AUTORITÉ DES MARCHÉS FINANCIERS

Group disability insurance cross-sectional analysis report

March 2019

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CONTEXT

In April 2018, the *Autorité des marchés financiers* (the “AMF”) decided to conduct a cross-sectional analysis of how group disability insurance claims (employee-employer plans),[1] including claims for mental health disabilities, are handled.

When the AMF looked at the information in its possession, it did not find any specific problem. However, it sought to develop a more detailed overall picture of current industry commercial practices and ensure that they were adequate and resulted in the fair treatment of consumers (FTC).

The analysis was conducted primarily by means of:

- a request for information sent to the ten largest group life and health insurers in Québec, which account for close to 90% of the group disability insurance market;
- interviews conducted in the summer and fall of 2018 with most of those insurers.

The AMF carried out this work as part of its supervision of insurers.

To determine how adequate commercial practices were and how fair they were for consumers, the AMF relied on several components of the *Sound Commercial Practices Guideline*[2] (the “Guideline”) published in June 2013, which applies to all insurers governed by the *Act respecting insurance*, CQLR, c. A-32 (the “Insurance Act”).[3]

The analysis focused mainly on items relating to claims examination and did not look at all aspects covered by the Guideline.

The Guideline sets out the AMF’s expectations for sound commercial practices, which are intended to ensure:

- FTC, which is a core component of the governance and corporate culture of insurers;
- that consumers have information allowing them to be properly informed and make enlightened decisions regarding a product, before, during and after the purchase of the product;
- that claims and complaints are examined diligently and settled fairly, using a procedure that is simple and accessible to claimants.

1 The analysis results do not include administrative services only (ASO) plans and products sold other than through a representative.

2 https://lautorite.qc.ca/fileadmin/lautorite/reglementation/lignes-directrices-assurance/ligne-directrice-saines-pratiques-commerciales_an.pdf

3 Section 222.2 of the Insurance Act states that every insurer must adhere to sound commercial practices, including properly informing persons being offered a product or service and acting fairly in dealings with them. This statute will be replaced on June 13, 2019 by the *Insurers Act*, (S.Q. 2018, c. 23. s. 3), Chapter IV of which will cover commercial practices.

OVERALL FINDINGS[4]

In 2017, $1.776 billion in premiums were collected, including nearly $408 million in short-term disability ("STD") premiums and $1.368 billion in long-term disability ("LTD") premiums.[5]

During that same year, insurers paid out in excess of $1.447 billion in benefits, including $360 million in STD benefits and $1.087 billion in LTD benefits.

The AMF observed that, on average, from 2015 to 2017, 86% of premiums written for short-term group disability insurance and 77% of premiums written for long-term group disability insurance were paid out each year in benefits.

From 2015 to 2017, an average of around 97,000 claims were received every year, approximately 30% of which were for mental health disabilities.

The annual average acceptance rate for claims received between 2015 and 2017 was 95% for short-term insurance claims and 88% for long-term insurance claims.

Therefore, overall, the analysis did not expose any systemic problems with the way the industry manages group disability insurance.

However, the AMF observed some practices that require corrective action in order to meet its expectations and ensure FTC, particularly regarding:

- the information provided to participants relating to the coverage offered under the master policy and the possible reasons for denying a claim, which information is not always sufficient, timely and in clear language;
- the decision review process, which is not always explicitly presented to participants and, moreover, often consists of multiple steps, making it onerous for the participant;
- the complaint examination process, information about which is not always easily accessible for participants; and
- the criteria used to determine whether or not a health professional needs to be consulted, which are not always formally documented.

4 The figures in this document are based on information for the years 2015 through 2017 provided by the insurers surveyed in May 2018 and have not been verified.

5 The maximum duration of short-term disability benefits and the commencement of long-term disability benefits are set out in the master policy and may vary between policies.

Nevertheless, the analysis also brought to light some good practices among insurers, including in the examination of mental health disability claims.

In order to, in particular, achieve industry-wide adoption of best practices, the AMF determined that it was appropriate to further clarify expected FTC good practices in group disability insurance by means of the recommendations presented in this report.

The AMF also devotes considerable attention to the special situations that it is made aware of through complaints and reports from consumers or that it learns about from reports or publications in the various media.

The AMF believes that the implementation of these recommendations will help reduce the occurrence of such situations while enabling insurers to prevent fraud and strengthen consumer confidence in the insurance industry.

RECOMMENDATIONS

1. INFORMATION FOR CONSUMERS

1.1 Insurer's and policyholder's roles and responsibilities

In group disability insurance, the holder of the insurance contract is usually called the "policyholder." The policyholder can be an employer, a union, a professional association or another entity.

The insurer and policyholder enter into agreements (master policy and related agreements) to offer group disability insurance coverage, on negotiated terms, to all participants in a particular group.

The policyholder takes on certain responsibilities under the agreements, including responsibility for giving policy information to participants.

Participants need proper information in order to understand their group disability coverage, anticipate the impact of their disability, and identify any exclusions[6] and pre-existing conditions that may affect them.

If policyholders are not properly informed of their roles and responsibilities, they may fail to inform the participants in a timely manner about specific aspects of coverage that could have major consequences for them, including:

- The benefit calculation formula:

  The disability benefit amount covers only a percentage of a participant's salary. The difference in income could have an impact on the participant's ability to meet his or her financial obligations.

- The definition of a disability:

  In the case of long-term disability, participants are usually entitled to their benefits only if they are incapable of performing any remunerative occupation (other than their current employment). Such disability insurance comes into effect upon the expiry of the short-term disability period.[7]

Sound Commercial Practices Guideline

The AMF expects consumers to have information allowing them to be properly informed and make enlightened decisions regarding a product, before, during and after the purchase of a product.

The AMF expects the information disclosed to consumers to be up to date and available, in a timely manner, on paper or any other durable medium.

6 For the purposes of this document only and for ease of reading, the term "exclusions" includes the terms "restrictions" and "limitations".

7 For clarification of the concepts of short-term disability insurance and long-term disability insurance, refer to the AMF website at the following link: https://lautorite.qc.ca/en/general-public/insurance/group-insurance/disability-insurance/.

- Exclusions and pre-existing conditions:

  Certain exclusions and pre-existing conditions could be misunderstood (e.g., those related to extreme sports such as skydiving and backcountry skiing). The AMF identified as many as 18 exclusion categories in the various agreements that it analyzed.

The AMF expects insurers to adhere to the following good practices to help ensure that both policyholders and insurers provide proper information to participants in a timely manner:

- The policyholder's roles and responsibilities are specified in the master policy or any other relevant document, and training is provided to the policyholder so that it gains a practical understanding of its roles and responsibilities in respect of participants, including:
  - the requirement to provide participants with an explanatory document when such a document is not otherwise available
  - the content of the information that is to be given to participants so that they are properly informed (e.g., presentation on insurance coverage, the benefit calculation formula, the definition of disability, and exclusions and pre-existing conditions)
  - the limits of its role (to provide participants with information, not advice)
  - times when they must refer participants to the insurer
- Measures are implemented to ensure that the policyholder carries out its roles and responsibilities as agreed (e.g., reminders or presentations to the policyholder, random participant survey);
- Tools are implemented to ensure that participants are properly informed (e.g., making the information available to them on a site specifically dedicated to them, offering them seminars, FAQs, telephone support, glossary, brochure summarizing key features of the insurance coverage);
- The insurer's obligations to the policyholder extend to anyone to whom the policyholder delegates its duties (e.g., the employer to whom the policyholder (e.g., union) has delegated activities).

1.2 Information in clear and plain language

Claimants are unfamiliar with the vocabulary used in group disability insurance.

The information given to participants at the time of enrolment or during the claims examination process must be in clear and plain language.

The AMF expects insurers to adhere to the following good practices to help participants better understand the information that is given to them:

- Clear and plain language is used, particularly in the explanatory documents provided at the time of enrolment or during the claims examination process (when describing the reasons for denying a claim, for example);
- Vocabulary that is technical or complex (e.g., disability definition, functional capacity, transferable skills, waiting period) and not open to interpretation (e.g., non-medically-necessary treatments or surgeries, hazardous sport or activity) is not used. When such language cannot be avoided, the information should be clarified to eliminate any confusion participants may have concerning the scope of their coverage;
- Tools are created and made available to participants to help them better understand the information that is given to them (e.g., glossary, explanatory passages or reference to policy clauses, participants' guide, FAQs).

Sound Commercial Practices Guideline

The AMF expects the information disclosed to consumers to be drafted in clear and plain language and in a manner that is not misleading.

In particular, the AMF expects claimants to be provided with a clear and careful explanation of the determining factors of the assessment and the reasons for the total or partial rejection of a claim, where applicable.

2. CLAIMS EXAMINATION AND SETTLEMENT

2.1 Mental health disability training offered to claims examination staff

Insurers need to provide group disability claims examination staff with basic training and continuing training.

Mental health disability training is essential, considering that these types of files involve an element of subjectivity and are often more complex than physical disability files.

The AMF expects insurers to adhere to the following good practices to help ensure adequate supervision and mental health training of claims examination staff:

- A basic training program and a continuing training program for claims examination staff are established that cover:
  - the characteristics of certain mental health illnesses
  - developments in the field of mental health illnesses
  - how to interact with participants who have a mental health disability
- Developments in the field of mental health illness are monitored and the basic training and continuing training programs are adjusted as and when required;
- A control system is established to ensure that mental health disability training is taken within the required time frames;
- An appropriate period of supervision is provided to all new employees working on mental health disability files;
- The training programs are adjusted to address any deficiencies that are identified when files are controlled for quality.

Sound Commercial Practices Guideline

The AMF expects claims to be examined diligently and settled fairly, using a procedure that is simple and accessible to claimants.

In particular, the AMF expects:

- *consumers to be aware of the existence of the claims examination and settlement service and the contact information for accessing the service;*
- *claimants to be aware of the main steps of the claims examination process and the anticipated time frame;*
- *claimants to be provided with a clear and careful explanation of the determining factors of the assessment and the reasons for the total or partial rejection of a claim, where applicable.*

2.2 Consulting a health professional

The analysis of a disability file can sometimes be very complex and require the opinion of a health professional (e.g., difficult-to-interpret medical documents, multiple diagnoses or mental health diagnoses). As a result, insurers make health professionals available to claims examination staff.

It is important to provide claims examination staff with formal guidance so that they can determine whether and when they should consult a health professional.

The AMF expects insurers to adhere to the following good practices to help ensure that health professionals are consulted at the appropriate time during the claims examination process:

- The health professional's role is formalized;
- The criteria to be applied by claims examination staff in order to determine whether and when they should consult a health professional are formalized;
- Any information related to the relevant staff's consultation with the health professional and the results of that consultation are kept in the file. If the staff responsible do not follow the health professional's recommendation, they must document the grounds for not doing so and the steps that led to the decision (e.g., exchanges with the health professional, discussion with and approval of a superior).

Sound Commercial Practices Guideline

The AMF expects complaints to be examined diligently and fairly, using a procedure that is simple and accessible to consumers.

2.3 Decision to deny, terminate or suspend a claim

The decision to deny, terminate or suspend a claim is always confirmed by the insurer in a letter sent to the claimant. Usually, claimants are also informed orally.

Claimants must obtain all the relevant information needed to properly understand the reasons for the total or partial rejection of their claim and the next steps.

The AMF expects insurers to adhere to the following good practices to help ensure that there is appropriate follow-up and that appropriate information is sent to participants:

- Appropriate follow-up is conducted with claimants when information is missing from the file; the file is suspended for the time it takes to obtain the information (instead of the claim being denied or the file being closed); and the claimant is informed of the suspension;
- Sufficient details are provided to claimants regarding:
  - the reason for the decision in the denial and termination letters. The reasons given must be tailored to the claimant's circumstances immediately upon first contact with the claimant
  - any additional information needed to make a decision about the claim
- The next steps are clearly indicated in the letters sent to the claimant (e.g., review process explained in the denial or termination letters, complaint examination and dispute resolution procedure following the review, analysis of additional information once the information is obtained).

Sound Commercial Practices Guideline

The AMF expects complaints to be examined diligently and fairly, using a procedure that is simple and accessible to consumers.

The AMF expects claimants to be provided with a clear and careful explanation of the determining factors of the assessment and the reasons for the total or partial rejection of a claim, where applicable.

2.4 Decision reviews

The decision review process for group disability insurance files should be fair, objective, straightforward and easily accessible and be communicated to claimants.

Claimants must be able rely upon a written reference document that they can access at a later date or if they need to consult an advisor or family caregiver. Such a written reference document is especially important where a claimant suffers from a mental health disability, because of the person's vulnerable state.

The AMF expects insurers to adhere to the following good practices to help ensure that the review process is accessible, communicated to claimants, streamlined, fair and objective:

- All claimants are systematically offered the possibility of having the decision reviewed, regardless of the reason for denial or termination (including contractual reasons);
- Claimants are informed in writing about the key elements of the decision review process (e.g., formalities, usual time frames, link to the relevant section or documents on the insurer's website (e.g., explanatory documents, FAQs));
- A decision review process is implemented that is straightforward for claimants and that, in particular:
  - reduces red tape
  - involves fewer steps
  - allows claimants to obtain a review by all the appropriate parties upon their first request for review
  - provides claimants with assurance that a health professional has been consulted as and when required
  - can be easily accessed by claimants (e.g., process that is available and easy to find on the insurer's website or on a secure site dedicated to claimants)
- A fair and objective analysis of the request for review is ensured by, among other things, having it carried out by someone other than the individual who initially examined the claim.

Sound Commercial Practices Guideline

The AMF expects claims to be examined diligently and fairly, using a procedure that is simple and accessible to claimants.

In particular, the AMF expects claimants to be aware of the main steps of the claims examination process and the anticipated time frame.

3. COMPLAINT EXAMINATION AND DISPUTE RESOLUTION

Claimants should be notified (e.g., by letter or via the insurer's website) of the insurer's complaint examination and dispute resolution procedure, including the contact information of the insurer's dispute resolution officer or ombudsman.

The procedure should be easy to find on the insurer's website so as to facilitate the filing of complaints.

Section 52 of the Insurers Act, which will come into force in June 2019,[8] will require insurers to make a summary of their complaint processing and dispute resolution policy publicly available on their website and disseminate it by any appropriate means to reach the clientele concerned.

The AMF expects insurers to adhere to the following good practices to help make information regarding the complaint examination and dispute resolution procedure more accessible and understandable to claimants:

- the letter sent to claimants after a denial is upheld includes the complaint examination and dispute resolution information available on the insurer's website (e.g., details included directly in the letter with a reference to the relevant section of the website);
- The complaint examination and dispute resolution information is made available in a readily identifiable location on the insurer's website;
- Claimants are reminded that they can request the transfer of their file to the AMF.

Sound Commercial Practices Guideline

The complaint examination and dispute resolution are key indicators for assessing an institution's performance regarding the fair treatment of consumers. The AMF expects consumers to know about the existence of a complaints examination and dispute resolution service and the contact information for accessing the service.

Among the best practices identified by the AMF, institutions can refer to the following:

- *common underlying causes of complaints are identified and appropriate measures are taken to eliminate or reduce them*
- *inappropriate behaviours by staff in charge of the complaint examination and dispute resolution process are identified and appropriate measures are taken.*

8 *Insurers Act*, S.Q. 2018, c. 23, s. 3

4. GOVERNANCE

4.1 Management information

Insurers should monitor indicators providing them with an overall view of FTC in group disability insurance so that a report may be provided to the board of directors and senior management that can be used to :

- assess FTC performance and obtain assurance that FTC objectives are being met
- develop findings, determine trends, identify risks and causes likely to have a negative impact on participants and on the insurer (e.g., reputational risk), and take timely action.

The AMF expects insurers to adhere to the following good practices to help provide insurers with an overall picture of their FTC performance and ensure proper FTC governance that is reflected in the corporate culture:

- FTC objectives are established for group disability insurance;
- Indicators are developed to assess the extent to which those objectives are being met, including:
  - the volume of premiums and benefits paid
  - claims examination and review time frames (including response and benefit payment time frames)
  - the number of claims by disability category or diagnosis
  - the percentage of denials that resulted in a request for review
  - the claim denial rate by disability category or diagnosis (including mental health claims)
  - the percentage of decisions that were upheld or modified following a review
  - the number, reasons and types of complaints and disputes
  - the client satisfaction rate for group disability insurance files (including an FTC component)
  - the quality assurance results
  - the results from monitoring FTC in group disability insurance
  - the distinction between physical and mental health disability indicators, where appropriate

Sound Commercial Practices Guideline

Among the best practices identified by the AMF, institutions can refer to the following:

- *generation of management information that makes it possible to:*
  - *assess the institution's performance with respect to fair treatment of consumers;*
  - *react, in a timely manner, to changes or risks likely to have a negative impact on the institution's clients;*
  - *prove that fair treatment of consumers forms part of the institution's corporate culture.*

- These indicators are analyzed to identify FTC issues or trends and take corrective action when required;
- A report is made to senior management and the board of directors so that they can obtain assurance that FTC objectives are being met;
- Mental health disability statistics are shared with the policyholder so the policyholder may implement improvement measures such as an employee assistance or health program. However, the policyholder must not be able to associate the information with a particular claimant.

4.2 Quality assurance

A quality assurance program helps ensure that the criteria set for the examination of group disability claims are being satisfied. Quality assurance checklists that are used to assess whether the criteria are being met should contain FTC-related items enabling insurers to ascertain that participants have been treated fairly throughout the disability claims process.

Incorporating such criteria into the quality assurance program is a valuable means of strengthening corporate FTC culture in group disability insurance files, especially as regards mental health disabilities.

The AMF expects insurers to adhere to the following good practices to better identify FTC-related issues in the quality assurance process:

- Quality assurance checklists include items to assess FTC, such as:
  - written and oral communications to the claimant are complete and meet the insurer's stated expectations, e.g.:
    - respectful tone and vocabulary tailored to the claimant's situation
    - reasons for denial stated in sufficient detail
    - reference made to the review and complaint examination process and dispute resolution process, when required
    - examination time frames clarified
  - claim file analyzed and handled appropriately (e.g., consideration of all items in the file; preparation of an intervention plan suited to the claimant's situation)
  - health professional consulted, if necessary, at the appropriate time
  - consultation with or authorization from a higher-level individual or a manager when required (e.g., in more complex cases)
  - calls returned in a timely manner
  - certain telephone calls monitored at key stages in the claims process
  - rules applicable to claim to claimant personal and confidential information duly followed

Sound Commercial Practices Guideline

Among the best practices identified by the AMF, institutions can refer to the following:

- *mechanisms and controls to identify and deal with any departure from the institution's strategies, policies and procedures, any conflicts of interest or any other situation likely to interfere with the fair treatment of consumers.*

- Quality assurance results are analyzed to identify and address issues;
- A review is conducted with the staff and teams involved so as to inform them of the items to be improved, require corrective actions when necessary (e.g., reassessment of a decision or an item), and monitor the implementation of the corrective actions required;
- Update the training program, provide instructors with awareness training, and, for training provided by the reinsurer, work with the reinsurer, to disseminate or adapt training in light of the quality assurance results.

5. PROTECTION OF PERSONAL INFORMATION

It is essential to maintain the confidentiality of personal information, including through the use of secure means of communication.

The AMF expects insurers to adhere to the following good practice to help better protect personal information and strengthen public confidence:

- Secure means of communication are used and are provided to the parties involved (e.g., participant, policyholder, employer, health professional) for the sending of highly sensitive personal data such as medical information.

Sound Commercial Practices Guideline

The AMF expects the personal information policy adopted by a financial institution to ensure compliance with the provisions of the Act respecting the protection of personal information in the private sector and reflect best practices in this area.

The protection of personal information is a key issue for a financial institution. The sustainability of its operations depends, among other things, on public confidence in this regard. Consumers expect that their information remains confidential and be handled accordingly.

CONCLUSION

Many of the good practices in this report are already being followed by some insurers, and insurers will identify the respective areas for improvement that are applicable to them.

Several insurers, following our work and our discussions with them, have confirmed that they have already started to review certain practices and will continue their efforts in light of the recommendations in this report.

To help achieve the objectives of this report, as part of its oversight mandate, the AMF will follow up individually with the insurers to verify the implementation of the recommended good practices by obtaining an action plans from each of them and carrying out its activities under its Supervisory Framework.

The AMF is aware that other stakeholders, including in the medical field, also have concerns about the fair treatment of mental health disabilities. The AMF remains available to hold a dialogue with those stakeholders in order to add to the conversation on this matter.

The AMF wishes to remind readers that general information about group disability insurance is available on the AMF website.[9] They can also obtain information from the AMF Information Centre by submiting an online request[10] or calling one of the numbers below:

Autorité des marchés financiers

Québec City
418-525-0337

Montréal
514-395-0337

Toll-free
1-877-525-0337

9 https://lautorite.qc.ca/en/general-public/insurance/group-insurance/disability-insurance/

10 https://lautorite.qc.ca/en/general-public/assistance-complaints-and-compensation/

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