The Promise Kept Last

Insurance claims in Canada, and the case for answering to the people who claim

The four checks of Channels, Not Dams, applied by David Eqbal

Key messages

- **The company that pays decides what it owes.** When a claim is disputed, the adjuster, engineer or examining doctor is chosen and paid by the insurer. Outside a few exceptions, the only fully independent decision is a court, often years later, at the claimant's cost.
- **Solvency is well supervised. The claim is not.** Canadian insurers rarely fail. But how they treat the people who claim rests on principles and guidance, not enforceable rules.
- **The checks are paid for by the checked.** The two industry ombudsmen are funded entirely by insurers and can only recommend. In April 2026 the regulators rewrote their framework and kept both features.
- **The data exists, but the public cannot see it.** Insurers in Ontario and Québec have reported complaint data to regulators since 2005. No regulator publishes, insurer by insurer, how often claims are denied or how long they take.
- **This brief proposes two tracks.** Track A makes every insurer answer to claimants. Track B creates a Canadian Insurance Trust: a public option in basic home and flood, disability income and, where provinces opt in, basic auto, and a backer for policyholder-owned mutuals.

The facts

Three layers, none built for the claimant. Solvency is supervised by OSFI for federal insurers and by the provinces for the rest, with Assuris and PACICC as safety nets. Market conduct belongs to the provinces (in Ontario, FSRA), coordinated through national

guidance issued in 2018. Disputes go first to the insurer, then to an industry ombudsman, then to the courts.

The ombudsmen, by the numbers. In its most recent record year the General Insurance OmbudService (home, auto, business) received more than 7,300 inquiries; 550 went to conciliation, six to mediation and two to its senior adjudicator. The OmbudService for Life and Health Insurance received 5,375 inquiries in the year to March 2025, including 1,470 complaints; 16 reached a full investigation. Disability was the second most complained-about product. Neither ombudsman's findings bind the insurer.

What the regulator found. In 2024 FSRA reviewed twenty home insurers. Some could not show they oversaw their adjusters, and some did not track why they deny claims. FSRA urged improvement. No enforcement was reported.

A concentrated market. The ten largest groups hold about 59 percent of home, auto and business insurance. Three companies hold about 67 percent of life and health insurance revenue; all three were owned by their policyholders until about 2000.

Where claims are hardest. Sewer backup and overland flood are separate endorsements, so the cause of the water can decide the claim. The Ontario and Québec storms of 30 June to 3 July 2026 caused an estimated $491 million in insured damage. The national flood insurance program promised for April 2026, with $450 million committed, has not launched, and about 1.5 million high-risk households cannot buy affordable flood cover. In long-term disability, the definition of disability commonly changes at twenty-four months, and benefits often end there.

Why the controls are still missing

No one had to be bought. Six forces produce the softness on their own: a mandate built around the solvency of the institution; a few organized insurers facing millions of claimants who each claim once and move on; checkers paid by the industry they check; a system split between federal and provincial bodies, where no one owns the claimant's problem; governments that retreated under pressure, as Ontario did from public auto insurance in 1991; and an industry that is also one of the country's largest long-term investors. The last is the least proven and is offered as a hypothesis.

The four checks applied

The series this brief belongs to asks whether a power is held in a way that can be trusted when the person holding it is ordinary. Applied to the moment of the claim:

Check	What exists	What is missing
Independent evaluation	Appraisal clauses for the amount of a property loss; Ontario's Licence Appeal Tribunal for auto accident benefits	Anyone the insurer does not pay, at the moment of decision, in every other line
Transparency	The claimant can usually get reasons and the file, sometimes only through a lawyer	Public, insurer-by-insurer data on denials, reasons, delays and reversals
Flagging channel	Insurer complaint process, two industry ombudsmen, the courts	Force: ombudsman findings bind no one, and the courts take years
Monitoring from below	None	Any standing way for claimants' experience to reach the public record

The two conditions also fail. The checks report upward, to regulators, not outward to claimants. And the regulator, funded by industry fees, is not evaluated by anyone who answers to the people who claim.

Recommendations

Track A: make every insurer answer to claimants (provinces and their regulators)

1. **Publish claims data for every insurer, every year:** claims paid, partly paid and denied; reasons; time to decision and payment; complaints, ombudsman outcomes and court losses.
2. **Make delay cost the insurer:** statutory deadlines to acknowledge, decide and pay, with interest and the claimant's reasonable costs running automatically when they are missed. Ontario already charges interest on overdue auto accident benefits.
3. **An independent review before anyone has to sue:** for disability terminations, disputes over the cause of a loss and large claims, a physician, engineer or adjuster from a public roster, assigned by the regulator, paid by an industry levy, binding on the insurer up to a limit.

4. **A binding ombudsman, funded at arm's length:** decisions bind the insurer if the claimant accepts them, as in the United Kingdom and Australia, with funding through a regulator-collected levy and outcomes published by insurer.
5. **Rights for group-plan members:** a plain summary at enrolment, including any change of definition, and the same rights as a policyholder to the file, the review and the ombudsman.
6. **A claimants' record:** a public way for claimants to put their experience on record, reported by insurer, with regulators surveying claimants in every review.
7. **Conduct enforcement that can be seen:** written reasons for every denial, oversight of adjusters and examiners, penalties for patterns, and the insurer named.
8. **A regulator that answers to claimants too:** a consumer office with a budget set by statute rather than industry fees, reporting publicly each year on how claimants are treated.

Track B: a Canadian Insurance Trust (federal government, provinces opting in)

9. **Model 1, a public option:** a federal Crown corporation, at arm's length like CMHC, offering basic home cover with fire, sewer backup and overland flood together; disability income with one definition that does not change without a fresh independent assessment; and basic auto in provinces that join. It competes; it does not replace.
10. **Model 2, a backer for mutuals:** start-up capital, reinsurance and shared claims infrastructure for policyholder-owned insurers, in return for the four checks, claimants on the board and an asset lock against demutualization.
11. **Deliver the national flood program through the Trust,** as the public reinsurer behind every flood policy and the insurer of last resort, using the $450 million already committed.
12. **Apply Track A to the Trust first and in full,** with premiums set by its board and published with reasons, no transfers to general revenue, OSFI supervision and an independent evaluation every five years.

For employers and unions

When buying or renewing a group plan, ask for the plan's claims data, bargain for a definition of disability that does not change without a fresh independent assessment, and write members' rights to their file and to independent review into the contract.

What this brief does not claim

It does not claim that insurers act in bad faith, and many claims are paid fairly. It does not know how many claims Canadian insurers deny, or whether shareholder insurers deny more than mutual or public ones; no published Canadian data answers either question, and that absence is part of the argument. The Canadian Insurance Trust has not been costed; that is work for actuaries, and the brief invites it. Public insurers can fail their claimants too, which is why the four checks apply to the Trust first. Nothing here is legal or financial advice.

About this brief

This brief summarizes *The Promise Kept Last: Insurance, Trust and the People Left Alone* (David Eqbal, October 2026, 58 pages), which applies the four checks of *Channels, Not Dams: Architectural Republicanism and the Design of Legitimate Power* (ssrn.com/abstract=7617458) to property and casualty, life, health and disability insurance in Canada. The full paper, with its sources, practical steps for claimants and a model letter to elected representatives, is free to read on SSRN (ssrn.com/abstract=7643938) and at **citizenstance.ca/research**.

Sources: Canadian Council of Insurance Regulators, Insurance OmbudServices Cooperation and Oversight Framework (29 April 2026); CCIR and CISRO, Conduct of Insurance Business and Fair Treatment of Customers (2018); FSRA, Home Insurance Thematic Review Report (June 2024); General Insurance OmbudService and OmbudService for Life and Health Insurance, annual reports; Catastrophe Indices and Quantification Inc. (17 August 2026); Insurance Business Canada (April to October 2026); Bank of Canada Staff Analytical Note 2024-7; *Whiten v. Pilot Insurance Co.*, 2002 SCC 18; *Fidler v. Sun Life Assurance Co. of Canada*, 2006 SCC 30. Full references are in the paper.

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