

OLHI External Review 2017/2018

REPORT by

Honourable Robert Wells Q.C.

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PREFACE AND ACKNOWLEDGEMENT


I was engaged in August 2017 to conduct the scheduled five year review of the operations of Ombuds Service for Life and Health Insurance (OLHI). I was also engaged in 2012 to conduct the second three-year review which I did and presented it to OLHI's Board of Directors in November of that year. In the interim the Ombuds Service requested that the Ombudsmen Oversight Committee change the requirement from three to five years and it was agreed that it be changed to five years.

My 2012 review contained a detailed account of OLHI's role and how it came into being. That review can be found at www.olhi.ca. I believe that, having given considerable detail in 2012, I need not repeat the full account of OLHI's inception and purpose, but instead give a more brief explanation of its role, for those who need it.

This review began later in the year than did the previous one and must be concluded by April 2018. Knowing what I do about OLHI and its work, I do not need the intense familiarization process which I required in 2012. Nevertheless, much has happened within OLHI in the past five (5) years and I am indebted to the Acting Executive Director, Ms. Brigitte Kent, the entire management and staff of OLHI, and as well the Board of Directors for bringing me up to date on the changes which have occurred.

In addition to the assistance from within OLHI, I am indebted to the member companies of the Canadian Life and Health Insurance Association (CLHIA), the appropriate Regulators and to the management of OLHI for commissioning an external research group to do a study of consumer expectations, opinions and satisfaction levels arising out of complaints to OLHI. I have found that study to be invaluable, because it was both extensive and detailed.

Without the help of all of the foregoing this review could not have been effectively conducted.



Honourable Robert Wells, Q.C.

EXECUTIVE SUMMARY

The 2017-18 review shows quite clearly that OLHI has matured as an organization that is both independent and skilled in dealing with complaints by customers against their insurance companies. The improvements of which I speak have been brought about by improving and strengthening its capabilities in its core business which is the resolution of complaints by customers against the decisions made by their insurance providers. These improvements are discussed in the full report and referred to in this summary.

REGULATORY

Over the years OLHI has had a satisfactory relationship with its regulators. In the course of this review it has become clear that provincial and federal regulators are preparing to work more closely with international regulators in the future. This review expects that OLHI will be called upon to work with and consult with its regulators more closely.

STRATEGIC PLAN

OLHI'S Board of Directors has developed in consultation with senior management a five year strategic plan. The plan is not a public document but its effects will be incorporated into OLHI's operations in the future.

SYNOPSIS OF THE REPORT

1. That management and staff should not hesitate to escalate matters to the OSO level when a complaint expresses a serious issue.
2. That OLHI should continue with a pilot project to provide OSOs, Deputy Ombudsmen and the Executive Director with specialist independent medical, legal or accounting advice in difficult or otherwise appropriate cases.
3. That the researchers' report commissioned by OLHI into consumers' satisfaction levels or otherwise should be repeated at least every four or five years. The report of three years ago gives a very useful analysis of complaint thinking as to the independence and value of OLHI's services.
4. That the increased level of staff training within OLHI be continued with training in both the insurance industry (life and health) as well as training in the practice and principles of alternative dispute resolution (ADR).
5. That the financial management of OLHI is of high quality as confirmed by interviews and the company's chartered accountants.
6. That OLHI's Board of Directors is chosen by a fair process and has resulted in an independent board of highly qualified persons.

7. That there has been a strengthening of OLHI's internal core processes over the past five years and that OLHI's core processes are showing the effects of that strengthening.
8. That staff training is strong and extensive in both the insurance (life and health) fields and in the field of ADR.
9. That the current system of independent review remains at five years.
10. That there should be two Senior Adjudicative Officers, one in Montreal and one in Toronto, and that there should be no hesitation in using their services in difficult cases.
11. That the publication of OLHI's nonbinding recommendations continues to give credibility to its work and its independence.

In conclusion, this report commends OLHI, its Board of Directors, its management and staff in the progress made in the past five years.

BACKGROUND

I am including a brief explanation of the history and mandate of OLHI as taken from the second review:

The OmbudService for Life and Health Insurance (OLHI) was incorporated in 2002. The original name was “Canadian Life and Health Insurance OmbudService.” For some years the insurance industry and its Regulators were becoming aware that there was a need for an independent organization to which purchasers of insurance products could direct complaints and requests for information. There are over 20 million purchasers of insurance products in Canada and it had become obvious that although the courts were and are the final arbiters of civil disputes, there was a need for independent and less formal mechanisms for complaints and dispute resolution, at no cost to the consumer.

As a result of that realization, three incorporated bodies were formed to deal with complaints and disputes in the three major areas in which insurance, banking and investment products are sold. These areas encompass banking and investments, general insurance, and life and health insurance. OLHI thus became the OmbudService for Life and Health Insurance.

....

In its most frequent modern usage, an ombudsman is an official, usually appointed by the government or by parliament but with a significant degree of independence, who is charged with representing the interests of the public by investigating and addressing complaints reported by individuals. Whether appointed by the legislature, the executive or an organization the typical duties of an ombudsman are to investigate constituent complaints and attempt to resolve them usually through recommendations (binding or not) or mediation. Making a complaint to an ombudsman is usually free of charge.¹

¹ Wikipedia

....

An ombud service is governed by rules which establish procedures which it must follow; in this case it will investigate complaints and hear the arguments of complainants and the insurance companies in an even handed manner. When it can negotiate an agreement between the disputing parties it will do so and in the case of OLHI if agreement is not reached, it will issue a nonbinding recommendation with respect to the dispute. With this brief introduction to the ombuds process, I will turn to OLHI'S Framework for Collaboration, Terms of Reference and Bylaws.

In the original **4. FINANCIAL SERVICES OMBUDS NETWORK – A FRAMEWORK FOR COLLABORATION**, OLHI worked under seven guidelines which are as follows:

- (1) Independence
- (2) Accessibility
- (3) Scope of Services
- (4) Fairness
- (5) Methods and Remedies
- (6) Accountability and Transparency
- (7) Third Party Evaluation

N.B. I have been informed that OLHI and General Insurance Ombuds Service (GIO) now have a new Cooperation and Oversight Framework, which will replace the original framework to which I have referred. I am not aware to what extent the new framework

will differ from the original, nevertheless my review is of the past five years during which time the original guidelines applied.

The framework document is available at website www.olhi.ca but I will refer to its salient points in order to give context to the reader. I should also note that I am writing not only for OLHI, the Life and Health Insurance Industry and the Regulators, but also for the consumers of life and health insurance products and the general public, because this report will be published. With that in mind I will refrain from the use of acronyms, which though understood by “insiders” are confusing and frustrating when encountered by the general reader. The only acronym which I will use consistently is OLHI which is the organization being reviewed.

The framework document provides for an accessible and effective complaint management system. It is intended to be an easily accessible dispute resolution system which is an impartial alternative to the legal system, is confidential and free of charge to the consumer. Regulators concluded that such a framework would result in an ombud service which would be independent of industry and at arm’s length from governments and able to offer an effective third party complaint resolution process.

Guideline No. 1, Independence: defines “independence” as meaning the absence of relationships with the affected industry which would cause a reasonable person to have doubts, or to question whether OLHI is able to evenhandedly resolve disputes and whether its Board of Directors is able to provide objective and disinterested oversight. The guidelines set forth structures to achieve the foregoing purposes including adequate funding. In OLHI’s case its funding comes solely from the member insurance companies.

Guideline No. 2, Accessibility: requires the articulation of a framework which will promote knowledge of OLHI's services, ensure convenient and well identified access to its services and provide those services at no cost to consumers.

Guideline No. 3, Scope of Services: requires Terms of Reference to provide participating insurance companies and their consumers with a clear understanding of the range of OLHI's activities and the nature of the complaints with which it will deal.

Guideline No. 4, Fairness: requires that the OmbudService will approach its work and make its recommendations by reference to a standard that is demonstrably fair to both the insurance company and the consumer.

Guideline No. 5, Methods and Remedies: requires OLHI to articulate the nature of its dispute resolution services, the results and possible remedies for a consumer whose complaint is assessed by it and lastly, the consequences which should follow noncompliance by an insurance company with a recommended remedy, or noncooperation by a company with the OmbudService.

Guideline No. 6, Accountability and Transparency: to provide a framework for accountability for OLHI and accountability to the public in respect of its public interest goals, accountability to the Regulators in meeting their information requirements and transparency in the provision of information as to its organization and structure.

Guideline No. 7, Third Party Evaluation: to provide a framework in which the structure and operations of OLHI will be the subject of knowledgeable, independent third party evaluation on a regular basis, to validate the effectiveness of the OLHI's ombud service in achieving its purpose and to identify opportunities for improvement.

5. **TERMS OF REFERENCE**

OLHI'S Terms of Reference stress:

- (a) *independence,*
- (b) *that it is not an advocate for either the life and health insurance company or the consumer, and*
- (c) *that it is a member of the Financial Services OmbudsNetwork, an industry based on an integrated consumer assistance system launched in 2002, to provide Canada's financial services consumers with recourse when they have concerns or complaints. It is endorsed by financial service regulators and sponsored by the financial services industry.*

6. **IMPORTANT DEFINITIONS**

- (a) *“Complainant,” who may be an individual consumer of a member company's products or a consumer's personal representative, guardian, trustee or executor;*
- (b) *the “Dispute Resolution Process,” which means an alternative method of resolving complaints outside of the court processes and includes mediation, consultation and arbitration;*
- (c) *“Services and/or Products” are defined as: life insurance, health insurance industry service and/or product for individuals or groups and include life insurance, supplementary health insurance, disability insurance, pensions, annuities, segregated funds and investment products.*

OLHI must act within its Terms of Reference which can be found at website www.olhi.ca and in particular I will mention:

- (a) *receiving complaints, as appropriate*
- (b) *advising the public about procedures for making complaints*
- (c) *considering and receiving complaints*

- (d) *where applicable, making non-binding recommendations*
- (e) *not providing legal, medical, accounting or any other professional advice.*

I list the foregoing because they may be of particular interest to the reader, whom I will not burden with further references to the report of the previous review which can be found at www.olhi.ca.

SCOPE OF WORK OF THE REVIEW

OLHI EXTERNAL REVIEW – 2017

General Project Description & Scope of Work

General Project Description

Conduct a review and prepare a written report on OLHI's structures and operations as measured against the Guidelines set out in the Framework for Collaboration ("Framework") to validate the effectiveness of the OmbudService in achieving its purpose and to identify any areas of improvement.

The focus of the review and report will be:

- assessing the steps taken by OLHI to implement the thirteen (13) recommendations contained in OLHI's second Independent Review,*
- reviewing any changes implemented since 2012 to OLHI's governance policies and operating procedures,*

- *a review of a representative sample of complaint case files completed since the implementation of the recommendations in the last Independent Review, and*
- *conducting interviews with stakeholders.*

Scope of Work

- a) *Meetings with the Acting Executive Director to:*
 - (i) *establish project schedule,*
 - (ii) *review background to implementation of the recommendations contained in the second Independent Review,*
 - (iii) *establish access plan for staff, external stakeholders and documentation, and*
 - (iv) *obtain contact information for internal and external stakeholders;*

- b) *Review OLHI's*
 - (i) *five year Strategic Plan and status reports pertaining to the implementation of the Strategic Plan,*
 - (ii) *response to the second Independent Review, and*
 - (iii) *framework Guidelines;*

- c) *Review OLHI's governance policies and related materials including its By-Laws, Terms of Reference, and such Board and Board Committee Meeting Minutes as may be required to fulfill scope of project;*

- d) *Draft evaluation measures (13 recommendations contained in second Independent Review) then review evaluation measures with the Acting Executive Director;*

- e) *Review any changes implemented since 2012 to OLHI's operating procedures, including:*

- (i) *complaint handling policies,*
 - (ii) *staff training materials,*
 - (iii) *any additional documentation related to scope of the project;*

- f) *Review OLHI's case management system, statistical data and 2013, 2014, 2015 and 2016 Annual Reports;*

- g) *Conduct a review of a representative sample of complaint files commenced and completed since the implementation of the recommendations in the second Independent Review to assess compliance with those recommendations relating to complaint handling and Framework Guidelines;*

- h) *Conduct interviews with key stakeholders:*
 - (i) *a representative sample of OOSC/CCIR [OmbudServices Oversight Standing Committee/Canadian Council of Insurance Regulations] representatives,*
 - (ii) *industry association representatives (CLHIA),*
 - (iii) *a selection of participating Member Companies,*
 - (iv) *consumers, and*
 - (v) *such OLHI staff as may be necessary to fulfill scope of project;*

- i) *Briefing with the Chair of the OLHI Board of Directors and/or the Chair of the Standards Committee of the Board of Directors;*

- j) *Analysis and assessment;*

- k) *Prepare interim draft report for OLHI Standards Committee, attend and present draft report to OLHI Standards Committee then obtain and incorporate committee feedback in draft report, as required;*

- l) Prepare a final written Report and Executive Summary of the Report for the OLHI Board of Directors, attend and present Report at OLHI Board meeting;*
- m) Presentation of the Report and recommendations at a meeting with the OmbudServices Oversight Standing Committee (OOSC) of the CCIR.*

Time Frame

By December 31, 2017: Complete steps (a) through (j) and draft written report for OLHI Standards Committee meeting;

By mid March, 2018; Complete final written report and executive summary;

By April 30, 2018: Complete presentations of report and recommendations to OLHI Board of Directors and to the OmbudServices Oversight Standing Committee (OOSC) of the CCIR.

There follows a list of the recommendations made in the Second Review which I am required to discuss with OLHI vis-à-vis their implementation or otherwise in the past five years, together with my findings with respect to each recommendation.

LIST OF 2012 RECOMMENDATIONS AND REVIEWER FINDINGS

- 1) That the present method of selecting directors should not be changed.*
The Board of Directors agreed with this recommendation and there have been no changes, nor will I be recommending changes.

- 2) *That a committee representing Regulators, the Industry and Independent Agents be set up to find a solution to the IA gap [Independent Agents non inclusion] in the dispute resolution process.*

That recommendation has been successfully followed and OLHI participated in a series of meetings in which it was agreed at least for now, that complaints against independent insurance agents would be dealt with by their errors and omissions insurers.

- 3) *That strong support for “plain language” in all documentation should continue.*

There has been strong support for the above recommendation and a Communications Director within OLHI has been given the responsibility for its implementation, which is being carried out on an ongoing basis with all of OLHI public communications including letters and emails to complainants.

- 4) *That the principal focus of this review is to discuss and recommend a strengthened use of the tools which OLHI has at its disposal.*

That recommendation has been followed as shown by the internal reorganization, which has resulted in more complaints being escalated to the level of the OmbudService Officers. Escalation decisions are now being made by two newly appointed Deputy Ombudsmen.

- 5) *That consideration should be given to publishing non-binding recommendations which favour the Insurer as well as those favouring the Claimant.*

Case studies now appear on OLHI’s website.

- 6) *That the views of Independent Agents should be sought concerning their participating in an OmbudService process.*

These meetings to which I have referred resulted in the present agreement to use the errors and omissions insurers of independent agents to resolve complaints. As of now OLHI has no specific role vis-à-vis the independent agents.

- 7) *That if the OmbudService Officer's recommendation favours the complainants' position and is not accepted by the Insurer, OLHI should carefully consider escalating the matter to a Senior Adjudicative Officer [SAO], unless there is cogent reason for not doing so. In all cases the final decision to escalate or not rests with the Executive Director under the Terms of Reference.*

Escalation did not occur from 2012 to midyear 2017, at which time two matters were referred to the SAO and were dealt with by her. One nonbinding recommendation favoured the complainant, the other the insurer.

- 8) *That additional funding should be provided by Members so that OLHI can seek specialized professional advice when appropriate.*

In the past five years other organizational matters were addressed before No. 8. Nevertheless, the recommendation has been partially addressed by a pilot project in which specialized medical advice has been negotiated. The CLHIA membership is aware of this pilot project, but OLHI has not yet encountered a complaint which required specialized professional advice.

- 9) *That a larger number of cases should be escalated to the OSO level to receive more extensive investigation and review.*

This has been accomplished and two Deputy Ombudsman positions were established and filled. That internal reorganization and the focus reinforced by the second review have resulted in additional escalations to OmbudService Officers.

- 10) *That the services of the Senior Adjudicative Officer (SAO) should be used more extensively.*

This recommendation has been carefully considered but neither consumers nor insurers have demanded more extensive use of SAO services. SAO services can only be considered on a case by case basis when the need has been demonstrated and agreed upon by the Executive Director.

- 11) *That a second SAO be found as soon as possible.*

The level of demand in the past five years has not necessitated a second SAO. But I am still of the opinion that there should be two SAOs, one in Toronto and one in Montreal; SAOs are not employees and are contractually employed only when needed. In OLHI's history SAOs have been infrequently called upon.

- 12) *That a way be found to publish a greater number of case summaries.*

These are now being published on a quarterly basis.

- 13) *That discussion take place between OLHI and Member companies to see if they would benefit from reading an SAO's non-binding recommendations with personal and corporate identifiers being redacted.*

The above recommendations have been discussed with member company representatives and the case studies now being published are in their view sufficient.

SPECIFIC ACTIVITIES

THE BOARD OF DIRECTORS

The Board is made up of eight directors, five of whom are independent directors including the Chair and three of whom are so-called industry directors, i.e. directors nominated by member insurance companies which sell life and health insurance products. These companies number about seventy-five (75), which figure changes as members cease to do business in Canada, merge with each other, or in the alternative begin to do business in Canada. In OLHI's fifteen (15) year operational history no member company has failed to honour an OLHI recommendation, nor has any company withdrawn from OLHI's ombud services.

In my considered opinion OLHI's Board of Directors is made up of competent and diligent men and women who take their responsibilities very seriously. In the past five years there have been forty-nine (49) full Board and Board committee meetings, which have discussed and/or made decisions on a wide variety of topics. There have been no instances of Board members who have been removed for failure to perform or any other reason, nor have any Board members interfered with or become involved in any way with

individual cases or complaints which have come before OLHI's staff members. Board members are restricted by the terms of their appointments from any such case involvement.

In addition to Board meetings, members serve on various committees which are:

- (a) the Governance Committee
- (b) the Standards Committee
- (c) the Human Resources Committee
- (d) the Independent Directors Committee
- (e) the Ombud Services Committee
- (f) the Ad Hoc Committee re Financial Agreement

In 2013 there were ten (10) meetings of committee and Board meetings. In 2014 nine (9) meetings. In 2015 ten (10) meetings. In 2016 ten (10) meetings, and in 2017 to mid-December eleven (11) meetings.

It would be inappropriate for me to mention specific topics of discussion and decision making, but it is appropriate to say that the Board guides and assists OLHI's management in every aspect of policy and the execution of its mandate. They also meet with and liaise with other entities that have a direct interest in OLHI's work. Those are usually referred to as stakeholders.

Taken as a whole, after reading the minutes of many meetings I have no hesitation in endorsing the work of the Board and its value to OLHI and its member companies. In 2012 I agreed with the composition of the Board, i.e. independent and industry directors, as well as its method of Board member selection. In summary, I have every confidence in the Board, its work and its selection process, and will recommend that the status quo of composition and selection be maintained.

FINANCIAL MATTERS

After discussions with OLHI's chief accounting officer and making inquiries of their KPMG auditor, I am satisfied that OLHI's accounts are being properly kept and are completely in order. In discussion with management I am assured that effort is being made to keep expenditures as low as possible for the level of services being provided. After meeting with representatives of the member companies (CLHIA), I am assured that the members have confidence in OLHI's handling of its funds. OLHI provides its services to the consumer and the industry for the proposed budget of slightly over \$2,000,000 for 2017-18. The financial situation therefore does not call for recommendations with respect to OLHI's management of the funds entrusted to it.

The reader will have noted that the Scope of Review requires a comprehensive assessment and evaluation of OLHI's functions and a discussion of the improvements since 2012 and where, if at all, further improvements might be made.

INTERNAL ORGANIZATION

When OLHI first began operation in 2002 inquiries as to insurance products in the life and health fields were largely received by telephone. As I have noted, by the time of the second review in 2012 telephone calls had substantially diminished and internet access to OLHI's website had largely taken over. By 2017 the telephone inquiries had almost entirely been replaced by website use. Thus in 2017 website inquiries will have increased by 10,000 or more and dedicated telephone access has discontinued. If and when a staff member of OLHI is telephoned, the calling individual will be told how to access the needed information.

A complainant's initial point of access to OLHI is through the Dispute Resolution Counsellor, who receives complaints from policy holders who believe that they have not been treated fairly by their insurance companies in respect of their policy claims. When an insurer has denied a claim, either fully or partially, a complaint to the insurer is dealt with as follows. Insurers have their own ombuds providers who are company employees who deal with complaints. These company ombuds persons deal with and analyze a consumer's complaint and may deal with it through negotiation if that is warranted, or by making a decision after hearing the complainant's side and learning the company's reasons for denying coverage.

Complaints are sometimes resolved by that process, some in favour of the complainant and others in favour of the insurer. It is only when the above process has been concluded, and has not resolved the issue, that an insurer informs a complainant of OLHI's ombuds process and that a complaint may be made to OLHI in writing. In 2016/17 OLHI received 2,632 such complaints. A received complaint first goes to the Dispute Resolution Coordinator, who determines whether or not the complainant has met initially required standards and can be dealt with by OLHI. If so, the file will be forwarded to a Dispute Resolution Officer. If the complaint does not meet basic requirements, the Dispute Resolution Coordinator will recommend that the file be closed forthwith and the complainant informed as to why that has been done. The majority of complaints are closed at this stage.

If basic requirements have been met, the Dispute Resolution Officer contacts both the complainant and the insurer and gathers information from both. After gathering sufficient information, the Dispute Resolution Officer makes a determination as to whether there is or is not a reasonable basis for the complaint.

If the Dispute Resolution Officer concludes that the complaint is without merit, she will recommend that the complaint not be further addressed and that the file be closed and the complainant be so informed. In such cases she must first seek approval from a Deputy Ombudsman or the Executive Director to close the file.

If the Dispute Resolution Officer believes that the complaint has or may have merit, she will refer the matter to a Deputy Ombudsman who after consideration has the authority to make a decision to recommend escalating the file to an OmbudService Officer (OSO) for a higher level of investigation and argument from both the claimant and the insurer.

After a careful review of all the available information the Deputy Ombudsman has two options. He or she may find:

- (a) that the claim is without merit, in which case the complainant is so informed in writing and that OLHI will be closing the file and taking no further action; or in the alternative
- (b) that the claim appears to have merit. If the decision is that the claim may have merit, the complainant is so informed in writing and that the case will be assigned to an OSO. The Executive Director must approve all escalations to an OSO, who will then begin an extensive review of the complaint by discussing the matter with the complainant and the insurer and obtaining all available additional information and argument. Eventually after full consideration the OSO may achieve an agreed settlement between the parties or make a nonbinding recommendation in favour of either the complainant or the insurer.

OmbudService Officers in the last fiscal year dealt with twenty-six (26) such complaint cases. It is when the case reaches that level that the most comprehensive investigation takes place and argument is again heard from both sides. The OSO conducts

a true alternative dispute resolution process and invites both sides to support their positions orally and/or in writing. That process may take as long as four or five months because of the number of people who may be involved. During that time mediation may also be attempted. The OSO process is often able to reach an agreed settlement between the parties, but if that cannot be achieved the OSO makes a nonbinding recommendation which may favour either side. Although the recommendation is nonbinding, no insurance company has in OLHI's history refused to follow such a recommendation when it favours a claimant.

I have mentioned earlier the one further available escalation which is to a Senior Adjudicative Officer, if approved by the Executive Director. That person will do an extensive review of the case and may choose to have a hearing where the parties and possibly lawyers or experts appear before him or her and will receive argument orally or in writing. The parties may appear by themselves or have lawyers to present on their behalf. The Senior Adjudicative Officer will consider the matter and provide a written finding on the merits of the case. That finding will also be in the form of a nonbinding recommendation, either that the claim should be paid fully or partially by the insurer, or that the claimant has not made out a convincing case, in which instance the recommendation will favour the insurer company.

In the history of OLHI there have been very few referrals to Senior Adjudicative Officers. When there have been referrals the nonbinding recommendations arising out of

them have gone both ways. In all cases the insurers have accepted and acted on nonbinding recommendations which have not been in their favour.

It is important to note also that a recommendation to close a file may be made by a Dispute Resolution Coordinator, Dispute Resolution Officer or OSO, but closures can be made by one of the two Deputy Ombudsmen as well as by the Executive Director.

Since the 2012 review, OLHI's processes have been reorganized and streamlined by the addition of Deputy Ombudsmen, in Toronto and Montreal, together with the hiring of a Dispute Resolution Coordinator/Office Manager and a Communications Manager in Toronto.

OLHI's core alternative dispute resolution has therefore been substantially reorganized. There has been throughout a provision for two Senior Adjudicative Officers, one in Toronto and one in Montreal. Since the death of the Toronto SAO, which was prior to the 2012 Review, the work has been done by the Montreal SAO, who has been able to accomplish it because of the low number of cases which have reached that level. The positions of Dispute Resolution Coordinator, Communications Manager and Deputy Ombudsmen have all been filled and have added in large measure to OLHI's effective operation.

I have found that in the five years since the second review the foregoing organizational changes and additions have enhanced OLHI's performance and ability to deal more effectively with the complaints brought to it. As of October 2017, and the opening of an office in Edmonton, OLHI's full complement of staff stands at 15 persons. Those staff members do not work in isolation but are in regular contact personally and by telephone or email and thus support each other as necessary.

TRAINING

In OLHI's early days almost all of its staff members were people who had spent most of their careers in the life and health insurance industries. Without that background the staff members would have been lost in the complexities of those industries. Fortunately, some employees had some exposure in the insurers' ombuds process, but it became apparent that in addition to past experiences a thorough training had become necessary.

Today there is still a strong background in staff members of insurance knowledge. There are also staff members where background experiences have involved other industries and professions, which together with training in alternative dispute resolution have resulted in a greater depth of knowledge and capability in the ombuds field. The training manual of 2014 exemplifies the latest approaches to getting employees with the necessary knowledge added to their past experiences, to fulfill their roles.

The Training Manual informs the trainee as to exactly what OLHI's role is and that it is available to 75,000 consumers annually and some 99% of the Canadian life and health insurers. It describes what OLHI does, its independence and its complaint resolution services and in addition explains that it has fully bilingual personnel with extensive life and health insurance and as well experience in alternative dispute resolution.

The manual also explains the percentage of complaints by life and health products, namely:

- (a) disability 36%
- (b) life 28%
- (c) EHCL Dental 12.5%
- (d) travel 8.2%
- (e) other 6.2%
- (f) retirement 4.1%

It explains the independent review process from the 2012 review which set certain goals and the reasons for them, the levels of implementation over a two year period and describes the results of the Consumer Satisfaction Survey.

When it moves to Life and Health Insurance with many pages of definitions of the various products sold, largely represented by "individual," "group insurance" and "creditor

insurance,” it names the companies represented in OLHI and the 13 provincial regulators to which it is answerable.

The reader may be surprised at its glossary of insurance terms and their meanings, in all approximately 160 entries. I will give just five examples of such entries chosen at random to illustrate the complexity of certain types of policy.

- (a) adjustable policy – a type of insurance policy that allows the insurance company to make changes to the policy under certain conditions. Changes can include the amount of insurance, the premiums charged and the cash value.

Details of how the insurance company can make changes are listed in the policy.

- (b) creditors group insurance – a type of insurance that helps to pay down or pay off a loan or a credit card or cover payments in certain situations such as if the policy holder dies or become disabled. It can be offered through financial institutions, auto dealers, mortgage brokers, retailers or credit card companies when a debt is taken on.

- (c) hospital indemnity – a health insurance benefit that pays a flat amount for each day a covered person is in hospital. The number of days covered is set and the daily amount paid does not vary, regardless of the medical expense the covered person incurs.

- (d) individual variable insurance contract – a contract, usually an annuity where premiums are invested in segregated funds managed by the life insurance company.

The value of the plan will vary over time based on the value of these investments.

These contracts guarantee to pay at least 75% of what has been paid into the plan on death or maturity, even if the investments are worthless.

- (e) segregated fund - a pool of investments held by the life insurance company and managed separately, i.e. segregated from its other investments. If one buys a variable insurance contract, sometimes called a segregated fund policy, the value of the policy varies according to the market value of the assets in the segregated fund.

As I have noted, there are 160 such definitions and explanations, as well as many other insurance explanations which take time to learn and become familiar with. I mention the foregoing only to give a few examples of the complexities of life and health insurance as they have been developed and offered to the public at this time.

As one insurance professional said to me, life and health insurance products have become so complex that the life and health insurance consumer may need a financial adviser to help him or her to buy an appropriate policy. Nevertheless, I doubt that many potential policy buyers seek such expert advice and therefore buy policies that sometimes give them or their beneficiaries an unexpected surprise at some later point. In that regard

I return to my belief that OLHI staff at the OSO level should have available to them when needed, expert advice, whether financial or medical or legal, when in the interests of consumers, they ought to have it. Without laboring the point further, I am of the opinion that the current training of OLHI staff has advanced to the point at which the training which they need is available to them. Specialized advice will only be needed in exceptional cases.

THE EXAMINATION OF OSO COMPLETED FILES

My purpose in reviewing OSO files was not to try to second guess the SAO's recommendations. My purpose was to ascertain how much effort was being put into the totality of the work which led to a resolution or a non-binding recommendation. I should mention here a factor which was not present in my 2012 review of files.

There is now a new system of maintaining files in which every step in the process no matter how minor in respect of a file is entered into a fully computerized version of the file. This system records every email, records of telephone conversations, the obtaining of medical reports from complainants' physicians in particular and a full review of the insurers' documentation, medical reports when applicable and the rationale of the insurers' decision making in both the initial decision and of the insurers ombuds process. The new process permits a markedly detailed view of the OSO's work which was not available in the files of 2012, which consisted largely of various reports, significant emails and written communications. The new system which reports all matters and runs often to two or three

hundred pages, and one of which exceeded five hundred pages, is a much more accurate portrayal of the OSO's detailed work.

It also explains why a single file may take as much as eight or more months for completion. The OSO is required to wait for explanations, reports and other communications, and as well at times for the insurer's information to be assembled and/or supplemented if necessary. Likewise, arguments are required from both sides and these take time to be prepared. As the process nears its conclusion the OSO must review everything in his or her materials and give serious thought as to what his or her recommendation will be. Although the OSO's finding is nonbinding recommendation unlike the binding decision of a judge or arbitrator, the process leading to it is not unlike the process of a judge or arbitrator.

It must also be remembered that an OSO file may turn into a conciliation or mediation, which again adds an additional time element, whether successful or not. After examining a significant number of Toronto and Montreal files prepared under the new system, I realized to a greater extent than I did in 2012 how much careful and comprehensive work had gone into each file. In no case did I encounter any failure of effort to obtain a recommendation which considered not only the contract, namely the insurance policy, but also the concept of fairness which is also a requirement which the OSO must consider and if necessary factor into a recommendation. My conclusion is therefore, the work of the OSOs is crucial to OLHI's effective work as an ombuds provider.

I need say much less about the two nonbinding recommendations made in the summer of 2017 by the Senior Adjudicative Officer. The SAO does not come from the insurance industry but is a prominent practitioner of all aspects of alternative dispute resolution and is recognized as such.

CONSUMER SATISFACTION

One of the difficulties which I faced in the 2012 review was to obtain clear and precise knowledge of consumer perceptions of OLHI. The consumers I wished to learn from were those who had actually engaged OLHI in the mediation and conciliation processes. The foregoing need was addressed by OLHI's engagement of a research firm in 2012 to conduct a survey of consumers who had used its complaint services in the previous three years. I have found their report invaluable in assessing levels of consumer satisfaction or otherwise with OLHI. To assist the reader, I will quote the Executive Summary of the research report in full.

OLHI'S USER SURVEY

Executive summary

The OmbudService for Life & Health Insurance (OLHI) is an independent complaint resolution and information service for Canadian consumers. In order to better understand the population it serves, OLHI commissioned ERIN Research to conduct a baseline survey of consumers who had used its complaint services in the past year. The survey was conducted by telephone from April to July 2013 and produced 242 completed interviews.

The purpose of the survey is to gauge consumers' perceptions of the service delivery process, to understand what contributes to satisfaction with OLHI's service, and to identify possible improvements.

Consumers fall into three groups:

***Step 1 Consumers** are at an early stage, exploring options and seeking advice. Most have not lodged a formal complaint with their insurer, and OLHI explains that they must complete the insurer's process, and how to begin that, before OLHI can become involved.*

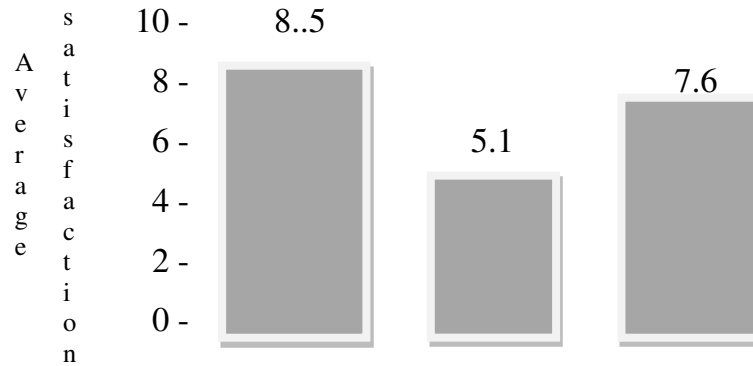
***Step 2 Consumers** have completed the insurance company's complaint review process, filed their complaint with OLHI, and received OLHI's written assessment. In all instances, OLHI has determined that the claim does not merit elevating to the Step 3 process.*

***Step 3 Consumers** are individuals who have completed Step 2 and OLHI has determined that their complaint contains grounds to conciliate with the insurer. While fewer than half of this group received payment, all are aware that OLHI is negotiating with a view to seeking a voluntary resolution of the complaint.*

As a result of their differing experiences, overall satisfaction with OLHI services differs across these groups. The research analyses the dynamics of the service

delivery process that contribute to satisfaction at each step, and identifies how satisfaction might be raised, especially for the Step 2 Consumers.

Figure a) Consumers' satisfaction with OLHI



OLHI Consumer Satisfaction Survey 2013

ERIN Research Inc. 4

It is not surprising that at Step 1 of OLHI's processes, when the consumer is seeking information, that the satisfaction level is high, averaging at 8.5 out of 10.

The Step 2 results are very revealing. At Step 2 it emerged that the consumers whose claims had been found to be without merit, when so informed, were usually disappointed or upset. They had been told that was the case by their insurance company, again by the company's ombuds process and again by OLHI. No doubt by that stage some consumers understand and accept the decision, but others may have blamed OLHI. It follows that the level of satisfaction at Step 2 was not more than 5.1 out of 10. That figure does not mean that OLHI was in error. It simply reflects the fact that a significant number of complaints are found after intensive investigation to be without merit.

Step 3 involved OLHI at the OSO level using its skills and resources to try to effect fair settlements. It follows that whatever the outcome, reasonable consumers acknowledged that OLHI had done its best whatever the final recommendation turned out to be. Thus, the third step, which is the OSO level, rated a consumer satisfaction level of 7.6 out of 10.

As the research report noted, those in the Step 2 consumers group who did not receive the payment they had hoped for, for the most part, continue to think that they were in the right and almost all say, “I still believe that my case has merit.”

In Step 3 those consumers who received payment from their insurers gave OLHI credit of five out of five on almost every measure of service quality, which again is not surprising. What is more significant in my opinion is that at Step 3 those who did not receive a payment were less enthusiastic but still gave OLHI good ratings, i.e. much higher than those disappointed in Step 2. As the report notes, “The additional communication that transpired with Step 3 consumers after filing their documentation, clearly contributes to their high satisfaction ratings.”

In terms of impartiality, Step 1 consumers are hopeful that the outcome will be positive. They feel supported and that OLHI is either impartial or on their side. Step 2 consumers by a large majority when they did not receive their hoped-for payment, felt that OLHI favoured the insurance company. They still thought that their claim had merit and

that OLHI did not reach the right conclusion. Step 3 consumers, when they received payment, saw OLHI as being impartial, as did half of those who did not receive payment.

In my view the work of the research company and its findings are valuable. It must be remembered that any person or organization, which has the authority or power to resolve disputes, will attract disapproval from unsuccessful parties. That applies across a broad spectrum that includes courts, arbitration boards and any entity with decision making power over disputes where differences of opinion are an issue.

In my view the report in its entirety is far from critical of OLHI's work. The fact that most categories of consumers feel that OLHI tried hard and carefully worked through its processes is an encouraging note. I wrote in the 2012 report that in my opinion more cases should be raised to the OSO level and that has happened, thus more matters have been receiving a more comprehensive review. It is also a fact that at the OSO level the complainant, whatever the outcome, has had a greater opportunity to present his or her facts and arguments. That opportunity cannot but raise the consumer opinions of OLHI's work and independence, and that has been the case. The research project which I have been reviewing need not be undertaken frequently, but such a snapshot of complainant views perhaps every five years would be very useful to OLHI in assessing and refining its ombuds processes.

REGULATORY RELATIONSHIPS

Canadian Council of Insurance Regulations (CCIR)

The CCIR included the following paragraph in its Forward to its Strategic Plan 2017 to 2020:

Consumer relationships and interactions with financial service institutions and professionals have increasingly become the focus of not only insurance regulators, but all financial services authorities both in Canada and abroad. The CCIR will continue to work to ensure that insurance consumers are treated fairly throughout their relationships with insurers and intermediaries. We expect that the work we conduct through this strategic plan will enhance these interactions, both in terms of the conduct of insurers and intermediaries as well as consumer awareness and decision making.

There follows the CCIR's mandate, mission, vision and values. In terms of specific priorities, it will:

- *Build upon cooperative supervision in aligning with best international practices 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 practicable and appropriate.*

On page 4 under the heading of Fair Treatment of Customers, the Plan says:

- a) *regulatory developments, internationally and in other financial services sectors, and evaluate their impact on and appropriateness for the insurance regulatory framework;*
- b) *industry practices and regulations relating to incentives management; and*

c) *the content and timing of information provided to customers.*

Specifically, on page 7 the CCIR's Plan says:

Oversee Insurance OmbudServices

CCIR is responsible for ensuring that third party dispute resolution systems in the insurance sector, including General Insurance OmbudService (GIO) and the OmbudService for Life and Health Insurance (OLHI), fulfill the public interest objectives of complaint resolution as an important component of a well-functioning consumer protection policy framework.

Bearing in mind the Strategic Plan, I have discussed OLHI's interactions with CCIR to learn how OLHI and its level of performance in its ombuds service meet required standards.

From the foregoing discussion I formed the opinion that there is a general satisfaction on their parts that OLHI is doing effective work under its present mandate. CCIR is nevertheless very concerned about the developing role of insurance regulators internationally. CCIR is a part of that international development and in that regard, wishes to have a closer relationship with ombuds providers such as OLHI, and to learn from it as well as from other sources, developing trends in life and health insurance, so that regulation can be more effective and CCIR be more aware of emerging trends both internationally and within Canada. I will therefore be recommending that OLHI respond to the invitation of CCIR at both the Board and administration levels and that discussion should take place with CCIR as to how an appropriate level of increased cooperation should be organized.

In my opinion OLHI has matured significantly over the years since I began the 2012 review. It has adapted to and made use of advancing IT. It has created new positions within to allow for more comprehensive consideration of complaints and greater thoroughness in its dealings with consumers' complaints and its relations with the industry and the general public.

OLHI's Board of Directors has developed in conjunction with senior management and staff a five year strategic plan to better address the needs of the future for the period April 1, 2016 to March 31, 2021. The Strategic Plan is not a public document, so that I will not be commenting on its specifics, but I think it is appropriate to quote its Mission Statement:

To provide fair, transparent, timely complaint resolution services for consumers of life and health insurance products, in the spirit of collaboration with stakeholders.

I think it also appropriate to refer generally to areas of the strategic plan which involve:

timely response,
specialized reviews,
small insurers,
interaction with regulators,
increasing web traffic,

media coverage,
public engagement, and
consumer engagement.

I have no doubt that the strategic plan will be refined over its five year life, but the fact that it has been developed and adopted is a very positive step.

This review has resulted in my forming a considered opinion that OLHI has matured and grown in the past five years and now offers a comprehensive and effective dispute resolution service to those complainants who seek its services. Having reached the level of maturity which it has, I will in this review be making few recommendations beyond staying on course and using to the full the dispute resolution tools which it has at its disposal.

Specifically, I recommend:

- (a) that management and staff not hesitate to escalate matters to the OSO level where they will receive a full consideration leading to either a settlement or a nonbinding recommendation.

- (b) that OLHI continue with the pilot project which would make available to OSO's, Deputy Ombudsman and the Executive Director specialist independent medical, legal, accounting or other advice when it could be helpful in the ADR process. I

recognize that there is a cost involved in obtaining such advice, but it is a cost which I believe the member companies should be prepared to bear to enable OLHI to achieve its full potential.

- (c) I recognize that some people may believe that OLHI should have the power to make binding decisions rather than nonbinding recommendations. I disagree with such thinking, which if implemented would turn OLHI into an arbitrator rather than a conciliator/mediator. An arbitral role would engage the adversarial system and necessitate an appeal process and lead to greater expense. OLHI's strength is in its nonbinding recommendations which have worked well and, in my opinion, should not be changed.
- (d) I agree that in its present state of development OLHI should stay with the current system of independent review every five years.
- (e) Although the services of a Senior Adjudicator Officer have not been extensively used in OLHI's history, I nevertheless believe that there should be two such SAOs as was the case in the beginning, one in Toronto, the other in Montreal. The cost of the SAOs is not really significant, because they are not employees and when matters are referred to them they are paid on a fee for service basis only which to date has not been a significant cost.

Dated at St. John's, NL this 12th day of April, 2018

A handwritten signature in blue ink, appearing to read "R. Wells".

Honourable Robert Wells Q.C.

OmbudService
for Life & Health
Insurance



Ombudsman
des assurances de
personnes

OLHI • OAP

**OLHI's RESPONSE TO THE
RECOMMENDATIONS OF THE THIRD
INDEPENDENT REVIEW**

May 2019

EXECUTIVE SUMMARY OF THE REVIEW

Excerpt from the 3rd Independent Review written by Justice Wells:

“The 2017-18 review shows quite clearly that OLHI has matured as an organization that is both independent and skilled in dealing with complaints by customers against their insurance companies. The improvements of which I speak have been brought about by improving and strengthening its capabilities in its core business which is the resolution of complaints by customers against the decisions made by their insurance providers.”

BACKGROUND

- ❖ In compliance with the Insurance OmbudServices Cooperation and Oversight Framework (“Framework”), Guideline #7, OLHI commissioned its 3rd Independent Review to have its operations reviewed by an independent third party evaluator.
- ❖ Prior to the Framework being revised to allow for the Independent Review to be done every five years, the earlier external evaluations were done every three years. The first one was delivered in 2008 and the second evaluation in 2011. Both were accepted by the Board and the recommendations from each were implemented.
- ❖ The Honourable Justice Robert Wells, Q.C., was mandated again in 2017 to conduct the Third Independent Review. An assessment of the implementation of his 2012 findings was necessary, and his appointment resulted in a timely and cost-effective review. Justice Wells delivered his report in April 2018.
- ❖ Justice Wells made five recommendations for improvement and commended OLHI, its Board of Directors, its management and staff for the progress made in the past five years.

GENERAL COMMENTS

- ❖ Over the last years, OLHI developed initiatives to enhance stewardship and governance within the organization in an effort to provide only the best services to consumers. Governance changes to align OLHI with current standards have been a priority of the board since the last review.
- ❖ As a result, a more rigorous and detailed process for recruiting independent directors has been established. OLHI's By-laws have been amended to ensure that OLHI attracts high quality independent directors and two (2) excellent new independent directors were added to the board in September 2018. Additionally, enhanced processes for evaluating directors and for assessing the performance of the Chair were put in place.
- ❖ Going forward, the board will undertake a thorough review of OLHI's By-laws, Policies and Guidelines to ensure they continue meeting current standards and are consistent with the Insurance OmbudServices Cooperation and Oversight Framework.

COMMENTS ON THE RECOMMENDATIONS

✓ RECOMMENDATION #1

"...Management and staff should not hesitate to escalate matters to the OSO level where they will receive full consideration leading to either a settlement or a nonbinding recommendation."

Comment: OLHI agrees that this is an essential step in its complaint review process. While consideration is already given to the merits of each case, OLHI will continue to ensure that all cases are reviewed thoroughly and escalated to an OmbudService Officer for additional examination when grounds are found to the complaint.

✓ **RECOMMENDATION #2**

"...OLHI continue with the pilot project which would make available to OSO's, Deputy Ombudsmen and the Executive Director Specialist independent medical, legal, accounting or other advice when it could be helpful in the ADR process. I recognize that there is a cost involved in obtaining such advice, but it is a cost which I believe the member companies should be prepared to bear to enable OLHI to achieve its full potential."

Comment: The pilot project initiated in July 2017 in collaboration with our members is still ongoing. To date, there has been no case that required the expertise of an external expert advisor due to the hire of new, experienced and knowledgeable employees in various positions. . If required, OLHI will not hesitate to obtain external expert advice.

✓ **RECOMMENDATION #3**

"I recognize that some people may believe that OLHI should have the power to make binding decisions rather than nonbinding recommendations. I disagree with such thinking, which if implemented would turn OLHI into an arbitrator rather than a conciliator/mediator. An arbitral role would engage the adversarial system and necessitate an appeal process and lead to greater expense. OLHI's strength is in its nonbinding recommendations which have worked well and, in my opinion, should not be changed."

Comment: OLHI agrees with Justice Wells' opinion on this matter. His view is strongly supported by the fact that to date, all final nonbinding recommendations in favor of the consumers, made at the last review step, have been accepted by our member companies.

✓ **RECOMMENDATION #4**

"I agree that in its present state of development OLHI should stay with the current system of independent review every five years."

Comment: Given all the progress and achievements made over the years following the implementation of the recommendations in the previous reports, OLHI is in agreement with this recommendation. The next review is scheduled to take place in 2023.

✓ **RECOMMENDATION #5**

"Although the services of a Senior Adjudicator Officer have not been extensively used in OLHI's history, I nevertheless believe that there should be two such SAOs as was the case in the beginning, one in Toronto, the other in Montreal. The cost of the SAOs is not really significant, because they are not employees and when matters are referred to them they are paid on a fee for service basis only which to date has not been a significant cost."

Comment: OLHI currently has one Senior Adjudicative Officer (SAO) based in Montreal. To date, the case volume requiring that level of review has been low hence no need was identified to actively search for another resource in Toronto. OLHI agrees to start searching for another SAO if there is a noticeable increase in cases referred to the SAO level.