CCIR | CCRRA
Canadian Council of Insurance Regulators
Conseil canadien des responsables de la réglementation d'assurance

2019 Annual Statement on Market Conduct - Public Report

December 2020

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EXECUTIVE SUMMARY

This report provides an overview of the findings from the 2019 Annual Statement on Market Conduct (Annual Statement)[1] administered by the Canadian Council of Insurance Regulators (CCIR) on behalf of its members.

This report:

- highlights key data points to provide a macro-level overview of the insurance industry in Canada;
- provides a means for insurers to compare their overall policies, procedures and performance against industry averages and, in some instances, creates benchmarks on key Fair Treatment of Customers (FTC) principles and practices;
- demonstrates how CCIR members use data from the Annual Statement; and
- provides key observations related to industry trends, how insurers are interpreting the Annual Statement questions, how results on examinations compare to how insurers answer the Annual Statement, and how the Annual Statement relates to the CCIR/Canadian Insurance Services Regulatory Organizations' (CISRO) Guidance on the Conduct of Insurance Business and Fair Treatment of Customers (FTC Guidance).

Data Utilization

This report provides examples of how CCIR members use data specific to each section of the Annual Statement. In general, CCIR members use the Annual Statement to:

- monitor and assess the effectiveness of regulatory requirements designed to satisfy the International Association of Insurance Supervisors' (IAIS) Insurance Core Principle (ICP) 19: Conduct of Business;
- provide a macro-level overview of the insurance industry that can be monitored on an annual basis;
- monitor and respond to new trends;
- conduct risk assessments of classes of insurance, distribution channels and individual insurers;
- assess the industry's adoption and implementation of FTC principles;
- establish key risk indicators to assist CCIR members in the development of examination assessments; and
- provide a reference tool during on-site examinations.

[1] The 2019 Annual Statement introduced a new section on Travel Health Insurance. As data for this section was provided on a "best efforts" basis, and is excluded from this report.

Key Observations

- Annual Statement results indicate while insurers value FTC principles, there are opportunities for some insurers to better demonstrate how they have incorporated FTC principles;
- Data quality is a key priority for CCIR members. Insurers should closely study this report, as well as the Annual Statement's definitions and instructions to ensure they are providing accurate data which conforms to CCIR's expectations.

BACKGROUND

The Annual Statement was introduced by the CCIR in 2017, to collect information from insurers across Canada related to their governance, practices, policies, and treatment of customers. The requirement to complete and file the Annual Statement is based on the authority of each provincial and territorial insurance regulator within their jurisdiction.

Purpose of the Annual Statement Dataset

The Annual Statement was developed by the CCIR as a harmonized approach to better understand and assess the insurance marketplace and insurer conduct. CCIR members have committed to increased cooperation and information sharing to improve customer protection and ensure alignment with international best practices and standards, in particular the ICPs. CCIR members have signed a Memorandum of Understanding and Protocol on Cooperation and the Exchange of Information (MOU)[2] which provides the basis for increased information sharing and cooperation in supervisory activities. The CCIR published its Framework for Cooperative Market Conduct Supervision[3]. This Framework outlines CCIR members' commitment to increasing collaboration and sharing information regarding the oversight of market conduct in Canada.

CCIR members use the data collected in the Annual Statement for various purposes, and the usage will vary by regulator. Members have used the data:

- to create a risk indicator system helping regulators determine which insurers should be examined;

[2] https://www.ccir-ccrra.org/Documents/View/3544
[3] https://www.ccir-ccrra.org/Documents/View/2592

- to verify how insurers' responses during an examination align with their actual policies and procedures; and
- for market intelligence purposes to gather information about the insurance industry as a whole, identifying long term trends, and flagging potential risks.

Cooperative Supervision Oversight Committee (CSOC)

CSOC is a CCIR committee overseeing the MOU and the Framework for Market Conduct Supervision in Canada. This includes oversight of CCIR's cooperative supervisory plans and activities, guided by the ICPs by IAIS. The committee may also lead cooperative supervision activities where emerging issues are examined on a thematic and/or insurer basis.

CSOC manages the collection of information and reporting through the Annual Statement and revises the data reporting requirements on an annual basis (working with CCIR members, working groups and committees to identify beneficial changes and areas for data collection). CSOC also oversees the sharing of information among CCIR members regarding the jurisdictional usage and validation of market conduct data.

Strategic Plan 2020-2023

CCIR is committed to three strategic priorities, each of which is focused on consumers, regulators, and industry:

- Build upon cooperative supervision in alignment with international standards to enhance consumer protection.
- Work collaboratively with regulatory partners to grow and leverage national regulatory capacity.
- Partner with industry stakeholders to identify opportunities to increase regulatory and supervisory harmonization where feasible and appropriate.

A key dependency on CCIR achieving its three strategic priorities is the effective use of data obtained through the Annual Statement.

RESULTS FROM 2019 ANNUAL STATEMENT

CCIR is sharing the following key results from the 2019 Annual Statement so insurers can utilize these results to compare against their own operations, policies and procedures, particularly as it relates to FTC outcomes. All of the results should be viewed based on the nature, size and complexity of an insurer's activities.

Throughout the report, CCIR highlights how its members use the Annual Statement data and makes key observations when appropriate. CCIR's comments have been expanded to include insights observed by CCIR members during on-site examinations in addition to analysis on the Annual Statement data itself.

The report is categorized in sections corresponding to the data in the Annual Statement. The type of data presented can sometimes differ between the property and casualty (P&C) and life and health (L&H) industries.

Filing Summary

P&C Summary

There were 231 insurers required to file the Annual Statement (broken down by size and jurisdiction of incorporation),[4] of those 164 were actively writing personal lines business.

Jurisdiction	Small	Medium	Large	Commercial & Run Off	Total
Alberta	2	5	0	3	10
British Columbia	0	1	0	0	1
Manitoba	0	1	0	0	1
New Brunswick	0	0	0	0	0
Nova Scotia	2	0	0	0	2
Ontario	40[5]	1	5	9	55
Quebec	20	11	4	4	39
Prince Edward Island	1	0	0	0	1
Saskatchewan	6	1	0	1	8
Federal - Foreign	9	2	2	31	44
Federal - Canadian	10	22	19	19	70
Total	**90**	**44**	**30**	**67**	**231**

[4] For P&C: Small insurers=Direct Written Premium (DWP) under $50M; medium insurers= DWP between $50M and $300M; large insurers= over $300M DWP.
[5] Including Ontario Farm Mutual Insurance Companies

L&H Summary

There were 82 insurers required to file the Annual Statement (broken down by size and jurisdiction of incorporation),[6] of those 63 were actively writing new business.

Jurisdiction	Small	Medium	Large	Run Off	Total
Alberta	1	1	0	0	2
British Columbia	0	0	0	0	0
Manitoba	1	0	0	0	1
New Brunswick	1	1	0	0	2
Nova Scotia	0	1	0	0	1
Ontario	3	3	0	3	9
Quebec	6	4	4	0	14
Saskatchewan	0	0	0	1	1
Federal - Foreign	5	3	0	7	15
Federal - Canadian	12	7	10	8	37
Total	**29**	**20**	**14**	**19**	**82**

Governance

FTC is a principle focused on customer outcomes, in particular, having due regard for the interests of the customers and treating the customers fairly. It refers to the customer-related conduct of insurers and how insurers treat customers at each stage of the life-cycle of a product. The life-cycle of the product begins with its design and covers services from the moment obligations under the contract arise until the point at which all obligations under the contract have been fulfilled.

The outcomes associated with FTC as described by the IAIS include the following:

- developing and marketing products in a way that pays due regard to the interests of customers;
- providing customers with clear information before, during and after the point of sale;
- reducing the risk of sales which are not appropriate to customers' needs;

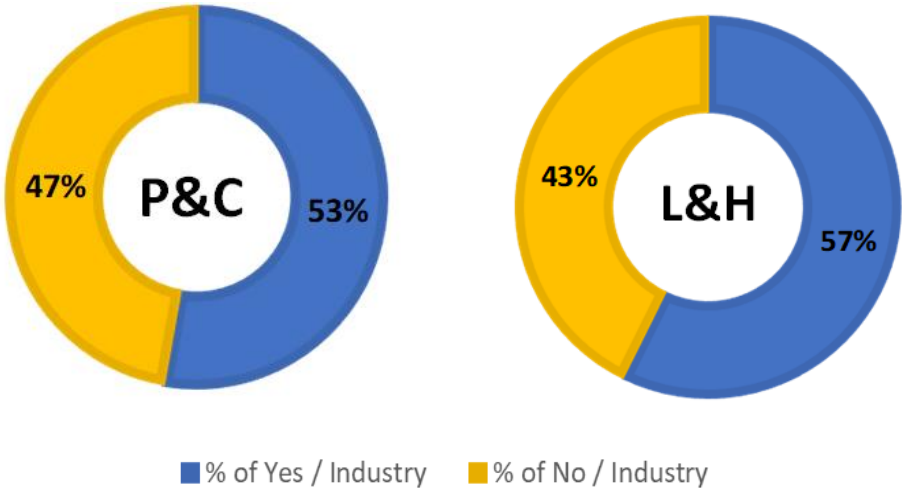
[6] For L&H: Small insurers=DWP under $150M; medium insurers= DWP between $150M and $800M; large insurers= over $800M DWP.

- ensuring any advice given is of a high quality;
- dealing with customer complaints and disputes in a fair manner;
- protecting the privacy of information obtained from customers; and
- managing the reasonable expectations of customers.

The Governance section of the Annual Statement requires insurers to answer questions designed to give an overall indication of their commitment to FTC principles.

FTC Code or Policy

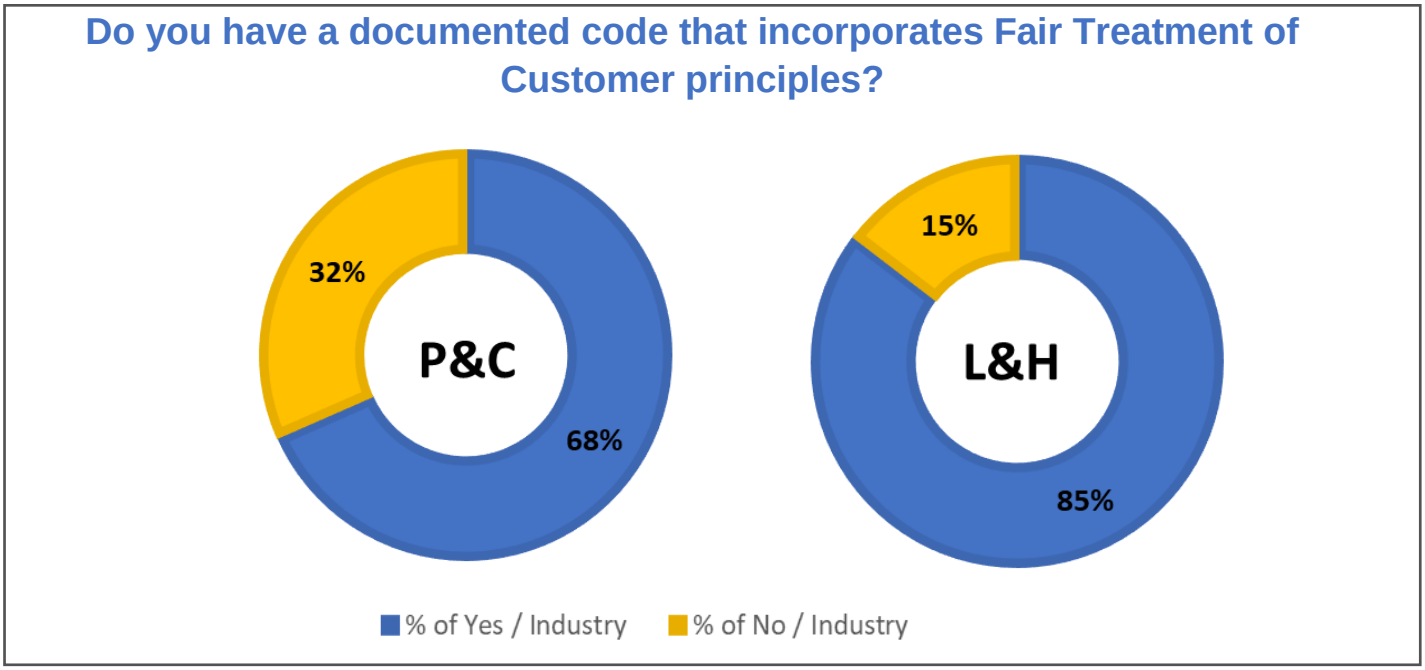
Do you have a standalone documented policy that specifically addresses the Fair Treatment of Customers?



As mentioned previously, CSOC consults on and subsequently updates the Annual Statement as needed each year. In 2019, the return was updated resulting in a small but substantial change to the question “Do you have a documented code or policy code or policy that specifically addresses the FTC?” in the 2018 Annual Statement. For 2019 data, it was split into two questions:

- Do you have a standalone documented policy that specifically address the FTC?
- Do you have a documented code that incorporates FTC principles?

52.8% of P&C respondents indicated they have a “standalone documented policy that specifically address the Fair Treatment of Customers”. The L&H industry reported a slightly higher adoption of this practice, with 57.3% answering “Yes”.



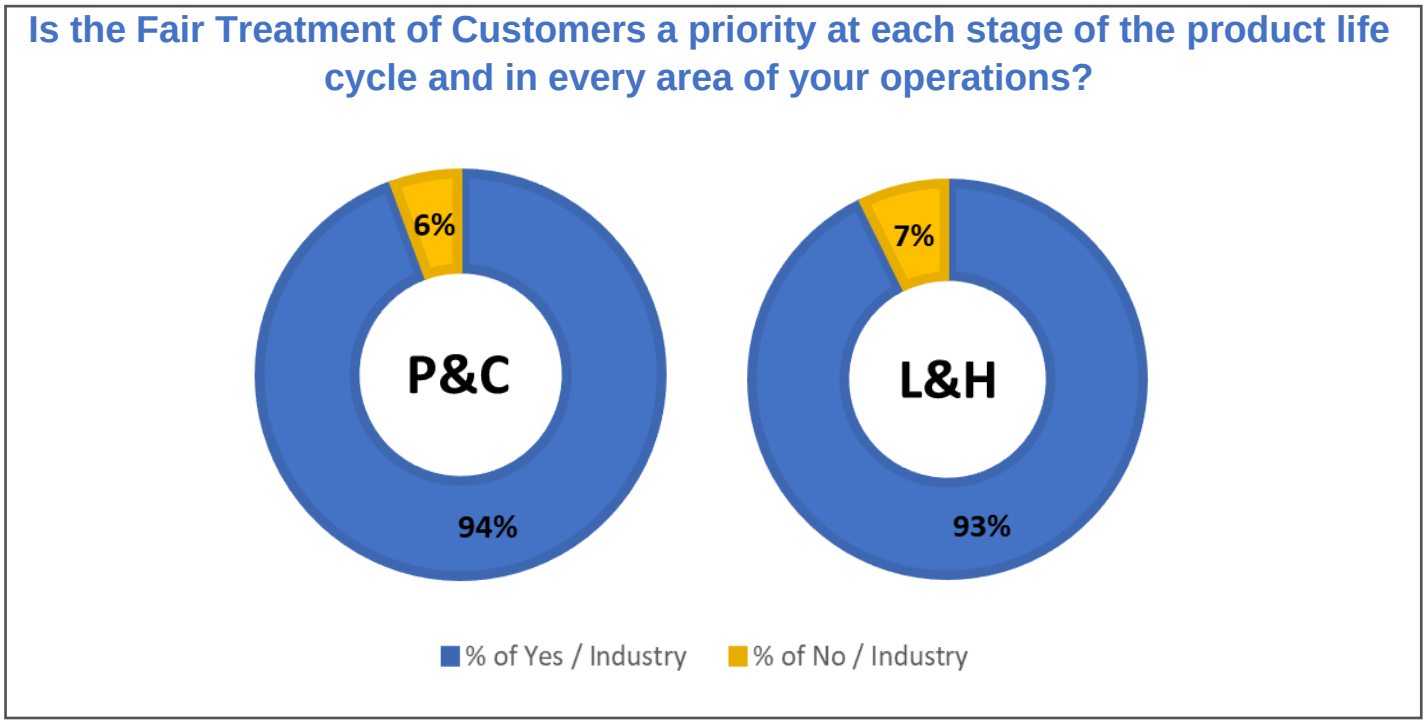
Insurers were much more likely to have a documented code incorporating FTC principles. 68.4% of P&C respondents and 85.4% of L&H respondents answered “Yes”. In both sectors these responses vary greatly based on size of insurer.

	Small	Medium	Large
P&C	61.1%	68.2%	96.7%
L&H	82.8%	95.0%	100.0%

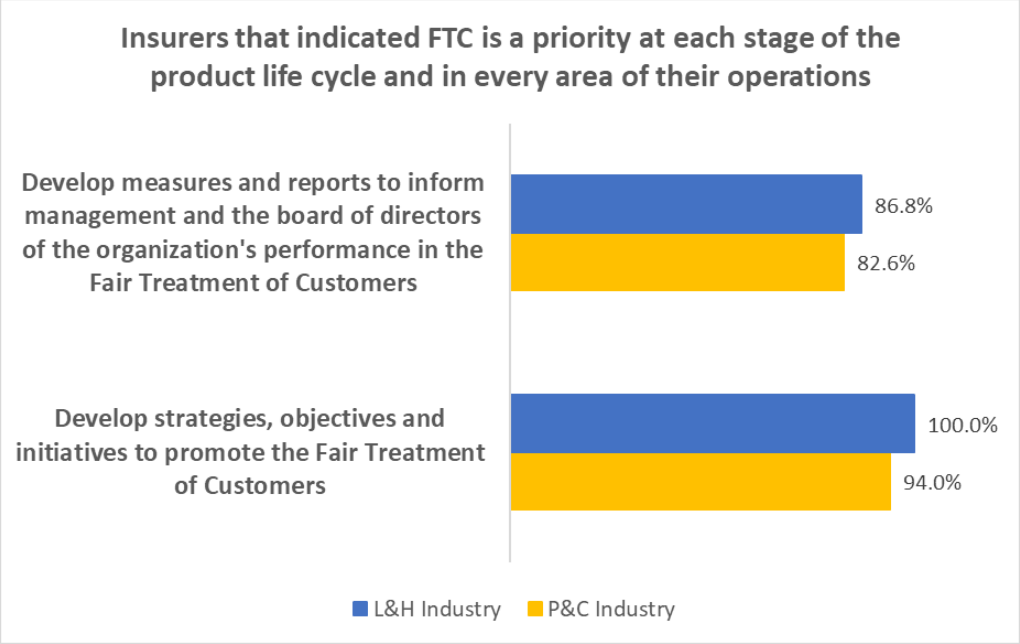
According to the FTC Guidance, CCIR recommends insurers “establish and implement policies and procedures on fair treatment of customers, as integral parts of their business culture”.

FTC Implementation

According to the FTC Guidance: “Sound conduct of business includes treating customers fairly throughout the life cycle of the insurance product. This cycle begins with product design and runs until all obligations under the contract are fulfilled.” In both the P&C and L&H sectors (94.4% and 92.7%, respectively), insurers predominately responded they have embraced this principle by making FTC a priority at each stage of the product life-cycle and in every area of their operation.

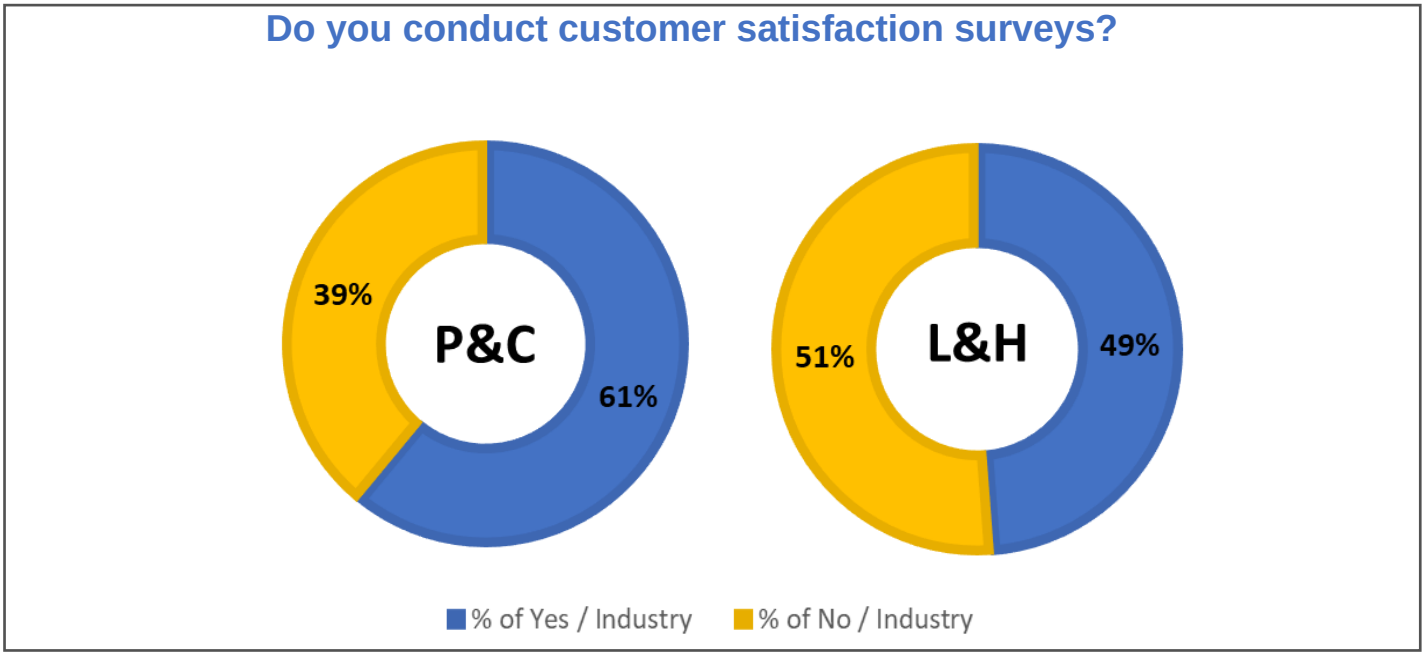


For those insurers who answered in the affirmative, both P&C and L&H respondents (94.0% and 100.0% respectively), largely answered they “develop strategies, objectives and initiatives to promote the Fair Treatment of Customers.” However, when asked if they “develop measures and reports to inform management and the board of directors of the organization’s performance in the Fair Treatment of Customers”, the percentage of the insurers who answered in the affirmative dropped to 82.6% for P&C insurers and 86.8% for L&H insurers.



Insurers generally indicated they consider FTC a priority during the entire life-cycle of the insurance product, but some insurers have not yet promoted FTC principles or implemented a reporting mechanism to measure FTC performance. Furthermore, there are still a large number of insurers who do not have a standalone documented policy specifically addressing FTC.

Customer Satisfaction Surveys



61.0% of P&C insurers and just under half of L&H insurers (48.8%) indicated they conduct satisfaction surveys in any scenario. Amongst the insurers who responded in the affirmative they conduct customer satisfaction surveys, the most common occurrence in the P&C sector was immediately following a claim (92.2%), while in the L&H sector the most common occurrence was an “other” instance that was not a claim, complaint or sale. A sizeable majority of respondents (75.2% in P&C and 65.0% in L&H) indicated they do not conduct customer satisfaction surveys following a complaint.

The FTC Guidance indicates insurers are responsible for assessing the “performance of the various models of distribution used, particularly in terms of fair treatment of customers and, if necessary, take the necessary remedial action.” While there are numerous ways through which an insurer can assess performance of employees/distributors (e.g. audits, reviews), direct contact with customers enable organizations to better assess how they are performing in regards to the fair treatment of customers. Surveys and other feedback mechanisms employed by insurers such as focus groups, online feedback forms, etc. are a simple and effective way for the voice of the customer to be heard. It enables insurers to identify areas of improvement and new opportunities to have open dialogue and deepen the relationship with customers.

How CCIR Members Utilize Governance Data

- Aids in tracking industry support and implementation of FTC principles
- Helps to assess risks and highlight risk indicators used in selecting risk-based examinations
- Verification tool on examinations to determine how FTC principles are actually implemented and operationalized
- Monitors number of FTC audits being performed by insurers throughout various distribution channels

Observations on Governance Data

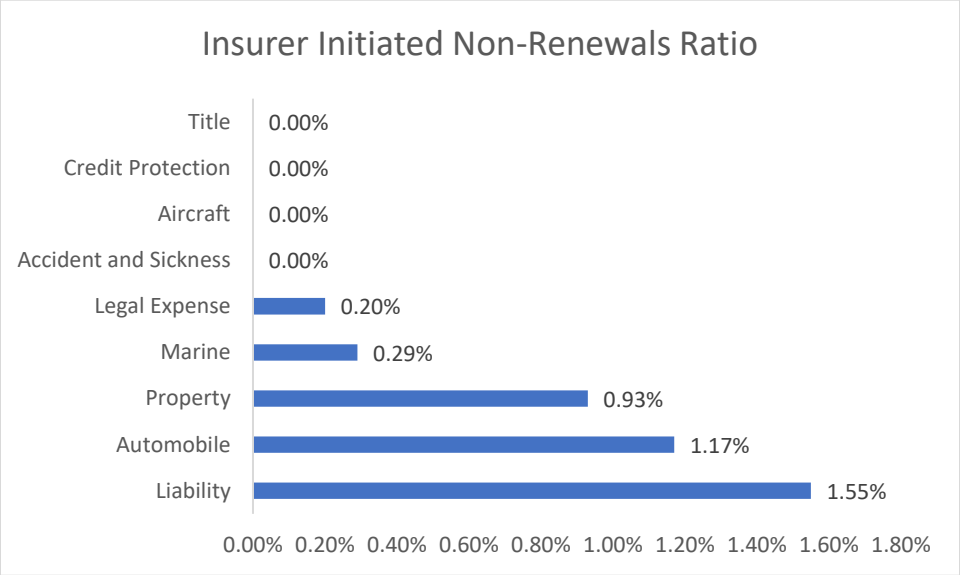
- The FTC Guidance outlines the expectation FTC needs to be a core component of the governance and business culture of Insurers and Intermediaries
- Insurers should be able to demonstrate how they ensure FTC is a priority throughout every area of their operations, including their distribution channels
- It was noted during examinations, some insurers did not fully implement and operationalize their FTC principles
- It is expected insurers will be prepared to demonstrate how they measure their organizations' FTC performance during an examination, this was not always the case

Policies

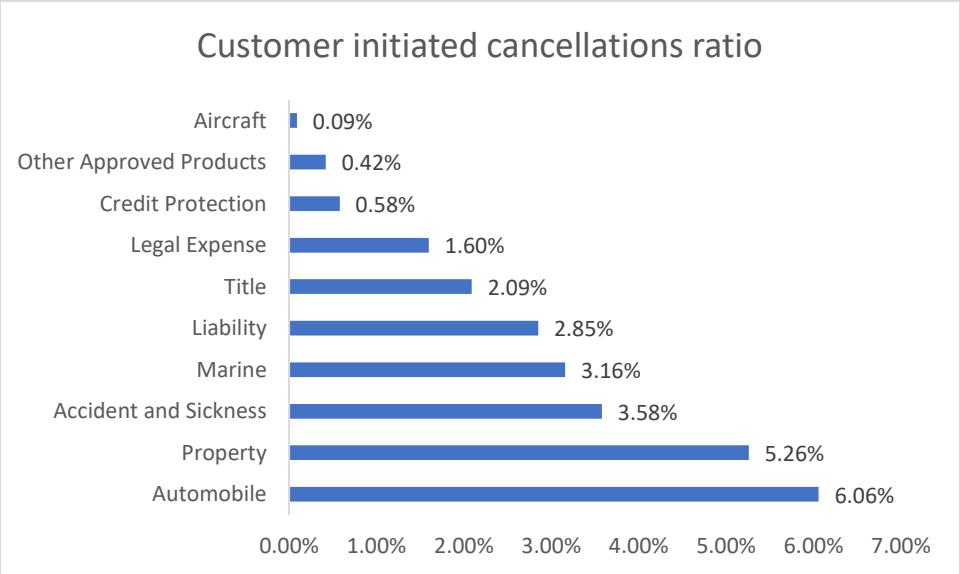
The Policies section of the Annual Statement requires insurers to provide information on the state of their policies in force as well as policies issued in their previous reporting period. Special emphasis is placed on data surrounding the cancellation of contracts or the denial of applications, in relation to the class of insurance. For P&C insurance, commercial insurance policies are excluded from the data.

CCIR has developed ratios based on the Policies data provided in order to better analyze risks and trends associated with particular classes of insurance. CCIR plans to track these data points over multiple years and analyze changes in insurer/customer behaviour.

P&C Insurance Policies

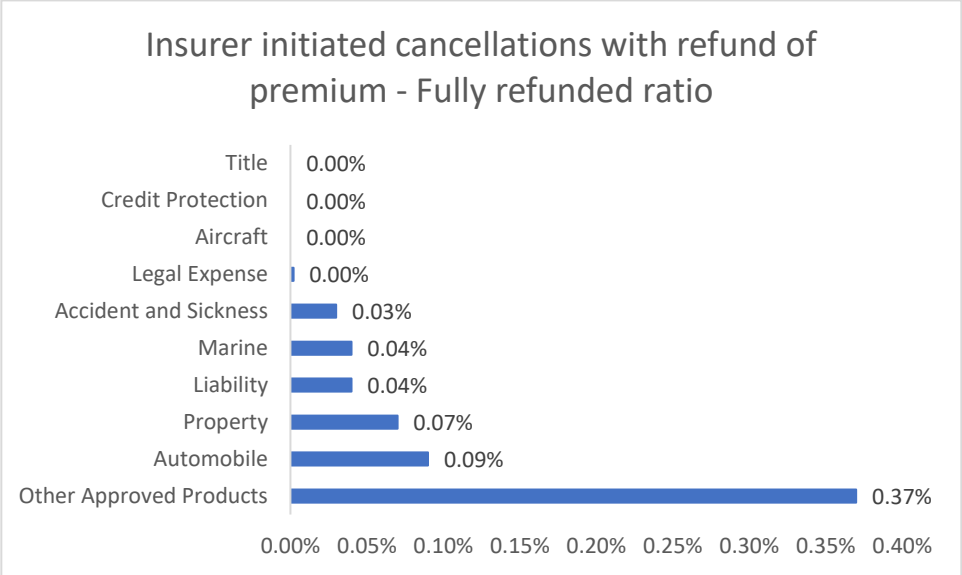


The insurer initiated non-renewals ratio[7] is designed to capture broad industry trends, as well as identify if an insurer has initiated a significant reduction in a class of insurance.



[7] Ratio calculation: Total number of insurer initiated non-renewals / (number of policies issued + number of policies renewed)

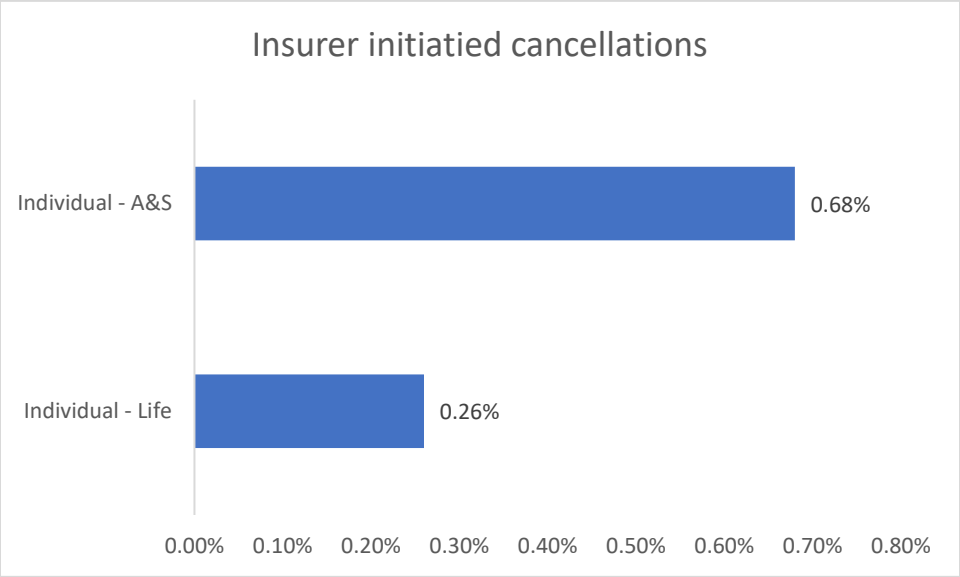
The customer initiated cancellations ratio[8] is designed to track customer mobility, as well as provide a broad indication of customer satisfaction with certain classes of insurance. This data is not used in isolation but is corroborated with other indicators, such as complaints, premiums, and media reports.



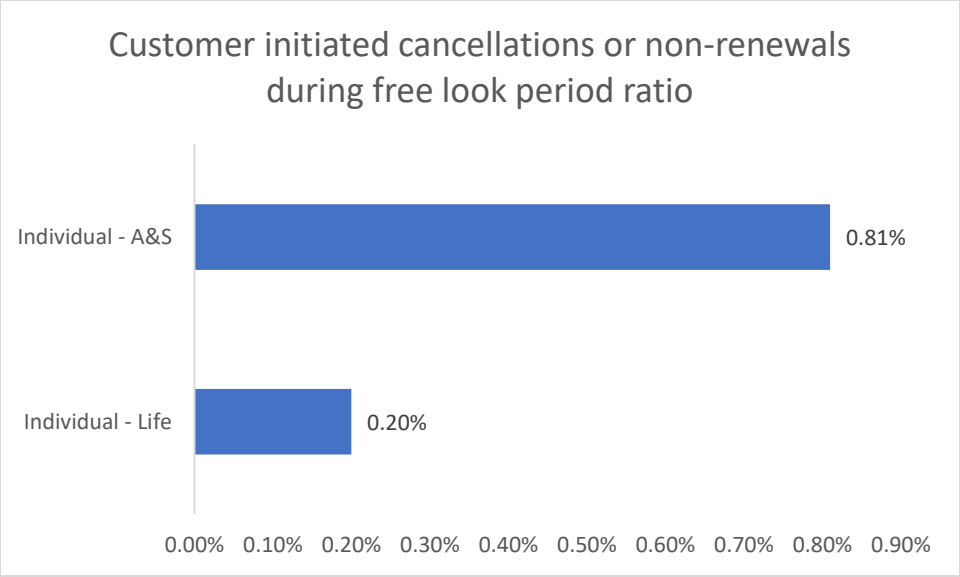
The insurer initiated cancellations with refund of premium – Fully refunded ratio[9], is designed to capture which classes of insurance customers are mostly likely to have their policies cancelled. In these cases, the insurer retroactively canceled the policy and fully reimbursed the insurance premium. Thus, insureds are left without insurance protection and may have difficulty getting a new insurance.

[8] Ratio calculation: Total number of customer initiated cancellations / (number of policies issued + number of policies renewed)
[9] Ratio calculation: Total number of insurer initiated cancellations with full refund of premium / (number of policies issued + number of policies renewed)

L&H Insurance Policies



The insurer initiated cancellations ratio[10] is designed to provide data on the number of policies cancelled by insurers in a specific class of insurance. It is also used on an individual insurer basis to determine if an insurer has a significant increase in the number of applications cancelled compared to previous years.



[10] Ratio calculation: Number of insurance initiated cancellations / policies in force

The 'customer initiated cancellations or non-renewals during free look period ratio'[11] is designed to broadly capture what classes of insurance are mostly likely to have customers cancel policies during the "free look" period. This ratio may be used to determine if a particular class of insurance is more likely to cause customers to experience "buyer's remorse" wherein they may feel a sense of regret and elect to cancel their policy. For individual insurers, this ratio may create a "red flag" that an insurer's distribution channel might not be properly selling policies to customers.[12]

How CCIR Members Utilize Policies Data

- Aids in tracking broad industry trends across classes of insurance, including denial of applications, and customer/insurer cancellations/non-renewals
- Enables tracking of growth/decline of certain classes of insurance based on total policies issued/renewed
- Allows CCIR members to track individual insurers' policies across classes of insurance
- Highlights risk indicators for CCIR members and identifies if customers are being treated fairly based on a specific class of insurance

Observations on Policies Data

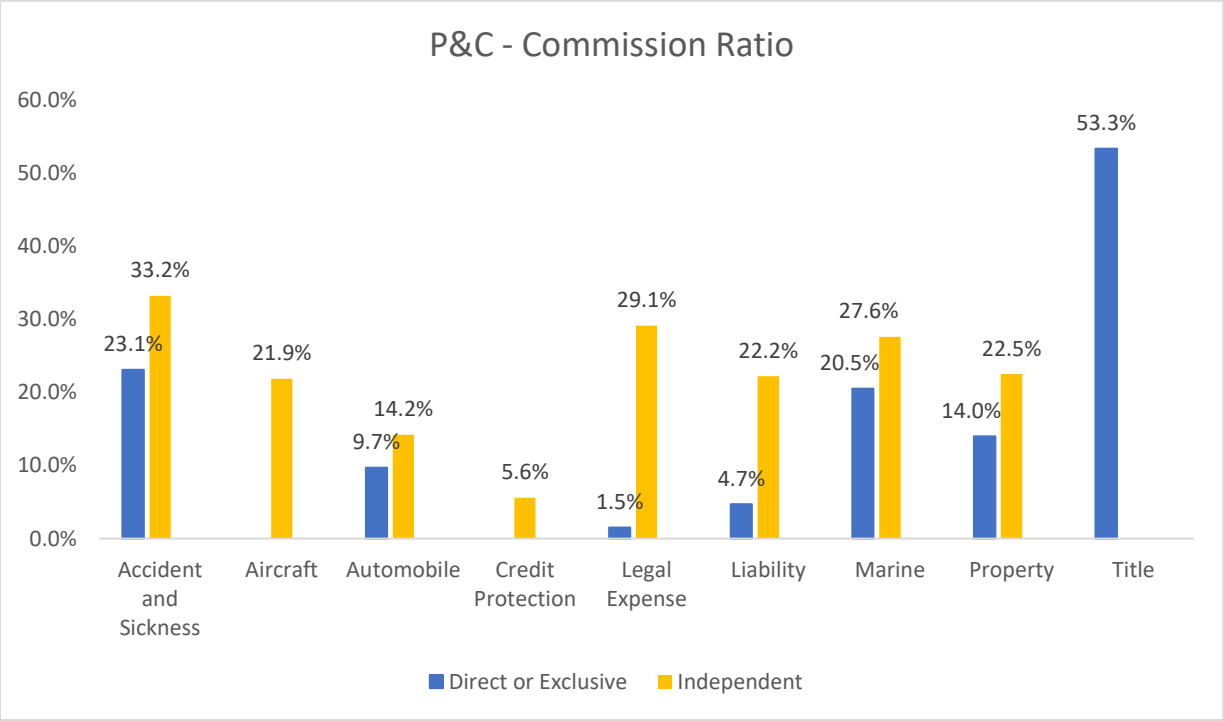
- According to the FTC Guidance, insurers are expected to service policies appropriately throughout the life-cycle of a product
- The FTC Guidance highlights the expectation insurers provide policyholders with information allowing them to make informed decisions throughout the lifetime of their contracts (this includes disclosing the terms and conditions in the case of switching between products or early cancellation of a policy)
- During examinations, some CCIR members have noted there are a lack of formal periodic reviews in place for information materials provided to customers
- Some CCIR members have noted during examinations there is insufficient training related to essential product information being disclosed to customers

[11] Ratio calculation: Total / policies in force (new policies + policies in force at end of previous period)
[12] CCIR members do not rely wholly on data collected from the Annual Statement and would verify information from sources, including examinations.

Premiums, Commissions and Claims

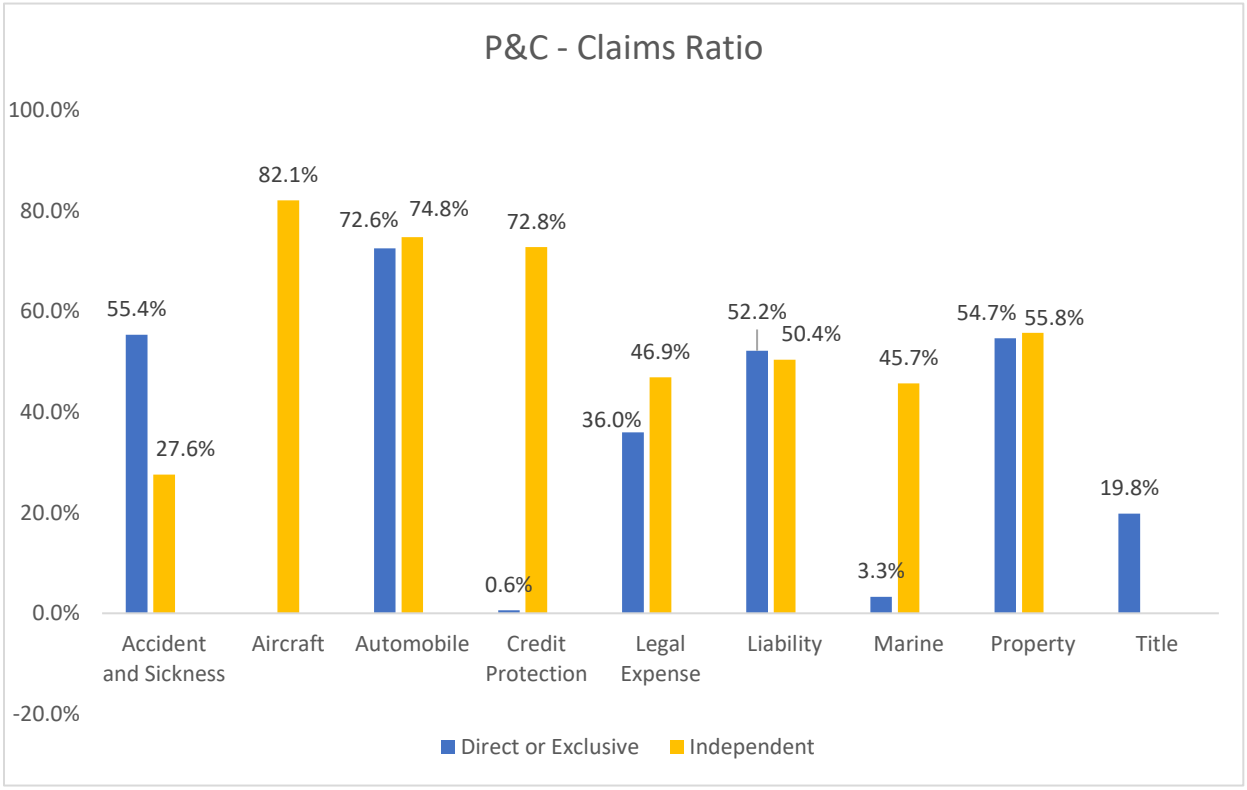
This section of the Annual Statement captures data on direct premiums written, categorized by distribution channel and by class of insurance. Data is collected on commissions earned and claims incurred, both of which are also categorized by class of insurance and distribution channel. This section enables CCIR members to obtain a macro-level scale and nature of a certain class of insurance and its distribution channels.

P&C Insurance[13]



The commission ratio[14] is calculated as the total amount of commissions paid in relation to the total direct written premiums (DWP) for a class of insurance. In this instance, commissions from commercial or reinsurance products are excluded. This gives a broad indication as to how commissions are paid relative to the amount of premium written based on the class of insurance.

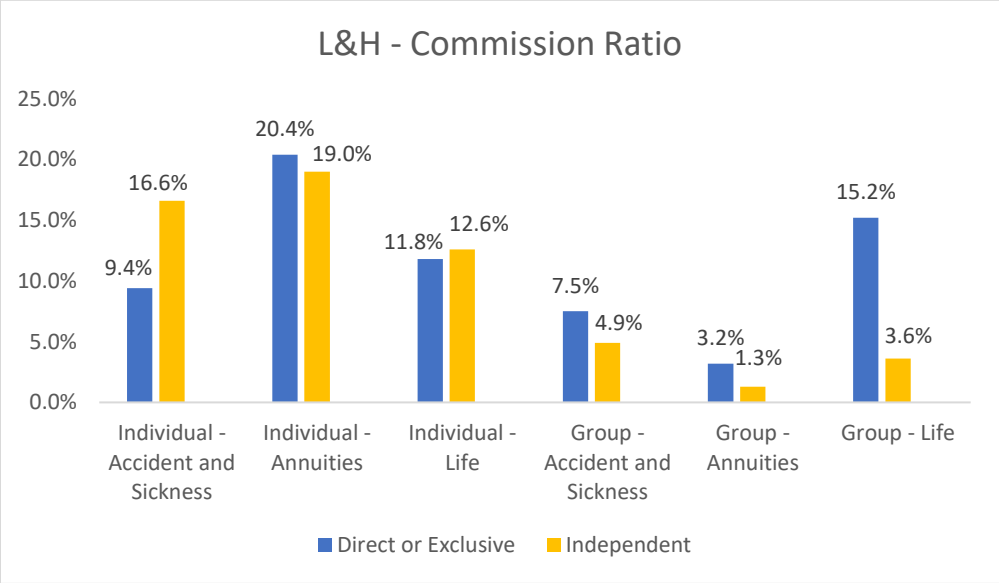
[13] The Annual Statement harmonizes definitions of classes of insurance to the P&C Quarterly Return / Annual Supplement: https://lautorite.qc.ca/fileadmin/lautorite/formulaires/professionnels/assureurs/definitions-declaration-annuelle-assurance-dommages_an.pdf
[14] Ratio calculation: Total all distribution channel commissions / total direct written premiums



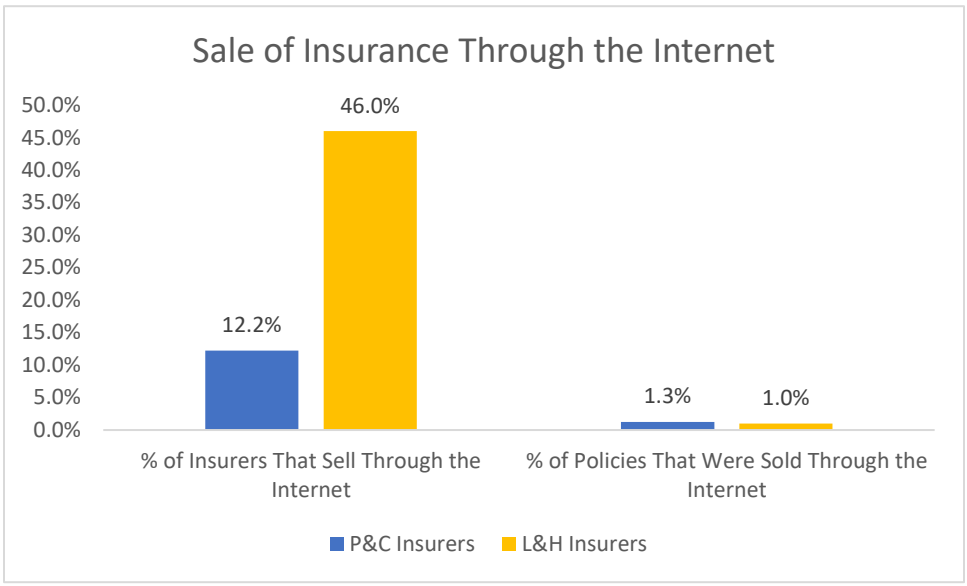
The claims ratio[15] is calculated as the total amount of claims incurred in a class of insurance in relation to the total DWP.

[15] Ratio calculation: Total claims / total DWP

L&H Insurance



Sales of Insurance Through the Internet



The Annual Statement is a useful tool to track the sale of insurance through the internet[16]. CCIR is interested in internet sales and plans to closely monitor the growth of sales in future iterations of this report. This data can be used to actively track the growth of internet sales, as well as

[16] A product is considered to be sold by Internet/online if the entire sale process is done online without using the services of an agent or broker. If a sale is completed by a licensed agent after the consumer obtains information or a price from a website, it is not considered as an Internet sale.

cross-reference against other data including: employment data, sales of insurance through different distribution channels, growth/decline of classes of insurance etc.

Although many insurers (12.2% of P&C insurers and 46.0% of L&H insurers) have already begun distributing insurance through the internet, internet sales do not yet make up a large proportion of sales. Only 1.3% of new P&C and 1.0% of L&H new policies issued were distributed through the internet. These policies represent only a small fraction of total direct written premium (0.8% of P&C and 0.06% of L&H).

The CCIR Position Paper on Electronic Commerce in Insurance Products[17] outlines CCIR's recommendations for ensuring consumer protection outcomes when an insurance product is distributed electronically.

How CCIR Members Utilize Premiums, Commissions and Claims Data

- Provides macro-level view of the insurance market, classes of insurance, commissions and claims
- Data feeds into risk assessments of classes of insurance
- Targeted tracking of incentive levels
- Tracking and monitoring of trends related to the sale of insurance through the internet

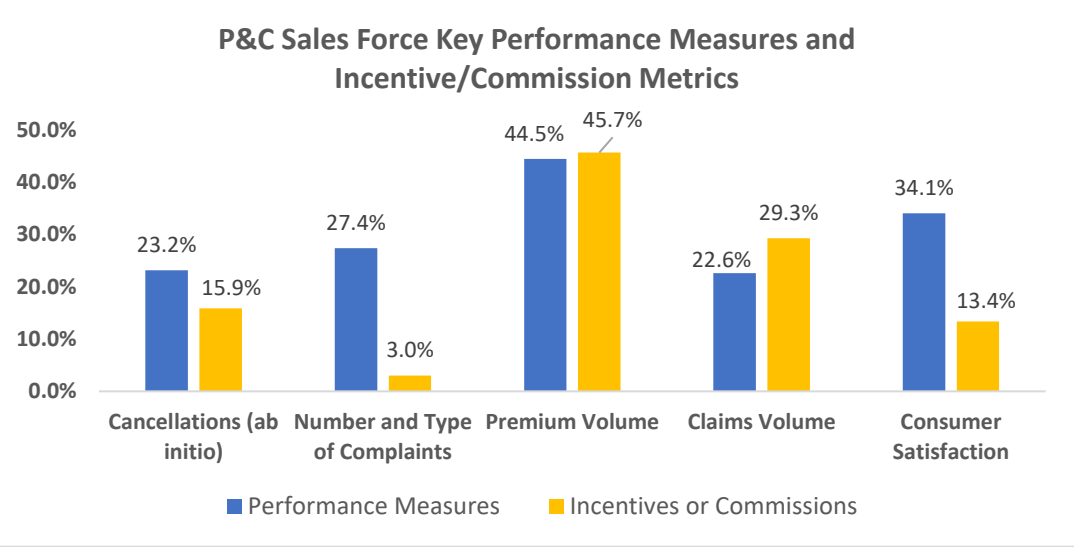
Observations on Premiums, Commissions and Claims Data

- According to the FTC Guidance, insurers and intermediaries are expected to place the customer's interests above their own
- The FTC Guidance emphasizes "minimizing the sales which are not appropriate to the Customers' needs" is an FTC outcome
- The CCIR Position Paper on Electronic Commerce in Insurance Products recommends customers purchasing insurance products electronically be given adequate information in order to ensure they are purchasing products suitable to their needs
- CCIR members have noted during examinations some insurers have inadequate supervision of their external sales force regarding conflict of interest and incentives

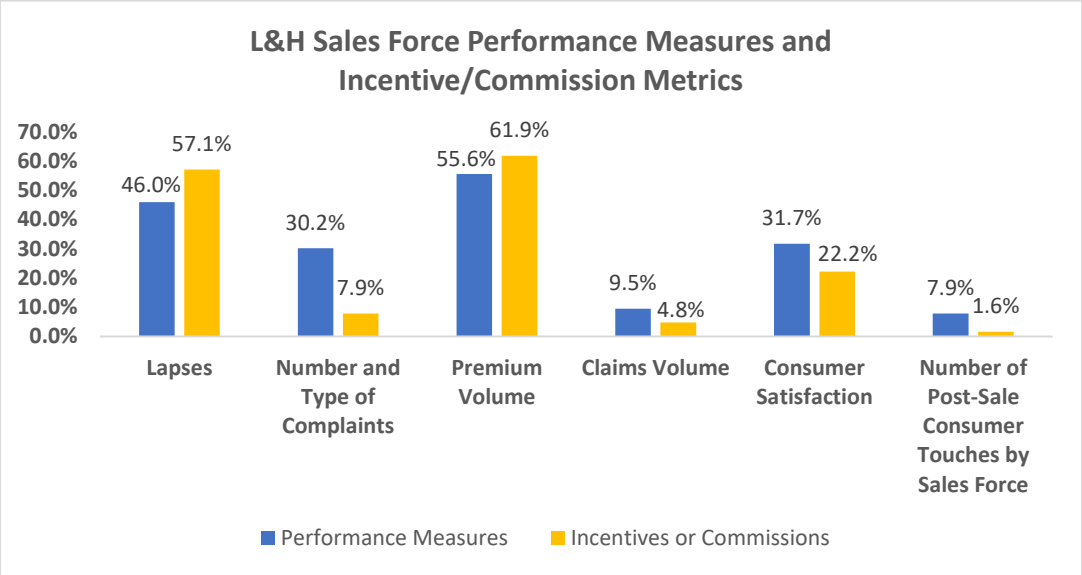
[17] https://www.ccir-ccrra.org/Documents/View/2725

Sales and Incentives Management

The Sales and Incentives section of the Annual Statement only captures data for incentives provided by the insurer, excluding compensation practices of any entity distributing the product of the insurer. In both the P&C and L&H sectors, the most common method for calculating both performance measures and incentives/commissions was by premium volume.



A minority of respondents from both the L&H and P&C sectors indicated they incorporate consumer satisfaction (34.1% in P&C and 31.7% in L&H) and number and type of complaints (27.4% in P&C and 30.2% in L&H) into their performance measures. However, there was also a significant drop in the number of insurers incorporating these metrics into their incentive/commission calculations. A small minority of insurers incorporated consumer satisfaction (13.4% in P&C and 22.2% in L&H) while few insurers incorporated the number of complaints (3.0% in P&C and 7.9% in L&H) into their metrics for incentives/commissions.



How CCIR Members Utilize Sales and Incentives Management Data

- Provides unique data on incentives utilized by insurers, including data on commissions offered to direct sales forces in the first and second years of a policy
- Enables CCIR members to monitor the development of qualitative criteria based on FTC principles into incentive programs
- Helps to assess risks and highlight risk indicators to aid in selecting risk-based examinations

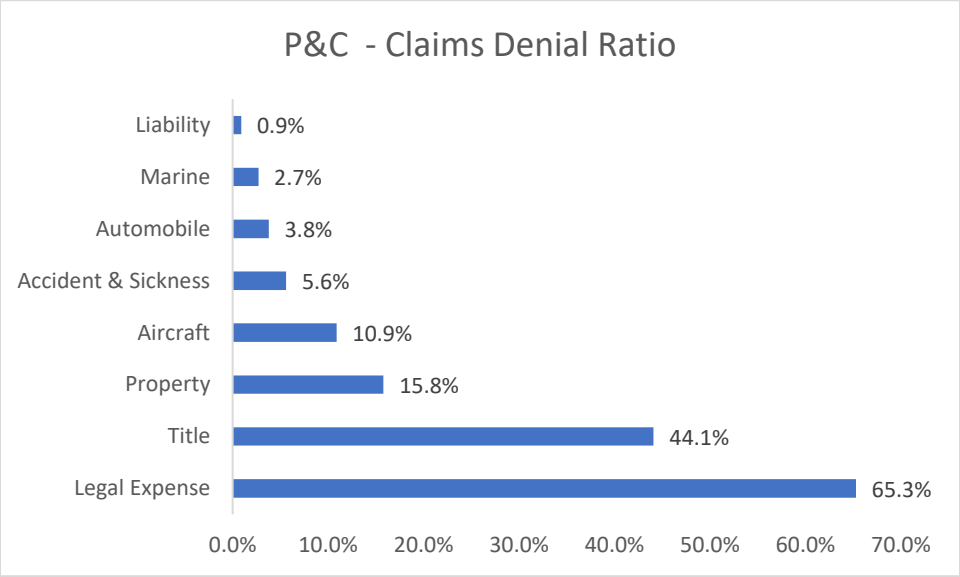
Observations on Sales and Incentives Management Data

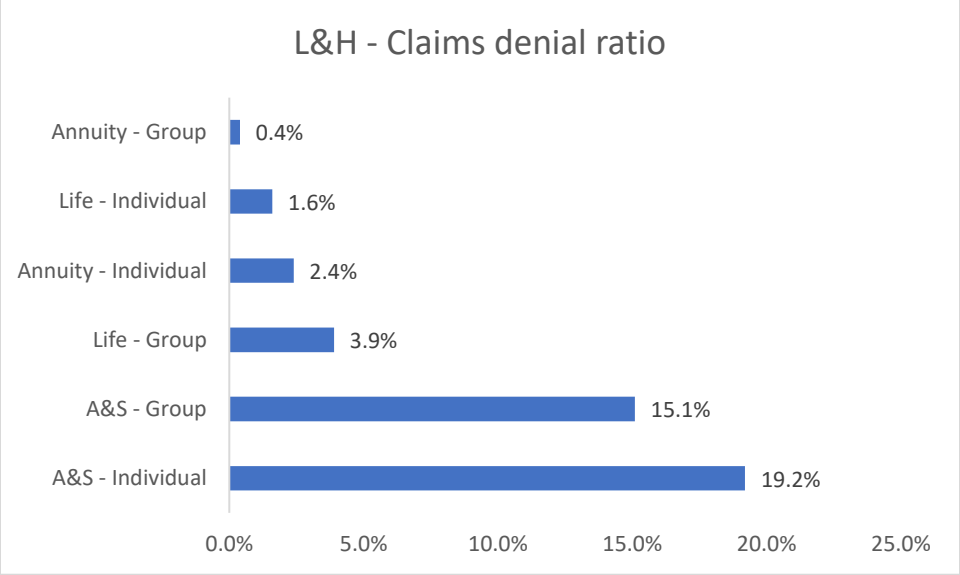
- CCIR expects remuneration, reward strategies and performance evaluation take into account the contribution made to achieving FTC outcomes
- During examinations, some CCIR members had noted there is a lack of integration of FTC elements in insurers' compensation structure and incentive programs – this is confirmed in data collected through the Annual Statement

Claims

The Annual Statement collects data related to claims, categorized by class of insurance. The data also tracks the denial of claims, and time taken to complete the claims process. This section helps CCIR members track adherence to the FTC Guidance's expectation for insurers to handle "claims in a timely and fair manner."

Claim Denials[18][19]

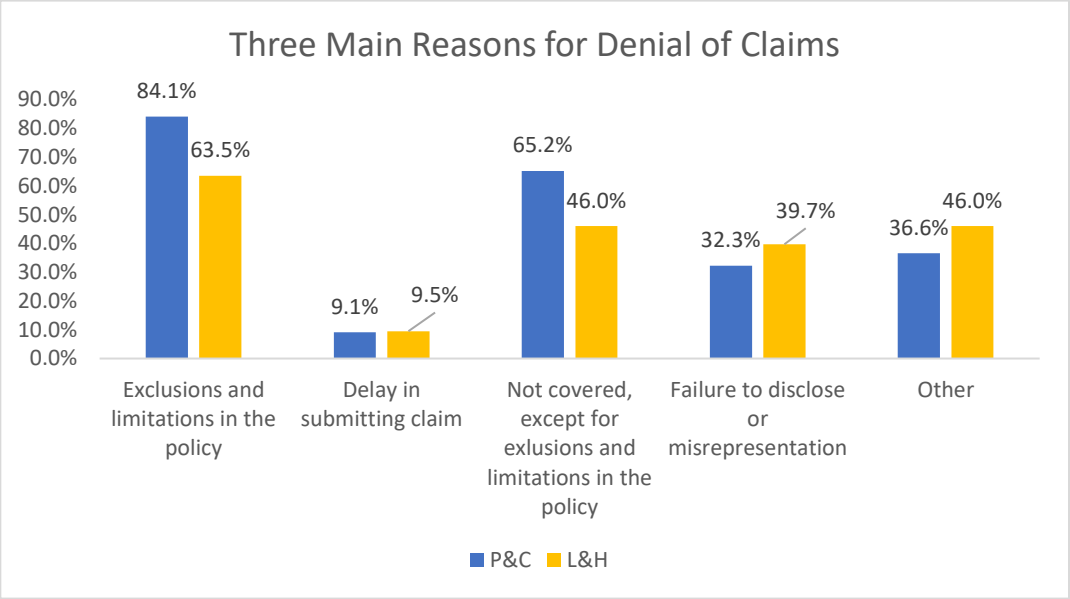




[18] For the P&C sector, CCIR excluded Credit Protection data from the Claims Denial Ratio as the results had been skewed by filing errors from the previous year's return.
[19] Title and Legal Expense have a limited number of insurers which may cause large changes in the data from year to year.

CCIR developed a claims denial ratio, which measures the amount of claims which were denied in relation to the total number of claims made.[20] [21] The ratio provides CCIR members a macro-level view of claims which were rejected based on class of insurance, or distribution channel.

The Annual Statement also requires insurers to indicate the three main reasons for denial of claims during the reference period and the total number of denials for the three reasons selected. For both the P&C and L&H sectors, the main reason for denying a claim was due to 'Exclusions and limitations in the policy', followed by 'Not covered' and 'Failure to disclose or misrepresentation'.



How CCIR Members Utilize Claims Data

- Provides macro-level data to CCIR members on claims, in particular data on how long insurers take to close claims and how often claims are denied in relation to class of insurance and distribution channel
- Assists CCIR members in assessing the risk for a particular class of insurance, distribution channel or insurer for their adherence to the expectation outlined in the FTC Guidance for claims to be "examined diligently and fairly settled, using a simple and accessible procedure"

[20] Ratio calculation: # claims denied in the period / (# of claims opened at the beginning of the period + # of new claims opened during the period – # of claims opened at the end of the period)
[21] A claim is considered denied if an insurer refuses to pay any amount of the claim.

Observations on Claims Data

- CCIR members noted some insurers do not have adequate information about their claims process easily available to customers
- Not all insurers adequately inform customers of the reasons for a claims' denial
- The FTC Guidance expects insurers "Maintain written documentation on their claims handling procedures, which include all steps from the claim being made up to and including settlement"

Complaint Examination

The FTC Guidance outlines several key expectations related to complaint examination and handling, including for the insurer to:

- Handle complaints in a timely and fair manner;
- Analyze complaints concerning Intermediaries in respect of products distributed by Intermediaries on their behalf, enabling them to assess the complete Customer experience and identify any issues to be addressed;
- Identify whether some Intermediaries or particular issues are subject to regular or frequent complaints;
- Establish policies and procedures to deal with received complaints in a fair manner; and
- Analyze the complaints received to identify trends and recurring risks

The Annual Statement collects key data assisting CCIR members in tracking insurers' adoption of FTC principles related to complaints.

Indicated that the following was present in their organization	P&C – Percentage that said 'Yes'	L&H – Percentage that said 'Yes'
Complaint handling policies and procedures guideline	96.5%	96.3%
Complaint handling unit or department	76.6%	80.5%

Indicated the following was present in their organization	P&C – Percentage that said 'Yes'	L&H – Percentage that said 'Yes'
Reporting mechanism that is sent to management and the board regarding aggregate complaints on a periodic basis	88.7%	93.9%
Ongoing training program regarding complaint handling for staff whose activities include complaint handling	71.9%	81.7%

Insurers largely indicated they have 'Complaint handling policies and procedures guideline' present in their organization (96.5% for P&C and 96.3% in L&H). However, there is a decrease in the percentage of insurers that have a 'Reporting mechanism sent to management and the board regarding aggregate complaints on a periodic basis'. For P&C insurers this decrease is more pronounced (88.7%) as compared to L&H insurers (93.9%). There are more substantial decreases in the percentage of insurers that indicated they have an 'Ongoing training program regarding complaint handling for staff whose activities include complaint handling' (71.9% for P&C and 81.7% for L&H).

How CCIR Members Utilize Complaint Handling Data

- Provides key data to assess overall effectiveness of regulatory requirements to satisfy ICP 19.11: "The supervisor requires insurers and intermediaries to handle complaints in a timely and fair manner"
- Helps to assess risks and highlight key risk indicators to aid in selecting risk-based examinations
- Acts as a verification tool on examinations to determine how FTC principles are actually implemented and operationalized

Observations on Complaint Handling Data

- The FTC Guidance highlights CCIR members' expectations for insurers to ensure "Relevant staff trained to deliver appropriate outcomes in terms of fair treatment of Customers"
- CCIR members have noted during examinations although an insurer has complaint handling policies and procedures in place, these protocols may be overly complicated and onerous/burdensome on the complainant to complete
- CCIR members noted organizations often lack effective monitoring, data analysis and reporting presented to management, which prevents them from properly assessing the organization's adherence to FTC principles

Complaints

Insurers are required to file all applicable complaints which meet the standards established through the Annual Statement[22]. Complaints are the expression of at least one of the following elements persists after being considered and examined at the operational level capable of making a decision on the matter:

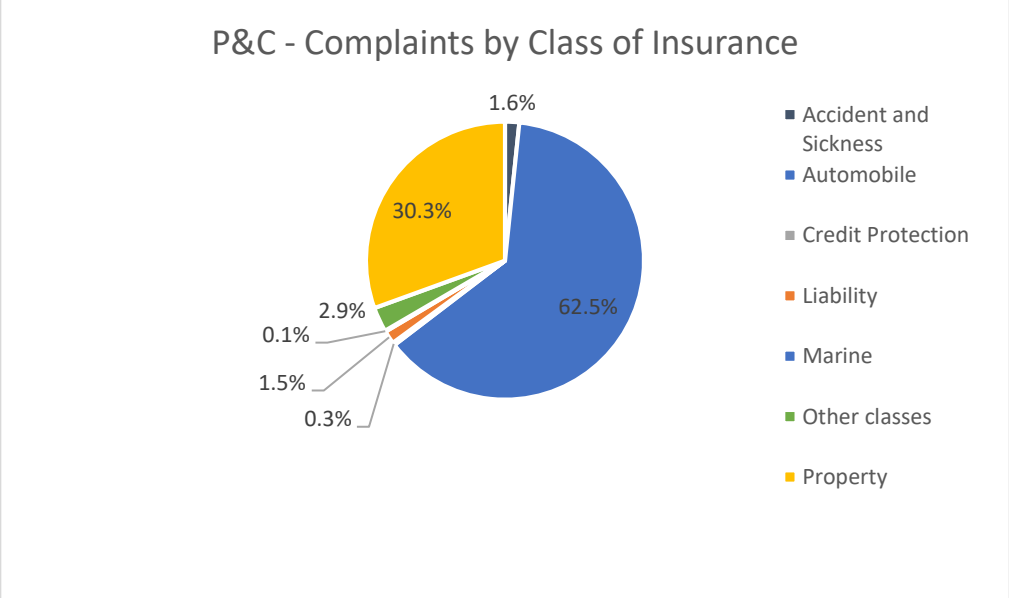
- a reproach against an organization;
- the identification of a real or potential harm a consumer has experienced or may experience; or
- a request for a remedial action.

Province	% of P&C Complaints	% of L&H Complaints	% of Population
Alberta	14.4%	8.0%	11.6%
British Columbia	3.0%	7.1%	13.5%
Manitoba	0.8%	2.3%	3.6%
New Brunswick	1.4%	1.7%	2.1%
Newfoundland and Labrador	1.1%	1.4%	1.4%
Northwest Territories	0.0%	0.0%	0.1%

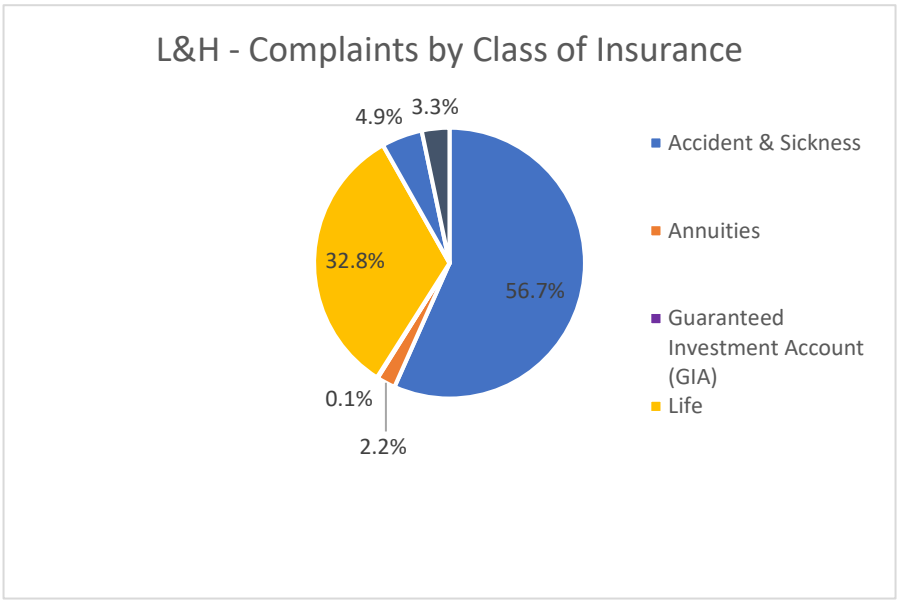
[22] Where a consumer makes a complaint by phone or in person and the complaint is handled and examined by the person responsible for the examination of complaints and designated as such in the organization's policy, the complaint must be documented so it can be kept on file. The initial expression of dissatisfaction by a consumer, whether in writing or otherwise, will not be considered a complaint where the issue is settled in the ordinary course of business. However, in the event the consumer remains dissatisfied and such dissatisfaction is referred to the person who is responsible for the examination of complaints and designated as such in the organization's policy, then it will be considered as a complaint.

Province	% of P&C Complaints	% of L&H Complaints	% of Population
Nova Scotia	2.3%	2.7%	2.6%
Nunavut	0.1%	0.0%	0.1%
Ontario	61.4%	34.1%	38.8%
Prince Edward Island	0.2%	0.3%	0.4%
Quebec	14.6%	40.2%	22.6%
Saskatchewan	0.5%	1.6%	3.1%
Yukon	0.1%	0.1%	0.1%
Not Classified	0.2%	0.4%	N/A

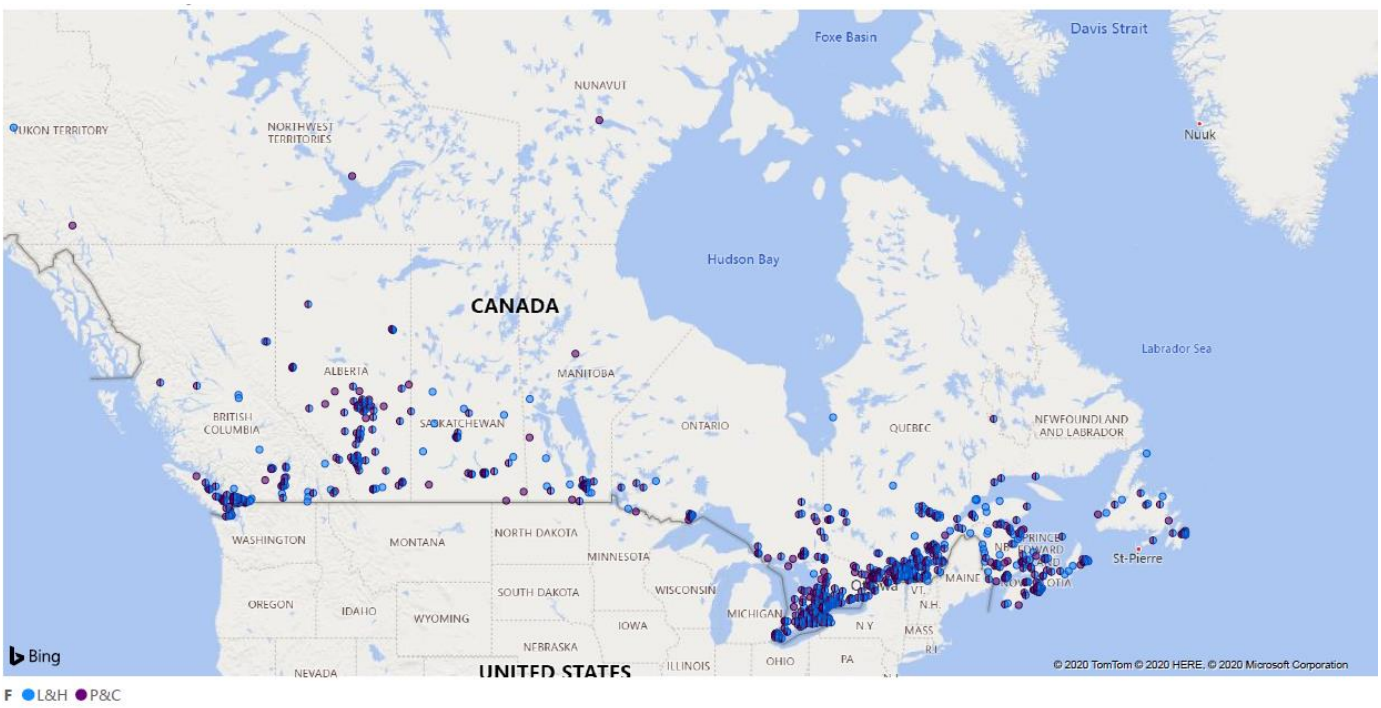
A disproportionate number of complaints originated in Ontario for the P&C sector, the majority of which originated in the automobile class of insurance. Automobile complaints, as a whole, comprised 62.5% of all personal complaints. Automobile and property combined for approximately 92.8% of all complaints in the P&C sector. The most common cause of complaint were categorized as “Claims/Settlement” or “Underwriting”.



For the L&H sector, a disproportionate number of complaints originated in Quebec (40.21%). Accident & Sickness represented more than half of all complaints (56.7%). For Group, the most common cause of complaints was “Claims/Settlement”, representing 78% of complaints (45% of all L&H complaints). For Individual, the most common causes for complaints on the were “Administration” related, representing approximately 30% of complaints (13% of total L&H complaints).



Total Complaints by Postal Code



The total complaints by postal code is a visualization of complaints submitted to CCIR through the Annual Statement[23]. While the map highlights complaints are denser in more populated

[23] Some complaints have been excluded from this map as they were not filed correctly.

urban areas, there are also some areas where complaints are being made in disproportionate amounts compared to the area's population.

Observations on Complaints Data

- CCIR members have noted some complaints included in the Annual Statement filing do not meet the definition of a complaint
- CCIR hopes insurers will take note of the CCIR definition of a complaint under the Annual Statement to ensure all appropriate complaints are being reported
- On examinations, CCIR members have discovered unreported complaints which should have been filed under the Annual Statement

How CCIR Members Utilize Complaints Data

- Helps to assess risks and highlight risk indicators to aid in selecting risk-based examinations
- Verification tool on examinations to determine how FTC principles are actually implemented and operationalized
- Macro-level monitoring of complaint trends

CONCLUSION

CCIR members find the Annual Statement to be an invaluable regulatory tool. The data obtained through the Annual Statement is a necessary resource, whose value will continue to grow with maturity of the data and emergence of key trends and indicators.

CCIR plans to issue variations of this report on an annual basis, each reflecting the results from the most recent Annual Statement. Depending on the results of the Annual Statement, future iterations of this report may focus on key areas of interest or CCIR priorities. CCIR expects the Annual Statement will become a valuable tool for industry benchmarking and this report can serve as an encouragement for insurers to achieve better customer outcomes as they seek to compare their individual results with the best practices in the industry and CCIR members' observations.

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