2021 Annual Statement on Market Conduct - Public Report

December 2022

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EXECUTIVE SUMMARY

This report provides an overview of the findings from the 2021 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 as well as note changes between data points year-over-year (y/y);
- provides a means for insurers to compare their overall policies, procedures and performance against industry averages and make improvements;
- in some instances, creates benchmarks on key Fair Treatment of Customers (FTC) principles and best 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 and how the insurers should use them.

In general, CCIR members use the Annual Statement to:
- monitor and assess the effectiveness of FTC Guidance and CCIR members FTC regulatory requirements. Those are 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;

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

- 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.

Key Observations

- There are indications throughout the Annual Statement that some of the data fluctuations that were probably the result of the unique circumstances of the Covid-19 pandemic are subsiding and many data points are returning to pre-pandemic levels.

- Annual Statement results continue to indicate although insurers value FTC principles, there are opportunities for some insurers to better demonstrate how they have incorporated FTC principles or to implement FTC principles through their activities and sectors.

- Data quality continues to be an issue for some respondents. **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.**

CCIR would like to highlight the 'CCIR Cooperative Fair Treatment of Customers (FTC) Review – Consolidated Observations Report' (FTC Observations Report)[2], which was published in October 2021. Many of the observations made in the FTC Observations Report will be flagged again in this report in their relation to the data CCIR has collected.

CCIR would also like to highlight the Incentive Management Guidance[3] which it proposed in 2022.

BACKGROUND

CCIR introduced the Annual Statement in 2017 to collect information from insurers across Canada related to their governance, practices, policies, and treatment of customers. The

[2] https://www.ccir-ccrra.org/Documents/View/3669
[3] https://www.ccir-ccrra.org/Documents/View/3690

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 for CCIR Members

CCIR developed the Annual Statement 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)[4] which provides the basis for increased information sharing and cooperation in supervisory activities. The CCIR published its Framework for Cooperative Market Conduct Supervision[5]. 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;
- 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.

[4] https://www.ccir-ccrra.org/Documents/View/3544
[5] https://www.ccir-ccrra.org/Documents/View/2592

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 FTC Guidance (aligned with the ICPs by IAIS). The committee oversees 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 shares 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 2021 ANNUAL STATEMENT

CCIR is sharing the following key results from the 2021 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 expanded comments to include insights observed by CCIR members during its examinations in addition to analysis on the Annual Statement data itself.

CCIR members expect insurers will use the information provided in this report to benchmark themselves against the industry, but also to identify CCIR members' expectations and best practices. Members expect insurers to be proactive in this regard and to take action when required. CCIR members will ensure these expectations are met in future examinations.

As this is the third iteration of this report, multiple data points now have three-year trending data. This enables CCIR, the property and casualty (P&C) and life and health (L&H) industries, and other stakeholders to gain insight into how the industries have changed over this period.

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

Filing Summary

P&C Summary

There were 225 insurers (232 in 2020) required to file the Annual Statement (broken down by size and jurisdiction of incorporation),[6] of those 159 (163 in 2020) were actively writing personal lines business.

Jurisdiction	Small	Medium	Large	Commercial & Run Off	Total
Alberta	2	3	2	2	9
British Columbia	0	3	0	2	5
Manitoba	0	1	0	0	1
New Brunswick	0	0	0	0	0
Nova Scotia	2	0	0	0	2
Ontario	37	3	3	9	52
Quebec	18	7	6	4	35
Prince Edward Island	1	0	0	0	1
Saskatchewan	4	1	0	3	8
Federal - Foreign	12	3	1	27	43
Federal - Canadian	9	23	18	19	69
Total	**85**	**44**	**30**	**66**	**225**

[6] For P&C: Small insurers=Direct Written Premium (DWP) under $50M; medium insurers= DWP between $50M and $300M; large insurers= over $300M DWP.

L&H Summary

There were 72 insurers (76 insurers in 2020) required to file the Annual Statement (broken down by size and jurisdiction of incorporation),[7] of those 57 (58 in 2020) were actively writing new business.

Jurisdiction	Small	Medium	Large	Run Off	Total
Alberta	1	1	0	0	2
British Columbia	0	1	0	0	1
Manitoba	0	0	0	1	1
New Brunswick	1	1	0	0	2
Nova Scotia	0	0	1	0	1
Ontario	4	2	2	2	10
Quebec	6	2	4	0	12
Saskatchewan	1	0	0	0	1
Federal - Foreign	4	4	0	5	13
Federal - Canadian	7	7	8	7	29
Total	**24**	**18**	**15**	**15**	**72**

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 in the FTC Guidance 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;

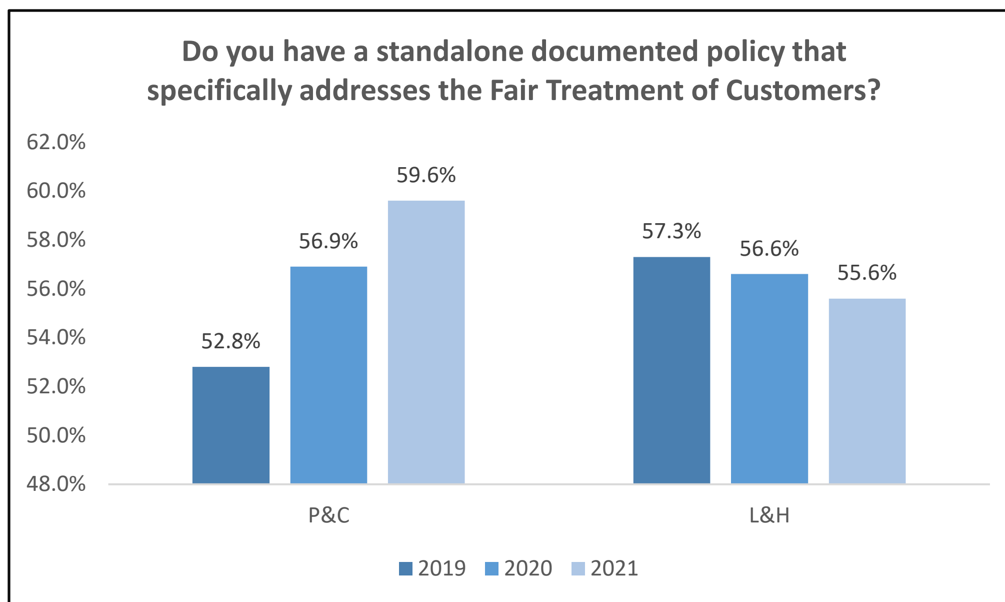
[7] For L&H: Small insurers=DWP under $150M; medium insurers= DWP between $150M and $800M; large insurers= over $800M DWP.

- 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

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”.



One of CCIR’s key outcomes for the Annual Statement Public Report is to encourage higher adoption and implementation of FTC principles by insurers. When asked if they have a “standalone documented policy specifically address the Fair Treatment of Customers”, 59.6% of P&C respondents answered in the affirmative, as did 55.6% of L&H respondents. While this result was largely stagnant for L&H respondents (56.6% in 2020), it represents a 4.6% increase in the percentage of P&C respondents having a standalone documented policy. This growth was largely driven by small and medium-sized insurers. This is the second year in a row where the

percentage of P&C respondents who have standalone documented FTC policies has increased. The percentage of L&H insurers has been steadily declining.[8]

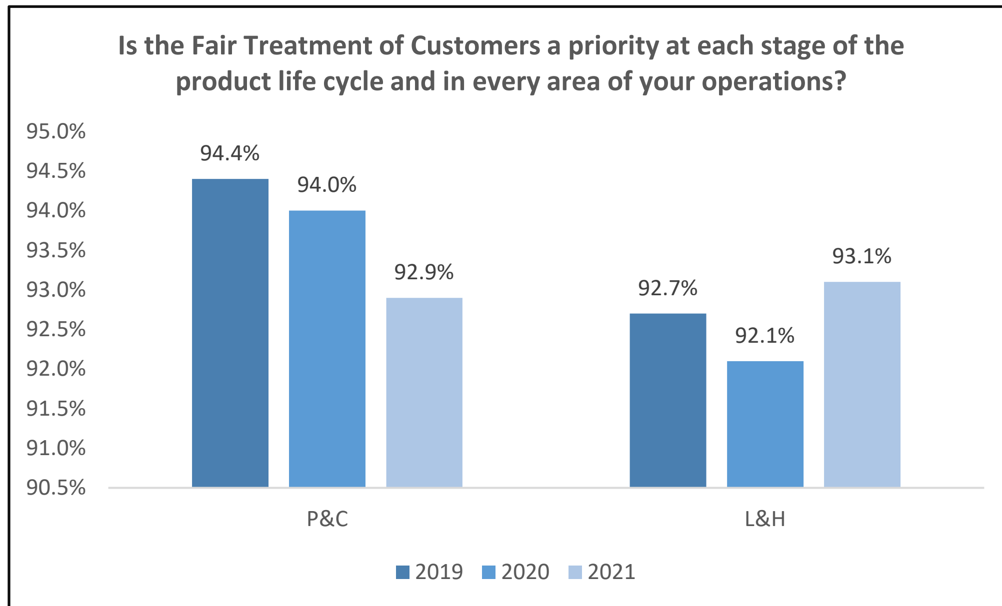
There were slight upticks in the number of P&C respondents (76.0% in 2021 compared to 75.4% in 2020) and L&H respondents (86.1% in 2021 compared to 85.5% in 2020) indicating they have a documented code incorporating FTC principles. This follows a three-year trend showing more insurers have adopted codes incorporating FTC principles since this report began in 2019. This trend is largely due to adoption of new documented codes by small and medium-sized insurers.

FTC Implementation

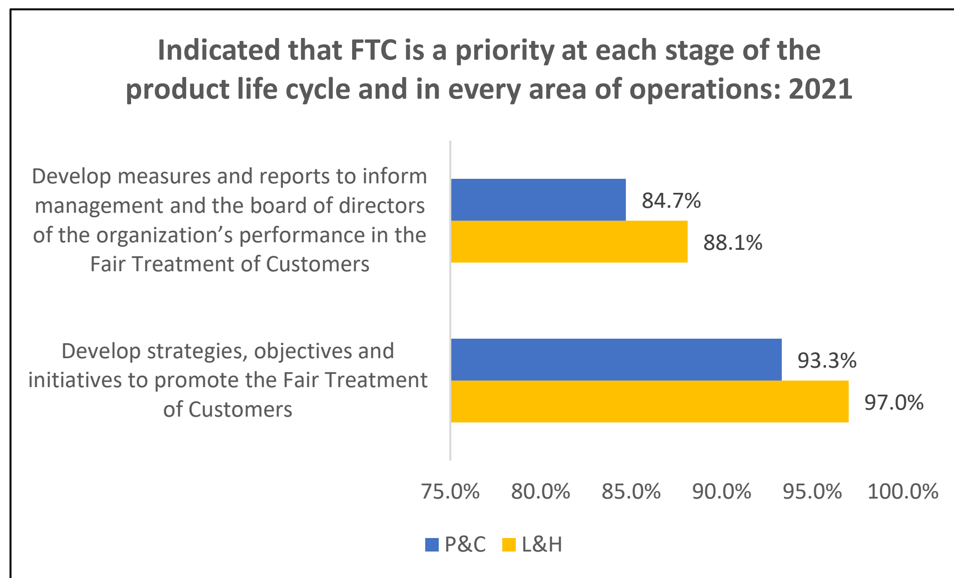
According to the FTC Guidance: “Sound conduct of business includes treating customers fairly throughout the life cycle of the insurance product. This cycle begins with product design and runs until all obligations under the contract are fulfilled.” In both the P&C and L&H sectors (92.9% and 93.1%, respectively), insurers largely 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.

Due to the high percentage of insurers who already indicated FTC is a priority to their organization, the results are largely unchanged. P&C respondent levels are slightly lower (from 94.0% in 2020), while L&H respondents increased 1% y/y. For those respondents answering “no” the exact reasons varied, but included insurers in run-off or currently developing their internal FTC culture and hope to be able to answer in the affirmative at a future date. As part of a plan to develop an FTC culture, insurers should ensure their expectations are clearly articulated to members of the organization and to their distribution channels. Insurers should also ensure they are able to measure their FTC performance

[8] There are several instances of L&H results from 2021 that appear lower than 2020 and 2019, but the total number of L&H insurers continues to decrease, resulting in superficial changes to some key data points.



For those insurers who answered in the affirmative to FTC being a priority for their organization, both P&C and L&H respondents predominately answered they “develop strategies, objectives and initiatives to promote the Fair Treatment of Customers.” The results from 2021 showed this is an area where respondents continue to develop as there were increases for both P&C respondents (84.7% in 2021 compared to 82.6% in 2020) and L&H respondents (88.1% in 2021 compared to 87.1% in 2020). The percentage of respondents indicating they have “develop(ed) measures and reports to inform management and the board of directors of the organization’s performance in the Fair Treatment of Customers” was slightly lower than the results from the 2020 report, but with results over 90% there are likely to be superficial changes on a y/y basis.



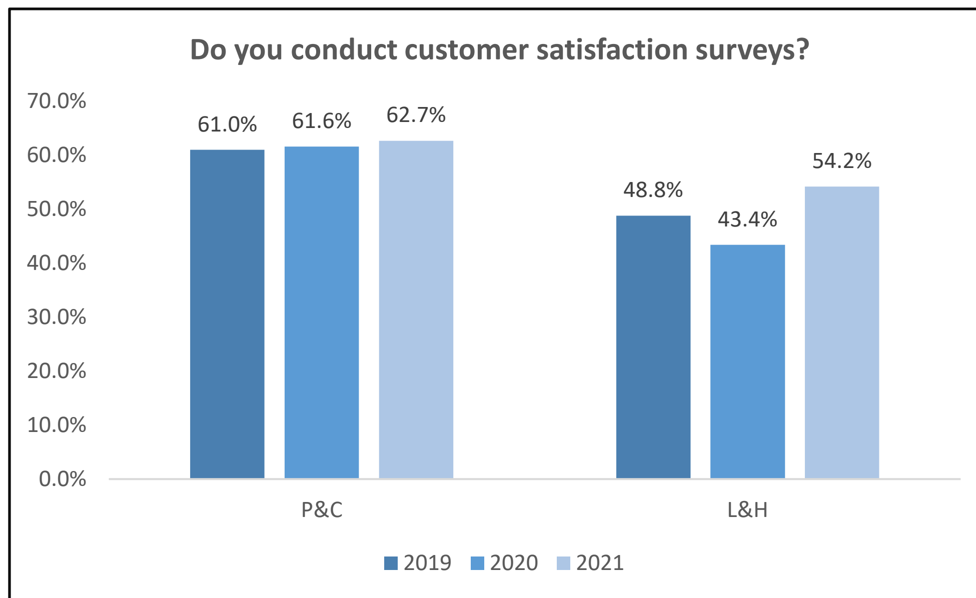
CCIR is encouraged it appears more insurers are moving towards being able to demonstrate they have incorporated FTC principles within their organizations, though room for improvement still exists. Furthermore, there are some discrepancies between what insurers indicate on their Annual Statement and the reality of their operations. The establishment of FTC principles and their governance is an important FTC governance element. The implementation of measures or reporting to senior management or the board of directors should not be limited to the number of complaints, satisfaction surveys results or response delay. See the table on 'FTC Governance Key Indicators' in Appendix 1 for some examples of key indicators that could be used by insurers to evaluate its FTC performance.[9]

Insurers generally indicated they consider FTC a priority during the entire life-cycle of the insurance product, but some insurers still have not yet promoted FTC principles or implemented a reporting mechanism to measure FTC performance or their risk related to FTC.

Furthermore, there are still many insurers who do not have a standalone documented policy specifically addressing FTC.

[9] Those key indicators were identified through CCIR members monitoring activities and from IAIS reports.

Customer Satisfaction Surveys



In the P&C sector, the percentage of respondents again slightly increased when asked if they conduct customer satisfaction surveys (increasing from 61.6% in 2020 to 62.7% in 2021). In the L&H sector, however, the number of insurers conducting customer satisfaction surveys greatly increased on a y/y basis (going from 43.4% in 2020 to 54.2% in 2021).

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 (95.7%), followed by sale (56.7%). In the L&H sector, the most common occurrence was following a sale (71.8%), followed by a claim (66.7%). Only a small percentage of respondents conducting customer satisfaction surveys, do so following a complaint (P&C – 22.7%; L&H – 23.1%), which represents a reduction in both sectors y/y.

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 regarding 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 assess risks and highlight risk indicators used in selecting risk-based examinations
- Verifies how FTC principles are implemented and operationalized in examinations
- Monitors number of FTC audits being performed by insurers throughout various distribution channels

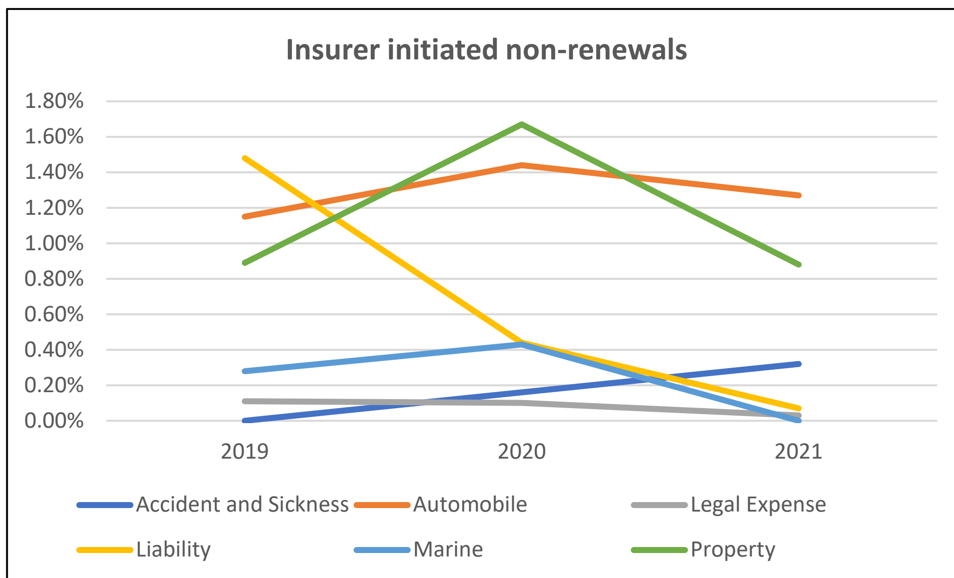
Observations on Governance Data

- 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 risk management and monitoring of their distribution channels
- CCIR members expect insurers to measure their FTC performance and if necessary, take remedial action
- CCIR and members examinations found:
  - There was a lack of consolidated reporting to assess the insurers' overall performance with respect to FTC;
  - The roles and responsibilities specifically related to FTC were not always clearly defined; and
  - The current policies and procedures were not fully evaluated to assess if pertinent FTC elements were incorporated, and no action plans were in place to implement and operationalize the FTC elements

Policies

The Policies section of the Annual Statement requires insurers to provide information on the state of their policies in force and 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 to better analyze risks and trends associated with particular classes of insurance. CCIR uses these data points to track and analyze changes in insurer/customer behaviour over multiple years.

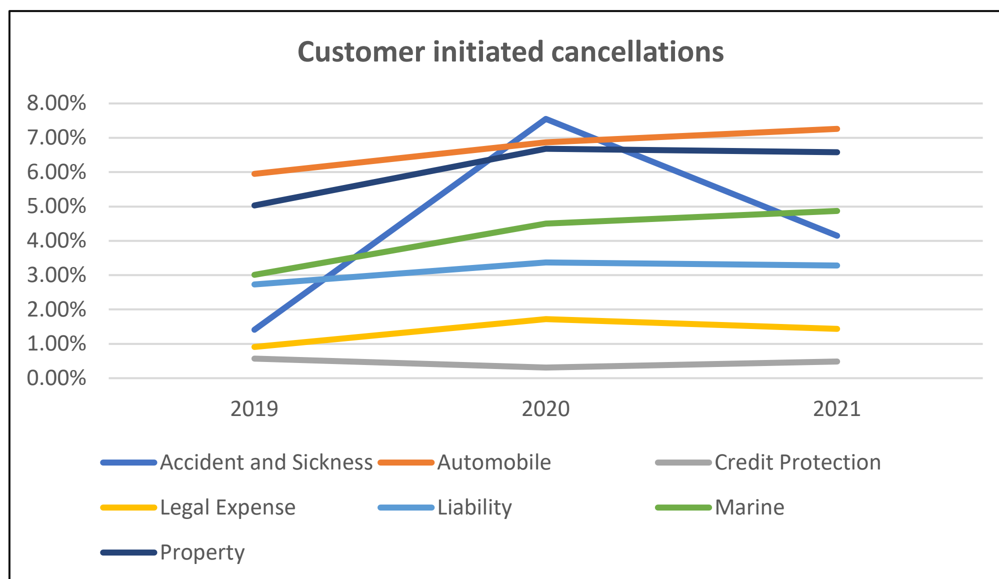


P&C Insurance Policies

The insurer initiated non-renewals ratio[10] is designed to capture broad industry trends, and identify if an insurer has initiated a significant reduction in a class of insurance. Aside from A&S, which increased to 0.32% in 2021 from 0.16% in 2020, all classes of insurance ratios decreased in 2021. Property has the largest decrease, going from 1.67% in 2020 to 0.88% in 2021, representing a decrease over 47% y/y, and returning closer to its 2019 level.

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

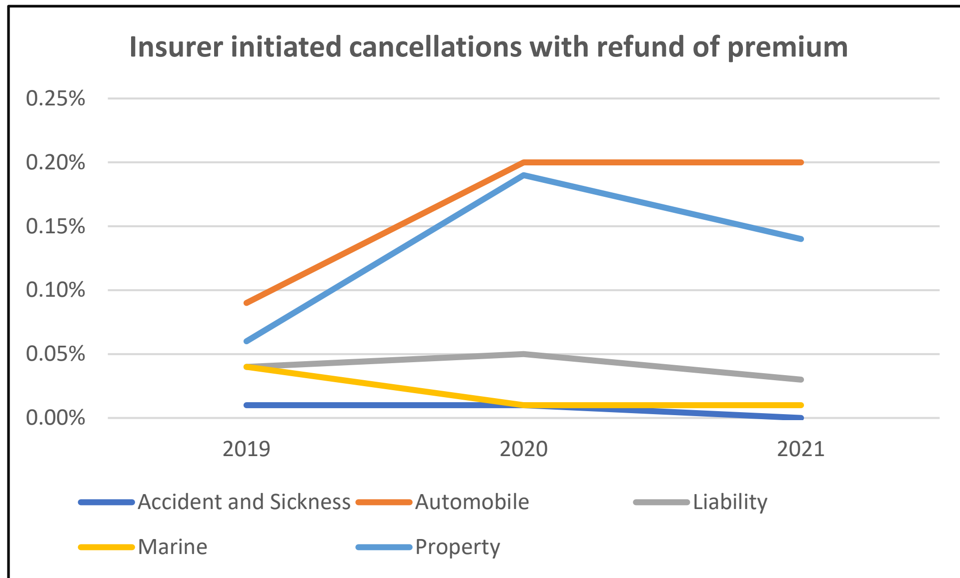
Classification: Protected A

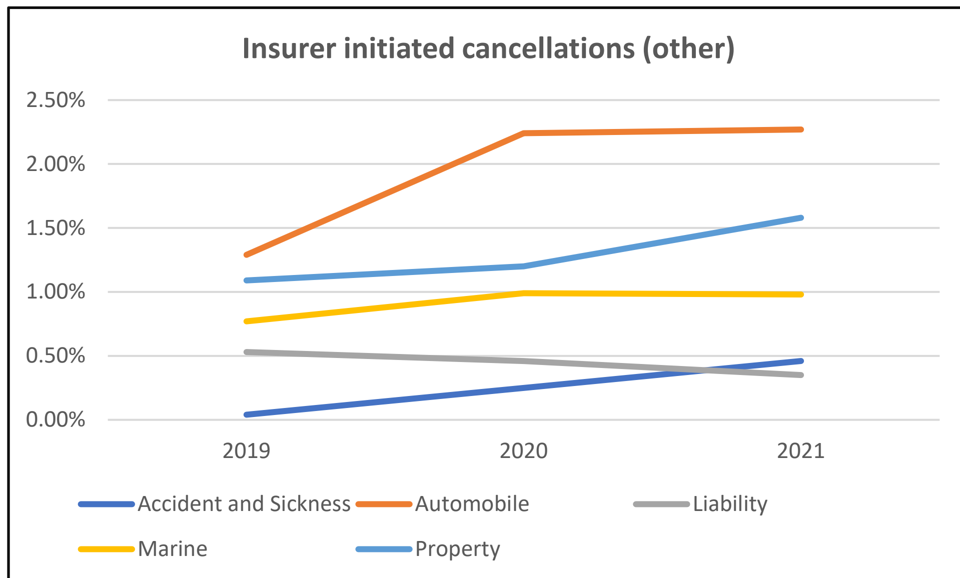


The customer initiated cancellations ratio[11] is designed to track customer mobility, and provide a broad indication of customer satisfaction with certain classes of insurance. This data is not used in isolation but is corroborated with other indicators, such as complaints, premiums, and media reports. The results for 2021 were relatively flat across most classes of insurance, the exception being A&S, which saw customers cancelling at a rate significantly lower than 2020 (4.15% in 2021 compared to 7.55% in 2020, a decrease of more than 45% y/y). However, 2021 cancellations were still roughly 194% greater than cancellations in the 2019 reporting period.

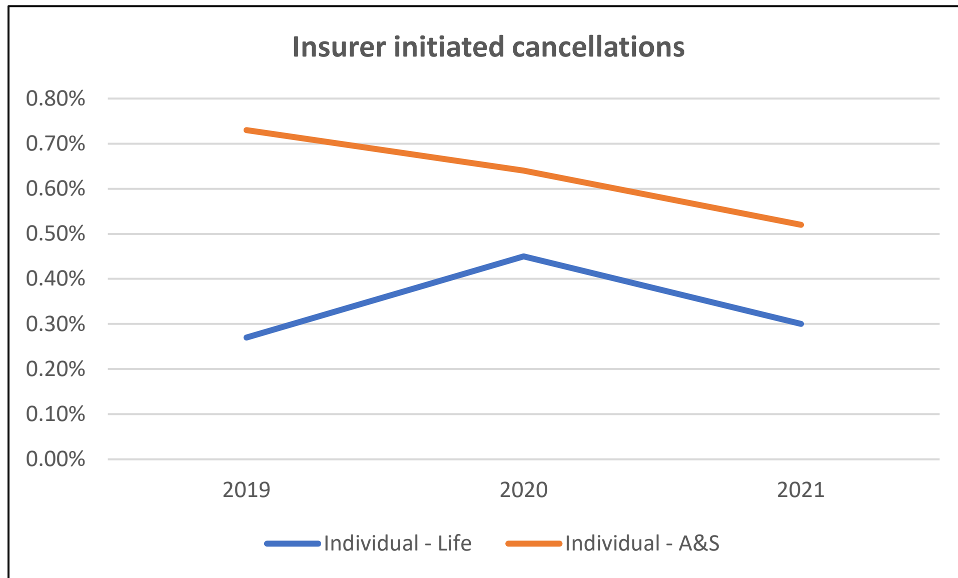
The insurer initiated cancellations with refund of premium – Fully refunded ratio[12] and the insurer initiated cancellations (other) ratio[13] are designed to capture which classes of insurance customers are mostly likely to have their policies cancelled. In these cases, the insurer retroactively canceled the policy and insureds are left without insurance protection. Insurer-initiated cancellations in auto remained flat for both ratios, following a spike in 2020. Insurer-led cancellations of property policies with a refund of premium declined, while they increased in instances without a refund in premium. A&S cancellations without a refund increased significantly for the second year in a row, increasing 84% y/y. The factors influencing these results will continue to be discussed with the industry to understand the causes and monitor the situation as it may have a significant impact on some consumers (e.g.: insurance accessibility issues).

[11] Ratio calculation: Total number of customer initiated cancellations / (number of policies issued + number of policies renewed)
[12] Ratio calculation: Total number of insurer initiated cancellations with full refund of premium / (number of policies issued + number of policies renewed)
[13] Ratio calculation: Total number of insurer initiated cancellations (other) / (number of policies issued + number of policies renewed)

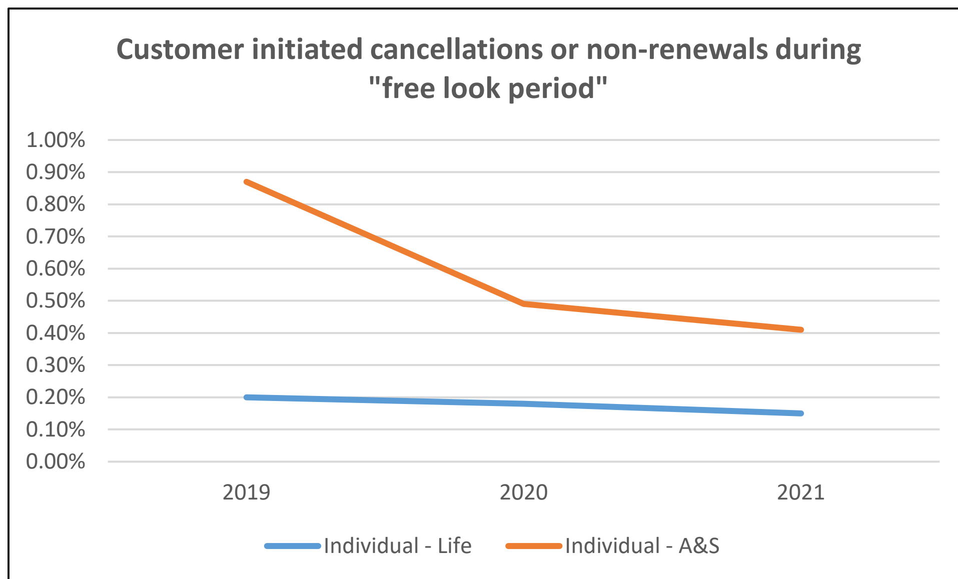

Insurer initiated cancellations with refund of premium
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
2019
2020
2021
Accident and Sickness
Automobile
Liability
Marine
Property


Insurer initiated cancellations (other)
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
2019
2020
2021
Accident and Sickness
Automobile
Liability
Marine
Property

L&H Insurance Policies

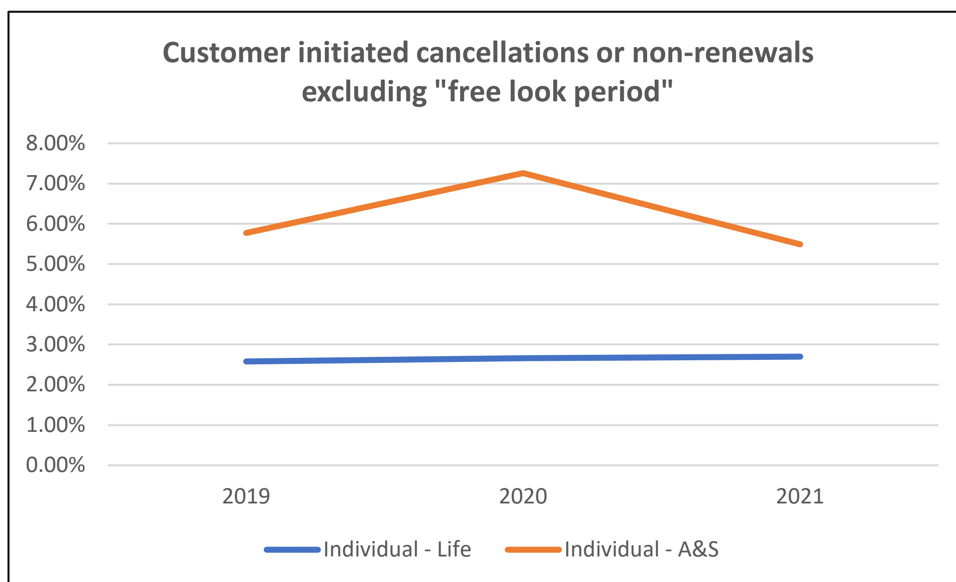


The insurer initiated cancellations ratio[14] is designed to provide data on the number of policies cancelled by insurers in a specific class of insurance. It is also used on an individual insurer basis to determine if an insurer has a significant increase in the number of cancelled policies compared to previous years. Both individual life (0.30% from 0.45%) and A&S (0.52% from 0.64%) ratios declined in 2021 and compared to 2020.



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

The ‘customer initiated cancellations or non-renewals during free look period ratio’[15] 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” an insurer’s distribution channel might not be properly selling policies to customers.[16] Both individual – life and individual – A&S declined in 2020, with individual – life declining 17% y/y after remaining flat in the previous reporting period, and A&S declining 16% y/y following a sharp decline the previous year.



The ‘customer initiated cancellations or non-renewals excluding "free look period" ratio’[17] is designed to capture which classes of insurance are being cancelled during the normal life span of a product excluding the initial “free look period”. This ratio is useful to CCIR in determining which classes of insurance customers may be dissatisfied with. Cancellations during this period remained stagnant in the individual – life class for the second year in a row, while they declined by over 24% for the individual – A&S class following a sharp increase in the previous reporting period.

[15] Ratio calculation: Total customer initiated cancellations or non-renewals during free look period / policies in force (new policies + policies in force at end of previous period)
[16] CCIR members do not rely wholly on data collected from the Annual Statement and would verify information from sources, including examinations.
[17] Ratio calculation: Total customer initiated cancellations or non-renewals excluding free look period / policies in force (new policies + policies in force at end of previous period)

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

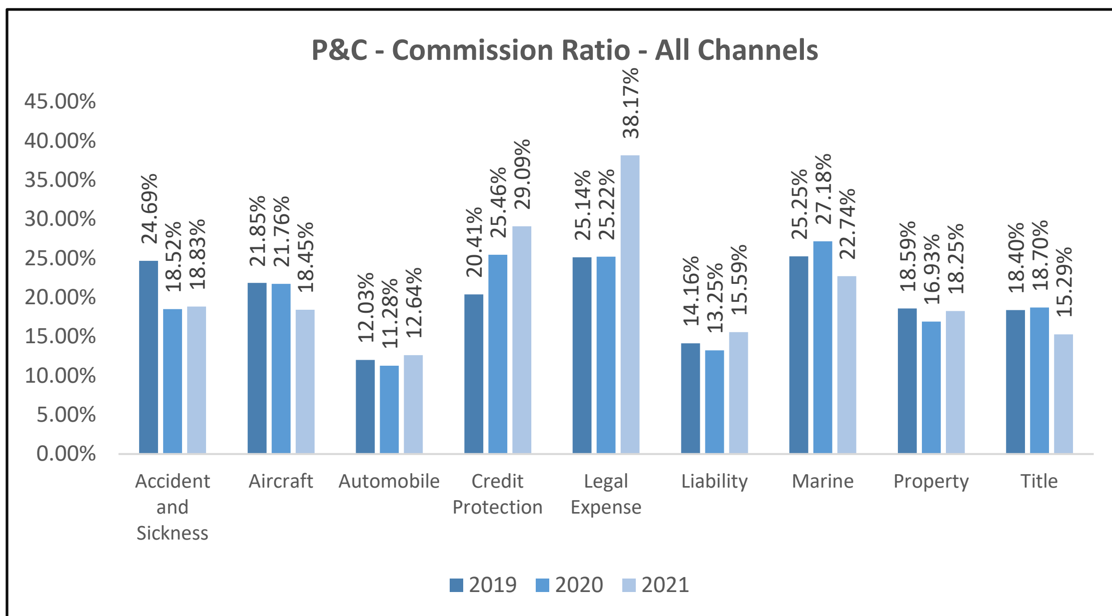
- The FTC Guidance highlights the expectation insurers provide policyholders with information allowing them to make informed decisions throughout the lifetime of their contracts (this includes disclosing the terms and conditions in the case of switching between products or early cancellation of a policy)
- 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
- CCIR members noted some insurers did not always provide insureds with post-purchase assistance and communications to ensure they are informed and they understand and know when to exercise their rights and obligations and of the impact of a decision

Premiums, Commissions and Claims

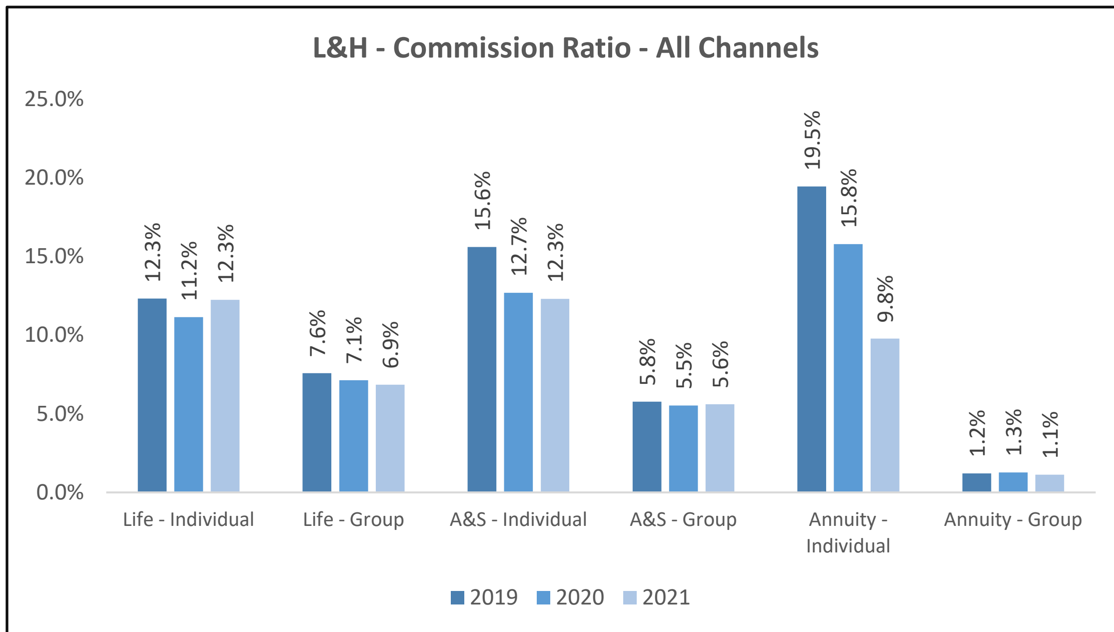
This section of the Annual Statement captures data on direct premiums written, categorized by distribution channel and by class of insurance. Data is collected on commissions earned and claims incurred, both of which are also categorized by class of insurance and distribution channel. This section enables CCIR members to obtain a macro-level scale and nature of a certain class of insurance and its distribution channels. For the P&C sector[18], only data on personal lines is included.

Commissions

The commission ratio[19] 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.



[18] 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
[19] Ratio calculation: Total all distribution channel commissions / total direct written premiums

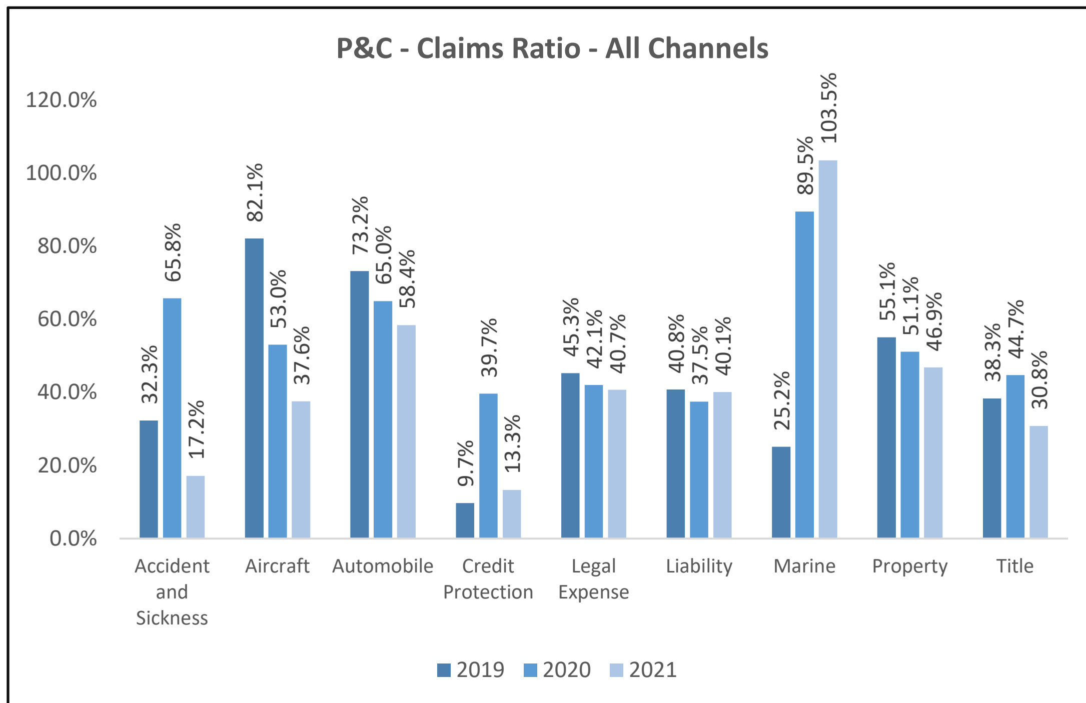


Data on commissions are likely to have moderate swings on a y/y basis. CCIR members will continue to monitor with interest the commission ratios and any other incentives, all in relation to the expectations that will be expressed to its future Incentives guidance.

Claims

The claims ratio[20] is calculated as the total amount of claims incurred in a class of insurance in relation to the total DWP. The claims ratio is useful for CCIR to determine which classes of insurance provide the highest value of return for customers, and if this is impacted by distribution channel. The automobile class continues to see noticeable reductions in its claims ratio on a y/y basis, probably due in large part to a continued reduction in kilometres because insured were working remotely. The auto claims ratio has declined over 20% since 2019. A&S and credit protection also had significant declines in their claims ratios on a y/y basis (declining 74% and 66% respectively). The marine class of insurance continued to face difficulties in 2021, with its claims ratio exceeding 100% (103.5%).

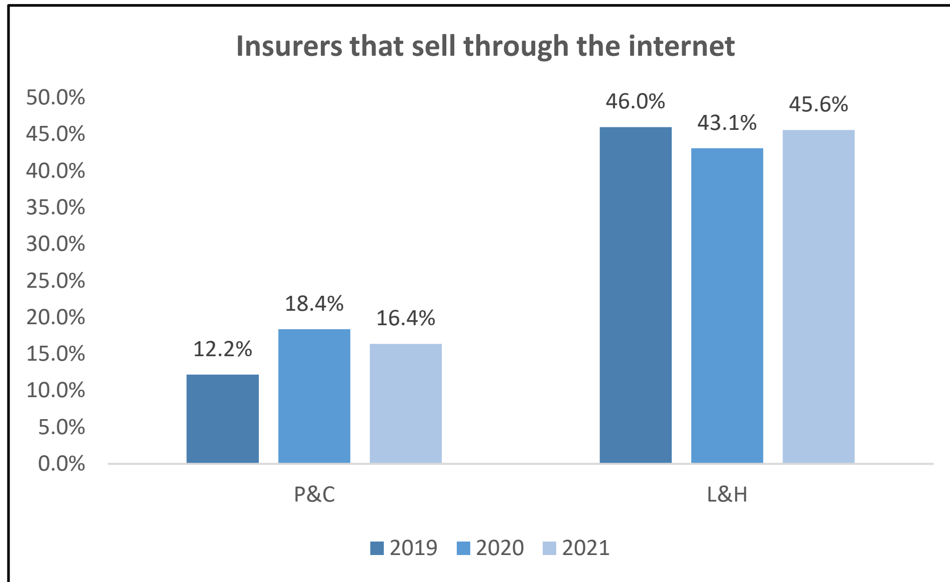
[20] Ratio calculation: Total claims / total DWP



Sales of Insurance Through the Internet

The Annual Statement is a useful tool to track the sale of insurance through the internet[21]. 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 cross-reference against other data including: employment data, sales of insurance through different distribution channels, growth/decline of classes of insurance etc. This data is of particular interest in the context of the Covid-19 pandemic's impact on the insurance sector.

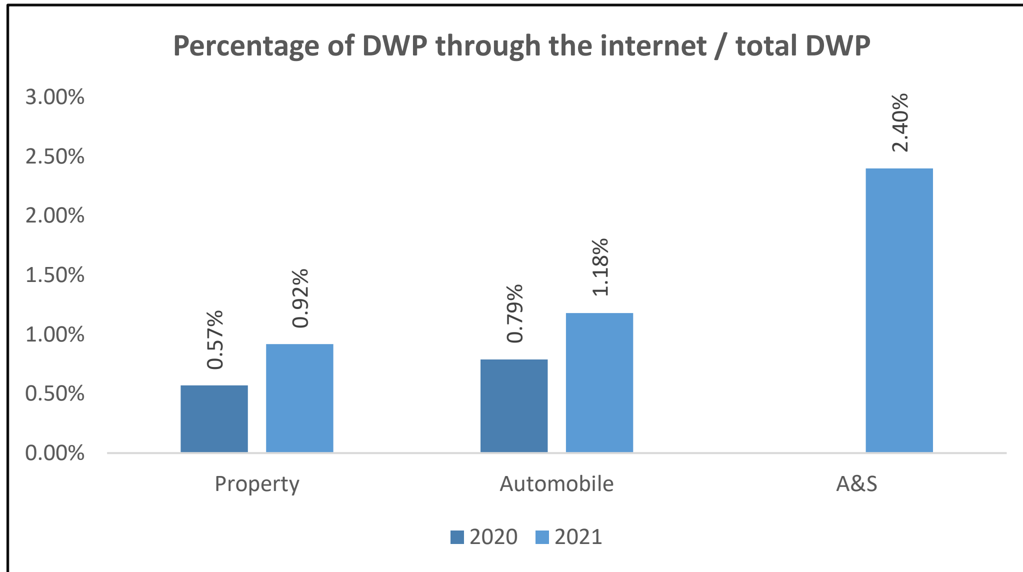
[21] A product is considered to be sold by Internet/online if the entire sale process is done online without using the services of an agent or broker. If a sale is completed by a licensed agent after the consumer obtains information or a price from a website, it is not considered as an Internet sale.

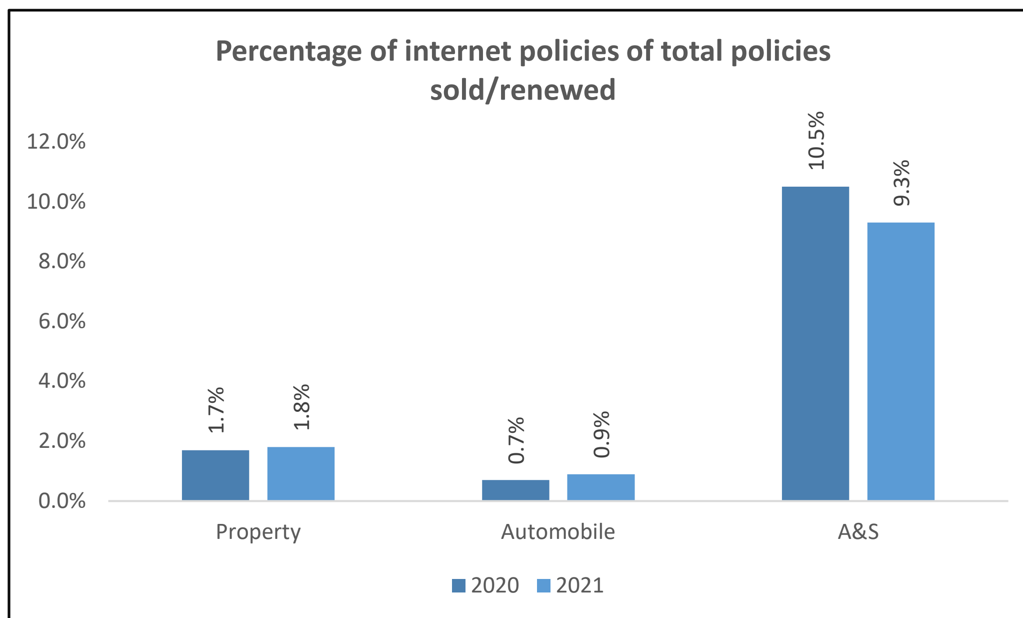


The number of L&H respondents selling through the internet has remained flat since 2019, while P&C respondents only increased slightly. In 2021, 16.4% of P&C respondents and 45.6% of L&H respondents indicated they sold products through the internet without the use of an intermediary. The data collected in the Annual Statement does not account for sales assisted by an intermediary but facilitated online. For example, a customer requesting a quote through a website and then finalizing the policy via telephone with an intermediary would not be captured through this data.

It appears the majority of insurers adopting new digital technologies are doing so to complement their existing distribution channels. CCIR will continue to closely monitor this trend in the future.

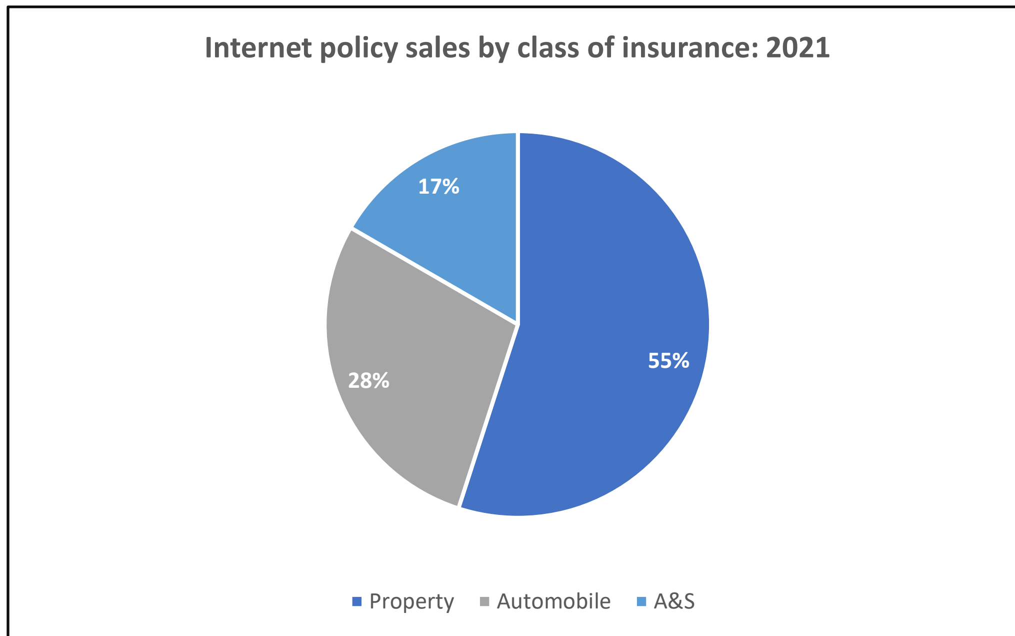
P&C Insurance





In the P&C sector, internet sales continue to be dominated by property insurance, accounting for around 55% of all P&C policies sold through the internet. Both property and auto policy sales increased in 2021 as a percentage of total policy sales (up to 1.8% and 0.9% of total policies sold respectively). For property, the percentage of DWP by internet was only 0.9%, compared to 1.8% of all policies, which suggests that the property sales were in simpler, less expensive

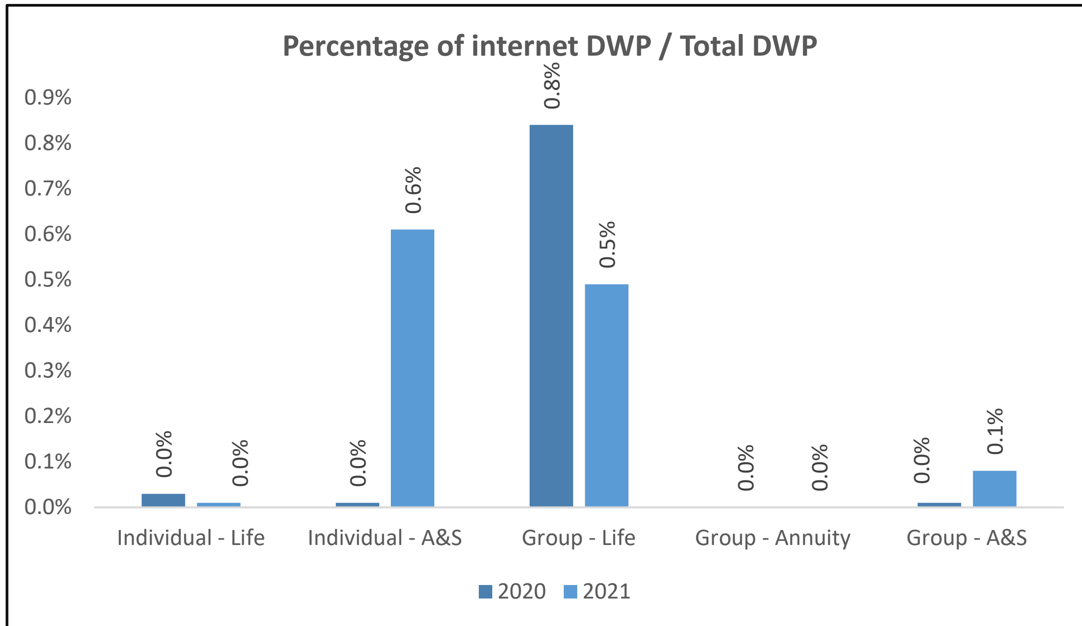
products. A&S made up the highest percentage of both DWP and policy sales (2.4% and 9.3% respectively in 2021).[22]

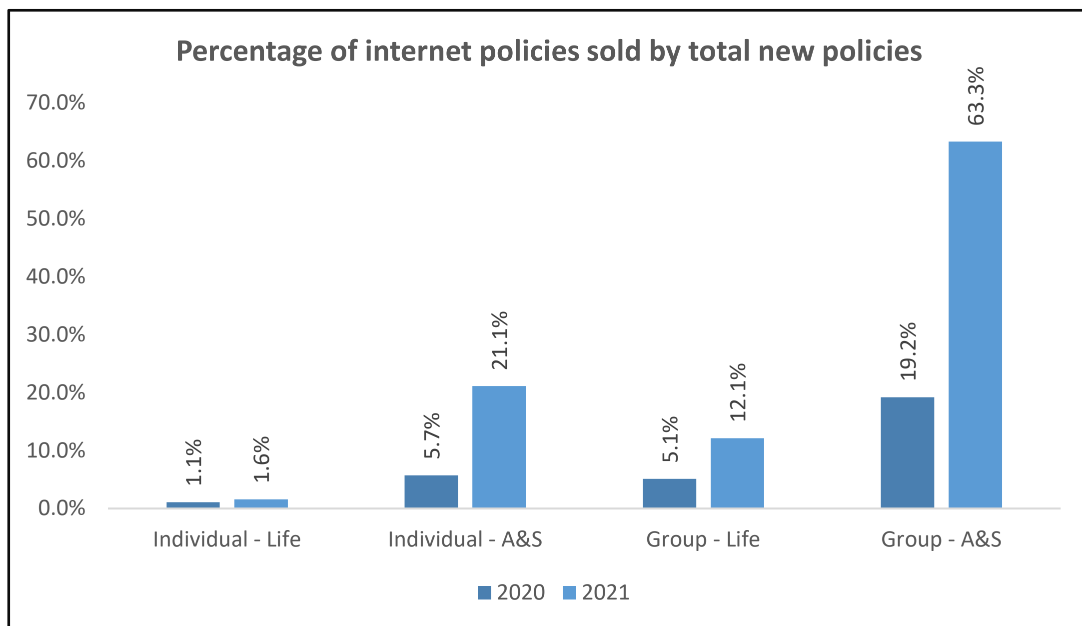


The majority of internet sales in the P&C sector are being undertaken by medium-sized insurers, which sold 68% of all policies sold in the sector. This is followed by small-sized insurers (22%) and large insurers (10%).

[22] Data from the A&S line in 2020 did not meet CCIR's quality standards and has been excluded from this report.

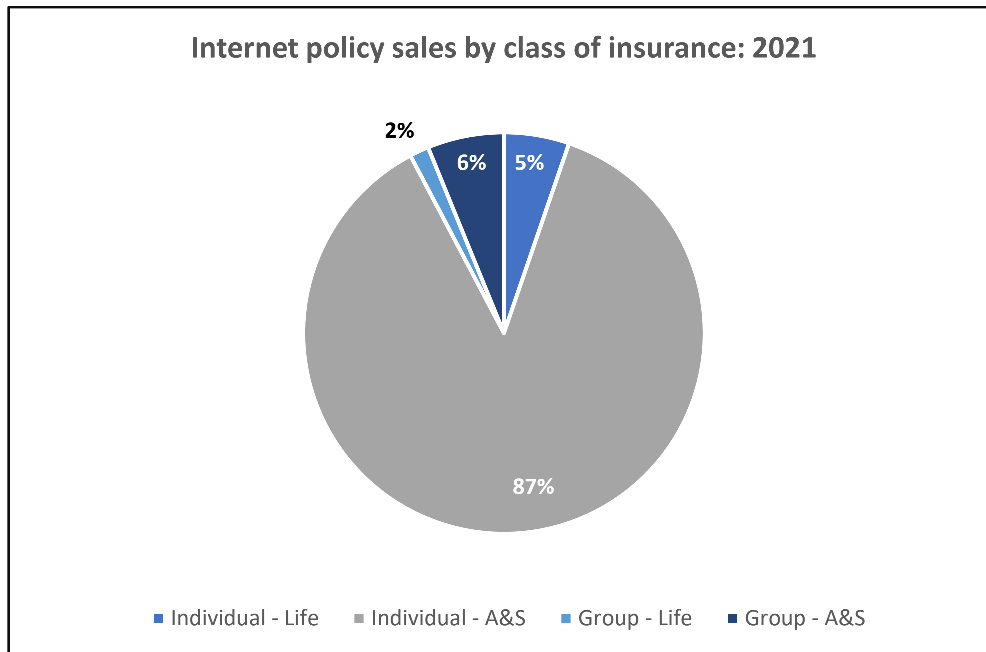
L&H Insurance





In the L&H sector, individual – A&S continued to dominate policy sales through the internet (87% of total L&H policy sales), followed by group – A&S (6%) and individual life (5%). In both A&S classes, the percentage of DWP through the internet and percentage of total policy sales through the internet grew exponentially. For individual – A&S, internet sales now account for 21.1% of all

policy sales, while the group – A&S class sold a majority of their new policies through the internet. In the life classes, the percentage of new policies sold increased in both individual (1.1% to 1.6%) and group (5.1% to 12.1%), while their total percentage of DWP declined.



Large-sized L&H insurers were responsible for the increase in policy sales, selling close to 80% of all policies through the internet. This was followed by medium-sized insurers (15%) and small-sized insurers (5%).

CCIR intends to closely monitor the results of future iterations of the Annual Statement to track the development of internet sales and its effects on FTC outcomes. The CCIR Position Paper on Electronic Commerce in Insurance Products[23] outlines CCIR's recommendations for ensuring consumer protection outcomes when an insurance product is distributed electronically.

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

How CCIR Members Utilize Premiums, Commissions and Claims Data

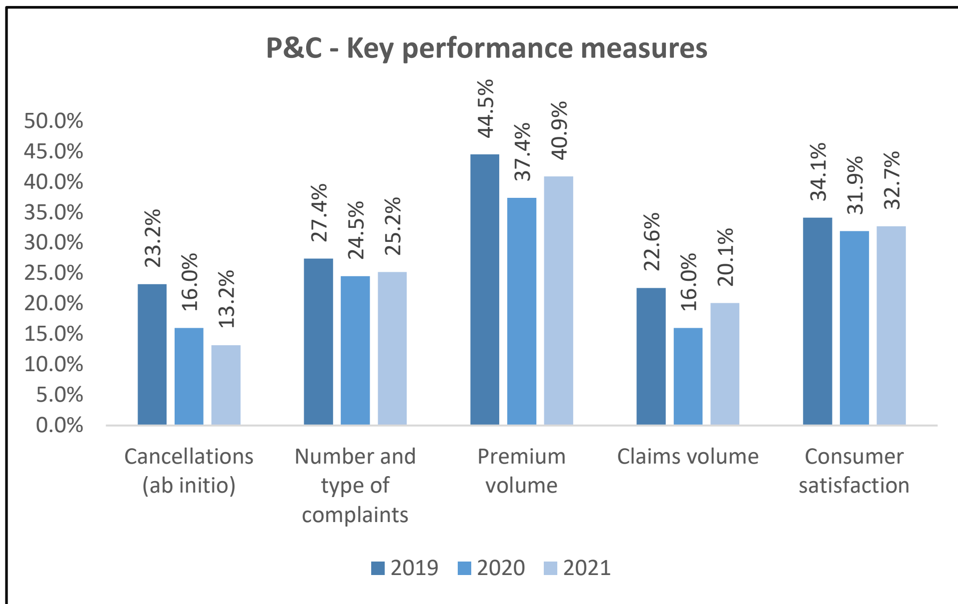
- Provides macro-level view of the insurance market, classes of insurance, commissions and claims
- Feeds data into risk assessments of classes of insurance
- Enables targeted tracking of incentive levels
- Tracks and monitors trends related to the sale of insurance through the internet

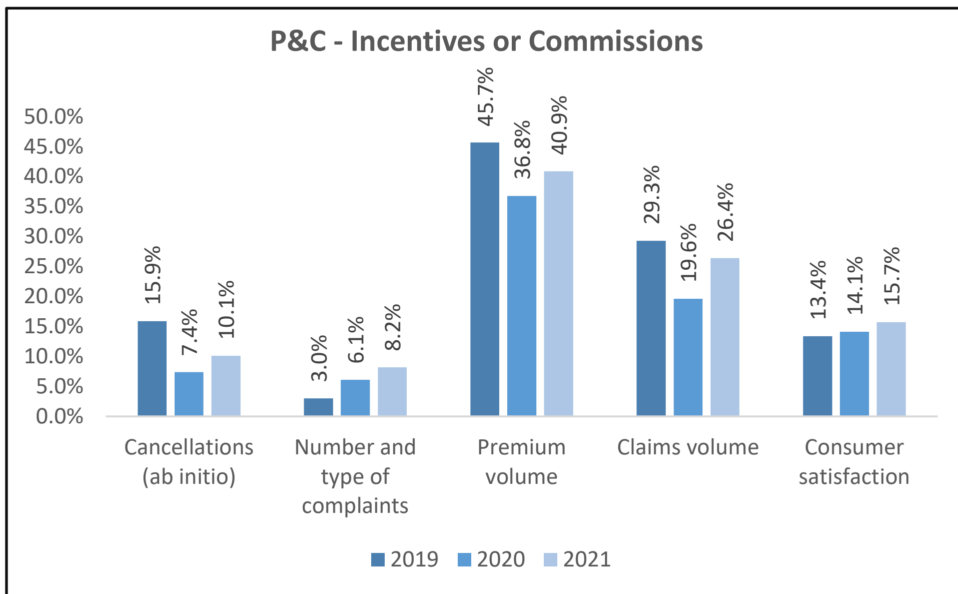
Observations on Premiums, Commissions and Claims Data

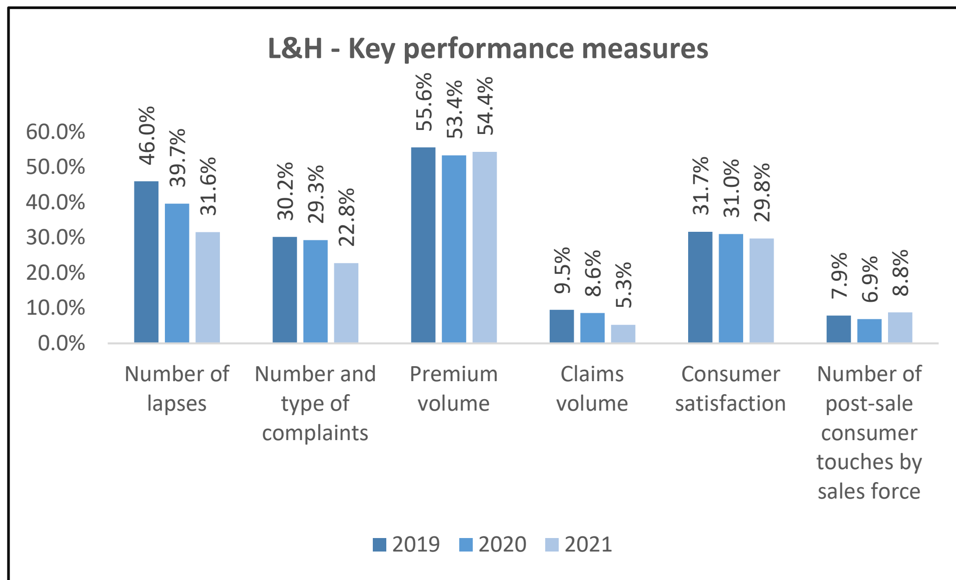
- The FTC Guidance emphasizes "minimizing the sales which are not appropriate to the Customers' needs" is an FTC outcome
- The CCIR Position Paper on Electronic Commerce in Insurance Products recommends customers purchasing insurance products electronically be given adequate information in order to ensure they are purchasing products suitable to their needs

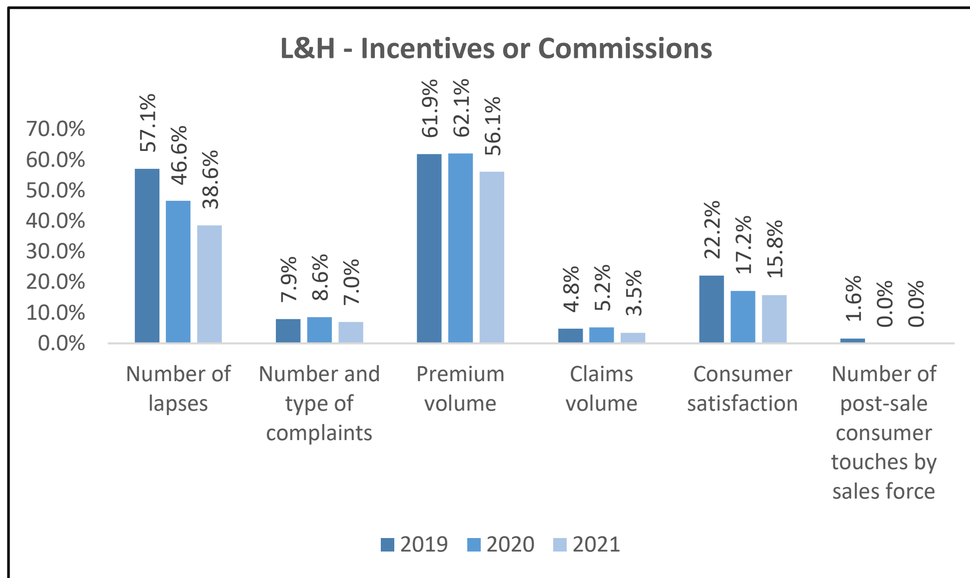
Sales and Incentives Management

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.


P&C - Key performance measures
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
23.2%
16.0%
13.2%
27.4%
24.5%
25.2%
44.5%
37.4%
40.9%
22.6%
16.0%
20.1%
34.1%
31.9%
32.7%
Cancellations (ab initio)
Number and type of complaints
Premium volume
Claims volume
Consumer satisfaction
2019
2020
2021


P&C - Incentives or Commissions
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
15.9%
7.4%
10.1%
3.0%
6.1%
8.2%
45.7%
36.8%
40.9%
29.3%
19.6%
26.4%
13.4%
14.1%
15.7%
Cancellations (ab initio)
Number and type of complaints
Premium volume
Claims volume
Consumer satisfaction
2019
2020
2021





Across both sectors, the most common form of performance measure or incentive/commission for respondents' sales force was through premium volume, which has remained consistent over the past three years. For the P&C sector, 40.9% of respondents indicated premium volume was a key performance metric for their sales force, while roughly the same percentage indicated they based incentives/commission around premium volume. In the L&H sector, 54.4% of respondents indicated premium volume was a key performance metric and 56.1% used it to determine incentives/commission.

In the P&C sector, the number and type of complaints has steadily risen as a key metric across both data fields over the past three years. In the L&H sector, the number of insurers conducting performance measures or offering incentives/commissions declined across almost all of the prescribed metrics in the Annual Report on a y/y basis.

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
- According to the proposed Incentives Management Guidance, insurers are expected to:
  - Have a governance and business culture placing FTC at the center of decisions concerning the way Incentive arrangements are designed and managed; and
  - design and implement Incentive arrangements including criteria ensuring FTC
- CCIR members noted, through their examination, that a structured incentive management program was not always in place, including a risk analysis of each type of incentive
  - The structure of incentive programs reviewed predominantly contained sales-related quantitative elements and the application of qualitative criteria based on FTC was absent or not formalized
- CCIR members have noted during examinations some insurers have inadequate supervision of their external sales force regarding conflict of interest and incentives

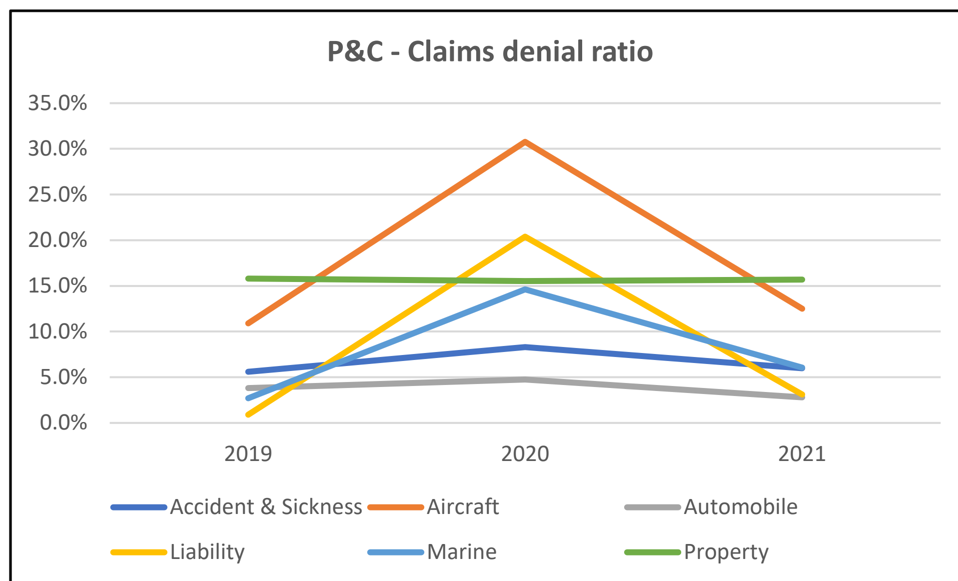
Claims

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 information helps CCIR members track adherence to the FTC Guidance's expectation for insurers to handle "claims in a timely and fair manner" and identify areas where improvements are needed in the information provided to the consumer.

Claim Denials[24] [25]

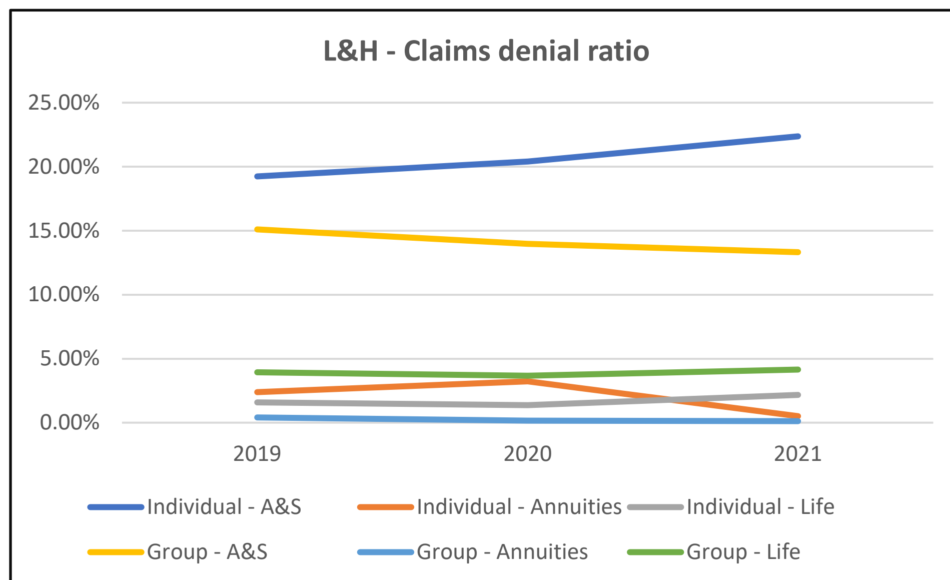
CCIR developed a claims denial ratio, which measures the amount of claims which were denied in relation to the total number of claims made.[26] [27] The ratio provides CCIR members a macro-level view of claims which were rejected based on class of insurance, or distribution channel.

For the P&C sector, claims denials declined across almost all classes of insurance, following a large spike in 2020. The greatest declines were witness in aircraft (30.8% in 2020 to 12.5% in 2021), liability (20.4% in 2020 to 3.1% in 2021), and marine (14.6% in 2020 to 6.1% in 2021). Property has remained consistently flat over the three year period.



[24] For the P&C sector, CCIR excluded Credit Protection data from the Claims Denial Ratio as the data has not reached an acceptable level of quality for two consecutive returns.
[25] Title and Legal Expense have a limited number of insurers which may cause large changes in the data from year to year.
[26] 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)
[27] A claim is considered denied if an insurer refuses to pay any amount of the claim.

The L&H sector remained relatively flat across all classes of insurance over the last three years compared to the P&C sector. There was a slight increase in individual – A&S (from 20.41% in 2020 to 22.37% in 2021), as well as a proportionally large increase in the percentage of individual – life claims being denied compared to the previous reporting period (1.37% in 2020 to 2.17% in 2021, representing an increase of over 58%). However, claim denials remained under 5% for all classes of insurance aside from individual and group A&S.



The claim denial ratio should be given special attention by insurers. Insurers should determine whether being above the 10% threshold undermines the fair treatment of consumers and, if so, they should take appropriate remediate action. This 10% rate is not a ceiling that should not be exceeded, but rather an indicator that should trigger a reflection by the insurer. The percentage of claims denied by insurers and the reasons for denial could, for example, illustrate the need to provide relevant and complete information to consumers, before and at the time of purchase, so that they can make an informed decision on the suitability of the product being offered.

A low claims ratio, alternatively, could reflect a value disparity for customers. For these products, insurers may want to consider improving or modifying the product to better meet customer needs.

Average final days to payment

For the P&C sector, the average final days to payment by class of insurance improved slightly upon the 2020 return when there were substantial increases in some lines. This reflects the classes like A&S[28], liability, and property and making improvements in paying out claims in a timely manner. Auto, which witnessed large improvements in 2020 due primarily to less claims total, returned to pre-pandemic levels.

Average final days to payment – P&C sector			
Class of insurance	2019	2020	2021
Accident & Sickness	30	106	92
Aircraft	2	9	8
Automobile	154	133	152
Legal Expense	20	14	11
Liability	218	262	253
Marine	49	72	62
Property	117	169	160
Title	8	4	7

The L&H sector, by contrast, has remained relatively flat over the past three years. The notable exception being individual – A&S in 2021 which saw a significant reduction compared to 2020 (going from 59 days on average to 24).

Average final days to payment – L&H sector			
Class of insurance	2019	2020	2021
Individual - Accident and Sickness	52	59	24
Individual - Annuities	17	21	18
Individual - Life	26	27	30
Group - Accident and Sickness	70	65	79
Group - Annuities	8	13	13
Group - Life	31	28	28

[28] There continue to be discrepancies in the data provided to CCIR through the Annual Return. Data regarding A&S claims from 2019 and 2020, for instance, has needed further refinement.

Reasons for denial

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 the P&C sector, over the past two years the main reason for denial of a claim was indicated to be 'exclusions or limitations in the policy'. In 2021, there were large increases in the number of claims being denied for lack of coverage (50.3% in 2020 to 64.8% in 2021) and 'failure to disclose or misinterpretation' (17.2% in 2020 to 27.0% in 2021). The 2021 return also indicated reductions in the number of claims being denied due to fraud (1.8% in 2020 to 0.6% in 2021), and a 'claim being abandoned by an insured' (21.5% in 2020 and 14.5% in 2021).

Three main reasons for denial of claims – P&C sector		
Reason for denial of claims	**2020**	**2021**
Exclusions and limitations in the policy	80.4%	76.7%
Delay in submitting claim	3.7%	5.7%
Not covered, except for exclusions and limitations in the policy	50.3%	64.8%
Failure to disclose or misrepresentation	17.2%	27.0%
Fraud	1.8%	0.6%
Below deductible	19.6%	9.4%
Claim abandoned by insured	21.5%	14.5%
Missing information or documentation	4.9%	6.3%

In the L&H sector, the main reason for denying a claim, like the P&C sector, was due to 'Exclusions and limitations in the policy'. Unlike the P&C sector, there were increases in the number of insurers denying claims for 'fraud' (1.7% to 2.5%) and 'claim abandoned by insured' (1.7% to 5.3%).

Three main reasons for denial of claims – L&H sector		
Reason for denial of claims	**2020**	**2021**
Exclusions and limitations in the policy	56.9%	52.6%
Delay in submitting claim	1.7%	3.5%
Not covered, except for exclusions and limitations in the policy	37.9%	33.3%
Failure to disclose or misrepresentation	22.4%	29.8%
Fraud	1.7%	3.5%
Claim abandoned by insured	1.7%	5.3%
Missing information or documentation	13.8%	10.5%
Pre-existing conditions	13.8%	14.0%
Insured not eligible	13.8%	22.8%

The reasons for denial are good indicators for insurers to realize the need to provide more relevant and complete information to consumers, before and at the time of purchase. The information enables consumers to make a more informed decision on the suitability of the product being offered.

Where applicable, insurers should create and provide tools to help consumers better understand the information that is given to them (e.g., guide, glossary or summary containing examples, explanations of terms of a more technical nature, illustrations, timeline with the various timeframes, FAQs).

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”

Observations on Claims Data

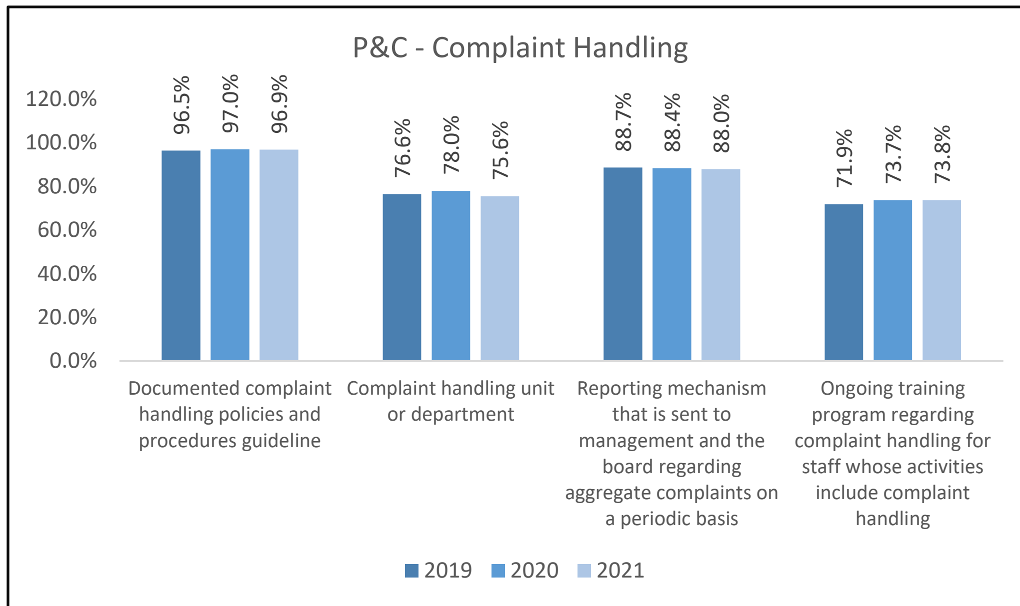
- CCIR members noted some insurers do not have adequate information about their claims process easily available to customers
- Not all insurers adequately inform customers of the reasons for a claims' denial
- The FTC Guidance expects insurers "Maintain written documentation on their claims handling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

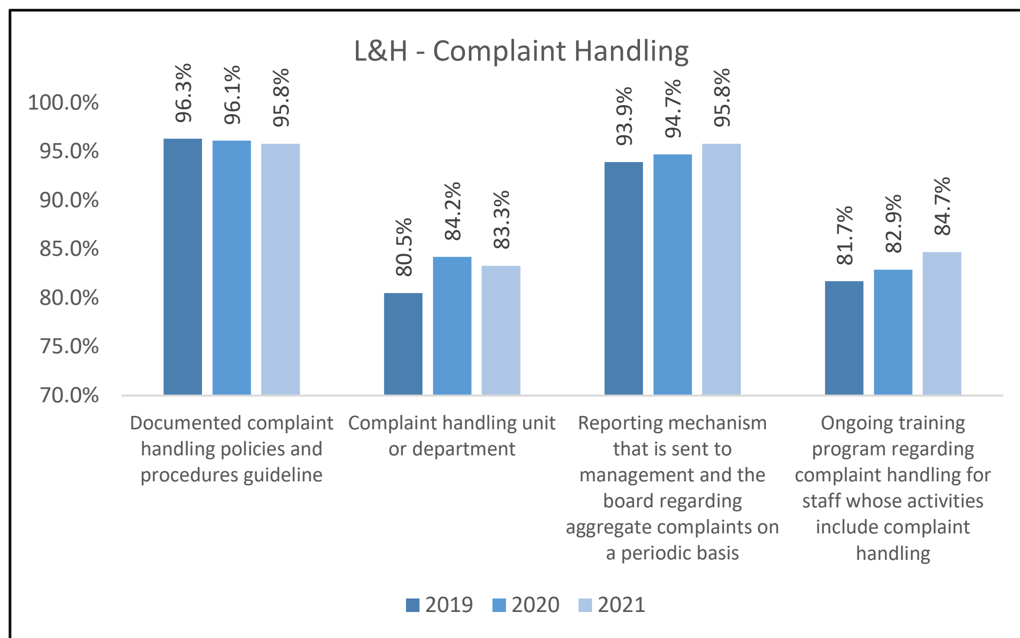
Complaint Examination

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.


P&C - Complaint Handling
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
96.5%
97.0%
96.9%
76.6%
78.0%
75.6%
88.7%
88.4%
88.0%
71.9%
73.7%
73.8%
Documented complaint handling policies and procedures guideline
Complaint handling unit or department
Reporting mechanism that is sent to management and the board regarding aggregate complaints on a periodic basis
Ongoing training program regarding complaint handling for staff whose activities include complaint handling
2019
2020
2021


L&H - Complaint Handling
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
96.3%
96.1%
95.8%
80.5%
84.2%
83.3%
93.9%
94.7%
95.8%
81.7%
82.9%
84.7%
Documented complaint handling policies and procedures guideline
Complaint handling unit or department
Reporting mechanism that is sent to management and the board regarding aggregate complaints on a periodic basis
Ongoing training program regarding complaint handling for staff whose activities include complaint handling
2019
2020
2021

For insurers active in the sale of insurance, 99.5% of P&C respondents and 100% of L&H respondents indicated they have a "senior officer responsible for complaints handling'". The insurers who answered in the affirmative were also asked what complaint handling elements were present within their organization. 96.9% of P&C respondents and 95.8% of L&H respondents indicated they have a "documented complaint handling policies and procedures guideline". This represents flat results in both sectors over the three-year period. The P&C sector across all four metrics has remained relatively flat over the three-year period. The L&H sector has made steady improvement in the number of respondents indicating they have a "reporting mechanism sent to management and the board regarding aggregate complaints on a periodic basis" and offer "ongoing training program regarding complaint handling for staff whose activities include complaint handling".

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 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 notes that complaints handling policies and procedures were not always simple, accessible, and complete

Complaints

Insurers are required to file all applicable complaints which meet the standards established through the Annual Statement[29]. For Annual Statement reporting purposes, complaints to be reported are those who 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	12.8%	7.2%	11.6%
British Columbia	13.9%	11.6%	13.7%
Manitoba	1.2%	1.9%	3.6%
New Brunswick	2.4%	1.7%	2.1%
Newfoundland and Labrador	1.1%	1.8%	1.4%
Northwest Territories	0.1%	0.1%	0.1%
Nova Scotia	2.1%	2.3%	2.6%
Nunavut	0.0%	0.0%	0.1%
Ontario	49.2%	33.0%	38.8%
Prince Edward Island	0.1%	0.2%	0.4%
Quebec	16.0%	37.7%	22.5%
Saskatchewan	0.6%	1.5%	3.1%
Yukon	0.1%	0.1%	0.1%
Not Classified	0.3%	1.0%	N/A

The overall number of complaints dropped by 12.8% in the P&C sector and increased 9.7% in the L&H sector compared to the 2020 Annual Return.

A disproportionate number of complaints originated in Ontario for the P&C sector, the majority of which are in the automobile class of insurance, however for the second consecutive year there was a substantial decrease in Ontario's share of P&C complaints (49.2% in 2021 decreasing

[29] 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.

from 54.4% in 2020 and 61.4% in 2019). BC continued to see its proportion of complaints grow in the P&C sector, increasing to 13.9% in 2021 compared to just 9.8% in 2020.

Quebec continues to have a disproportionate number of complaints in the L&H sector, though the percentage of complaints originating in Quebec declined on a y/y basis (going from 39.9% in 2020 to 37.7% in 2021).

In the P&C sector, complaints continued to decline in auto as a percentage of total complaints. This may be due to a reduction in the frequency of claims tied to less kilometers driven as a result of the Covid-19 pandemic. The number of property related complaints remained steady from the previous year, but was still significantly higher than 2019. The percentage of complaints in A&S continued to increase, reaching 6.8% of all complaints, while the class only represents about 1.5% of the DWP in the P&C sector. The travel health segment of A&S is responsible for driving complaints in the class, representing 6.0% of all complaints made in the P&C sector.

The most common cause of complaints in the P&C sector continues to be related to claims/settlements. Like 2020, ‘refusal of claim’ was the largest percentage of complaints, representing 22.9% of all complaints made in the sector, followed closely by ‘claim procedure’ with 21.0%.

Breakdown of complaints percentage by class of insurance			
Class of Insurance	**2019**	**2020**	**2021**
Accident & Sickness (Total)	1.6%	3.9	6.8%
Automobile	62.5%	51.5%	46.5%
Credit Protection	0.3%	0.6%	0.4%
Liability	1.5%	1.7%	2.0%
Marine	0.1%	0.1%	0.2%
Property	30.3%	38.6%	37.9%
Title	0.8%	0.5%	0.7%

In the L&H sector, individual complaints represent around 36.2% of all complaints, compared to 63.8% in group. For individual complaints, the majority (57.7%) of complaints originate in the life class, followed by 33.5% in A&S. The most common causes of complaints in individual classes are in the claims/settlement category, representing 33.6% of all complaints, followed by product based complaints (26.6%) and administration (25.1%). Similar to 2020, the most common cause of complaint in individual classes was ‘refusal of claim’ which represented 24.1% of all complaints made, followed by ‘policy provisions’ (11.2%).

In the group classes, the vast majority of complaints are made in the A&S sector, which has driven complaints over the past three years, increasing its total share of complaints over the period. Critical illness (with 33.8% of complaints) and health and dental (33.3%) are the leading sub-classes of insurance within A&S contributing to the high number of overall complaints. 'Refusal of claim' is also the largest driver of complaints for the group classes, but it has a much higher percentage of total complaints, representing 53.5% of all complaints made.

Breakdown of complaints percentage by class of insurance - Individual			
Class of Insurance (Individual)	**2019**	**2020**	**2021**
Accident & Sickness	28.3%	37.2%	33.5%
Annuities	3.3%	2.1%	1.9
Guaranteed Investment Account (GIA)	0.2%	0.4%	1.2%
Life	58.3%	51.9%	57.8%
Segregated Funds	7.2%	8.2%	5.7%

Breakdown of complaints percentage by class of insurance - Group			
Class of Insurance (group)	**2019**	**2020**	**2021**
Accident & Sickness	78.9%	85.1%	90.3%
Annuities	1.5%	1.5%	0.2%
Guaranteed Investment Account (GIA)		0.2%	0.1%
Life	12.5%	11.8%	8.6%
Segregated Funds	0.4%	1.3%	0.8%

How CCIR Members Utilize Complaints Data

- Helps to assess risks and highlight risk indicators to aid in selecting risk-based examinations
- Verifies how FTC principles are implemented and operationalized during examinations
- Monitors macro-level complaint trends

Observations on Complaints Data

- CCIR members have noted that all the complaints meeting the definition of a complaint weren't filed in the Annual Statement. 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
- CCIR noted that many insurers' reporting of complaints was still not being done in accordance with the Annual Statement requirements

CONCLUSION

CCIR members find increasing value in the Annual Statement every year. With each subsequent reporting period, CCIR finds the overall quality of data is improving. With multi-year trending, CCIR can better track new developments in the P&C and L&H sectors, as well as identify potential areas of concern.

CCIR members continue to see value in making data available to the sectors and the general public through this public report. Through the report and CCIR's commitment to harmonized, co-operative examinations and messaging, CCIR believes the industry is showing signs of improvement and commitment to achieving positive outcomes for consumers. As is noted in the report, however, there are still several areas for improvement. CCIR encourages insurers to examine the results of this report closely, benchmark their organization's results with the results of the industry as a whole and take the actions required to meet CCIR members FTC expectations.

Classification: Protected A

Appendix 1 – Key FTC Performance Indicators

FTC Governance Key Indicators	
Focus area	**Example indicators**

Claims	• Claims volumes and amounts
	• Claims outcomes or status such as whether registered, pending, denied, accepted or withdrawn
	• Claims ratio[30]
	  • Refusal claim rate (Number of claims refused / Number of claims processed)
	  • Retention rate of claims decisions / number of claims reviews
	• Reasons for claims not being paid or delayed
	• Average days to final payment and global claims closed delay in treatment of a claim

Policies/Certificates, premiums and persistency, renewals and alterations	• Change in number of policies / certificates • Lapse[31] and cancellation rates [32]or persistency[33] ratio • Total benefits paid and incurred / premiums written • Renewal ratio[34] • Reasons for poor persistency • Proportion of cancellations post a certain period eg free-look or time tranches, churn and replacement rates
Complaints	• Overall complaint volumes • Complaints broken down by issue, status/resolution outcome or by channel and product line • Complaint rates[35]

[30] Claims ratio: measures how much the insurer is paying out in claims relative to the premium.
[31] Lapse rate: measures the number of policies discontinued due to non-payment of premiums by the policyholder relative to the total number of policies at the beginning of the period.
[32] Cancellation rate: measures the number of policies proactively cancelled (i.e., during the policy term) either by the insurer or the policyholder relative to the total number of policies. Sometimes cancellation rate is differentiated according to cancellation by the policyholder vs the insurer.
[33] Persistency ratio: the ratio of policies that have not lapsed, been cancelled/surrendered, matured or terminated upon claim at the end of a given period relative to the total number of policies at the beginning of the period (minus those which have matured or terminated upon claim) which shows the business that the insurer can retain.
[34] Renewal ratio: measures the number of renewed policies in a period relative to the total number of policies at the beginning of the period.
[35] Complaint rate: A complaint rate measures the number of complaints relative to the total number of policies in force. Complaint rates can be further disaggregated to provide more targeted insights, for example complaints that are still outstanding relative to the total number of complaints received, complaints resolved in favour of the consumer relative to the total number of closed complaints etc.

	• Complaint reasons • Dispute numbers and rates[36]
Pricing & cost structure - fees, commissions, Expenses, incentives	• Combined ratio[37] • Expense ratio[38] • Amount of commission and non-commission fees • Incentives aligned or not on the FTC principles put in place by the insurers
Product design and selling practices	• Surveys results (consumers and distribution channels surveys, Focus groups, etc.)
Customer satisfaction	• Surveys results
Insurers' internal policies and practices	• Implementation of the Fair Treatment of Customers (FTC) policy and the FTC performance of the insurer • FTC code respect through the organisation • FTC Reviews or audits conducted results and action taken when appropriate • FTC Quality control results • Protection of the personal information performance and breaches
Others	• Advertising channels and practices • Outsourcing

[36] Dispute rate: 'dispute' can refer to the specific type of complaint when a consumer does not agree to the terms of a claim settlement that has been decided by the insurer and raises the disagreement through the appropriate dispute resolution system. The dispute rate then measures the number of claims disputed relative to the number of claims finalized.
[37] Combined ratio: shows the underwriting profit or loss before taking investment income into account.
[38] Expense ratio: shows the insurer's cost of business relative to its revenue from gross written premiums.

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