

Fair Benefits Fairly Delivered

A Review of the Auto Insurance System in Ontario

Final Report
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Introduction

OBJECTIVES AND SCOPE OF THE STUDY

In February 2016, I was appointed by Order in Council as a Special Adviser to the Minister of Finance to review and make recommendations as to improvements in the system of auto insurance in the Province of Ontario.


Auto insurance is compulsory for drivers in Ontario. The Financial Services Commission of Ontario (FSCO), is an agency of the Ministry of Finance that regulates insurers and approves most insurers' auto insurance rates.

Auto insurance impacts all consumers in Ontario as the cost and the coverage it provides impacts not only the over 9.7 million private passenger drivers and other road users, but also is a component cost of transportation for all goods and services in the province. There are approximately 60,000 injuries in motor vehicle collisions each year in Ontario. As a result, the price of auto insurance is of significant policy interest to the government.

Ontario is frequently criticized as having the most expensive auto insurance rates in the country. The government has been taking a range of actions to meet its commitment to rate reduction, including the passage of Bill 15, Fighting Fraud and Reducing Automobile Insurance Rates Act, 2014 and a number of regulation changes.

I was asked to provide advice to the Minister of Finance on the development of further initiatives to reduce claims costs and uncertainty in Ontario's auto insurance system. In developing advice, I was asked to focus on improving the efficiency and effectiveness of claims management in the system based on best practices in Ontario and other jurisdictions. In particular, I was asked to focus on:

- **Coverage options.** The option to give consumers more flexibility to buy coverage options that reflect individual needs, and the possibility of a lower cost auto insurance product focused on essential coverages as a means of providing additional insurance options for Ontario drivers.
- **Comparable systems.** Structures of comparable auto insurance systems in Canada.
- **Common traffic injuries.** The development and implementation of a successor to the current Minor Injury Guideline (MIG) based on the most recent medical evidence presented in "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person," a report developed for FSCO by a team of medical experts led by Dr. Pierre Côté.

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- **Medical examinations and assessments.** Measures to improve efficiency and reduce duplication in the provision of the overall management and delivery of health care on behalf of auto insurance claimants and insurers in Ontario's auto insurance system.
 - **Legal costs.** The nature and extent of legal fees currently incurred by individuals pursuing claims in Ontario's auto insurance system, the effectiveness of current rules in place to protect consumers from unreasonable fees and possible measures to improve transparency, competition and consumer protection in this area.
 - **Dispute prevention.** Approaches to preventing disputes, particularly over accident benefits claims, in Ontario's auto insurance system. This could include further examination of the Honourable J. Douglas Cunningham's recommendations in the 2014 Ontario Automobile Dispute Resolution System Review Final Report (Cunningham Final Report) for further restrictions on lump-sum settlements of certain accident benefits claims and the need for individual insurance companies to establish internal review processes.
 - **Engagement and education.** Strategies to engage consumers and health care practitioners regarding changes in the auto insurance system, including strategies to inform consumers regarding new coverage options, promote adoption of new evidence-based treatment protocols and minimize the development of disputes between claimants and insurers.
 - **Evidence-based treatment protocols.** Adopting new protocols and minimizing the development of disputes between claimants and insurers.



CONDUCT OF WORK

In conducting my work, I examined extensive records and conducted research and interviews, including interviews and discussions with officials within FSCO, the Ministry of Finance and representatives of Insurance Companies and Associations within Ontario and other provinces (see Appendix I for full list). As well, I inquired into the auto insurance system of Alberta which has a similar private sector distribution system as Ontario and the systems in Saskatchewan, British Columbia and Quebec, which have various forms of public/private distribution systems.

I received significant support from the leadership and staff of FSCO without which I could not have completed my review. I would also like to acknowledge the value of the Superintendent's Report on the Three-Year Review of Automobile Insurance, completed in December 2014. In many instances, the Report was prescient in that it suggested lines of inquiry and possible improvements that anticipated my own findings and recommendations.



Executive Summary

Auto insurance in Ontario is mandatory. It comes in two parts. A no-fault part, (also called the accident benefits part) where benefits are provided whether or not a driver is at fault; and recourse to sue an at-fault driver for damages through a court action (also called the tort or bodily injury part). The insurance premium reflects the total cost of both parts.


Ontario delivers its program through private sector insurance companies. Alberta and Nova Scotia do the same. Other provinces (like Manitoba, Saskatchewan and British Columbia) run their insurance either exclusively or mostly through government agencies, while Quebec provides all the medical and rehab benefits through the province and allows private sector companies to sell insurance for damage to the car or other property.

Since it is mandatory for drivers to purchase automobile insurance, there is a corresponding responsibility on government to create a marketplace where fair benefits are fairly delivered, at a reasonable cost. This report examines Ontario's auto insurance marketplace and provides recommendations for improvement.

Overall, Ontario has one of the lowest levels of auto accidents and fatalities in Canada and the most expensive auto insurance premiums. Historically, periods of cost reduction have inevitably been followed by cost increases. What is more disappointing is that while the number of automobile accidents in Ontario – especially very serious ones – have consistently come down, the cost of claims has consistently gone up. Ontario also has one of the least effective insurance systems in Canada. It is filled with disputes and inefficiencies, and a very high percentage of premiums are being used to pay experts and lawyers and not going directly to injured persons.

The opportunity gap: Ontario's average auto insurance premium for 2015 at \$1,458 per vehicle, represents a significant expenditure for the average Ontarian. That premium is 24 per cent higher than Alberta's, double the premium in Quebec and almost 55 per cent higher than the Canadian average, excluding Ontario. Ontario drivers pay about \$10 billion in insurance premiums a year. If Ontario could achieve a premium level approaching the Canadian average of about \$930 it would save Ontario drivers almost 40 per cent off its current level - about \$4 billion a year or some \$20 billion over a five-year period – that's the opportunity gap.

The value gap: No one in the system is actively managing medical care for accident accident victims. There are clear indications that accident victims are not receiving appropriate care, they are taking longer to recover and many report that they have developed permanent impairments from simple soft tissue injuries – that's the value gap.




The structure is flawed: Current trends do not indicate that the system will self-correct. Claim costs continue to rise while automobile accidents continue to fall. The main cause is not inefficiency or excess profits by insurance companies or the behaviour of claimants, providers or lawyers. It is the way the system is structured.

The goal of the government is to provide a guaranteed safety net for those injured in auto accidents. Guaranteed safety nets work best when they are administered by a government agency, which is an administrative tribunal, with authority to interpret the governing legislation and set policy and practices. Private sector insurance companies work best when they can write policies with defined conditions and benefits. Ontario has devised a guaranteed safety net for victims of auto accidents and outsourced it to insurance companies without giving them the authority to decide how to deliver it.

The legislation is at once very broad and open to a wide latitude of interpretation and at the same time regulations are very prescriptive as to how insurance companies can deliver the product. This creates an opening for disputes as to interpretation on the one hand and restrictions on efficiency on the other. It is a structural flaw in the system.

The results are not good: There is little agreement as to what constitutes fair diagnosis and care for injuries. Consequently, many applications for benefits are rejected based on medical opinions obtained by insurance companies while claimants hire lawyers and generate countervailing medical opinions. Simple minor injury sprains and strains (80 per cent of claims) often take over a year to settle and incur high medical costs. Instead of a system that helps accident victims recover from their injuries, a significant portion of the system has been diverted into a cash settlement system in lieu of care. Each year about one third of benefit costs, some \$1.4 billion – about \$7 billion over five years – is being paid for competing expert opinions, lawyers' fees and insurer costs to defend claims – instead of going to treatment of injured parties.

The solution does not lie in reducing benefits. Fair benefits must be taken as the starting point in any recovery, and they must be delivered fairly. If these two conditions do not exist, the system will always fail to meet expectations. Nor does the solution, purely from a cost point of view, lie in changing from a private sector delivery to a public sector delivery system. Run properly, the premium cost for drivers under either system can be roughly the same.



While Ontario's benefits, taking into account both the no-fault and tort portions are, on the whole, fair, they are not being fairly delivered. The main cause is that the system does not promote a timely, conflict-free means of deciding what care is needed and providing it to accident victims. The system allows participants to work at cross purposes to its original goals:

- Insurers do not aim to provide care to their customers rather they focus on controlling costs.
- Accident victims may seek to maximize their entitlement rather than address their need.
- Lawyers working on contingency fees work to boost the value of claims.
- Providers are paid on volume of treatments, not results.


The system has strayed far from its goals. Justice Cunningham in his review of the Ontario dispute resolution system put it this way: “the whole notion of getting benefits to deserving claimants quickly and inexpensively has been lost.”¹

Broadly speaking, this report outlines a five-part action plan.

First, the government should fix the structural flaw in the system by setting up an arms-length regulator with a skills-based board. Thankfully this is already underway through the creation of the new Financial Services Regulatory Authority in Ontario. The legislation should set broad policy goals for auto insurance in the province and give the regulator powers to enact policies and procedures. The regulator must substantially overhaul existing Regulations to make them simpler to understand and easier to apply. The regulator will need to be very much more involved and proactive in the functioning of the auto insurance marketplace than it is today.

Second, the system of compensation for catastrophically injured persons needs to be substantially changed. Cash settlements are being drained by having to pay legal fees and, in any case, cash settlements often do not adequately meet the needs of catastrophically injured persons. They need lifetime care as their needs and available treatments will change over time. This must be actively explored with the Ministry of Health and Long-Term Care.

Third, the system needs to adopt a care not cash approach. The solution lies in focusing on timely, appropriate medical care, not cash settlements. All the other expenses such as wage replacement, attendant care, pain, and suffering build from the basis of the extent of recovery from an accident. The regulator must create programs of care – evidence-based treatment protocols, used extensively in several Canadian jurisdictions – that cover most common injuries. The programs of care need to be kept up to date and new ones introduced where necessary. Investment needs to be made on research into the diagnosis and treatment of mental stress and other neurological injuries.



This serves to avoid disputes as to what care is appropriate and delivers care to the majority of injured parties immediately. Where the programs of care don't apply, or don't work, a roster of hospital-based independent examination centres should be established by the regulator to provide diagnoses and future treatment plans. Insurers must provide the treatments prescribed in the programs of care or those that are stipulated by the independent examination centre without dispute. The advice given by the independent examination centres should be taken as mandatory in accident benefits and tort disputes and courts should afford these opinions a zone of deference in tort cases.

Where the legislation provides for care, care should be provided and not cash. This shifts the focus to the needs of the patient rather than the amount of the settlement.


Fourth, contingency fees for lawyers should be made much more transparent. The need for accident victims to hire lawyers to access benefits needs to be greatly reduced by simplifying the benefits and making them more readily available. And lawyers need to be held accountable for much more transparency in how they advertise and how they charge their fees.

Fifth, the auto insurance industry is likely to undergo major changes over the next ten years as innovation and competition from non-traditional sources come into the picture. The current regime of heavy regulation and price controls is poorly suited to adapt to the future. More open systems should be explored including changes to allow insurers to introduce new consumer products and to compete more freely on price and service in the marketplace.

There are several other supporting and useful recommendations that, for example, address more efficiency in the dispute resolution system; suggestions to improve the fairness of the tort system; ways to provide better education to consumers and improve innovation in the marketplace.

Ontario must strive to close the opportunity gap and achieve a premium rate for insurance that is close to if not at the Canadian average of about \$900 a year. Ontario must also close the value gap in its service and obligations to accident victims. There is absolutely no reason this cannot be achieved.

No one government bears the responsibility for the current state of automobile insurance in Ontario. Successive governments from all political parties over the past 30 years have tried to improve the cost and value that auto insurance delivers to the citizens of Ontario. No-fault benefits have been increased and decreased, access to tort has been increased and decreased, private vs. public delivery has been analyzed, cost control measures have been tried, anti-fraud measures have been introduced and freezing of insurance premiums has been tried. None of these measures has succeeded in improving service or reducing costs for a sustained period.



There is no magic bullet. To achieve lasting value for its citizens, the government must push beyond the old methods of tinkering with aspects of the system and make some of the structural changes to the delivery system as recommended in this report.

There is no need to make any reductions in benefits; indeed, catastrophically injured accident victims can be better served. There should be new investments in health care particularly for brain and mental injuries, such as chronic pain. Access to early, appropriate, health care should be made readily available. Accident victims will recover faster and fewer will develop permanent impairments from their injuries.

Disputes will be significantly reduced. Billions of dollars currently being spent on disputes can be diverted and made available to provide benefits for accident victims and those who pay premiums. The focus of the system will change from managing costs to helping injured parties recover and return to their former functioning lives. Insurers can compete on service and price. There will be robust and independent regulatory oversight.

None of the measures proposed in this report is revolutionary. There is no need to make a disruptive change from a private to a public system of delivery. The government has already put in place legislation to create an independent regulator and evidence-based programs of care are already being used to benefit thousands of injured persons in other jurisdictions across Canada. In Ontario, hospital-based teams are already engaged in providing independent opinions of future care where needed, and catastrophically injured persons are already receiving lifetime care rather than cash settlements in some auto insurance jurisdictions in Canada and in all of the provincial worker compensation systems.

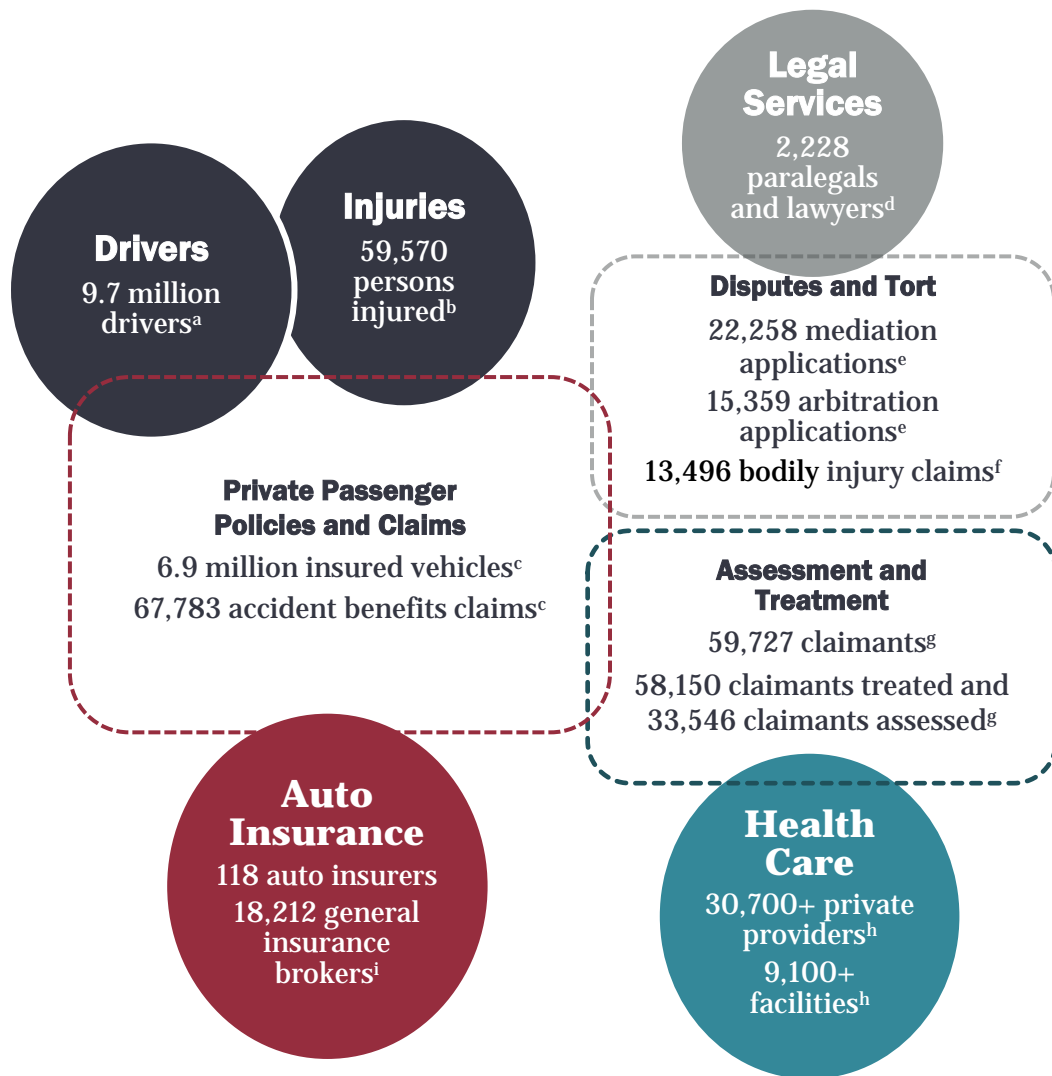
The biggest challenges will be in implementation. The independent regulator will be a new function and will have to evolve into its mature role in regulating the auto insurance industry in ways that help it deliver good value. Insurance companies will have to change from managing cash to managing care. There are plenty of examples of how this is being done today from which they can learn. Structural change does take time to deliver results. In the case of automobile insurance, the results are likely to be felt in eighteen months to two years from when action is taken. This is likely sooner than one would expect from such a transformational change in such a large system, but not as soon as some might like, namely an immediate reduction in costs.

The rewards are great for all parties concerned; and best of all they are sustainable. Ontario has an opportunity to lead the way in auto insurance.

Auto Insurance in Ontario

BACKGROUND/CONTEXT

Figure 1: Major Participants and Interactions in the Ontario Auto Insurance System – 2013²



The law obliges citizens who own automobiles to carry a certain level of insurance to protect against injury to themselves and others who may be injured as a result of an auto accident. It also requires a certain amount of insurance to be carried

to help with the cost of repairs to the automobile if the driver is not at fault. The benefits that are available to consumers to help them recover from an accident are sometimes referred to as the accident benefits, ABs or no-fault benefits.

Table 1: Auto Insurance Coverage in Ontario

Mandatory Coverage	Optional Coverage
<u>Accident Benefits</u> Provides benefits if an insured individual is injured in an accident, regardless of who caused the accident (“no-fault” benefits)	<u>Optional Accident Benefits</u> Can include greater limits for standard accident benefits coverages or new coverages such as indexation of benefits
<u>Third-Party Liability</u> Pays for claims as a result of lawsuits, minimum coverage by law is \$200,000	<u>Collision</u> Pays for losses when an insured vehicle is involved in a collision with another object, including another vehicle
<u>Direct Compensation</u> Covers damage to an insured vehicle to the extent that the insured driver was not at fault for the accident	<u>Comprehensive</u> Pays for losses from a number of different perils, including theft, vandalism, fire or hail
<u>Uninsured Automobile Coverage</u> Protects drivers from damage caused by an uninsured motorist	<u>Other Optional Coverages</u> Such as coverage for the cost of a rental vehicle while an insured vehicle is being repaired

Source: Ministry of Finance

If the driver of an automobile is not at fault, the law permits him or her to recover additional damages, after meeting certain thresholds, from the at-fault driver through the courts under tort law. This is referred to as the bodily injury (or BI) or tort portion of the system. Ontario drivers are obliged to carry insurance to deal with this “third-party liability.” Optional coverage is available to drivers over and above the mandatory coverages.

Table 2: Tort Claims

1. Verbal Threshold	2. Tort Deductible
<ul style="list-style-type: none">▪ The verbal threshold is permanent serious disfigurement or permanent serious impairment of an important physical, mental or psychological function▪ Only accident victims that meet the verbal threshold can receive tort compensation for pain and suffering and excess health care expenses	<ul style="list-style-type: none">▪ Court awards for pain and suffering of less than \$124,616.21 are also subject to a deductible of \$37,385.17 (amounts linked to annual inflation)▪ A lower deductible and lower threshold apply for claims under the <i>Family Law Act</i>


Source: Ministry of Finance

Automobile insurance in Ontario is not taxpayer funded. Owners of vehicles predominantly carry the cost of accidents and injuries through insurance premiums. In that sense, it is not a social welfare system. Nor is it a full tort system. Rather it occupies an intermediate zone between the two systems. The no-fault (accident benefits) part of the insurance system acts like a safety net collectively funded by the owners of motor vehicles, and the bodily injury part acts like a tort system where injured parties who are not at fault can sue the at-fault parties for additional compensation.

Because carrying automobile insurance is mandatory, the government has an obligation to create a marketplace where insurance is available and affordable. The government is also obliged to see that the system is fair and reasonably efficient in providing the intended benefits.

Governments across the country have had to decide how to balance the no-fault collective liability portion of the system with the right to sue at-fault drivers in the tort system.

The tort system is confrontational, time-consuming, involves the cost of legal counsel and experts, and ties up negotiating time if settled out of court or court time if cases go to trial. Moreover, using the court system to get injured parties what they deserve results in a significant leakage in the benefit they actually receive since the award they get is reduced by the need to pay expert witnesses and large fees to lawyers.



The no-fault portion of the system is intended by many governments to provide most, if not all, essential needs of injured parties through a system that is more efficient, less costly and delivers more of the end benefit to the consumer than the tort system. Where the no-fault portion of the system is outsourced to the private sector as in Ontario, the goals are challenging to meet. If not structured properly, this part of the system can start to mirror the tort system with its inevitable confrontation, costs and delays, which is what is happening in Ontario today.

It is important to remember that in the end, the citizen who owns a vehicle pays, through their insurance premiums, for the full cost of the combined no-fault and tort systems, whichever way the system is structured. There is no free lunch. It is also important to remember that not all injured persons have access to sue – only those who are not at fault. About 30 per cent of drivers who are involved in accidents are at fault which leaves this substantial proportion of injured persons out of the tort system and with access only to the basic no-fault coverage.


HISTORY OF AUTO INSURANCE REFORMS

Ever since mandatory auto insurance came into force in Ontario in 1980, successive governments have been continuously striving to balance the essential goals of the system: adequacy of benefits, cost, efficiency and fairness. It is not as though these issues have been ignored.

Before 1990, Ontario auto insurance operated with minimal accident benefits on the no-fault side and largely as a tort system. Lawyers represented the majority of accident victims.

However, costs rose rapidly, and the government tried to put a lid on costs by freezing insurance premiums. In 1986 the government appointed Justice Coulter Osborne to look into the matter. In Justice Osborne's report, Report of Inquiry into Motor Vehicle Accident Compensation in Ontario (Osborne Report), he stated that rising costs due to the costs of litigation and court awards and restricted premium increases were the main cause of an insurance marketplace "crisis."

In 1990, the government shifted the balance of compensation needs from the tort system to the no-fault accident benefits system. Henceforth, to save time and money most of the requirements for compensation were to be met through the accident benefits system with restrictions on what could be obtained through the tort system. The government also introduced other recommendations of the Osborne Report namely a process of rate approvals and a system for dispute resolution outside of the courts.



Since then, a succession of governments in Ontario has grappled with the problem of the degree of protection from the effects of automobile accidents which citizens should maintain vs. affordability and efficiency.

In 1994, the then government considerably expanded the benefits under the accident benefits system, extended the right to sue under tort for pain and suffering, but eliminated the right to sue under tort for economic damages.

In 1996, the government reintroduced the right to sue for economic damages but reduced the amount of coverage for medical and rehabilitation benefits under the accident benefits system. The government also introduced additional cost control measures, such as setting maximum fee schedules for providers of health care and the requirement to submit treatment plans for approval by insurance companies. Initially, these fee schedules were based on a negotiated agreement between providers and the insurance industry. The same government introduced further refinements to these reforms in 2003.

Later, in 2003, a new government introduced legislation to temporarily freeze auto insurance rates and set an objective to reduce rates by 10 per cent.

In 2006, the government eliminated the Designated Assessment Centres (DAC) system and moved back to addressing accident benefits disputes through insurer examination assessors.

In 2010, the government introduced further substantial changes, changing benefits under the standard accident benefits coverage and presenting a series of reforms to try to control costs, exploring the use of evidence-based treatment plans, capping the cost of medical assessments, capping the maximum benefit for a minor injury and other measures. Later the government introduced many of the recommendations of the Ontario Auto Insurance Anti-Fraud Task Force.

In June 2013, the government passed the Prosperous and Fair Ontario Act, which set out a target to reduce insurance premiums by 15 per cent over the next two years.

Finally, in 2015, the government introduced legislation impacting no-fault benefits, and in April 2016 a new dispute resolution system was introduced based on recommendations in Cunningham's Final Report.

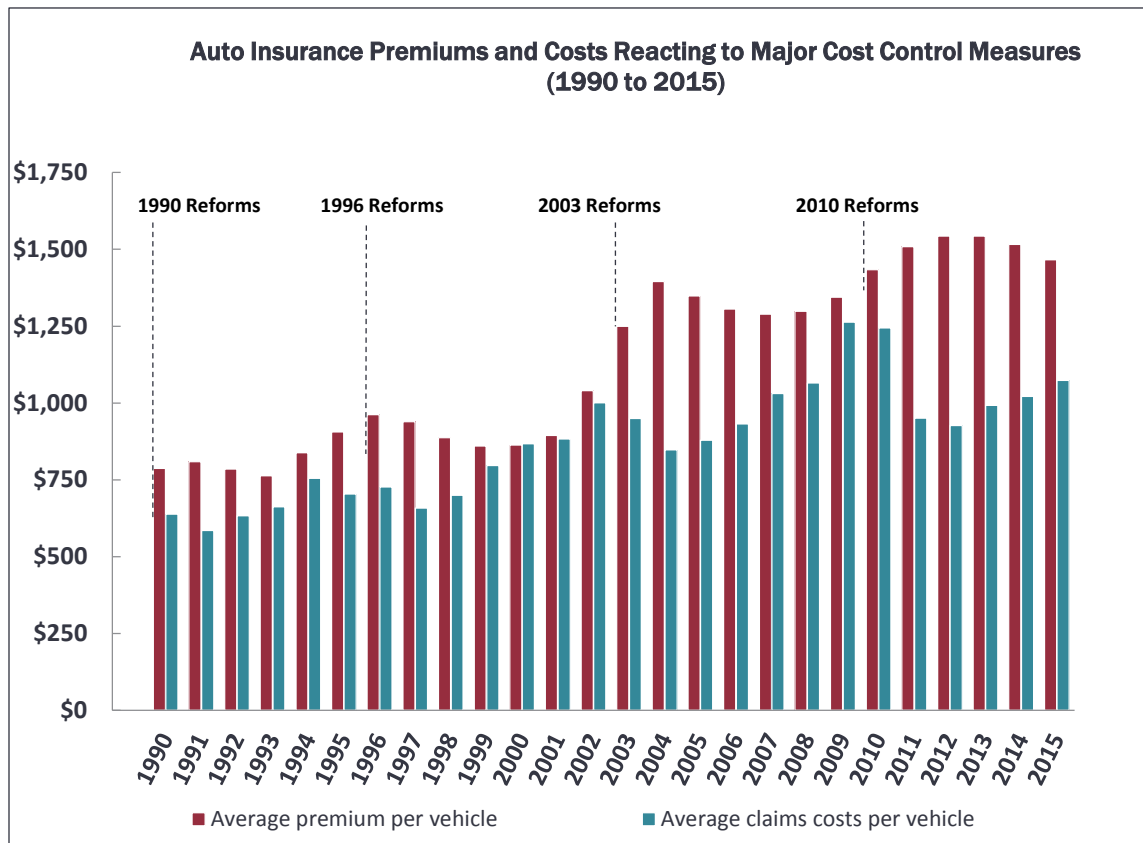
The government is presently engaged in implementing the recommendations in the report of an expert advisory panel that undertook a review of the mandates of the Financial Services Commission of Ontario, the Financial Services Tribunal and the Deposit Insurance Corporation of Ontario (FSCO Mandate Review). If adopted, these changes have the potential to substantially improve the regulatory oversight of financial services in Ontario, giving the regulator more powers to enact policies and respond to the needs of the financial services marketplace.

What this long list of interventions and initiatives by successive Ontario governments from all three political parties shows is that there has been no lack of effort to try to improve the system of auto insurance. No-fault benefits have been increased and decreased, access to tort has been increased and decreased, cost control measures have been tried, anti-fraud measures have been introduced, freezing of insurance premiums has been tried and now a complete restructuring of the regulatory body is underway.

There has been no lack of trying to improve the system.

Chart 1 shows that following each of the reform measures over the past years, costs and premiums come down for a few years and then begin to rise sharply to establish new highs. This has been a challenge for governments for a long time.

Chart 1: Auto Insurance Premiums and Costs Reacting to Major Cost Control Measures

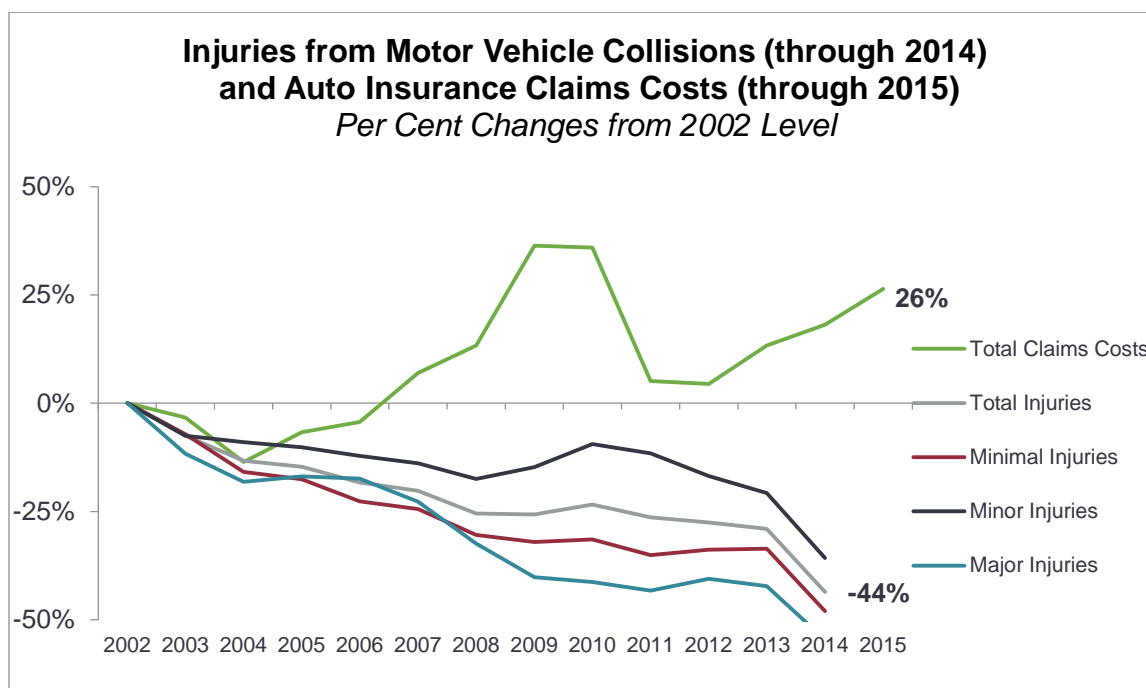


Source: General Insurance Statistical Agency exhibits for private passenger vehicles

Further changes in benefits were implemented in 2015 to curb costs, but trends indicate that costs will once again rise despite these changes.

What is even more disappointing is that while the number automobile accidents – especially very serious ones – have consistently come down, the cost of claims has consistently gone up (see Chart 2).

Chart 2: Collision Injuries vs. Costs



Source: General Insurance Statistical Agency exhibits for private passenger vehicles and Ontario Road Safety Annual Reports (ORSAR), Ministry of Transportation

The long, winding road we have taken over 50 years to tinker with and adjust the system of auto insurance has fallen short in one crucial respect – there has been scant innovation in the system. Aside from a few new features, such as premiums based on driving behaviour (usage-based insurance) which are not widely available or purchased, the system is still delivering the same product in the same way it has for over half a century. Part of the responsibility must lie with how the industry has been structured



and regulated. Everywhere around us industries that have failed to change are being disrupted. There is clearly a need to structure the system so that it can be encouraged to innovate and change.



Where We Are Now – The Opportunity Gap and The Value Gap

THE SYSTEM IS EXPENSIVE

Ontario today remains in an unenviable position. Ontario's roads continue to be among the safest in North America. In 2013, Ontario's fatality rate of 0.54 per 10,000 licensed drivers was the second lowest ever recorded. It was the second lowest in all of North America, behind only the District of Columbia. In 2013, Ontario's injury rate of 62.1 per 10,000 licensed drivers is the lowest injury rate ever recorded and among the lowest in Canada.³

Expenditure not going directly to the benefit of claimants ... is threatening the very foundation of the system.

Nonetheless, in 2015, at an average premium per vehicle of \$1,458, Ontario's is the highest in Canada. Auto insurance premiums represent a significant expenditure for the average Ontarian. That premium is 24 per cent higher than Alberta's at \$1,179, a province with a similar distribution structure, double the premium of Quebec at \$724 and more than 55% per cent higher than the Canadian average, excluding Ontario, of about \$930 (see Table 3 below). Collectively, Ontario drivers pay about \$10 billion a year in automobile insurance.

To put it another way, if Ontario's auto premiums per vehicle could approach the Canadian average premium, it would represent a premium reduction of almost 40 per cent over the current level, or nearly \$4 billion a year, to Ontario's consumers. That's a lot of money. **This represents the opportunity gap we must try to close.**

IS IT DELIVERING VALUE?

Ontario also has other serious challenges. First, the amount of leakage of funds in the system – expenditure not going directly to the benefit of claimants at about \$1.4 billion a year (see Table 6 below) is extraordinarily high. Second, in the course of my discussions, insurers shared with me that it is taking them over a year to close even the simplest claims on a full and final basis. Third, accident victims are having a difficult time getting what they perceive to be fair benefits. One out of three accident benefits claims goes into a dispute resolution system (see Figure 1, Disputes and Tort and Appendix VI).



And finally, despite expending large amounts on health care, a very high percentage – some 25 per cent of claims – present themselves as having developed serious and permanent impairments from what began as mostly simple soft tissue injuries.⁴
These challenges represent a value gap we must try to close.

THE STRUCTURAL PROBLEM

The system of regulation and delivery of auto insurance in Ontario is poorly structured.


It induces participants to act against each other rather than to ensure a common goal. Over time, governments have enacted legislation and increasingly complex and detailed regulations in attempts to solve this problem. Private sector insurance companies sell and implement this program on a cost recovery plus profit margin basis.

This hybrid structure; a government-mandated service delivered by private industry, brings with it inherent challenges that have not been well understood and have contributed to undermining the intent of the government.

Insurance companies work best when they write policies with well-defined parameters and outcomes, which allows them to estimate risk and set the premiums accordingly. We see this in typical supplementary medical coverage benefit plans or short-term and long-term disability plans. The conditions under which benefits will be available are well defined and the amount of the benefit is defined. For example, the coverages for drugs and dental care are described as being eligible for payment as long as they represent usual and habitual costs and they invariably have a maximum per person and per year or a lifetime maximum. Both parties, the insurer and the insured, understand the contract. Very few disputes arise, benefits are paid promptly and they are rarely taken to court for a decision.

AUTO INSURANCE AS A GUARANTEED SAFETY NET FOR ACCIDENT VICTIMS

Programs like auto insurance, which have overarching goals and apply to a broad segment of society (such as worker's compensation, social assistance and others) are usually given to government agencies to administer. These agencies are given the powers and authority of an administrative tribunal. Basically, the agency is given the authority to enact policies and procedures that interpret the governing legislation and further refine their application.



Quebec, for example, has elected to provide no-fault auto insurance through an empowered government agency. This is not the case in Ontario. The government has designed a guaranteed safety net and then assigned it to private sector agents (about 100 insurance companies) to deliver without giving those agents the ability to decide how to deliver the program.

To complicate matters greatly, the current automobile insurance regulations are vague and broad in many important ways and at the same time extremely detailed and restrictive.


For example, in dealing with an injured person's entitlement to rehabilitation benefits, the Statutory Accident Benefits Schedule (SABS) enumerates a list of benefits and then concludes with:

"Rehabilitation benefits shall pay for necessary expenses ... for the purpose of reducing or eliminating the effects of any disability resulting from the impairment, or to facilitate the person's reintegration into his or her family, the rest of society and the labour market."⁵

The interpretation of this provision is wide open to dispute and disagreement. Since there is no person or agency empowered to make rules or regulations other than the Cabinet itself, the eligibility of any particular form of benefit for a given claimant is left to be contested as between claimants and their lawyers; and insurers and their lawyers either before mediators, arbitrators or before the courts.

At the same time regulations attached to the Insurance Act are extremely detailed and restrictive; insurers must follow 50 pages of prescribed forms and actions (the much-contested SABS) in virtually every interaction with their clients and providers of services. These regulations are designed to provide protections to consumers and also consistency of service across multiple insurers. These are laudable goals but there is no doubt that they also restrict innovation, efficiency and competition since every insurer must do the same things in the same way.

To access benefits a person must first fill out an eight-page form that can be difficult to understand, even though they may have already registered their claim with the insurance company by telephone. In all cases where the injury is more than "minor," a service provider must ensure the insurer approves the treatment plan to confirm that the treatment will be paid. An insurer is restricted from having a sensible discussion about the treatment. Instead, the only option is to accept the treatment plan or reject it. Plans are often rejected, but generally only after obtaining an expensive "independent" medical exam (also called an insurer examination). The injured person's only recourse, if the plan is rejected, is to seek help, usually from a lawyer, and likely to generate expensive, opposing medical exams, the cost of which get deducted from the maximum benefit available.



A large number of accident victims have some alternative health or income replacement insurance through their workplaces. The SABs stipulates that the auto insurer is the “second payer.” In these cases, the auto insurance company will not pay the health care provider until after they have recovered any eligible amounts from the claimants’ workplace or other insurer. Claimants are often surprised and annoyed to learn that they must first exhaust their workplace medical and sick day insurance before they can benefit from their auto insurance.

The goals of all the principal stakeholders are not well aligned. As a result, the government’s goal ... is being undermined.

Insurance companies are not required to, and therefore many do not see their role as providing health care for their clients. They treat every claim as a cash expense and act to minimize their cash outlays. Insurance company front line staff are not “case managers,” they are “adjusters.” As a consequence, they are often viewed by their clients not as someone there to help them recover from their injury but as someone having a conflict of interest – since they might try to limit the amount of benefits. In my consultations with insurance companies it became clear that they are not happy with this role. They recognize that their policyholders are their clients, and they wish to provide good service. However, they feel hamstrung by the legislative and regulatory framework within which they have to work. Unfortunately, despite restrictive regulations, insurance companies could do more for their clients in the area of helping them manage health care. But the roles and positions taken up by claimants, their legal representatives and the government are such that insurance companies have found it comfortable to remain in their expected role of managing the cost of claims rather than the care. This is the outcome of decades of “expectations.” All of the participants in the system have come to accept the status quo and have learned to live with it.

Most injured parties seek to receive the help they need and move on with their lives. However, a small but significant number have a propensity to maximize their entitlements rather than address their needs. They approach the insurance company with expectations that their injuries are serious and expect to encounter a reluctant payer – and in many instances their expectations are fulfilled. On the other hand, insurance companies often suspect that claimants may be exaggerating their needs in order to get a larger settlement. At present, there is no efficient, professional and unbiased way to diagnose the true needs of an injured person and to provide appropriate treatment.

Personal injury lawyers, representing clients on a contingency-fee basis, have a financial stake in the outcome and are incented to maximize the presentation of their client’s disability. They enlist the services of multiple medical experts in this effort who also have to be paid for their services.



Health care providers (of which there are myriad) are incented to over-treat the client as they are being paid for treatments rather than the outcomes.

In Ontario, there are more than 30,000 providers belonging to 26 different professional bodies to treat some 60,000 injured claimants a year (see Figure 1 above).

The goals of all the principal stakeholders are not well aligned. As a result, the government's goal, to provide affordable and efficient care for those injured in automobile accidents, is being undermined by the way the structure of the system is exploited. This puts the government on the defensive when the system exhibits dysfunctional symptoms.



The Results

CROSS-JURISDICTIONAL COMPARISONS

Cross-jurisdictional cost comparisons are difficult to make because the level of benefits in the no-fault system and access to tort vary. Simply put, a province may provide fewer no-fault benefits but allow more access for plaintiffs to sue at-fault drivers for additional benefits. The “no-fault” insurance premium may be low but the premium to defend policyholders against claims in the event they are at fault will be higher. The resulting overall auto insurance premium thus reflects the total cost of the two benefit access systems combined. There is no free lunch.

In terms of benefits provided, Ontario has a higher level of no-fault benefits compared to Alberta and Nova Scotia, which have a similar private sector delivery structure, as well as B.C., which has a predominantly government-run, no-fault system. But Ontario has more restrictions on what can be obtained through the tort system than these other provinces. On the other hand, Quebec and Manitoba, which deliver their health care and rehabilitation program through a government agency, have much more generous benefits in their no-fault systems than Ontario. In Quebec and Manitoba, there are no limits to medical care either in dollar value or time frame, catastrophically injured persons get all the medical care they need for as long as they live and generous wage replacement till age 65. Saskatchewan’s government-run, no-fault system has a maximum lifetime benefit of \$6.7 million. But, in these cases, there is no access to the courts for tort recovery.

One could make a general assumption that the combined access systems provide fair benefits overall – generous no-fault benefits are accompanied with restrictions to access in tort and vice versa. There is, however, one major exception and that is that the tort system excludes at-fault drivers (about 30 per cent of injured parties.) who cannot sue under tort. Hence it is likely true to say that the more generous no-fault systems treat all accident victims more fairly than those that require access to tort. As well, when benefits are obtained through the tort system, accident victims lose a significant portion of their benefits because they have to pay lawyers and other experts to prosecute their case.



TOTAL PREMIUMS

The combined premium costs of the two benefit access systems no-fault and tort for provinces across Canada for 2015 are shown in Table 3. We can see from this table that Ontario has the highest average premium costs across all provinces. The average premium amongst the provinces and territories excluding Ontario is approximately \$930 vs. Ontario’s at \$1,458. Table 3 compares overall provincial auto insurance premiums. The provinces which have a private sector delivery system similar to Ontario’s (Alberta and the Atlantic provinces) are shown in blue. The average premium of this group of provinces for 2015 is \$914 and Ontario’s premium at \$1458.

With the exception of Ontario, the average premium level of provinces with private delivery systems (\$914) is lower than the average premium of provinces with government-run delivery systems (\$937), indicating that the method of delivery – government vs. private sector – is not necessarily a major determinant of cost.

Table 3: Auto Premiums 2015

Calculation method	Province	Avg. Written Premium
Per vehicle – private passenger vehicles (PPV) (1)	Ontario	1,458
Per vehicle – PPV (1)	New Brunswick	763
Per vehicle – PPV (1)	Newfoundland and Labrador	1,090
Per vehicle – PPV (1)	Nova Scotia	783
Per vehicle – PPV (1)	Prince Edward Island	755
Per vehicle – PPV (1)	Alberta	1,179
Per vehicle – PPV (1)	Northwest Territories	974
Per vehicle – PPV (1)	Yukon	806
Per vehicle – PPV (1)	Nunavut	968
Per vehicle – PPV (5)	British Columbia (ICBC +private)	1,316
Per vehicle – PPV (4)	Quebec (public+private)	724
Per vehicle – all vehicles (2)	Saskatchewan Auto Fund only	775
Per vehicle – PPV (3)	Manitoba Public Insurance only	1,001

Source: Based on (1) General Insurance Statistical Agency, (2) Saskatchewan Government Insurance Annual Report, (3) Manitoba Public Insurance 2017 Rate Application, (4) Société de l'assurance automobile du Québec, (5) Written premium data from Insurance Corporation of British Columbia and MSA Research Inc.

Claims are per accident year in Ontario, Alberta, the Atlantic provinces, N.W.T., Yukon and Nunavut



PREMIUM MIX ACCIDENT BENEFITS VS. THIRD PARTY LIABILITY

The relative emphasis as between no-fault and tort premiums for those provinces with a private sector distribution system similar to Ontario's is shown in Table 4. What this shows is that Ontario's higher accident benefits system is reflected in significantly higher premium costs for no-fault coverage among provinces with a similar private sector distribution system. To recognize a more generous accident benefits system Ontario has the highest barriers for access to tort. However, despite this, Ontario still has by far the highest third party liability premium among provinces with a similar distribution system. Ontario is more expensive on both the no-fault and tort side of the equation which signals that there is something wrong with the way the system is being managed.

PUBLIC VS. PRIVATE DISTRIBUTION SYSTEMS

Alberta, Ontario and the Atlantic Provinces have a private sector distribution system for auto insurance while Quebec and all the western provinces except Alberta, have predominantly government-run systems for auto insurance. Table 3 shows that both systems achieve premiums that are well below Ontario's. There are provinces with privately-run auto insurance systems that achieve a lower premium than some with government-run systems and vice versa.

Ontario's auto insurance premium is too high by a wide margin, whether it is compared to provinces with government-run or privately-run auto insurance systems. The system of distribution, whether public or private and the mix as between more or less generous no-fault systems with more or less access to tort do not seem to impact overall premium costs as much as how the systems are managed. Ontario can do well by taking the best from the other systems and improving its own.

Table 4: Average Premium Cost per Passenger Vehicle, Select Provinces

Average Premium Cost Per Private Passenger-Vehicle (\$) by Major Coverage Ontario and Other Provinces with Privately-Delivered Auto Insurance Accident Years 2011 to 2015						
	Ontario	Alberta	New Brunswick	Nova Scotia	Newfoundland and Labrador	Prince Edward Island
Total*						
2011	\$1,509	\$1,073	\$817	\$801	\$1,006	\$760
2012	\$1,543	\$1,078	\$804	\$786	\$1,014	\$744
2013	\$1,544	\$1,100	\$785	\$775	\$1,032	\$747
2014	\$1,516	\$1,134	\$771	\$775	\$1,054	\$756
2015	\$1,466	\$1,165	\$759	\$775	\$1,075	\$756
2011-2015	\$1,515	\$1,112	\$787	\$782	\$1,037	\$753
Third Party Liability						
2011	\$651	\$508	\$401	\$396	\$634	\$359
2012	\$678	\$504	\$392	\$378	\$629	\$352
2013	\$693	\$517	\$386	\$369	\$631	\$348
2014	\$707	\$539	\$379	\$386	\$633	\$347
2015	\$716	\$566	\$373	\$386	\$634	\$347
2011-2015	\$690	\$528	\$386	\$383	\$632	\$351
Accident Benefits						
2011	\$541	\$52	\$126	\$73	\$73	\$61
2012	\$558	\$52	\$117	\$66	\$73	\$60
2013	\$544	\$54	\$108	\$63	\$74	\$59
2014	\$500	\$55	\$100	\$65	\$73	\$58
2015	\$439	\$57	\$91	\$65	\$71	\$55
2011-2015	\$516	\$54	\$108	\$66	\$73	\$58

Source: 2013-2015 General Insurance Statistical Agency exhibits for private passenger vehicles.

* May include coverages not listed separately.

Note: There are slight, but not significant differences between the 2015 premiums in this table vs. Table 3 above due to different sources of data.

Table 4 shows the relative emphasis placed by different provinces on the no-fault and tort systems as a means of compensating auto injuries. Overall, Ontario's system is the most expensive.



CLAIMS APPEAR TO BE UNUSUALLY EXPENSIVE, ARE TAKING TOO LONG TO RESOLVE, AND TOO MANY ACCIDENT VICTIMS ARE SUFFERING A PERMANENT SERIOUS IMPAIRMENT FROM WHAT BEGAN AS SOFT TISSUE INJURIES

Table 5 shows that average overall claims costs (no-fault and tort combined) for those provinces with similar, private delivery systems. Ontario's average claim costs at about \$11,600 is double that of most of the other provinces with similar delivery systems.


Table 5: Avg Premiums and Avg Claims Costs 2015

Calculation method	Province	Avg. Written Premium	Avg. Claim Cost (incl adj. exp.)
per vehicle – private passenger vehicles (PPV)	Ontario	1,458	11,556
per vehicle – PPV	New Brunswick	763	5,712
per vehicle – PPV	Newfoundland and Labrador	1,090	6,235
per vehicle – PPV	Nova Scotia	783	5,491
per vehicle – PPV	Prince Edward Island	755	4,306
per vehicle – PPV	Alberta	1,179	9,150

Source: General Insurance Statistical Agency

Claims are per accident year in Ontario, Alberta and the Atlantic Provinces

Medical care drives all the other costs in the system. The longer an injury takes to resolve, the more likely it is to become chronic, the more medical care is needed and all the other costs – replacement of lost wages, attendant care, compensation for pain and suffering also go up. Worst of all, the injured person is not well served by extending their disability.



The majority of injury claimants report that they have “minimal” or “minor” injuries at time of the accident. While symptoms may manifest themselves long after an accident, the fact is that most people are not seriously injured. Some 83 per cent of motor vehicle injuries involve whiplash or other soft tissue injuries such as a sprained back, which, most of the time, can be treated by relatively simple, short-term and inexpensive procedures that are well understood by health care providers.⁶

The system is open to inefficiency, excessive cost and over treatment.


In the course of my inquiries, insurers indicated to me that on average, claims that fall under the minor injury definition – mostly soft tissue sprains and strains – take just over one year to close if they are not disputed and incur an average medical cost of \$2,000 to \$3,000. If the claims are disputed the average time to resolve minor injuries increases to roughly 900 days and involves medical costs averaging \$10,000 to \$15,000. These costs, not covered by OHIP, which are for generally minor soft tissue injuries, would indicate that either there is a fairly intensive set of treatments taking place or providers are being overpaid.

Individual insurance companies do not keep track of when claimants reach medical recovery, nor does the regulator. Records are only kept on how long it takes to close a claim file. There is no record kept of outcomes or the effectiveness of medical treatments. In the absence of understanding how effectively medical care is being delivered, the system is open to inefficiency, excessive cost and over treatment. Moreover, there is no opportunity to improve outcomes for patients. Considering that support for medical recovery is one of the cornerstones of the legislation, the system is not currently meeting this standard.

The longer a claim takes to settle the longer the claimant must continue to fight with the insurance company and to assert that they continue to suffer consequences of the accident or might suffer such consequences sometime in the future.

Dr. Côté, in his study on the outcome of insurance claims for whiplash injury, points out that “there was a strong and consistent association between the time to the closure of claims and recovery from the injury. A lower level of pain and a higher level of physical functioning and the absence of depression were strongly associated with shorter time to closure under both tort and no-fault systems.”⁷

The Association of Worker’s Compensation Benefit Systems in Canada reports on its web site that the average duration of injury claims for 2015 (the length of time taken to get a worker back to health and to close the file) is just 76 days, about two and a half months.⁸ This compares with the one year to two years or more it takes to resolve minor injury claims in the auto insurance system.



The Ontario auto insurance system could achieve better health care outcomes for accident victims and save considerable money by creating programs of care and aligning the payment schedule to those of other payers.

The study Initial Patterns of Clinical Care and Recovery from Whiplash Injuries: A Population-Based Cohort Study put it this way:

“We found that increasing the intensity of care beyond two visits to (family doctors), beyond six visits to chiropractors, or adding chiropractic to medical care was associated with slower recovery from whiplash injuries even after controlling for initial injury severity. Clinicians who promote frequent visits may inadvertently encourage patients to cope passively with their pain...patients who cope passively with their pain may demand more clinical care. Relying on repetitive clinical care likely reinforces some patients’ belief that whiplash is a serious disorder with a long, disabling course. As with low-back pain aggressively treating patients with acute whiplash injuries likely promotes illness behaviours and disability rather than return to normal activities.”⁹

Other studies have pointed to long recovery times and over-treatment of injured persons. The Automobile Insurance Third Party Liability Bodily Injury Closed Claim Study in Ontario conducted by Pinnacle Actuarial Resources, Inc (Pinnacle Study) found that soft tissue injuries (neck and back sprains) were associated with claimants who accounted for 67 per cent of the total claim payments in the study.¹⁰ The study also reported that roughly 70 per cent of the claimants were classified as having no injuries or having minimal or minor injuries in the police report. Nonetheless, the majority of these claimants developed serious and permanent impairments and the median time lost from work for these claimants was seven months.

Each year an average of about 25 per cent of injured persons make bodily injury tort claims.¹¹ In order to make a bodily injury claim, the individuals must produce medical evidence that they have suffered a permanent serious impairment of an important physical, mental or psychological function (necessary to pass the verbal threshold). This is a very high level of impairment from what are mostly soft tissue injuries. The provincial worker’s compensation systems in Canada find that the proportion of claims awarded permanent impairment benefits across Canada is about 13.5 per cent or almost half that found in the auto insurance system in Ontario.¹²

Soft tissue injuries should not normally develop into permanent impairments if they are treated properly to begin with. The rate of impairment in the auto insurance system is a warning sign that medical care is not being properly handled. Appropriate medical treatment has been shown to reduce or prevent the development of permanent impairments from soft tissue injuries by as much as 80 per cent.¹³



THERE ARE TOO MANY CLAIMS GOING INTO DISPUTE – EVEN MEDIATION ATTEMPTS FAIL AT LEAST 40 PER CENT OF THE TIME

Each year approximately 23,000 or about 30 per cent of all accident benefits claims – go into the dispute resolution system (see Figure 1 above). This level of breakage is a signal that there is something seriously wrong with how claims are being handled. In Ontario's auto insurance system, claims that go into dispute are represented by legal counsel nearly all the time. Over the five-year period 2011-2015, an average of 9,000 claims (40 per cent) that went into dispute resolution failed to reach full and final agreement at the mediation stage and went on to an arbitration process, adding further time and cost to the system (see Appendix VI).

ACCIDENT VICTIMS ARE SUFFERING LARGE LOSSES


In order to understand where the costs and benefits in the auto insurance system are going, I undertook an examination for the 2013 fiscal year. What I found is that there is tremendous leakage of costs in the system. Out of the \$3.87 billion in costs for 2013 (combined accident benefits and bodily injury), only \$2.5 billion is going to claimants. The rest, approximately \$1.4 billion, is going to other parties. Over five years this amounts to almost \$7 billion going to other parties – a staggering sum which is threatening the very foundation of the system.

Table 6: Cost Leakage Analysis (\$ Billions) 2013 Accident Year

	Accident Benefits	Bodily Injury
1. Total claim costs excluding overheads	2.170	1.700
2. Direct cost to Insurers (legal fees + expenses) to defend claims in dispute or tort	0.272	0.213
3. Amount attributable to claim payments for claimants (1-2)	<u>1.899</u>	<u>1.487</u>
4. Cost of insurer initiated medical exams	0.278	0.000
5. Total claim payments (available) for claimants (3-4)	<u>1.621</u>	<u>1.487</u>
6. Cost of provider initiated medical exams	0.065	0.000
7. Contingency fees	0.096	0.373
8. Disbursements for medical and other experts	0.000	0.057
9. Net received by claimants (5-6-7-8)	<u>1.460</u>	<u>1.058</u>
10. Benefit administration loss (3-9)	<u>0.439</u>	<u>0.430</u>
11. Percentage leakage from claimants (10/5)	27%	29%
12. Total cost leakage to the system (2+4+6+7+8)	<u>0.711</u>	<u>0.642</u>
Total leakage as a percentage of direct claim costs	33%	38%

Source: Analysis based on data from General Insurance Statistical Agency exhibits for private passenger vehicles, the Pinnacle Study, Ministry of Finance and insurers.

Based on 2013 expenses, in the no-fault accident benefits system, out of about \$1.9 billion in benefit payments by insurance companies, about \$440 million, more than one dollar out of every four is not received by the accident victim in benefits; that is, \$340 million is going to pay for competing medical opinions because insurers and claimants – or their lawyers – disagree on what is appropriate medical care, and another \$100 million is going to lawyers' contingency fees. And this is in a no-fault system which is intended to eliminate disputes over fault.



In the tort or bodily injury part of the system the diversion of costs is proportionally higher. Out of about \$1.5 billion in benefit settlement payments made by insurance companies, \$430 million or almost one dollar out of every three is not going to accident victims; that is, \$373 million dollars is going to pay lawyers contingency fees to fight with insurance companies and a further \$57 million is going to pay for more medical and other experts to support accident victims claims against the insurance companies.

When you add in the costs incurred by the insurance companies to manage and defend claims in the dispute resolution and the tort systems, a further cost of almost \$500 million is added to the overall costs which contribute to higher premiums but do not reach the accident victim.


Overall, out of total claim costs of about \$4 billion in benefits, about \$1.4 billion or some 35 per cent of the benefits costs are not going to accident victims. In my opinion, this is undermining the integrity of the system.

Commenting on his review of the dispute resolution system, Justice Cunningham said “The whole notion of getting benefits to deserving claimants quickly and inexpensively had been lost.”¹⁴

MEDICAL EXAMS AND ASSESSMENTS

In the no-fault system, despite the fact that the majority of injuries are relatively routine and common, a major element of delay and extra cost is caused by the inability of parties to agree on an appropriate diagnosis and treatment of the injury. As a result, many thousands of expensive medical examinations are ordered by insurers and claimants in an effort to resolve this matter. Claimants frequently have to attend more than one insurer examination. The average total cost of examinations for each of the 30,000 to 35,000 claimants is approximately \$9,000 for the life of the claim.¹⁵ The aggregate cost of these insurer medical exams is huge. In the no-fault accident benefits system, the table in Appendix III shows that they grew from \$248 million in 2004 to \$847 million in 2010; then in response to a cap on the cost per medical opinion and other changes, they came down to \$282 million in 2012 and has grown again to \$347 million in 2013. The equivalent average annual cost of medical opinions in the whole of the Ontario Workplace Safety and Insurance Board system was just \$30 million in treating 170,000 injured workers.¹⁶

A major element of delay and extra cost is caused by the inability of parties to agree on an appropriate diagnosis and treatment of the injury.



These medical opinion expenses in the Ontario auto system which in 2013 amounted to over 20 per cent of money spent on actual medical treatment costs do not go to medical care for the individual. What is perhaps even worse is that the usefulness of the medical opinions is questionable. In his final report, Justice Cunningham puts it this way:

“Today’s insurer examination (IE) reports appear to have little credibility with claimants and only serve to trigger disputes. ... IE assessors are not accountable to FSCO, have no standard assessment protocols, report formats or timelines and are not insulated from outside influence.”¹⁷

SYSTEM IS FOCUSED ON CASH NOT CARE

As indicated earlier, the main reason is that the system of regulation and delivery is poorly structured. The government has enacted overarching legislation and then enacted regulations which are extremely prescriptive and handed the system to private sector insurance companies to deliver. These insurers do not have the powers of the administrative tribunal to govern their actions. Until there is a direct intervention by government to alter the system, the result will continue to experience very high level of disputes that can only be dealt with through a battle of experts and the added cost of legal fees.

It has become a system that is largely focused on cash rather than care. ... The outcomes are not only more expensive but worse for injured parties.

From the insurer perspective, many argue that the current structure effectively blocks them from managing the health care and recovery for their clients. As a result, claimants are left on their own to navigate the health care system with the frequent help of lawyers who themselves are not medical professionals. Overall recovery from injury is not the primary goal of anyone in the system – nor is it being measured or managed. This leads to suboptimal care, lengthy recovery times, overtreatment and escalation of simple soft tissue injuries into permanent impairments.

Faced with the structure of the legislation, insurers view claims through the lens of what they cost to settle – not what is the best medical outcome for the patient. Some claimants approach the process from the point of view of the maximum benefit they can get from the system, usually this is expressed as the dollar value of a cash settlement from the insurance company. Some health care providers in part are interested in maximizing their fees and there are lawyers, likewise, who are incented to obtain the largest cash settlement they can get for their clients since their fees are entirely contingent on the size of the settlement.



How health care goes, so goes the rest of the system. If medical recovery takes an extended time, wage replacement costs go up, attendant care costs go up, pain and suffering awards go up and all the other costs that derive from the extent of the time it takes to recover and get back to normal function go up, including legal costs.

The system has been diverted from its original goal: a medical safety net with ancillary financial compensation as a bridge. Instead it has become a system that is largely focused on cash rather than care. Paradoxically, the outcomes are not only more expensive but worse for injured parties.



What Is Needed – A Sound Regulatory Regime with Fair Benefits Fairly Delivered

Fair benefits must be taken as the starting point in restoring the system to its original intent, and they must be delivered fairly. If these two conditions do not exist, the system will always fail to meet expectations and incur unnecessary cost. Benefits in the current Ontario auto system are fair, the system does not always deliver fairness – such as in cases of catastrophic impairment where lifetime care is essential. But benefits are not being fairly delivered, too many claims for treatment are being rejected and these are going into dispute.

This is mainly because of the legal and regulatory structure which does not allow for proper assessment of accident victims' needs.

Ontario doesn't have to have a poor system of auto insurance. There are good and sound ways to improve the process. The key to improvement must begin with clear goals for the system.

Implementation of the goals must be practical, simple and efficient. The system must deliver the best for the most people in each tier of injury severity. It cannot attempt to deal with all exceptions. The no-fault system should:

- **Provide an adequate safety net for individuals injured in an auto accident**

The majority of auto related injuries are relatively minor. The system should provide appropriate scope for medical treatment and care. The focus of the system should be on the serious or catastrophically injured, as those cases are often unique to each individual and cannot be addressed by common treatments, such as in the case of minor injuries. That is where the most need lies. To the extent possible the no-fault system should satisfy the needs of the majority of injured parties without the need to resort to an expensive tort system.

- **Benefits should be simply described and easily understood**

There is general agreement among stakeholders that the current description and entitlement provisions are overly complex. Very few people outside those who are professionals in the system are able to understand them. This needs to change.



- **Benefits should be easy to access without the need for legal counsel**

The insurance system should be able to quickly respond to the legitimate needs of accident victims. Not only is it clear that accident victims are worse off if medical care is difficult to obtain and extended over a long period, but it is also evident that insurers can limit costs by supporting appropriate care on a timely basis. Currently, the design of the system allows for, and actually encourages, far too many delays and disputes.

- **Premiums should be affordable**

It goes without saying that Ontario drivers do not have unlimited resources. Since they are required to purchase insurance for automobile accidents, the government has a special responsibility to create a marketplace that is efficient and affordable. At the present time insurance premiums in Ontario need to be made more affordable.

- **The system should be able to adapt and innovate**

No matter what changes are adopted today, they are going to be obsolete in the near future just because of the nature of the rapid change that is a constant of our time. Because the current system is so firmly tied to legislation and regulation only the Legislature or the Cabinet can make any meaningful adjustments to the system. The system is not able to adapt and improve in a rational way as circumstances change. Hence you have major upheavals every three to four years. Nor is the system able to encourage innovation in product design and delivery. In a world where rapid changes are occurring in both the financial and automotive worlds these are serious shortcomings. It needs to change.



A Better Future – Should Ontario Move to a Government-Run Auto Insurance System?


This is a question that has come up more than once over the years. On the surface, it would seem that provinces with government-run auto insurance systems like Quebec and most of the Western provinces are able to achieve satisfactory auto insurance benefit systems at a much lower cost than Ontario has been able to achieve with its privatized model. The choice of delivery model – public or private – is not a simple one, nor is it a silver bullet. For example, provinces with government-run systems like Quebec, Manitoba and Saskatchewan have chosen to greatly enhance their no-fault insurance benefits and effectively restrict access to tort. B.C. has gone somewhat the other way with a relatively skinny no-fault benefit scheme with maximum access to tort with its attendant burden on the justice system. There are provinces with privately-run auto insurance systems that are less expensive than those of provinces with government-run auto systems. The B.C. system which is predominantly government-run, as well as subsidized, is the second most expensive in Canada, second only to Ontario's.¹⁸

The key to achieving lower cost and better value does not lie simply in the type of delivery model that is used. The key is to ensure that appropriate management and regulatory tools must be used which are appropriate for the model chosen. **Whichever model is chosen there needs to be certainty and speed of decision-making, simple benefit structures, efficient access to benefits without the need for intervention by third parties; incentives that are client-centric rather than provider-centric and continuous measurement and improvement processes.**

There are several good reasons why Ontario should avoid a major shift in its delivery model for auto insurance at this time.

First, a seismic change in Ontario's business model brings with it significant disruption to customer service; significant job losses in the private sector; major investments in time and money as new computer systems and administrative processes are put in place; high risk of failure and no guarantee that the outcome will be any better than the model you began with unless changes in benefits and process are also introduced at the same time. It is far superior and less risky to carefully analyze what is lacking in the current model and incrementally correct it than to take a giant leap into a new system.

Second, in privatizing the delivery of a financial product, the government is presumably hoping to capture the efficiency of the private sector arising from competition. But to reap this benefit the regulatory control governing the service must be such as to encourage rather than discourage competition and innovation.



Third, and likely most important, the insurance industry like almost every major sector of the economy is undergoing major disruption and change resulting from technology and customer demand. Driver-assisted and fully-automated cars will develop new opportunities to understand customer behaviour and tailor-made insurance and financial products will emerge. As well, non-traditional competitors are likely to try to enter the auto insurance field, including technology companies and the car manufacturers themselves as they chase the value chain. All the financial industry players including auto insurance providers are either in the middle of or about to commence major technology and systems investments to capture and analyze customer data. This would be the wrong time to ring fence and bring the auto insurance system in-house. It would be a solution to yesterday's problem while the ground is shifting in unpredictable ways. In times of rapid change, private companies are best poised to innovate and provide competitive services to customers, providing they are freed up to do so.

Recommendation

1. The government should not move to a government-run auto insurance system at this time. There is an opportunity to learn from past experience and fix the problems in the current auto insurance delivery system in Ontario as described in this report.



A Better Future – Fair Benefits

BENEFITS TODAY

It is possible to achieve a much better system. The key is to cut waste, which can come in a variety of forms, such as, overtreatment, failures in coordinating proper care and administrative complexities, not benefits.

Ontario has chosen to retain its relatively rich, no-fault, first-party system with the intent that most of the needs of an injured person could be met without having to go to the courts under tort, as the vast majority of injuries are minor in nature. The richness of Ontario's no-fault benefits is often referred to as an explanation for why its auto insurance premiums are so much higher than in other provinces. But analysis shows that a more generous no-fault system is fairer to accident victims than one which requires access to tort and does not require more cost. Quebec, Manitoba and Saskatchewan – all public or hybrid systems – all have more generous no-fault systems than Ontario's yet their costs are not only lower than Ontario's, but also lower overall than the provinces with a mix of no-fault and access to tort. So the answer to Ontario's cost problem does not point to lower accident benefits costs.

Recommendation

2. Ontario's current no-fault benefits should not be reduced.

CATASTROPHICALLY INJURED PERSONS

While there is no need to cut Ontario's current accident benefits levels, there is a need for a different approach to the needs of the approximately one per cent of claimants who are catastrophically injured each year.

Table 7: Estimated Number of Catastrophically Impaired (CAT) Claimants in Ontario

Accident Year	CAT claimants originally identified by 2011 survey	CAT claimants identified in 2013 survey	Total 2013 CAT claimants extrapolated for entire market	Total number of reported Accidents*	Total number of reported Injured Persons
2002	376	433	546	244,642	84,192
2003	362	403	508	246,463	77,879
2004	383	466	588	231,548	73,008
2005	457	537	677	230,258	71,850
2006	461	589	743	216,247	68,793
2007	403	570	719	233,487	67,166
2008	273	479	604	229,196	62,743
2009**	-	487	614	216,315	62,562


**Source: Ontario Road Safety Annual Report 2011*

***2009 data incomplete for several companies*

Table adapted from the FSCO Three Year Review

The definition for being catastrophically injured is contained in the SABS. It is extremely complex – see Appendix II – and requires several specialists to come to a determination of whether or not an accident victim fits the catastrophic injury definition. This determination is extremely important since the benefits payable to an accident victim judged to be catastrophic are many times higher (\$1 million vs. \$65,000) than for an injury not judged to be catastrophic. As a result, tens of thousands of dollars – in the range of \$15,000 to \$20,000 are spent by the claimant and the insurer on medical reports to arrive at or challenge a determination.

As well, the process of arriving at a decision often goes through the dispute resolution system and takes more than a year to resolve (it has yet to be seen how quickly these issues will be resolved at the new License Appeal Tribunal – LAT).




There are several problems with how catastrophically injured claims are handled. In the first place, we have a claimant who is put through multiple tests administered by competing sets of doctors. Secondly, the claimant may wait a year or more to receive confirmation of the medical and financial help to which they are entitled during an extremely stressful and life changing time in their lives. The accident victims are, of course, using up their lower tier of accident benefits and accessing the regular OHIP and social support systems as best they can in the meantime. And in many cases, the insurer will advance funds for treatment if the person is obviously catastrophically impaired for life. However, more problematically, the accident victim may resort to financing from one of the settlement loan companies at very high interest rates. Finally, because the process to access benefits is so complex, the accident victim often hires a lawyer in order to properly access them. What can happen then, is the accident victim may ultimately find themselves with significantly less than the \$1-million benefit to which they were entitled, since this amount would be partially reduced by the cost of medical exams and legal fees.

A catastrophically injured person's needs change as they age.

In any event, the payment of a cash settlement for needs that can run many years in the future is not well suited to catastrophically injured persons. Injured persons who receive a lump-sum payment during a period of crisis in their lives, should not be forced to figure out how to make the settlement work for their needs, not only now, but also in the future, where they could very well change significantly. As well, lump-sum settlements could very well run out during the lifetime of the injured person.

Alternatives to monetary compensation, how it is delivered and the method of support should be explored. The goal should be to increase the support given to this group of claimants. Specifically, catastrophically injured victims should receive lifetime care. Of the benefits available under the no-fault policy, the benefit for catastrophically injured persons is arguably the most important of all because there isn't the simplicity of treatment that is found in minor injuries.

If the accident benefits system does not fairly address catastrophic injuries, injured parties will go to the tort system if they can. Those who are at fault (30 per cent) will not be able to do so; those who can will pay a heavy price – in time as they fight through the dispute system – and in lawyer's contingency fees and expert fees to obtain any additional benefit.



In Australia and New Zealand lifetime care and support is provided to seriously or catastrophically injured persons. Here in Canada, the Saskatchewan no-fault system offers up to \$6.7 million for seriously injured persons in their no-fault system, whereas in Quebec, lifetime care is provided in their no-fault system. Both have lower premiums than Ontario. All workers' compensation boards in Canada also provide lifetime care and support with no upper limits on costs. At the present time, the Ontario Workplace Safety and Insurance Board is looking after some 7,000 seriously injured persons for their lifetime. So, there are several examples of lifetime care being made available to catastrophically injured persons.

A further complication is that the definition of catastrophic impairment in the accident benefits system is causing many challenges both in how to qualify for the benefit and in the details as to how the benefit is to be calculated (see Appendix II). This results in long and expensive negotiations with claimants. Further, where the claimant is also seeking redress under tort, the offset of any accident benefits catastrophic payment is unclear, opening the possibility of duplicate or double recovery, which I address in depth in another section of this report.

The current definition of catastrophic injury and process for qualification of benefits is highly complex and is likely causing more problems than necessary in the system. To reduce the complexity, evaluation of catastrophic impairment should be done using an objective guide such as the most current American Medical Association guide and supplemented, where appropriate, by specialized and well established guidelines. The evaluation should be done by a competent, hospital-based independent examination centre (IEC), which is discussed below.

Until lifetime care is made available, these claimants should continue to be awarded lump-sum payments. However, the lump-sum payment should be calculated based on the IEC assessment, using the degree of impairment and an adjustment for age and be made immediately and without delay by the insurance company upon receiving the report of the IEC. There should not be a need for a catastrophically injured person to retain legal counsel. The decision from the IEC should not be subject to dispute or further medical examination. Furthermore, the payment must be made fully deductible from the total settlement received under tort, another issue addressed later in this report.



Recommendations

- 3. The regulator should undertake serious discussions with the Ministry of Health and Long-Term Care to develop a service for lifetime management of care for seriously injured accident victims. Eventually, as the province develops this expertise, the expertise and even services could expand to address other injuries outside of the auto insurance system. This would allow for continuing improvements in care to develop and recommendations for preventative measures to be generated while ensuring that patients are being treated by a reliable and sustainable system.**
 - 4. There should be a minimum of disputes and delays in accessing single lump-sum awards for those who are catastrophically injured. Such awards, should be efficiently and quickly determined by an independent examination centre and based on objective measures, such as the American Medical Association guide, supplemented, where appropriate, by specialized and well-established guidelines.**
 - 5. Insurers should make sure that seriously injured persons are given top priority and do not need to hire lawyers or other professionals to get their entitlement.**
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A Better Future – Benefits Fairly Delivered

PROGRAMS OF CARE

As stated earlier, the central failing of Ontario’s auto insurance system – and the largest contributor to its cost – is the singular inability of participants to agree on what constitutes an appropriate medical diagnosis and treatment for injuries. Again, improved health outcomes must be the central goal of the system.


The SABS provides for a \$3,500 financial limit within which the majority of injuries – sprains strains and minor whiplash injuries – ought to be satisfactorily treated. The \$3,500 limit for treatment automatically starts the process of debate over cost rather than care. It invites claimants and lawyers to find ways to show that their injuries do not fall within the definition of a “minor injury” and hence need to breach the financial limit and access the greater benefits in the \$65,000 limit applicable to more serious injuries. On the other side, insurance companies may also fight to keep claimants to the minor injury limit if at all possible.

In the course of this dynamic, claimants, lawyers and insurers spend large amounts of money – up to \$2,000 on each medical evaluation – and insurers end up rejecting between 25 and 30 per cent of the amounts proposed for treatment each year. The efficacy of this process can be judged by the fact that 25 to 30 per cent of claims go into a dispute resolution system where they take longer and cost much more to settle (see Appendix VI). Cunningham’s Interim Report states that 61 per cent of disputes concerned medical benefits and related assessment and examination expenses.¹⁹

Since there is no monitoring of medical outcomes, it is highly uncertain whether accident victims are indeed getting the right kind of care in the right facilities. Drs. Côté and Soklaridis observed in an article in Spine Journal:

“It is an unsettling fact that most interventions used in clinical practice are not supported by scientific evidence. ... It is likely that a high proportion of patients are treated every day with ineffective or unproven clinical interventions. These findings emphasize that clinicians need to be educated on the use of evidence based interventions.”²⁰

It is necessary and essential to find a better way to resolve the issue of how to efficiently diagnose and treat injuries under the no-fault system.



It is necessary and essential to find a better way to resolve the issue of how to efficiently diagnose and treat injuries under the no-fault system.


Programs of care

The solution is to adopt programs of care, based on the principles of evidence-based medicine, for the most common (70 to 80 per cent) of injuries. Programs of care are patient- and outcome-focused for the best results in treatment. They are designed around what the patient needs, not the processes of the providers. They are also focused on health outcomes for the patient not the number of treatments provided.

Michael Porter and Thomas H. Lee, in their Harvard Business Review article, put it this way:

“In health care, the days of business as usual are over. Around the world every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. Health care leaders and policy makers have tried countless incremental fixes – attacking fraud, reducing errors, enforcing practice guide-lines...but none have had much impact. Its time for a fundamentally new strategy. At its core is maximizing value for patients...We must move away from supply-driven health care systems organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume of...physician visits...procedures and tests – to the patient outcomes achieved.”²¹

Programs of care minimize uncertainty and disputes about what treatment is needed on a case by case basis. The vast majority of accident victims get proven care strategies and insurers do not dispute them. This provides quality care on a consistent basis, reduces delays and saves enormous cost and aggravation, while creating a fair system where accident victims are no longer forced to navigate a complex system, or find themselves caught between lawyers and insurers.



Programs of care are developed for specific types of injuries, the most common and high-volume ones. For example, there will be a program which treats musculoskeletal injuries such as whiplash, others that treat low back injuries, shoulder injuries, mild traumatic brain injuries and so forth. The programs set out clear expectations to providers and insurers: the treatment goals are defined, the duration of the care is defined and the total fee for the treatment is set.

Importantly, providers should be required to examine the patient and record their medical condition – level of pain, functionality of injured body part – prior to commencing the program and then to measure and report on the outcomes of the treatment.

Porter and Lee put it this way:

“Rapid improvement in any field requires measuring results – a familiar principle in management. Teams improve and excel by tracking progress over time and comparing their performance to that of peers inside and outside their organization. Indeed, rigorous measurement of value (outcomes and costs) is perhaps the single most important step in improving health care.”²²


Where they are used, programs of care have been developed in consultation with the relevant professional bodies and are well understood by all providers. For example, the musculoskeletal program of care used for injured workers in Ontario was developed with the participation and contribution of regulated health professional associations, namely the Ontario Chiropractic Association, the Ontario Physiotherapy Association, the Ontario Society of Occupational Therapists and the Registered Massage Therapists’ Association of Ontario.

Variations of programs of care are in use in many jurisdictions including in auto insurance delivery systems in Alberta, Nova Scotia and some states in the United States, as well as in workplace injury systems throughout Canada.

The Ontario Auto Insurance Anti-Fraud Task Force Final Report expressed the view that (well-defined) evidence-based treatment protocols could make fraudulent behaviour more difficult and made the following recommendation:

“The government should reduce uncertainty and delay for those who have legitimate auto insurance claims by moving aggressively to introduce treatment protocols for minor injuries that are based on scientific evidence.”²³

In Alberta and Nova Scotia, diagnostic treatment protocols (protocols), which are similar to programs of care, provide a structured model for the treatment of strains, sprains and whiplash injuries. The focus of the protocols is patient recovery.



The patient is entitled to the number of treatments under the protocols, subject to the health professional's opinion. The treatments may not be disputed by an insurer and are considered pre-approved. Reasonable and predictable costs have been negotiated with providers, patients are treated quickly and appropriately, and treatment providers understand the parameters within which they are working and treat their patients accordingly. Disputes around the protocols themselves are infrequent because they have been established in consultation with the relevant medical practitioners and organizations.

Under the guidance of FSCO, Ontario has already made a start along this path through the development of a Common Traffic Injury Guideline, which lays out very detailed, evidence-based treatment paths for common injuries and was designed after consultations. This work would be a good starting point from which to develop appropriate programs of care for the auto insurance industry in Ontario.

The issue of quality control of health care providers was raised more than once during my study. Professional groups of providers suggested that while most practitioners were honest and competent there exist some who are not providing appropriate care.

No doubt there will be some providers who are not meeting acceptable standards. The Ontario Auto Insurance Anti-Fraud Task Force had several suggestions to address this issue. There is a practical means of promoting good providers and dis-incenting poor providers and that is to monitor the effectiveness of treatment and the outcomes achieved. This is an essential part of the process of improving both the design and the execution of programs of care. Monitoring of provider performance also helps detect and manage fraud to the extent that it exists.

While several useful and necessary programs of care have already been developed in other systems, there is always more to be done. There are more needs that must be urgently addressed. For example, chronic pain, stress related impairment and post-traumatic stress. These medical conditions have been recognized by the courts as legitimate injuries but they are often extremely difficult to diagnose and treat. They are also a significant factor in the rising cost of benefits in the auto insurance industry. Rather than passively waiting for solutions to emerge, the insurance industry should be conducting research to develop evidence based standards for the diagnosis and treatment of mental injuries.




INDEPENDENT EXAMINATION CENTRE (IEC)

Both the Alberta and the Ontario Workplace Safety and Insurance Board (WSIB) systems have a process by which an injured person is referred to an independent expert where a program of care has not resulted in the full recovery of the injured person. In the WSIB system, where a program of care is not working or there is uncertainty around the appropriateness of different care programs, the patient is referred to a regional evaluation centre (not dissimilar to the independent examination centres, or IECs, defined in this report). The purpose of the referral is to provide an expert diagnosis of the present condition of the patient and to recommend future care needs.

In Ontario, the IEC would be a hospital-based service that brings multidisciplinary skills to the assessment and treatment plan for a patient. Being hospital based, physicians from multiple disciplines can be brought in to the assessment, as required. The IEC is also required to contact and have a conversation with the patient's family doctor who can provide a whole person context to the situation at hand. The role of the IEC is to examine the patient to establish a diagnosis and to provide recommendations on the best treatment options to facilitate recovery. The role of the IEC is forward looking and helpful to both the patient and the insurer in terms of the best options for future care. It is not concerned in any way with approving or denying a claim.

At WSIB, typical costs for a multi-discipline examination and treatment plan is much less expensive than the cost of medical examinations in the Ontario auto insurance system in two ways. It costs less than the \$2,000 per opinion that is currently paid by the Ontario auto insurance system and the injured party does not have to submit to multiple separate examinations. As a point of reference the total cost of medical examinations paid by the WSIB in a year is about \$26 million for a system handling 170,000 injury claims a year, compared with the approximately \$350 million currently paid in the Ontario auto system for handling just 60,000 injury claims.²⁴

To be adopted in the Ontario auto insurance system, the auto insurance regulator must keep a roster of reputable, competent, hospital-based IECs to which insurers can refer patients for assessment. The regulator would need to monitor the quality and timeliness of the advice given. Further, it is essential that the opinion of the IEC be taken as final and not subject to competing opinions from either the insurer or the patient. For this reason, it is also essential for the IEC to be a hospital-based team that can bring multidisciplinary skills to the evaluation and recommendation for treatment. Hospital-based teams already meet high medical and ethical standards. The WSIB, for example, has thirteen hospital-based centres on its roster, including Sunnybrook Health Sciences Centre and the University Health Network in Toronto, Health Sciences North in Sudbury and others located across the province. This model could be explored, as it provides an example of how the roster of IECs could be developed throughout the province.



The Ontario auto insurance system did try to institute something similar to the IEC concept with the introduction of Designated Assessment Centres (DAC) in 1994. These were discontinued in 2006 for several reasons. In the first place, DAC evaluations were used late in the claims process – that is as means of accepting or denying a claimant medical care as precursor to a mediation or arbitration hearing or litigation. Furthermore, DAC assessments were not unique. A claimant would have gone through assessments by the insurer before being assessed by a DAC, and either party could dispute the DAC assessment during the dispute resolution process. DAC assessments were often long, drawn out and expensive, as several experts, frequently from different organizations, were asked for separate opinions based on their area of competency. Furthermore, arbitrators and courts failed to give a DAC opinion any degree of deference over any other medical opinion produced by either the claimant or the insurer. If this wasn't bad enough, the independence of the DAC opinion became compromised as DAC assessors also frequently acted on behalf of insurers or claimants in providing medical assessments to them separately. Ultimately, with a lack of respect for the DAC process, the cost and time involved and the independence brought into question, the DAC system failed and was discontinued.

In contrast, the IEC process is quite different in its purpose, its conduct and its process. An IEC evaluation takes place much earlier in the treatment cycle. It is not designed to accept or deny a claim. It is designed to provide guidance as to the best options for future care in cases where a program of care has not resulted in satisfactory recovery of the injured party. The IEC is hospital based and has access to a wide variety of medical and rehabilitation experts. In this role, the IEC is an extraordinary resource of first class expertise to aid in the treatment of the patient. IECs are also completely independent of either the insurer or the patient and they come with the quality control of a major hospital organization – their orientation and high level of competency is to provide the best possible medical advice.

In terms of the volume and intrusiveness of insurer medical exams, one of the issues with the current system is the frequency with which medical exams are sought by the insurers and claimants. As reported above, some 30,000 to 35,000 claimants per year, more than half of all claimants, are subjected to medical examinations at a cost of \$9,000 for the life of the claim. Because the proposed system will be based on programs of care, there will be greater certainty around treatment and the need to dispute will be greatly reduced. Only those patients who are not responding to the programs of care will be referred to an IEC. Those referrals will not be in order to deny a claim. The IEC, in consultation with the patient's family physician, conducts an examination and makes a recommendation for additional care, where appropriate, in order to help the patient make a sound recovery.



Recommendations

6. The regulator should move as quickly as possible to create programs of care for the most common types of automobile injuries. The programs should be based on the evidence-based findings of the Common Traffic Injury Guidelines.

7. The regulator should be provided with a sufficient budget to monitor and continuously improve the outcomes of existing programs of care and partner with the government on research into the development of new programs of care as the need arises – for example for neurological injuries, injuries from concussions, spinal cord injuries, chronic pain and post-traumatic stress disorder. Consideration should be given to leveraging existing programs of care that have been developed by other jurisdictions.

8. The government should empower the regulator with the authority and direction to establish a roster of independent examination centres (IEC) which should be hospital-based and must be able to provide a multidisciplinary team to provide appropriate diagnoses of injured patients and recommended treatment plans. Insurers must follow, without dispute, the recommendations of the IEC for future treatment within the financial limits of the insurance policy as provided by law. The dispute resolution process must respect the evaluation of the IEC without resorting to competing opinions from either party to a dispute.

9. The regulator should conduct regular quality control studies of the outcomes of future care recommended by IECs to monitor the quality of such recommendations and ensure their effectiveness. As part of this process the regulator should consider instituting a system of professional peer review of roster assessors to ensure quality is maintained.

10. The regulator should undertake a complete overhaul of the pricing schedules for treatment by providers and evaluators to bring them more in line with prices being paid by other similar bodies, such as workers' compensation boards, and to emphasize outcomes rather than the number of treatments.



PROVIDE CARE NOT CASH

The intention of the legislation is clearly to provide accident victims the medical care they need to recover their health with some income replacement support as a bridge during the recovery period. The legislation never intended the auto insurance system to be a cash jackpot. Many insurance companies, however, are incented not to see their role as providing medical care to their clients. Rather, they are incented to close their liability with as little cash cost as possible and hence they introduce the practice of negotiating cash settlements with claimants in lieu of medical treatment, future wage loss and other future benefits under the SABS. In Cunningham's Interim Report he put it this way:


“Disputes and settlements need to be focused on getting claimants timely access to necessary treatment and assessments.”

— Justice Cunningham

“Although I sympathize with the insurance industry's desire to close files on a full and final basis, I find the practice in some circumstances counter-productive. It only encourages the type of behaviour insurers have raised with me during this review. Other insurance systems such as worker's compensation or supplementary health plans will never or only in exceptional cases pay a lump sum for future health care benefits. I would support extending the one-year prohibition on settlements if it would have an impact on the 'cash for treatment' approach to care that is widely practiced. Disputes and settlements need to be focused on getting claimants timely access to necessary treatment and assessments.”²⁵

Justice Cunningham is referring to the practice of insurers to want to get a full and final release of the claims against them so that they can finalize their cost and release any capital that is tied up to support future amounts that might be owing on the claim. Hence insurers often drive towards getting a release on settlement of all future claims via a lump-sum payment.

This practice is counterproductive and goes against the main goal of the system which is to provide the necessary medical care and related support – not to provide a cash lump sum in lieu of care. Trying to estimate the care and other benefits needed in the future leads to lengthy negotiations over amounts which may or may not ever be put to the uses estimated.




It also introduces professional negotiating via lawyers, which can result in a large dose of exaggeration and gamesmanship on both sides in an attempt to figure out what the other party is likely to settle for, not necessarily what the claimant actually needs. As long as there is a prospect of a lump-sum payment at the end of a process, injured parties may be advised to boost a claim in order to maximize the size off the payment. This does not serve either the injured person well (boosting a claim requires spending money on expert opinions and lengthening the time of disability) nor does it serve the system as a whole since added costs which are not necessary increases the cost of insurance for all participants.

To avoid this situation a major cultural shift needs to occur. As a start, insurers must stop pushing to reach full and final releases from their clients. A claim should be handled on its merits. If health care is needed it should be provided either through the programs of care mentioned above or through the diagnosis and treatment recommended by the independent examiner –within the dollar and time limits of the policy.

Once the claimant reaches medical recovery the claim is closed, but the claimant can return for more treatment – up to five years after their injury or other time limit in the legislation – if they can show that their condition has resurfaced and that it can be related to the original accident. This process has two big advantages: there is an incentive for the insurance company to stay in touch with their client to ensure they get the proper medical care so that they can return to normal function as quickly as possible; and there is no pressure to keep the claim open for long periods of time while negotiations for a release go on. The patient can come back for more treatment if that is what is fair and right.

With respect to the impact of removing a cash incentive, the study by Dr. David Cassidy et al. reported that when the Province of Saskatchewan changed its auto insurance system from a tort system where all compensation was given in cash vs. treatment to a no-fault system where treatment was provided instead of cash, the Saskatchewan system experienced a 28 per cent reduction in whiplash claims. Median time to closure of whiplash claims came down from 433 days to about 200 days. The study goes on to say that a decision to make a whiplash claim could involve factors beyond actual medical need and include a prospect of financial gain.²⁶ As pointed out by the Ontario Auto Insurance Anti-Fraud Task Force, the adoption of programs of care combined with the elimination of cash for care will have the effect of substantially reducing the opportunity for fraud in the system.



In terms of the need to tie up capital against future claims, experience within the worker's compensation system shows that the majority of claimants, once they have recovered from their injury do not need further care and do not come back for more treatment. Those that do, account for a fairly small proportion. The actuaries will quickly adapt to the rate of recurrence and are able to advise management as to how much capital to set aside for this eventuality. This is also the process followed by the Quebec auto insurance system which has demonstrated that their costs are the lowest in Canada.

Recommendation

11. There should be no cash settlements in the accident benefits portion of the Ontario auto insurance system for those benefits specified in the legislation as being for medical and rehabilitation care. Where the legislation provides for cash payments, for example for lost wages and lump-sum payments for catastrophically injured persons, these would, of course, continue to be paid.


LEGAL REPRESENTATION, ADVERTISING AND CONTINGENCY FEES

Insurance companies reported to me that about 25 to 35 per cent of claimants – some 15,000 to 20,000 a year – come to them at the time of making a claim or shortly thereafter with a lawyer already hired. From this point on, the insurance company must deal with their client only through their lawyer.

The incidence of legal representation quickly rises through the handling of the claim as difficulties arise. Going into the dispute resolution system at FSCO, there was virtually 100 per cent legal representation of clients and there is little reason to believe this situation has changed with the move of the dispute resolution system to the Licence Appeal Tribunal.

“Money out of the pockets of claimants.”

— Justice Cunningham



Legal fees are not cheap. In the no-fault system alone the cost of contingency fees annually is approximately \$100 million, and in the tort system the contingency fees are about \$400 million. And this doesn't count the legal costs incurred by insurers. (see Table 6 above). Clearly, a better way to deliver fair benefits to accident victims needs to be found.

Justice Cunningham's Interim Report states:

"Ontario's auto insurance system is extremely complicated.... Not only are the SABS complicated but so are the forms required to be completed by claimants to apply for benefits or for mediation and arbitration. ... In its early days, many clients accessed the DRS without a representative. This is no longer the case. ... Legal representation is not free and not necessarily inexpensive. Legal representatives are charging SABS claimants contingency fees which I am told can be as high as 30 or 35 per cent. This is money out of the pockets of claimants who need these funds to replace lost income and pay for treatment." ²⁷

In many ways, the need to have lawyers involved to negotiate settlements in what should be a straightforward, no-fault, accident benefits system signals a failure in the system. The system should not be as complex as it has come to be, there should not be so much uncertainty that neither accident victims nor insurers are confident as to what constitutes fair benefits.

Many of the recommendations in this report are directed at improving this situation. The simplification of the regulations referred to in a section below; the introduction of evidence-based programs of care, delivered promptly and without dispute, an independent examination centre to guide future care if needed and strong oversight by the regulator are all measures which should greatly improve speed of access to benefits, reduce the time to recovery and reduce disputes. In the section under improvements to the tort system, the recommendation that the independent examination centre opinion on the medical condition of the accident victim and the indication of future care be given deference by the court will further improve the quality and independence of evidence provided to a court.

Contingency fees permit enhanced access to legal representation, nevertheless, it is clear that there are concerns with how the contingency fee regime is operating in Ontario auto insurance cases today. The Law Society of Upper Canada's Professional Regulation Committee (LSUC Committee) looked into the issue of advertising, contingency fees, referral fees and related matters in the practice of personal injury law. The LSUC Committee recently issued its final report which did not provide specific recommendations on contingency fees. However, in its June 23, 2016, Interim Report to Convocation, the Committee addressed Advertising and Fee Arrangements and had this to say:

- In Ontario, lawyer advertising appears to have rapidly become “big business.”
- Referral fees – the practice of obtaining clients through advertising then passing them onto other lawyers for a fee – in personal injury law have become unreasonable and disproportionate and in many cases clients are not sufficiently aware that they are being referred to another lawyer.
- Due to the high cost of acquiring cases, counsel might not be able to afford to spend adequate time with the client or be prepared to take the case to trial if necessary.
- The Working Group is concerned that contingency fee pricing is not currently sufficiently transparent at the outset to consumers. In the personal injury market, the fee that a prospective client can expect to ultimately be charged often remains opaque, and it is difficult to determine whether a competitive fee structure is being proposed.

One area of particular concern is the reported practice by some lawyers of double dipping, which is, keeping part of the legal costs awarded to clients or charging their contingency fee on top of the legal costs. Keeping the disbursements and other practices not fully explained to the client up front are either in violation of the Solicitors Act or potentially questionable.

One of the more serious and unfortunate results of the delay in finalizing claims in the Ontario auto insurance system is the burden it places on claimants when they do not receive timely assistance. Consequently, clients often suffer financial hardship. To meet this need, specialized firms called settlement loan companies step into the picture. The settlement loan companies state that the loan is on a contingency basis, promising that no credit check is necessary and no principle or interest is payable unless the client wins a settlement from the insurance company. These companies provide bridge loans to auto insurance claimants ranging from an estimated \$500 to \$50,000 at high interest rates. There is very little transparency on who owns these settlement loan companies, how they obtain their financing and who refers clients to them.

Handling of an accident benefits claim in a no-fault system ought to be straightforward. There should be very little, if any reason to have to hire a lawyer or resort to a finance company to provide a bridge loan, especially in cases where there are minor injuries. In the future, when the core entitlement decisions are readily determined by programs of care and neutral independent examiners, there should be little structural need for conventional litigation and a consequent improvement in both health outcomes, and the efficiency and cost of the system.



Recommendations

12. There is clear urgency to make the accident benefits system simple and accessible without the need for legal representation. Since accident victims are in a vulnerable position and contingency-fee arrangements are not very transparent, the government should consider:

- Banning or restricting advertising and referral fees, and restricting contingency fees in personal injury cases, as the law society reports is being done in some jurisdictions such as in England, Wales and Australia.
- Requiring contingency-fee arrangements to be filed with the regulator, who should inquire into their fairness on a spot-check basis and work with the relevant authorities to curtail abuses if they arise.
- Settlement cheques should be made payable jointly to the accident victim and the lawyer. This will allow the accident victim to clearly understand the relationship between the total settlement and what he or she eventually receives.
- Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer and where to apply to do so.

13. The regulator should monitor the overall use of legal representation in the accident benefits system to analyze why claimants are needing to resort to legal advice. Also, the regulator should examine if the system should be further simplified, barriers should be removed or other practices changed to reduce the need for the time and expense of legal involvement.

14. The regulator should monitor, on a continuous basis, the length of time insurance companies are taking to provide benefits to claimants and determine if undue delays are causing financial harm to accident victims.



Dispute Resolution

In his final report, Justice Cunningham observed:

“One of the things I quickly realized...was how polarized the system has become. I am certain that when the first no-fault auto insurance system was introduced in 1990, policy makers did not contemplate that the claims process and the [dispute resolution system] would become so adversarial. This was very much reflected in the feedback received from stakeholders. The insurance industry points to the plaintiff bar as the source of the system’s problems, while the legal community blames the practices of the insurance industry. Neither is an accurate portrayal of the current system.”²⁸


In the Ontario auto insurance system, in one out of every three cases, the insurer and the claimant cannot agree on what is a fair compensation for the injury involved. Until the Licence Appeal Tribunal began in April 2016, accident benefits disagreements were first sent to mediation and evidence shows that almost 40 per cent of the time the disagreements were not resolved at mediation and cases proceeded to arbitration (see Appendix VI). Justice Cunningham made proposals to streamline the process of mediation/arbitration and his proposals have for the most part been accepted and implemented this past year. And, while on the right path, there is more work to be done to improve the system.

The recommendations noted in earlier sections regarding introduction of programs of care, continuous care, absence of cash settlements and an independent examination centre should go a long way towards reducing disputes in the no-fault system. There should be a goal to achieve a dispute level of no more than 10 per cent compared to the current average of over 30 per cent. Later, even more challenging goals can be set.

Following Cunningham’s Final Report, the dispute resolution system moved from FSCO to the Licence Appeal Tribunal of the Safety, Licensing Appeals and Standards Tribunals Ontario and many reforms were put in place.

INTERNAL APPEAL PROCESS

Justice Cunningham recommended that insurance companies set up an internal appeal process. The system of dispute resolution can be greatly helped if it becomes mandatory for insurers to have an internal appeal process. It should be staffed with case managers who have the experience and judgment to review decisions made by front line staff. The appeal team should be required to issue written decisions with explanations and support for their opinion.



Experience in the Quebec auto insurance and worker's compensation systems has shown that an internal appeal function can usually resolve half or more of disputes without the need to go any further. The internal appeal function adds further value by acting as a feedback and training loop for front line staff who learn about mistakes they may have made and are able to improve their decisions going forward. It also gives management an opportunity to adjust and change procedures based on results from the appeal team.

The auto insurance regulator should monitor the functioning of the automobile insurance dispute resolution system. For example, if a particular insurance company is generating an unusual number of appeals at the Licence Appeal Tribunal or an unusual level of reversal of their adjudicative decisions on claims, the regulator should be given the right to audit and examine the internal management and training practices of those insurers with a view to improving decision making and lowering the number of disputes going to the dispute resolution system.

GATEKEEPER FUNCTION

There is great value in establishing a gatekeeper function at the Licence Appeal Tribunal, as recommended by Justice Cunningham. More recently, a gatekeeper function has been established at the Licence Appeal Tribunal. Experience in other systems shows that this function can significantly improve the efficiency of a dispute resolution system by ensuring that claims have all the necessary documents and qualifications to proceed to examination. The gatekeeper should perform two important services.

First they must make sure that an appeal is ready to proceed, that is, all the required documents are present and all processes have been followed, which is now in place. The gatekeeper function should also insist that the claimant provide evidence of having gone through the insurer's internal appeal function before allowing the claim to proceed further.

Second, the gatekeeper must determine if new information is being introduced that has not previously been shared by either party with the other. The dispute resolution process should not become an exercise in gamesmanship or ambushing an opposing party. If there is new information that is relevant to the case it should be presented back to the original decision-maker at the insurance company or to the claimant. This might well change the decision and avoid the need to proceed any further. Only after the new information has been thoroughly considered and a new decision rendered should the appeal be allowed to proceed through the formal appeal process if necessary.



EXPERT WITNESSES

Overwhelmingly, disputes centre around or are related to the medical condition and necessary treatment of claimants. Trying to resolve this type of dispute through the process of sifting through competing expert opinions is not the most efficient or even the best way to arrive at fair conclusions. Both insurer and claimant will seek experts whose opinion is likely to support their position.

Justice Cunningham put it this way in his final report:

“Part of the culture shift that I see being needed within the Dispute Resolution System (DRS) is that medical experts appearing before adjudicators should have a duty to the DRS and not to the party that has retained them. Experts should be required to certify their duty to the tribunal and to provide fair, objective and non-partisan evidence. Arbitrators should ignore evidence that is not fair, objective or non-partisan.”²⁹

In order to meet the standard of objectivity and professional competence, adjudicators should be required to rely on the opinion of the independent examination centre (IEC) referred to above. IECs will be selected by the regulator who will create a roster of such centres. In the first place this serves the injured person extremely well since he or she will be getting advice from a highly qualified and independent team. Secondly, the opinion of the IEC can be relied upon, in the great majority of cases, to reflect some of the best medical thinking and techniques available.

As described earlier, the opinion of the IEC, in consultation with the family physician, must be relied upon during the management of care in the first instance that it becomes apparent that the current approach to treatment is not working. It should also be taken as final in the case of a claim going into dispute resolution. The case manager at dispute resolution may ask for a second evaluation from the roster of IECs if it appears necessary for whatever reason, but there must be no submission of competing evaluations by either the insurer or the claimant. This process would best satisfy the essential requirement that an expert witness be competent and objective and not beholden to either party in a dispute. It would also allow disputes to be handled efficiently, with less cost and with the least damage to trust in the system.

Dispute resolution in New Jersey’s auto insurance system has an analogous provision. There, the arbitrator of a dispute must use a certified medical review organization as designated by the New Jersey Department of Banking and Insurance to perform a medical review of the claimant’s case. The determination of the medical review organization is presumed to be correct unless the arbitrator finds the opinion to be clearly wrong, in which case he or she must provide written explanation of the reason.



Recommendations

15. Insurers should be required to establish an internal appeal process to provide an early resolution to claims and reduce the number that have to proceed to the external dispute resolution system. The regulator should monitor the effectiveness of the internal appeal process and be empowered to order corrective action if a particular insurer is generating an unusual number of claims to the dispute resolution process.

16. The gatekeeper function at the Licence Appeal Tribunal should insist that a claim has gone through the insurer's internal appeal process before allowing it to proceed further. The gatekeeper should also determine that if new information is being introduced in the claim, it should go back to the original decision-maker to see if it changes the decision before the appeal proceeds.

17. In relation to medical condition and treatment, the opinion of the independent examination centre should be taken as definitive by arbitrators. If, in exceptional circumstances, the arbitrator has reason to be concerned about the independent examination centre opinion under consideration, the arbitrator can ask for a second opinion from a second independent examination centre from the regulator's roster. Competing examination opinions from experts hired by either the claimant or the insurer should not be permitted.



Bringing Simplicity and Responsiveness to the System

Generally, all parties who participate in the system agree that is that the current legislation and SABS is complex and very difficult to interpret. This is surely a major contributing factor to disputes and disagreements.

The Ontario Trial Lawyers Association's (OTLA) letter to me observes:

"Those who work daily within this system have a difficult time interpreting the complex legal maze that is now Ontario auto insurance. ... The ability of the average policyholder to competently manage his or her own insurance claims and related disputes is essentially non-existent. Both the tort and accident benefits legislation and regulations involve multiple, often incomprehensible tests for benefit and compensation entitlement that have led to decades of litigation, at an enormous cost. As much as possible, we must eliminate those tests that lead to uncertainty and litigation."

Justice Cunningham put it this way:

"The SABS has become a complex and difficult document to interpret; many stakeholders noted that it is very difficult to work with it. Insurance companies need to make a considerable investment in training and developing adjusters, as does FSCO in respect to its mediators and arbitrators. Claimants need to find representatives well versed in the regulations. The learning curve associated with the SABS adds cost to the system. **Other no-fault schedules are far less complex and not so procedure-oriented** [emphasis added]. Everyone would benefit from a wholesale review of the SABS in an effort to simplify the regulation."³⁰

See Appendix IV for the sections from the SABS that describe income replacement benefits, one of the main types of benefits available under the auto insurance policy. There are various procedural and definition provisions that would be relevant to a claim, but these are the main sections that set out the terms and amount of entitlement. It would take many close readings of this section to understand what the entitlement to benefits amounts to, if indeed a lay person were able to understand it at all.

"The ability of the average policyholder to competently manage his or her own insurance claims and related disputes is essentially non-existent."

— Ontario Trial Lawyers Association (OTLA)



There is an urgent need to address the complexity of the auto insurance regulations.

There should be well defined schedules of benefits with limited or no need for complex adjudication. The [Société de l'assurance automobile du Québec \(SAAQ\) website](#) offers a good example of simple, clearly understood benefits and how to access them.

The new rules should encourage the direct contact of insurers with their clients so that insurers and health care providers can work collaboratively for the health care needs of their client.

Having the regulator responsible for formulating the rules (as opposed to government amending regulations) will allow this function to respond to the need to change and evolve much more efficiently than the current structure that has to be deployed before any change can be made.

Moreover, the rules should focus on outcomes rather than process. Instead of particular forms to be used there should be a requirement to meet certain standards; for example, standards of care, standards of fair treatment, benefit of the doubt to claimants and other key components of a well-functioning system.

Recommendations

18. There is an urgent need to revise and simplify the legislation and current set of regulations and focus on desired outcomes and less on the details of process.

19. The new regulator should be given authority to make regulations (already underway). Rules should support insurers to be in direct contact with their clients so that they can manage care and recovery for their clients.




CONSUMER CHOICE – LEAVE IT TO THE MARKETPLACE...

The question of consumer choice is a difficult one to address since the auto insurance system at its heart is a safety net designed to provide needed coverage and not a suite of options based on the personal opinion of the policy holder. Consumer choice in this context usually means allowing drivers to pick a less costly coverage if they are willing to take the risk of a lower safety net. This may result in a compromise of people's safety or a lack of access to necessary treatment. On the other hand, the option to buy more coverage brings with it the need to ensure there is transparency across insurers and some confusion and lack of understanding of what is being purchased may result.

Having said that, there is a legitimate question as to how far the safety net should extend. Should the mandatory safety net cover just the most serious injuries? After all, coverage costs money. Should the government insist on coverage for catastrophic injuries and allow consumers to buy coverage for less serious injuries if they want to?

These questions lie at the heart of consumer choice. If current trends like ridesharing are any indication, increasingly in the future, consumers will push to be allowed to tailor their purchases to their needs rather than be forced into a one size fits all product. How the government addresses this movement is of great importance. This is not the purview of this study, but it is true to say that it is an issue that is not going to go away and that the government needs to equip itself with sufficient structures and research to understand what society is likely to need in the near- and medium-term future. All of these issues should be taken into consideration as the new regulator is established.

Having said that, there are some particular cases where consumer choice can make sense. For example, according to the Canadian Life and Health Association close to 70 per cent of drivers have access to some form of medical or income replacement insurance, mostly through their workplaces, in addition to carrying auto insurance. At the same time auto insurance is a second payer – after other insurance coverages of the claimant have been used – which means that for those drivers who already have workplace insurance, they are caught between two competing insurance companies with potentially different claims processes and criteria for accepting claims. As well they must first use up their workplace insurance entitlements before they can access their auto insurance. This is a source not only of administrative complexity but also a source of surprise and frustration to claimants.



As well, there are several drivers who, due to their youth or other circumstances, would like to carry less insurance than the standard policy. After protecting others through a minimum liability insurance, a sensible system of consumer choice whereby a person may consciously take less auto insurance and save money should be explored.

At the other end of the scale, insurers should be empowered to offer additional coverages and new products if consumers are willing to pay and insurers should be encouraged to innovate and introduce new products.

Consumer choice is a powerful force that is going to change the nature of auto insurance in the not too distant future. An independent regulator held accountable for the functioning and responsiveness of the system, less prescriptive regulation, more outcome-based regulation and more flexibility on setting price should all be part of an overall regime to encourage and adopt innovation.

PROVIDING ENHANCED EDUCATION TO CONSUMERS

One of the frequent observations of stakeholders familiar with the system, is that consumers are generally ignorant of their insurance coverage and hence become annoyed and feel taken advantage of when it comes time to access benefits. Simplifying the regulations concerning entitlements will go a long way to increasing transparency and trust.


Two actions might further improve this situation:

One consideration could be to institute an “Office of the Driver Adviser” or something similar to the proposed “Office of the Consumer” to the Financial Services Regulatory Authority. Such an office would be available to explain how auto insurance works, how to access benefits efficiently and the rights and obligations of drivers. Second, it may be useful to consider making some basic insurance concepts part of the driver education program and requirement to pass a driving test.

The Ontario Auto Insurance Anti-Fraud Task Force also had a number of good suggestions to help create an informed consumer as a protection against illegal or fraudulent practices. The task force’s final report suggested, among other things:

“With respect to *prevention*, our key recommendations include:

- “The government should join with insurers to form an Anti-Fraud Awareness Implementation Group to implement a consumer engagement and education strategy. This group should oversee the creation of:

- 
- “educational material in different media that could instruct consumers at critical moments such as when they learn to drive, select an insurer, choose optional coverage, collide with another vehicle or make an insurance claim; and
 - “a dedicated, multilingual website that would explain how to make an auto insurance claim, what to expect by way of treatment and recovery after an injury, and how to avoid, detect and report improper activity.”³¹


Recommendation

20. Consumer education in the field of auto insurance is a key component of a well-functioning system. In conjunction with making the rules and regulations governing the system simpler, the government should seriously address the need for enhanced consumer education. The recommendations of the Ontario Auto Insurance Anti-Fraud Task Force and the creation of an “Office of Driver Adviser” should be considered.

ENSURING GOOD FAITH

At present there are no specific rules about the consequences of false statements in the context of tort liability claims for damages. This needs to change to send a clear signal that the tort system will not be used to fuel fraudulent claims.

Claims under insurance policies, including claims for accident benefits are subject to provisions that apply consequences if a person makes a false statement. The logic for this is strong. Benefits administrators largely depend on the claimant’s own recitation of facts, portrayal of symptoms and assertions of impairment in order to evaluate entitlement. Assessors and adjudicators also must make decisions based on the veracity of the claimant’s own description of condition and circumstance. Much hinges on that foundation of personal credibility.



If a testimony is not reliable, then the system is deprived of the best evidence necessary to determine entitlement.

The Insurance Act recognizes the public policy of negating entitlement for dishonest claimants. Section 233 of the Insurance Act states:

Misrepresentation or violation of conditions renders claim invalid

233. (1) Where,

(a) an applicant for a contract,

(i) gives false particulars of the described automobile to be insured to the prejudice of the insurer, or

(ii) knowingly misrepresents or fails to disclose in the application any fact required to be stated therein;

(b) the insured contravenes a term of the contract or commits a fraud; or


(c) the insured wilfully makes a false statement in respect of a claim under the contract,

a claim by the insured is invalid and the right of the insured to recover indemnity is forfeited. R.S.O. 1990, c. I.8, s. 233 (1).

Statutory accident benefits protected

(2) Subsection (1) does not invalidate such statutory accident benefits as are set out in the Statutory Accident Benefits Schedule. R.S.O. 1990, c. I.8, s. 233 (2); 1993, c. 10, s. 1.

Section 233 broadly applies the false statement rule, but subsection 233(2), above, paradoxically exempts accident benefits claimants from the general rule.



Within the SABS regulation a modified version of the false statement rule is applied. Section 53 of the SABS 2010 states that an insurer may terminate **the payment of benefits to or on behalf of an insured person if the insured person has wilfully misrepresented material facts with respect to the application for the benefit but not to any other aspects of evidence provided.**

Recommendation

21. Repeal subsection 233 (2) and amend 233 (1) so that SABS claims and tort claims are subject to exactly the same rule that applies to other auto insurance claims.

IMPROVEMENTS TO THE TORT SYSTEM


Applications for compensation under tort in Ontario accounts for a significant part of the premiums of the system – equal to or greater than the first-party, no-fault system (see Table 4 above).

The FSCO Three Year Review states that:

“Between the 2004 to the 2013 accident years, [bodily injury] claims costs for private passenger vehicles increased from approximately \$1.32 billion to \$2.48 billion, an increase of approximately 88 [per cent]. This is mainly due to a significant increase in the frequency of these claims.”³² While at the same time the number injuries, especially major injuries, from motor vehicle collisions was falling rapidly (see Chart 2 above). The Pinnacle Study of bodily injury claims found that the majority (67 per cent) of claimants for serious and permanent impairment had suffered soft tissue injuries – sprains and strains – at the time of the accident.

Clearly something is happening in the bodily injury portion of the system that is not being driven by changes in the number or severity of injuries. As well, it seems that the generous benefits in the no-fault portion of the system are not having the effect of reducing the amounts awarded under tort claims, while the no-fault system has itself become fraught with legal disputes and delays.

The inefficiency and cost of tort claims has a large impact on the cost of the system as a whole.



The improvements to medical care described above should significantly improve the incidence of permanent impairments, particularly from soft tissue injuries. As well, timely and objective recommendations of care from independent examination centres should reduce disputes and improve care for accident victims. Nonetheless, a number of administrative inefficiencies and some unfairness to one party or the other has crept into the system. This has led to drawn-out negotiations and in the relatively few instances where the cases go to trial, there are long delays – up to two or three years, and considerable costs before a claimant gets to receive any benefits due to them.

The current process for tort claims follows procedures in the court system developed over many years for all kinds of claims, some of which are highly complex. Auto insurance tort claims, while numerous (about 15,000 to 17,000 a year) are relatively straightforward. The issues in dispute recur frequently and seldom involve complex issues of law.

Under the current system, the basic issue of parties exchanging relevant documents and information is highly inefficient. There is no prescribed set of documents that must be produced by each party. If one party refuses to offer certain documents, the other must make a motion to the court, often a lengthy process, to compel the party to produce the documents. There is no provision for an early examination of the plaintiff or expert witnesses, which might help resolve the case before it has to go to court. As a point of comparison, the dispute resolution system at the Licence Appeal Tribunal provides for an early “case conference” to resolve issues before the case proceeds.

In the tort system, examination for discovery under oath comes much later in the litigation process and does not permit the examination under oath of expert witnesses for either side. And there is no process to encourage parties to move the case along and avoid delay.

In terms of compensation under tort, measurement of the amount and nature of future care is an area that is particularly complex and hotly contested. The opinion of an objective independent examination centre should go a long way to helping the parties to a claim come to a fair resolution of this matter. As well, amounts awarded under the no-fault system are difficult to relate to the awards made under the tort system leading to the potential for double dipping by the claimant.

As it stands today, policyholders are paying for a tort system with very little transparency as to its costs and relative benefits. And accident victims – who pay a high price for legal representation – are walking away with a lot less compensation than they ought to get. Furthermore, the tort system excludes access to drivers who are at fault, (approximately 30 per cent of accident victims). The challenge is to find the right balance between the freedom and right to sue for damages and the time and cost involved. After all it is fundamentally this reason why the no fault accident benefit system was created in the first place.



Recommendations

22. The government should consider implementing ways to make the system for automobile accident tort claims more streamlined, particularly:

- Creating a prescribed list of documents that must be produced.
- Allowing for earlier examination under oath for both claimants and expert witnesses.
- Providing for some form of case management that encourages cases to proceed with a minimum of delay.

23. The regulator should monitor the awards and costs of the tort system to determine if changes need to be made to the no-fault system to avoid having to sue under tort and to recommend changes to the tort system if costs appear to outweigh benefits from a public policy point of view.

24. The independent examination centre's opinion as to the claimant's medical diagnosis and future care needs, should be given a zone of deference by the courts in tort cases. This means that the opinion of the independent examination centre should be taken as definitive unless there is compelling reason to doubt it.

25. There should be full deductibility of accident benefits awards from tort awards.

26. Contingency fees in tort cases should be made fully transparent to the client, including notification that fees can be appealed.

27. Claimants should be informed in writing, possibly on a final settlement schedule, of their right to appeal the fees charged by their lawyer.

28. Settlement cheques should be made payable jointly to the claimant and his or her lawyer to allow the claimant to fully understand and accept the disposition of the funds.



INNOVATION AND PRICE REGULATION


It is safe to say that in just a few years – perhaps as few as ten years - automobile insurance in Ontario will not be the same as it is today. In every part of the economy change and innovation is taking place. Traditional providers are being displaced and whole sectors of the economy are being disrupted by technology. The financial industry is no exception. Automobile insurance in Ontario, a multibillion dollar industry, is ripe for disruption.

**Automobile insurance
in Ontario will not
be the same as
it is today.**

In order to adapt to consumer demands, it is more than likely that auto insurers will need to merge or cooperate with players in other industries such as car manufactures, technology companies or providers of home security systems who are attempting to gain primary control over the relationship with home owners through knowledge-based monitoring of their behaviour.

It is critical that the legal and regulatory framework for the industry be so organized as to allow rapid evolution to take place in at least a rational and secure way, while continuing to protect consumers. The current framework is singularly unsuited for this role because it is not structured to be flexible and able to adapt to change.

Let us imagine one plausible disruptive scenario. A major automobile manufacturer decides to sell their cars with insurance bundled in at \$400 for three years or 30,000 kilometres, whichever comes sooner. The coverage is simple, \$x for medical care geared to the loss of a limb or bodily function or damage to the brain or nervous system; repair of the automobile. Part of this scenario, lifetime insurance coverage for damage and repair to the car, has already been announced by Tesla for the Asian market and by Volkswagen in Europe. It is not a stretch to find that the coverage could be extended to health care and income loss for accident victims as car manufacturers seek to find new sources of income. How will the government react? Will it try to protect the existing industry by making such an offer illegal? How will they deal with consumers who demand they be allowed to purchase such a product? How will the SABS apply? This is not a dissimilar scenario than what is being faced by the hospitality industry and the taxi industry today. To react to consumer demand, governments will have to rethink the meaning of the health care safety net incorporated into the current auto insurance product and flexibility around how it might be delivered, as large parts of the existing regulations would likely become obsolete. The long and cumbersome premium rate setting regime will be outdated or even useless. There will be far fewer disputes and costs.



While all of these are important questions that address how the system might evolve, the point is that the system needs to be geared to adapting to rapid change demanded by consumers. For example, to what extent do consumers really want or need the level of coverage the government has deemed necessary? Are there better ways of delivering value? At the present time, several of the key players are simply carrying on as if change will come gradually. That's a recipe for unwelcome disruption.

“A ... trend away from regulation of the pricing of automobile insurance.”

— FSCO Mandate Review

The system of pricing approvals today is becoming quickly outdated, time consuming and expensive. It needs to be addressed. Basically, it is a cost plus margin-for-profit system. Insurance companies present their costs and are given a margin, until recently five per cent, above their costs to set their premium. Critics have pointed to this system as being unfair to consumers since it protects insurance company profits and subsidizes inefficient providers. There are some 100 insurance companies providing auto insurance in Ontario with about 20 companies accounting for the majority of market share. Because of the built-in inertia and complexity of the rate approval process, insurers' ability to respond to market changes and take advantage of opportunities for innovation and competitiveness is reduced.

Commenting on the current rate regulation regime in Ontario, the FSCO Mandate Review expert advisory panel made the following observation:

“[There is] an international trend away from regulation of the pricing of automobile insurance while consumers seek more personalized coverage options. Many jurisdictions, particularly throughout the United States and Europe, have moved away from the prior approval system that is used to regulate auto insurance rates in Ontario. We heard from one U.S. jurisdiction that it experienced auto insurance rate reductions for nearly 80 per cent of drivers following the introduction of a more flexible system.”³³



Recommendations

29. To the extent possible, the regulatory regime should be overhauled to encourage insurers to innovate and introduce new products even on a trial or experimental basis.

30. The government should undertake a comprehensive review of auto insurance pricing alternatives with a view to providing more competition in the marketplace.



Role of the Regulator

If Ontario's system of government legislation with private sector delivery has any chance of operating well, a new role for the insurance regulator must be constructed. As discussed earlier, individual insurance companies, much less 100 of them, are in no position to, nor should they devise rules governing the delivery of insurance and the general operation of the insurance marketplace. Further, the government of the day should not be tasked with directly addressing these issues because there are more pressing big-picture issues to be addressed. In the absence of a strong central guiding force to conduct these functions, disagreement, confrontation and dysfunction are bound to prevail.

A new role for the insurance regulator must be constructed.

The insurance regulator in this case must take on the rule-making authority normally granted to an administrative tribunal. That is, the regulator must be an independent office and must have the authority to make policies and regulations which are binding in the field of automobile insurance. The Regulator should be responsible for the efficient and effective functioning of the auto insurance marketplace. As long as the policies and regulations set by the regulator are in keeping with the letter and spirit of the legislation, the regulator's actions should not be challenged in court.

Fortunately, the FSCO Mandate Review also recommended independent regulatory powers for the new Financial Services Regulatory Authority (FSRA). The government has accepted this advice and the FSRA Act was passed in December which, in summary:

- Establishes FSRA as a Crown agency which brings with it specific accountability requirements such as annual reports, agency business plans, and risk assessments.
- Sets out the object of FSRA to regulate the regulated sectors and requires FSRA to work with the Minister to prepare to carry out that regulatory function.
- Establishes the foundation of the governance structure for the agency by enabling the government to appoint a Board, composed of at least three and no more than 11 directors, and to designate one director as Chair.
- Specifies that the Board will govern FSRA's affairs, including appointing a CEO and making bylaws.

- Helps facilitate the start-up of the organization by providing for potential loans from the Minister of Finance if required and for assessments from the regulated sectors to finance the new regulator.

The key next step is the appointment of the initial Board to work with the Ministry of Finance on an implementation plan.

Of particular importance in the context of automobile insurance is that the regulator, in addition to its role of consumer protection, must have its responsibilities expanded to include or enhance the following:

- Establishment of programs of care for common injuries and establishment of a roster of qualified independent examination centres. This must be a central role of the regulator. The office will need to acquire staff with medical, health care and rehabilitation expertise to ensure that medical and market practices are constantly monitored and the effectiveness of programs of care and the quality of independent examinations are monitored and adjusted as needed. If this is not done on an ongoing basis the system risks deterioration and a return to the dysfunction it is currently experiencing.
- Establishment of a roster of independent examination centres and overseeing the operation of the centres to ensure that the advice given is objective, medically sound and reasonable in the circumstances.
- Proactive analysis and monitoring of the auto insurance marketplace with changes to policies and practices being proactively promulgated. This will require statistical, analytical, medical and policy expertise to reside with the regulator.
- Conduction of research, working alongside the government, into new and emerging health care challenges such as concussions, chronic pain and post-traumatic stress.
- Monitoring the business practices of insurance companies and providers. If a particular insurance company is exhibiting an unusual number of disputes going into the Dispute Resolution process, the regulator should have the power to audit that insurer with a view to determining if claim handling or management practices are contributing to an unusual level of consumer disagreement with decisions being rendered.
- Monitoring the accident benefit, tort and dispute resolution processes to ensure that they are operating efficiently and that lessons learned are continuously translated into policy changes and improvements to benefit consumers.

The regulator should be required to set objective targets for the insurance marketplace and to report at least annually, or as regularly as seen fit by Cabinet, to the Legislature on



performance versus the targets. The targets should be set in a Memorandum of Agreement between the regulator and the Minister of Finance and should, as an illustration, include targets and improvement plans in areas such as:

- Average number of days to restore accident victims to health.
- Level and trend of accident victims acquiring permanent impairments.
- Average number and percentage of claims going to dispute resolution.
- Trend and number of benefit claims compared with automobile accidents in the province.
- Comparison of premium rates vs. other provinces.
- Average settlement costs in the no-fault and tort portions of the system, and the amount of funds going directly to medical and other needs of claimant's vs. examination, legal and other overhead costs.

Recommendations

31. A new, independent regulator with its own board of directors for automobile insurance be established either as part of the new Financial Services Regulatory Authority or a new separate office specifically for auto insurance.

32. The Insurance Act and regulations should be amended to include only broad principles and entitlements for benefits. The regulator should be responsible for interpreting the legislation and, following appropriate consultation with stakeholders, creating policies, guidelines and rules that are enforceable and not subject to challenge in the courts as long as they are in keeping with the letter and spirit of the legislation.

33. The new regulator needs to be equipped with the staff and expertise to act as a central governor over the automobile insurance marketplace including the conduct of all the players and providers within that marketplace.

34. The new regulator should be required to set standards of performance for the marketplace and to be accountable to the government for meeting those targets.



Role of Insurance Companies

Insurers do carry a share of the blame for their reputation as being difficult to deal with. In a new system the role of insurance companies will also have to change. They must move from an approach of “closing a claim” to actually providing appropriate medical care and income support to injured parties. This after all is the fundamental intent of the legislation. During my inquiries I was surprised by how little effort, overall, the insurance companies were making to manage health care for their clients instead of managing costs. The argument they presented was that they were effectively precluded from directly helping their clients due to the presence of lawyers who acted as gatekeepers. However, a large part of their clients, more than half, did not come to the insurers with a lawyer in the first instance. I believe that insurers will need to change their mind set and approach to their clients.

**Insurance companies
will also have
to change.**

Insurance companies must stop seeking to close claims via a cash settlement, something that changes the focus from health care to cash. Injured persons should be able to return for additional care as needed in accordance with the terms of the insurance policy.

Insurance companies will have to equip themselves with staff who have an appropriate level of medical and rehabilitation expertise. Their front line staff must become “case managers” rather than “claims adjusters.” They need to monitor the effectiveness of health care providers and give feedback to both providers and the regulator on issues or conditions which can improve care for injured persons or remove barriers to early and efficient care.

They will need to establish an internal appeals function and they will need to monitor the reasons and outcomes of appeals and improve their management of claims accordingly.

Following a goal that is aligned directly with the intent of the legislation and focusing on the client’s needs rather than on costs will yield significant results both in the value delivered to customers as well as reducing costs.

They will also need to innovate and compete on service and cost which is a role that would ensure their continued relevance and value and which most of them would welcome. The leading insurers of auto insurance, collectively represent a deep and formidable pool of talent. In a marketplace structured to take advantage of this resource, and with the right attitude, both the insurers and consumers can derive tremendous value.



Recommendation

35. Insurance companies must change their role from managing costs to delivering care to their customers. They will need to change their claims management and related practices in the process. They will also need to innovate and compete on service and cost.



Appendix I

AUTO SECTOR GROUPS CONSULTED

Note: Consultation does not mean endorsement. The opinions expressed in this report are entirely my own, unless they have been clearly attributed to a third party.

CONSUMERS:

Fair Association of Victims for Accident Insurance Reform (FAIR)

GOVERNMENT:

Alberta Treasury Board

Brian Jarvis, Former VP – Insurance Corporation of British Columbia

Financial Services Commission of Ontario

Florence Holden – Financial Services Tribunal

Ministry of Finance

Ministry of Health and Long-Term Care

Société de l'assurance automobile du Québec

HEALTH CARE:

Dr. Pierre Côté – University of Ontario Institute of Technology

Ontario Neurotrauma Foundation

Ontario Physiotherapy Clinic Alliance

Ontario Psychological Association Auto Insurance Subcommittee

Ontario Rehab Alliance



INSURERS:

Aviva Canada

Canadian Association of Direct Relationship Insurers

Desjardins General Insurance Group

Insurance Bureau of Canada

Intact Insurance Company (Ontario and Alberta)

The Cooperators Group

TD General Insurance Company

Travelers Canada (Ontario and Hartford)

Workplace Safety and Insurance Board

LEGAL:

Justice Douglas Cunningham

Justice Warren Winkler

Lee Samis – Samis + Samis

Ontario Trial Lawyers Association

MISCELLANEOUS:

Ben Kasic – CANATICS

Holly Bakke, former New Jersey Commissioner – Department of Banking and Insurance

George Cooke – Martello Associates Consulting

Rob Sampson

Willie Handler – Willie Handler and Associates



Appendix II

CATASTROPHIC IMPAIRMENT – ONTARIO REGULATION 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE – EFFECTIVE SEPTEMBER 1, 2010

Catastrophic impairment

3.1 (1) For the purposes of this Regulation, an impairment is a catastrophic impairment if an insured person sustains the impairment in an accident that occurs on or after June 1, 2016 and the impairment results in any of the following:

1. Paraplegia or tetraplegia that meets the following criteria:

i. The insured person's neurological recovery is such that the person's permanent grade on the ASIA Impairment Scale, as published in Marino, R.J. et al., *International Standards for Neurological Classification of Spinal Cord Injury*, Journal of Spinal Cord Medicine, Volume 26, Supplement 1, Spring 2003, can be determined.

ii. The insured person's permanent grade on the ASIA Impairment Scale is or will be,


A. A, B or C, or

B. D, and

1. the insured person's score on the Spinal Cord Independence Measure, Version III, item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation*, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5,

2. the insured person requires urological surgical diversion, an implanted device, or intermittent or constant catheterization in order to manage a residual neuro-urological impairment, or

3. the insured person has impaired voluntary control over anorectal function that requires a bowel routine, a surgical diversion or an implanted device.



2. Severe impairment of ambulatory mobility or use of an arm, or amputation that meets one of the following criteria:

- i. Trans-tibial or higher amputation of a leg.
- ii. Amputation of an arm or another impairment causing the total and permanent loss of use of an arm.
- iii. Severe and permanent alteration of prior structure and function involving one or both legs as a result of which the insured person's score on the Spinal Cord Independence Measure, Version III, item 12 (Mobility Indoors), as published in Catz, A., Itzkovich, M., Tesio L. et al, *A multicentre international study on the Spinal Cord Independence Measure, version III: Rasch psychometric validation*, Spinal Cord (2007) 45, 275-291 and applied over a distance of up to 10 metres on an even indoor surface is 0 to 5.

3. Loss of vision of both eyes that meets the following criteria:

- i. Even with the use of corrective lenses or medication,
 - A. visual acuity in both eyes is 20/200 (6/60) or less as measured by the Snellen Chart or an equivalent chart, or
 - B. the greatest diameter of the field of vision in both eyes is 20 degrees or less.
- ii. The loss of vision is not attributable to non-organic causes.

4. If the insured person was 18 years of age or older at the time of the accident, a traumatic brain injury that meets the following criteria:

- i. The injury shows positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.
- ii. When assessed in accordance with Wilson, J., Pettigrew, L. and Teasdale, G., Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use, Journal of Neurotrauma, Volume 15, Number 8, 1998, the injury results in a rating of,
 - A. Vegetative State (VS or VS*), one month or more after the accident,
 - B. Upper Severe Disability (Upper SD or Upper SD*) or Lower Severe Disability (Lower SD or Lower SD*), six months or more after the accident, or




C. Lower Moderate Disability (Lower MD or Lower MD*), one year or more after the accident.

5. If the insured person was under 18 years of age at the time of the accident, a traumatic brain injury that meets one of the following criteria:

- i. The insured person is accepted for admission, on an in-patient basis, to a public hospital named in a Guideline with positive findings on a computerized axial tomography scan, a magnetic resonance imaging or any other medically recognized brain diagnostic technology indicating intracranial pathology that is a result of the accident, including, but not limited to, intracranial contusions or haemorrhages, diffuse axonal injury, cerebral edema, midline shift or pneumocephaly.
- ii. The insured person is accepted for admission, on an in-patient basis, to a program of neurological rehabilitation in a paediatric rehabilitation facility that is a member of the Ontario Association of Children's Rehabilitation Services.
- iii. One month or more after the accident, the insured person's level of neurological function does not exceed category 2 (Vegetative) on the King's Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124.
- iv. Six months or more after the accident, the insured person's level of neurological function does not exceed category 3 (Severe disability) on the King's Outcome Scale for Childhood Head Injury as published in Crouchman, M. et al, *A practical outcome scale for paediatric head injury*, Archives of Disease in Childhood, 2001: 84: 120-124.
- v. Nine months or more after the accident, the insured person's level of function remains seriously impaired such that the insured person is not age-appropriately independent and requires in-person supervision or assistance for physical, cognitive or behavioural impairments for the majority of the insured person's waking day.

6. Subject to subsections (2) and (5), a physical impairment or combination of physical impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more physical impairment of the whole person.



7. Subject to subsections (2) and (5) a mental or behavioural impairment, excluding traumatic brain injury, determined in accordance with the rating methodology in Chapter 14, Section 14.6 of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 6th edition, 2008, that, when the impairment score is combined with a physical impairment described in paragraph 6 in accordance with the combining requirements set out in the Combined Values Table of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 percent or more impairment of the whole person.

8. Subject to subsections (3) and (5), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993 results in a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning or a class 5 impairment (extreme impairment) in one or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3; O. Reg. 116/16, s. 1.

(2) Paragraphs 6 and 7 of subsection (1) do not apply in respect of an insured person who sustains an impairment as a result of an accident unless,

(a) two years have elapsed since the accident; or

(b) an assessment conducted by a physician three months or more after the accident determines that,

(i) the insured person has a physical impairment or combination of physical impairments determined in accordance with paragraph 6 of subsection (1), or a combination of a mental or behavioural impairment and a physical impairment determined in accordance with paragraph 7 of subsection (1) that results in 55 per cent or more impairment of the whole person, and

(ii) the insured person's condition is unlikely to improve to less than 55 per cent impairment of the whole person. O. Reg. 251/15, s. 3.

(3) Paragraph 8 of subsection (1) does not apply in respect of an insured person who sustains an impairment as a result of the accident unless,

(a) two years have elapsed since the accident; or

(b) a physician states in writing that the insured person's impairment is unlikely to improve to less than a class 4 impairment (marked impairment) in three or more areas of function that precludes useful functioning, due to mental or behavioural disorder. O. Reg. 251/15, s. 3.



(4) Subsection (5) applies to an insured person who was under the age of 18 at the time of the accident and whose impairment is not a catastrophic impairment within the meaning of subsection (1). O. Reg. 251/15, s. 3.

(5) If the insured person's impairment can reasonably be believed to be a catastrophic impairment for the purposes of paragraph 6, 7 or 8 of subsection (1), the impairment shall be deemed to be the impairment referred to in paragraph 6, 7 or 8 of subsection (1) that is most analogous to the impairment, after taking into consideration the developmental implications of the impairment. O. Reg. 251/15, s. 3.

Appendix III

EXAMINATION CLAIMS EXPERIENCE (PRIVATE PASSENGER VEHICLES) BY ACCIDENT YEAR

	2004	2009	2010	2012	2013
Number of examination claims	36,448	47,375	48,970	31,070	36,127
Number of claims per 100 insured vehicles	0.615	0.73	0.746	0.459	0.527
Accident benefits earned vehicles	5,926,718	6,492,051	6,563,999	6,774,926	6,856,005
Average cost of examinations per insured vehicle	\$41.94	\$130.34	\$129.05	\$41.74	\$50.60
Total examination costs	\$248.6 million	\$846.2 million	\$847.1 million	\$282.8 million	\$346.9 million
Total accident benefits claims costs	\$1.60 billion	\$3.81 billion	\$3.78 billion	\$1.92 billion	\$2.15 billion

Source: 2013 General Insurance Statistical Agency exhibits for private passenger vehicles.



Appendix IV

INCOME REPLACEMENT BENEFITS – ONTARIO REGULATION 34/10: STATUTORY ACCIDENT BENEFITS SCHEDULE – EFFECTIVE SEPTEMBER 1, 2010

Income Replacement Benefits Interpretation

4. (1) In this Part,

“gross employment income” means salary, wages and other remuneration from employment, including fees and other remuneration for holding office, and any benefits received under the *Employment Insurance Act* (Canada), but excludes any retiring allowance within the meaning of the *Income Tax Act* (Canada) and severance pay that may be received; (“revenu brut d’emploi”)

“gross weekly employment income” means, in respect of an insured person, the amount of the person’s gross annual employment income, as determined under subsection (2), divided by 52; (“revenu brut hebdomadaire d’emploi”)


“other income replacement assistance” means, in respect of an insured person who sustains an impairment as a result of an accident,

(a) the amount of any gross weekly payment for loss of income that is received by or available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan, other than,

(i) a benefit under the *Employment Insurance Act* (Canada),

(ii) a payment under a sick leave plan that is available to the person but is not being received, and

(iii) a payment under a workers’ compensation law or plan that is not being received by the person because the person has elected under the workers’ compensation law or plan to bring an action and is not entitled to the payment, and



(b) the amount of any gross weekly payment for loss of income, other than a benefit or payment described in subclauses (a) (i) to (iii) that may be available to the person as a result of the accident under the laws of any jurisdiction or under any income continuation benefit plan but is not being received by the person and for which the person has not made an application. (“autre assistance au titre du remplacement du revenu”) O. Reg. 34/10, s. 4 (1).

(2) The gross annual employment income of an insured person is determined as follows:

1. In the case of a person referred to in subparagraph 1 i of subsection 5 (1) who was not a self-employed person at any time during the four weeks before the accident, the person’s gross annual employment income is whichever of the following amounts the person designates:

i. The person’s gross employment income for the four weeks before the accident, multiplied by 13.

ii. The person’s gross employment income for the 52 weeks before the accident.

2. Subject to paragraph 3, the person’s gross annual employment income is his or her gross employment income for the 52 weeks before the accident if,

i. the person qualifies for a benefit under subparagraph 1 i of subsection 5 (1) and was a self-employed person at any time during the four weeks before the accident, or


ii. the person qualifies for a benefit under subparagraph 1 ii of subsection 5 (1).

3. If the person described in subparagraph 2 i was self-employed for at least one year before the accident, the person may designate as his or her gross annual employment income the amount of his or her gross employment income during the last fiscal year of the business that ended on or before the day of the accident. O. Reg. 34/10, s. 4 (2); O. Reg. 370/10, s. 1.

(3) A self-employed person’s weekly income or loss from self-employment at the time of the accident is the amount that would be 1/52 of the amount of the person’s income or loss from the business for the last completed taxation year as determined in accordance with Part I of the *Income Tax Act* (Canada). O. Reg. 34/10, s. 4 (3).

(4) A self-employed person’s loss from self-employment after an accident is determined in the same manner as losses from the business in which the person was self-employed would be determined under subsection 9 (2) of the *Income Tax Act* (Canada) without making any deductions for,

(a) any expenses that were not reasonable or necessary to prevent a loss of revenue;



(b) any salary expenses paid to replace the self-employed person's active participation in the business, except to the extent that the expenses are reasonable in the circumstances; and

(c) any non-salary expenses that are different in nature or greater than the non-salary expenses incurred before the accident, except to the extent that those expenses are reasonable in the circumstances and necessary to prevent or reduce any losses resulting from the accident. O. Reg. 34/10, s. 4 (4).

(5) If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident shall be determined for the purposes of this Part without reference to any income the person has failed to report contrary to that Act or legislation. O. Reg. 34/10, s. 4 (5).

(6) The amount of a person's gross annual employment income and the amount of the person's income or loss from self-employment may be adjusted for the purposes of this Part to reflect any subsequent change in the amount determined by the Canada Revenue Agency under the *Income Tax Act* (Canada) or by the relevant government or agency under the legislation of another jurisdiction that imposes a tax calculated by reference to income. O. Reg. 34/10, s. 4 (6).

Eligibility criteria

5. (1) The insurer shall pay an income replacement benefit to an insured person who sustains an impairment as a result of an accident if the insured person satisfies one or both of the following conditions:

1. The insured person,

i. was employed at the time of the accident and, as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of that employment, or

ii. was not employed at the time of the accident but,

A. was employed for at least 26 weeks during the 52 weeks before the accident or was receiving benefits under the *Employment Insurance Act* (Canada) at the time of the accident,

B. was at least 16 years old or was excused from attending school under the *Education Act* at the time of the accident, and

C. as a result of and within 104 weeks after the accident, suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident.



2. The insured person,

- i. was a self-employed person at the time of the accident, and
- ii. suffers, as a result of and within 104 weeks after the accident, a substantial inability to perform the essential tasks of his or her self-employment. O. Reg. 34/10, s. 5 (1).

(2) Despite subsection (1), an insured person is not eligible to receive income replacement benefits if he or she is eligible to receive and has elected under section 35 to receive either a non-earner benefit or a caregiver benefit under this Part. O. Reg. 34/10, s. 5 (2).

Period of benefit

6. (1) Subject to subsection (2), an income replacement benefit is payable for the period in which the insured person suffers a substantial inability to perform the essential tasks of his or her employment or self-employment. O. Reg. 34/10, s. 6 (1).

(2) The insurer is not required to pay an income replacement benefit,

- (a) for the first week of the disability; or
- (b) after the first 104 weeks of disability, unless, as a result of the accident, the insured person is suffering a complete inability to engage in any employment or self-employment for which he or she is reasonably suited by education, training or experience. O. Reg. 34/10, s. 6 (2).

Amount of weekly income replacement benefit


7. (1) The weekly amount of an income replacement benefit payable to an insured person who becomes entitled to the benefit before his or her 65th birthday is the lesser of “A” and “B” where,

“A” is the weekly base amount determined under subsection (2) less the total of all other income replacement assistance, if any, for the particular week the benefit is payable, and

“B” is \$400 or, if an optional income replacement benefit referred to in section 28 has been purchased and applies to the person, the amount fixed by the optional benefit. O. Reg. 34/10, s. 7 (1).

(2) For the purposes of subsection (1), the weekly base amount in respect of an insured person is determined as follows:

- 1. Determine whichever of the following amounts is applicable:

- 
- i. 70 per cent of the amount, if any, by which the sum of the insured person's gross weekly employment income and weekly income from self-employment exceeds the amount of the insured person's weekly loss from self-employment, if the weekly income replacement benefit is for one of the first 104 weeks of disability, or
 - ii. the greater of the amount determined for the purposes of subparagraph i and \$185, if the weekly income replacement benefit is for a week for which the person is entitled to receive an income replacement benefit after the first 104 weeks of disability.

2. To the amount determined under paragraph 1, add 70 per cent of the amount of the insured person's weekly loss from self-employment that he or she incurs as a result of the accident. O. Reg. 34/10, s. 7 (2).

(3) The insurer may deduct from the amount of an income replacement benefit payable to an insured person,

(a) 70 per cent of any gross employment income received by the insured person as a result of being employed after the accident and during the period in which he or she is eligible to receive an income replacement benefit; and

(b) 70 per cent of any income from self-employment earned by the insured person after the accident and during the period in which he or she is eligible to receive an income replacement benefit. O. Reg. 34/10, s. 7 (3).


(4) The insurer shall pay an expense incurred by or on behalf of an insured person for the preparation of a report for the purpose of calculating the person's income from employment or self-employment if all of the following conditions are satisfied:

1. The insured person is applying for an income replacement benefit under this Part that is based on the employment or self-employment considered in the report.

2. The report is prepared by a member of a designated body within the meaning of the *Public Accounting Act, 2004*.

3. The expense is reasonable and necessary for the purpose of determining the insured person's entitlement to an income replacement benefit. O. Reg. 34/10, s. 7 (4); O. Reg. 289/10, s. 2.

(5) The insurer is not required to pay more than a total of \$2,500 for the preparation of one or more reports under subsection (4) in respect of an insured person. O. Reg. 34/10, s. 7 (5).



Adjustment after age 65

8. (1) If a person is receiving an income replacement benefit immediately before his or her 65th birthday, the weekly amount of the benefit is adjusted, on the later of the day of the person's 65th birthday and the second anniversary of the day the person began receiving the benefit, to the amount determined in accordance with the following formula:

$$C \times 0.02 \times D$$

in which,

“C” is the weekly amount of the income replacement benefit that the person was entitled to receive immediately before the adjustment, before any deductions permitted by subsection 7 (3),

“D” is the lesser of,

(a) 35, and

(b) the number of years during which the person qualified for the income replacement benefit before the adjustment is made.

O. Reg. 34/10, s. 8 (1).

(2) Despite section 6, an income replacement benefit that has been adjusted under subsection (1) is payable, without any deductions under clause 7 (3) (a) or (b), until the person dies. O. Reg. 34/10, s. 8 (2).

If entitlement first arises on or after 65th birthday

9. (1) If an insured person becomes entitled to receive an income replacement benefit on or after his or her 65th birthday,

(a) subject to clause 6 (2) (a) and despite clause 6 (2) (b), the insured person is entitled to an income replacement benefit for not more than 208 weeks after becoming entitled to the benefit; and

(b) the weekly amount of the benefit is the weekly amount of the income replacement benefit otherwise determined under section 7 before any deductions permitted by subsection 7 (3), multiplied by the factor set out in Column 2 of the Table to this subsection opposite the number of weeks that have elapsed since the person became entitled to receive the benefit.

TABLE

Column 1	Column 2
Number of weeks since Entitlement Arose	Factor
Less than 52 weeks	1.0
52 weeks or more but less than 104 weeks	0.8
104 weeks or more but less than 156 weeks	0.6
156 weeks or more but less than 208 weeks	0.3

O. Reg. 34/10, s. 9 (1).

(2) No deduction may be made under clause 7 (3) (a) or (b) from an income replacement benefit determined under subsection (1). O. Reg. 34/10, s. 9 (2).

No violation of *Human Rights Code*

10. The age distinctions in sections 8 and 9 apply despite the *Human Rights Code*.
O. Reg. 34/10, s. 10.

Temporary return to employment

11. A person receiving an income replacement benefit may return to or start employment or self-employment at any time during the first 104 weeks for which he or she is receiving the benefit without affecting his or her entitlement to resume receiving any benefits to which he or she is entitled under this Part if, as a result of the accident, he or she is unable to continue the employment or self-employment. O. Reg. 34/10, s. 11.

Appendix V

GENERAL INSURANCE STATISTICAL AGENCY – PRIVATE PASSENGER VEHICLES ACCIDENT BENEFITS CLAIMS FOR MEDICAL AND REHABILITATION – 2013

Breakdown of costs between Medical Care and Other

	Medical Care	Other	Medical Care %**	Other %
Medical	\$898,987,620		50%	
Visitation		\$4,976,449		0.28%
Dependant Care		\$38,751		0%
Housekeeping		\$34,685,455		2%
Examination		\$335,134,533		19%
Rehab - other than renovation	\$89,186,509		5%	
Renovation Rehab	\$33,772,102		2%	
Attendant Care	\$381,312,138		21%	
Replacement etc.*	\$3,514,809		0%	
All Med/Rehab	\$1,406,773,177	\$374,835,188	79%	21%

Total Med/Rehab Expenditure \$1,781,608,366

* Replacement of clothing, hearing aids, glasses and other devices

** Percentage are over total med/rehab amount

Notes:

- This segregation of amounts is based on the definitions of the accident benefits coverages.
- When settlements are paid, insurers allocate the amounts to one of the coverages above.



- To determine how much of any of these payments go to the actual purpose it is meant for is not possible given the information available.
- The allocation of an expenditure category to "Other" does not necessarily imply that the expenditure does not contribute to the well being of the individual in medical terms. For example visitation costs for relatives to visit the injured are not direct medical expenditures, however may contribute to their emotional well being.

Appendix VI

INFORMATION SUPPLIED BY THE FINANCIAL SERVICES COMMISSION OF ONTARIO

Dispute resolution services – mediation and arbitration from 2011/12 to 2015/16

	Mediation	Arbitration
A. Total applications less admin closures	115,908	
B. Full and partial Settlements	54,790	
Total value of full and partial settlements	\$777,400,000	
Annual average	\$17,143	
C. Settlements with zero value	(9,523)	
D. Move to arbitration		44,599
E. Offline ³⁴		25,701 ³⁵
F. Failed Settlements		61,118
G. Total	115,908	

Conclusions

A. Average number of claims going to mediation	23,200
B. Average annual settled at mediation with value >\$0	((B-C)/A); 39%
a. Average annual value	\$155,500,000
b. Annual average value of settlement	\$17,143
C. Settlements with zero value (annual average / %)	2,000; (C/A) 8.2%
D. Moved to arbitration (annual average / %)	9,000; (D/A) 38%
E. Moved off line (annual average / %)	5,140; (E/A) 22%

Over a five-year period (2011-2015), the average number of applications going into mediation at FSCO annually was 23,200 (or about 35 per cent of total claims).

Declined amounts as a % of proposed amounts – OCF18³⁶

	Proposed Amounts*	Declined Amounts**	Declined for Reason: Not Reasonable or Necessary	Percentage Declined
2011H1	\$331,346,422	\$147,703,454	\$38,236,804	45%
2011H2	\$321,560,134	\$120,913,044	\$31,386,306	38%
2012H1	\$259,966,717	\$91,108,386	\$25,784,396	35%
2012H2	\$295,848,707	\$95,396,549	\$28,035,888	32%
2013H1	\$264,960,375	\$81,626,632	\$22,915,597	31%
2013H2	\$317,989,691	\$97,928,001	\$29,145,141	31%
2014H1	\$257,335,801	\$73,690,588	\$20,959,038	29%
2014H2	\$269,959,037	\$70,281,773	\$18,039,737	26%
2015H1	\$212,584,457	\$52,652,108	\$14,193,819	25%
2015H2	\$185,646,061	\$42,058,878	\$10,173,917	23%
2016H1	\$53,299,204	\$13,185,308	\$2,093,520	25%

Source: HCAI

Note: Later year data is still developing.

* Proposed Amounts: Sum total of all amounts proposed for treatment.

** Declined Amounts are for the following reasons:

- Diagnosis indicates that MIG is appropriate
- Diagnosis Is Inconsistent With The Provider Type
- Procedure Is Inconsistent with the Diagnosis
- Diagnosis Is Inconsistent With The Cause of Loss
- Not Reasonable and Necessary
- Service/Product Is Inconsistent With The Cause of Loss
- Fee Exceeds Reasonable Fees for Product or Service
- Fee Exceeds Maximum Allowed
- Service/Procedure Time Adjustment
- Policy Coverage Limits Exceeded
- Good or service not covered
- There is a conflict of interest
- Other please provide an explanation



Endnotes

¹ Meckbach, Greg, Canadian Underwriter, “‘Lots of room for improvement’ with new Ontario auto dispute resolution system: Judge Cunningham,” <http://www.canadianunderwriter.ca/insurance/lots-room-improvement-new-ontario-auto-dispute-resolution-system-judge-cunningham-1004102925/>, November 2, 2016.

² Sources of data for Figure 1 (The cited General Insurance Statistical Agency data represents only transactions related to private passenger vehicles.):

a – Preliminary 2014 Ontario Road Safety Annual Report Selected Statistics, Ministry of Transportation.

b – Ontario Road Safety Annual Report 2013, Ministry of Transportation.

c – 2013 accident year, 2015 General Insurance Statistical Agency (GISA) loss ratio exhibit for private passenger vehicles. Accident benefits claims is estimated based on GISA actuarial calculations.

d – 2013 FSCO dispute resolution system data.

e – 2013 accident year data from FSCO DRS group.

f – 2013 accident year, 2015 GISA loss ratio exhibit for private passenger vehicles. Number is estimated based on GISA actuarial calculations.

g – 2013 accident year data from Ontario Health Claims Database (HCDB), September 2016 report. Please note that the assessments include both insurer initiated as well as provider initiated. A claimant could have both, however are counted once. Also note that provider initiated assessments may include a count for assessments that are offered as part of treatment.

h – 2013 annual average based on business information reported to Health Claims for Auto Insurance (HCAI).

i – Registered Insurance Brokers of Ontario, as of August 2014; not specific to Auto Insurance.

³ Ontario Road Safety Annual Report – 2013

⁴ FSCO Three Year Review, December 2014, Chart 9, p. 41,
<http://www.fSCO.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf>

⁵ O. Reg. 34/10, s. 16 (1).

⁶ Drs. Côté P., et al., Early and Aggressive Care and Delayed Recovery From Whiplash, June 15, 2007, p. 861.

⁷ Cassidy, J. David et al., “Effect of Eliminating Compensation for Pain and Suffering on the outcome of Insurance Claims for Whiplash Injuries,” The New England Journal of Medicine, Volume 342, Number 16, April 20, 2000, p. 1184

⁸ Association of Workers’ Compensation Boards of Canada Key Statistical Measures Data, 2015
http://awcbc.org/?page_id=9759&sm_au=iVV5R7SWWnFtj1RP

⁹ Drs. Côté P., Hogg-Johnson S., Cassidy JD., Carroll L., Frank JW. in their study *Initial Patterns of Clinical Care and Recovery from Whiplash Injuries: A Population-Based Cohort Study*, p. 2261.

¹⁰ *Automobile Insurance Third Party Liability Bodily Injury Closed Claim Study in Ontario* conducted by Pinnacle Actuarial Resources, Inc (Pinnacle Study), August 13, 2014, p. 4, <https://www.fSCO.gov.on.ca/en/auto/Documents/abbreviated-report.pdf>

¹¹ FSCO Three Year Review, December 2014, Table 5, p. 40, <http://www.fSCO.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf>

¹² Association of Workers' Compensation Boards of Canada Key Statistical Measures Data, 2015, http://awcbc.org/?page_id=9759&sm_auiVV5R7SWWnFtj1RP

¹³ Ontario Workplace Safety and Insurance Board, 2015 Economic Statement, available at www.wsib.on.ca

¹⁴ Meckbach, Greg, Canadian Underwriter, "Lots of room for improvement' with new Ontario auto dispute resolution system: Judge Cunningham," <http://www.canadianunderwriter.ca/insurance/lots-room-improvement-new-ontario-auto-dispute-resolution-system-judge-cunningham-1004102925/>, November 2, 2016.

¹⁵ GISA Examination Claims Experience. See Appendix III.

¹⁶ By the Numbers, Ontario Workplace Safety and Insurance Board Health Care Benefit Payments by Service Categories by Payment Year www.wsib.on.ca

¹⁷ Cunningham, the Honourable J. Douglas, *Ontario Automobile Insurance Dispute Resolution System Review Final Report* (Cunningham Final Report), p. 6

¹⁸ Insurance Corporation of British Columbia's financial statement

¹⁹ Justice Cunningham's Interim Report, p. 13

²⁰ Spine Journal, "Does Early Management of Whiplash-Associated Disorders Assist or Impede Recovery?", Drs. Côté P. and Soklaridis S., p. S276

²¹ Porter, Michael E. and Lee, Thomas H., "The Strategy That Will Fix Health Care," *Harvard Business Review*, October 2013.

²² Ibid.

²³ Ontario Auto Insurance Anti-Fraud Task Force Final Report, p. 28

²⁴ By the Numbers, Ontario Workplace Safety and Insurance Board Health Care Benefit Payments by Service Categories by Payment Year www.wsib.on.ca

²⁵ Justice Cunningham's Interim Report, p. 31

²⁶ Cassidy, J. David et al., "Effect of Eliminating Compensation for Pain and Suffering on the outcome of Insurance Claims for Whiplash Injuries," *The New England Journal of Medicine*, Volume 342, Number 16, April 20, 2000, p. 1184

²⁷ Justice Cunningham's Interim Report, p. 26

²⁸ Justice Cunningham's Final Report, p. 5

²⁹ Justice Cunningham's Final Report, p. 23

³⁰ Ontario Automobile Insurance Dispute Resolution System Review Final Report, p. 14

³¹ Ontario Auto Insurance Anti-Fraud Task Force Final Report, p. 19

³² FSCO Three Year Review, December 2014, p. 40, <http://www.fSCO.gov.on.ca/en/auto/3yr-review/Documents/aoda-3yr-review.pdf>

³³ Review of the Mandates of the Financial Services Commission of Ontario, Financial Services Tribunal, and the Deposit Insurance Corporation of Ontario, p. 80

³⁴ It is unclear how these cases settled, or whether they were settled. Data not available.

³⁵ The cases that FSCO has no information on how they finally settle, as information is not provided to FSCO, are: 115,908 – 45,608 (Full Settlements) – 44,599 (Proceed to Arbitration) = 25,701.

³⁶ An OCF 18 is used to make the following claims:



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- Ambulance or other goods or services provided on an emergency basis
 - Drugs prescribed by a regulated health professional
 - Goods with a cost of \$250 or less per item
 - Dental goods or services