



Financial Services
Commission
of Ontario

**Report on the Five Year Review of
Automobile Insurance
March 31, 2009**

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Report on the Five Year Review of Automobile Insurance

Executive Summary

In 2003, the Legislature amended the *Insurance Act* (the Act) to include a requirement in section 289.1 that the Superintendent of Financial Services undertake a review of Part VI of the Act and any Regulations made under Part VI at least once every five years or more often if requested by the Minister of Finance. The Superintendent is to report back with recommendations to improve the effectiveness and administration of Part VI of the Act and the Regulations. Part VI of the Act and the Regulations includes statutory accident benefits, court proceedings and dispute resolution.

The Financial Services Commission of Ontario (FSCO) embarked on a stakeholder consultation process in the second half of 2008 to support the auto insurance review process. In addition, FSCO regularly hears from stakeholders on numerous issues. The opinions expressed by stakeholders represent a broad range of experiences and perspectives. Many of the recommendations in this report reflect the comments received through the consultation process.

In the past few years, profitability has not been an issue for the P&C insurance sector in Canada or Ontario. However, financial results for the P&C industry declined in 2008. Following the 2003 auto insurance reforms, loss costs fell in 2004. Loss costs have been rising since then and have resulted in an upward swing of rate changes approved by FSCO in 2008. However, rate increases have not kept pace with rising loss costs and the insurance sector reports significant rate inadequacy in the system. Declining profitability, significantly lower earnings and loss cost increases will accelerate in 2009 in the absence of structural changes to stabilize costs.

Recommendations

Virtually every stakeholder commented on the complexity of the existing accident benefit system and the level of regulatory burden created by the Statutory Accident Benefits Schedule (SABS). Ironically, many stakeholders proposed additional procedures to address non-compliance and abuses in the system which would invariably add more complexity to the system.

Recommendation #1: When determining the merits of any future regulatory changes, consideration should be given to whether a change would increase complexity and regulatory burden. There should be a compelling reason for making a change that would add complexity to the accident benefit system.



Recommendation #2: Review the SABS to identify provisions that: a) are overly complex and could be simplified without changing the intent of the Regulation, or b) are essentially ineffective and could be eliminated without changing the impact of the Regulation.

Many health care providers report being asked to assist patients in completing their accident benefit claims forms. The number of forms required by the SABS has created an unnecessary paper burden for claimants, adjusters and other participants in the auto insurance system.

Recommendation #3: Contract a forms consultant to assist FSCO and stakeholders in simplifying the application process and revising forms that should first be tested on consumers.

Consumers have never entirely understood or been comfortable with the Fault Determination Rules (FDRs). One point of confusion is the notion that someone who is 50% at-fault is one half the risk of someone who is 100% at-fault – a notion not supported by industry actuarial data. The percentage of fault is used to determine which coverage is used to repair the damaged vehicles rather than to assess risk. Some jurisdictions in Canada and the United States protect consumers from rate increases when they are only partially at-fault below a specific threshold.

Recommendation #4: No element of a risk classification system should use past claims for which a driver is 25% or less at-fault.

For property damage disputes, a dispute resolution mechanism is set out in section 128 of the Act. The provision stipulates that both parties must agree to participate in this process. Otherwise, the only mechanism available to consumers is to challenge an insurer's determination in the courts.

Recommendation #5: Provide some best practice guidelines that would set out standards for communicating information on the fault determination process and how to challenge a determination.

Recommendation #6: Make the existing statutory appraisal process under section 128 of the Act mandatory on insurers for property damage claims if the consumer prefers this process over the courts.

In 2005, the Ontario government amended Ontario Regulation 664 to add certain financial information and other "lifestyle" factors to the existing list of underwriting and risk classification criteria that are expressly prohibited. However, the Regulation does not prohibit insurers from asking such questions. Concern has been expressed by some stakeholders that some quoting practices are being used to frustrate the intent of the existing prohibitions.



FSCO has issued a bulletin directing insurance companies not to use criteria that are prohibited for rating or underwriting purposes (e.g., criteria related to a consumer's social, personal and/or economic status) to decline to provide quotes, to hinder or delay a consumer's efforts to obtain insurance coverage or an insurance quote, or as a basis for differential treatment of consumers in the quoting and application process. Consideration could also be given to creating an expressed prohibition in Ontario Regulation 7/00 (Unfair or Deceptive Acts or Practices).

Recommendation #7: Consider prohibiting objectionable quoting practices including delays in providing quotes, requiring written applications for quotes and certain screening techniques.

Ontario Regulation 283/95 was introduced in 1995 to ensure claimants receive accident benefits in a timely fashion while disputes between insurers over the liability to pay for a particular claim are being resolved. Despite the Regulation, which sets out an insurer's obligation to pay benefits, a number of disputes, court cases, and differences in interpretation have emerged that have led to delays in payment of claimants' benefits.

Recommendation #8: Regulation 283/95 should be amended to make it more difficult for insurers to deflect claims and to ensure that claimants receive accident benefits while the issue of liability for a claim is resolved.

Bill 18 amendments limit the vicarious liability of leasing and rental companies with respect to liability claims arising out of the use of a leased or rented vehicle to \$1 million in most cases and extends coverage for rented vehicles only to vehicles with a Manufacturer's Gross Vehicle Weight Rating (GVWR) of less than 4,500 kg. This creates a gap in coverage for those consumers who own a policy but wish to rent a vehicle with a greater GVWR.

Recommendation #9: The Superintendent intends to amend the OAP 1 to provide a limited amount of coverage for vehicles with a GVWR over 4,500 kg.

There have been significant developments since the introduction of the "catastrophic impairment" definition in 1996. Court decisions have expanded the definition in order to address perceived inequities but in so doing, have exposed the system to potential abuse. Most stakeholders continue to support the concept of providing two tiers of benefits based on injury severity. However, the integrity of the model is dependent on a clear and fair definition of "catastrophic impairment."



Recommendation #10: Further consultation with experts in the field is needed to amend the definition of “catastrophic impairment.” The goal for this review should be to ensure that the most seriously injured accident victims are treated fairly.

One area where stakeholders appear to be in agreement is that there is a problem with overutilization of assessments in the auto insurance system. The Insurance Bureau of Canada (IBC) submitted that in 2007, based on incurred losses (paid claims plus reserves), for each dollar spent on treatment, another 60 to 80 cents were spent on assessments. Multiple requests for assessments may be sent to insurers involving treatment plans, completion of certificates and forms, and benefit applications. It has been suggested that adjusters frequently refer requests for an insurer examination in order to buy themselves more time which only adds more transaction costs, paper and delays.

Recommendation #11: Section 24 assessments expenses should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under section 19 of the SABS.

Recommendation #12: The fee for completing forms including any assessment required to complete the form should be capped at \$200. The cost of all other assessments should be capped at \$2,000.

Recommendation #13: The time frame provided to adjusters to review assessment requests should be the same as the time frame that applies to treatment plans (10 business days) to allow for proper claims handling.

The IBC reports that the number of in-home assessments has also been increasing with the additional cost of providers’ travel borne by insurers. Providers who review requests for in-home assessments on behalf of insurers reported that they also have observed an increase in in-home assessments which are used to support a claimant’s request for treatment, rehabilitation benefits, attendant care benefits, housekeeping and home maintenance expenses, and caregiver benefits.

Recommendation #14: Availability of in-home assessments should be limited to seriously injured claimants and should only be used to evaluate their need for attendant care services and home modifications.

Prior approval has not been an effective tool in controlling the utilization of assessments. Any regulated health professional or social worker is able to submit a request for an assessment and the insurer must respond. There is a lack of accountability in the system which can lead to multiple and duplicative assessments and fragmented treatment.



FSCO has concluded that having a single health professional directing the claimant's rehabilitation and initiating assessments, rather than multiple professionals initiating assessments, maintains control and creates a single individual who can respond to questions from the claimant and adjuster concerning the appropriateness of proposed assessments.

Recommendation #15: Consider having assessment requests completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Assessment requests would continue to be submitted by providers following a referral.

Stakeholders have expressed concern regarding the quality of insurer examination reports and the qualification of providers conducting insurer examinations. Insurer examinations are used to respond to applications for benefits or to determine whether a claimant is, or continues to be, entitled to a benefit.

Recommendation #16: The health care professional associations and the insurance industry should jointly develop standards for the delivery of third party medical examinations as well as qualifications for assessors. FSCO would facilitate the process.

Assessments done to determine catastrophic impairment seem to be more problematic in terms of costs and quality. Stakeholders have suggested that unqualified assessors are being utilized leading to inaccurate ratings, disputes and additional assessments, all adding costs to the system. The Workplace Safety and Insurance Board (WSIB) conducts an analogous assessment, paying assessors – who are predominantly specially trained physicians – a substantially lower flat fee which covers time spent with the injured worker, reviewing documentation, and preparing a report.

Recommendation #17: Restrict the ability to conduct catastrophic impairment assessments to practitioners with appropriate training and experience.

Insurer examinations continue to be a contentious part of the accident benefits system and an irritant to claimants, treatment providers and representatives. Insurer examinations also add to the high transaction costs in the system. Just as insurers would like to see fewer assessments under section 24 of the SABS, claimants would welcome a reduction in the number of examinations under section 42. Capping insurer examination costs would provide the appropriate balance to the system if the cost of assessments is capped, as is also recommended.



Recommendation #18: The cost of insurer examinations should be capped at \$2,000.

Recommendation #19: Provide adjusters with some discretion in reviewing assessment and treatment requests and modify Ontario Regulation 7/00 to reflect possible amendments to the SABS.

The policy intent for introducing assessments under section 42.1 was to assist claimants reviewing issues raised in an insurer examination as part of a dispute. The objective was to provide some balance to the system. Stakeholder feedback on whether that objective is being met has been mixed. However, section 42.1 assessments have also added to the already high transaction costs in the system. They have also contributed to the growing “dueling” assessment process.

Recommendation #20: Revoke section 42.1 of the SABS which allows claimants to obtain an assessment from their health care provider to address issues raised in an insurer examination.

FSCO believes there should be a single health professional directing a claimant’s rehabilitation. Once that professional prescribes an intervention, the actual provider who treats the claimant would submit a treatment plan for approval. This would better coordinate rehabilitation as well as eliminate the potential conflict of interest situation inherent in the existing delivery model. Multiple interventions could still take place but under the direction of a single professional. In seven of the ten provinces, the legislative framework dictates that physicians only may certify the need for treatment or disability.

The increased involvement of physicians is not expected to impact on the doctor shortage in Ontario. Auto insurance claimants with more serious injuries already see their family doctors following an accident. The proposed changes will not significantly increase the number of doctor visits and will benefit claimants by keeping their family doctors better informed on their progress.

Recommendation #21: Consider having treatment plans completed only after a referral is made by the health professional primarily responsible for the claimant’s rehabilitation (in most cases a family physician). Treatment plans would continue to be submitted by providers following a referral.

Some consumers have also proposed reductions in mandatory accident benefits. Those with access to extended health care benefits have complained that they are forced to purchase accident benefit coverage that is available from other plans. Consumers could reduce their premiums if some existing mandatory benefits were made optional. With the introduction of new optional benefits, insurers, agents and brokers would have to ensure that consumers are made aware of the implications of reducing coverage.



Recommendation #22: Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to \$25,000. Introduce a \$100,000 optional medical and rehabilitation benefit along with the existing \$1 million optional benefit.

There have been some proposals for expanding the Pre-approved Framework (PAF) Guidelines to include other minor injuries. This idea is worth exploring from a number of perspectives. If feasible, it would expand the amount of treatment without requiring prior approval by the insurer, thereby simplifying the system and reducing transaction costs. As well, if the accident benefit system moves towards designating primary health professionals, expanded PAF Guidelines would reduce the time spent by designated professionals in managing minor claims and allow them to focus on the most seriously injured.

In February 2008, the Neck Pain Task Force (NPTF) of the World Health Organization published a series of articles summarizing its findings. There may be some merit in providing a more extensive continuum of care to ward off chronicity and recurrences based on the NPTF findings.

Recommendation #23: In partnership with key stakeholders, FSCO should contact members of the Neck Pain Task Force to examine the feasibility of expanding the PAF Guidelines to provide a more extensive continuum of care and to include the treatment and assessment of other soft tissue injuries.

FSCO's statistical agent indicates that between 2004 and 2007 attendant care costs increased by 59.1%, with claim severity decreasing by 1.2%, and claims frequency increasing by 61.6%. Anecdotal information from the insurance industry suggests that an increasing number of claimants with minor injuries are now claiming and receiving attendant care benefits. FSCO is also concerned that assessments are being conducted by individuals without explicit training in functional assessments to address functional impairment resulting from a combination of physical, cognitive and psychosocial impairments.

Recommendation #24: Only occupational therapists and nurses who have been trained on the use of Form 1 should be permitted to assess auto accident victims for the attendant care benefit. This should apply to assessments conducted under both sections 24 and 42 of the SABS.

Early FSCO arbitration decisions supported the principle that for an expense to have been "incurred" there must have been at least a promise to pay. While insurers contend that obliging them to pay for the cost of services not rendered amounts to a windfall for the insured, the courts and arbitrators have ruled that permitting insurers to deny repayment (except for amounts already paid by claimants) would amount to a windfall for insurers especially in the case of impecunious claimants. FSCO believes there needs to be a balance between



maintaining the concept of indemnification and protecting seriously injured claimants where there is a statutory obligation to pay.

Recommendation #25: The attendant care benefit should continue to compensate claimants for incurred expenses. However, to enhance consumer protection and transparency, the SABS could clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.

The reduced fees introduced in 2003 were intended to bring fees in the auto insurance system in line with the fees paid by the WSIB. Earlier in the year, the WSIB updated their health care fees. It appears that fees in the auto insurance system remain on par or higher than those paid by the WSIB. A number of submissions have suggested that experienced providers have been exiting the auto insurance system since fees were rolled back five years ago, leaving the system with a greater proportion of inexperienced providers. Unfortunately, FSCO did not have access to detailed information regarding health care provider manpower in the sector.

Recommendation #26: FSCO needs to continue to monitor fees and the availability of services in the auto insurance sector, in particular for seriously injured claimants.

Several consumer submissions suggested that the maximum income replacement benefit cap be increased from the current level of \$400 per week which has been in place since 1996. Since its introduction, the percentage of earners who fall below the benefit maximum has dropped considerably. The increase would bring coverage back to 1996 levels.

Recommendation #27: Increase the maximum income replacement benefit to \$500 per week.

Stakeholders also commented on the adequacy of payments for transportation expenses incurred to and from treatment, rehabilitation and counselling sessions or assessments.

Recommendation #28: Conduct annual review of reimbursement rate for travel in a personal vehicle.

FSCO is concerned about the growing cost of the caregiver benefit and housekeeping and home maintenance expenses. One approach is to provide consumers with more choice by converting some mandatory benefits to optional benefits. This would provide consumers with the ability to customize coverage according to their needs and reduce their premiums. However, insurers, agents



and brokers would have to ensure that consumers are made aware of the implications of reducing coverage.

Recommendation #29: Make housekeeping and home maintenance expenses and caregiver benefits optional. Reimbursement for housekeeping and home maintenance expenses and for replacement caregivers needs to reflect actual economic losses.

Section 59 of the SABS excludes accident victims from claiming accident benefits if they are entitled to receive workers' compensation benefits. Insurer representatives report that although it is presumed that some level of harmony exists between the operation of the SABS and *Workers Safety and Insurance Act*, it is not always the case.

Recommendation #30: FSCO, WSIB and auto insurers should meet to discuss how to better harmonize the auto insurance and workplace insurance systems.

Although the Regulation defining serious and permanent impairment (Regulation 461/96) is almost five years old, there have been only two court decisions dealing with the Regulation and those decisions have not been definitive or effected any significant change to interpretations predating the Regulation. Therefore revoking the defining Regulation is not expected to have an impact on who meets the threshold or on costs to the system. FSCO reviewed the proposal to entirely eliminate the verbal threshold with insurance industry actuaries who were of the view that the verbal threshold was screening out a significant number of cases and that without it costs would rise considerably.

Over the past five years a significant number of consumers have expressed their unhappiness with the tort deductible levels. A similar perspective was shared by consumers who provided submissions to FSCO as part of this review. Consumers indicated that too many innocent accident victims are denied access to the courts as a result of the deductibles. In addition, for those that are able to sue for pain and suffering damages, the reduction in their awards was seen as unfair. It is clear that many consumers do not feel the current deductible levels are fair.

Recommendation #31: The government should consider reducing the deductibles to \$20,000 and \$10,000, eliminating the deductibles for fatal claims, and revoking the definition of serious and permanent impairment set out in Regulation 461/96. A closed claim study would assist in determining the impact of further tort changes being considered.

There is wide agreement among both representatives for insurers and claimants that the \$1,500 maximum expense award is insufficient for accounting reports and is not recoverable elsewhere in the accident benefit system. Accounting



reports are often used by self employed claimants to substantiate quantum of a weekly benefit.

Recommendation #32: Amend the SABS to provide for an appropriate cap on the cost of accounting reports to substantiate a claim for weekly benefits.

Future care cost reports assess and summarize a claimant's need for medical and rehabilitation benefits into the future. They cover more than just the attendant care benefits that are determined using the Form 1. Claimants often submit these reports as an expense to be paid under section 24 of the SABS. It is FSCO's view that these reports are not covered by the SABS and should not be covered by the SABS. Future care cost reports are not requested by health care providers to access benefits. Rather, they are requested by lawyers as part of the settlement process.

Recommendation #33: The cost of future care cost reports should not be an expense recoverable under the SABS.

In Ontario, much as in other Canadian jurisdictions, auto insurance is a second payer to other programs and plans. Several issues were raised by stakeholders as current problems in the system. FSCO acknowledges that there may be a need to examine the language of the *Insurance Act* and the SABS to determine whether and how to address lump sum payments by disability carriers.

Recommendation #34: Investigate options for enabling auto insurers to more effectively enforce the existing provisions in the SABS and the *Insurance Act* that require deductions of all collateral sources of income benefits.

Several stakeholder groups have commented on the difficulty insurance adjusters have in managing claims involving serious injuries, as there are adjusters who are not sufficiently trained or experienced in dealing with seriously injured claimants, which can lead to unnecessary assessments, high rates of benefit denials and delays in accessing benefits. A WSIB operating unit administers a Serious Injury Program that is responsible for arranging specialized treatment, equipment and services for seriously injured workers.

Recommendation #35: Insurance claims departments need to better focus on the needs of claimants with serious injuries. The IBC, Insurance Institute of Ontario and the Ontario Insurance Adjusters Association should work together to train adjusters on the needs of claimants with serious injuries to reduce exposure to potential allegations of unfair and deceptive acts or practices.



Consumers, health care providers and insurers lack information about which treatments are most effective for minor injuries – including, sometimes, no treatment at all. Education is needed around the appropriate timing of interventions and duration. Most of all, consumers need to be empowered with knowledge about treatment and recovery, and the risks of being over treated. Part of the problem stems from the complexity of the system – confusing regulations, numerous time limits, long and detailed forms, etc. Simply put, it is very difficult to understand the auto insurance system as it stands. Issues around complexity may be remedied through recommendations suggested earlier in this report.

Recommendation #36: Consumers, health care providers and insurers should work together to improve consumers’ awareness and expectations around treatment and outcomes. Some of the savings from changes in the accident benefits system should be used to fund these educational efforts.

Several municipalities and municipal transit authorities have reported a rapidly increasing utilization of assessments and attendant care benefits. Injuries are often not reported at the time of the incident but days or weeks later, and without the driver having any knowledge of the incident. The transit authorities must accept these claims in good faith because it is often impossible to even verify whether the claimant was a passenger of the vehicle. One transit authority reported that 73% of claims do not involve an actual collision. These claims are for injuries resulting from bumps and falls while entering and leaving vehicles, standing in aisles, and getting in and out of seats.

FSCO agrees that public transit services operated by municipal authorities should be provided with additional protections that reflect their unique status. Injuries sustained on public transit vehicles involving collisions should continue to be covered under the auto insurance legislation. However, all other injuries should fall under a general liability insurance policy.

Recommendation #37: The government should consider legislative amendments to reflect the unique status of public transit services operated by municipal authorities by excluding injuries from no-fault where no collision has occurred.

Insurers would like greater flexibility in incorporating electronic technologies for consumer-provider communication and transactions. FSCO acknowledges that electronic transactions are also welcomed by a significant proportion of consumers.

Recommendations #38: Auto insurers should explore and take advantage of their existing ability to implement electronic commerce options under Ontario’s *Electronic Commerce Act, 2000*.



FSCO notes that the current review pursuant to section 289.1 of the *Insurance Act* is in addition to the review of the SABS mandated by section 289 of the Act. Section 289 requires a report to the Legislature on the adequacy of statutory accident benefits at least once every two years. The last report was submitted at the end of the 2008. In addition, section 417.1 requires that the Superintendent submit a report to the Legislature on the risk classification and rate determination Regulations at least once every three years. The next report is due in 2010. FSCO notes that the timing and content of the different reviews have the potential to overlap, creating confusion for stakeholders.

Recommendation #39: The government should consider harmonizing the reports required under sections 289, 289.1 and 417.1 of the *Insurance Act*.



1. Introduction

In 2003, the Legislature amended the *Insurance Act* (the Act) to include a requirement in section 289.1 that the Superintendent of Financial Services undertake a review of Part VI of the Act and any Regulations made under Part VI at least once every five years or more often if requested by the Minister of Finance. The Superintendent is to report back with recommendations to improve the effectiveness and administration of Part VI of the Act and the Regulations. Part VI of the Act and the Regulations include statutory accident benefits, court proceedings, and dispute resolution.

This report is intended to fulfill the requirements of section 289.1 of the *Insurance Act*.

2. Background

2.1 Previous auto insurance reforms

In order to curb rising auto insurance costs, the government introduced Ontario's first no-fault system in 1990 under Bill 68 (also known as the Ontario Motorist Protection Plan or OMPP). It was referred to as a "threshold no-fault system" because the ability to sue was restricted to those with permanent serious physical impairments. The ability to recover accident benefits, however, did not depend on fault.

Bill 68 introduced comprehensive first party accident benefits as well as mediation and arbitration to resolve disputes regarding accident benefit compensation. In cases of disagreement, rehabilitation costs deemed medically necessary were paid by insurers pending dispute resolution. Treatment could be certified by a physician, psychologist, chiropractor or dentist. There were four claim forms that applied to claims under Bill 68.

Reforms introduced in 1994 under Bill 164 eliminated the ability to sue for economic losses and established an extensive accident benefit schedule. A \$10,000 deductible (\$5,000 for *Family Law Act* (FLA) claims) was introduced to restrict access to tort. The verbal threshold was expanded to allow lawsuits for serious (but not necessarily permanent) impairments of an important physical, mental or psychological function.

All accident benefit limits were increased and indexed. An additional dispute resolution mechanism was created through designated assessment centres (DACs) in order to address disputes about disability, treatment and rehabilitation. Treatment could now be certified by a physician, psychologist, chiropractor, dentist or optometrist. The number of claim forms that applied to Bill 164 claims increased to eighteen.



In 1996, another set of reforms were introduced restoring the right to sue for economic losses. Under Bill 59, the deductible was increased to \$15,000 (\$7,500 for FLA claims). The serious and permanent impairment verbal threshold was restored, and a new threshold based on catastrophic impairment was introduced to apply to tort claims for excess health care expenses.

The accident benefit schedule was scaled back but now had two tiers of benefits. The higher tier was accessible only to those who sustained a catastrophic impairment. To address overutilization of case management services, the benefit was limited to those who had sustained a catastrophic impairment. In an attempt to control spiralling medical costs, Bill 59 introduced the requirement of prior approval for treatment through a treatment plan; treatment could be certified by a physician, psychologist, chiropractor, dentist, optometrist or physiotherapist. With this set of reforms, the number of claim forms grew to twenty. In addition, the Regulations authorized the Commissioner (now the Superintendent) to establish fee schedules for health care providers, several of which were introduced between 1997 and 2001.

The auto insurance system went through another series of reforms in 2003 under Bills 198/5. The deductible applied to non-pecuniary loss awards was increased to \$30,000 (\$15,000 for FLA claims); however, awards over \$100,000 (and over \$50,000 for FLA claims) became exempt. The catastrophic impairment threshold that applied to economic loss tort claims was replaced with the serious and permanent threshold. As well, a definition of serious and permanent impairment was set out in a Regulation.

Bills 198/5 introduced further changes to the accident benefits schedule in order to address rising medical costs. Pre-approved Framework (PAF) Guidelines for treatment of whiplash injuries were introduced to provide quicker access to treatment and introduce more cost certainty. The Superintendent issued a Guideline that reduced most health care provider fees by 30%. As insurers had reported increased assessment costs following the introduction of prior approval of treatment, Bill 198/5 reforms attempted to curtail rising assessment costs by introducing prior approval of assessments. Treatment could now be certified by a physician, psychologist, chiropractor, dentist, optometrist, physiotherapist, occupational therapist or speech-language pathologist. Under Bill 198/5, the number of claim forms increased to twenty-one. In addition, a code of conduct was created for paralegals and they were required to file information with the Superintendent if they were to continue handling accident benefit claims.

The most recent reforms which saw the DAC system eliminated were implemented in 2006. Instead, claimants were provided with an opportunity to undergo an additional assessment (referred to by stakeholders as a rebuttal assessment) following a benefit denial for use in the dispute resolution system. The Unfair or Deceptive Acts or Practices Regulation (Ontario Regulation 7/00) was expanded to address the use of medical assessments in the claims adjusting



process. With the elimination of the DAC system, the number of claim forms was reduced to nineteen.

Finally, in 2008, the requirement for paralegals to file information and adhere to a code of conduct was eliminated with the full implementation of a regulatory framework for paralegals under the Law Society of Upper Canada.

2.2 Review process

On June 3, 2008, FSCO wrote to stakeholders asking for assistance in conducting this review. The letter was also posted on the FSCO website in order to reach out to a broader group of stakeholders including consumers. Stakeholders were advised that the review would focus on enhancing protection for automobile insurance consumers and ensuring ongoing product affordability and availability. Interested parties were asked to provide FSCO with written submissions identifying issues and concerns, and to provide suggestions that would improve Ontario's automobile insurance system. In addition, stakeholders could arrange to meet with FSCO staff to discuss some of the issues raised in their submissions.

A total of 90 individuals and groups took the time to provide FSCO with their perspectives (see Appendix B). This amounted to almost 1,000 pages of material. Many groups expended a considerable amount of resources in assembling their submissions. The Coalition Representing Health Professionals in Automobile Insurance Reforms surveyed 750 health professionals in order to properly represent the views of their constituents. The Ontario Bar Association, in partnership with the Ontario Trial Lawyers Association and the United Senior Citizens of Ontario, hosted a two day Insurance Summit in April 2008 to provide the opportunity for various auto insurance stakeholders to discuss possible auto insurance reforms. The Insurance Bureau of Canada (IBC) approached the Ontario Neurotrauma Foundation to form an expert panel to review the current science and evidence with which to measure and define brain impairment. FSCO appreciates the effort made to provide an informed input.

The opinions expressed in the submissions represent a broad range of experiences and perspectives. FSCO is pleased to report that the largest group of submissions came from consumers – 24 individuals who took the time to provide their views. In particular, there was a brain injured accident victim who took the time to put together a written submission and meet with FSCO staff.

To enhance the transparency of the review process, FSCO asked the stakeholders who contributed a submission for their consent to post their submissions on the FSCO website. With their cooperation, 76 stakeholder submissions were posted.



This report does not attempt to cover all the issues raised by stakeholders during consultations. Many submissions proposed detailed, technical changes that may be helpful should the government decide to move forward on some reforms. In this report, FSCO has identified key issues that the government may wish to address. Additional consultation will likely be required to further develop some of these ideas.

3. Affordability and Availability

3.1 Industry profitability

Based on reports from the federal Office of the Superintendent of Financial Institutions (OSFI), the property and casualty (P&C) insurance sector recovered from 2002 in which it saw Canada-wide after tax net income fall to \$242 million and return on equity (ROE) shrink to 1.4%. The figures cover all federally regulated P&C insurers. Although these numbers broken down by province or line of insurance are not available, it is known that Ontario's auto insurance market represents approximately 25% of the P&C insurance market in Canada, based on written premium.

In the past few years, profitability has not been an issue for the P&C insurance sector in Canada or Ontario. The peak occurred in 2006 when the industry earned \$5.5 billion in after tax net income and 20.1% ROE. The table below summarizes the financial results for the P&C insurance industry for the past five years.

ALL CLASSES OF P&C INSURANCE		
YEAR	AFTER TAX NET INCOME (000,000)	ROE
2003	\$2,199	11.9%
2004	\$4,084	19.0%
2005	\$4,043	16.5%
2006	\$5,534	20.1%
2007	\$4,953	16.1%
2008	\$2,318	7.5%

Financial results for the P&C industry declined significantly in 2008. Based on reports from OSFI, federally regulated P&C insurers' after tax net income was about \$2.3 billion for 2008 and ROE was 7.5%.



3.2 Premium and cost trends

Based on industry data, auto insurance became more affordable during the past five years. Average premiums in Ontario peaked at \$1,385 per vehicle in 2004 and subsequently fell to a low of \$1,290 per vehicle in 2007. Another indicator of rate movement is the average rate change approved by FSCO. The cumulative rate change from 2004 to 2007 was a reduction of 13.75%. The chart below illustrates how the average written premium and FSCO rate approvals changed over the past five years. There is always a lag in premium impact following a rate approval because a rate change does not impact consumers until their insurance is being renewed.

YEAR	AVERAGE WRITTEN PREMIUM (PER VEHICLE)	AVERAGE RATE APPROVAL BY FSCO
2003	\$1,355	+10.91%
2004	\$1,385	-10.60%
2005	\$1,323	-2.43%
2006	\$1,298	-1.27%
2007	\$1,290	+0.55%

Source: GISA Exhibit AU 10-N and FSCO

Rate approvals continued to trend upward in 2008. The average rate change weighted by market share was +5.59% in 2008. FSCO projects that the average rate change weighted by market share will be approximately 3.0% for just the first quarter of 2009.

Following the reforms introduced in 2003, loss costs for all types of coverages fell in 2004. However, they have since begun to increase. The reduction in loss costs in 2004 can only be partly attributed to auto insurance reforms since some coverages largely remained unchanged. Stakeholders have suggested that in response to rising rates, consumers have under-reported accidents, which has reduced claim frequencies and loss costs. Below is a chart that shows how loss costs for major coverages per vehicle have changed during the past five years.

YEAR	BODILY INJURY	DIRECT COMP	ACCIDENT BENEFITS	COLLISION	COMPREHENSIVE	ALL
2003	\$247	\$146	\$331	\$182	\$83	\$977
2004	\$238	\$134	\$286	\$161	\$68	\$880
2005	\$248	\$134	\$318	\$161	\$68	\$928
2006	\$270	\$131	\$353	\$154	\$66	\$973
2007	\$269	\$143	\$385	\$172	\$65	\$1,034

Source: GISA Exhibit AU 10-N



Loss costs for accident benefits saw the largest relative increases during the past five years. Accident benefits rose by 16.3% since 2003 but since 2004, the increase has been 34.6%. The current overall loss trend rate is 6%, however the trend rate for accident benefits is over 10%. Rising loss costs have resulted in the upward swing of rate changes approved by FSCO. However, rate increases have not kept pace with rising loss costs and the insurance sector reports significant rate inadequacy in the system. Consumers will likely see their premiums increase significantly in 2009 and 2010 without some structural changes to the auto insurance product to reduce and stabilize costs in the system.

3.3 Availability

A good indicator of the availability of auto insurance is the number of drivers forced to purchase insurance from the Facility Association. The number of vehicles in the Facility Association peaked at approximately 226,000 in December 2003. In December 2008, the number of vehicles in the Facility Association had fallen to just over 15,000. This would suggest that consumers have been able to shop the market and take advantage of competitive pricing.

Another indicator of availability in the marketplace is the number of consumer calls regarding this issue received at FSCO's Contact Centre and Market Regulation Branch. During the past three years, there have been very few complaints and inquiries from consumers regarding the availability of auto insurance.

4. Consumer Protection

The focus of this review was on enhancing protection for auto insurance consumers and ensuring product affordability and availability. This section of the report deals primarily with issues of how to better protect consumers.

4.1 Complexity of the accident benefits system

Virtually every stakeholder commented on the complexity of the existing accident benefit system. A number of stakeholders compared the Statutory Accident Benefits Schedule (SABS) to the *Income Tax Act*. To provide some context to this issue, the current SABS is estimated to be six times the length of the schedule that was introduced under Bill 68. The current SABS is also estimated to be 40% longer than the Bill 164 SABS which stakeholders used to refer to as "bloated." An argument could be made that the SABS has increased the regulatory burden on both consumers and the insurance industry.

The technical provisions of the SABS periodically impose impractical time deadlines in obtaining and forwarding claims information. For example, under



section 42 of the Regulation, claimants are at risk of having benefits suspended if they do not comply with the requirement to forward relevant documents to assessors within five business days. Roughly only 25% of the SABS contain a description of accident benefits available to claimants; the remainder sets out the procedures for applying for benefits or denying entitlement. However, based on feedback from stakeholders, these procedural provisions in the SABS may not be accomplishing what they were created to do.

Faced with such complexity, consumers must turn to those more familiar with the system for guidance. Entirely new industries have been created to support the accident benefits system. When the first-party benefit system was introduced under Bill 68, it was contemplated that consumers would be able to access benefits without a representative. In 2007, data from FSCO's Dispute Resolution Group indicated that the percentage of claimants represented by a lawyer or paralegal at mediation was 98%.

The FSCO invitation for comments on the auto insurance system asked stakeholders for proposals to reduce complexity in the SABS and to reduce regulatory burden in the auto insurance system. Unfortunately, the consultation process produced few suggestions along those lines. Ironically, though many stakeholders commented on how difficult it was to comply with the Regulation, many also proposed additional rules to address non-compliance and abuses which would invariably add more complexity. However, FSCO believes that stakeholders could be a good source of ideas for simplifying the system. For example, one stakeholder suggested that the income replacement benefit could be calculated based on a percentage of gross income instead of 80% of net income. This would simplify determining the amount of the benefit and eliminate the need to amend the Regulation each time the *Income Tax Act* changes the tax credits and deductions used to determine net income for tax purposes. In addition, simplifying the system would empower consumers by making them less reliant on a third party to assist them with their claims.

Recommendation #1: When determining the merits of any future regulatory changes, consideration should be given to whether a change would increase complexity and regulatory burden. There should be a compelling reason for making a change that would add complexity to the accident benefit system.

Recommendation #2: Review the SABS to identify provisions that: a) are overly complex and could be simplified without changing the intent of the Regulation, or b) are essentially ineffective and could be eliminated without changing the impact of the Regulation.

4.2 Accident benefit claim forms



In a survey of 750 health care providers conducted by the Coalition Representing Health Professionals in Automobile Insurance Reforms, providers were asked how often they were approached by patients to complete their accident benefit claims form package. About 19% of respondents indicated “always,” 43% indicated “sometimes” and about 39% responded with “rarely” or “never.” The feedback may not be scientifically valid, but it is consistent with other evidence suggesting that consumers struggle to complete benefit application forms.

The initial application package consisted of five forms totalling twenty pages to be completed by persons claiming benefits, their employer and their health care provider. An application can be considered incomplete and its processing delayed if an adjuster decides that missing information is needed to determine entitlement to a benefit. There are nineteen current claim forms that could apply to existing claimants. And, there are additional claim forms that could apply to older claims. The large number of forms creates a paper burden for claimants, adjusters and other participants in the auto insurance system.

The process used to create the forms has involved FSCO and most system stakeholders (insurers, health care providers and lawyers), but not consumers. Despite the many hours dedicated by people with considerable knowledge and experience in the accident benefit system to design forms intended to expedite the claims process, past results may have fallen short of the mark. Perhaps it needs to be acknowledged that claims handlers, health care providers, lawyers and the regulator may not be experts on forms design.

The Ministry of Health and Long-Term Care (MOHLTC) is currently running a Third Party Services Project which has a mandate to streamline and standardize, across four ministries (MGS, MTO, MOHLTC and MCSS), forms and reports requiring physician authorization. FSCO will work in collaboration with this project to simplify forms that are part of the auto insurance system.

Part of the complexity can be justified by the need to develop a database of health care claims information. Health Claims for Auto Insurance (HCAI) is a long term insurance industry project being developed in consultation with FSCO, health care provider associations and other stakeholders in the auto insurance system. To a certain extent, it is necessary to balance the need for a simpler application process with the commitment to HCAI and need for quality data.

Recommendation #3: Contract a forms consultant to assist FSCO and stakeholders in simplifying the application process and revising forms that should first be tested on consumers.

4.3 Fault determination rules

Ontario’s Fault Determination Rules (FDRs) were created in 1990 under Ontario Regulation 668 and have not been updated since. Consumers have never



entirely understood or been comfortable with the interrelationship between the FDRs, the different physical damage coverages (Direct Compensation – Property Damage (DCPD) coverage and Collision coverage) and insurer risk classification systems which are used to determine rates. The percentage that a driver is found to be at-fault determines which coverage is used to repair the driver's vehicle rather than to calculate the next renewal rate increase. Insurers generally utilize any at-fault accident for rating purposes regardless of the apportionment percentage of size of the claim.

For example, assume a driver has purchased Collision coverage with a \$500 deductible and no deductible on DCPD coverage. If the driver is found to be 100% at-fault for the accident, the repairs will be paid for by the driver's Collision coverage and the full \$500 deductible applies. If the same driver is found to be 50% at-fault for the accident, then 50% of the repairs will be paid for by the driver's DCPD coverage and 50% by the Collision coverage, and a \$250 deductible (50% of \$500) would apply. Finally, if the same driver is found to be not-at-fault for the accident, then the repairs will be paid for by the DCPD coverage and no deductible will be applied.

This type of apportionment is neither used nor relevant when assessing risk. Any person whose driving has been determined to have contributed to an accident is considered to be a higher risk. The notion that someone who is 50% at-fault is one half the risk of someone who is 100% at-fault is not supported by industry actuarial data.

However, there are jurisdictions in Canada and the United States where consumers are protected from rate increases when they are only partially at-fault. An at-fault threshold could be introduced such that fault determinations below the threshold would not trigger rate increases. It needs to be noted that consumers are already provided with some protection through regulation because insurers cannot rate based on not-at-fault (or 0% at-fault) accidents. This protection exists regardless of the fact that actuarial data suggests that drivers who have not-at-fault accidents are a higher risk than drivers who don't have any accidents at all. However, there may be the capacity to expand beyond the existing prohibition which protects drivers who are 0% at-fault to apply to drivers who are at-fault at or below a 25% threshold.

Recommendation #4: No element of a risk classification system should use past claims for which a driver is 25% or less at-fault.

A number of FDRs outline specific circumstances where a 50:50 determination must be made. In addition, adjusters may reach a 50:50 determination when the accident facts cannot be established, such as when there are no witnesses or inconsistent reports from the consumers involved.



Some consumers have complained that adjusters make 50:50 fault determinations too frequently because adjusters are not investigating claims thoroughly enough and consequently are not making the correct fault determination. Often, accidents involving property damage are being reported by drivers to police at Collision Reporting Centres and not at the accident scene. Because drivers are self-reporting accidents, determining fault becomes more difficult when the drivers involved in a collision provide conflicting versions of the accident. Consumers have a reason to be concerned because an adjuster's fault determination can have a long term impact on a driver's insurance rates.

A review of inquiries received by FSCO's Market Regulation Branch shows that after accident benefit inquiries, the next largest group of calls comes from consumers who disagree with their adjuster's determination of fault. Many calls were prompted by consumers who received a large insurance premium increase upon renewal. FSCO believes that consumers are not always aware how adjusters allocate fault, how an at-fault determination will affect their premium and/or how they can appeal an adjuster's determination.

For property damage disputes, a dispute resolution mechanism is found in section 128 of the *Insurance Act* which allows each party to appoint an appraiser to resolve the dispute. The two appraisers can appoint an umpire who is used only if the two appraisers cannot agree on a resolution. The costs are split by the parties. However, both parties must agree to participate in this process (Statutory Condition 9(2.1) found in Ontario Regulation 777/93). Otherwise, the only other mechanism available to consumers is to challenge an insurer's determination in the courts.

Recommendation #5: Provide some best practice guidelines that would set out standards for communicating information on the fault determination process and how to challenge a determination.

Recommendation #6: Make the existing statutory appraisal process under section 128 of the Act mandatory on insurers for property damage claims if the consumer prefers this process over the courts.

4.4 Auto insurance quoting practices

FSCO receives frequent complaints that certain insurers, before agreeing to provide a quote, request and collect personal information that they are prohibited from using for underwriting or rating purposes, or is not collected on the Ontario Application for Automobile Insurance (OAF1).

The *Insurance Act* governs the formal "application" process by which an auto policy is issued to a person who seeks to purchase auto insurance. The Act does not apply to the quoting or "pre-application" process used to comparison shop.



The formal application process begins when the consumer requests an application form or otherwise expresses an intention to make an application. The agent or broker must provide an OAF1 and forward the completed form to the insurer at the applicant's request. The insurer cannot refuse to issue a contract except in accordance with approved underwriting/declination rules filed with FSCO.

On-line forms used to provide quotes are distinct from the OAF1. In addition to the information required to underwrite and rate the policy, consumers applying for a quote may also be asked to provide:

- consent to a credit rating check
- information relating to one's employment/occupation
- medical information

In 2005, the Ontario government amended Ontario Regulation 664 to add certain financial information and other "lifestyle" factors to the existing list of underwriting and risk classification criteria that insurers are expressly prohibited from using. However, the current Regulation does not prohibit insurers from asking such questions. Concern has been expressed by some stakeholders that some quoting practices are being used to get around the existing prohibitions.

Insurers may be using this information to decline on-line quotes or delay providing a quote pending the receipt of a written application. Insurers are not prohibited from requiring prospective applicants to submit a completed OAF1 before issuing a quote.

When applying for a quote on-line, all fields or questions asked on the form must be completed. If the answers match predetermined acceptable responses, an immediate quote is generated.

Upon receipt of the quote, consumers wishing to purchase insurance may immediately complete the transaction on-line by proceeding through a number of additional information-gathering steps or, if this option is not available, through a call centre, usually the same or next day.

If the answers do not match the insurer's predetermined acceptable responses, consumers may be denied an on-line quote and further instructed to contact the insurer, at which point they may be informed that a written application is required to obtain a quote. At this stage, some consumers choose not to proceed. It has been reported that it may take anywhere from 1 - 4 weeks to complete the paper application process and obtain a quote.

It should be noted that brokers may also be using similar quoting practices, in line with the insurance companies they represent, to screen risks perceived as



borderline or risks that may be seen as having the potential to adversely impact business.

FSCO has issued a bulletin directing insurance companies not to use criteria that are prohibited for rating or underwriting purposes (e.g., criteria related to a consumer's social, personal and/or economic status) to decline to provide quotes, to hinder or delay a consumer's efforts to obtain insurance coverage or an insurance quote, or as a basis for differential treatment of consumers in the quoting and application process. Consideration could also be given to creating an expressed prohibition in Ontario Regulation 7/00 (Unfair or Deceptive Acts or Practices).

Recommendation #7: Consider prohibiting objectionable quoting practices including delays in providing quotes, requiring written applications for quotes and certain screening techniques.

4.5 Disputes between insurers

One key objective of Ontario's no-fault accident benefit system is to meet claimants' immediate needs following an automobile accident and provide prompt payment of benefits without regard to fault. Without a system of prompt payments, claimants could be left without the ability to pay for ongoing household and living expenses and medical and rehabilitation costs resulting from an accident.

The *Insurance Act* sets out a priority ranking for determining liability to pay statutory accident benefits in situations where more than one insurer may be liable to pay these benefits. In situations where a claimant is injured by an uninsured driver or is the victim of a hit and run accident and there is no automobile policy available, the Motor Vehicle Accident Claim Fund (MVACF) pays. MVACF is operated by the Ontario government and responds to claims in the same fashion as insurance companies. However, MVACF is funded by drivers and increases in costs to MVACF are passed on to the driving public.

Despite these priority rules, difficulties have emerged in resolving disputes between companies over which insurer was liable to pay and these disputes were often addressed in the FSCO dispute resolution system. Often, claimants who were entitled to accident benefits received no benefit payments until the resolution of this dispute.

To remedy the situation, Ontario Regulation 283/95 was introduced in 1995 to ensure claimants receive accident benefits in a timely fashion, while these disputes are being resolved. The Regulation sets out a mandatory process for private arbitration of all disputes between insurers regarding which insurer is liable to pay accident benefits.



The Regulation requires that the first insurer receiving a completed application for accident benefits respond to the application and pay any benefits for which the person qualifies despite any objections it has to being named. If that first insurer believes that it is not the correct insurer under section 268 of the Act, it must give notice of its objection to every other insurer it claims is required to pay accident benefits, as well as to the insured person. Any other insurer that receives a notice may dispute its obligation to pay and give notice to those insurers it believes have priority.

Over the years, a number of disputes, court cases, and differences in interpretation have emerged that have led to delays in the payment of claimants' benefits. These delays often have detrimental effects on injured accident victims. Some insurance companies have refused to respond to applications on the basis that the person making the application is not an "insured person." They maintain that there was no existing policy in place at the time of the accident (e.g., policy had expired, been cancelled or never existed) or that the claimant was not covered by a policy (e.g., the claimant was not a dependant of one of their policyholders). As well, insurers have indicated that they receive incomplete accident benefit applications and do not have enough information to determine if they are the insurer required to pay benefits. In some cases, claimants submit more than one application to different insurers when they are unsure which company is obligated to pay. Some court decisions have criticized insurance companies for the way they handle these claims.

FSCO conducted a consultation with a small group of stakeholders in 2006 to identify problematic provisions in the Regulation. A small number of stakeholders also raised issues regarding the operation of the Regulation as part of the current review.

FSCO has concluded that there is a lack of clarity over what constitutes the "first insurer" and what constitutes a "completed application." Further, court decisions have called into question the role of the MVACF and whether the MVACF is an "insurer" under the Regulation. This can result in claimants receiving no benefits until the dispute is resolved or applications for benefits being inappropriately directed to the MVACF.

Recommendation #8: Regulation 283/95 should be amended to make it more difficult for insurers to deflect claims and to ensure that claimants receive accident benefits while the issue of liability for a claim is resolved.

4.6 Vicarious liability

Bill 18 made amendments to the *Insurance Act*, the *Compulsory Automobile Insurance Act* and the *Highway Traffic Act* effective March 1, 2006, to change the order in which insurers respond to liability claims arising from accidents involving a leased or rented vehicle. The amendments also limited in most cases the



vicarious liability of leasing and rental companies with respect to liability claims arising out of the use of a leased or rented vehicle to \$1 million.

Brokers and rental companies have pointed out that under the current standard owner's auto insurance policy (OAP 1) coverage for rented vehicles extends only to vehicles with a Manufacturer's Gross Vehicle Weight Rating (GVWR) of less than 4,500 kg. This has allegedly created a gap in coverage for those consumers who own a policy but wish to rent a vehicle with a greater GVWR. Brokers have suggested that the legislation could be amended to require vehicle owners to carry higher coverage for heavier vehicles. They also pointed out that since Bill 18 was enacted, vehicle rental and leasing companies generally carry only \$1 million of coverage. Representatives of the vehicle rental industry have proposed that vehicle rental companies be allowed to sell additional liability coverage to those customers who have neither an existing policy nor additional coverage. However, the *Insurance Act* prohibits unlicensed individuals from doing so. FSCO has determined that a simple solution might be for the Superintendent to amend the OAP 1 to include coverage for vehicles with a GVWR over 4,500 kg if rented for only a limited period of time (such as 15 days per policy year). This may not cover all consumers who rent heavy vehicles but would likely benefit a large number of renters.

Recommendation #9: The Superintendent intends to amend the OAP 1 to provide a limited amount of coverage for vehicles with a GVWR over 4,500 kg.

5. Statutory Accident Benefits Schedule

As previously mentioned, accident benefit costs increased by 34.6% between 2004 and 2007. During that period, the actual number of accident benefit claims decreased by 3.5% but the average cost of an accident benefit claim increased by 39.5%. This section of the report will attempt to identify the pressures in the system that are driving claim costs up and could potentially threaten product affordability. In addition, a number of recommendations suggested in this section would also enhance consumer protection and improve access to accident benefits.

5.1 Definition of "catastrophic impairment"

The Bill 59 reforms in 1996 introduced two tiers of accident benefits with the higher tier of benefits for claimants whose impairments are found to be "catastrophic." The SABS set out the definition for "catastrophic impairment" (see Appendix A). Minor changes to the definition were made in 2003 under the Bill 198 reforms but otherwise the definition has largely remained the same over the past 12 years.



Some stakeholders have suggested that the references to paraplegia and quadriplegia in clause (a) of the definition may no longer be appropriate. Complete paraplegia and quadriplegia are rare and these injuries are better measured with reference to the severity of a spinal injury. It has been proposed that consideration be given to including the ASIA (American Spinal Injury Association) Spinal Cord Classification and Impairment Scale in the “catastrophic impairment” definition.

The definition in the SABS uses the Glasgow Coma Scale to identify catastrophic brain impairment. In 1996, based on stakeholder feedback, the government understood that the Glasgow Coma Scale was a poor predictor of ongoing brain injury severity however no alternative was available at the time. Most stakeholders have expressed some dissatisfaction with the definition of “catastrophic impairment” as it pertains to brain injuries. In the fall of 2007, the IBC approached the Ontario Neurotrauma Foundation to form an expert panel to review the current science and evidence with which to measure and define brain impairment. The IBC provided FSCO with a copy of the panel’s report as part of this review. The report sets out an algorithm for determining catastrophic brain impairment. The insurance industry is currently testing the algorithm for its accuracy and predictability.

The American Medical Association Guides to the Evaluation of Permanent Impairment (the Guides), 4th edition (published in 1993), are incorporated into the SABS by reference. The Guides provide health professionals with a format for analyzing, assessing and recording functional impairments to all parts of the body. After assigning a percentage value to an individual’s particular impairments, a formula set out in a chart is used to combine them into a final “whole person impairment.” If this “whole person impairment” is 55% or above, the SABS prescribes that the injured person is designated catastrophically impaired.

Every impairment type, except mental or behavioural disorders, is given a percentage in the Guides. These impairments have a separate categorization set out in Chapter 14 of the Guides and are categorized as mild, moderate, marked and extreme. The SABS separates out mental and behavioural disorders under clause (g) of the definition as distinctly qualifying for the catastrophic impairment designation.

The most influential decision interpreting the “catastrophic impairment” definition to date is *Desbiens v. Mordini*, released in November 2004. In *Desbiens*, the court decided that:

- Physical impairments (under clause (f) of the definition) and psychological impairments (clause (g)) can be combined to determine if an individual has sustained a whole person impairment of 55% or more.



- Psychological impairments can be given percentage ratings despite the fact that the Guides state that the absence of rating guidelines were not merely a passive omission but in fact an act of deliberate proscription

Following *Desbiens*, there has been uncertainty around whether an injured accident victim's physical and psychological injuries will be combined and a court or arbitration proceeding is often commenced before the issue is resolved. Insurers support an amendment to the Regulation that would restore the concept that clauses (f) and (g) are not to be combined. Other stakeholders have indicated that this would be unfair. Stakeholders have informed FSCO that a clarification is needed. Some medical assessors are providing two reports because of uncertainty regarding this issue. FSCO is unable to conclude based on stakeholder feedback to date, whether it is more appropriate to combine physical and psychological injuries or treat them separately. Further consultation with experts in this area is needed.

The Guides were first published in 1970 and have been revised periodically to reflect emerging scientific knowledge and judgment. In December 2007, the most recent edition of the Guides, the 6th edition, was published. The SABS continues to reference the 4th edition.

A number of stakeholders have suggested that the 6th edition of the Guides should be incorporated into the Regulations. However, moving to the 6th edition of the Guides would not resolve all the difficulties associated with the "catastrophic impairment" definition, as they provide limited percentage ratings for mental and behavioural impairments and limited consideration of emotional and/or behavioural impairments even when attributable to a neurological impairment.

The Workplace Safety and Insurance Board (WSIB) conducts an analogous assessment to determine the amount to be paid (as a non-economic loss benefit) to an injured worker who sustains a permanent impairment. This assessment is also based on the Guides, however, the WSIB uses the 3rd revised edition rather than the 4th. The WSIB assigns permanent impairment percentages for mental and behavioural impairments which includes psychotraumatic disabilities, chronic pain disabilities and fibromyalgia syndrome. It would be worth examining its scale to determine whether it could be utilized in the auto insurance system.

FSCO has concluded that significant developments have occurred since the introduction of the "catastrophic impairment" definition. Court decisions have expanded the definition in order to address perceived inequities but by doing so, have also exposed the system to potential abuse. Most stakeholders continue to support the concept of providing two tiers of benefits based on injury severity. However, the integrity of the model is dependent on a clear and fair definition of "catastrophic impairment."



Recommendation #10: Further consultation with experts in the field is needed to amend the definition of “catastrophic impairment.” The goal for this review should be to ensure that the most seriously injured accident victims are treated fairly.

5.2 Assessments and examinations

One area where stakeholders appear to be in agreement is in the overutilization of assessments in the auto insurance system. The anecdotal information from various stakeholders is quite disturbing. The allegations include:

- Numerous “assessment mills” operating in the auto insurance system and providing claimants with inappropriate or unnecessary assessments given either the diagnosis and/or stage of recovery.
- Assessments being conducted by facilities not involved in a claimant’s treatment.
- Multiple requests for assessments being sent to insurers in order to overwhelm company adjusters.
- Assessments being requested in support of routine benefit applications even though there are no indications that insurers will deny the benefits.
- Assessments being requested without the knowledge and consent of the claimant.
- Assessment requests completed on behalf of providers without their knowledge or consent and in some cases with forged signatures.
- Unqualified providers carrying out assessments.
- A recent trend of conducting in-home assessments at a higher cost to the system without any justification.
- Costs of these assessments are out of line with the benefit to the claimant or insurer.
- Illegal payments being made to those initiating referrals.

The IBC submitted that in 2007, based on incurred losses (paid claims plus reserves), for each dollar spent on treatment, another 60 to 80 cents were spent on assessments. For minor claims (between \$1,000 and \$20,000) they suggest that assessment costs were between 70 and 80 cents for every dollar of treatment. This level of assessment activity is reported to be inconsistent with other jurisdictions including the public health care system.

It is worth looking back at earlier reforms to track how Ontario evolved into the current environment. Under Bill 68, there was no prior approval of treatment and certain disputed expenses had to be paid by the insurer pending the resolution of the dispute. Insurers could request statements from providers (limited to physicians, psychologists, chiropractors and dentists) but there were no assessment costs associated with the treatment and statements. Section 23 of Ontario Regulation 672 did provide for assessments related to certificates requested by insurers with respect to claims for weekly benefits but they were



rarely carried out. Insurer medical examinations were allowed in respect of claims for weekly benefits but these examinations also reviewed proposed treatment.

One of the significant changes introduced in 1993 under Bill 164 was the designated assessment centre (DAC) system. Policymakers at the time may have envisioned that DAC assessments would reduce the need for insurers to request insurer examinations. Section 57 of Ontario Regulation 776/93 provided for payments for cost of examinations related to a certificate or report required under the Regulation. Again, this provision did not produce the results seen today.

In 1996, a new version of the SABS (Ontario Regulation 403/96) came into effect under Bill 59. Section 24 of that Regulation contained similar language to section 57 of Regulation 776/93 but also covered the cost of examinations related to treatment plans. Under Bill 59, treatment became subject to prior approval by an insurer and a treatment plan was the mechanism that providers were required to use to obtain approval. The attempt to control the cost of treatment seemed to have triggered a change in health care practice patterns; the number and cost of assessments have steadily grown in the last 12 years. In 2003, the Regulation was amended to introduce a prior approval process for assessment but stakeholder feedback suggests that this change has had a minimal impact.

It has been suggested by some groups that assessments are necessary in every instance involving treatment plans, completion of certificates and forms, and benefit applications. FSCO questions whether this is the case and whether one assessment can cover a number of different purposes.

Another disturbing trend is the involvement of lawyers and SABS representatives in the assessment process. FSCO has been informed by stakeholders that it is not unusual to have requests for assessments faxed from legal offices. FSCO is concerned that claimants' representatives are arranging these assessments as a way to increase the settlement value of claims rather than to address the treatment needs of their clients.

The 2006 amendments to the SABS included a deemed approval provision to ensure that requests for prior approval of assessments are not ignored. Insurers who do not respond to a request for approval within 3 business days must pay for the assessment. This provision was included in the Regulation to ensure claimants received quick access to treatment and other benefits. However, some of the consequences of this provision may be outweighing the benefits. Some health care providers and facilities are submitting multiple requests for assessments for the same claimant rather than combining them into one request, which is overwhelming insurance company adjusters. During consultations, a number of stakeholders suggested that adjusters frequently refer requests for an



insurer examination in order to buy themselves more time, which only adds more transaction costs, paper and delays.

Some insurers report receiving assessment requests that are not necessarily related to any treatment or other benefit. One insurer reported that it examined internal data which suggested that on average it was receiving one assessment request for every nine treatment plans submitted. However, the data showed regional differences and the ratio in one area of the province was as high as one assessment request for every two treatment plans.

The assessments being conducted under the SABS are increasingly taking the form of medical-legal examinations that are routinely conducted as part of the tort system. It is questionable whether these expenses are justified under the SABS. Section 24 of the SABS was created to address clinical assessments required as part of the treatment process and consideration was never given to establishing limits for these expenses. It appears limits need to be introduced to reduce the over-reliance on examinations that are used to justify a claim or an entitlement decision rather than to guide clinicians. There is a role for medical-legal examinations in a dispute resolution setting but not as part of a rehabilitation process.

Recommendation #11: Section 24 assessments expenses should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under section 19 of the SABS.

Recommendation #12: The fee for completing forms including any assessment required to complete the form should be capped at \$200. The cost of all other assessments should be capped at \$2,000.

Recommendation #13: The time frame provided to adjusters to review assessment requests should be the same as the time frame that applies to treatment plans (10 business days) to allow for proper claims handling.

The IBC reports that the number of in-home assessments has also been increasing. “In-home assessment” is not a term used in the Regulation but these assessments have become widely used in recent years. These assessments take place in a claimant’s home rather than in a clinical setting and are used to support a claimant’s application for treatment, rehabilitation benefits, attendant care benefits, housekeeping and home maintenance expenses, and caregiver benefits. Existing industry data does not separate out assessments conducted in the claimant’s home. However, there is sufficient anecdotal information to support the suggestion that they have become a growing source of costs. Providers who review requests for in-home assessments on behalf of insurers reported that they have also observed an increase of in-home assessments. The Ontario Society of Occupational Therapists reported that some health care professionals routinely request two or three in-home assessments to determine



benefit needs when one assessment could address all needs. In addition to assessments conducted in a claimant's home, there are also assessments that take place in a claimant's workplace or school.

The focus on in-home assessments has to do with cost. Insurers bear the additional cost of providers who travel to assess claimants rather than have claimants travel to assessors. This particular issue is similar to the problem related to other multiple assessment requests under section 24 of the SABS.

At one time, the only in-home assessments being conducted in the auto insurance system related to attendant care and home modifications. In order to assess independence in daily living, it was necessary to observe claimants in their home environment. The WSIB conducts similar assessments but they are limited to their most seriously injured clients. FSCO has concluded that there is nothing unique about auto accident victims when it comes to assessment needs. Expensive and limited health care resources are being tied up by health care providers travelling to clients. Therefore, most assessments should be conducted in a clinical setting.

Recommendation #14: Availability of in-home assessments should be limited to seriously injured claimants and should only be used to evaluate their need for attendant care services and home modifications.

FSCO has concluded that prior approval has not been an effective tool in controlling the utilization of assessments. There appears to be little accountability in the system and service delivery seems very fragmented. Any regulated health professional or social worker is able to submit a request for an assessment and the insurer must respond. In addition, the Regulation states that an insurer cannot deny the request until an insurer examination has been conducted. This means that an insurer must incur additional costs in response to even the most questionable assessment requests.

There were a number of suggestions proposed by stakeholders to better control utilization of assessments. Some stakeholders recommended restrictions on the number of assessments that can be carried out in a specific time frame or requiring providers or facilities to request multiple assessments on one form. Another submission suggested that there was a lack of accountability and proposed requirements that claimants sign all assessment requests. FSCO is concerned that additional rules will only add complexity without necessarily controlling overutilization. Given that the current process is not adequately controlling utilization, making the process more complicated will likely only cause more frustration without achieving the desired results.

FSCO did review other Canadian jurisdictions to determine how practices compare to Ontario. This has not been identified as a cost driver in other provinces. The other jurisdictions have not reported providers conducting multiple



assessments to initiate benefits and treatment. More extensive assessments are normally conducted in cases where recovery is not progressing as expected. For example, in Saskatchewan, secondary and tertiary assessment centres are used to review more difficult cases.

Why is the Ontario auto insurance system so different than other systems? FSCO has concluded that one area where Ontario differs is in how treatment is managed. The Ontario system appears to lead to multiple and duplicative assessments and fragmented treatment. Feedback provided by stakeholders suggests that family physicians are often not managing the treatment of auto accident victims. In approximately half of Canadian jurisdictions, physicians direct assessments and treatment. In Saskatchewan claimants are asked to designate a primary practitioner who can be a physician, chiropractor or physiotherapist. In Ontario there are 24 professions that are authorized to conduct an assessment, and legislation passed in 2006 will further expand that number by 4 (kinesiologists, psychotherapists, naturopaths and homeopaths). This expansion in the number of regulated health professions may create even more cost pressures on the auto insurance system when implemented such that they begin to conduct assessments. FSCO has concluded that assessments should be initiated by the health professional directing the claimant's rehabilitation and not the professional conducting the assessment. A single professional responsible for rehabilitation can fully and accurately respond to questions from the claimant and adjuster concerning the appropriateness of the proposed assessments and treatment.

The increased involvement of physicians is not expected to impact on the doctor shortage in Ontario. Auto insurance claimants with more serious injuries already see their family doctors following an accident. The proposed changes will not significantly increase the number of doctor visits and will benefit claimants by keeping their family doctors better informed on their progress.

Recommendation #15: Consider having assessment requests completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Assessment requests would continue to be submitted by providers following a referral.

The 2006 SABS amendments that eliminated the DAC system also changed the role of insurer examinations under section 42 of the Regulation. Insurer examinations are used to respond to applications for benefits or to determine whether a claimant is, or continues to be, entitled to a benefit. An insurer cannot deny or terminate benefits without an insurer examination and to do so would be considered an unfair or deceptive act or practice. As a result, eliminating the DAC system did not reduce the number of assessments in the accident benefit system. On the contrary, it appears that the number of insurer examinations has increased over the past two years.



An insurer examination can be a paper review (based on criteria in the SABS) which eliminates the need for the claimant to attend in person, however, in many cases the claimant is still required to undergo a physical examination. The insurer examination process in the SABS was developed to deliver speedy responses to entitlement issues. In order to meet this objective, the Regulation provides a series of tight timelines and procedural rules with respect to notice delivery, document exchange, appointment scheduling, and report delivery. If the insurer examination report from the assessor cannot be delivered within the timeframe set out in the Regulation, insurers are required to pay benefits until the report is provided.

A number of unusual insurer practices have been reported by other system stakeholders. Insurer examination providers report that most insurers insist that all reports be delivered within the timeframes set out in the SABS. This creates pressures for assessors in particular when a multi-disciplinary assessment is necessary. Stakeholders are of the view that in some cases the quality of reports has been negatively impacted by the pressure to meet timelines. In addition, claimants are being pressured to attend appointments within the short timeframes which contributes to the high numbers of “no shows,” further adding to overall costs.

Insurer examinations are arranged in response to requests for goods and services even though the cost of the examination may exceed the original request. Some stakeholders suggest that a “proportionality principle” should apply. In situations where the cost of an insurer examination exceeds the benefit being claimed, insurers would not be permitted to conduct an insurer examination. However, FSCO is concerned that applying such a principle could change behaviours, thereby creating unintended results. Perhaps one way to apply the principle could be to provide adjusters with more discretion when reviewing small benefit claims.

The SABS sets out geographic restrictions on insurer examinations in order to minimize inconvenience to claimants. The Regulation requires insurers to refer claimants to assessors within 30 kilometres of their home if they reside in the Greater Toronto Area and 50 kilometres for those outside the region. If there is no qualified assessor reasonably available, the Regulation allows insurers to arrange examinations outside these geographic boundaries. In some cases, where the appropriate assessor is from outside these geographic boundaries, insurers have paid assessors to travel to the claimant rather than the other way around. This costly practice is analogous to the practice of conducting in-home assessments under section 24 instead of in a clinical setting. Insurers have suggested that the geographic boundaries have created “regional monopolies” for assessors who are willing to conduct examinations within the SABS timelines which is driving up the cost of examinations. Submissions from the insurance industry recommended that the geographic boundaries for location of examinations be removed from the Regulation. No further details were provided



by the industry and FSCO is unable to comment on the extent of this particular problem.

A significant number of stakeholders expressed concern regarding the quality of insurer examination reports and the qualifications of providers conducting insurer examinations. Regulation 7/00 states that it is an unfair or deceptive act or practice to require a claimant to be examined by a person who is unqualified to conduct the examination. However, there are no standards or qualifications for assessors in the auto insurance system. Some stakeholders suggested that FSCO develop guidelines that cover best practices for insurer examinations, standardized reports and assessor qualifications. FSCO is of the view that some stakeholders would like to see FSCO regulate the provision of third party medical examinations. FSCO believes that this is neither an appropriate role for a regulator of financial services nor is it an area that requires the involvement of another regulator since all assessors are already regulated by one of the health regulatory colleges. What is needed is a process to develop some industry-wide standards.

Recommendation #16: The health care professional associations and the insurance industry should jointly develop standards for the delivery of third party medical examinations as well as qualifications for assessors. FSCO would facilitate this process.

Based on feedback from stakeholders, one area of assessment which appears to be more problematic is the assessment used to determine catastrophic impairment. Feedback suggests that both the costs and quality of these assessments have raised concern. The Toronto Transit Commission reports that these assessments often cost between \$20,000 and \$30,000 and involve a multi-disciplinary team of professional experts. The IBC proposes that the total amount available for assessments to determine whether a catastrophic impairment exists be capped at \$15,000. Insurers must conduct a catastrophic impairment assessment in response to applications from claimants alleging this level of impairment.

FSCO questions why so much is being spent on catastrophic impairment assessments. As mentioned previously, the WSIB conducts an analogous assessment to determine the amount paid as a non-economic loss benefit to an injured worker who sustains a permanent impairment. The assessment is also based on the AMA Guides, but based on the 3rd revised edition rather than the 4th. In the WSIB system, assessors are predominantly physicians who are trained on the use of the Guides. Assessors are paid a flat fee of \$214.01 which covers time spent with the injured worker, reviewing documentation, and preparing a report. A premium is paid (up to an additional \$214.01) for longer assessments. There are approximately 900 roster physicians who conduct about 17,000 assessments each year. Approximately 80% of these assessments deal



with musculoskeletal impairments. The WSIB is in the process of integrating the non-economic loss assessments into their 22 regional evaluation centres.

FSCO cannot fully explain why there is such a large differential between the workplace insurance system and the auto insurance system. FSCO understands that the WSIB adjudication staff review the file and only send the assessor documentation that would be relevant for the assessment. In most cases the assessors limit their examinations to the criteria set out in the AMA Guides in order to arrive at an impairment rating of the “whole person.”

One insurer provided FSCO with examples of insurer examinations to determine catastrophic impairment that ranged in cost from \$15,000 to \$43,000. The insurer was asked whether there would have been an impact on the final outcome if the company had restricted these insurer examinations to only clinical reviews without a file review. They were unable to answer but did acknowledge that in some cases the whole person ratings were so low that it would have been nearly impossible to challenge the insurer examination report. Yet insurers insist on lengthy medical-legal reports in response to requests for catastrophic impairment determinations that have little merit. This type of security comes at a very high price.

Stakeholders have suggested that unqualified assessors are being utilized under both sections 24 and 42 to determine catastrophic impairment. Inaccurate ratings add costs to the system, increase the number of disputes and often lead to additional assessments. Though these assessments are quite specialized, there also appears to be considerable training available on the use of the Guides. It seems reasonable to restrict catastrophic impairment assessments only to those who have been properly trained, as is done by the WSIB.

Recommendation #17: Restrict the ability to conduct catastrophic impairment assessments to practitioners with appropriate training and experience.

At the same time as amendments were made to the SABS in 2006 to eliminate the DAC system, Ontario Regulation 7/00 was also amended to introduce a number of new unfair or deceptive acts or practices pertaining to the use of insurer examinations. The most significant additions dealt with the use of unqualified assessors making entitlement decisions before receiving an insurer examination report and requiring a claimant to attend an insurer examination which is not reasonably required under the SABS. Insurers report that paralegals and lawyers use these provisions to threaten adjusters with complaints regarding unfair practices. In fact, FSCO’s market conduct staff receive many inquiries and complaints from representatives regarding possible unfair practices of insurers. Upon review, FSCO has not identified a compliance issue. The lack of standards or benchmarks has created confusion among stakeholders on what would constitute an unfair practice.



Insurer examinations continue to be a contentious part of the accident benefits system and an irritant to claimants, treatment providers and representatives. Insurer examinations also add to the high transaction costs in the system. Just as insurers would like to see fewer assessments under section 24 of the SABS, claimants would welcome a reduction in the number of examinations under section 42.

Numerous submissions proposed limits on the number of insurer examinations during a specified time period. This approach has the same inherent problems as limiting the number of section 24 assessments. Any limit chosen is arbitrary and creates difficulties in managing complex or serious cases. However, capping insurer examinations would provide appropriate balance to the system if the cost of assessments were also capped.

Still, FSCO sees a need to reduce the number of insurer examinations that are being conducted. A reduction in insurer examinations would be expected if the number of section 24 assessment requests dropped off. One recommendation already made in this report is to provide adjusters with more time to review assessment requests. This would reduce the incidence of adjusters sending claimants for an insurer examination to buy more time before making an entitlement decision. It would be ideal if adjusters could be given more discretion to determine entitlement without an insurer examination. For example, insurers report that some providers resubmit assessment requests and treatment plans that have previously been denied. FSCO is unable to comment, given its technical knowledge and experience, on what types of entitlement decisions adjusters are able to make without medical input.

FSCO has concluded that the requirement to conduct an insurer examination before denying entitlement to a benefit has increased the number of assessments and costs of the system. Conceptually, the need for an assessment before denying benefit entitlement was introduced with the designated assessment centres. However, the practice is inconsistent with other jurisdictions where insurers conduct third party assessments only when they perceive a need. The OMPP also provided insurers with discretion to request assessments only when the insurer felt it was needed. Transaction costs and claimant inconvenience would be decreased if some discretion were re-introduced into the system.

Recommendation #18: The cost of insurer examinations should be capped at \$2,000.

Recommendation #19: Provide adjusters with some discretion in reviewing assessment and treatment requests and modify Ontario Regulation 7/00 to reflect possible amendments to the SABS.



A further change introduced in 2006 with the elimination of the DAC system was the ability for claimants to obtain an assessment from their health care provider to address issues raised in an insurer examination. Stakeholders refer to these assessments (provided for in section 42.1 or the SABS) as “rebuttal assessments.” The circumstances whereby a rebuttal assessment can be obtained are set out in the Regulation but in all cases they are in response to an insurer denying entitlement to a benefit as a result of an insurer examination. The fees for a rebuttal assessment are capped in the Regulation except in cases where the claimant has a catastrophic impairment or is being considered for one.

The policy intent for introducing assessments under section 42.1 was to assist claimants reviewing issues raised in an insurer examination as part of a dispute. The objective was to provide some balance to the system. The stakeholder feedback on whether that objective is being met has been mixed. Health care providers report that rebuttal assessment reports have occasionally resulted in insurers reversing benefit denial. It has been reported that errors made by assessors conducting insurer examinations have been identified through a rebuttal assessment.

Rebuttal assessments have also added to the already high transaction costs in the system. Insurers have indicated that in some cases, the original health care providers have been known to resubmit their original assessment under section 42.1. Stakeholders have indicated that it is common practice for insurers to ask the assessor who conducted the insurer examination to review the rebuttal assessment report. Health care providers have expressed frustration because input via a rebuttal assessment does not often change the insurer’s decision. FSCO notes that section 42.1 was not intended to develop a “duelling” assessment process. However, that appears to be happening. If the government wishes to simplify the accident benefit system, eliminate further levels of assessments and review, and reduce transaction costs, FSCO recommends that section 42.1 be revoked. The claimant would continue to have access to FSCO’s dispute resolution services.

Recommendation #20: Revoke section 42.1 of the SABS which allows claimants to obtain an assessment from their health care provider to address issues raised in an insurer examination.

5.3 Access to treatment

With certain exceptions, health care providers must complete a treatment plan to facilitate approval and payment for medical and rehabilitation goods and services by an insurer. In addition, the necessity of the recommended treatment must also be certified by a “health practitioner.” There are eight regulated health professions that fall under the definition of “health practitioner” under the SABS. These are: physicians, chiropractors, occupational therapists, nurse practitioners, optometrists, physiotherapists, psychologists, and speech-language pathologists.



Following each reform to the system, this list has grown to the point where most treatment is now being certified by the health professional actually providing the treatment.

The health practitioner designation in the SABS was created in 1993 and originally comprised of five regulated health professions based on the *Regulated Health Professions Act* which designated these professions as “diagnosing professions.” In addition to certifying treatment, health practitioners are also used to certify disability which suggests that the ability to diagnose is significant. When the definition was expanded to include physiotherapists, occupational therapists and nurse practitioners, the original criteria were eventually abandoned.

The original intent of the requirement for certification by an individual with health practitioner status was to facilitate the designation of a health professional that would act as the claimant’s primary practitioner and oversee the claimant’s rehabilitation.

As part of the consultation for this review, both the Ontario Massage Therapist Association and the Ontario Association of Social Workers wrote to FSCO requesting that their members also be included under the definition of “health practitioner.” FSCO also received submissions from registered nurses regarding the expansion of the health practitioner definition.

FSCO expects that there will be additional requests regarding health practitioner status. Legislation was passed in 2006 to expand the number of regulated health professions in Ontario to include kinesiologists, psychotherapists, naturopaths and homeopaths. In addition to these four new professions coming on stream as fully regulated professions in a few years, traditional Chinese medicine practitioners and acupuncturists are in the advanced stages of becoming fully recognized regulated health professions. Expanding health practitioner status within the SABS will further increase complexity and diffuse accountability in the system.

In 7 of the 10 provinces, the legislative framework dictates that physicians only may certify the need for treatment or disability.

What insurers accept in actual practice may be different. In British Columbia, for example, under the public Insurance Corporation of British Columbia, adjusters have the authority to approve treatment and generally pre-approve early chiropractic and physiotherapy treatment without necessarily obtaining direction from a physician. Quebec, on the other hand, requires all treatment to be prescribed by a physician and treatment providers must provide the physician with a progress report.



Saskatchewan and Manitoba are similar to Ontario and grant signing authority for treatment and disability to a wider number of regulated health professionals. However, both Saskatchewan and Manitoba have a single payer system that is structured to provide more complex case management and are able to deal with multiple providers.

This report previously covered the issue of fragmented health care delivery and the lack of accountability under the previous section covering assessments. Another problem associated with our current system is that while the number of health professions included in the definition of “health practitioner” has expanded, very often there is no single health professional actually overseeing a patient’s rehabilitation.

At one time, family physicians were much more involved in managing their patients’ rehabilitation following an auto accident. However, FSCO suspects that the complexity of the system and forms have created a disincentive for physicians to coordinate rehabilitation. As physicians became less involved in the system, rehabilitation became more fragmented. In some cases, legal representatives have been filling the void. This has led to fragmented health care delivery and duplication that is not tolerated in other areas of our health care system. Still, the current fragmented delivery system would be more acceptable if it resulted in better health outcomes.

FSCO believes there should be a single health professional directing a claimant’s rehabilitation, ideally the claimant’s family physician. That professional would be responsible for a claimant’s health care and prescribe treatment or make referrals in the same manner in which family physicians manage the care of all of their patients. The professional coordinating rehabilitation would not be acting as a gatekeeper to services but rather carrying out a triage function by directing claimants to the most appropriate services or service providers. Once that professional prescribes an intervention, the actual provider who treats the claimant would submit a treatment plan directly to an insurer for approval. The “health practitioner” designation would no longer be necessary and a treatment plan would not need to be certified by another professional before being submitted to an insurer. As well, treatment under a Pre-approved Framework Guideline would continue without a physician referral although the family physician would be notified that treatment was being provided.

Following a course of treatment, the claimant would return to the health professional coordinating their care to determine whether further treatment, or some alternate intervention or investigation, is needed. Multiple interventions could still take place but under the direction of a single professional.

FSCO also believes that designating a health professional who is not delivering services to coordinate rehabilitation would eliminate the potential conflict of interest situation inherent in the existing delivery model. As such, the designated



health professional could not be another provider at the facility or clinic where the claimant is receiving treatment.

In most jurisdictions, the family physician is engaged in coordinating treatment and rehabilitation. Family physicians could be better utilized in Ontario's auto insurance system by directing their patients to appropriate health care providers and services. Ontarians without family physicians access medical services from walk-in clinics and other ambulatory care facilities. These facilities could also be utilized by auto insurance claimants.

The increased involvement of physicians is not expected to impact on the doctor shortage in Ontario. Auto insurance claimants with more serious injuries already see their family doctors following an accident. The proposed changes will not significantly increase the number of doctor visits and will benefit claimants by keeping their family doctors better informed on their progress.

Recommendation #21: Consider having treatment plans completed only after a referral is made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician). Treatment plans would continue to be submitted by providers following a referral.

Some consumers have proposed reductions in mandatory accident benefits. Those with access to extended health care benefits have complained that they are forced to purchase accident benefit coverages that is available from other plans. Some consumers could reduce their premiums if some existing mandatory benefits were made optional.

The existing cap on medical and rehabilitation benefits is \$100,000 for auto accident claimants with injuries that are not considered catastrophic. Those with catastrophic injuries can access up to \$1 million in medical and rehabilitation goods and services. In addition, consumers are currently able to purchase \$1 million in optional medical, rehabilitation and attendant care benefits coverage.

A reduced mandatory cap for those with non-catastrophic injuries would provide consumers with more choice and would allow them to customize coverage according to their needs. The insurance industry has proposed that a reduced cap of \$25,000 would adequately meet the needs of many consumers. Consumers that feel they need a higher level of coverage could be provided the option of purchasing \$100,000 in medical and rehabilitation benefits to cover non-catastrophic injuries.

Considering the rate inadequacy that currently exists in Ontario, consumers will appreciate opportunities to reduce coverage that they may not need and avoid possible premium increases. As an alternative, the cap could be reduced to \$50,000 but this would reduce the opportunity for consumers to realize savings. Some auto accident claimants would be eligible for compensation beyond the



\$25,000 by suing an at-fault driver. Those eligible would have to have injuries that exceed the existing “serious and permanent impairment” threshold in the *Insurance Act*.

With the introduction of new optional benefits, insurers, agents and brokers would have to ensure that consumers are made aware of the implications of reducing coverage.

Recommendation #22: Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to \$25,000. Introduce a \$100,000 optional medical and rehabilitation benefit along with the existing \$1 million optional benefit.

Following the implementation of the PAF Guidelines in 2003, it was anticipated that a pre-approved treatment approach with block fees would help stabilize overall treatment costs by providing streamlined access to treatment for whiplash associated disorders which FSCO has been told constitutes the largest group of auto accident injuries. Despite the PAF Guidelines, the costs associated with accident benefits, particularly medical and rehabilitation benefits and assessment costs have continued to rise.

Insurers have suggested that more treatment could be provided under the PAF Guidelines. Health care providers reported that claimants are reluctant to agree to treatment under the PAF Guidelines because the SABS restricts eligibility to income replacement benefits and attendant care for those with WAD I and II injuries. The insurance industry reported that a substantial number of claimants are treated outside of the PAF Guidelines to allow for treatment to address depression or post-traumatic stress. The IBC proposes expanding the PAF Guidelines to accommodate some psychological or social work support. A number of health care stakeholders have indicated that lawyers are advising their clients to refuse treatment under the PAF Guidelines because of the implications on other benefits. They propose that these restrictions be removed. Again, FSCO believes that it is inappropriate for lawyers to be directing treatment.

Insurers and some health care providers also reported that the number of treatment plans submitted after treatment under the PAF Guidelines has been completed is on the rise. Providers suggested that there is insufficient information on why additional treatment is being proposed. They feel that speculation on the reasonableness of this treatment is not productive. FSCO agrees that there are insufficient answers as to why additional treatment is being recommended but cannot agree that a debate on the root causes would be unproductive. FSCO is concerned that while rehabilitation costs are growing, industry data is suggesting that the duration of disability is also growing.

Many stakeholders discussed a recent international study on neck pain. The World Health Organization launched the Bone and Joint Decade in 2000 to



improve health related quality of life for people with musculo-skeletal disorders worldwide. This would be achieved through raising awareness, promoting cost effective prevention and treatment, and advancing the understanding of the disorders. As part of the Bone and Joint Decade, the Neck Pain Task Force (NPTF) was created in 2002 represented by 14 disciplines and 9 countries including Canada. In February 2008, the NPTF published a series of articles summarizing its findings.

FSCO reviewed a number of the articles and is concerned that some commonly held ideas about neck pain and its treatment are out of date. According to the NPTF, the generally held idea that 90% of patients with neck pain recover in six weeks may be overly optimistic. Risk factors for injury are multi-faceted, including personal, societal and collision factors. The NPTF found that neck pain results in recurring periods of absenteeism for high numbers of workers. The evidence does not appear to support extending care beyond six to eight weeks. No evidence demonstrated that a particular course of care improves recovery.

FSCO is concerned that the PAF Guidelines may not be providing the best direction for health care providers. There may be some merit in providing a more extensive continuum of care to ward off chronicity and recurrences. For example, the NPTF concluded that patient education on neck pain that consisted of brochures was less effective than information provided on a DVD. The existing PAF Guidelines provides only a brochure for patient education. The Canadian Society of Chiropractic Evaluators recommended that the authors of the NPTF be engaged to assist in developing a guideline as an educational tool for stakeholders.

The IBC proposed expanding the PAF Guidelines to include other minor injuries as is the case under the Alberta auto insurance treatment protocols for minor injuries. This idea is worth exploring from a number of perspectives. If feasible, it will expand the amount of treatment without requiring insurer prior approval, resulting in a simplified system and reduced transaction costs. As well, if the accident benefit system moves towards designating primary health professionals, it will reduce the need for these designated professionals to manage minor claims and allow them to focus on the most seriously injured.

Recommendation #23: In partnership with key stakeholders, FSCO should contact members of the Neck Pain Task Force to examine the feasibility of expanding the PAF Guidelines to provide a more extensive continuum of care and to include the treatment and assessment of other soft tissue injuries.

5.4 Attendant care benefit

The IBC submission indicated that overutilization of the attendant care benefit is becoming a problem. The submission indicated that the cost per vehicle



increase for attendant care between the first half of 2004 and 2007 was 101%. Data provided by FSCO's statistical agent indicates that between 2004 and 2007 attendant care costs increased by 59.1% with claim severity decreasing by 1.2% and claims frequency increasing by 61.6%. By comparison, for the same time period, the claim frequency for medical benefits saw a 2.0% decrease. The data seems to suggest that the number of claimants who are accessing attendant care benefits is growing substantially. Anecdotal information from the insurance industry suggests that an increasing number of claimants with minor injuries are now claiming and receiving attendant care benefits.

The attendant care benefit was originally introduced to allow seriously injured claimants to live independently in their home by allowing them to purchase the services of an attendant or aide. Conceptually, it was understood that without the services of an attendant, a claimant would likely require institutionalization. However, for those who are unable to live independently in the community, the benefit also pays for care at a long-term care facility. An assessment tool (Form 1) was adapted from the workers' compensation system in 1994 to determine which activities of daily living (feeding, bathing, dressing, etc.) a claimant was incapable of carrying out on their own. This change was recommended in 1993 by the Task Force on Rehabilitation and Long-Term Care, a multi-stakeholder group created by The Honourable Brian Charlton, Minister Responsible for the Automobile Insurance Review.

The Form 1 is also used to determine the quantum of benefits. No disability or functional test was included in the SABS because the Form 1 was successfully screening out claimants with less serious injuries. During the past few years, the number of claimants qualifying for the benefit has grown despite that fact that the assessment tool has largely remained unchanged.

The WSIB assesses every injured worker within their Serious Injury Program for personal care needs using an assessment tool that is almost identical to the Form 1. The assessments are conducted by either an occupational therapist or a nurse on staff at the WSIB who have been trained on how to properly use the assessment tool. The Form 1 can be completed by any regulated health professional and some stakeholders reported that a broad range of professions are conducting attendant care needs assessments. FSCO is concerned that assessments are being conducted by individuals without explicit training in functional assessments to address functional impairment resulting from a combination of physical, cognitive and psychosocial impairments. Consequently, excessive attendant care benefits are being prescribed without objective findings. As well, an improperly completed Form 1 can lead to a series of multiple assessments when entitlement is disputed.



Recommendation #24: Only occupational therapists and nurses who have been trained on the use of Form 1 should be permitted to assess auto accident victims for the attendant care benefit. This should apply to assessments conducted under both sections 24 and 42 of the SABS.

The SABS provides three types of accident benefits: weekly benefits which are intended to compensate for wage loss; death benefits; and expense incurred benefits which cover a broad range of expenditures arising from an auto accident. The attendant care benefit was intended to indemnify claimants for losses as a result of an accident to cover the services of an attendant or aide. The IBC submission cites a number of arbitration decisions that have eroded the concept of indemnity. Insurers are concerned that claimants need only show that they are entitled to the benefit by demonstrating that attendant care was reasonable and necessary.

The concern regarding the indemnity concept speaks partly to concern regarding the credibility of claims where it is neither clear that the claimant has received attendant care services nor that an attendant or aide received compensation. This is particularly the case where a family member is providing the services. This concern does not exist at the WSIB. Injured workers who receive attendant care for more than 24 hours a week are required to register as an employer with the Canada Revenue Agency and the WSIB. As an employer, the injured worker is required to remit employer and employee contributions for Canada Pension and Employment Insurance, income tax deductions for their attendant, WSIB assessments and the Ontario Employer Health Tax. Extra costs associated with registering as an employer including the cost of a bookkeeper are paid for by the WSIB.

Early FSCO arbitration decisions supported the principle that for an expense to have been “incurred” there must have been at least a promise to pay (*Morelli v. Zurich* in 2000; *Jelusic v. Guarantee* in 1999). Arbitration decisions later determined that a promise to pay or an expectation of payment was not required for an expense to be “incurred,” only that the expense was reasonable and necessary (*LF v. State Farm* in 2002). In more recent years, arbitrators required insurers to pay for attendant care benefits where there had been no promise by the claimant to pay, no out-of-pocket expenditure by the claimant and no provision of goods or services to the claimant (*Belair Insurance Co. v. McMichael* in 2005). Arbitrators have based their reasoning on the public policy concern that insurers should be prohibited from benefiting from an insured's lack of financial resources and familial support. While insurers contend that obliging them to pay for the cost of services not rendered amounts to a windfall for the insured, the courts and arbitrators have ruled that permitting insurers to deny repayment except for amounts already paid by claimants would amount to a windfall for insurers especially in the case of impecunious claimants.



FSCO believes there needs to be a balance between maintaining the concept of indemnification and protecting seriously injured claimants where there is a statutory obligation to pay. If the previous recommendation regarding the use of the Form 1 is adopted, insurers should have more confidence of the necessity of attendant care when it is part of an application for accident benefits. There should be fewer instances where the benefit is disputed.

Recommendation #25: The attendant care benefit should continue to compensate claimants for incurred expenses. However, to enhance consumer protection and transparency, the SABS could clarify that where an arbitrator has found that the insurer has been unreasonable in denying the attendant care benefit, payments should be made even if no expenses have been incurred.

Another issue raised in the IBC submission relates to the payment of the attendant care benefit to a claimant's family members and friends. Insurers are concerned that the benefit can become a windfall for the claimant if no actual services are provided. The SABS does not restrict who can provide attendant care to claimants. Under Bill 68, there was no standardized assessment tool used to determine the need for care. The benefit compensated claimants for the cost of professional caregivers or for the wage loss incurred by other individuals (including family members and friends) in caring for the claimant. In 1993, the Task Force on Rehabilitation and Long-Term Care recommended that a "qualified attendant" should include anyone who was capable of providing attendant care services, including family members. Bill 164 dropped the requirement for a "professional caregiver" and the need for non-professionals to incur wage loss in order to qualify for compensation. The IBC's solution is to restrict payments to family members only where it can be shown that an economic loss has been incurred.

FSCO recognizes that families play a vital role in providing care for seriously injured accident victims. Only in exceptional circumstances are professional caregivers required but in these situations the expenses may fall under the medical and rehabilitation benefits. The circumstances under which family members provide care can vary. For example, family members may be used to supplement the care provided by a full-time caregiver, especially where 24-hour care is needed. In such cases, there may be no actual wage loss incurred by the family member. The issue is not so much who is providing the care but whether care is actually required. FSCO believes that proper use of the Form 1 to screen claims is the most effective approach to ensuring that the benefit is paid to those who truly need the care. Introducing additional disability or functional eligibility tests or requiring caregivers to demonstrate economic loss would add more complexity to the system.



5.5 Health care provider fees

Health care fee schedules were first introduced as part of the implementation of Bill 59. As part of these reforms, the government requested that the auto insurance industry and health professional associations negotiate fee schedules and utilization guidelines in order to further stabilize costs and reduce disputes in the automobile insurance system.

Fee schedules were seen as a key element in the government's overall efforts to stabilize costs and premiums. The commitment to develop fee schedules was a result of concerns raised during public hearings in February 1996 that the draft auto insurance legislation did not include controls on escalating health care costs.

In October 1997, the IBC reached an agreement on fees and utilization guidelines with the Ontario Physiotherapy Association. This was followed by agreements with the Ontario Podiatric Medical Association in March 1998 and the Ontario Society of Occupational Therapists in April 1998. Negotiations between the IBC and other health professional associations stalled in 1998. Additional agreements were reached in 2001 with psychologists, speech-language pathologists and audiologists with the assistance of a facilitator.

On August 28, 2003, the Minister of Finance issued a Policy Statement directing FSCO to review health care fees in order to generate significant savings to automobile insurance rates while maintaining availability of services. Following that review, FSCO reduced fees to bring them in line with other jurisdictions and payers. At the time, FSCO committed to monitoring the impact of these fees on the availability of service, billing and utilization patterns, and total expenditures.

A revised fee schedule became effective on November 1, 2003, and annual increases have been made to the fees each July 1, beginning in 2005. In addition, a second tier of fees was introduced in 2004 which applied to treatment provided to claimants with catastrophic impairments.

FSCO receives a number of letters from the health professional associations each year requesting that either the fee schedule be eliminated or fees be increased substantially. However, the issue received very little comment in submissions received by FSCO. Several consumers complained that massage therapists were extra-billing. On a rare occasion, a consumer has contacted FSCO regarding the availability of speech-language pathologists.

The reduced fees introduced in 2003 were intended to bring fees in the auto insurance system in line with the fees paid by the WSIB. At the time, comparisons were difficult to make because the WSIB paid most providers on a per visit basis rather than an hourly rate basis as is the case in the auto insurance system. Earlier in 2008, the WSIB updated their health care fees,



converting more of their fees to an hourly rate, thus making it easier to compare fees in the two systems. It appears that fees in the auto insurance system are on par or higher than those paid by the WSIB.

Over 20,000 health care providers enrolled in HCAI before the system was suspended earlier this year. Considering that there are just over 60,000 bodily injury claims each year, there does not appear to be a shortage of providers practicing in the auto insurance sector. FSCO suspects that many of these providers are working in the sector because of the high demand for assessors. It is likely that a high proportion of providers are only working part-time in the sector. A survey conducted by the Coalition Representing Health Professionals in Automobile Reforms indicated that 29.5% of respondents reported that auto accident claimants represent less than 10% of their caseload. For chiropractors, more than 50% reported that auto accident claimants represent less than 10% of their caseload.

Chiropractors, physiotherapists and massage therapists collectively make up 44% of providers signed up on HCAI. This also represents approximately 50% of registered chiropractors, physiotherapists and massage therapists in Ontario. This would suggest an adequate number of providers available to treat soft tissue and other minor injuries in the auto insurance sector.

A number of submissions have suggested that experienced providers have been exiting the auto insurance system since fees were rolled back five years ago, leaving the system with a greater proportion of inexperienced providers. The Ontario Association of Speech-Language Pathologists and Audiologists reports that there are approximately 2,500 speech-language pathologists in Ontario but only 10% work in the private sector. The Association also reports that 28% of speech-language pathologists that responded to a survey indicated that they are taking on fewer auto insurance clients as compared to two years ago. The HCAI registration information indicates that only 161 speech-language pathologists signed up on HCAI. Unfortunately, FSCO did not have access to more detailed information regarding health care provider manpower in the sector.

Recommendation #26: FSCO needs to continue to monitor fees and the availability of services in the auto insurance sector, in particular for seriously injured claimants.

5.6 Other accident benefits

Stakeholder comments on the other accident benefits fell into two groups: accident benefits are viewed as inadequate; and accident benefits are viewed as overly generous.

FSCO received several consumer submissions regarding the income replacement benefit cap and it was suggested that the maximum benefit be



increased. The current maximum of \$400 has been in place since 1996. At the time it was estimated that between 41% and 57% of full time earners (depending on a person's exemptions) and between 61% and 70% of all earners (full time and part time) would fall below the benefit maximum, based on 1995 tax data. Using 2007 tax data, between 35% and 42% of full time earners and between 49% and 55% of all earners now fall below the \$400 benefit maximum. To bring coverage back to 1996 levels, the maximum would have to be increased to \$500 per week.

Stakeholders also commented on the adequacy of payments for transportation expenses incurred to and from treatment, rehabilitation and counselling sessions or assessments. Consumers complained that reimbursement for travel in personal vehicles is payable only after the first 50 kilometres per round trip, except for those with catastrophic impairments.

Eligibility for reimbursement is set out in a Superintendent's Guideline first published in November 1996 and subsequently amended in March 2001, March 2004 and January 2006. The reimbursement rate for using one's own personal vehicle is currently 34¢/kilometre. For the January 2006 mileage rate increase, FSCO referred to the kilometre reimbursement rates for personal vehicle use under Province of Ontario Travel, Meal and Hospitality Directive for Management and Excluded Staff. Though no formal review process exists, in light of ongoing volatility in gas prices, a more regular review should take place, perhaps annually, coinciding with the review of health care provider fees.

Recommendation #27: Increase the maximum income replacement benefit to \$500 per week.

Recommendation #28: Conduct annual review of reimbursement rate for travel in a personal vehicle.

The IBC submission indicated that utilization of housekeeping and home maintenance expenses has also been increasing at a significant rate (in particular for claimants with minor injuries) and is contributing to rising claim costs. The IBC proposed limiting entitlement to two weeks for those with the least serious injuries. The IBC also recommended that the benefit not be payable to family members where no economic loss had been incurred. Other industry submissions proposed excluding claimants with minor injuries from claiming these expenses. The feedback from the insurance industry suggests that many claimants are routinely claiming the benefit in order to be able to collect an additional \$100 per week in compensation although no outside service is purchased. In its submission, one insurer indicated that the company can receive claims for housekeeping expenses from three or more individuals within a household.



The complaints from the industry are analogous to their concerns regarding the attendant care benefit – that payments are being made although it appears that expenses are not always being incurred. Even though the benefit payments are small, if every claimant automatically claims the benefit, it will significantly increase the average cost of an auto insurance claim. In addition, the cost of challenging questionable claims makes it impractical to dispute claims for housekeeping expenses. The provision as it exists appears to entitle most claimants to the benefit. In addition, Ontario appears to be one of only four Canadian jurisdictions (the others are British Columbia, Quebec and Manitoba) that provides this type of benefit.

The industry is reporting a similar situation with respect to the caregiver benefit. The benefit is designed to compensate primary caregivers who are impaired and unable to care for children and disabled adults living with them. This benefit is also intended to compensate claimants for incurred expenses. Insurers report that a high proportion of payments are made to other family members and not to outside caregivers (although numbers were not provided). The industry has experienced a significant increase in caregiver benefit claims over the past three years. The IBC submission indicates that between the first half of 2004 and 2007, the cost per vehicle increase for the caregiver benefit was 146%. In that period, the number of claimants receiving the benefit nearly doubled.

FSCO is concerned about the growing cost of the benefit. The SABS does not restrict who the claimant may use to provide care for dependants while they are disabled. However, rising costs appear to suggest that access to the caregiver benefit has become so wide-spread that payments may no longer be indemnifying claimants for actual losses. Research of the situation in other jurisdictions showed that five provinces do not provide accident benefit compensation to caregivers.

One approach to address rising costs and utilization is to provide consumers with more choice by converting a number of mandatory benefits to optional benefits. This would provide consumers with the ability to customize coverage according to their needs.

Recommendation #29: Make housekeeping and home maintenance expenses and caregiver benefits optional. Reimbursement for housekeeping and home maintenance expenses and for replacement caregivers needs to reflect actual economic losses.

5.7 Interaction of the SABS with Workplace Safety and Insurance Act

Section 59 of the SABS excludes accident victims from claiming accident benefits if they are entitled to receive workers' compensation benefits. There is an exception where the injured worker can make an election under section 30 of the *Workplace Safety and Insurance Act* (WSIA) to bring an action. The election to



bring an action cannot primarily be to claim benefits under the SABS. No benefits are payable by an auto insurer during the period before the person makes the election. If there is a dispute over whether the person can claim benefits under the SABS, the person must assign any workers' compensation benefits that become payable to the auto insurer.

Insurer representatives report that although it is presumed that some level of harmony exists between the operation of the SABS and WSIA, this is not always the case. In practice, issues arise because of the sometimes unclear and conflicting jurisdictions of judges and arbitrators in determining issues related to the Workplace Safety and Insurance Appeals Tribunal (WSIAT), such as the question of election between civil action and WSIA, the standing of auto insurers to come before the Tribunal, collecting payments made by WSIB, and the different standards of payments made between the SABS and WSIA.

The WSIAT has exclusive jurisdiction to determine whether WSIB benefits are available to an insured and whether section 28 of the WSIA eliminates the right to sue. There is often considerable delay in determining whether the SABS apply. There is a disincentive for auto insurers to make interim accident benefit payments due to the cost of pursuing a reimbursement from WSIB and uncertainty of recovery.

Stakeholders have asked that the government look at ways to ensure that the two systems operate in a complementary fashion so that accident victims are not stranded between the two.

Recommendation #30: FSCO, WSIB and auto insurers should meet to discuss how to better harmonize the auto insurance and workplace insurance systems.

6. Tort

The development of no-fault auto insurance in Ontario has always included an attempt to find the proper balance between access to tort and first party benefits. Section 2 of this report describes how the tort provisions have evolved in Ontario since 1990. No single aspect of the system stirs more passion in people than the right to sue an at-fault party in an accident.

Consumers generally want to be able to sue a negligent driver but also want to be able to access generous no-fault benefits while their lawsuit works its way through the system. However, a system that offers both a high degree of access to the courts and generous accident benefits would be unaffordable. Both the courts and statutory accident benefits compensate accident victims for bodily injuries but in very different ways. Consequently, the government has always



had to make some difficult choices regarding these two competing systems and the price of auto insurance.

Court awards are not subject to the same types of complex cost control mechanisms that exist in no-fault, such as eligibility criteria or payment limits. The main tool in controlling third party liability costs is by limiting the number of individuals who are able to sue. In Ontario, not-at-fault victims are subject to a verbal threshold and monetary deductibles should they choose to sue an at-fault party. Both the verbal threshold and monetary deductibles are intended to restrict individuals with minor injuries from suing. This is the trade-off for having access to a comprehensive accident benefits system that remains affordable.

The 2003 reforms under Bill 198 made a number of significant changes to tort access. The threshold for suing for excess health care expenses (those expenses not covered by the SABS and collateral sources) was changed from catastrophic impairment to the serious and permanent impairment verbal threshold that applied to non-pecuniary loss damage suits. This change expanded access to the courts. However, other changes reduced access. The deductible that applied to non-pecuniary loss awards was increased to \$30,000 (\$15,000 for FLA claims). However, awards over \$100,000 (and over \$50,000 for FLA claims) were exempt from the deductibles.

A third change involved the inclusion of a definition for serious and permanent impairment in Ontario Regulation 461/96 which is intended to assist the courts as well as insurers and injured persons in settling claims by providing more certainty on what injuries exceed the verbal threshold.

6.1 Verbal threshold

For persons injured in auto accidents through no fault of their own to be able to sue for non-pecuniary damages (pain and suffering), their injuries must exceed a certain level, or “verbal threshold” defined in the *Insurance Act* as: “death, a permanent serious disfigurement, or a permanent serious impairment of an important physical, mental or psychological function.” In Canada, due to a cap set by a trilogy of court cases, non-pecuniary damage awards do not exceed roughly \$325,000.

In addition, the same verbal threshold is applied to health care expenses. The *Insurance Act* limits not-at-fault parties from suing for health care expenses unless the injured person dies, sustains a permanent serious disfigurement, or sustains a permanent serious impairment of an important physical, mental or psychological function.

Regulation 461/96 sets out: a detailed definition of the criteria for impairment hinging on a test of substantial interference; detailed criteria for determining when a function that is impaired may be considered an important function; and further



detailed criteria for assessing whether the impairment is permanent. Section 4.3(1) then sets out the medical evidentiary requirements that must be met to support a claim of permanent serious impairment.

Justice Coulter Osborne, as part of the Civil Justice Reform Project report, recently commented on the verbal threshold. He noted that when the threshold is an issue, and where the trial is by jury, the trial judge typically will deal with the threshold issue after the jury charge and while the jury is deliberating (because of the statutory requirement that the jury is to determine the amount of damages but only the judge may determine whether the verbal threshold has been met). If the trial judge concludes that the plaintiff has not met the threshold, the plaintiff has no right to sue. Justice Osborne has noted that making a determination on whether a plaintiff has met the threshold involves considerable transaction costs because both parties must submit costly medical-legal reports. He questioned whether the verbal threshold actually screened out any minor injuries not already excluded by a \$30,000 deductible.

The trial lawyers suggested that the definition in the Regulation discriminates against those outside the workforce: children, the elderly, homemakers and the disabled. They suggested that the test for those outside the workforce is more onerous than for those who are employed. These plaintiffs must prove they cannot carry out most of their usual activities. Submissions from senior and student groups have also suggested that the definition is discriminatory. Consumers and trial lawyers would like to see the Regulation revoked and the verbal threshold eliminated.

FSCO has not been able to confirm the suggestion that the Regulation discriminates against certain groups. Although the Regulation amendment is almost five years old, there have been only two court decisions dealing with the defining Regulation and those decisions have not been definitive or effected any significant change to interpretations predating the Regulation. Therefore revoking the defining Regulation is not expected to have an impact on who meets the threshold or on costs to the system. The system would simply revert to interpretations that existed prior to 2003. Revoking the Regulation would also be consistent with efforts to reduce complexity and regulatory requirements on the public.

FSCO determined that there was no available data that could be relied on to assess the impact of completely eliminating the verbal threshold. It has been suggested that eliminating the verbal threshold would not have a cost impact on the auto insurance system. FSCO reviewed the issue with insurance industry actuaries who were of the view that the verbal threshold was screening out a significant number of cases and that without it costs would rise considerably. Further, a reduction in the deductibles along with the elimination of the verbal threshold would result in more dramatic cost increases. FSCO suggests that a



closed claim study would assist in making more informed decisions regarding the verbal threshold.

6.2 Deductibles

There are currently two deductibles that apply to tort awards in Ontario. Awards for pain and suffering are subject to a \$30,000 deductible and awards for loss of care, guidance and companionship under the *Family Law Act* (FLA) are subject to a \$15,000 deductible. The deductibles do not apply if the pain and suffering damage award is \$100,000 or more or if the FLA award is \$50,000 or more.

Over the past five years a significant number of consumers have expressed their unhappiness with the deductible levels. A similar perspective was shared by consumers who provided submissions to FSCO as part of this review. Consumers indicated that too many innocent accident victims are denied access to the courts as a result of the deductibles. In addition, for those that are able to sue for pain and suffering damages, the reduction in their awards was unfair. It is clear that many consumers do not feel the current deductible levels are fair.

The trial lawyers have requested that the deductibles be returned to their 2003 levels - \$15,000 for pain and suffering damage awards and \$7,500 for FLA awards. In addition, they have recommended that the deductible be eliminated for fatality claims under the FLA. The Advocates' Society made similar recommendations as well as suggesting the elimination of the provision that has the deductibles not apply if the pain and suffering damage award is \$100,000 or more or if the FLA award is \$50,000 or more.

Justice Osborne also commented on the deductibles and indicated that he accepted that they had a role in keeping automobile premiums under control, which is a substantial public and government interest. As such, he felt it was up to the government to determine appropriate deductible levels. Bodily injury loss costs clearly fell following the 2003 reforms as fewer injured persons have been able to sue. A corresponding bump would be expected if the deductibles were reduced. It is also likely that reducing the deductibles to the pre-2003 levels would allow more individuals to sue than were able to when the deductible amounts were first introduced in 1996. Considering inflation, \$15,000 in 1996 is approximately equal to \$20,000 in 2008.

FSCO accepts the argument made by consumers and other stakeholders that there is desire for better access to the courts. However, it may be more appropriate to consider the impact of inflation rather than return to the 1996 levels. This is consistent with how the courts have been treating the cap on pain and suffering damages that was created by a trilogy of Supreme Court decisions some 30 years ago.



6.3 Other proposed tort reforms

The insurance industry also proposed a number of reforms that would further reduce the cost of bodily injury tort claims. Their proposal includes:

- Exclude recovery of punitive damage awards from insurers under auto insurance policies.
- Disallow recovery in tort for health care provider extra-billing and dispute resolution costs for accident benefit claims.
- Change the “joint and several liability” standard for motor vehicle collisions.
- Provide the government with regulatory authority to negate the precedent-setting effect of court decisions that can increase costs in the system.

Recommendation #31: The government should consider reducing the deductibles to \$20,000 and \$10,000, eliminating the deductibles for fatal claims, and revoking the definition of serious and permanent impairment set out in Regulation 461/96. A closed claim study would assist in determining the impact of further tort changes being considered.

7. Dispute Resolution at FSCO

Only a small number of submissions received commented on the dispute resolution process at FSCO. The insurance industry commented that the system has become expensive, slow and that processes duplicate each other. Only a small proportion of cases in the arbitration process deal with actual entitlement decisions, and most of those cases are about matters other than benefits (e.g., procedure, expenses, and assessments). Procedural issues are dominating the system and thus adding unnecessary costs. The IBC would like to ensure that arbitration decisions are not capable of creating legal precedent and would like to remove the authority of FSCO arbitrators to make special awards. They also proposed that appeals from a decision of a FSCO arbitrator be made directly to the courts, which would affirm or reverse the decision on grounds of correctness as to law, or unreasonableness as to facts. It is suggested that bringing appeals to the courts would merge together the two dispute streams, effectively creating only one body of law to know and apply.

The trial lawyers suggested that mediation and pre-arbitration hearings be combined – that when a party files for mediation, they should be able to elect to proceed directly to arbitration should the mediation fail. Following a failed mediation, parties should be prepared to set an arbitration date, exchange production requests and deal with any other issues related to the arbitration. Trial lawyers see these changes as reducing costs and avoiding the repetitive process of mediation followed by arbitration. Mediators should have the ability to schedule an additional hearing for more complicated disputes. A simplified



summary procedure should be introduced for disputes involving smaller monetary amounts. FSCO's Dispute Resolution Services (DRS) Branch has undergone a number of operational reviews over the past few years and has been implementing changes as part of the DRS Excellence Project. The Project's objective is to facilitate continuous improvement in the delivery of dispute resolution services.

7.1 Payment for expert reports

Ontario Regulation 664 includes a schedule of dispute resolution expenses and provides that the amount of expenses paid by or on behalf of the insured person or the insurer to an expert for the preparation of a report may be awarded, to a maximum of \$1,500. This amount has not changed since 1996.

Accounting reports are often used by self employed claimants to substantiate quantum of a weekly benefit. There is wide agreement among both representatives for insurers and claimants that the \$1,500 expense award is insufficient for accounting reports and is not recoverable elsewhere in the accident benefit system.

There is also general consensus that certain other expert reports, such as engineering, neuropsychological and psychiatric reports, cost much more than the current maximum set under the Regulation, although they are used less frequently in proceedings and, in the case of medical reports, may be recoverable through the tort claims process.

Insurer representatives argue that while the \$1,500 maximum under Regulation 664 may not reflect the actual cost of all reports by neuropsychologists, psychiatrists and other medical experts, those costs are payable by the insurer pursuant to subsection 24(1) of the SABS. And, while the *Professional Services Guideline* establishes maximum hourly rates for services of listed health care professions including the provision of reports, the Guideline does not apply to services of physicians.

Insurer representatives suggest that reports should not be generated outside of the section 24 process, where they must be connected to a benefit claimed. They also submit that reports should not be prepared after the arbitration process has commenced since there is no opportunity for the insurer to commission a similar report and arbitration proceedings deal with disputed claims and not future needs. As well, when a report made as part of an assessment is not approved or remains unpaid by the insurer, the issue of payment for the report becomes a dispute around a benefit and forms part of the benefits claimed at arbitration, not part of the arbitration expenses.



Another route by which claimants may generate reports payable by the insurer is by the use of rebuttal reports. The SABS establishes caps of between \$450 and \$900 for these reports.

Claimant representatives tend to not make full use of the section 24 and 42.1(8) provisions due to a lack of familiarity with the provisions or because of a litigation orientation. They state that while expert reports may be paid by insurers under these sections of the SABS, many reasonably required reports fall outside these sections. Claimant representatives point to the need for updated medical reports where they have been retained after a dispute has been ongoing, in order to fully understand the claimant's medical status, identify any new problems, and support claims for benefits.

Claimants' representatives state that there is little competition in the expert report marketplace where reports from orthopaedic surgeons, the experts used most often at arbitration, generally cost between \$2,000 and \$3,000 or more. They state that due to the limit on the awards for expert report expenses, claimants must absorb much of the costs. Further, some claimants may be dissuaded from entering the FSCO arbitration system in favour of the court system where these expenses may be recovered. According to Tariff A under the *Courts of Justice Act* a "reasonable amount" may be recovered as a disbursement for expert reports that are reasonably necessary for the conduct of the proceeding.

Claimant representatives indicate that the existence of a tort action along with the accident benefit claim does not make it more likely that the report will be paid since its purpose may be identified as supporting the accident benefit claim but not the tort claim.

Recommendation #32: Amend the SABS to provide for an appropriate cap on the cost of accounting reports to substantiate a claim for weekly benefits.

7.2 Future care cost reports

Future care cost reports assess and summarize a claimant's need for medical and rehabilitation benefits into the future. They cover more than just the attendant care benefits that are determined using the Form 1.

Claimants often ask for the reports to be paid for as an expense under section 24 of the SABS. Insurers may dispute this claim since it is based on care that has not yet been provided, and therefore is not an incurred expense. Future care cost reports generally cost between \$6,000 and \$10,000.

At one time, the reports were produced for severely injured claimants, but have become very widespread over the last three to five years. Claimant



representatives began to use the reports to ensure they are protected from negligence claims based on improvident settlements.

The use of these reports will likely change again since the release of the decision in *Monks v. ING* earlier this year. In the *Monks* decision, the Court of Appeal granted declaratory relief for future, not yet incurred, medical and rehabilitation expenses outlined in a future care cost report. The court stated that the claimant would have to submit the expenses to the insurer in order to receive payment but agreed in advance that they were reasonable and necessary and related to the accident. In the past, insurers handling accident benefit files could decide not to settle claims for future medical and rehabilitation expenses which often was a better decision financially. Following *Monks*, there may be a change in insurer practices.

Insurers have indicated that future care cost reports include not only attendant care, but also 24-hour supervisory services and future housing needs that are well beyond the community standards applied by the Community Care Access Centre (CCAC) system operated by the Ministry of Health and Long-Term Care.

The insurance industry has expressed considerable concern regarding the *Monks* case and predicts significant cost pressures if no action is taken. The industry has proposed a number of changes to address this issue. They would like to see FSCO develop a guideline governing development of future care cost reports for the accident benefit and tort compensation streams that are based on the community standards established by the CCAC system. Insurers should be permitted to deny payment under the SABS for claimant-initiated future care cost reports that do not follow the FSCO guideline. The industry would also like to have a legislative rule introduced that prohibits declaratory relief for future medical rehabilitation and attendant care based on a future care cost report introduced at trial.

FSCO understands that these reports have been in use for quite some time and in some instances are a legitimate tool used to settle claims. There appears to be some overlap between accident benefit claims and tort claims. However, it is FSCO's view that these reports are not covered by the SABS and should not be covered by the SABS. Future care cost reports are not requested by health care providers to access benefits. Rather, they are requested by lawyers as part of the settlement process. FSCO believes that regulating their use would also add further complexity to the system.

Recommendation #33: The cost of future care cost reports should not be an expense recoverable under the SABS.



8. Other issues

8.1 Collateral benefits

In Ontario much as in other Canadian jurisdictions, auto insurance is a second payer to other insurance programs and plans. Auto insurance as a second payer has existed to reduce the cost of insurance for consumers. The insurance industry has been concerned that their second payer status has been eroded over the years by extended health care carriers and is resulting in difficulty in collecting future benefits from other insurance in tort. Insurers have also noted that the interface between disability carriers and accident benefit insurers is also problematic. Some consumers have complained that they are forced to purchase accident benefit coverage for losses that are covered by other plans, while other consumers have complained that they are required to use up limited coverage available under extended health care plans which leaves them without benefits for non-auto related injuries and illnesses.

FSCO notes that auto insurers have raised the issue of extended health care carriers excluding coverage for auto accidents for quite a number of years. However, FSCO has been provided with no data that would assist in evaluating the extent of the problem. In addition, FSCO has concerns about prohibiting extended health care carriers from excluding or limiting coverage for auto accident injuries and how such a provision could be enforced.

FSCO acknowledges that there may be a need to examine the language of the SABS to determine whether and how to address lump sum payments by disability carriers.

FSCO also agrees that double recovery for income loss should not occur but notes that the SABS and the *Insurance Act* already include numerous provisions prohibiting double recovery. Consideration could be given in investigating options for enabling auto insurers to enforce these provisions more effectively.

FSCO also notes that attempts in the past to resolve differences in payment schemes between auto insurers and health and disability carriers in tort cases have not been successful. The idea raised by the IBC to introduce mandatory commutations is not new. The IBC has asked that a process be put in place to place a value on the non-auto insurance benefits which would then limit their liability. This could potentially place the plaintiff in a difficult situation if the valuation turns out to be incorrect. There would likely be no mechanism to go back to the auto insurer to make up the difference.

The issue of considering access to collateral benefits when purchasing auto insurance has also been raised on numerous occasions in the past. FSCO's view is that providing some consumers with premium reductions if they have access to collateral benefits would add considerable complexity to the system.



Insurers and brokers would likely need to confirm that coverage actually exists. Should consumers lose their collateral benefit coverage due to job change or job loss, they would not have adequate accident benefit coverage (which is mandatory) if they failed to purchase additional coverage. As well, any cost savings realized by those with collateral benefits would be offset by premium increases for those consumers who have no collateral benefits. This proposal would not reduce the cost of insurance. It would only shift some of the costs from one group of drivers to another.

Finally, FSCO has also previously heard from health care providers regarding the difficulty encountered in coordinating extended health care benefits. Health care providers have suggested that auto insurers be responsible for the coordination of benefits. FSCO has looked at other jurisdictions as well as consumers with access to multiple extended health care plans. Only in the Ontario auto insurance system are health care providers coordinating different benefit plans. In all other situations that FSCO reviewed, consumers are typically coordinating their own benefits. It is the view of FSCO that health care providers who do not wish to take on the additional administrative responsibility should be returning the function back to their patients.

Recommendation #34: Investigate options for enabling auto insurers to more effectively enforce the existing provisions in the SABS and the *Insurance Act* that require deductions of all collateral sources of income benefits.

8.2 Seriously injured claimants

Several stakeholder groups have commented on the difficulty insurance adjusters have in managing claims involving serious injuries. It has been suggested that there are adjusters who are not sufficiently trained or experienced in dealing with seriously injured claimants which can lead to unnecessary assessments, high rates of benefit denials and delays in accessing benefits. The IBC noted in their submission that the insurance community is unable to engage and retain adequate numbers of personnel who are qualified and interested in handling accident benefit claims. Specialized training is necessary and that training is not easily transferred to other insurance claims opportunities. FSCO is also concerned that treatment providers and assessors may also be involved with complex and serious cases without an adequate combination of training and experience.

FSCO looked at the way the WSIB structures its claims adjudication functions to address seriously injured workers. The WSIB operates a unit referred to as a Serious Injury Program that is responsible for arranging for specialized treatment, equipment and services to seriously injured workers. This group of clientele is analogous to auto accident claimants with catastrophic impairments. Each injured worker is assigned a team from the Serious Injury Program that meet to



discuss each case and develop solutions for each individual injured worker. The team consists of a nurse case manager, a claims adjudicator and an occupational therapist. Adjudicators in the unit have a minimum of five years experience and many have over twenty years experience. There is no specialized training for new adjudicators in the unit but they work with a mentor for a period of time and participate in a program of continuing education in order to expand their knowledge on their client base.

FSCO realizes that individual insurers do not have the capacity to provide the same level of service as the WSIB. In addition, claimants in the auto insurance sector often have lawyers involved in both their accident benefits and tort claims. However, many stakeholders agree that claimants with minor injuries are provided with much better access to benefits than those with serious injuries. FSCO believes that insurers can be more proactive in delivering services. They need to better develop expertise in handling these claims and concentrating that expertise in special units. Caseloads need to be reduced to properly manage these claims and reduce turnover. Some of the recommendations contained in this report may reduce the focus on minor injuries to facilitate better claims management on catastrophic claims.

Recommendation #35: Insurance claims departments need to better focus on the needs of claimants with serious injuries. The IBC, Insurance Institute of Ontario and the Ontario Insurance Adjusters Association should work together to train adjusters on the needs of claimants with serious injuries to reduce exposure to potential allegations of unfair and deceptive acts or practices.

8.3 Public education

Consumers, health care providers and insurers lack information about which treatments are most effective for minor injuries – including, sometimes, no treatment at all. Education is needed around the appropriate timing of interventions and duration. Participants in the auto insurance system need to know more about expected outcomes following a minor injury. Most of all, consumers need to be empowered with knowledge about treatment, rehabilitation and the risks from being over treated.

As well, improvements are needed in order to ensure that new research findings are disseminated and implemented. Publication of the research on its own is insufficient. Engagement of health care providers and insurers is critical for the successful dissemination of this information. Social marketing that seeks to influence social behaviours to benefit the target audience and the general society may also be utilized to raise awareness around appropriate treatment and change expectations about outcomes for the most common auto accident injuries.



Many stakeholders also commented on the fact that the auto insurance system is too difficult to understand and that system users need more education. This difficulty is felt by accident victims who may have never encountered the system before, as well as by health care providers, insurers and legal representatives who may be regular users of the system.

Part of the problem stems from the complexity of the system – confusing regulations, numerous time limits, long and detailed forms, etc. Simply put, it is very difficult to understand the auto insurance system as it stands. The insurance industry, health care providers and legal associations regularly organize training and update sessions. Consumers and stakeholders can also access information available from FSCO's website, Contact Centre and written brochures. In submissions from stakeholders, it was suggested that additional sessions be organized by FSCO to facilitate discussion and knowledge exchange among user groups. Issues around complexity may be remedied through recommendations suggested earlier in this report.

Recommendation #36: Consumers, health care providers and insurers should work together to improve consumers' awareness and expectations around treatment and outcomes. Some of the savings from changes in the Accident Benefits system should be used to fund these educational efforts.

8.4 Public transit authorities

FSCO received submissions from eight municipalities and municipal transit authorities regarding their experience with the Ontario auto insurance system. Many of the issues they raise are similar to those raised by insurers, including rapidly increasing utilization of assessments and attendant care benefits. The Toronto Transit Commission (TTC) reports a 62.5% increase in accident benefit payments between 2004 and 2007. During the same period, Mississauga Transit reported an increase in accident benefit payments of 133.3%. York Region Transit reported their accident benefit costs rose from \$56 million in 2004 to \$558 million in 2006.

Erratum: The previous sentence should read: "York Region Transit reported their accident benefit costs rose from \$56,000 in 2004 to \$658,000 in 2006."

There are a number of factors contributing to the rising costs experienced by public transit authorities. A high proportion of transit riders do not own their own vehicles and are not covered by another auto insurance policy. Therefore, accident benefits payable as a result of any injury sustained on a transit vehicle are the responsibility of the transit authority's auto insurer. However, a limited ability to investigate claims is suggested to be driving costs up. The SABS requires quick access to accident benefits. Injuries are often not reported at the time of the incident but days or weeks later, and without the driver having any knowledge of the incident. The transit authorities must accept these claims in good faith because it is often impossible to even verify whether the claimant was a passenger of the vehicle. One transit authority reported that 73% of claims do not involve an actual collision. These claims are for injuries resulting



from bumps and falls while entering and leaving vehicles, standing in aisles and getting in and out of seats.

The public transit authorities have requested that they be exempt from the no-fault scheme and instead fall under a pure tort scheme. They propose that the authorities also be exempt from the benefit of the verbal threshold and the tort deductible which would allow all claims against them to be handled in the courts as tort claims. FSCO has concerns that this proposal would create two classes of accident victims in Ontario. For example, a pedestrian hit by a car would have access to no-fault benefits. However, those injured while travelling on a transit bus would not have access to no-fault benefits but would have to initiate a lawsuit to recover any losses. To be successful in such a lawsuit, it would be necessary for the victim to prove negligence by the transit authority or its vehicle operator.

FSCO notes that the anomaly created by this would be in addition to those that already exist with public transit authorities. Buses and streetcars are deemed to be motor vehicles under the *Compulsory Automobile Insurance Act* and fall under Ontario's auto insurance regime. However, the subway and LRT systems operated by the TTC fall outside the auto insurance system. The TTC is therefore liable for injuries sustained by subway and LRT passengers only to the extent the TTC is determined to be negligent. So, a TTC patron injured by a streetcar door is entitled to accident benefits regardless of fault but if that same person is injured by a subway door they receive nothing unless they are able to prove negligence by the TTC.

In some U.S. jurisdictions, transit systems are considered "common carriers" and regulated by a federal regulatory body. Consequently, their governing legislation sometimes expressly exempts them from state auto insurance schemes.

FSCO agrees that public transit services operated by municipal authorities should be provided with additional protections that reflect their unique status. Injuries sustained on public transit vehicles involving collisions should continue to be covered under the auto insurance legislation. However, all other injuries should fall under a general liability insurance policy.

Recommendation #37: The government should consider legislative amendments to reflect the unique status of public transit services operated by municipal authorities by excluding injuries from no-fault where no collision has occurred.

8.5 Electronic commerce

Several insurers raised the issue of electronic commerce. Specifically, they have proposed amendments to the *Insurance Act* in order to facilitate greater flexibility in incorporating electronic technologies for consumer-provider communication and transactions.



According to insurers, the current paper-based system is expensive, inefficient, wasteful and is not reflective of the increased familiarity of industry and consumers with electronic technologies (telephone and Internet). Updating legislation and regulations so that transactions regarding applications, policies, endorsements and renewals could be conducted electronically would provide greater expediency and satisfaction in the auto insurance market.

A U.S. study by J.D. Power and Associates found that in 2008, sales transactions processed entirely on the Internet now account for 21% of all new customer insurance sales. A 2008 comScore study of online auto insurance purchases shows that the number of quotes requested online increased by 15% and the number of auto insurance policies purchased online increased by 37% from 2006 to 2007. Consumers requested more than 100 million auto insurance rate quotes between 2004 and 2007, according to the study. Celent estimates that nearly 30% of auto insurance sales will take place online by 2011.

FSCO acknowledges that electronic transactions are welcomed by a significant proportion of consumers. Electronic commerce has the potential to reduce costs and paper. As a regulator, the primary concern regarding electronic commerce is the production of fraudulent liability cards. However, FSCO acknowledges that fraudulent paper liability cards currently exist and that technological solutions may exist to address these concerns.

Based on the submissions received, it appears that not all industry stakeholders are aware that Ontario's *Electronic Commerce Act, 2000*, already enables auto insurers and others doing business in Ontario to implement electronic document delivery and electronic counterparts to traditional written documents and written signatures, provided certain functional equivalency rules are followed. At least one Ontario insurer has, in reliance on these enabling provisions, already implemented an option that enables its customers to make formal applications for auto insurance online, and to receive their insurance policy documentation in electronic form by email rather than in paper form by regular mail. No amendments to the *Insurance Act* or its Regulations were required to achieve this result.

FSCO would also like to point out that there is a joint program between the Ontario Ministry of Transportation and the insurance industry called the Uninsured Vehicles Project. The project is aimed at reducing fraud, improving road safety and contributing to fair insurance rates by reducing the number of uninsured vehicles on Ontario's roads. When this project is rolled out it will provide the Ministry of Transportation with an additional electronic tool for enforcing the *Compulsory Automobile Insurance Act* and addressing fraudulent liability cards.



Recommendations #38: Auto insurers should explore and take advantage of their existing ability to implement electronic commerce options under Ontario's *Electronic Commerce Act, 2000*.

8.6 Rate regulation

Part XV of the *Insurance Act*, which deals with the setting of auto insurance rates, is not within the scope of this review (Part VI). Even so, the IBC is urging the government to consider possible changes to Ontario's rate regulation system.

In 2003, the Legislature passed the *Automobile Rate Stabilization Act, 2003* (Bill 5), as a temporary measure to freeze auto insurance rates and facilitate a rate reduction of 10%. Bill 5 increased the authority of the Superintendent to deal with rate applications. In 2004, Cabinet repealed part of Bill 5 to allow insurers to file new rates. The insurance industry has since requested that the remainder of Bill 5 be repealed and that the system be returned to its pre-October 2003 status.

The IBC also proposed a phased transition from the current prior-approval system where rates must be approved by FSCO before they can be used, to a "file and use" system where insurers would be able to use filed rates immediately and approval would take place some time after. Rates that are not approved would be withdrawn.

Following the last insurance cycle, a number of Canadian jurisdictions moved to a prior approval process. However, in the U.S., some jurisdictions have moved to file and use schemes.

8.7 Premiums based on distribution method

In 2000, FSCO carried out consultation on the feasibility of partially basing premiums on expenses associated with various distribution methods (brokers, agents, Internet, etc.). No consensus was reached at that time.

Apart from the availability of Internet discounts, FSCO has not approved rates for a single insurer that allow for different rates based on different distribution expenses. Over the years, insurers have inquired as to whether a single auto insurance company could be permitted to sell the same product at different rates based on distribution expenses. Although this issue has not been raised during consultations conducted as part of this review, FSCO recognizes that there is ongoing interest within the insurance community.

While there is no clear statutory prohibition against a rating model that incorporates distinct price points with multiple distribution methods, apart from the availability of Internet discounts, there are currently no companies operating such a model in the market.



Some have suggested that permitting variable rates based on distribution method may lead to cost savings for some consumers, however, others have expressed concern around the sufficiency of consumer disclosure and ensuring that rate differentials truly reflect the reasonable costs of the distribution system.

8.8 Timing of future reviews

Stakeholders commented on how frequently the auto insurance system should be reviewed and the role of stakeholders in managing the system. The IBC proposed that FSCO report annually to the Minister of Finance on the state of the auto insurance market. The Coalition Representing Health Professionals in Automobile Reforms proposed the establishment of an ongoing multi-stakeholder forum, led by FSCO, to discuss issues of concern in the auto insurance sector and to provide recommendations to FSCO. Other stakeholders also made offers of future assistance and advice.

FSCO notes that the current review pursuant to section 289.1 of the *Insurance Act* is in addition to the review of the SABS mandated by section 289 of the Act. Section 289 requires a report to the Legislature on the adequacy of statutory accident benefits at least once every two years. The most recent report was submitted at the end of 2008. In addition, section 417.1 requires that the Superintendent submit a report to the Legislature on the risk classification and rate determination Regulations at least once every three years. The next report is due in 2010.

FSCO notes that the timing and content of the different reviews have the potential to overlap and cause confusion for stakeholders. Both insurers and consumers raised issues regarding rating and underwriting as part of this review regardless of the fact that they do not fall under Part VI of the Act and are therefore outside the scope of this review. Although two of the reports need to be tabled in the Legislature and one does not, it may be possible to harmonize the different reviews into one comprehensive report.

Recommendation #39: The government should consider harmonizing the reports required under sections 289, 289.1 and 417.1 of the *Insurance Act*.



Appendices

Appendix A

Ontario Regulation 403.96 (Statutory Accident Benefits Schedule) Subsections dealing with “catastrophic impairment”:

(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,

- (a) paraplegia or quadriplegia;
- (b) the amputation or other impairment causing the total and permanent loss of use of both arms;
- (c) the amputation or other impairment causing the total and permanent loss of use of both an arm and a leg;
- (d) the total loss of vision in both eyes;
- (e) brain impairment that, in respect of an accident, results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
- (f) subject to subsections (2) and (3), an impairment or combination of 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 impairment of the whole person; or
- (g) subject to subsections (2) and (3), 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) or class 5 impairment (extreme impairment) due to mental or behavioural disorder. O. Reg. 281/03, s. 1 (5); O. Reg. 314/05, s. 1 (1, 2).

(1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,

- (a) paraplegia or quadriplegia;
- (b) the amputation or other impairment causing the total and permanent loss of use of both arms or both legs;



- (c) the amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs;
- (d) the total loss of vision in both eyes;
- (e) subject to subsection (1.4), brain impairment that, in respect of an accident, results in,
 - (i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or
 - (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
- (f) subject to subsections (1.4), (2.1) and (3), an impairment or combination of 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 impairment of the whole person; or
- (g) subject to subsections (1.4), (2.1) and (3), 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) or class 5 impairment (extreme impairment) due to mental or behavioural disorder. O. Reg. 281/03, s. 1 (5).

(1.3) Subsection (1.4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (1.2) (e), (f) or (g) can be applied by reason of the age of the insured person. O. Reg. 281/03, s. 1 (5).

(1.4) For the purposes of clauses (1.2) (e), (f) and (g), an impairment sustained in an accident by an insured person described in subsection (1.3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (1.2) (e), (f) or (g), after taking into consideration the developmental implications of the impairment. O. Reg. 281/03, s. 1 (5).

(2) Clauses (1.1) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs before October 1, 2003 unless, (a) the insured person's health practitioner states



in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or

(b) three years have elapsed since the accident. O. Reg. 403/96, s. 2 (2); O. Reg. 281/03, s. 1 (6).

(2.1) Clauses (1.2) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless, (a) the insured person's health practitioner states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or

(b) two years have elapsed since the accident. O. Reg. 281/03, s. 1 (7).

(3) For the purpose of clauses (1.1) (f) and (g) and (1.2) (f) and (g), an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person. O. Reg. 403/96, s. 2 (3); O. Reg. 281/03, s. 1 (8).



Appendix B

The following organizations, municipal authorities and insurance companies provided FSCO with submissions as part of this review. As well, FSCO heard from 24 consumers, 3 insurance industry professionals, 3 health care providers, 4 lawyers and 2 other stakeholders. With the consent of stakeholders FSCO posted 76 submissions on its website (www.fSCO.gov.on.ca).

ACE INA Insurance
The Advocates' Society
Allstate Canada
Associated Canadian Car Rental Operators
Association of Independent Assessment Centres
Bar Dispute Resolution Forum
Canadian Association of Direct Response Insurers
Canadian Association of Financial Institutions in Insurance
Canadian Federation of Students
Canadian Life and Health Insurance Association
Canadian Society of Chiropractic Evaluators
Canadian Urban Transit Association
Coalition Representing Health Professionals in Automobile Insurance Reforms
City of Brampton
City of Cornwall
City of Mississauga
City of Thunder Bay
Consumer Interest Alliance
The Co-operators Group
Democracy Watch
The Dominion of Canada General Insurance Company
The Economical Insurance Group
Facility Association
ING Canada
Insurance Brokers Association of Ontario
Insurance Bureau of Canada
Jevco Insurance Company
Kingsway General Insurance Company
London Transit
Motorcycle and Moped Industry Council
Ontario Association of Social Workers
Ontario Association of Speech-Language Pathologists and Audiologists
Ontario Bar Association
Ontario Brain Injury Association
Ontario Chiropractic Association
Ontario Massage Therapist Association
Ontario Municipal Insurance Association
Ontario Municipal Insurance Exchange



Ontario Physiotherapy Association
Ontario Psychological Association
Ontario Society of Occupational Therapists
Ontario Trial Lawyers Association
Paralegal Society of Ontario
Provincial Towing Association (Ontario)
RBC General Insurance Company
Regional Municipality of Durham
Regional Municipality of York
Risk and Insurance Management Society
Royal SunAlliance Insurance Company of Canada
TD Meloche Monnex
Toronto Transit Commission
Unifund Assurance Company
United Senior Citizens of Ontario
Zurich Insurance Company