FSRA
Financial Services Regulatory Authority of Ontario

Ontario

www.fsrao.ca

Home Insurance Thematic Review Report

June 2024

25 Sheppard Avenue West
Suite 100
Toronto ON
M2N 6S6
Telephone: 416-250-7250
Toll free: 1-800-668-0128

25, avenue Sheppard Ouest
Bureau 100
Toronto (Ontario)
M2N 6S6
Téléphone: 416-250-7250
Sans frais: 1 800 668-0128

Executive summary

Home insurance plays an important role in protecting one of the most valuable assets many Ontarians will own. Having adequate home insurance coverage provides peace of mind and protection for homeowners and renters in cases of loss, damage, or theft.

FSRA identified Property & Casualty (P&C) insurance as a priority supervision area to ensure Ontario consumers are treated fairly. See FSRA's 2023-26 Statement of Priorities for key deliverables and planned outcomes. FSRA takes a risk-based and evidence-informed approach to supervision. This thematic review is an important example of FSRA's proactive approach to supervision in the P&C insurance sector.

Market intelligence gathering suggested that consumers were experiencing service delays in the adjustment and settlement of home insurance claims. Coupled with increased pressure on P&C insurers due to rising claim costs, inflation, and supply chain issues, FSRA initiated the thematic review with a focus on home insurance claims to better understand the customer claim journey.

FSRA reviewed home insurance claims practices of the top 20 insurance companies writing personal property insurance in Ontario. These companies represented 97% of the market share in 2021, based on direct written premiums. The data was self-reported and not independently verified by FSRA.

Based on the data submitted by insurers for the review period of 2019 to 2022, FSRA has identified potential areas of risk to consumers. These key findings are:

- varying duration for resolution of claims between insurers
- inconsistent use and tracking of proof of loss forms
- lack of demonstrated oversight of adjusters
- lack of tracking and reporting of reasons for claim denials
- inconsistent and inadequate consumer communication

FSRA expects insurers to treat consumers fairly in accordance with established FTC principles. Additionally, insurers are expected to adhere to regulatory requirements. FSRA's Home Insurance Thematic Review identified areas of opportunity for insurers to enhance their claims handling practices in support of fair treatment of customers.

FSRA will integrate the information gathered in this review to support future supervision initiatives. In addition, FSRA may seek to validate the information provided in this review and confirm that insurers have reviewed and, where necessary, revised their claims handling and other practices against the areas of opportunity identified in this report during future supervisory activities. Finally, the outcomes of the review will inform the development of FSRA's Market Conduct Supervision Framework for P&C Insurance and will further assist FSRA in assessing priority areas for supervision in the sector.

Part one: Setting the stage

1. Principles based regulation and fair treatment of customers

FSRA's objects establish its purpose as a regulator and help to guide outcomes-focused, principles-based supervision and regulation of the financial services sector. The objects include:

- promoting high standards of business conduct,
- promoting transparency and disclosure of information,
- promoting protection of the rights and interests of consumers, and
- deterring deceptive or fraudulent conduct, practices, and activities.

FSRA applies a principles-based approach toward regulation, which means moving away from reliance on detailed, prescriptive rules toward high-level, broadly stated principles to set expectations for market conduct. The key principle in market conduct supervision is the fair treatment of customers. Principles-based regulation (PBR) requires that insurers have systems, processes, policies, data, reporting, and culture to act consistently and in a

manner that supports the fair treatment of customers. It requires that senior management and boards of insurers and the regulator are satisfied that the organization is achieving the desired outcomes. Ensuring fair outcomes for customers helps to protect the public interest by enhancing trust and confidence in the Property & Casualty (P&C) Insurance sector.

FSRA utilizes risk assessments of its regulated sectors to better understand trends, as well as identify emerging risks and potential harms that may impact consumers. This risk-based approach allows FSRA to focus its supervision resources on the areas of greatest potential for consumer harm.

FSRA considers an insurer's compliance with the *Insurance Act* (Ontario), its regulations, as well as the FSRA Rule *Unfair or Deceptive Acts or Practices* ("UDAP"). As a principles-based regulator, the UDAP Rule is aimed at making the supervision of insurance more transparent, dynamic, and flexible. It contains specific provisions that explicitly prohibit insurers and intermediaries from engaging in conduct that does or could lead to unfair treatment of customers, such as matters related to unfair claims practices.

FSRA internal principles, processes and practices are consistent with FSRA Approach Guidance No. GR0008APP, *Fair Treatment of Customers in Insurance*, (FTC Guidance) in which FSRA indicates it will use 'Guidance: Conduct of Insurance Business and Fair Treatment of Consumers adopted jointly by the Canadian Council of Insurance Regulators (CCIR) and the Canadian Insurance Services Regulatory Organizations (CISRO), to supervise the conduct of insurers, and other entities FSRA regulates under the Insurance Act (Ontario), with respect to the fair treatment of customers.

As part of our supervision work, FSRA considers whether insurers follow the FTC Guidance in setting and maintaining business policies and practices that are effective in ensuring fair treatment of customers. While FSRA expects compliance with the FTC Guidance, since the FTC Guidance is principles-based, licensees have latitude to determine how best to achieve the expected outcomes, and reasonably demonstrate the application of the principles in ways appropriate to the nature, size and complexity of their business operations and activities.

2. Risk-based, evidence informed approach supervision

In carrying out conduct supervision, FSRA relies on the collection of data, market intelligence and risk analysis to make evidence based and informed decisions. Information and data are key to FSRA's supervision approach, and FSRA must collect sufficient evidence and data to identify potential risks. FSRA can utilize a variety of supervisory tools to assess the conduct of insurers which include Insurance Act, Regulations, FSRA Act, Fair Treatment of Customers (FTC), FSRA Rules and Guidelines as well as the UDAP Rule.

3. Home insurance thematic review purpose and approach

Home Insurance is a type of property insurance that covers loss and damage to an individual's residence and its contents as well as personal liability coverage. The insurance covers the owners or tenants for unforeseen losses in the residence or on the property. It is considered by many to be an essential insurance coverage for Ontario homeowners and tenants. There are limited legislative requirements regulating this coverage and products are complex, with policy wordings/endorsements varying by insurer.

In 2023, FSRA conducted the Home Insurance Thematic Review focusing on home insurance claims. The purpose of the review was to identify the greatest risks for consumer harm in home insurance and inform FSRA of other potential issues in P&C insurance (for example, insurer's outsourcing arrangements for activities such as distribution and claims management). In May 2023, FSRA sent a Home Insurance Questionnaire to 20 P&C insurers representing approximately 97% of the market share for P&C personal property insurance direct written premiums in 2021. As such, FSRA is of the view that the observations set out in this report are reflective of P&C insurance industry practices in Ontario.

The Home Insurance Thematic Review encompassed claims related to property, contents, and personal liability of homeowners and renters, therefore directly impacting the outcomes for consumers at the time of loss. The review excluded home warranty and product warranty.

FSRA gathered information from 2019 to 2022 covering the following areas:

- length of claim cycle
- denials of claims and what type of claims are denied
- claims procedures
- proof of loss
- policies and procedures, management oversight, and file maintenance
- complaint handling processes specific to escalations, and
- outsourcing of claims handling by insurers to adjusters licensed under the Insurance Act (Ontario) (“independent adjusters”).

For the purposes of the review, a claim is:

- opened or reported when the insurer opens the claim file
- considered denied if the insurer refuses any amount of the claim (In these cases, no indemnity payment is made but payment of certain fees -- expert fees, claim adjuster fees, etc. may be made. Partial denials were excluded.), and
- closed when the final payment is transmitted to the insured.

Prior to the thematic review being launched, FSRA engaged stakeholders, including multiple insurers and industry groups, regarding the approach and the data which FSRA was requesting through the questionnaire. The questionnaire sent to insurers was aligned with some of the data sought at a national level through the CCIR Annual Statement on Market Conduct (ASMC) to leverage data already being tracked by insurers and limit burden.

It should be noted that while 20 P&C insurers were selected for this review, only 19 wrote home insurance policies during the survey period. As such, the results reported herein are from 19 insurers. Of the 19 insurers who responded to the survey, some reported separately the information from their group of companies, and these have been amalgamated for data analysis purposes. In some cases, FSRA conducted follow up interviews with the insurers to gather additional context on the information reported. The results were self-reported by the insurers and have not been independently verified by FSRA.

The review was aligned with FSRA's 2023/2024 priority to ensure the fair treatment of customers in the P&C industry. It provided FSRA with current data and market intelligence regarding home insurance claims in Ontario. In addition to the next steps identified in this report, the observations from the review will support the establishment of a supervisory framework for the non-auto P&C sector.

Part two: Key findings and FSRA expectations

The key findings below outline the information self-reported to FSRA by the insurers surveyed and interviewed under the Home Insurance Thematic Review. FSRA encourages insurers to utilize the data in this report as a point of reference to improve their claims practices and assess and align their policies and procedures with industry standards and FSRA's expectations.

The 5 key findings are:

- varying duration for resolution of claims between insurers
- inconsistent use and tracking of proof of loss forms
- lack of demonstrated oversight of independent adjusters
- lack of tracking and reporting of reasons for claim denials
- inconsistent and inadequate consumer communication

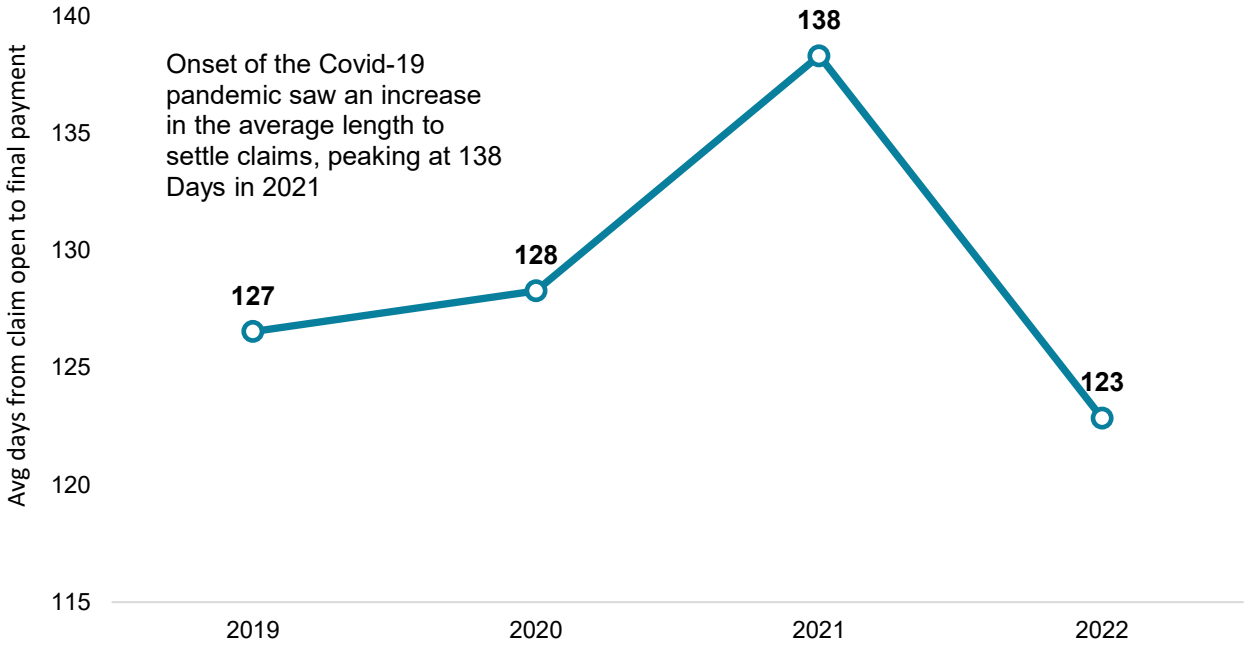
From the responses received by FSRA, it is evident that insurers are working to provide fair resolutions to consumers with home insurance claims. However, there are also areas of opportunity to improve their claim-handling practices and support better outcomes for consumers. Details on each of these areas are set out below.

Key finding 1:

Varying duration for resolution of claims between insurers

Based on analysis of data collected for years 2019 – 2022, it was observed that in 2019, the average number of days to settle a home insurance claim was 127 days. The average settlement peaked at 138 days in 2021, as indicated in Table #1 below.

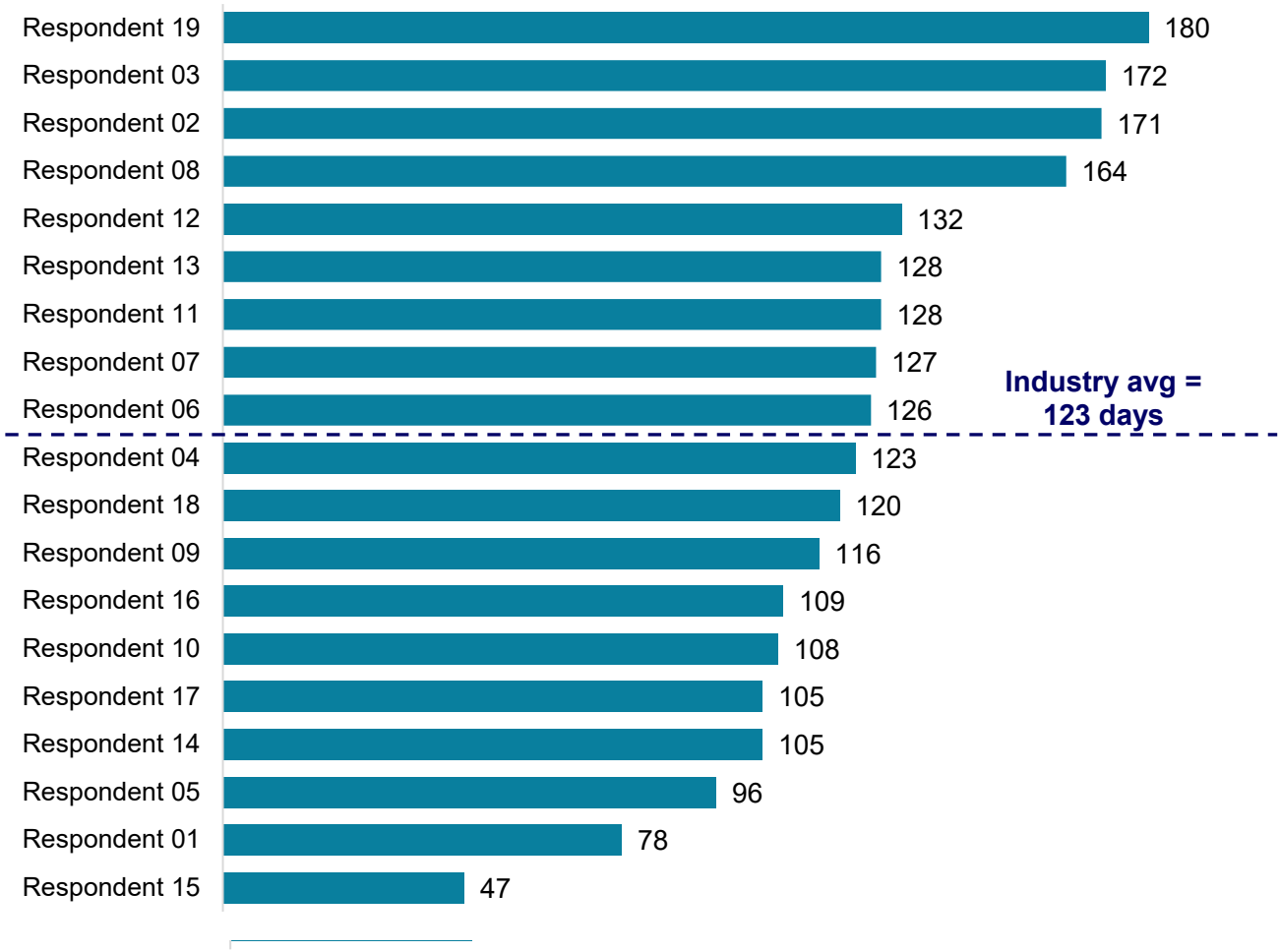
Table # 1 - Average days from opening claim to final payment (all insurers)



The year 2021 stands out as an anomaly. It was the first post-pandemic year which imposed unprecedented challenges on the industry related to the pandemic. It was characterized by the reopening of businesses and lingering supply chain challenges, which prolonged the settlement of claims compared to other years. In 2022, there was a reversal in this upward trajectory and there was a modest improvement in average settlement days to 123. This may indicate a positive sign that industry is adapting and working towards addressing ongoing challenges. It is imperative for insurers to continue to enhance claim handling procedures to ensure that homeowners receive timely resolution to their claims.

Table #2 below, illustrates the time intervals reported to settle claims by insurer and is based on individual insurers for the year 2022.

Table # 2 - Average days from claim open to final payment (2022)



FSRA conducted further analysis for data from 2022 as this was the most recent data collected. It was observed that the average number of days reported, from a claim being opened to final payment, was 123 days. The chart shows there is a significant variation in the time insurers require to settle claims. On average, the duration to resolve claims in 2022 ranged broadly from as long as 180 days to as short as 47 days. Longer durations to resolve claims can put financial strain on customers who are relying on indemnity payments for recovery.

FSRA initiated follow up interviews with select insurers to better understand the reasons behind the varying times in claim settlement duration. This was partially attributed to factors such as supply chain disruptions, catastrophic events, and a shortage of skilled labour. Additional factors encompass scarcity of insurer staffing, large complex losses, extended duration of liability claims, and claims necessitating further investigation, such as suspicious and fraudulent claims.

FSRA was made aware that some insurers faced challenges in extracting the final indemnification payment date (a claim is closed when the final payment is transmitted to the insured) versus the final expense payment. In such cases, even after issuing a final payment to the insured, the file remained open until a separate payment was issued to a third-party vendor (adjuster fees, expert fees, etc.). This issue arises from reporting limitations within insurers claim systems.

FSRA's expectations

FSRA expects all P&C insurers in Ontario to be prepared to support their customers in an ever-changing landscape. FSRA urges insurers to review and improve their claims handling practices to optimize their processes and reduce the potential for consumer harm. Establishing target timelines for claims processing and benchmarking performance to those targets and the industry average would be a positive step to ensure that prompt settlement of claims remains a key deliverable. It is imperative for insurers to continue refining claim processes to meet consumer expectations and ensure that homeowners receive timely resolutions to their claims.

Insurers should maintain written documentation on their claims handlings procedures including timeframes. An adjuster or insurer not providing a claimant timely, clear, comprehensive, and accurate information about the status of a claim is reasonably expected to result in the outcome set out in s. 5(1) of the UDAP rule. This is also consistent with the FTC Guidance, regarding claims settlements. FSRA encourages insurers to communicate to consumers if claims settlement timeframes are being extended due to exceptional circumstances.

Key finding 2:

Inconsistent use and tracking of Proof of Loss forms

A proof of loss (POL) is a formal declaration provided by the claimant, detailing facts about a loss in a format specified by the insurer. While many insurers typically distribute POL forms at the onset of a claim, they often lack consistent tracking of completed forms. Some insurers send blank POL forms for every claim but do not require it to be completed as part of the claims process in all circumstances. Based on discussions with insurers, POL is typically requested for losses involving theft, potential fraud, large losses, or disputes etc. in claim settlements. Insurers expressed that they use POL to ensure transparency, thoroughness, and fair treatment in handling claims.

FSRA's expectations

Regardless of whether insurers advise claimants that the POL is not required on their claim, FSRA expects that consumers are treated fairly. An insurer failing to follow claims procedures which are fair, simple, and accessible is reasonably expected to result in the outcome set out in s. 5(1)(v) of UDAP. This includes providing a proof of loss to a claimant as required by the *Insurance Act* (Ontario). In accordance with the FTC Guidance, FSRA expects that claimants are informed about procedures, formalities, and common timeframes for claims settlement.

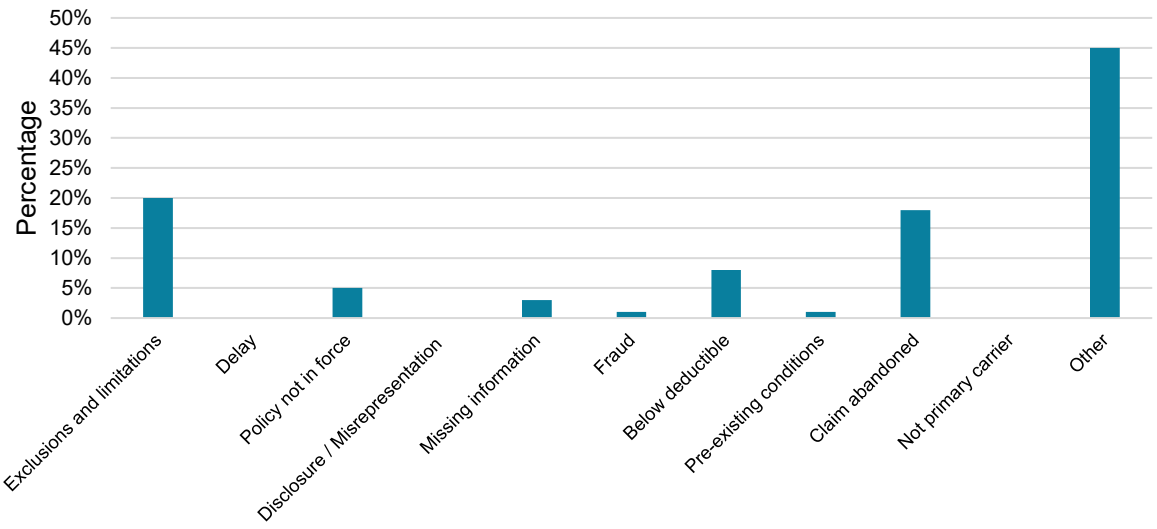
Key finding 3:

Lack of consistent tracking and reporting of reasons for claim denials

Among the surveyed insurers, 16% did not provide data for claim denials due to system limitations. Based on the data submitted, the most common reasons for denials in 2022 were (see illustration in Table #3):

1. Other (45%)
2. Exclusions and limitations (20%)
3. Claim abandoned (18%)
4. Below deductible (8%)
5. Policy not in force (5%)

Table # 3 - Reasons for claim denial (in 2022)



Other

In 2022, the classification of “Other” for claim denials accounted for approximately 45% of denials based on the data reported. The remaining insurers either did not provide any information on claim denials or reported no denials under “Other.” In subsequent interviews, the companies provided various factors to explain the large number of claims categorized as "Other," including:

- limitations in reporting, such as lacking fields to consistently capture data,
- data fields meant for detailed reporting and tracking were not consistently utilized because they were not mandatory in the insurer's claim process, and
- duplicate claims opened in error were closed under the "Other" category.

Based on the information collected from insurers, there are potential gaps in the claims tracking and reporting systems of insurers, with a large volume of claims classified as “Other.” Further, from discussions with insurers, these potential gaps may stem from deficiencies and possible inadequacies in both systems and staff training.

Exclusions and limitations

As depicted in Table #3, approximately 20% of reported claim denials were under "Exclusions and Limitations" in policies. Insurers noted water damage as a common exclusion in home insurance policies. In addition, insurers noted that issues like mold-related problems may have limited coverage, and wear and tear are typically excluded to emphasize homeowners' upkeep responsibility. The number of claims denied because of exclusions and limitation may indicate a need for further consumer education at point of sale regarding policy terms and endorsements.

FSRA’s expectations

Claim denials are a key market conduct metric. Monitoring trends in claims denials can assist insurers in promptly identifying business practices that may create potential for consumer harm. FSRA expects transparent customer communication, including upfront

disclosure of all relevant policy information. FSRA recommends that insurers evaluate their operations for gaps in tracking and reporting claim information, including denials, and the impact of that a lack of information may have on decision-making to support the fair treatment of customers.

An insurer or independent adjuster can better demonstrate that it is treating its claimants reasonably and fairly and not achieving the outcomes in s. 5(1) of UDAP if the insurer or independent adjuster: (a) retains information that allows it to explain the reasons for its decisions and (b) provides the claimant with timely, clear, comprehensive and accurate information about a decision made respecting the claimant's claim in accordance with s. 5(1)(vi) of UDAP. In accordance with the FTC Guidance, FSRA expects claims to be examined diligently and fairly settled, using a simple and accessible procedure.

Key finding 4:

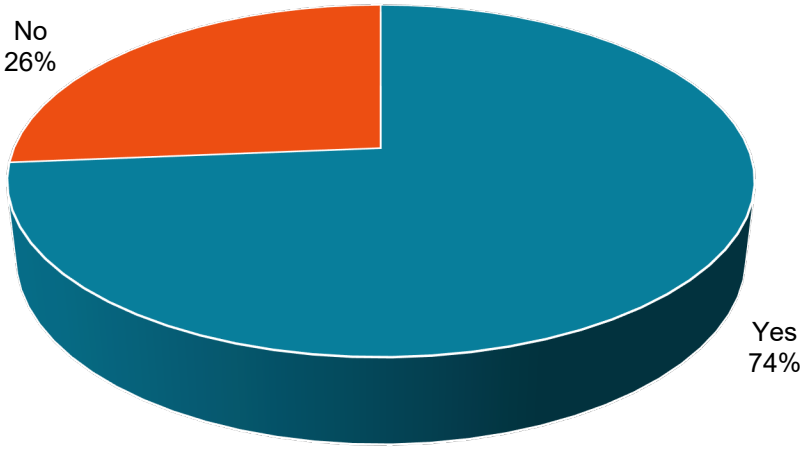
Lack of demonstrated oversight of Independent Adjusters

Based on the review of the data submissions from insurers, it was noted that most insurers use independent adjusters to varying degrees. The general reasons for the use of independent adjusters are:

- to meet capacity requirements and shortage of in-house staff,
- to service geographical areas where the insurers do not have nearby staff,
- to provide strong and convenient claims experience for customers and to uphold claims service standards, and
- to deal with large losses that are better suited for in-person visits depending on the loss and location of loss.

Based on interviews with the surveyed insurers, FSRA observed that some insurers do not have processes in place to effectively demonstrate oversight of independent adjusters. Additionally, FSRA identified that approximately 26% of insurers surveyed did not have service level agreements (SLAs) with independent adjusters.

Table # 4 - Insurer service level agreements with independent adjusters



The lack of service-level agreements and reviews/audits of independent adjusters may be an indicator of insurers lacking internal controls to ensure business and claims processes support the reasonable and fair treatment of consumer insurance claims as required under s. 5(1) of UDAP.

Lack of proper oversight procedures may lead to:

- delays in claim processing due to undefined timelines,
- inconsistent service quality without mechanisms for ensuring consistency,
- limited accountability for adjuster performance, potentially leading to poor service, and
- increased customer dissatisfaction from poorly handled claims.

FSRA's expectations

Insurers are ultimately accountable for ensuring the intermediaries they outsource to, including adjusters, comply with regulatory requirements. Outsourcing and/or delegating functions to independent adjusters does not discharge insurers of their regulatory obligations. Unreasonable or unfair resolution or delay in the adjudication, adjustment or settlement of any claim is reasonably expected to result in the outcome set out in s. 5(1) of the UDAP rule. An insurer's lack of compliance oversight to ensure obligations are being met by independent adjusters is reasonably expected to result in the outcome set out in 5(1) of UDAP. SLAs are one of the ways insurers can safeguard better outcomes for consumers and support compliance with its obligations under UDAP. As set out in the FTC Guidance, when outsourcing functions, insurers should retain full responsibility for those outsourced functions and monitor them accordingly.

Key finding 5:

Inconsistent and inadequate consumer communication

FSRA's review revealed varying processes and procedures among insurers for communicating with consumers. Communication methods included insurers opting for email while others utilized telephone conversations with a written follow up via mail. Some insurers also have portals to assist with consumer communication.

Additionally, based on follow-up meetings and questionnaire data, insurers also have varying processes for notifying claimants of next steps upon denial of a claim. While some insurers outline the claims dispute process in denial letters, others refer policyholders to their website. Some insurers were not able to demonstrate processes to effectively communicate to consumers, the avenues available if the consumer is not satisfied with an insurer decision or claim outcome.

FSRA's expectations

Regular and consistent communication between the insurer and the claimant to ensure consumer awareness of the claims process will support fair treatment of consumers. FSRA encourages insurers to provide consumers with information with respect options for next

steps should they be dissatisfied with the claim outcome or insurer decision. Providing dispute resolution options upon claims denials will support transparency and improve consumer outcomes. Any insurer and adjusters not following fair, simple, and accessible claims handling is reasonably expected to result in the outcome set out in s. 5(1)(vi) of UDAP rule. Per FTC Guidance FSRA expects insurers to examine complaints diligently and fairly, using a simple and accessible procedure.

Part three: Additional observations

Navigating catastrophic (NatCat) claims

During discussions with FSRA, insurers outlined various innovative approaches to support prompt payment of claims and support fair treatment of consumers for NatCat claims. Some insurers have formed dedicated catastrophe response teams with specialized adjusters, equipped for rapid deployment post-catastrophe. These teams use streamlined, automated procedures for quick damage assessment, loss estimation, and fair compensation determination tailored for such events, excelling in efficiently managing large volumes of NatCat claims and leveraging advanced technology for faster processing.

External factors may impact claims handling and present challenges to insurers, including securing contractors and experiencing supply chain disruptions. Insurers need to strike a balance between efficiency and due diligence to maintain sound financial health and integrity of their operations while ensuring customers are treated fairly. With catastrophic events increasing in severity and frequency, insurers must accept this as the “new normal” and prioritize fair customer outcomes.

Customer satisfaction surveys

Based on the reported information, many insurers send customer satisfaction surveys once a claim is resolved. Some insurers stated that surveys are not sent to claimants whose claims are denied. Insurers may consider sending out surveys to all customers, rather than excluding those whose claims are denied. A broader pool of respondents will serve to enhance insights into the customer experience to assist in continuous improvement in the claim handling process.

Recruit, develop, and retain staff

Shortages of qualified staff can lead to longer claim processing times, gaps in effective claims handling and poor customer outcomes. During the review and in follow up meetings, insurers pointed to challenges facing the P&C industry related to recruitment and retention of skilled staff. Insurers outlined efforts being undertaken to mitigate these challenges. These include recruitment and retention efforts for claims staff, increasing training and feedback for staff, and building a broader network of independent adjusters.

FSRA acknowledges insurers' recruitment efforts to address staffing issues and ongoing efforts in this area. Additionally, insurers are encouraged to continue to adapt and improve their claims management capacity and processes to account for a more challenging claims environment.

Part four: Messages for consumers

Outside of auto insurance, home insurance may be the most impactful insurance coverage that many Ontarians buy. It is important for consumers to prioritize safeguarding their property through well-informed insurance decisions. Below are some steps that consumers can take.

Explore different insurers to get the best value: Do your research and work with your agent or broker to learn about home coverages and pricing before making a policy purchase. Obtaining quotes from multiple insurers enables comparison of coverage options and prices.

Understand your coverage options: Learn how your home insurance policy works and what is covered in the policy. FSRA has developed tips for Helping you navigate property insurance, offering an array of crucial questions to contemplate before acquiring property insurance. It is especially important to be aware of any exclusions as property policies and coverages may differ from one insurer to another.

Review your policy: Regularly review your home insurance coverage by contacting your insurer, agent, or broker to ensure it aligns with your evolving needs and circumstances through adequate coverage and appropriate endorsements.

Understand the claim process: Familiarize yourself with the procedures for filing a claim and ensure you understand your insurer's claim dispute process and your rights if you disagree with your insurers' final position.

Part five: Conclusion and next steps

In recent years, the Canadian insurance market has been impacted by new challenges including COVID-19 pandemic, aging infrastructures, and climate change. The P&C insurance industry will continue to experience a dynamic environment where robust underwriting and assessment, crisis preparedness and risk mitigation are essential to the sustainability of insurers.

FSRA expects insurers to treat consumers fairly in accordance with established FTC principles and adherence to regulation. FSRA's Home Insurance Thematic Review identified areas of opportunity for insurers to enhance their claims handling and other practices in support of fair treatment of customers.

Based on the findings and areas of opportunity identified in this report, FSRA expects the following from insurers:

- Insurers should maintain written documentation on their claims handlings procedures including timeframes. FSRA urges insurers to communicate to consumers if claims settlement timeframes are being extended due to exceptional circumstances.

- Insurers should inform claimants about procedures, formalities, and common timeframes for claims settlement.

- Insurers should examine claims diligently and settle them fairly, using a simple and accessible procedure.

- When outsourcing functions to independent adjusters, insurers should retain full responsibility for those outsourced functions and monitor them accordingly.

- Insurers should examine complaints diligently and fairly, using a simple and accessible procedure.

FSRA will continue to monitor the landscape of home insurance claims in Ontario. Ongoing engagement with industry and the Non-Auto P&C Insurance Technical Advisory Committee (TAC) is an essential component of informing FSRA's supervision priorities for the sector going forward. FSRA takes a risk-based and evidence-informed approach to supervision and will integrate the information gathered in this review to support future supervision initiatives. In addition, FSRA may seek to validate the information provided in this review and confirm that insurers have reviewed and, where necessary, revised their claims handling and other practices against the areas of opportunity identified in this report during future supervisory activities. FSRA may also conduct further risk-based examinations on Home Insurance and other key insurance coverages for Ontarians. The outcomes of this review will also be incorporated into FSRA's forthcoming P&C Insurance Supervision Framework.