



Leveraging Customer Complaints as Strategic Risk Intelligence

SIFM 2025 Annual Conference

September 2025



Speakers



Paul Avinger
Senior Manager
Risk Advisory Services

D +1 704 926 0355
E paul.avinger@us.gt.com



Demille Kelly
Senior Associate
Risk Advisory Services

D +980-242-4624
E demille.kelly@us.gt.com

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Introduction



Purpose

- **Goal:** To reframe customer complaints as a source of insight—not just a compliance obligation, and to highlight how innovative insurers use complaints to enhance risk management and customer experience.
- **Why Now?**
 - Rising regulatory scrutiny and customer expectations
 - Increasing complexity of fraud and misconduct risks
 - Demand for data-driven, cross-functional decision making

Current State: Complaints as a Compliance Exercise

Regulatory-Driven Mindset

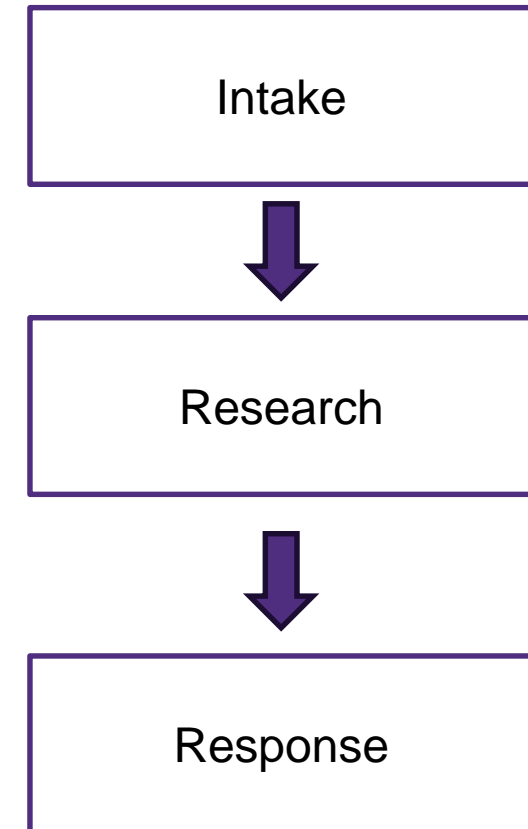
- **Reactive rather than proactive:** In many insurance companies, the complaints process is governed almost entirely by state-level regulations, NAIC model laws, and oversight bodies. This results in programs focused **on timely response and documentation rather than strategic insight.**
- **Minimal compliance threshold:** Success is defined as avoiding fines or regulatory inquiries—**not on the depth of issue resolution** or learning from complaint trends.
- **Audit and exam focus:** Procedures are often built to satisfy regulators (e.g., proof of resolution within X days, standard templates, tick-box documentation) rather than business leaders or risk owners.

Operational Fragmentation

- **Siloed by function and product:** Many insurers route complaints through specific product teams, third-party administrators (TPAs), or call centers with little integration or holistic oversight.
- **Lack of centralized analytics:** Even when centralized complaint units exist, they may operate independently from key risk, fraud, or customer experience functions.
- **Inconsistent categorization and taxonomy:** Complaint types may vary across platforms, with limited or no root cause tracking, making trend analysis nearly impossible.

Cultural Framing as a Burden

- **Low-priority perception:** Internally, complaints are often seen as “problems to resolve” rather than “signals to understand,” leading to **underinvestment in people, systems, and analytics.**
- **Customer service fatigue:** Frontline staff may be incentivized to *close* complaints quickly rather than *learn* from them—creating shallow resolution and rework cycles.



Regulatory Guidance - NAIC

According to NAIC '2025 Market Regulation Handbook Examination Standards Summary'

“The complaint handling review includes, but is not limited to, the following standards addressing various aspects of a regulated entity’s operations:

- 1. All complaints are recorded in the required format on the regulated entity’s complaint register.***
- 2. The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.***
- 3. The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.***
- 4. The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.”***



The Opportunity: Complaints as Strategic Intelligence

- **The shift from “compliance lens” to “risk and intelligence lens” enables insurers to:**
 - Predict rather than react to reputational and financial risk
 - Proactively address root causes before they scale
 - Align complaints data with broader enterprise risk priorities
- **Strategic Outcomes Enabled by Complaints Intelligence**
 - Enhanced Fraud and Misconduct Detection - detect early indicators of:
 - Claims fraud (e.g., repeated denial or delay themes)
 - Identity theft (e.g., unauthorized policy changes or payments)
 - Producer performance, Ghost broking or churning complaints tied to specific agents or ZIP codes
 - Product and Process Optimization
 - Inform product redesign and UI/UX improvements
 - Stronger Customer Experience and Retention
 - Surface root causes behind NPS declines, lapse rates, or cancellations



Foundational Elements



End-to-End Complaints Management Overview

1. Intake & Capture
 - a. Channels: Phone, email, web, regulators, social media
 - b. Data standardization and triage
2. Categorization & Routing
 - a. Risk-based classification (e.g., fraud flags, regulatory urgency)
 - b. Assigning ownership (business unit, risk, compliance)
3. Research, Resolution, & Response
 - a. Timeliness, documentation, and regulatory responsiveness
 - b. Importance of consistent root cause coding
 - c. Dashboards and escalation protocols
 - d. Integration with ERM, Quality Assurance, and Internal Audit reporting
4. Analytics & Feedback Loop
 - a. Trend analysis and linkages to fraud, producer performance, or ops issues
 - b. Closed-loop feedback into business processes and training

NAIC 2024 Complaint Reason Overview

Reasons Closed Confirmed Consumer Complaints Were Reported

YEAR	Reason for Complaint	F	Count	% of Total SumCount alon..
2024	Claim Handling - Delays		14,975	22.78%
	Claim Handling - Unsatisfactory Settlement/Offer		7,862	11.96%
	Claim Handling - Denial of Claim		7,741	11.78%
	Claim Handling - Adjuster Handling		3,808	5.79%
	PolicyHolder Service - State Specific		3,530	5.37%
	Underwriting - Cancellation		2,653	4.04%
	Claim Handling - Prompt Pay		2,603	3.96%
	PolicyHolder Service - Coverage Question		2,223	3.38%
	Underwriting - Nonrenewal		1,888	2.87%
	PolicyHolder Service - Delays/No Response		1,692	2.57%
	Underwriting - Premium & Rating		1,678	2.55%
	PolicyHolder Service - Premium Refund		1,606	2.44%
	Claim Handling - State Specific		1,376	2.09%
	PolicyHolder Service - Inadequate Reimbursement Rates		1,349	2.05%
	PolicyHolder Service - Premium Notice/Billing		1,263	1.92%
	Claim Handling - Out-of-Network Benefits		749	1.14%
	Claim Handling - Medical Necessity		651	0.99%
	Claim Handling - Co-pay Issues		438	0.67%
	Claim Handling - Recoupment		438	0.67%
	Marketing & Sales - State Specific		432	0.66%
	Underwriting - State Specific		430	0.65%
	Marketing & Sales - Fraud/Forgery		369	0.56%
	Marketing & Sales - Misrepresentation		347	0.53%
	PolicyHolder Service - Surrender Problems		304	0.46%

Source: National Association of Insurance Commissioners. “Closed Confirmed Consumer Complaints by Reason – CIS.” NAIC. Retrieved from NAIC’s Consumer Information System (CIS) portal.

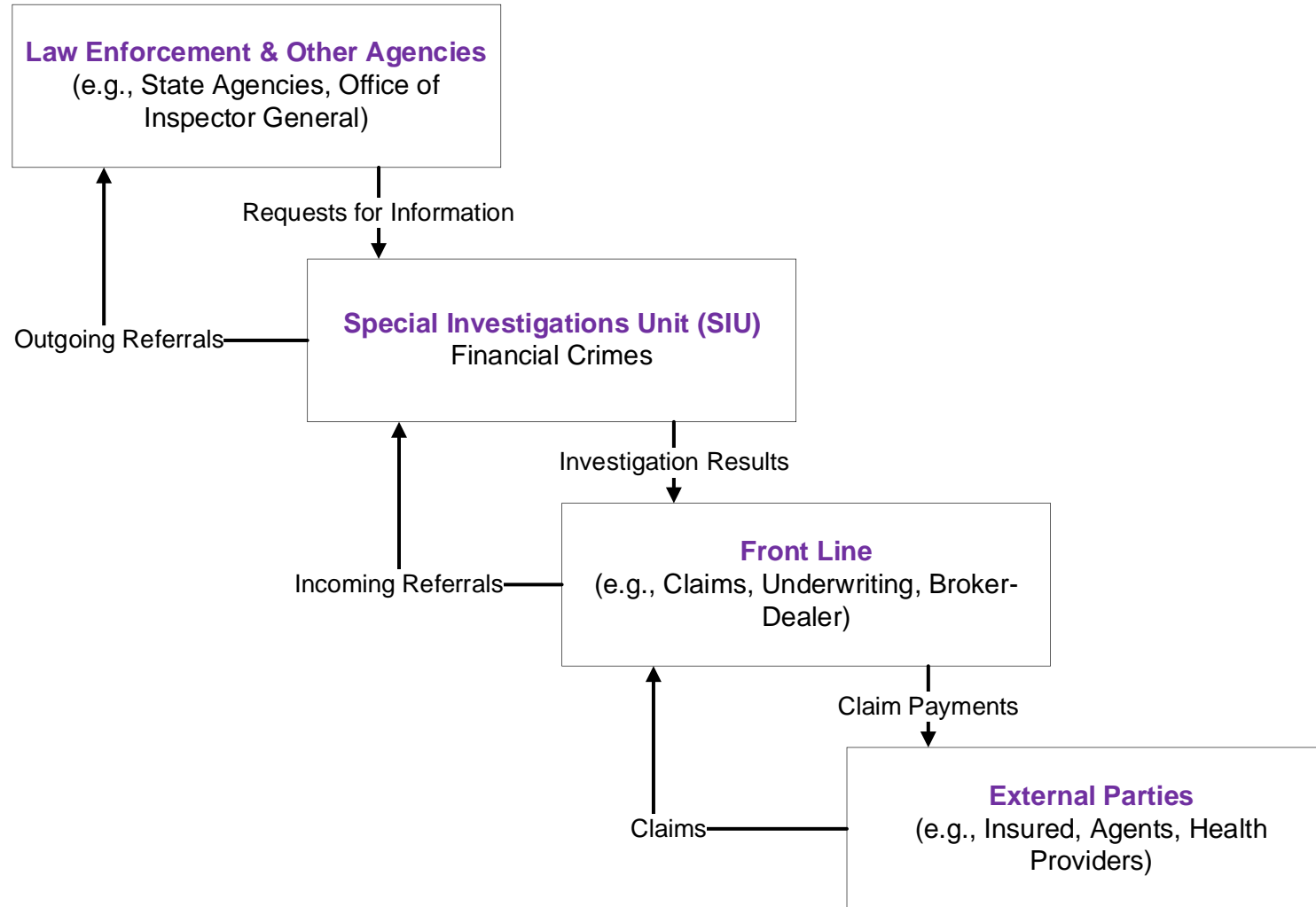
What is Fraud?

- “Fraud” is **any activity that relies on deception in order to achieve a gain**
 - (Association of Certified Fraud Examiners)
- Fraud **becomes a crime** when it is a “knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment”
 - (Black’s Law Dictionary)

Fraud Risks by Product

Product Category	Common Fraud Risks
Health	<ul style="list-style-type: none">• Durable Medical Equipment (DME) Fraud• Upcoding• Long Term Care Overbilling
Auto	<ul style="list-style-type: none">• Staged Accidents• Exaggerated Claims• False Vehicle Theft
Life	<ul style="list-style-type: none">• Application Fraud• Premium Diversion• Death Fraud
Disability	<ul style="list-style-type: none">• Exaggeration of Symptoms or Conditions• Unreported Income or Double-Dipping• Fake or Misrepresented Medical Documentation
Financial Investment	<ul style="list-style-type: none">• Producer Performance, Churning• Account Takeover• Elder Abuse

Fraud Referral Process Overview



Spotlight: Producer Performance Concerns

- **Producers (agents, brokers, and representatives)** are the front line of insurance distribution and customer interaction. Their conduct directly impacts:
 - Customer trust and satisfaction
 - Regulatory exposure
 - Fraud and reputational risk
 - Persistency, lapse ratios, and product suitability
- **Producer performance concerns** or unethical conduct can manifest as:
 - Fraudulent applications or forged documents
 - Misrepresentation of coverage or benefits
 - Unauthorized policy changes
 - Premium theft or refund abuse
 - Aggressive upselling or churning
- Complaints often serve as **early indicators of these risks**, particularly when analyzed in aggregate across lines of business, geographies, or distribution channels.

Potentially Indicative Complaint Categories

Based on NAIC and industry data, producer-related concerns often surface under:

- Marketing & Sales – Misrepresentation
- Marketing & Sales – Fraud/Forgery
- Underwriting – Premium & Rating Manipulation
- Policyholder Service – Delays or Premium Refunds
- Claim Handling – Adjuster Handling (when adjusters are aligned with producer networks)

These complaints may reflect:

- Intentional deception (e.g., ghost broking)
- Negligence or insufficient training
- Incentive misalignment (e.g., sales contests driving misconduct)
- Inadequate onboarding, oversight, or monitoring by the carrier

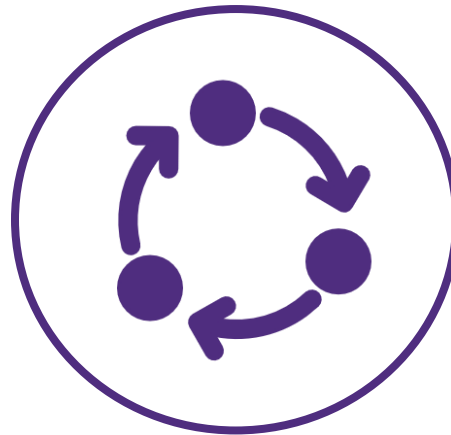
Root Cause Analysis

Companies should perform root cause analysis on **patterns and trends observed in complaints data** to pinpoint the underlying drivers of potential issues. This ensures that corrective actions address the true source of the problem—whether operational, behavioral, or systemic—rather than just the symptoms.



People

Issues related to errors or actions taken by employees due to lack of training, miscommunication, or fatigue



Process

Issues related to unclear standards or gaps in controls and procedures.



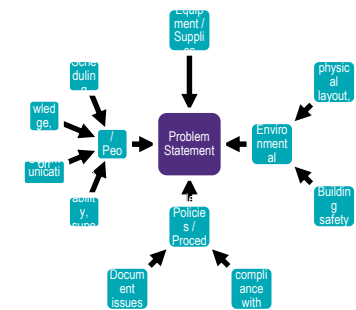
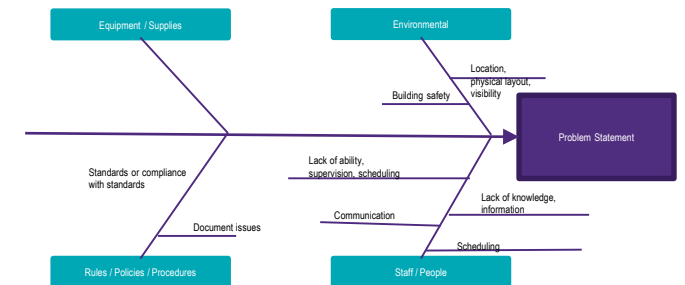
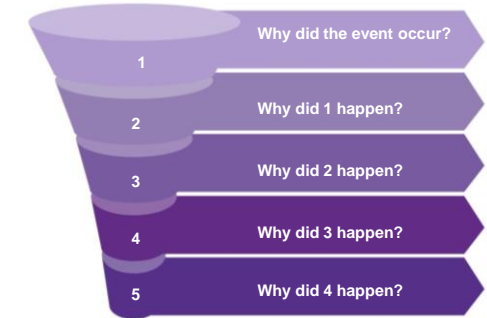
Technology

Failures or defects in equipment, tools, and technology used in everyday operations

Root Cause Methodology

Establish an enterprise root cause methodology. It is imperative to identify the true root cause of an issue to effectively remediate the issue and prevent reoccurrence. There are various root cause methodologies that can be deployed.

- The **5 Why's Method** is used to drill down to the key source of the event or problem identified by the organization. The process of asking at least five whys give companies the ability to attack not just the symptoms of poor quality but the underlying root cause — the core reason behind what happened.
- A **Fishbone Diagram** is a technique used to evaluate complex issues by breaking down specific components or input data analyzed. Lines on the map indicate how the causes cascade or flow to the effect / problem.
- A **Mind Map** is a visual technique used to capture and organize all of the possible causes and contributing factors linked to a problem. The tree-like diagram demonstrates how deeper systemic issues contribute to the surface level problem.



Root Cause Example – Producer Performance

The results of a root cause analysis should identify the underlying reasons for trends identified in complaints data and help to uncover potential risks and process gaps.

Summary: ABC Insurance Company’s complaints data indicated a gradual increase in complaints related to life insurance premiums increasing after renewal. Because the Company categorizes complaints by region, they identified that a disproportionate number of complaints came from the same geographic area.

Root Cause Questions	Responses
1. Why did the issue happen?	Customers reported that life insurance premiums were increasingly unaffordable following renewal.
2. Why did 1 happen?	Policies were written with inflated incomes and placed customers in higher coverage amounts than they can afford.
3. Why did 2 happen?	The producer inflated incomes to qualify customers for larger policies and earn higher commissions. Although the incomes on these policies were inflated, they were just below the company’s income verification threshold, so the underwriting process did not require proof of income.
4. Why did 3 happen?	Producers may be incentivized to submit inaccurate information to earn higher commissions.
5. Why did 4 happen?	The company’s commission structure for that geographic market may be misaligned to its risk tolerance for producer performance concerns.

Identified Root Causes

People and Process: The RCA process identified specific areas of producer performance concerns as well as opportunities for process improvement. As a result, ABC Insurance Company took action to refine its incentive compensation design for specific markets.

Root Cause Analysis – Corrective Action

The results of Root Cause Analysis should indicate next steps for the Company to address the systemic issue/problem identified. Companies should provide standard classifications for results with risk-based requirements:

- **Business as Usual:** Findings identified that the event(s) was the result of conduction normal business activities. No action required.
- **Enhancement:** Findings identified a breakdown in processes that could be enhanced through additional training or procedural guidance, but do not rise to the level of an issue.
- **Issue:** Findings identified a systemic issue or problem that puts the Company at high risk for financial, reputational, or compliance related consequences.

Findings requiring corrective action should be assigned **Corrective Actions Milestones** - measurable tasks or achievements that mark progress towards resolving the issue. These milestones help track the implementation of corrective actions, ensuring that the plan stays on schedule and that each step is completed effectively.



Implementation



Key Considerations for Implementation

Best complaints management practices include:



Data Governance: Organizations should have foundational governance documentation that establishes the process by which Complaints should be documented and maintained. Key data elements should be required for each complaint documented across the enterprise.



Centralized Complaint Management System: It is optimal to record complaints in a single system of record to enable consistent workflow and an enterprise view of complaint-related analysis and reporting.



Complaint Escalation Process: Develop a process to escalate complaints based on their level of risk.

- **Low risk** complaints are inclusive of customer concerns that could be resolved easily and do not indicate that the customer was harmed as a result of Company processes or practices.
- **High risk** complaints may contain indications of regulatory concerns and customer harm. These complaints should be investigated further to ensure the customer is made whole and Company identifies effective corrective actions if necessary.

Key Considerations for Implementation

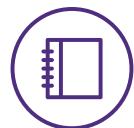
Best complaints management practices include:



Cross Functional Collaboration: Organizations should work with Business Units and Subject Matter Experts (SMEs) in areas such as compliance and fraud risk to analyze complaints that indicate potential fraud and regulatory compliance risks.



Monitoring: Organizations should develop and implement processes that analyze complaints data to monitor front line adherence to Company policies and procedures (e.g., QA / key performance indicators). Additionally, monitoring processes should be implemented to identify and address risks / issues caused by gaps in Company procedures and processes (e.g., Root Cause Analysis).



Reporting: Organizations should develop reporting to relevant business group leaders and committees that provide insights on specific products and services. Reporting promotes awareness and enables oversight of business performance, and the risks identified through complaints.

Maintaining Complaints Data

Where possible, complaints should be stored and tracked in a **centralized system of record**. Some of the most important elements to be captured during the Complaints lifecycle include the following:

- **Customer Information:** Information related to the customer/individual submitting the complaint.
- **Related Product/Policy:** The product or service the complaint is related to, including the policy type / number associated with the complaint.
- **Business Unit:** The business unit the complaint is related to. This groups may also be responsible for researching and resolving the complaint.
- **Complaint Source:** The method by which the complaint was logged (e.g., phone, email).
- **Risk Level:** The initial assigned risk level to the complaint based on its characteristics (e.g., regulatory related complaints).
- **Complaint Description:** A detailed description of the complaint, including a problem statement, background context, and root cause of the issue.
- **Complaint Reason:** A high-level description that describes the cause of customer dissatisfaction (e.g., Delayed Claims Processing).
- **Issue Identified Date:** The date the issue was identified.
- **Resolution:** A high-level description of the actions taken by the associated business owner/business group to resolve the complaint.

Leveraging AI for Complaints

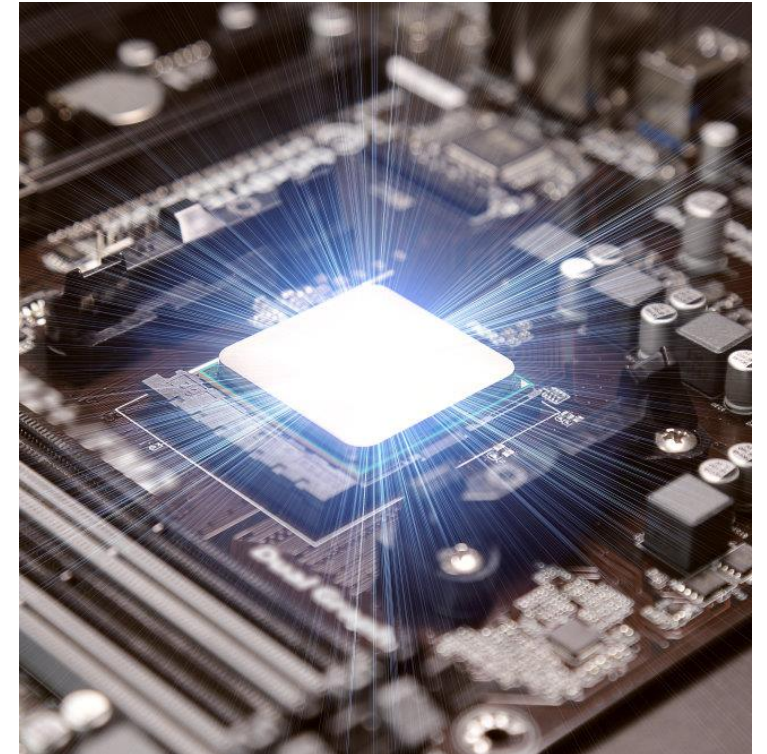
Organizations are using artificial intelligence to identify potential instances of fraud and more effectively manage their complaints management programs. Implementation opportunities include:



Advanced Listening: Organizations implement advanced listening technologies to analyze customer calls for potential complaints not logged by employees. This supports the **effective and consistent** capturing complaints across the organization.



Case Management: AI can be used to streamline some processes more prone to human error. For example, Companies leverage AI to populate complaint and fraud referral case details based on customer information and interactions. This **lowers the risk of human error and streamlines the case management process.**



Case Study – Underwriting Enhancements

Complaint

ABC Insurance Company's complaints data indicated a 35% increase in complaints related to home insurance products. Based on a high-level review of the complaints, customers reported that they could not close on their homes because their home insurance policies excluded roof coverage, and that lenders frequently required additional inspections.

The data revealed a systemic issue related to how roof coverage requirements were handled in underwriting and communicated during policy issuance.

Root Cause

Underwriting Process: Company guidelines and requirements for roof inspections / exclusions were not consistently applied as part of quotes.

People: Policy documents and customer communication lacked clarity regarding roof coverage exclusions and inspection requirements.

Technology: There was no automated flag or alert system to notify agents or customers of these requirements during the quoting or binding process.

Outcome

ABC Insurance integrated underwriting rules into the quoting system to automatically flag roof coverage requirements.

ABC Insurance rolled out supplemental training modules focused on roof coverage and inspection protocols.

ABC Insurance updated policy documents and added pre-bind disclosures to ensure customers are aware of all coverage conditions.



ABC Insurance Company conducted root cause analysis on a set of complaints and identified enhancements to the home insurance underwriting process to improve customer experience.

Customer Remediation & Why it Matters

Customer Remediation is the process a company undertakes to identify, address, and resolve issues that have negatively impacted customers—especially when the company is at fault.

Core Activities Typically Include:

- **Identifying impacted customers:** defining the affected population based on root-cause analysis and data review
- **Quantifying impact:** calculating financial or non-financial impact
- **Communicating with customers:** delivering clear and timely outreach
- **Ensuring proper closure:** documenting decisions, controls, and outcomes to support audit and regulatory review

Why it Matters:



Preserve Trust

Timely and fair remediation helps maintain and rebuild customer confidence after a service failure or error



Protect Brand Reputation

How a company handles mistakes can significantly impact public perception and long-term brand value



Legal and Regulatory Risk

Effective programs help companies stay compliant and avoid fines, lawsuits, or enforcement actions



Operational Improvement

Remediation efforts strengthen governance, improve controls, and promote continuous improvement to prevent reoccurrence

Thank you