research other anomalies such as why companies were not in our database "dump," why not survey recipients, why not on complaint ratio brochure, *etc*.
(d) Top 25 Automobile and Homeowners Lists (source is DOI Annual Report or website). Check to see if all companies in the lists are also on complaint ratio brochure; if not, research why not.
(e) NAIC Financial Database. Look for companies with auto and homeowner premium (refer to (1) above for the Annual Statement premium lines) and identify any companies that did not receive or return a survey.
(f) Consumer Complaints need to be verified. If a company reports 0 policies and has complaints against it, contact Consumer Affairs and verify accuracy of complaints. Company may need to be contacted as well.

13. Work with Public Information Office and edit verbiage on brochure as needed to reflect new survey year and any other appropriate changes.

14. Translate verbiage into Spanish.

15. Create brochure in Adobe Acrobat format for website. Complete a System Service Request (SSR) form seeking modification of the Department's website, and forward to Public Information Officer. Provide Computer Room Administrator a copy of the new English and Spanish brochures to be posted on the Department's website (either provide the location on the J:\ drive or provide a disk with the Adobe formatted versions).

16. Provide final of Personal Lines Complaint Ratio Brochure for printing to the Public Information Officer in Director's Office.

**Oregon**

Oregon uses the internet in several ways in our Market Analysis program. Sometimes we review the company's web sites to see what information they are providing to consumers. Recently we looked at several P&C companies web sites to see if they were discouraging consumer to file small claims. We also obtain information regarding class action law suits and other legal information, identification of emerging issues, and industry trends. In addition to the companies' own websites, some of the Web sites we use are:

- www.naic.org
- www.insure.com
- www.sec.gov
- www.hoovers.com
- www.ambest.com
- www.standardandpoors.com
- www.weissratings.com
- www.census.gov
- www.findarticles.com

**Maine**

In 2003, the Maine Bureau of Insurance began an in-depth study of the availability and affordability of homeowner's insurance and small business commercial liability coverage. In October, Superintendent Iuppa held a series of public meetings at various locations across the state to gather first hand information from the public regarding their experience with these lines. To encourage attendance, the meetings were held in the evening, after work hours. The Bureau has posted an interactive survey questionnaire on its web site at http://www.maineinsurancereg.org in order to obtain further input.

The meetings, attended by consumers, producers, and legislators, were covered by local and statewide media and were preceded by a statewide publicity campaign. In a press release, Superintendent Iuppa explained: "Rates have increased substantially and the availability of coverage has become an issue both in Maine and countrywide. The information we receive from these meetings will help us determine recent developments in the homeowners and business insurance markets concerning pricing, changes made to coverage not requested by the policyholder, problems trying to buy policies, and any other general problems that people may have with these types of insurance. The feedback received from these forums and the survey results will be submitted in a report from the Bureau of Insurance to the Legislature by January 5, 2004. In addition to the public forums, the Bureau has conducted a number of surveys to agents, insurance companies, small businesses, and consumers to further examine the dynamics of the marketplace. Once the report is complete, we expect it to be one of the most comprehensive studies done by any state on this issue."

## PAIRS/SOARS

In October 2002, APRA introduced an upgraded risk-rating system (the Probability and Impact Rating System/Supervisory Oversight And Response System or PAIRS/SOARS) that formally integrates the probability of a regulated entity's failure with the potential impact of that failure into a single combined supervisory measure.

### Assessing Impact

The Impact Index and descriptive Impact Ratings are intended to measure the potential economic cost that could result from the failure of each rated institution. The rating measurement addresses not only the initial impacts on creditor stakeholders directly effected by the failure, but also the indirect knock-on or systemic effects of the initial failure.

Currently Impact Index and descriptive Index Ratings are determined solely with reference to each institution's Australian resident total assets, subject to APRA management override. In some cases, APRA will adjust an impact rating into a higher range when the institution's failure would have an impact disproportionate to its assets. In rare circumstances, APRA will adjust an impact rating downward, where a regulated institution does not take money from the public and where the impact of failure is disproportionately low compared to asset levels. Work continues on identifying more sophisticated impact indicators.

The impact of an entity's failure is categorizing them on a quantitative scale of impact as follows:

| Risk Level | Asset Range ($AUS) | Corresponding Asset Range ($ CDN)[19] | Corresponding Impact Index[20] |
|---|---|---|---|
| Low | under $250 million | under $247 million | less than 1.25 |
| Medium | $250 million - $2.5 billion | $247 million – $2.47 billion | 1.25 – 12.5 |
| High | $2.5 billion - $12.5 billion | $2.47 billion - $12.3 billion | 12.5 – 62.5 |
| Extreme | over $12.5 billion | over $12.3 billion | greater than 62.5 |

*Source: APRA*

The Impact Index is a continuous curve, ranging from a minimum of 0.25 (for entities with less than $50 million in assets) to a maximum (for entities with assets of $50 billion or more) based on total asset size, ranging between an assumed minimum total assets figure of A$50 million and a maximum figure of A$50 billion. These figures represent the assumed minimum and maximum limits to the overall negative impact that could result from any one failure. The Impact Index is calibrated to a range not dissimilar to that of the Probability Index. The great majority of APRA's regulated institutions are rated as 'Low' and 'Medium' impact, but the bulk of regulated money is controlled by 'High' and 'Extreme' impact firms.

### Probability Ratings

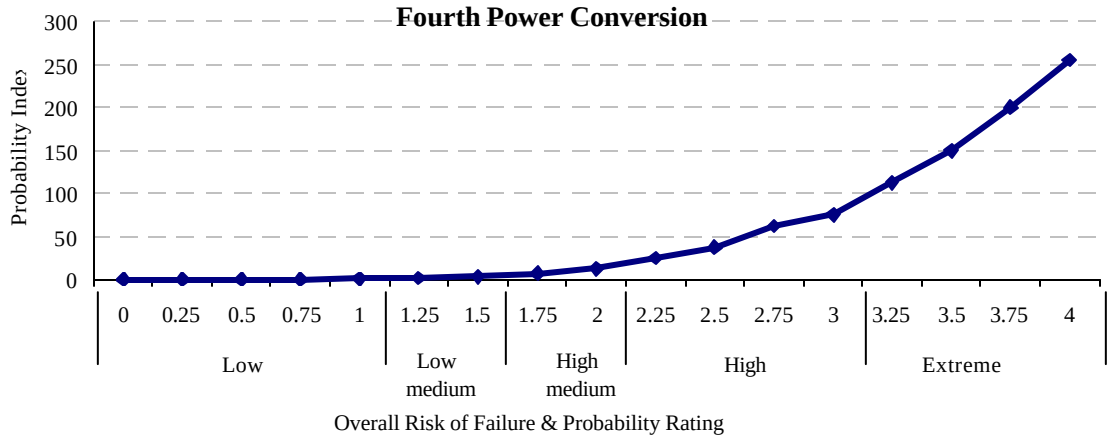
In addition to an impact rating and index, supervisors using PAIRS must develop an assessment of the overall probability of failure of an entity. APRA assesses the likelihood of an institution's

[19] Currency conversion from Bank of Canada using exchange rate of March 16, 2004

[20] The impact index, for entities with assets between A$50 million and A$50 billion, is calculated by the following formula: IMPACT = Asset size*0.005

failure based on the inherent risk of the institution, balanced by the management and controls and the capital support available.
The PAIRS Probability rating for each institution is derived from the assessed overall risk of failure.

Overall risk of failure is a measure of the likelihood that an institution will incur losses of a magnitude that exceed available capital support and consequently lead to its failure to meet the claims of Australian financial consumers. Capital support is assigned the same weighting as inherent risk and management and control individually. This risk is calculated on a scale running from 1 (lowest risk) to 225 (extreme risk). The figures are then assigned to rating ranges: 'Low', 'Low Medium', 'High Medium', 'High', and 'Extreme'.




*Source: APRA*

The non-linear relationship between the descriptive PAIRS Probability Ratings and their corresponding Probability Indices roughly approximates the relationships found between the ratings of the major international debt rating agencies and their relative default expectations, based on long term average actual default experience. Indicative absolute five year cumulative failure rates, based on long term average international debt rating agency experience, range from around 0.25% for 'Low', around 0.50% for 'Low Medium', around 2.00% for 'High Medium', around 10.00% for 'High', and above 20% for 'Extreme'.

**Supervisory Attention Index**

The probability and impact indexes are multiplied to give a Supervisory Attention Index. APRA anticipates using its Supervisory Attention Indexes for three main purposes. At an organisational level, the total of the indexes for all regulated entities is a proxy for the total amount of supervisory attention and resources that should be applied. At the entity level, PAIRS provides an objective measure of risk and supervisory oversight with the corresponding allocation of resources applied to those entities with the highest index. Within an industry, the indexes can be used to track relative riskiness over time. For instance, if the total indexes for all the entities in an industry rise markedly over time, it is likely to indicate that the industry is moving into a state of higher risk.

The Supervisory Attention Index is also used to decide its supervisory stance with respect to individual entities, using the Supervisory Oversight And Response System (SOARS). SOARS is

represents APRA's propensity to intervene and once the PAIRS Supervisory Attention Index is set, one of four supervisory stances applies, as follows:

• **Normal:** APRA collects and analyses data and makes routine on-site visits.
• **Oversight:** A significant step-up in information collection and in the intensity of supervision. APRA may increase minimum capital requirements for 'Oversight' institutions. As a general rule, APRA is to intervene early and often in these 'middle' risk situations, particularly with larger regulated institutions.

• **Mandated Improvement:** The institution is operating in an unsustainable way. APRA will direct institutions in this category to present and execute a remediation plan that addresses the area of identified weakness and restores financial stability. At this level, APRA is to allow the regulated institution to retain control of its destiny but will clearly signal that improvements must be made. APRA may issue directions and take other enforcement actions.

• **Restructure:** The institution is in serious danger of failure. APRA is to apply its full enforcement powers, including issuing directions to replace persons and service providers and to restrict business activities. APRA's paramount concern will be to quarantine the entity from further deterioration and to minimise losses to depositors, policyholders and superannuation fund members

Under SOARS, the stance APRA intends adopting with respect to an individual entity depends directly on APRA's calculation of the entity's impact and probability ratings under PAIRS.

Adopting a supervisory stance under the Supervisory Oversight And Response System (SOARS)

| | | Probability Rating | | | | |
|---|---|---|---|---|---|---|
| | | | **Medium** | | | |
| | | **Low** | **Low** | **High** | **High** | **Extreme** |
| Impact Rating | Extreme | Normal | Oversight | Mandated Improvement | Restructure | Restructure |
| | High | Normal | Oversight | Oversight | Mandated Improvement | Restructure |
| | Medium | Normal | Normal | Oversight | Mandated Improvement | Restructure |
| | Low | Normal | Normal | Oversight | Mandated Improvement | Restructure |

*Source: Australian National Audit Office*

The PAIRS/SOARS system is intended to encourage more vigorous intervention by APRA supervisors in areas of high risk. APRA expects the implementation of PAIRS/SOARS to place it in a stronger position to gauge the scale of its overall supervisory task, identify priority areas within the regulated population and allocate resources according to the degree of risk.

In a risk assessment-based supervisory system, reviews are scheduled based on an assessment of the nature, significance and scope of the risks to which individual entities are exposed, including the business focus, the risk profile and the internal control environment. Furthermore, recognising the inherent limitations of off-site analysis, better practice is for all supervised entities to be visited on a regular basis, with higher risk entities visited more often and/or subject to more intensive visits

The FSA has developed a detailed probability scoring matrix for the following risk groups:

- strategy
- market, credit, insurance, underwriting and operational risk
- financial soundness
- nature of customers/users and products/services
- treatment of customers/users
- organization
- internal systems and controls
- board management and staff
- business and compliance culture

The following table is a sample of the standard (default) table used by FSA supervisory staff.

| Risk Group | Risk Elements | Financial Failure | Misconduct & Mismanagement | Consumer Understanding | Incidence of Fraud or Dishonesty | Incidence of Market Abuse | Incidence of Money Laundering | Market Quality |
|---|---|---|---|---|---|---|---|---|
| Treatment of customers/users | Sales force training and recruitment | N/A | L | L | N/A | N/A | N/A | N/A |
| | Basis of remuneration of sales force | N/A | L | L | L | N/A | N/A | N/A |
| | Financial promotion | N/A | L | L | N/A | N/A | N/A | N/A |
| | Accepting, advising and reporting to consumers/users | N/A | L | L | N/A | N/A | N/A | L |
| | Dealing and managing | N/A | L | L | L | L | N/A | L |
| | Security of consumer/user assets | N/A | L | L | L | N/A | N/A | L |
| | Disclosure/ adequacy of product literature | N/A | L | L | N/A | N/A | N/A | N/A |
| | Membership arrangements | L | N/A | L | L | L | N/A | L |
| Treatment of Customers/Users Score | | L | L | L | L | L | N/A | L |
| Treatment of Customers/Users - OVERIDE | | | | | | | | |

*Note: Intersections which are shaded are not generally applicable. However, there may be cases where they are indeed applicable and therefore all shaded boxes are subject to manual override.*

**Scoring Summary**

Risk elements are scored against the risk to objective (RTO) groups that they may affect. In this scoring process, six levels are used: High, Medium High, Medium Low, Low, Don't Know and N/A. These mean:

N/A: no relation between the risk element and the RTO group.
D/K: insufficient knowledge – investigate further if relevant
Low: default score – no action

Medium Low: flagged risk – action optional
Medium High: significant risk – action likely unless otherwise mitigated
High: high risk – action necessary unless otherwise mitigated.

Scoring is conducted at the risk element level. In this scoring, a single issue can lead to scores across several risk elements where it has a number of components.

These detailed scores are aggregated to find an overall probability score against each of the statutory objectives.

| RTO Groups | Financial failure (RTO's 1 & 8) | Misconduct & Mismanagement (RTO's 2 & 9) | Consumer Understanding (RTO's 7 & 12) | Incidence of Fraud or Dishonesty (RTO's 3 & 13) | Incidence of Market Abuse (RTO's 3, 10 & 14) | Incidence of Money Laundering (RTO's 3 & 15) | Market Quality (RTO's 4 & 11) |
|---|---|---|---|---|---|---|---|
| **RISK GROUPS** | | | | | | | |
| Strategy | L | L | N/A | L | L | N/A | L |
| Market, Credit, Insurance, Underwriting & Operational Risk | L | L | L | L | L | L | L |
| Financial soundness | L | L | N/A | L | L | L | L |
| Nature of Customers/Users and Products/Services | N/A | L | L | L | L | L | L |
| **TOTAL BUSINESS RISK SCORE** | L | L | L | L | L | L | L |
| Treatment of Customers/Users | L | L | L | L | L | N/A | L |
| Organisation | L | L | N/A | L | L | L | L |
| Internal Systems and Controls | L | L | L | L | L | L | L |
| Board, Management and Staff | L | L | L | L | L | L | L |
| Business and Compliance Culture | L | L | L | L | L | L | L |
| **TOTAL CONTROL RISK SCORE** | L | L | L | L | L | L | L |
| | | | | | | | |
| **PROBABILITY SCORE PER RTO GROUP** | L | L | L | L | L | L | L |

*Source: FSA*

### Aggregation and Scores by statutory objective:

These detailed scores are aggregated to find an overall probability score against each of the statutory objectives. In aggregation, control risks can mitigate or magnify business risks. In addition there is scope for the supervisor to override the aggregation method if it is felt that, at any level of aggregation, the result does not adequately reflect the judgment of the risk.

| Statutory objective | Derived IMPACT | Impact override | Override Comment | Derived PROBABILITY | Probability Override | Override Comment |
|---|---|---|---|---|---|---|
| CONSUMER PROTECTION | | | | L | | |
| PUBLIC AWARENESS | | | | L | | |
| REDUCTION OF FINANCIAL CRIME | | | | L | | |
| MARKET CONFIDENCE | | | | L | | |

*Source: FSA*

# 1. Introduction

### 1.1 Outline of the Code

The General Insurance Code of Practice (the Code) is a self regulatory Code to promote good relations between insurers, agents and consumers and good insurance practice by describing standards of good practice and service.

It is intended that the Code will raise service standards across the general insurance industry. For this purpose the Code is to be a "living Code" which will be progressively developed after consultation with interested groups.

Although no specific consumer redress is provided by the Code, it requires participating insurers to establish internal and external dispute handling procedures and insurers may be penalised if they fail to meet the Code's requirements.

### 1.2 The Objectives

**The Code will:**

describe standards of good practice and service to be met by participating insurers;

promote disclosure of information relevant and useful to consumers so as to allow them to make an informed choice and compare one product with another;

facilitate the education of consumers about their rights and obligations under insurance contracts;

promote informed and effective relationships between consumers, insurers and agents;

require insurers to have fair procedures for resolution of disputes between consumers and insurers or consumers and agents;

provide representation for consumer views in the administration and development of the Code,

but apart from the provisions for enforcement and sanctions in this Code, a breach of the Code shall not give rise to any legal right or liability.

### 1.3 Principles

The objectives of this Code shall be achieved and the provisions of this Code shall be applied having regard to:

the requirement of insurers to meet the prudential standards established under the Insurance Act 1973;

the fact that both insurance contracts and arrangements between consumers, insurers and insurance intermediaries are governed by the Insurance Contracts Act 1984 and the Insurance (Agents & Brokers ) Act 1984;

the duty of utmost good faith and the fact that the insurance contract is the governing document of the relationship of the consumer and an insurer;

the need for effective competition and cost efficiency being promoted in the general insurance industry, and ensuring flexibility in the development and enhancement of products and services for consumers;

the need to protect consumers and insurers from increased costs from fraud;

the need for consumers to be made aware of the provisions of this Code.

**1.4 Monitoring**
Compliance with the Code and the Code's operations shall be monitored by Insurance Enquiries and Complaints Limited ("IEC").

**1.5 Code Compliance Committee**
The Code Compliance Committee shall be a committee of the IEC board made up of the chief executive of the Insurance Council ("ICA") or his nominee, a consumer member on the board of IEC and an independent chair being a person with experience in the insurance industry nominated by ICA, and appointed by unanimous decision of the board of IEC.

## 1.6 Review and Development of the Code

**1.6.1 Guidelines**
ICA may develop guidelines to assist in the implementation and administration of the Code to be endorsed and promulgated by the IEC. The Code Compliance Committee may also approve guidelines developed by individual insurers for their own use.

**1.6.2 Living Code**
ICA with the assistance of IEC shall be responsible for the development of the Code on an ongoing basis. Any recommendations for change to the Code shall be discussed with consumer representatives, the insurance industry and ASIC before implementation. ASIC approval will be required for any change to the Code.

**1.6.3 Formal Review**
Every three years the Code shall be generally reviewed with the intention that the review will be completed within one year. This review shall be undertaken by an independent party agreed between IEC and ASIC and commissioned by ICA and shall consider whether its operation is in accordance with the objectives and principles set out above. This general review shall be conducted in consultation with the IEC, the insurers, consumer representatives and ASIC. Subject to the approval of ASIC any agreed changes arising from that review shall be incorporated into the Code.

**1.7 Endorsement**
Each insurer may endorse insurance business to which the Code applies by specifying that the insurer participates in the General Insurance Code of Practice and the insurer shall specify how and where consumers may obtain information about this Code and its operation.

**1.8 Publication of Code by Insurers and Agents**
Insurers shall, and shall require their agents to, have available for consumers information about the Code and its operation.

**1.9 Adoption of Code**
An insurer may adopt this Code by entering an agreement with IEC, on terms approved by IEC, agreeing to comply with the Code and any sanction imposed under it.

## 2. Defined words and operative date

**2.1 Defined Words**
In this Code:

**"agent"** means an insurance intermediary as that term is used in the Insurance ( Agents & Brokers) Act 1984 but does not include any general insurance broker or life insurance broker other than where such a broker is an agent of an insurer;

**"consumer"** means an individual, when that individual, whether alone or jointly with another individual, enters or proposes to enter into an insurance contract which is wholly and exclusively for the consumer's private or domestic use;

**"CRP"** means the General Insurance Claims Review Panel;

**"dispute"** means an unresolved complaint about a product or service of an insurer and for this purpose a complaint is an expression of dissatisfaction conveyed to an insurer together with a request that the complaint be remedied by the insurer;

**"insurance business"** means:

contracts of insurance (including interim contracts of insurance as defined in subsection 11(2) of the Insurance Contracts Act 1984) which are prescribed contracts under section 34 of the Insurance Contracts Act 1984. These contracts are described in the Insurance Contracts Regulations as:

Motor Vehicle (comprehensive, third party property damage only or extended third party property damage policies)

Home Buildings

Home Contents

Sickness and Accident

Consumer Credit

Travel

contracts of insurance which insure personal and domestic property (including movables, valuables, caravans, on-site mobile homes and marine pleasure craft); and

other contracts of insurance in respect of which an individual insurer determines to apply the Code;

**"insurance contract"** or "policy" means each general insurance contract arising out of or in connection with insurance business between an insurer and consumer;

**2.2 Operative Date**
**Sections 1, 2, 6 and 7**

The provisions contained in Section 1 (Introduction), Section 2 (Defined Words and Operative Date), Section 6 (Dispute Resolution) and Section 7 (Responsibility, Review and Sanctions) of the Code shall operate in respect of insurance contracts issued on or after 1 July 1995 or from such later date on which an insurer agrees to adopt the Code.

**2.3 Operative Date**
**Sections 3, 4 and 5**

In the case of any insurer who adopts the Code after 1 July 1995, each insurer shall on the date of adoption propose a plan to the Code Compliance Committee for its approval setting out the steps it proposes to take and a timetable for compliance with the provisions of Section 3 (Agents and Employees), Section 4 (Policy Documentation) and Section 5 (Claims Handling). Each plan shall provide that full compliance is achieved no later than 6 months of the date of adoption. An insurer is required to comply with the provisions of Section 3 (Agents and Employees), Section 4 (Policy

Documentation) and Section 5 (Claims Handling) of the Code as set out in its approved compliance plan.

## 3. Agents and employees

**3.1 Supervision of Agents**
Insurers shall require their agents to:

possess the necessary skills appropriate to the insurance they are arranging and the insurance services they are providing; and

inform consumers of their status, the identity of the insurer for whom they are acting and the nature of any association between the insurer and the agent.

**3.2 Authority**
Insurers should ensure that agents are not authorised to arrange insurance for consumers which does not match the agent's expertise, having regard to the services the agent is providing.

**3.3 Agent Training**
Insurers shall require their agents to receive adequate training or instructions, and documentation to competently arrange insurance contracts for and provide the insurance services to consumers which they are authorised to arrange or provide. The obligation to provide training or instruction, and documentation shall be ongoing and include training or instruction and documentation in the areas of:

principles of general insurance and any relevant consumer protection law;

product knowledge;

what to do in the event of a claim;

the requirement of this Code,

as may be appropriate in relation to the authority and responsibility of the agent.

**3.4 Agent Record Keeping**
Insurers shall keep and require their agents to keep records relating to their appointment and training for at least 5 years and on request shall make those records available for examination by the IEC.

**3.5 Employees**
Insurers shall:

ensure that employees involved in arranging insurance, claims handling and dispute resolution are familiar with the provisions of this Code and that they possess the necessary skills appropriate to their responsibilities; and

provide adequate training to employees having regard to the employee's role and responsibility and the insurance contracts for and the insurance services to consumers that they are authorised to arrange or provide.

**3.6 Implementation for Agents and Employees**
In implementing these requirements insurers shall have regard to whether the agent or employee would ordinarily provide advice to consumers and, if this is not the case, insurers shall provide such agents or employees with information as to how consumers may be able to obtain advice.

Insurers shall instruct agents and employees not to provide advice in relation to any product in respect of which they have not been trained to provide advice.

## 4. Policy documentation

### 4.1 Policy Documentation

Insurers shall:

express policy documentation in plain language, and, design and present policy documentation, with the aim to assist comprehension by consumers;

make available to consumers copies of policy wordings;

prior to each renewal:

provide to consumers information on any changes to the policy being renewed in plain language and in a format aimed to assist comprehension by consumers; and

clearly inform the insured that the duty of disclosure applies on renewal and the consequences of any non-disclosure; and

make available with policy documentation:

advice that the documentation should be read carefully and retained;

where appropriate, advice that evidence of the value of the property insured or the amount of any loss should be kept by the insured; and

information about the existence of the Code and the availability of internal and external dispute resolution processes.

### 4.2 Proposals

Insurers shall use proposal forms or have procedures for collecting information in relation to the provision of cover that:

identify all usual information that the insurer ordinarily requires to be disclosed and which the insurer wishes to know prior to providing cover;

clearly informs consumers of their duty of disclosure and the consequences of non-disclosure;

express questions in plain language and, where instructions are necessary, provide information on how the questions are to be answered; and

provide adequate space or opportunity to answer questions or if there is inadequate space or opportunity provide advice as to how the additional information is to be provided.

### 4.3 Declined Cover

Where an insurer declines cover or refuses to renew a policy because of factors that do not relate to the assessment of the particular risk (for example, the insurer has ceased to offer the cover) then the insurer shall notify the consumer of that fact.

An insurer shall not require a consumer to disclose to it prior refusals of cover or renewal where another insurer (whether that insurer has adopted this Code or not) has advised the consumer that the refusal was because of factors that did not relate to the assessment of the particular risk.

### 4.4 Consumer Information Brochures

Where an insurer publishes consumer information brochures developed by itself or ICA relating to the general nature of insurance or the effect and operation of a policy, then the insurer shall make those brochures available to consumers on request.

# 5. Claims handling

### 5.1 Principles

Insurers shall:

make claim forms or claim procedures readily available to claimants free of charge.

in plain language explain what information is required and the procedure for making a claim;

promptly respond to reasonable requests by claimants for assistance in making a claim; and

provide information as to the internal dispute resolution procedures of the insurer and the availability of the external dispute resolution procedure if any dispute remains unresolved.

Claim forms or other methods of collecting information for the processing of a claim shall be in plain language, be designed and set out in a manner that aids comprehension and identify all usual information that the insurer shall ordinarily require to process the claim and the manner in which that information is to be provided.

Completed claims shall be promptly considered and assessed by insurers having regard to the type of claim made. In normal circumstances, insurers shall within 15 business days of receipt of a claim respond to the claim.

Insurers shall keep consumers informed as to the progress of a claim unless the insurer is awaiting a response from the consumer.

Where a reasonable period for consideration and assessment of a claim has passed and where all information required by the insurer for the purposes of the claim has been provided, the insurer shall advise the claimant whether the claim is accepted or rejected.

If an insurer decides to accept a claim or requires further information, the insurer shall promptly advise the claimant.

Where a claim is rejected an insurer shall promptly advise the claimant of that decision and the reasons for it, and the availability of the insurer's dispute resolution process described in Section 6.

Where reasons are provided by an insurer, those reasons shall not require disclosure of:

information provided by third parties that is confidential or the identity of those third parties;

information that is subject to legal professional privilege;

information that may prejudice the insurer in any further investigation or in any dispute over the claim.

Where reasons are not given by an insurer, the insurer shall advise the consumer of the availability of the insurer's internal disputes resolution procedure and of the CRP. This notice is in addition to the general publicity requirements of the CRP.

### 5.2 Supervision of Investigators, Assessors Collection Agents and Loss Adjusters

Insurers shall require investigators, assessors, collection agents and loss adjusters acting on behalf of the insurer to:

operate in a professional manner;

inform consumers of their status and the identity of the insurer for whom they are acting; and

comply with the law and this Code.

Insurers should ensure that investigators, assessors, collection agents and loss adjusters are not authorised by the insurer to act in matters which do not match their expertise. Complaints relating to investigators, assessors, collection agents and loss adjusters shall be handled by an insurer under the insurer's internal dispute resolution process.

**5.3 Investigators**
Insurers should ensure that each investigator acting on behalf of the insurer (not being an employee) has:

been approved by the insurer;

a current licence as required under relevant State legislation; and

sufficient expertise to act in relation to the matter that they are investigating.

**5.4 Assessors Collection Agents and Loss Adjusters**
Insurers should ensure that each assessor, collection agent or loss adjuster acting on behalf of the insurer (not being an employee) has:

been approved by the insurer; and

membership of an assessing or loss adjusting professional body or sufficient expertise to act on behalf of the insurer.

## 6. Dispute resolution

**6.1 Internal Dispute Resolution**
Each insurer shall have a fully documented internal process for resolving a dispute between the consumer and the insurer, the consumer and the insurer's agent or the consumer and the insurer's investigator, assessor or loss adjuster. This process shall be readily accessible by consumers without any charges imposed by the insurer. The internal process shall provide a fair and timely method of handling disputes. The insurer shall establish procedures for the monitoring of disputes that are referred to this process.

**6.2 Brochures**
The insurer shall have brochures available providing general descriptive information on:

the procedures for handling a dispute by the insurer;

the time within which a dispute will be normally handled by the insurer; and

the fact that the dispute will be handled by an officer of the insurer with appropriate powers to deal with the dispute.

**6.3 Resolution Requests**
Where an insurer receives from a consumer a request, whether written or oral, for the resolution of a dispute or a request for a response from the insurer in writing in relation to the dispute, the insurer shall promptly reply to the consumer and, if the dispute is not resolved in a manner acceptable to the consumer, the insurer shall provide:

where appropriate, the general reasons for that outcome; and

information on the further action that the consumer can take such as the process for resolution of disputes referred to in 6.4 below.

Where reasons are supplied in relation to a dispute relating to a claim, the provisions of Section 5.1(h) shall apply to those reasons.

### 6.4 External Dispute Resolution

Each insurer shall participate in the General Insurance Enquiries and Complaints Scheme operated by IEC.

## 7. Responsibility, review and sanctions

### 7.1 Responsibility of Insurer

An insurer shall ensure that it:

implements appropriate systems and documentation for the insurer to comply with the Code;

prepares an annual report to IEC on the operation and compliance with the Code in accordance with the guidelines promulgated by IEC;

monitors disputes with consumers and compliance with the Code.

### 7.2 Review of Compliance

IEC may from time to time review compliance of this Code by an insurer and an insurer shall take all reasonable steps to ensure that procedures are established to stop any breach occurring or recurring. Insurers shall co-operate with the staff of IEC in such a review and provide information about any alleged breach and the procedures adopted by the insurer to comply with the Code.

IEC shall receive complaints about alleged breaches of the Code by insurers, and shall consult with insurers in respect of the alleged breaches and make recommendations, if necessary, about the alleged breach and the insurer's compliance with the Code.

Any panel, adjudicator, body or individual having jurisdiction in relation to the Scheme may report any alleged breaches of the Code to IEC.

### 7.3 Publication of Participants and Annual Report by IEC

IEC shall publish the names of participants in the Code and an annual report reporting on the operation of this Code including compliance.

IEC shall publish and make available to consumers the names of insurers who have adopted the Code and information about the requirements of the Code.

### 7.4 Sanctions imposed by IEC and the Code Compliance Committee

If IEC is of the view that there has been a material breach of the Code and the insurer has not taken all reasonable steps to ensure procedures are established to prevent the breach recurring, then IEC shall immediately report the matter to the Code Compliance Committee.

If the Code Compliance Committee has satisfied itself that the insurer has not complied with the Code and not put in place procedures to stop the material breach recurring, it shall consult with the insurer and ask for the breach to be rectified. The insurer shall have an opportunity to make representation to the Code Compliance Committee in respect of such breach. If the Code Compliance Committee is still of the opinion that the insurer has not complied with the Code it shall request the insurer to do so by writing to the Chief Executive of the insurer.

If the insurer refuses to co-operate with a request of the Code Compliance Committee, the Code Compliance Committee may give notice to the insurer that it proposes to impose sanctions on the insurer for non-compliance with the Code. A copy of the notice shall be sent to the Chief Executive Officer of the insurer.

The Code Compliance Committee shall not impose sanctions for at least 20 business days after the notice has been given. The insurer shall have an opportunity during this period to make

further representations to the Code Compliance Committee in respect of such breach for the Code Compliance Committee's further consideration. If the Code Compliance Committee is still of the opinion that a material breach has occurred and the insurer has not put in place a remedy to comply with the Code, the Code Compliance Committee may impose sanctions.

Before imposing any sanctions on an insurer, the Code Compliance Committee shall have regard to:

the objectives and the principles governing the Code; and

the severity of the breach of the Code and the appropriateness of the sanction.

The Code Compliance Committee may impose one or more of the following:

a requirement that particular rectification steps be taken by the insurer in accordance with a specified timetable and imposing a timetable for rectification;

a requirement that a compliance audit be undertaken;

corrective advertising; and

a recommendation to the board of IEC that the insurer be named in the annual report as not having complied with the Code and setting out the nature of the non-compliance.

**7.5 Reporting**
The Code Compliance Committee may report to the board of IEC in respect of its activities but it shall not disclose the name of an insurer who is alleged to have breached the Code or on whom sanctions have been imposed unless it recommends that the insurer be named in the annual report or unless the insurer consents.

**7.6 Review of Sanctions**
An insurer who is sanctioned under this Code may request that the sanction be reviewed by the board of IEC and in that case, if the board considers that there are grounds for review, the board may refer the matter to the Code Compliance Committee for reconsideration.

**7.7 Failure to Comply**
The Code Compliance Committee may report to the board of IEC any failure by an insurer to comply with a sanction imposed on it and recommend action to be taken by IEC and that the insurer be named in the annual report as having failed to comply with a sanction.

**7.8 Naming and Enforcement of Sanctions**
Upon the recommendation of the Code Compliance Committee, the board of IEC may determine to name an insurer in the annual report as having failed to comply with the Code and set out in the report the nature of the non-compliance.

IEC may take such steps as it believes appropriate to enforce any sanctions imposed by it or the Code Compliance Committee and may report such a matter to the ASIC.

# Life Insurance Code of Practice
# Life Insurance Act 1995

Circular to Life Insurance Companies and Life Brokers
Consumer Issues No G.II.1
Code of Practice for Advising, Selling and Complaints Handling in the Life Insurance Industry - August 1995

**Contents**

1. Introduction
2. Background to the Development of the Code of Practice
3. The Role of the ISC in Consumer Issues
4. Commencement Date of the Code of Practice
5. Implementation of the Code of Practice
6. Monitoring of the Enforcement of the Code of Practice
7. Administration of the Code of Practice
8. Attachments

**Part I**
Introduction
Objectives
Application
Interpretation

Part II
Advising and Selling practices
Exemptions
Disclosure of capacity
Same-Day Sales
Fact find and needs analysis
Incomplete fact find
Customer Advice Record
Requirements where advice is given
Requirements where advice is not given or fact find is not undertaken
Requirements where an existing life policy is replaced
Completion and retention of the Customer Advice Record
Application Forms

**Part III**
Training and competency
Basic competencies
Product-specific competencies
Multi-agents
Continuing education requirements

**Part IV**
Inquiries, complaints and disputes
Internal inquiry and complaint arrangements
External dispute resolution mechanisms

**Part V**
Monitoring and reporting

Code of Practice for advising, selling and complaints handling in the Life Insurance industry

## 1. Introduction

On 1 July 1995 the Life Insurance Act 1995 (the Act) came into effect establishing a new regime for the regulation of the life insurance industry. A stated object of the Act is:

> "to protect the interests of the owners and prospective owners of life insurance policies in a manner consistent with the continued development of a viable, competitive and innovating life insurance industry."

Specific consumer protection measures have always been an intended component of the new regulatory regime. The Consumer Protection Provisions are expected to be passed as an amendment to the Act in the early part of 1996. These provisions will provide the statutory framework for development of legislative instruments (Commissioner's rules) in respect of:

requirements for product information disclosure (Disclosure rules)

requirements for advising selling and complaints handling (Code of Practice)

In the interim, these initiatives will be implemented by way of Circular.

## 2. Background to the Development of the Code of Practice

It has long been a recognised concern of the government of the day that, in respect of the dealings between large corporations and individual consumers there may not be equality of bargaining power. In respect of the life insurance industry in particular, this view was supported, and raised to the public agenda, by three major reports published during the period 1992-1993. These were:

The Trade Practices Commission Report on "Life Insurance and Superannuation", December 1992

The Senate Select Committee on Superannuation Report No 6 "Super Fees, Charges and Commissions", June 1993

The Australian Law Reform Commission Report No 65 "Collective Investments, Other People's Money", June 1993

These reports were consistent in their criticism of selling practices in the life insurance industry - highlighting as potential problem areas commission levels, pressure sales and low early termination values.

The Consumer Protection Provisions represent the Government's response to perceived, and evidenced, poor practice in the life insurance industry. These provisions, in concert with the other elements of the new regulatory regime, will facilitate a more equitable relationship between the life insurance company as provider and its customers.

The Code of Practice for Advising, Selling and Complaints Handling in the Life Insurance Industry (the Code of Practice) is a key element in achieving a better balance in the relationship between insurance providers and consumers, and an increased level of protection for policyowners.

The early development of the Code of Practice was driven by a Government Taskforce chaired by the Insurance and Superannuation Commission and including representatives from the Federal Bureau of Consumer Affairs and the Trade Practices Commission.

A draft code of Practice was released for public comment in August 1994 and over 70 submissions were received. These submissions highlighted the diversity of opinion amongst the various stakeholders and interest groups affected by the proposals.

Accordingly, in the final stages of the development of the Code of Practice, a Working Group was established, chaired by LIFA, with a membership representative of the major stakeholder groups including government, consumer groups, product providers and intermediaries. The Working Group was instrumental in facilitating discussion and achieving a consensus position across the stakeholder groups on a number of the issues. The final version of the Code of Practice reflects those consensus positions, but required final decisions on some remaining contentious issues to be taken by the Government.

While the Code of Practice, as issued, is clearly aimed at improving selling practices and ensuring policyowner protection immediately, it is anticipated that many companies will impose higher standards and that, in time, the Code itself will reflect an overall lifting of minimum standards.

**Proposed Registration Board**
During the development of the Code of Practice the original intention to include basic competency requirements and recruitment standards for life insurance advisers was set aside, pending the development of an industry based Registration Scheme. Such a scheme was strongly advocated by the agents' association, supported by the insurance companies and accepted in concept by the Government. The development phase of the scheme is well advanced and is expected to be completed during 1996.

## 3. The Role of the ISC in Consumer Issues

The draft Consumer Protection Provisions under the Act require the establishment within each life company of a Compliance Committee. The principal purpose of this committee being to assist in dealing with consumer-related issues that arise in the course of the life company's operations, and to ensure that the life company at all times has a proper system of management controls that will enable it to comply with the Disclosure Rules and the Code of Practice.

The motivation for establishing the Compliance Committee was to reinforce with life companies the importance of the Consumer Protection Provisions and to ensure that directors recognised that the responsibility in respect of these matters was theirs.

In keeping with this motivation is must be stressed, at this early stage of implementation of the Code of Practice, that enforcement of these provisions of the Code of Practice is the responsibility of the life company or life broker as appropriate. Within the ambit of this responsibility it is the life company or life broker that must make the operational and commercial judgements necessary in determining acceptable standards of practice to achieve compliance with the Code of Practice.

The ISC accepts responsibility for, and intends to play an active role during, the introduction of the concepts and intentions underlying the Code of Practice. Further the ISC will be taking an active role in monitoring the industry and the procedures life companies and life brokers have in place to enforce the requirements of the Code of Practice. The ISC cannot, and will not, accept responsibility for the interpretation of the specific requirements which the Code of Practice imposes or the judgmental decisions on how they should be complied with.

The ISC will be seeking to establish a relationship with representative industry groups and facilitate a communication process that works largely through these industry channels. The ISC encourages individual life companies and life brokers to similarly establish networks within the industry for communication of, and discussion on, the operationsal aspects of the Code of Practice. The function of the Compliance Committee and/or the nomination of a compliance officer is seen as integral to the development of appropriate communication lines between the ISC and the individual life companies or life brokers.

## 4. Commencement Date of the Code of Practice

Individual parts of the Code of Practice will take effect on the following dates:

| | | |
|---|---|---|
| 1 September 1995 | Part I | Introduction |
| | Part IV | Inquiries, Complaints and Disputes |
| 1 January 1996 | Part II | Advising and Selling Practices |
| | Part III | Training and Competency |
| | Part V | Monitoring and Reporting |

While life companies and life brokers do not have to formally comply with Parts II, III and V until January 1996 it is expected that they strive for full compliance as early as possible.

## 5. Implementation of the Code of Practice

The implementation phase for the Code of Practice is the period from the launch of the Code of Practice (3 August 1995) to the date on which the full requirements of the Code of Practice have commenced (1 January 1996). During the implementation phase, the ISC will be acting to ensure that industry is responding to the requirements of the Code of Practice and that life companies and life brokers will be in a position to comply with the full requirements by 1 January 1996.

To assist the ISC in this process, life companies and life brokers are required to provide the following information:

### *a. Code of Practice implementation plan*

The implementation plan will assist the ISC in monitoring industry implementation of the Code of Practice.

Life companies and life brokers are required to complete the attached implementation plan (Attachment 2) and forward it to the ISC by 30 September 1995.

### *b. Pre-Code statistical survey*

The purpose of the statistical survey is to gather pre-code statistics on life company and life broker practices. This information will be used as benchmark data against which changes in practices and procedures can be measured.

Life companies and life brokers are required to complete the attached statistical survey (Attachment 3) and forward it to the ISC by 30 September 1995.

### *c. Interim compliance report*

The purpose of this report is to monitor life company and life broker progress in putting in place procedures and mechanisms in anticipation of the implementation of the Code of Practice. This report will target the matters set out in paragraph 41.

The ISC will distribute an interim compliance report in November 1995 for completion and return by December 1995.

## 6. Monitoring of the Enforcement of the Code of Practice

The ISC's role in monitoring the enforcement of the Code of Practice will commence, in respect of the particular requirements of the Code of Practice, on the respective dates of commencement of those requirements. In this capacity, the ISC will be acting to ensure that, on an ongoing basis, life companies and life brokers remain in a position to comply with the requirements of the Code of Practice (ie. maintain and develop the systems and management controls in place to enable compliance).

This monitoring will be primarily achieved through:

i. statistical reports from life companies and life brokers; and
ii. an audit program implemented by the ISC involving routine and special on-site inspection of the companies and brokerages.

*Statistical report*
Life companies and life brokers will be required to report to the ISC by completing a regular statistical report (paragraph 45 of the Code of Practice). The Pre-Code Statistical Survey included in this package should not be taken as indicative of the type, or level of detail, of information which will be sought on a regular basis.

Development of the format and content of the statistical returns to be required of life companies and life brokers will be progressed over the next three to six months. The development will occur in close consultation with industry representative bodies, and as a part of the total review of the financial and statistical returns required under the Act. This will ensure consistency and avoid duplication of the information sought under the Code of Practice and provided through other statistical returns under the Act.

As an indication of the matters on which it is expected information will be requested, the following list highlights some of the areas identified to date. (This should not be taken as an exhaustive list).

use of Fact Finders

business written and terminated by reason of replacement business

same day sales

experience under the cooling off provisions

discontinuances by duration in force

The ISC will publicly report the findings of its data-gathering. In addition a comprehensive report will be presented to Parliament by inclusion in the ISC Annual Report.

## 7. Administration of the Code of Practice

*a. Customer Advice Record*
There is no requirement under the Code of Practice for the Customer Advice Record (CAR) to be signed by the customer (refer to paragraphs 18-26).

The Commissioner is of the view that industry best practice would require the signing of this record by the customer. Life companies and life brokers are encouraged to adopt industry best practice in respect of the CAR.

LIFA has undertaken to monitor this by way of periodic survey, the results of which will be made available to the ISC. Further the ISC, in its own monitoring program, will have regard to this issue.

*b. External Dispute Resolution Mechanisms*
Under the Code of Practice paragraphs 37-39, the Commissioner has power to grant and revoke approval for external dispute resolution mechanisms.

At the time of releasing this Circular the Commissioner has granted approval to the following:

Life Insurance Complaints Service Limited

Superannuation Complaints Tribunal

## 8. Attachments

1. Code of Practice for Advising, Selling and Complaints Handling in the Life Insurance Industry
2. Implementation Plan
3. Pre-Code Statistical Survey

## Part I - Introduction

### Objectives

1. This Code is intended to:

a. promote the provision of high quality advice in relation to life policies, so that where policies are issued they are appropriate to the needs of the persons to whom they are issued;

b. ensure that life companies, life brokers and life insurance advisers maintain a minimum standard of service when dealing with customers in relation to life policies;

c. ensure life companies and life brokers play an active role in overseeing the conduct and competence of their life insurance advisers;

d. ensure that life insurance advisers are competent in arranging the issue of life policies;

e. ensure that life companies and life brokers have adequate procedures for dealing with inquiries and complaints by owners and prospective owners of life policies and by any persons who have an interest in a life policy; and

f. ensure that, in the case of disputes that are not able to be resolved under procedures referred to in paragraph (e), owners and prospective owners of life policies and any persons who have an interest in a life policy have access to an adequate external dispute resolution mechanism.

**2. The function of this Code is to require:**

a. the observance of standards to ensure that customers are placed in a position to make an informed choice;

b. the establishment of arrangements to ensure that life insurance advisers meet relevant competency standards and follow principles of fair dealing; and

c. the establishment of inquiries and complaint-handling mechanisms which ensure that customers are provided with timely and acceptable standards of assistance.

**3.** Compliance with the requirements of this Code shall be assessed having regard to the principle of utmost good faith that applies to contracts of insurance, as set out in the Insurance Contracts Act 1984.

### Application

**4. This Code applied to:**

a. all life companies registered under the Life Insurance Act 1995; and
b. all life brokers registered under the Insurance (Agents and Brokers) Act 1984;

in respect of their conduct and the conduct of their life insurance advisers.

**5.** Parts I and IV of this Code commence with effect from 1 September 1995, with the remainder of the Code to commence with effect from 1 January 1996. The provisions of the Code apply in respect of conduct engaged in by life companies, life brokers and life insurance advisers, and policies issued, on or after the date of commencement of the relevant Part. Notwithstanding the above, the complaint-handling and dispute resolution arrangements referred to in Part IV of this Code apply to complaints in respect of events which occurred before the date of commencement of this Code.

**6.** Where a group life or group superannuation policy is effected and any individual whose life is insured under the scheme, while not the policyowner, is making the effective purchasing decision, all the provisions of the Code will apply as if that individual were the customer. In all other cases where a group life or group superannuation policy is effected, Part II of the Code will not apply.

## Interpretation

**7.** References to the singular include references to the plural and vice versa.

**8.** For the purposes of this Code:

"advice" means any recommendation, express or implied, made to a customer with respect to the purchase, variation or termination of a life policy, but does not include:

a. answers to routine administrative queries;
b. factual information about a particular life policy;
c. collection of premiums and issue of receipts without other contract;
d. placing promotional statements on display, or merely handing them out or posting them;
e. merely acting as a facilitator, such as arranging for medical examinations;
f. non-personalised advice which merely analyses and reports on life policies and does not involve any needs analysis or a particular customer; or
g. merely incidental advice.

"agent", in relation to a life company, means a person in relation to whom an agency agreement is in force with the life company.

"association" for the purposes of this Code has the same meaning as "association with" has in respect of life brokers under section 38 of the Insurance (Agents and Brokers) Act 1984, except that it also extends to all employers or contractors of life insurance advisers.

"authorised product" means a product which a life insurance adviser is authorised by a life company or life broker to give advice on.

"Commissioner" means the Insurance and Superannuation Commissioner.

"complaint" means an expression of dissatisfaction conveyed to a life company or life broker about a product, advice or service offered or provided coupled with a request to remedy it.

"customer" means a person who deals with a life insurance adviser for the purpose of either:

a. purchasing, varying or terminating a life policy; or
b. seeking advice regarding a life policy;

and includes a policyowner, a life insured, a prospective policyowner and a person with an interest, or a prospective interest, including under a superannuation policy.

"dispute" means an unresolved complaint.

"life company" means a company registered under the Life Insurance Act 1995.

"life insurance adviser" is a natural person who, for reward, provides advice in respect of, or arranges, life policies.

"life broker" means a person who is for the time being registered under Part III of the Insurance (Agents and Brokers) Act 1984 in respect of life insurance business.

"life policy" for the purposes of this Code has the same meaning as in the Life Insurance Act 1995.

"merely incidental advice" is advice provided by a solicitor, accountant or other adviser in circumstances where that solicitor, accountant or adviser;

a. does not provide a discrete advisory service in respect of life policies;
b. does not receive a fee, commission or other benefit for

providing such advice; and
c. attaches to their advice a written recommendation that the customer seeks the advice of a life insurance adviser.

"multi-agent" is an agent who is authorised to act as a life insurance adviser by more than one life company.

"product" means a particular kind of life policy.

"risk policy" means a policy which provides no surrender value and benefit payable on a specified date or dates.

"sale" means a customer's request, expressed in writing, for the issue of a new life policy, or for the variation of an existing life policy where that variation results in increased expenditure by the customer.

"sell" means obtain a sale, and sold and selling have corresponding meanings.

"superannuation policy" for the purposes of this Code has the same meaning as in the Life Insurance Act 1995.

"termination" means the giving by a customer of an instruction to terminate a life policy.

"unsolicited contact" means contact between a life company, life broker or life insurance adviser and a customer made where there has been no previous contact between the parties, but excludes a meeting which has been initiated by the customer.

## Part II - Advising and selling practices

This part specifies standards of practice that life companies and life brokers are to observe and to require their life insurance advisers to observe.

**Exemptions**
**9.** The requirements of this Part do not apply to risk policies where the annual premium payment under such policies is less than $500 in total per life insured.

**Disclosure of Capacity**

**10.** At the earliest reasonable opportunity during advising or selling, a life insurance adviser must provide written advice to a customer of:

a. the name and address of the life insurance adviser;
b. the means of remuneration of the life insurance adviser, who is responsible for the life insurance adviser's conduct and whether the life insurance adviser's primary duty is to the customer or the life company; and
c. if the life insurance adviser is only authorised to sell or advise on a restricted range of products - a statement to that effect.

**Same-Day Sales**

**11.** A life insurance adviser must not sell a policy (other than a risk policy) to a customer where that life insurance adviser has already sold another policy (other than a risk policy) on the same site (eg. workplace, flats) or to someone of the same community group (eg. sporting club, ethnic group), within the previous 24 hours. Such sales will be permitted where the sale does not result from an unsolicited contact. Where a same-day sale occurs, this must be clearly indicated on the application/proposal form.

**Fact Find and Needs Analysis**

**12.** In all cases where advice is given by a life insurance adviser, he or she must:

a. analyse the needs, circumstances and objectives of the customer to ensure that advice is given on a reasonable basis and is not inappropriate; and
b. take reasonable steps to ensure that the customer can sufficiently comprehend the advice and the basis for the advice to place the customer in a position to make an informed choice.

**13.** Unless the customer chooses (in terms of paragraph 17 of this Code) not to provide information, a life insurance adviser must undertake a fact find, that is, he or she must obtain sufficient information from the customer, subject to paragraph 16 of this Code, to satisfy the requirements of paragraph 12. This information would generally include, where relevant:

a. the customer's financial and family circumstances;
b. details of the customer's needs and objectives for income, capital growth, secuirty, liquidity, and the time period the customer is planning for;
c. individual investment preferences and aversion or tolerance to risk;
d. the level and type of retirement benefit which the customer (and domestic partner) can currently expect to receive;
e. other customer details such as employment security, age, partner's age, expected retirement age and partner's expected retirement age.

Where the customer has indicated prior to the fact find or in its early stages that his or her interest extends only to risk policies, the fact find may not need to proceed through (b) to (e) above.

**14.** The information obtained during a fact find must be recorded in writing, the resultant document being referred to in this Code as a Fact Finder. The Fact Finder must be signed by the life insurance adviser as a record for the purposes of paragraph 40.

**15.** In satisfying the requirement in paragraph 13, a life insurance adviser may utilise information previously collected from the customer, provided that the customer agrees that the information remains relevant and up to date.

**16.** Where the customer and the life insurance adviser agree that only certain types o products or identified objectives are to be considered, the life insurance adviser need only obtain, and the Fact Finder need only contain, information that is relevant to the types of products or objectives under consideration. A reference to this agreement must be included in the Customer Advice Record referred to in paragraph 18.

**Incomplete Fact Find**

**17.** Where the customer chooses not to provide all information requested by the life insurance adviser for an effective fact find, the customer must be advised of the implications of not allowing an effective fact find and needs analysis to be conducted. The Customer Advice Record (referred to in paragraph 18) must contain:

a. a specific warning that appropriate advice may not be able to be given without complete information; and
b. a statement that, by not providing sufficient information, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs.

**Customer Advice Record**

**18.** The customer must be provided with a copy of a written Customer Advice Record containing the information prescribed in paragraphs 16, 17 and 19 to 25 of this Code, no later than at the commencement of the cooling-off period.

**Requirements where advice is given**

**19.** Where advice is given, the Customer Advice Record must contain an explanation of the life insurance adviser's status and obligations that includes:

a. the name and business address of the life insurance adviser;
b. the types of products which the life insurance adviser is authorised to give advice on, arrange or sell and the authorising life company(ies) or life broker which he or she represents;
c. a description of any association the employer or contractor of a life insurance adviser has with the life company(ies) whose product(s) is/are recommended; and
d. the means of remuneration of the life insurance adviser, who is responsible for the life insurance adviser's conduct and whether the life insurance adviser's primary duty is to the customer or the life company(ies).

**20.** Where advice is given, the Customer Advice Record must also contain the basis for advice including:

a. a brief summary of the information and material on which the advice is based;
b. the type(s) of product(s) that was/were identified as suitable and an explanation of why that/those type(s) of product(s) is/are likely to satisfy the customer's identified needs and objectives;
c. the name(s) of the particular product(s) that is/are recommended;
d. an explanation of the reasoning that led to the recommendation and how the particular product(s) is/are likely to satisfy the identified needs and objectives of the customer;
e. a statement in the Customer Advice Record that a copy of the Fact Finder is available on request; and
f. any additional information required by paragraphs 21, 22 and 24.

**21.** If advice is given that does not, either wholly or in part, address the customer's identified needs and objectives, this must be documented in the Customer Advice Record.

**22.** If the customer elects to purchase a life policy that differs from the life insurance adviser's recommendation, or elects only to receive advice about a more limited range of products than the life insurance adviser offers (other than in terms of paragraph 16), the Customer Advice Record must contain:

a. information about this election; and
b. a statement that, by making this election, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs and objectives.

**Requirements where advice is not given or fact find is not undertak**en
**23.** Where no advice is given to the customer, or on fact find is undertaken, the customer must be advised of any implications, and the Customer Advice Record must contain:

a. a specific warning that a life policy sold without the completion of a fact find may not be appropriate to the customer's needs; and
b. a statement that, by not receiving advice, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs and objectives.

**Requirements where an existing life policy is replaced**
**24.** Where termination of an existing life policy and sale of a new life policy is advised by a life insurance adviser, the advice must be appropriate and have a reasonable basis and all reasonably forseeable and relevant consequences of the change must be listed in the Customer Advice Record, including:

a. termination charges for the existing life policy;
b. entry/establishment charges for the proposed replacement life policy;
c. any duplication of initial costs; and
d. any loss of benefits, temporarily or otherwise, that may arise when replacing the existing life policy.

Upon request and with the consent of the policyowner, a life company must provide to the life insurance adviser the necessary information to enable compliance with subparagraphs (a) and (d) within 20 working days.

**Completion and retention of the Customer Advice Record**
**25.** The Customer Advice Record must being with a clear boxed statement that this is an important document that the customer should read. It must also invite the customer to contact the life insurance adviser or life company or life broker if he/she disagrees with, or does not understand, the Customer Advice Record. The opening statement should also reminder the customer of the 14 day cooling-off period.

**26.** The Customer Advice Record must be dated and signed by the life insurance adviser and forwarded to the life company(ies) of the recommended product(s), or the life broker. The life company(ies)/life broker must retain the Customer Advice Record signed by the life insurance adviser. The Customer Advice Record must be made available by the life company or life broker to the Commissioner or the relevant external dispute resolution mechanism promptly following request.

**Application Forms**
**27.** Life companies must ensure that their application/proposal forms make appropriate provision for a signed acknowledgment by the customer that either:

a. the customer provided information requested by the life insurance adviser to form the basis of a complete fact find and needs analysis, and elected to purchase the life policy(ies) recommended by the life insurance adviser; or
b. the customer chose not to provide all information requested by the life insurance adviser, and understands that by not providing sufficient information, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs; or
c. the customer elected to purchase a life policy that differs from the life insurance adviser's recommendation, or elected only to receive advice about a limited range of products, and understands that by making this election, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs and objectives; or
d. the customer was not given any advice, or no fact find was undertaken, and the customer understands that by not receiving advice, the customer risks making a financial commitment to a life policy that may not be appropriate to his or her needs and objectives.

**Part III - Training and competency**

This part specifies requirements of life companies and life brokers regarding the training and competency of life insurance advisers.

**Basic Competencies**
**28.** Prior to the commencement of life insurance adviser registration, a life company or life broker must ensure that a life insurance adviser authorised on its behalf has adequate knowledge to enable him or her to demonstrate the following competencies:

a. the requirements of this Code, including complaint handling mechanisms;
b. how to conduct a fact find and needs analysis and complete a Customer Advice Record; and
c. legal requirements under all relevant legislation, together with the requirements of Insurance and Superannuation Commission circulars.

The necessary basic competencies applicable from the commencement of life insurance adviser registration will be determined by the then established Registration Board.

**Product-Specific Competencies**
**29.** A life company or life broker must ensure that a life insurance adviser receives sufficient information and/or training to enable him or her to satisfy the following competencies for each specific company product that the life insurance adviser has been authorised to sell on its behalf:

a. an adequate knowledge of the relevant product, including (where the product is investment linked) knowledge of the risk and return profiles or relevant securities;
b. the ability to clearly explain the product and product-related material;
c. an adequate knowledge of any specific laws which affect the product; and
d. an adequate knowledge of the life company's systems, forms and procedures for that product, including procedures in the case of a claim or termination.

**Multi-Agents**
**30.** Each life company must provide sufficient information and/or training to ensure that multi-agents are competent to sell those company-specific products which the multi-agent is authorised to sell.

**Continuing Education Requirements**
**31.** A life company or life broker must ensure that its life insurance advisers receive adequate continuing education, to enable them to continue to meet competency requirements.

**Part IV - Inquiries, complaints and disputes**

All life companies and life brokers must handle inquiries in a timely manner, must have internal complaint-handling mechanisms which meet minimum standards and must ensure that complainants have access to effective and independent external and free dispute resolution mechanisms.

**Internal Inquiry and Complaint Arrangements**

**32.** A Customer of a life company or life broker is entitled to a response to written requests for:

a. information about existing policies, including requests about the surrender value;
b. variation of life policies; or
c. termination of life policies;

within 20 working days of receipt of the inquiry.

**33.** Where a life company or life broker is unable, on reasonable grounds, to respond to a customer's written inquiry or request within 20 working days the customer is entitled to be advised of that fact as soon as it is practicable within 20 working days and to be given an indication of when a response will be made.

**34.** Each life company and life broker must establish an internal complaint-handling mechanism. The mechanism must:

a. be free of charge to the complainant;
b. be open to all persons who have an interest in a life policy;
c. be capable of addressing all possible complaints against the life company or life broker;
d. have documented procedures including time lines for making a decision and informing the complainant of those procedures in relation to a complaint;
e. have a complaint dealt with by an office of the life company or life broker who has authority to resolve most complaints without further referrals within the life company or life broker;
f. provide written advice to the complainant of a decision and, unless the decision has been resolved to the satisfaction of the complainant, of the reasons for the decision;
g. record decisions, reasons for decisions and maintain appropriate statistics; and
h. provide information to the complainant at the outset on the availability of the eternal complaint-handling mechanism and have arrangements for referral of relevant complaints to an external mechanism if the complaint is not resolved internally. The complainant must be reminded in writing of the availability of the external complaint-handling mechanism in the event that the claim is rejected in whole or in part.

**35.** All complaints should be resolved by the internal complaint-handling mechanism with 45 days of lodgement. However, where there are special circumstances relating to the complaint such that it is not reasonable for it to have been resolved in that period, the life company or life broker must inform the complainant of the reasons for the delay and that the complainant may, if the complaint has not been resolved within 90 days of lodgement, then take it to the relevant external dispute resolution mechanism in terms of paragraph 37 of this Code.

**36.** If the internal complaint-handling mechanism has not resolved a specific complaint within 90 days, the life company or life broker must inform the complainant of the reasons for the further delay and that the complainant may take the complaint to the relevant external dispute resolution mechanism referred to in paragraph 37 of this Code.

**External Dispute Resolution Mechanisms**

**37.** Each life company and each life broker that offers insurance directly to the public must be party to an external dispute resolution mechanism which:

a. has the unrevoked approval of the Commissioner;
b. does not consider a complaint or dispute unless it has first been lodged with the relevant life company or life broker and:

i. has been resolved by the life company or life broker, but not to the satisfaction of the complainant; or

ii. has not been resolved by the life company or life broker and 90 days have elapsed since lodgement with the life company or life broker;

c. provides annual reports to the Commissioner and the Minister for Consumer Affairs (the Commissioner may require a specific format and content for annual reports); and

d. reports any systemic, persistent or deliberate conduct (including that of life insurance advisers) that infringes the requirements of this Code to the Commissioner and to the relevant life company(ies) or life broker(s) as soon as they are identified.

**38.** Before granting an approval under paragraph 37, the Commissioner must be satisfied that the mechanism will:

a. operate free of charge to the complainant;
b. cover a sufficiently broad range of complaints;
c. be independent of the parties to the complaint;
d. be overseen by a body which includes consumer representation (appointed or approved by the Minister for Consumer Affairs) and a delegate of the Commissioner;
e. have procedures which accord with the principles of natural justice (including written reasons for decisions);
f. make decisions by reference to what is fair in all the circumstances, observes applicable law, relevant judicial authority and this Code, and has regard to good life insurance practice;
g. have appropriate published procedures, including suitable standards of timeliness;
h. be effectively promoted;
i. have adequate resources;
j. obtain observance by life companies and life brokers of its decisions;
k. have adequate remedies available to it;
l. maintain and publish appropriate statistics on its operations; and
m. provide to the Commissioner, and to relevant industry associations, details of the decisions made in respect of all complaints, or a representative selection of complaints, including the reason for the decisions but excluding information that would identify any of the parties to the complaint.

**39.** The Commissioner may revoke an approval granted under paragraph 37 if he/she is satisfied that a dispute resolution mechanism does not meet the conditions referred to in paragraph 38.

**Part V - Monitoring and reporting**

**40.** Responsibility for compliance with this Code rests with individual life companies and life brokers. Each life company and life broker must have appropriate documented procedures in place to monitor the performance of its life insurance advisers in relation to all aspects of this Code.

**41.** The monitoring procedures required by paragraph 40 must achieve a standard acceptable to the Commissioner. Without limiting the matters that the Commissioner may consider in determining whether a life company or life broker meets the requirements of paragraph 40, the Commissioner must be satisfied that procedures are in place to:

a. ensure that fact finds are undertaken in line with the requirements of this Code;
b. monitor the appropriateness of advice provided by its life insurance advisers to customers;
c. closely monitor complaints about the conduct of life insurance advisers;
d. ensure that there are appropriate pre-recruitment screening procedures;
e. verify that life insurance advisers are trained to the necessary level of competence; and
f. ensure adequate documentation is maintained.

**42.** Each life company and life broker must maintain adequate records including:

a. internal complaint-handling mechanism statistics;
b. all conduct (including that of life insurance advisers) known to the life company or life broker that infringes this Code including a record of systemic or repetitive infringements;
c. a record of remedial action and its effect; and
d. a record detailing training of life insurance advisers.

43. All serious or persistent conduct infringing this Code must be referred to the life company's Compliance Committee (or to the Board of the life company), or to the Directors or Principals of the life brokers, so that systemic problems or problems with particular life insurance advisers can be **identified and rectified.**

**44**. Where a life company or a life broker becomes aware of a material breach of this Code, it must check the appropriateness of the procedures applicable, and of relevant policies previously issued through that life insurance adviser during the three year period preceding the date on which it became aware of the breach (as noted in paragraph 5, this obligation only applies to policies issued on or after the date of commencement of the Code) and take remedial action where appropriate.

**45.** A life company or life broker must provide regular reports to the Commissioner on its compliance with this Code.

Where an intermediary engages in advisory activities in securities and life insurance products concurrently, minor amendments are made to paragraphs 10b and 19 of the Life Insurance Code of Practice. Refer to Circular G.II.6 ISC/ASC (Harmonisation initiatives and consequential amendments to the Code of Practice) for details and further information.

## ■ INTRODUCTION

The Fair Insurance Code has been prepared to help you understand insurance and what our responsibilities are to you. The Code tells you what to do if we do not carry out our responsibilities. And it shows you how you can help us.

**The Code applies to insurance company members of the Insurance Council, whether transactions are made directly with the insurance company, or through an agent including a bank or broker.**

All members of the Insurance Council must comply with this Code and ensure that it is promoted to customers.

## ■ OUR RESPONSIBILITIES TO YOU

❑ **We will act fairly and openly in all our dealings with you. This means we will;**

- Answer your questions accurately,
- Explain the information you need to provide when applying for insurance, renewing cover, when making a claim and the importance of this information being complete, up-to-date and relevant. Please ask us for advice if you are unsure what information is relevant.
- Provide you with a copy of your policy which sets out in plain English what is insured, what is not insured and your obligations.
- Advise you of any changes to your policy.

❑ **We will provide you with information which allows you to select the cover that best suits your needs.**

❑ **You are entitled to ask for and will then receive information and assistance to help you understand your insurance cover, terms and exclusions.**

❑ **You are entitled to ask for and will then receive, a copy of the information you gave with your application for insurance.**

❑ **When you make a claim, we will;**

- Explain how to report a claim, what information you must provide, the steps we will take while handling your claim and the likely time frame.
- Advise you of the need for absolute accuracy when providing claims information.
- Keep you informed of the progress of your claim.
- Settle all claims fairly and promptly.
- Tell you how settlement has been reached.
- Clearly explain the reason if a claim is declined.

- **We will train our staff so that they can fulfil our responsibilities to you**

## HOW YOU CAN HELP US

- You need to provide complete, accurate and relevant information when applying for insurance, renewing your policy, or making a claim. Please ask us for advice if you are unsure what information is relevant. The information you provide is treated confidentially.

- To help us decide whether to insure you and under what conditions, you need to tell us any facts that may affect our decision – whether or not a specific question is asked.

- If you do not give us these facts, we may refuse to pay your claim or we may even cancel your insurance from the start date of your policy.

- Examples of the relevant facts applying to yourself, your partner, or others living on the premises and/or driving the motor vehicle, include:

- *Criminal convictions or traffic violations,*
- *Previous claims or history of losses,*
- *Refusal by an insurance company to insure you,*
- *Bankruptcy,*
- *Previous history of flooding,*
- *Non-factory modifications to vehicles or boats.*

**This list is not exhaustive. Please ask us for advice if you are unsure what information is relevant. The fact that any of these apply does not necessarily mean your application or claim will be declined.**

- You need to read your insurance policy and let us know if there is anything you want explained or altered.
- You need to keep us informed of any changes to your contact details.

## COMPLAINT PROCEDURES

**If you make a complaint to us, we will:**

- Acknowledge your complaint within 3 working days.
- Ensure your complaint is fully investigated as soon as possible by someone not involved in the original decision.
- Provide you with the name of the person handling your complaint.
- Send you written advice about the progress or outcome of the complaint within 10 working days of receiving your complaint.
- Advise you within 2 months if we are unable to resolve your complaint and inform you of any further options that may be available to you, such as the Insurance and Savings Ombudsman.

**Insurance and Savings Ombudsman's Office**

The Office of the Insurance and Savings Ombudsman (ISO) is an independent disputes resolution body that considers claims complaints against insurance companies, within the ISO jurisdiction.

The Fair Insurance Code is taken into account when decisions are made.

The ISO considers claims complaints under personal insurance policies up to a maximum of $100,000.

The insurance company must follow the ISO decision.

You may reject the ISO ruling and take your claims complaint to another means of dispute resolution, such as a Disputes Tribunal.

Customers do not have to pay to take a claims complaint to the ISO Office, but they must have their complaint considered by their insurance company first.

## ■ GENERAL INFORMATION

### Administration of the Fair Insurance Code

The Insurance Council administrates and maintains the Code. The Insurance Council also:

- Ensures knowledge and awareness of the Code is promoted throughout its membership and the public
- Monitors compliance by member companies.

The Insurance Council reviews the Code every 3 years, in consultation with community and consumer groups.

### Breaches of the Fair Insurance Code

The Insurance Council will provide advice and guidance to you should you have any concern over the application of this Code.

Where you feel there has been a breach of the Code, write to the Insurance Council which will investigate your concern and respond within 14 working days.

The Insurance Council will act on breaches of the Code by its members, having regard for the severity of the breach.

### Claims Paying Rating

Member insurance companies all have a financial rating for their claims paying ability. This rating must be declared to you when you enter into or renew a policy.

## ■ ANY QUESTIONS?

*If you have any questions about the Fair Insurance Code, please contact your insurance company or the Insurance Council of New Zealand – they'll be pleased to assist you.*

# INVESTMENT SAVINGS & INSURANCE ASSOCIATION OF NEW ZEALAND

## MANUAL OF PRACTICE STANDARDS

CONTENTS


| | Page |
|---|---|
| Introduction | 3 |
| Definitions and Interpretations | 4 |
| Benefit Projections Involving Investment Performance | 6 |
| Management Expense Ratio | 8 |
| Measurement and Investment Returns | 18 |
| Policy Illustrations | 21 |
| Promotional Standards | 24 |
| Sale of Term Life and/or Disability Insurance | 28 |


INTRODUCTION

These Standards have been prepared as an aid to members in the preparation and presentation of those parts of their selling and marketing material which are not covered by the statutory disclosure requirements.

They also aim to provide consistency of presentation in such areas as the measurement of investment returns, the calculation of benefit projections and the management expense ratio.

Some pieces of information such as benefit projections and policy illustrations are not mandatory but where members do seek to provide them, they must be presented in accordance with the relevant standard.

There are currently no statutory disclosure requirements for term life or disability products and the standard for the sale of these products is therefore provided to present the minimum information requirements for both insurers and intermediaries.

Compliance with these standards is mandatory for all relevant retail products being offered in New Zealand by members or any of their subsidiary or associated companies and will include investment funds such as unit trusts, group investment funds or retain superannuation schemes and life insurance products such as insurance bonds, term life or disability policies.

Where there is any doubt as regards a member's obligation to comply, or where there may be substantive grounds for a waiver from compliance with any part of these standards, the decision of the Board on any waiver or obligation to comply shall be final and binding.

--- as excerpted from the ISI Manual of Practice Standards. For the full manual please see: http://www.isi.org.nz/files/Manual%20of%20Practice%20Standards.PDF

## The Private Customer Code

Note: In the United Kingdom there is a separate general insurance code for commercial customers.

This Private Customer Code sets the minimum standards of good practice which all members of GISC must follow when they deal with private customers. It gives you important protection and should help you to understand:

- how insurers, intermediaries and agents, and anyone acting for them, must deal with you;
- what information you should receive before you commit yourself to buying any insurance; and
- how your insurance should be dealt with once it is in place.

## Insurance products and services covered by the Private Customer Code

The Private Customer Code covers all types of general insurance products and services that are sold to private customers, including:

- motor insurance;
- home insurance – buildings and contents;
- insurance for caravans, boats, pets and other property;
- travel insurance;
- private medical and dental insurance;
- personal accident insurance;
- extended warranty and breakdown insurance;
- legal expenses insurance; and
- payment protection insurance for mortgages and other loans.

## Understanding the Private Customer Code

Within the Private Customer Code, ‘you’ means the private customer and ‘we’ and ‘us’ means the member of GISC (an insurer, intermediary or agent), and anyone acting for them, who you deal with.

## Contents

1 **Our commitments**

2 **Marketing**

2.1 Advertising

3 **Helping you find insurance to meet your needs**

3.1 Explaining our service

3.2 Matching your requirements

3.3 Information about products and services

3.4 Information on costs

3.5 Advice and recommendations

3.6 Customer protection information

3.7 Your duty to give information

3.8 Quotes

3.9 'Cooling-off' period

3.10 Choosing to receive limited information

4 **Confirming your cover**

4.1 Confirming your cover

4.2 Proof of payment

4.3 Full policy documentation

5 **Providing our service to you**

5.1 Questions

5.2 Changes to your policy

5.3 Notice of renewal

5.4 Expiry or cancellation

6 **Claims**

6.1 Information on claims procedures

6.2 If you make a claim

7 **Documentation**

7.1 Information in writing

7.2 Standards of written information

7.3 Sending you documentation

7.4 Withholding documentation

8 **Confidentiality and security**

8.1 Confidentiality

8.2 Security

9 **Complaints**

9.1 Information on complaints procedures

9.2 If you make a complaint

9.3 Dispute resolution scheme

10 **Other information**

10.1 GISC monitoring

10.2 The Private Customer Code and your legal rights

10.3 Copies of the Private Customer Code

10.4 More information

**Our commitments**

1.1 As members of GISC, we promise that we will:

- act fairly and reasonably when we deal with you;
- make sure that all our general insurance services satisfy the requirements of this Private Customer Code;
- make sure all the information we give you is clear, fair and not misleading;
- avoid conflicts of interest or, if we cannot avoid this, explain the position fully to you;
- give you enough information and help so you can make an informed decision before you make a final commitment to buy your insurance policy;
- confirm your insurance arrangements;
- make sure that our service meets GISC's standards;
- handle claims fairly and promptly;
- make sure you receive all the documentation you need;

- protect any personal information, money and property that we hold or handle for you; and
- handle complaints fairly and promptly.

**Marketing**

**Advertising**

2.1 We will make sure that all our advertising and promotional material is clear, fair and not misleading.

3 **Helping you find insurance to meet your needs**

**We will give you enough information and help so you can make an informed decision before you make a final commitment to buy your insurance policy.**

**Explaining our service**

3.1 We will explain the service we can offer and our relationship with you, including:

- the type of service we offer;
- whether we act for an insurer or act independently for you as an intermediary;
- whether we act as an agent of another intermediary or agent; and
- the choice of products and services we can offer you.

**Matching your requirements**

3.2 We will make sure, as far as possible, that the products and services we offer you will match your requirements.

- If it is practical, we will identify your needs by getting relevant information from you.
- We will offer you products and services to meet your needs, and match any requirements you have.
- If we cannot match your requirements, we will explain the differences in the product or service that we can offer you.
- If it is not practical to match all your requirements, we will give you enough information so you can make an informed decision about your insurance.

**Information about products and services**

3.3 We will explain all the main features of the products and services that we offer, including:

- who the insurer is;

- all the important details of cover and benefits;
- any significant or unusual restrictions or exclusions;
- any significant conditions or obligations which you must meet; and
- the period of cover.

**Information on costs**

3.4 We will give you full details of the costs of your insurance, including:

- separate insurance premiums for each of the individual products or services we are offering;
- details of any fees and charges other than the insurnce premium, and the purpose of each fee or charge (this will include any possible future fees or charges, such as for changing or cancelling the policy or handling claims);
- when you need to pay the premiums, fees and charges, and an explanation of how you can pay; and
- if we are acting on your behalf in arranging your insurance and you ask us to, we will tell you what our commission is and any other amounts we receive for arranging your insurance or providing you with any other services.

**Advice and recommendations**

3.5 If we give you any advice or recommendations, we will:

- only discuss or advise on matters that we have knowledge of;
- make sure that any advice we give you or recommendations we make are aimed at meeting your interests; and
- not make any misleading claims for the products or services we offer or make any unfair criticisms about products and services that are offered by anyone else.

**Customer protection information**

3.6 We will explain the customer protection benefits under our GISC membership, including:

- our complaints procedures, together with details of who you should contact first if you want to make a complaint; and
- whether any of the products or services we are offering you are not covered by this Private Customer Code.

**Your duty to give information**

3.7 We will explain your duty to give insurers information before cover begins and during the policy, and what may happen if you do not.

**Quotes**

3.8 If you want to consider the products or services we have offered you, we will:

- confirm how long you have to take up your insurance on the terms we have quoted to you;
- give you a written quote if you ask for one, including all the information you need to make an informed decision; and
- give you a sample policy if you ask for one.

**'Cooling-off' period**

3.9 Under the Private Customer Code, we have to give you certain information before you make your decision. If we have not given you this information when you buy your insurance (and you have not told us you do not want it), we will allow you a 'cooling-off' period of at least 14 days from the time you receive the information. If you do not want to continue with the insurance, you may cancel your cover within this period and get all your money back (as long as you have not made any claims).

**Choosing to receive limited information**

3.10 If you want to buy your insurance without receiving all the information about the products and services that the Private Customer Code requires, we will keep a record of your agreement to this and there will not be a 'cooling-off' period.

4 **Confirming your cover**

**We will confirm your insurance arrangements and provide you with full policy documentation.**

**Confirming your cover**

4.1 When we put your insurance arrangements in place, we will give you written confirmation of cover, including:

- enough information so you can check the details of your cover;
- the date when your cover starts and the period of cover;
- any certificates or documents which you need to have by law; and
- details of any 'cooling-off' period.

**Proof of payment**

4.2 We will make sure that you have proof that you have paid the premiums, fees and charges.

**Full policy documents**

4.3 We will send you full policy documentation promptly.

5 **Providing our service to you**

**We will make sure that our service meets the GISC's standards.**

**Questions**

5.1 We will answer any questions promptly and give you help and advice if you need it.

**Changes to your policy**

5.2 We will deal with any changes to your insurance policy promptly. We will:

- give you written confirmation of any changes to your policy;
- give you full details of any premiums or charges that you must pay or we must return to you;
- give you any certificates or documents that you need to have by law;
- make sure that you have proof that you have paid extra premiums, fees and charges; and
- send you any refunds of the premiums, fees or charges that are due to you.

**Notice of renewal**

5.3 We will tell you when you need to renew your policy, or when it will end, in time to allow you to consider and arrange any continuing cover you may need. We will:

- explain the renewal terms (if offered);
- tell you about any changes to the cover, service or insurer being offered;
- explain your continuing duty to give insurers information; and
- send you any certificates or documents that you need to have by law.

**Expiry or cancellation**

5.4 When your policy ends or is cancelled, we will send you all the documentation and information that you are entitled to, if you ask for it.

6 **Claims**

**We will handle claims fairly and promptly.**

**Information on claims procedures**

6.1 When you first become a customer, we will give you details of how you can make a claim and tell you what your responsibilities are in relation to making claims.

**If you make a claim**

6.2 If you make a claim:

- we will respond promptly, explain how we will handle your claim and tell you what you need to do;
- we will give you reasonable guidance to help you make a claim under your policy;
- we will consider and handle your claim fairly and promptly, and tell you how your claim is progressing;
- we will tell you, in writing, and explain why, if we cannot deal with all or any part of your claim; and
- once we have agreed to settle your claim, we will do so promptly.

## 7 Documentation

**We will make sure you receive all the documentation you need.**

**Information in writing**

7.1 We will give you information in writing, especially if there is a lot of information or if it is very complicated.

**Standards of written information**

7.2 We will make sure that all the written information and documents we send you are clear, fair and not misleading.

**Sending you documentation**

7.3 We will send you all the documentation you need promptly.

**Withholding documentation**

7.4 We will not withhold any insurance documentation from you without your permission, unless we are allowed to do so by law. If we do withhold any documents, we will make sure that you receive full details of your insurance cover and any documents that you need to have by law.

## 8 Confidentiality and security

**We will protect your personal information, money and property.**

**Confidentiality**

8.1 We will treat all your personal information as private and confidential to us and anyone

else involved in providing your insurance, even when you are no longer a customer. We will not give anyone else any personal information about you, except:

- when you ask us to or give us permission;
- if we have to because we are a member of GISC; or
- if we have to by law.

**Security**

8.2 We will take appropriate steps to make sure that any money, documents, other property or information that we handle or hold for you is secure.

9 **Complaints**

**We will handle complaints fairly and promptly.**

**Information on complaints procedures**

9.1 When you first become a customer, we will give you details of our complaints procedures in our policy or service documentation.

**If you make a complaint**

9.2 If you make a complaint:

- we will acknowledge it promptly, explain how we will handle your complaint and tell you what you need to do; and
- we will consider and handle your complaint fairly and promptly, and tell you how your complaint is progressing.

**Dispute resolution scheme**

9.3 We are a member of a recognised independent dispute resolution scheme. If you are not happy with our final response to your complaint, we will tell you how you can contact this scheme.

10 **Other information**

**GISC monitoring**

10.1 We are monitored independently by GISC to make sure that we meet the standards of this Private Customer Code. If we do not satisfy the requirements of the Private Customer Code, we may face a penalty.

**The Private Customer Code and your legal rights**

10.2 The Private Customer Code forms part of the Membership Contract (which is governed by English law) between GISC and us. Nothing in the Private Customer Code or in our

Membership Contract with GISC will give any person any right to enforce any term of our Membership Contract which they would otherwise have under the Contracts (Rights of Third Parties) Act 1999.

**Copies of the Private Customer Code**

10.3 You can get a free copy of the Private Customer Code if you ask any GISC member, or from GISC at the address below.

**More information**

10.4 If you want to check that we are members of GISC, or if you have any questions about the Private Customer Code, you can contact GISC at the address below.

**General Insurance Standards Council**
**110 Cannon Street**
**London**
**EC4N 6EU**
**Phone: 020 7648 7810**
**Fax: 020 7648 7808**
**E-mail (general enquiries): enquiries@gisc.co.uk**

THE CODE OF MARKET CONDUCT

--- as excerpted from the FSA Code of Market Conduct ----

1.1 Application

1.1.1 Application: Who?
The Code of Market Conduct ("the Code") is made under section 119 of the Act which requires the FSA to produce a code giving guidance on what does and does not amount to market abuse. This Code is relevant to all persons seeking guidance as to whether or not behaviour amounts to market abuse.

1.1.2 Application: What?
Part VIII of the Act (Penalties for market abuse) contains provisions relating to market abuse which are described in this Code as the market abuse regime.

Three tests in the Act which must be satisfied in order to establish that behaviour (see MAR 1.3), whether by one person alone or by two or more persons jointly or in concert, amounts to market abuse are as follows:

(1) the behaviour must occur in relation to a qualifying investment traded on a prescribed market (see MAR 1.11);
(2) the behaviour must satisfy one or more of the three conditions identified in section 118(2) of the Act (Market abuse), the text of which is set out below:
    a. "the behaviour is based on information which is not generally available to those using the market but which, if available to a regular user of the market, would or would likely to be regarded by him as relevant when deciding terms on which transactions in investments of the kind in question should be effected"
    b. "the behaviour is likely to give a regular user of the market a false or misleading impression as to the supply of, or demand for, or as to the price or value of, investments of the kind in question"
    c. "a regular user of the market would, or would be likely to, regard the behaviour as behaviour which would, or would likely to, distort the market in investments of the kind in question", and"

(3) the behaviour must be likely to be regarded by a regular user of the market as a failure on the part of the person concerned to observe the standard of behaviour reasonably expected of a person in the position of the person in question.

For the full Market Conduct Code of Conduct please see:
http://www.fsa.gov.uk/marketconduct/#MarketAbuse

## REFERENCES


AIAF, 2003. "Code of Conduct for AIAF members," Associazione Italiana degli Analisti Finanziari, Milan, Italy.

APRA "How PAIRS Ratings are Determined," Australian Prudential Regulation Authority.

ASIC, 2000. "ASIC's submission to the Senate Select Committee on Superannuation and Finacnial Services," Inquiry into Superannuation and Financial Services, Australian Securities and Investments Commission, January 2000.

ASX, 2003. "ASX referrals to ASIC," Australian Stock Exchange.

Boik, Nigel & Somogyi, Steve, 2003. "APRA – Current Developments," Institute of Actuaries of Australia, XIV General Insurance Seminar, November 2003.

Bond, Kim., Cronin, Colin., Hall, Alicia. 2003. "APRA's Prudential Supervision of Superannuation Entities: Australian Prudential Regulation Authority," Australian National Audit Office, The Auditor-General Audit Report No.6 2003–04 Performance Audit, September 2003.

BCSC, 2002. "New Proposals for Securities Regulation: A New Way to Regulate," British Columbia Securities Commission, Vancouver, British Columbia, June 2002.

Carpentier, Cecile & Suret, Jean-Marc, 2003. "Securities Regulation in Canada," WPC Committee to review the structure of securities regulation in Canada, Vancouver, British Columbia.

Chance, Clifford., 2002. *"International Insurance Regulation: current and proposed regulation explained*," Reactions Publishing Group Ltd.

Collier, Berna, 2003. "A knock on the door in the middle of the night, is it ASIC, ACCC or ATO? ASIC's Enforcement Powers and Activities," Commissioner, Australian Securities and Investments Commission, Law Institute of Victoria, October 2003.

Crawford, Alastair, 2004. "Regulation of General Insurance," Freshfields Bruckhaus Deringer, London, United Kingdom.

Davies, Howard, 2003. "A new approach to insurance regulation," address by the Chairman of the Financial Services Authority to the Geneva Association 30th General Assembly, June 2003.

Davies, Howard, 2004. "Creating a Single Financial Market in Europe: What do we Mean?" address by the Chairman of the Financial Services Authority, FMG Lecture, February 2004.

Di Giorgio, Giorgio., Di Noia, Carmine, Piatti, Laura., 2000. "Financial Market Regulation: The Case of Italy and a Proposal for the Euro Area," Financial Institutions Center, Wharton School, University of Pennsylvania.

Doherty, David P., Okun, Arthur S., Korostoff, Steven F., Nofi, James A. 1991. "*The Enforcement Role of the New York Stock Exchange*," Northwestern University Law Review, 85 Nw. U.L. Rev. 637.

Donaldson, William H. 2004. "Testimony Concerning Fiscal 2005 Appropriations Request for the U. S. Securities and Exchange Commission" Chairman, U.S. Securities and Exchange Commission, Before

the Subcommittee on Commerce, Justice, State, and the Judiciary, Committee on Appropriations, United States House of Representatives, March 31, 2004.

Emde, Thomas., 2002. "The financial services sector in Europe: Regulatory investigation and enforcement issues in Germany," Freshfields Bruckhaus Deringer, Frankfurt, Germany.

FFIEC, 1999. "IS Supervision by Risk," Chapter 2, IS Examination Handbook, Federal Financial Institutions Examinations Council.

Finansinspektionen, 2001. "Supervision of Private Insurance in Sweden," Finansinspektionen, Stockholm, Sweden, November 2001.

Finansinspektionen, 2004. "Finansinspektionen – who we are and what we do," Finansinspektionen, Stockholm, Sweden, March 2004.

FSA, 2000. "A new regulator for a new millennium," Financial Services Authority, January 2000.

FSA, 2001. "An Introduction to the Financial Services Authority," Financial Services Authority.

FSA, 2003. "The firm risk assessment framework," Financial Services Authority, February 2003.

GAO, 2003. "Insurance Regulation: Preliminary Views on States' Oversight of Insurers Market Behaviour," United States General Accounting Office, Washington, D.C.

GAO, 2003. "Insurance Regulation: Common Standards and Improved Coordination Needed to Strengthen Market Regulation," United States General Accounting Office, Washington, D.C.

Holstein, David, 1999. "How to avoid bad grades on market conduct exams," The Regulator, Insurance Regulatory Examiners Society, Olathe KS.

Gomez-Acebo, Javier, 2002. "The financial services sector in Europe: Regulatory investigation and enforcement issues in Spain," Freshfields Bruckhaus Deringer, Madrid, Spain.

Hyndman, Douglas, 2003. "Regulation that works for our markets," Chair, British Columbia Securities Commission, Vancouver, B.C.

IAA, 2002. "Report of Solvency Working Party," International Actuarial Association Insurance Regulation Committee.

IEC, 2003. "General Insurance Enquires and Complaints Scheme Annual Review," Insurance Enquiries and Complaints Limited, Melbourne, Australia.

IDA, 2004. "Member Regulation Sales Compliance Annual Report 2003," Insurance Dealers Association.

IOSCO, 2003. "Objectives and Principles of Securities Regulation," International Organization of Securities Commissions, Madrid, Spain.

IOSCO, 2003. "Investment Management Risk Assessment: Marketing and Selling Practices," Report of the Technical Committee of the International Organization of Securities Commissions, Madrid, Spain.

Jenvey, Simon, 2004. “A General Insurer’s experience of an FSA Compliance Audit,” an address by Prudential Compliance Manager, Zurich Financial Services, UK General Business at the Insurance Institute of London, London, United Kingdom.

Klein, Robert, 1995. “Structural Change and Regulatory Response in the Insurance Industry,” Director of Research, National Association of Insurance Commissioners, Kansas City, MO.

Knutsson, Peter, 1999. “Financial Services and Consumer – A Comparison Between the UK and Swedish Systems,” Discussion paper, Karolus Programme.

KPMG, 2001. “Corporate Governance in Italy: A practical guide to internal control,” KPMG Audit S.r.l. Corporate Governance Services.

KPMG, 2003. “Regulatory Requirements and Capital Measurement: the Italian Perspective,” KPMG Insurance Risk Management Special.

Lener, Raffaele, 2002. “The financial services sector in Europe: Regulatory investigation and enforcement issues in Italy,” Freshfields Bruckhaus Deringer, Rome, Italy.

L’Homme, Jean & Kleiman, Elie, 2002. “The financial services sector in Europe: Regulatory investigation and enforcement issues in France,” Freshfields Bruckhaus Deringer, Paris, France.

Lucy, Jeffrey, 2004. “FSR, CLERP 9 and surveillance programs: ASIC priorities over the next 12 months,” address by Acting Chairman to the Institute of Chartered Accountants of Australia Queensland 2004 CA Business Forum, March 2004.

Mortlock, Geof, “New Zealand’s financial sector regulation,” Financial Stability Department, Reserve Bank of New Zealand, Bulletin Vol. 66, No. 4, 2003.

NAIC, 2003. “A Reinforced Commitment: Insurance Regulatory Modernization Action Plan,” National Association of Insurance Commissioners, Kansas City, MO.

NAIC, 2004. “Market Analysis Handbook,” Market Regulation Division, National Association of Insurance Commissioners.

NAIC, 2004. “ Concept Illustration Integration of Examination Handbook into Market Analysis Handbook,” Market Regulation Division, National Association of Insurance Commissioners, spring Meeting 2004.

NCOIL, 2004. “Market Conduct Surveillance Model Law,” National Conference of Insurance Legislators, January 2004.

OSC, 2002. “A Risk-based Approach for More Effective Regulation,” OSC Staff Notice 11-719, Ontario Securities Commission.

OSC, 2003. “Statement of Priorities for Fiscal 2003/2004,” Ontario Securities Commission.

Richards, Lori. 2002. “The Evolution of the SEC's Inspection Program for Advisers and Funds: Keeping Apace of a Changing Industry” Office of Compliance Inspections and Examinations U.S. Securities and Exchange Commission.

SEC. “Risk Assessment Report for Brokers and Dealers,” Form 17-H, United States Securities and Exchange Commission, Washington, D.C.

Sterling, Robert, 2000. “Insurance Regulation and Supervision in OECD Countries, Asian Economies, Latin American Countries and CEEC and NIS Countries,” Insurance and Private Pensions Compendium for Emerging Economies, Book 1, Part 2:1)b, Organization for Economic Co-operation and Development.

Thompson, John, 2001. “Risk-based Supervision of Insurance Companies, An Introduction,” World Bank.

Trade and Development Board, 1995. “Review of Critical Areas with Regard to Insurance Legislation, Regulation and Supervision: Establishment of effective insurance regulatory and supervisory systems,” United Nations Conference on Trade and Development, Geneva.

Trade and Development Board, 1995. “Regulation and supervision of insurance operations: analysis of responses to a questionnaire and possible elements for establishing an effective insurance supervisory authority,” United Nations Conference on Trade and Development, Geneva.

Venkatramani, S.G., 2002. “APRA’s Risk Management Framework – Life Insurance and Superannuation/Pensions,” address by General Manager, Diversified Institutions Division, Australian Prudential and Regulation Authority at the Managing Regulatory Change in Life & Pensions Symposium, Singapore, November 2002.

Vollbrecht, Jorg, 2000. “Insurance Regulation and Supervision in OECD Countries,” Insurance and Private Pensions Compendium for Emerging Economies, Book 1, Part 2:1)a, Organization for Economic Co-operation and Development.

Whittaker, Andrew, M, 2003. “FSA’s role in resolving issues facing the insurance industry,” address by General Counsel for the Financial Services Authority at the Barlow Lyde and Gilbert Conference Risk Management for Reinsurers.

Wolf, Christina, 2003. “Strong and Efficient Investor Protection: Dealers and Advisors under the BC Model – A Regulatory Impact Analysis,” British Columbia Securities Commission.

**Additional Resources Utilized:**

*Telephone/E-mail Survey/Interviews*

ASIC, Assistant Director, Regulatory Risk Analysis

ASIC, Lawyer, regulatory Operations, Financial Services Regulation

ASIC, Assistant Director, Policy Education, Consumer Protection

Commission de Contrôle des Assurances, International Affairs

Embassy of France, Economic Commission, Economic & Trade Commissioner

Finaninspektionen, Chief Actuary, Sweden

Financial Services Authority, Manager, Global Team International Policy Co-ordination and EU Affairs Office of the Chairman.

Insurance Council of New Zealand, Corporate Affairs Manager

Ministry of Economic Development, Regulatory and Competition Policy Branch (New Zealand)

Ministry of Finance, France

*Key Websites Reviewed*

Alberta Securities Commission (www.albertasecurities.com)

Australian Competition and Consumer Commission (http://www.accc.gov.au/content/index.phtml/itemId/142)

Australian Prudential Regulation Authority (http://www.apra.gov.au/)

Australian Securities and Investments Commission (http://www.asic.gov.au/asic/asic.nsf)

Autorité des marchés financiers (www.lautorite.qc.ca)

British Columbia Securities Commission (www.bcsc.bc.ca)

Bundesanstalt für Finanzdienstleistungsaufsicht (http://www.bafin.de/cgi-bin/bafin.pl)

Canadian Securities Administrators (http://www.csa-acvm.ca/home.html)

Centre for the Financial Services OmbudsNetwork (http://www.cfson-crcsf.ca/en/)

Commission de contrôle des assurances (http://www.cca.gouv.fr/info/00)

Department of Finance, Canada's Securities Industries (http://www.fin.gc.ca/toce/2002/cansec_e.html)

Dirección General de Seguros y Fondos de Pensiones (http://www.dgsfp.mineco.es/dgsfp)

Europa – Gateway to the European Union (http://europa.eu.int/index_en.htm)

Federal Financial Institutions Examinations Council (http://www.ffiec.gov/)

Financial Services Authority (http://www.fsa.gov.uk)

Finansinspektionen (http://www.fi.se/english/index.asp)

International Association of Insurance Superintendents (http://www.iaisweb.org/)

International Organization of Securities Commissions (http://www.iosco.org)

Istituto per la vigilanza sulle assicurazioni private e di interesse collettivo (http://www.isvap.it/isvsl001.htm)

Insurance Enquiries and Complaints Limited (http://www.iecltd.com.au/index2.html)

Insurance Council of New Zealand (http://www.icnz.org.nz/index_ie.html)

Ontario Securities Commission (http://www.osc.gov.on.ca/en/about.html)

Organization for Economic Co-operation and Development (http://www.oecd.org/home/)

Ministry of Economic Development (New Zealand) (http://www.med.govt.nz/buslt/ins-sup.html)

National Association of Insurance Commissioners (http://www.naic.org)

NASDAQ (www.nasdaq.com)

New Brunswick, Securities Administration Branch (www.investor-info.ca)

New York Stock Exchange (www.nyse.com)

Nova Scotia Securities Commission (www.gov.ns.ca/nssc)

Ombudsman for Banking Services and Investments (http://www.obsi.ca/obsi/pages_english/ehome.php3)

Saskatchewan Financial Services Commission (www.sfsc.gov.sk.ca)

United States Securities and Exchange Commission (www.sec.gov)

Wise Persons Committee (http://www.wise-averties.ca/main_en.html)