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Lundi 28 mai 2012

Standing Committee on General Government

Comité permanent des affaires gouvernementales

Automobile insurance review

Examen de l'assurance-automobile

Chair: David Orazietti
Clerk: Sylwia Przezdziecki

Président : David Orazietti
Greffière : Sylwia Przezdziecki

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Monday 28 May 2012

Lundi 28 mai 2012

The committee met at 1407 in room 228.

AUTOMOBILE INSURANCE REVIEW

The Chair (Mr. David Orazietti): Good afternoon, folks. Welcome to the Standing Committee on General Government, here today to consider the comments of various stakeholders with respect to an NDP motion that was put forward to review the auto insurance industry.

AUTO INSURANCE ANTI-FRAUD TASK FORCE

The Chair (Mr. David Orazietti): I'm going to call first Fred Gorbet to come forward. Mr. Gorbet, you have an hour in total, but you have half an hour for your presentation. Then we'll leave half an hour for questions among members of the committee, to be divided up as 10 minutes for each caucus. Any time that you don't use in your presentation—so if you're not going to use the entire half an hour, we'll divide that time up among members to ask questions. So, good afternoon, and welcome today. You can start by stating your name for our recording purposes and proceed when you're ready.

Mr. Fred Gorbet: Thank you very much, Mr. Chair and members of the committee. My name is Fred Gorbet. I chair the steering committee of the task force and I'm pleased to have the opportunity to appear before you today.

I appreciate that the mandate of your committee study is much broader than fraud, which is the focus of the task force, but we believe that fraud is an important issue in Ontario, and the task force is very pleased that the committee is taking an interest and has invited our participation.

I'll take the opportunity in my presentation to do three things: to lay out the structure of the task force, describe the highlights of the interim report that was released last December, and provide a brief update on our timetable for completion of the mandate that we have been given.

With respect to the structure and the mandate of the task force, there is a five-person steering committee that is independent of government, which I chair. The other members of the steering committee are Margaret Beare, who is a professor of law and sociology at York University; George Cooke, who is the CEO of Dominion of Canada General Insurance Co.; James Daw, a retired reporter with the Toronto Star who focused on consumer finance issues during the 30 years or so that he wrote for the Star; and Bob Percy, who is the deputy chief of operations for the Halton Regional Police Service.

The five of us, as a steering committee, provide direction to three working groups. There is a working group on prevention, detection, intervention and enforcement; there is a working group on regulatory practices; and there is a working group on consumer engagement and education. Each of these working groups is chaired by a senior public servant and has representatives from stakeholder groups as well as from government departments.

In choosing the membership of the working groups, we have adopted a working principle that says that if you're going to be at the table in a working group, you or your organization should have some accountability for being able to implement whatever recommendations the task force might make. So, for example, we have members of the regulatory colleges that regulate the health professions at the working group table. We have a representative from the Law Society of Upper Canada. We have representatives from the industry through the Insurance Bureau of Canada.

We do not have representatives of other groups that have interests but don't have accountability. With respect to those groups, we have invited any and all of them that wish to participate to make presentations to the working groups or to the task force. We have had about 30 individuals and groups make such presentations in the period of time that we have been active.

The task force itself is made up of the five-person steering committee, the chairs of the working groups, Ministry of Finance support for the task force, and representatives from the two other ministries that are involved with the Ministry of Finance, and that would be the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General. To date, as I said, we've had about 30 presentations.

We were appointed in July 2011, and our mandate has two parts to it. The first part is to commission research into the extent of automobile insurance fraud in the province, and the second part is to make recommendations to the government and other concerned stakeholders about ways to minimize auto insurance fraud.

In December 2011, we released an interim report, which is available on the Ministry of Finance website.

I'll take you briefly through the highlights of the interim report. There are four main things that we did in the interim report.

First of all, we had a fairly lengthy chapter that tried to summarize the evolution of Ontario's automobile insurance system at a pretty high level. It's a very complex system, as you know, and you're going to have presentations from FSCO, I understand, after my presentation, so I'm not going to go down very far. I'm also not qualified to go down very far. But we felt that it was important that we try to understand it, as a steering committee, and we did try to turn our understanding into a section of the report that allowed us to explain to the public our perceptions of the system and how it had evolved.

For example, we looked at just a chart of auto insurance premiums in constant dollars from 1985 to 2010, which is quite an interesting chart—it's in the report—and it basically shows a cycle of auto insurance premiums peaking and then falling and peaking and then falling and coming back up. What is interesting is that every time they hit a peak, the government of the day, whatever the political stripe of that government, would intervene and change the system and introduce changes to the system that would then start premiums on a downward trajectory again, and they would begin to rise after some time. So it's a complex system where cost affects premiums. Very high political visibility: High premiums bring government action and changes to a system that's already complex. That's the first task that we set for ourselves in the interim report: to try to describe those interrelationships.

The second thing was, we turned our attention to trying to see what we could say about fraud. There is an estimate that has been around for some time about the cost of fraud in Ontario auto insurance. The number that has been around for almost 20 years, I believe, is the number $1.3 billion. We tried to figure out where that number came from; we could not. We could not really satisfy ourselves that it had credibility. In the interim report, we basically said that we can't credibly put forth any quantitative estimate of the extent of auto insurance fraud in the province. Our first research project, which I will get to in a minute, is directed at actually trying to provide that quantitative information in a robust and credible way.

What we did do in the report was look at the evolution of costs for the system from 2006 to 2010. In particular, we looked at the increase in the costs for statutory accident benefits, and we did quite a detailed analysis of how those costs had moved. I'll give you just the highlights very briefly.

From 2006 to 2010, the total claims costs for automobile insurance increased by $3 billion in the province. Accident benefit costs increased by $2.4 billion from 2006 to 2010. So the bulk of the total increase was in accident benefit costs.

The amount of accident benefit costs, the level in 2010, amounted to about $370 per registered motor vehicle in the province of Ontario. From 2006 to 2010, accident benefit costs increased by 118%. Over the same period, there was a 7% decrease in the number of accidents. There was a 9% decrease in the number of individuals seriously injured in accidents. There was a 6% decrease in the severity of injuries suffered by victims, and there was a 7% increase in price inflation for our health care services in the province.

So we said to ourselves, what would we have expected accident benefit costs to be in 2010 if from the 2006 base they had grown at rates that one might expect to be logically related to these kinds of drivers of costs? The answer we got was that there was an unexplained gap between what we estimated accident benefit costs probably should have been and what they actually were, a gap that amounted in the province of Ontario to about $300 per registered motor vehicle. In the greater Toronto area, the GTA, we did the same analysis, and that gap amounted to about $700 per registered motor vehicle in the greater Toronto area.

Now we can't, and we did not, say that that was an estimate of fraud. We don't really have the basis to make that kind of claim. All that we can say at this stage is that that magnitude can't be explained by the kinds of things one would normally look to to try to explain growth in that particular variable.

We did say in the interim report that while we could not quantitatively estimate fraud, anecdotally there were a lot of stories around that we were hearing from people who appeared before us and from others that suggested that fraud was a problem and it was a growing problem. We conceptually, in the interim report, identified three different types of fraud, and in our research work we are trying to put quantitative estimates around each one of them.

The first type of fraud was organized fraud. We have brief definitions and some examples in the interim report. I won't go into those in great detail here because I don't really have time for it. But at a high level, organized fraud we defined as fraud that involved several participants with different roles within Ontario's auto insurance system that work together to create an organized scheme designed to generate cash flow through a pattern of fraudulent activity.

We defined premeditated fraud as fraud committed by a participant within Ontario's auto insurance system who consistently charges insurers for goods or services not provided, or provides and charges for goods and services that are not necessary.

We defined opportunistic fraud as fraud that is committed by an individual claimant who might do such things as padding the value of an auto insurance claim by claiming for benefits or for other goods or services that are unnecessary or unrelated to the collision that caused the claim.

We speculated, in the report—our hypothesis, if you like that word better than speculation, was that the growth in accident benefits to the extent that we could not explain that growth from 2006 to 2010 and to the

extent that it turned out to be fraud-related, was more likely related to the growth in organized and premeditated fraud rather than opportunistic fraud, which we regarded as kind of a—because it's individual, acting in individual circumstances, something that probably is relatively constant over time and wouldn't exhibit those kinds of growth characteristics.

So that was the hypothesis that we set out, but again, we are in the process, through our research, of trying to put some numbers and a credible methodology around that hypothesis.

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The third thing that the interim report did was set out a research agenda. It had two major components to it. One was to develop the estimates of fraud, which I've talked a little bit about. The second was to do what we call a multi-jurisdictional scan.

On the first one, through an RFP process, we engaged Ernst and Young to work with us and to work with the Insurance Bureau of Canada, who had also engaged KPMG to try to do a quantitative estimate of the three different elements of fraud. That work is ongoing. It is nearing completion. We have not yet seen a draft. IBC and KPMG are the main actors in that research that is going on. Ernst and Young is engaged by us to get involved with them and to try to ensure, for our benefit, that the methodology is credible and robust and provides numbers that we, as a task force, feel confident in standing behind. That's the role that Ernst and Young is playing.

We engaged Deloitte to do a jurisdictional scan, to do a report on what other jurisdictions that have similar types of auto systems and are experiencing fraud problems are doing in the areas of our three working groups to deal with those problems. It is a secondary-source scan, so they are essentially looking at publicly available material, compiling sources for us, putting all of that together. We have seen a draft of that research, but we do not have the final research available.

Our agreement with the ministry is that the research projects that are funded by the ministry under the auspices of the task force will be made public when they are finished.

The fourth area that we dealt with in the interim report was to try to set out, at a reasonably high level, our own agenda for the balance of our mandate, based on what we knew and what we believed last December. We did that to try to provide a framework where we could get feedback from interested parties, the stakeholders, that would help us pursue those issues. We listed five issues that we would be pursuing. We are looking at the regulation of health care clinics—I should say the licensing and regulation of health care clinics.

We are looking at other possible gaps in the regulatory system, and I would characterize those other possible regulatory gaps as falling into three different categories, if you will. First, we are looking at the towing industry and whether there should be greater regulation or oversight of the towing industry. I know that there's a private member's bill that's introduced in the House, and we are looking at that and other possible options.

The second regulatory area we are looking at has to do with FSCO and FSCO's authorities. We are looking at whether FSCO's authorities with regard to the auto insurance business as a business are clear enough and broad enough. My understanding, and FSCO can correct me if I have it wrong, is that the authorities now derive from the Insurance Act, and they relate to those engaged in the business of insurance. I believe a case could be made that that goes beyond the actual employees of a regulated insurance company to those people who supply goods and services to the insurance industry, such as health care professionals or towers or others. But if there is ambiguity, we think that that ambiguity should be clarified. We also believe that FSCO's regulatory authorities probably should be broadened to explicitly deal with other actors in the system.

In our work on regulating clinics, we would be considering designating, or recommending to the government that they designate, FSCO as the regulator of clinics. I should make it clear that when we talk about regulating clinics, we're not talking about regulating the competencies or qualities of the health care practitioners. We're talking about regulating the integrity of the business processes within those clinics in terms of looking for fraudulent business activities.

The third area of regulatory oversight that we're looking at I could generally characterize as the relationship between insurance companies and claimants. There are two sides to that. There's looking at the array of regulations that govern how insurance companies can interact with auto insurance claimants and things like timelines, modalities, those kinds of questions. But we are also looking at regulatory options that would mandate more disclosure by insurance companies, to the benefit of automobile insurance purchasers.

Right now, if a purchaser wants to do a search to try to find information about how to buy auto insurance, it's relatively easy to get rate information.

The Chair (Mr. David Orazietti): Sorry to stop you. You're doing great, a great job. We've got to take a break for a second, by the standing orders of the committee, so that members can go down the hall to the Legislature to vote. We'll come back as soon as they vote.

Mr. Fred Gorbet: Okay.

The Chair (Mr. David Orazietti): We'll continue. You're about 20 minutes into your time, so—

Mr. Fred Gorbet: And I've got about nine and a half minutes left.

The Chair (Mr. David Orazietti): No problem. Perfect. See you in a few minutes.

The committee is in recess.

The committee recessed from 1427 to 1437.

The Chair (Mr. David Orazietti): Okay, folks, if we could resume. Thank you very much for your patience. Go ahead.

Mr. Fred Gorbet: Okay, thank you. I was talking about regulatory gaps and I was talking about relationships between the industry and consumers generally.

We are considering mandating more disclosure by companies in certain areas, and I was saying that it's relatively easy to cross-company-shop for premiums. It is not so easy to cross-company-shop to get a sense of how different companies might actually deal with you if you happen to be injured in an automobile accident. We're looking at the possibility of recommending that companies be required to disclose some of their practices in that regard. For example, if they contract for independent medical assessments, or independent medical examinations, I guess they're called—IMEs—we may want to consider asking them to disclose on their website what criteria they use; how they go about choosing the professionals they choose. If they have preferred providers, we might want them to talk about how people can become part of their preferred-provider network. We might want them to talk about the claims process generally—what claimants should expect from that company.

The model for that is something I was involved with 20 years ago, which was corporate governance generally. I was executive director of a similar kind of task force, not for government but for the accounting industry and the stock exchanges, where we mandated disclosure of corporate governance practices. My sense is that over the 20 years that that disclosure has been required, the general quality of corporate governance has increased. People understand what best practices have been. Outside commentators focus on it. We're looking at the possibility of seeing whether that model could have applicability to that aspect of how companies deal with their claimants. That's the third part of the regulatory gap issue that we're looking at.

In addition to regulation of clinics and other gaps in regulation, it has been suggested to us that we recommend the establishment of a dedicated task force. This would be a task force with prosecutors and law enforcement to pursue criminal investigations. It exists in other jurisdictions. We're looking at it, but in our judgment it would be really tough to try to transpose that kind of model into the Ontario justice system, and we are not sure that it would necessarily be the most effective way to deal with the issue.

It seems to us that the quickest and most effective way to deal with fraudulent activity is to cut off the flow of funds to the fraudsters, and we are focusing a lot more of our attention on recommendations that may allow that to happen. This is not to the exclusion of trying to make the possibility of criminal investigation and prosecution work better. We think there are some ways to do that and we're looking at some options in that regard. We haven't ruled out a dedicated task force, but it's not something that I could tell you today that we're prepared to recommend.

Then finally, we set out in the interim report the need for a broad education and engagement strategy for consumers. There are three parts that we're looking at to that strategy. One is trying to deliver the right message at the right time to the right people. The working group is working really hard. That sounds almost platitudinous when I say it, but there's a lot of hard work going into defining what "right" means in each of those circumstances. I think we will come out at the end of the day with a strategy that is well-thought-out and that is specific enough for actors to engage in, in a meaningful way.

The second part of that is to try to develop a web portal for consumers that would really try to accomplish three main things. It would be a comprehensive portal. It would try to help consumers figure out how to avoid being entangled in a fraudulent scheme. It would try to educate consumers about what to do if in fact they believe there is fraud going on around them: who to report it to, how to report it. Finally, if a consumer happens to become a claimant, we would try to provide information on that website about what they ought to expect in terms of being treated as a claimant from their insurance company, from their health professionals, from others in the system.

Then the third part of the consumer education strategy would be the regulatory disclosure aspect that I talked about just a few minutes ago.

That is our agenda, Mr. Chair. The next steps: We put that out in December. We're continuing to hear from people. We're continuing to work on those issues. We are now working on a status report which we hope to release end of June, early July, that kind of time frame. That status report will take stock of the kinds of things that have happened since December in the external environment, in our own work. We will use that to report the results of our research. We will use that to provide more detail about the direction of our thinking on those issues, as a basis for feedback and consultation. We will go from that status report to our final report to the Minister of Finance, which is due in the fall and which we are targeting, Mr. Chair, to try to deliver in the September time frame—fall, for me, starts after Labour Day.

Thank you very much. I'm pleased to take questions.

The Chair (Mr. David Orazietti): Thank you very much. We'll start over here with the Conservative caucus.

Mr. Rosario Marchese: Mr. Chair, I have a question, please, and a request.

The Chair (Mr. David Orazietti): Okay.

Mr. Rosario Marchese: I would like it if we would start with the government members and go around.

The Chair (Mr. David Orazietti): The Conservative caucus is normally first, so it's up to you. If opposition—

Ms. Laurie Scott: I was just wondering. Do you think that we'll have the opportunity to have a rotation after each of the presenters? The first couple for sure, because they're an hour long.

The Chair (Mr. David Orazietti): That's the way we've been proceeding with committee, so—

Ms. Laurie Scott: Yes. Is that okay with you, then, if we go—

The Chair (Mr. David Orazietti): If we're going to—

Mr. Rosario Marchese: So we'll start with the government members, if you don't mind? They'll start with the 10 minutes, and then they will and then we will?

Ms. Laurie Scott: Oh, I see.

The Chair (Mr. David Orazietti): It's up to the Conservative caucus. Normally opposition is first, so government, you know—

Ms. Laurie Scott: So, when we get down to the smaller time frames, will we be able to get a question—

The Chair (Mr. David Orazietti): We're going to go in rotation, and it will have to be just one member from each party asking questions.

Ms. Laurie Scott: But each party should be able to ask a question.

The Chair (Mr. David Orazietti): We will, but they'll have to be brief and concise if we're going to do that.

Ms. Laurie Scott: What do you want to do, Jeff? Rosario, I think, wants—

Interjections.

The Chair (Mr. David Orazietti): Right now, opposition is up first for questions.

Interjections.

Mr. Yasir Naqvi: Mr. Chair, how much time do I have to ask questions?

The Chair (Mr. David Orazietti): A little less than what we had before, so go ahead.

Mr. Yasir Naqvi: Seven or so minutes?

The Chair (Mr. David Orazietti): Yeah.

Mr. Yasir Naqvi: Okay, great. Good afternoon, sir, and thank you very much for joining us today. Let me start first by thanking you and your task force for the excellent work that you've been doing on anti-fraud. I've had the chance to read your preliminary report and it's fairly extensive work. I know the final report has even more detail to it. Thank you very much for the work that you're doing, and thank you for being here.

Auto insurance fraud is a serious issue that I think we need to address. Some have claimed that auto insurance fraud is not a large problem at all and that the government should be elsewhere. Could you comment on that?

Mr. Fred Gorbet: Well, I guess the only comment that I feel qualified to make at this time is to repeat what I said before, that if you look at the numbers on accident benefits, our conclusion is that there is about $700 in 2010 per registered vehicle in the greater Toronto area that we can't explain satisfactorily by any kind of drivers that one would normally expect to explain that kind of number. That's a big number. Now, whether all of that's fraud or not, or part of it's fraud or how much of it's fraud, I really can't say, but it can't be explained. That, together with a lot of the anecdotes that we are hearing as a task force, suggests to us that it is quite a significant problem.

Mr. Yasir Naqvi: And obviously it has an impact on the premiums.

Mr. Fred Gorbet: It does. It has a direct impact on the costs, and the costs have a direct impact on the premiums.

Mr. Yasir Naqvi: Would it also be fair to say that fraud may be more acute in certain areas, certain territories, so that a province-wide figure of fraud as a percentage of total provincial premiums may be misleading and could underestimate the problem in certain areas?

Mr. Fred Gorbet: Yes, I think that's a fair conclusion. Again, the numbers that we looked at suggest that that unexplained difference is about $300 per registered vehicle, on average, in the province of Ontario but $700 in the GTA.

Mr. Yasir Naqvi: You were also talking about the role of FSCO and that part of your recommendation as to how FSCO can deal with fraud. Any more detail that you can share at this time as to how FSCO can tackle fraud and how precisely can they play a role in anti-fraud and checking the premiums and perhaps, hopefully, reducing the premiums?

Mr. Fred Gorbet: Let me say that I think FSCO has done a very, very good job so far in the kinds of measures that they've taken. The comments I made really should not be taken in any way as a criticism of what FSCO has been doing under the terms and authorities of their legislation. My comments really go to whether their authorities are broad enough to allow them to do what they might do. The substance of my comments really is that I believe that we are coming to a conclusion that suggests they are not broad enough and they should be expanded. But I have to say that I really am not in a position to provide more specifics, because we have not, really, as a steering committee or a task force wrestled with these issues to the point where I feel comfortable getting out ahead of where we might come out.

I could give you my own ideas, but my own ideas would be my own ideas. They wouldn't be as chair of the steering committee. I think to be fair to my colleagues on the steering committee, I have to really respect the fact that we need to have further conversations.

But you will see in our status report where we think we want to go, and you will see in our final report where we have got to.

Mr. Yasir Naqvi: No, I think that's fair, and I appreciate the brief comments that you have provided as to what you foresee as the role of FSCO and that, obviously, we wait for the final report, once you have ample time to address that.

Last question, Chair, and that's in regard to private member's Bill 41—I'm sure you may have had the chance to review that; that's tabled by my colleague Mr. Singh—that begins to address some issues around auto insurance fraud. Could you provide a few comments on the bill and whether you think it's headed in the right direction?

Mr. Fred Gorbet: I think it's a very—this is the bill that deals with whistle-blowing?

Mr. Yasir Naqvi: No.

Mr. Fred Gorbet: Oh, 41.

Interjection: It's 45.

Mr. Fred Gorbet: Which one is 41? Is that—

Mr. Yasir Naqvi: I'm referring to—what's Mr. Singh's? Bill 45.

Mr. Fred Gorbet: Sorry, I thought 41 was whistle-blowing.

Mr. Yasir Naqvi: Sorry, I'm talking about 45.

Mr. Fred Gorbet: Oh, okay. Mr. Singh, which bill is yours? Is this one of the rights-setting bills?

Mr. Jagmeet Singh: It's getting rid of geographic discrimination.

Mr. Fred Gorbet: Oh, yes, that one. No, I really can't comment on that because—I mean, we're not in the rate-setting business. I think that's a fair question for FSCO, but our focus is really on fraud and not on how to set rates.

Mr. Yasir Naqvi: Safe answer.

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Mr. Fred Gorbet: But if you want to ask me about whistle-blowing, I could tell you maybe gratuitously that I think that—

Mr. Yasir Naqvi: Tell me about whistle-blowing, yes.

Mr. Fred Gorbet: I think that is an issue, and that it's an issue we're looking at. I think that there are a lot of very interesting aspects to that private member's bill that is tabled. There are two that we're looking at. One is on whistle-blowing and the other is Mr. Zimmer's bill on self-regulation of the towing industry. We're looking at both of those. We haven't concluded on either one.

Mr. Yasir Naqvi: Okay. Great.

The Chair (Mr. David Orazietti): Right. Thank you. Mr. Yurek, you're up.

Mr. Jeff Yurek: Thanks, Chair. Thanks very much for coming today and giving us your feedback on the fraud task force. I've read the report and it's very, very in-depth and went along well with the Auditor General's report, which came out basically at the same time.

I didn't hear if you mentioned anything about the HCAI and possibly using that system to open up and share information, and perhaps that's a good way to cut off the fraud that's going on with the clinics. Can you elaborate on that?

Mr. Fred Gorbet: I can, and thank you for the question, because if I had more time—I should have. It's a very important aspect and I was remiss not to mention it.

HCAI is now mandatory. It was originally designed as a processing engine to try to be efficient, to increase efficiencies. It has the potential to be a very effective anti-fraud tool, and as a task force, we have actually commissioned a separate working group on HCAI. They are pursuing three different initiatives right now that are nearing—well, two of them are. One is complete, one is nearing completion and one is probably about a year away, but they're all very important anti-fraud devices.

The one that is complete and operating is, they're using HCAI to actually send out regular statements to insurance companies of everything that has been billed to that insurance company by every biller. So it's like a credit card statement where periodically—I think it's every month—each insurance company and each clinic will get a list of everything that's billed. So that's an opportunity just to take stock, kind of the way I do with my credit card. I check the invoices when I get the bill and make sure there's nothing funny going on. So that's important as information.

Secondly, they are working with the colleges to build a feature into the system that will allow health care practitioners, through their college, to actually access information about which billing facility is using that particular health care practitioner's identity. This is an important potential tool to counter the identity theft of medical practitioners' identity.

They've tested; they've done a proof of concept. The HCAI working group has worked on pilots with, I think, two of the different associations of health care professionals. It's proving out very well, and it's welcomed by the practitioners and by the colleges. It's close to being implemented.

The third initiative, which is a little further away because it's a little more difficult, is actually taking that second one even further. It will be providing every health care practitioner with an identifiable PIN number in HCAI, so that when that is actually rolled out, you will not have to go through the college anymore, but every health care practitioner will have the ability to access HCAI directly and learn what is being billed in his or her name.

So we think that that is a very important set of anti-fraud initiatives.

Mr. Jeff Yurek: Okay, thank you. Do I still have time or—you have no idea?

The Chair (Mr. David Orazietti): No, I said you had a brief—

Mr. Jeff Yurek: Oh, sorry.

The Chair (Mr. David Orazietti): —another minute or two.

Mr. Jeff Yurek: You said the task force with a crown attorney would be tough to place in our system here in Ontario, even though it's worked elsewhere in the world. What resources does FSCO have for going after fraud? How many inspectors do they have to actually deal with this problem?

Mr. Fred Gorbet: I think you should ask them when they come—

Mr. Jeff Yurek: We haven't seen that in your task force report.

Mr. Fred Gorbet: I think they'll be here. You know, I'm going by memory. I think two or three, but I'm going by memory and I could be wrong. We probably believe—I think we're coming to the conclusion they should have more than they do.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. David Orazietti): Okay. NDP caucus, Mr. Singh, go ahead.

Mr. Jagmeet Singh: Sir, just to clarify some points, the $1.3-billion figure that's been used has been used for about 20 years, and based on your research, that number doesn't seem to be supported by any research that you have. Is that correct?

Mr. Fred Gorbet: We could not find any research we thought was credible that could support it in today's marketplace.

Mr. Jagmeet Singh: In fact, you can't attribute an actual number to the fraud cost in Ontario; is that correct?

Mr. Fred Gorbet: That is correct.

Mr. Jagmeet Singh: You indicated the types of fraud: organized, premeditated and opportunistic.

Mr. Fred Gorbet: Yes, sir.

Mr. Jagmeet Singh: Amongst those three, if you were able to rank those, would you agree with me that organized fraud—you can just rank it however you think which is contributing the most to fraud of those three.

Mr. Fred Gorbet: I really have no basis to rank them but I would guess—and it is a purely personal guess—that a combination of organized and premeditated is more substantial than the opportunistic, and I could not begin to break down the organized versus the premeditated.

Mr. Jagmeet Singh: So in fairness, your answer is an opinion but you can't base that on any concrete or quantitative analysis.

Mr. Fred Gorbet: That is correct.

Mr. Jagmeet Singh: But it's your hunch that it's organized and premeditated. I would have suggested the same thing as well.

In terms of organized, do you know who that is or do you have a sense of where that's happening or a sense of who is involved in that?

Mr. Fred Gorbet: No, I don't. The only information that's available to the task force on that is, from time to time, press reports about enforcement actions.

Mr. Jagmeet Singh: So we're not able to say with certainty who is the organized crime, if it's one particular crime network or if it's in a particular area or region. It's just based on a colloquial knowledge, when a press release comes out that there's a fraud ring that was exposed. That's what you're basing your knowledge on.

Mr. Fred Gorbet: That's correct.

Mr. Jagmeet Singh: And with respect to the premeditated component, what's your sense of what makes up a premeditated component of fraud?

Mr. Fred Gorbet: Again, it's anecdotal. It would be clinics or health care professionals that are billing in a consistent way for activities that were not performed, services that were not performed, for example.

Mr. Jagmeet Singh: Okay.

Mr. Fred Gorbet: There are other examples in the interim report.

Mr. Jagmeet Singh: Thank you. So premeditated would be more related to the clinics and the health care providers.

Again, with the second component, are you able to attribute a particular area—the cost, the number or a quantitative analysis of where that's going on?

Mr. Fred Gorbet: Not yet. We hope to be able to do that.

Mr. Jagmeet Singh: Then the third category, the opportunistic, just by the very nature of it, it requires an actual accident occurring and then there's an overestimate of what happened in that accident. You'd agree with me that, as an individual involved in the task force, on a commonsense approach that could contribute to a significant component of fraud? Do you agree with that?

Mr. Fred Gorbet: Yes, that would be my hunch.

Mr. Jagmeet Singh: Now, you indicated fraud and its connection to premiums. I just want to question you further on that. Would you agree with me that it's not fraud, it's actually the total cost incurred by an insurance company that's related to the premiums?

Mr. Fred Gorbet: Yes, I agree with that.

Mr. Jagmeet Singh: One component of total cost may be attributed to fraud.

Mr. Fred Gorbet: I agree with that.

Mr. Jagmeet Singh: The rest of the cost equation, would you agree with me that it's substantially different, when you did your analysis from 2006 to 2010, relying on the data that you had—that from 2010 onwards with the change in regulations, there's going to be a significant impact on the amount of costs incurred in terms of claims because of the substantial cutting of those benefits. Do you agree with—

Mr. Fred Gorbet: One would think that that would be the case. I mean, I haven't seen the numbers that would show that, but one would think that that would be the case.

Mr. Jagmeet Singh: Do you have any sense of what the numbers are from 2010, since the change in the regulations, onwards? You did cite some numbers from 2006 to 2010, but from 2010, since the regulations were amended or brought into effect, from that point onwards are you aware of what the costs and the claims are?

Mr. Fred Gorbet: We did look at some of the accident benefit numbers for the first six months of 2011. They tended to show a decrease. We were cautioned that probably it would be wiser to wait for a full year before you could begin to draw hard conclusions from them.

Mr. Jagmeet Singh: And those numbers that you had for the first six months, do you have access to those numbers? Can you provide a sense of what those numbers were?

Mr. Fred Gorbet: I don't have them with me.

Mr. Jagmeet Singh: Would you be able to table those numbers with this committee, if requested?

Mr. Fred Gorbet: I think maybe you should ask FSCO because I think they really come from FSCO.

Mr. Jagmeet Singh: They come from FSCO? Okay.

The Chair (Mr. David Orazietti): Mr. Singh, is there any way to wrap it up at present so we can go and vote? Otherwise we're going to have to—

Mr. Rosario Marchese: A quick question, though, on the whole issue of the $1.3 billion that the insurance companies say is related to fraud. Did you look at their numbers or their studies to see whether or not it jibes with any of the studies you're doing?

Mr. Fred Gorbet: We did. We looked at some. Some of the support people for the task force looked at some of those studies, and some of the steering committee members looked at some of those studies. What we could find was very dated and used a different methodology than we think is the appropriate methodology now.

Mr. Jagmeet Singh: Sorry; I have a couple of questions but I think it's time. Could I return and ask just one or two quick questions?

The Chair (Mr. David Orazietti): Okay, briefly. Recess.

The committee recessed from 1502 to 1508.

The Chair (Mr. David Orazietti): Thanks, folks. If we can resume, that would be great. Mr. Singh, you get the floor, so go ahead. You've got a couple of minutes and let's wrap it up. Go ahead.

Mr. Rosario Marchese: Mr. Gorbet, you wanted to complete the answer to the question.

Mr. Fred Gorbet: We did look at some of the earlier studies. We couldn't find any that we felt were credible and robust. A lot of them were old and they used a method called closed claim counts. They would do a sample of claims and just go through them and extrapolate.

The methodology that is being used now in the research that we're conducting is—at least with regard to organized and premeditated—a much more robust methodology that uses sophisticated data analytics to try to look for connections across different claims. We're quite excited about it. We're reasonably confident although, as I said, we haven't seen the draft of the results yet. We're reasonably confident that it will give us great numbers.

Mr. Rosario Marchese: Very good. Thank you. He's got a quick question for you.

Mr. Jagmeet Singh: Thank you so much, and thank you, Mr. Chair, for this. Just two quick questions.

You indicated a $400 amount for most of Ontario and then a $700 amount for—

Mr. Fred Gorbet: It's $300 for all of Ontario.

Mr. Jagmeet Singh: —$300 for all of Ontario and $700 for the GTA.

Mr. Fred Gorbet: Yes.

Mr. Jagmeet Singh: Now, you indicated you couldn't say how much of that was fraud-related. What can you say in terms of the differences between most of Ontario and the GTA that may result in the $400 difference that's not fraud-related? What other factors could be at play here?

Mr. Fred Gorbet: I really couldn't speculate—I really couldn't. What we've said is that—and we used the different drivers, right? So for the province we used province-wide number of accidents, severity, all that stuff, and for the GTA we used GTA-specific numbers, and we got two separate estimates. The unexplained gap is $700 in the GTA and $300 in the province as a whole. So outside the GTA, it's even less. But I can't tell you any more at this point in time. All I can tell you is that it's unexplained.

Mr. Jagmeet Singh: What I meant by that: Would traffic, congestion, urban density, any of those factors—

Mr. Fred Gorbet: No, no, what we used was the number of accidents, the number of individuals hurt, severity of the injuries and price inflation.

Mr. Jagmeet Singh: Okay. That's fine.

The Chair (Mr. David Orazietti): Thank you very much for your presentation, and we appreciate your patience through the voting as well.

Mr. Fred Gorbet: Thank you, sir, and let me just say that I wish you well with your deliberations. I would be pleased, should you wish, when we have more stuff out, to come back.

The Chair (Mr. David Orazietti): Thank you very much. Noted.

Mr. Jagmeet Singh: I just had a quick question, Mr. Chair. I noticed that we have a projector. Are we using that projector for anything? It is being used?

The Clerk Pro Tem (Ms. Tamara Pomanski): PowerPoint.

Mr. Jagmeet Singh: Okay, that's fine.

FINANCIAL SERVICES COMMISSION OF ONTARIO

The Chair (Mr. David Orazietti): Next presentation: Financial Services Commission of Ontario. Mr. Howell and Mr. Golfetto are both here. Good afternoon, gentlemen. Welcome to the Standing Committee on General Government. We appreciate you coming in today. You've got roughly half an hour. I'd ask you to be a little bit flexible on the time and please be as concise as possible so we've got a few minutes for questions. I anticipate the bells may be ringing again, so I apologize in advance if that's the case. Anything you can do to make the presentation brief and concise would be greatly appreciated. Just state your name and you can start.

Mr. Philip Howell: Thank you, Mr. Chair. My name is Philip Howell; I'm the CEO of FSCO. I'd like to also introduce Tom Golfetto, the executive director of the auto insurance division at FSCO. We will share the delivery of this presentation. I believe a slide deck has been distributed?

The Clerk Pro Tem (Ms. Tamara Pomanski): Everything's been distributed.

Mr. Philip Howell: Okay, excellent.

We're very grateful for the opportunity to present to the committee today. Before I begin, I should mention that many of the topics and issues we'll be speaking about are addressed in considerably more detail in our submission, which we have also tabled today. In addition, as I just mentioned, we'll refer to the slide deck.

As current debate on Ontario's auto insurance system is centred primarily around private passenger auto insurance, that will be the focus of today's presentation.

Auto insurance in Ontario is a form of property and casualty insurance. It is a contract that is purchased by owners and drivers of motor vehicles from an insurance company that, in turn, undertakes to compensate those injured in accidents for eligible costs arising from vehicle damage and personal injuries. In addition to providing compensation, the insurer also undertakes to protect the owner and the driver of the vehicle from any legal claims for injuries or damages caused to others.

The auto insurance premiums that drivers pay represent the cost of transferring the risk of loss from themselves to an insurer.

I'd like to stress that the auto insurance product is a product that is designed to give people peace of mind—and people are willing to pay a price for this peace of mind. The vast majority of drivers will never have to make a claim of any kind and even fewer will ever have to make an accident benefits claim.

Auto insurance is mandatory in Ontario and has been since 1980. It is privately delivered in a competitive market. There are over 100 licensed companies in the province. These companies compete for the business of nine million Ontario drivers who drive 6.6 million vehicles.

In Ontario, the auto insurance system is a closed-loop system. In simplest terms, this means that the costs of the insurance system are recovered through premiums charged to drivers. These premiums fund the cost of claims, including the cost of treatment provided to those injured in accidents. Consequently, the more generous the benefit levels, the higher the cost to drivers, the higher the premium levels. In order for auto insurance to be affordable, fairly priced and available, a balance needs to be maintained between price and appropriate coverages for policyholders.

Historically, the reforms of the Ontario system have largely been motivated by the need to maintain this balance, and the need to stabilize rising costs and premiums. The auto insurance system is complex, and there have been several reforms over the past 30-odd years. With each set of changes to the system, there was some initial success in stabilizing costs and premiums, followed by another cycle of rising costs. In addition, the system continues to face challenges associated with fraud and abuse that contribute to rising costs.

Prior to the September 2010 reforms, Ontario saw claims costs increase dramatically while the number of accidents in the province actually decreased. As I will later describe, this experience was not consistent with what was happening in other Canadian jurisdictions. This trend, shown in slide 1, suggests there was considerable abuse of the system.

The reforms announced by the Ontario government in 2009 and implemented in 2010 have addressed rising costs, many of which stemmed from abuse. They've stabilized premiums and have given drivers more options to tailor coverages to their needs. To try and avoid a repeat of past reform cycles, the government continues to focus on improving the auto insurance product in Ontario.

At this point, I would just like to outline the coverages provided in the current system, and they are described in slide 2. They include protection in case of death, injury or property damage sustained to other vehicles; death or injury as a result of a hit-and-run or uninsured driver; and damage to the policyholder's vehicle. A standard policy also includes benefits to cover treatment and rehabilitation bills in case of injury. The current system provides drivers with options for increasing their coverages.

I'd like to talk now about FSCO's role in the auto insurance system. FSCO is assigned the responsibility for providing regulatory services that protect the public interest and promote public confidence in auto insurance. The FSCO Act and the Insurance Act provide the legislative framework for this responsibility.

The decision to amend or undertake any reviews of this legislation of course rests with the government. FSCO's role is to administer the legislation through underwriting rules, rates and risk classification approval processes; an accident benefits dispute resolution system; a market conduct and enforcement regime; and the administration of the motor vehicle accident claims fund. Each of these functions is described in more detail in the paper that we tabled today.

Tom will now provide you with an overview of how the auto insurance product is priced, as well as how underwriting rules and risk classification systems are approved.

Mr. Tom Golfetto: Thank you, Phil. As Phil mentioned, my name is Tom Golfetto. I'm the executive director of the auto insurance division. Thank you, Mr. Chairman, for the opportunity to present at this committee today.

As noted earlier, insurance is a contract that protects consumers financially against a loss. Insurance is priced prospectively—that is, for the coming year—and, therefore, before claims are made and, thus, before claims' costs are fully known.

Insurers and actuaries examine patterns in past claims to estimate future costs. Their goal is to determine what rates to charge a consumer for the policy period to cover claims costs and operating expenses, and to make a profit after taking into account investment income. Based on their actual experience, companies may need to revise their assumptions on prospective costs and future premiums.

Insurers must submit proposed changes to their rates to FSCO for approval. FSCO reviews rate filings, analyzing the data supporting the insurer's actuarial assumptions, to ensure that the proposed rate changes are adequate to maintain the financial solvency of insurers without being excessive.

Where FSCO finds that the assumptions are not reasonable based on the data, insurers are asked to modify their rate filings prior to approval. Failure to modify a rate filing would result in approval not being granted. In practice, companies may file for rates that are too high or too low according to their actuaries' rate indication. The latter can occur when companies strive to remain competitive or to minimize the impact of rate increases for their customers. FSCO ensures that rates approved are neither excessive nor going to impair a company's long-term financial solvency.

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Companies do need to earn a return on capital invested. Return on equity—or ROE, as it's known—is one factor that is considered in reviewing the reasonableness of rates proposed, and an ROE benchmark of 12% is used

in this process. The Auditor General's 2011 report recommended that FSCO review what constitutes a reasonable level for profit when approving rates. FSCO agrees with this recommendation and will conduct a review this year.

I'm going to talk briefly now about the approvals process for auto insurance underwriting rules. The Insurance Act sets out authority for FSCO to regulate insurers by approving insurers' underwriting rules. Companies must file their underwriting rules with FSCO. These are the rules that insurance companies use to determine the risks that they may not accept. Regulations under the Insurance Act define the criteria that cannot be used to deny auto insurance coverage; for example, not-at-fault claims. Specifically, underwriting rules may not be subjective, be arbitrary, be contrary to public policy or bear little relationship to the risk.

So let's now look at how individual rates are set. It's important to understand that consumers are not all charged the same rate for auto insurance. Premiums vary based on the individual consumer's risk characteristics. The mechanism for determining rates is an insurance risk classification system. Risk classification systems set out the factors that an insurer will use when setting the price they charge for auto insurance. They group risks with similar characteristics and expected claims costs.

Under the Insurance Act, risk classification systems must be just and reasonable, reasonably predictive of risk and distinguish fairly between the risks.

Risk classification systems include territories, which I'll speak about in a moment.

Similar to underwriting rules, regulations impose restrictions on what factors an insurer cannot consider when calculating a driver's auto insurance rates. For example, credit history cannot be used to calculate a driver's rate.

Auto insurance rates are determined by a combination of factors, called a risk classification system, including the driver's personal profile, the amount of coverages that they're purchasing, the deductible that's selected and the location.

Actuarial principles require that the rates reflect costs. Claims costs vary across the province, as do rates.

Risk classification systems include the driving record of the various drivers of the vehicle, where the person lives, the completion of a driver training course, how much a person drives, the age and numbers of years licensed, the vehicle use and the vehicle type.

Other factors affecting rates include the amount of additional optional coverages purchased and the level of deductibles selected for certain coverages.

As I mentioned, auto insurance rates are affected by where a person lives. Territorial rating recognizes that all vehicles within a given territory share similar risk posed by factors such as traffic density, terrain, road conditions, weather and crime rates. Each company establishes its own territories based on its data and market information. To establish a territory, insurance companies must provide actuarial evidence to FSCO demonstrating that claims costs are higher or lower in the proposed territory than in other existing territories. As the auto insurance system has evolved and populations have increased, insurance companies have expanded the number of territories to better reflect risk and claims experience.

To ensure that a territory rating is conducted fairly, FSCO guidelines allow for no more than 55 territories in Ontario and no more than 10 in Toronto, a minimum of 2,500 vehicles in each territory, contiguous territories only and rate changes of no more than 10% from an existing territory when establishing a new one.

Now I'll turn it back over to Phil to continue with the presentation.

Mr. Philip Howell: Thanks, Tom.

Ontario's auto insurance system is expensive and it's complex. To understand why this is, it's important to know how the system has evolved over time. Changes made over the years have added levels of complexity, created unintended financial incentives for its participants and, in my view, resulted in some participants in the system losing sight of what auto insurance is intended to do.

As noted earlier, in 1980 auto insurance became mandatory in Ontario. Vehicle owners previously had the option of buying insurance or self-insuring by paying a fee into the motor vehicle accident claims fund. The fund would pay claims when an at-fault driver was unable to fully compensate a not-at-fault person injured in an accident. Often, those injured in accidents had to go to court to determine who was at fault in the accident and get compensation to pay for medical treatment, as well as the damage or loss of their vehicle.

The growing costs of the fund, as well as the increasing number of uninsured vehicles, led the government to make auto insurance mandatory. From 1979 to 1990, Ontario relied primarily on a court-based or tort system of compensation while providing minimal no-fault accident benefits to those injured in accidents. In many cases, those benefits did not cover the cost of basic necessary medical treatment or provide for adequate income replacement when injuries kept people out of work.

To access additional funds, those injured in accidents had to sue at-fault drivers. However, court awards or settlements took a long time to complete, putting financial pressure on not-at-fault drivers. Similarly, in many cases at-fault drivers had inadequate coverages to recover properly when they were injured.

Faced with this situation, the government expanded Ontario's no-fault system in 1990. This change meant that all insured drivers had access to a comprehensive accident benefits package, regardless of fault. In exchange for higher no-fault accident benefits, the government restricted the ability to sue at-fault drivers. These changes were designed to balance price and appropriate levels of coverage.

Also in 1990, the government introduced an approvals process for rate and risk classification systems. The goal was to ensure that the premiums charged reflected the costs of auto insurance.

Since 1990, Ontario's auto insurance system has undergone several sets of reforms. A common characteristic of these reforms has been a period of premium stability followed by rising costs and rising premiums. The reforms also added levels of complexity to the system and, unfortunately, often created more opportunities for abuse. And they created what is, and what has been for years, the most generous accident benefit system of all provinces with privately delivered auto insurance in Canada.

Rising costs and premiums led to the reforms that were brought in by the government on September 1, 2010. Those reforms responded to a number of troubling trends that emerged between 2006 and 2010. These are illustrated in the graphs that appear on your slides. As shown in slide 3, between 2006 and 2010 claims costs in Ontario increased by $3 billion, and during this period the cost of an average claim increased 43%.

As noted in the Auditor General's 2011 report, in 2010 the average injury claim in Ontario was about $56,000. This was almost five times more than the average injury claim in most other provinces and contributed to much higher premiums for Ontario drivers compared to those paid by drivers in other provinces. Accident benefits costs, the primary driver behind these increases, skyrocketed by 118%. This is illustrated in slide 4. The graph on slide 5 shows accident benefit costs in Ontario growing more rapidly here than in other provinces.

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Notable is that a huge portion of these costs were for examinations and assessments, activities that do not involve treatment for those injured in accidents. Between 2006 and 2010, examination and assessment costs increased by 228%. Without the September 2010 reforms, the cost of assessing those injured in accidents likely would have surpassed the cost of treating them by 2011. Most concerning of all, though, was the disconnect between increasing costs and personal injury accident trends.

As I noted earlier, while costs were increasing, the number of accidents actually decreased. From 2006 to 2009—the latest data available—personal injury collisions reported to the Ministry of Transportation went down by over 7%. At the same time, the number of claims for accident benefits made to insurers increased by almost 20%. Similarly, slide 6 shows that while accident benefit costs increased, the costs of repairing and replacing damaged vehicles remained relatively stable. And from 2006 to 2010, the total claims costs for collisions and comprehensive coverages actually dropped.

The most dramatic increase in costs occurred in the GTA, where less than half of all accidents involving injuries occurred. As illustrated on slide 7, from 2006 to 2010 accident benefits costs in the GTA increased by 169%—this despite there being no evidence that injuries sustained in the GTA are more severe than in other parts of the province. It's therefore not surprising that premiums are higher in the GTA than elsewhere in Ontario.

The cost increases and, consequently, premium increases in the years prior to the 2010 reform stem from the overutilization of accident benefits. Key factors contributing to the overutilization included some private health care practitioners providing services in the auto insurance system without due regard to outcome-based treatment results for injured parties, participants who use the system to their financial advantage, inadequate claims management processes by companies, and outright fraud.

Currently, there are over 8,000 health care clinics treating those injured in motor vehicle accidents in Ontario. There are close to 29,000 health care providers authorized to treat those injured in accidents in Ontario; over 15,000 of these are members of regulated health care professions. However, the latest Ministry of Transportation data shows only about 62,500 people injured, the vast majority of whom suffer only minor issues, such as soft-tissue injuries, and recover quickly. As noted earlier in my remarks, the number of personal injury collisions has actually been trending down and decreasing.

Prior to the September 2010 reforms, many health care participants were able to bill insurers for all sorts of treatments and assessments, with few limits. Available data suggest that some participants took advantage of the lack of controls and caps. For example, one month prior to the introduction of the reforms, health care providers flooded insurers with over 205,000 claims forms. In my view, this surge was motivated by the knowledge that easy access to payments would soon disappear. Today, under 84,000 claims forms are being submitted per month. This trend is shown on slide 8.

Insurers bear some responsibility for overutilization in the system, particularly when it comes to claims management. To deal with the volume of claims they were receiving before the reforms, some insurers would simply approve requests for assessments without verifying whether they were necessary. These extra costs were passed on to consumers through premium increases. Legal and paralegal representatives also stepped up their activity; evidence is provided by the dramatic increase in claims being disputed in the dispute resolution process at FSCO. In 2006, FSCO received just over 13,000 requests for mediation. In 2010, we received over double that number. Looking at those numbers, one would think that between 2006 and 2010 there was a huge spike in Ontario accidents and that a large number of these accidents involved serious injuries. But as earlier slides indicated, the data for this time period tells a much different story.

Also of note is the fact that approximately 80% of these dispute resolution applications originated in the GTA, though only 45% of accidents involving injuries occurred there. There is no evidence that injuries sustained in the GTA collisions are more severe than in other parts of the province.

The September 2010 reforms have tackled many of the problems and issues that I've spoken about. Early indications show that the reforms are working. Premiums are stabilizing. During the first quarter of 2012, premiums actually declined an average of 0.18%.

Since the September 2010 reforms, the government has introduced several new measures. The 2011 and 2012

Ontario budgets contained announcements about auto insurance. This focus appears to be motivated by a desire to avoid a repeat of past cycles, where rapidly rising costs and premiums followed a period of rate stability.

Several of these measures reflect an outcome-based approach to treatment for those injured in accidents—an approach that is based on current medical science. Current medical science recognizes the risks of over-treatment to successful patient outcomes for soft-tissue injuries. A new evidence-based minor-injury treatment protocol is being developed by medical experts as part of the current reforms. The new protocol will provide a medical outcome-based approach to treating soft-tissue issues, with the objective being to get people better as soon as possible and back to normal life.

As noted earlier, the vast majority of injuries sustained in motor vehicle accidents are minor, but a small percentage of accidents each year are more serious. The government's 2010 reforms included a commitment to ensure that those who are most seriously injured in accidents are treated appropriately. The government directed FSCO to consult with the medical community on the definition of "catastrophic impairment" as set out in the SABS regulation. It also directed FSCO to consult with the medical community on the qualifications and experience requirements for health care participants who conduct catastrophic-impairment assessments.

An expert medical panel was formed in 2010 to review the definition. The expert panel delivered its reports in 2011, and these were posted on our website and followed by extensive consultations. Following those consultations, I submitted a report to the Minister of Finance with recommendations. The 2012 Ontario budget indicated that this report would be made public and also announced that the government would move forward to propose regulatory amendments to the definition of catastrophic impairment.

Also in the 2012 Ontario budget, the government announced that it would undertake a review of the auto insurance dispute resolution system. In 2011, the government appointed an auto insurance anti-fraud task force, the chair of which you have just heard from. As he noted, the task force is expected to release a report with recommendations later this year.

The Chair (Mr. David Orazietti): Mr. Howell, just so you know, you've got about another minute, so I would ask you to try to—

Mr. Philip Howell: I've got less than half a page.

The Chair (Mr. David Orazietti): Okay.

Mr. Philip Howell: Next year, another five-year review of Ontario's auto insurance system will be undertaken by FSCO.

I'd like to end by emphasizing once again that auto insurance is a product that is designed to give people peace of mind, and peace of mind for which people are willing to pay a premium. Most drivers will never have to make a claim; even fewer will have to make an accident benefits claim. The insurance must balance price and appropriate levels of coverage. Above all, it's a system that needs to be focused on the best interests of the driving public. All participants in the system have an important role to play in keeping the auto insurance system healthy by maintaining that focus.

Thank you, Mr. Chair, and we look forward to questions.

1540

The Chair (Mr. David Orazietti): Thank you very much for your presentation. So we have a concern about starting—what's the request?

Interjection.

The Chair (Mr. David Orazietti): It's up to the Conservative caucus.

Mr. Rosario Marchese: What I was asking was that we start the rotation with the Liberals, so we continue.

Mr. Michael Coteau: Wouldn't it go to the Conservatives now and wrap around this way? I think it's a fair process.

The Chair (Mr. David Orazietti): It normally starts that way. The request was made—

Mr. Rosario Marchese: The request that I was making was that we would start the rotation with the Liberals and we'd just go the other way.

The Chair (Mr. David Orazietti): I understand; I hear the request. It's up to the Conservatives whether or not they want to ask the questions now or wait.

It's your turn to ask questions.

Mr. Jeff Yurek: That's fine; I'll start.

The Chair (Mr. David Orazietti): Mr. Yurek, go ahead.

Mr. Jeff Yurek: Thank you, Chair.

Thanks for showing up and giving us your report. I just have a few questions.

I guess we'll start with the "catastrophic" report; you said you've made a report to the Minister of Finance with recommendations. Do you have a copy of that report that you could give the committee?

Mr. Philip Howell: No. The report was submitted to the minister; it's the minister's report. He's announced in the budget that it would be released.

Mr. Jeff Yurek: So he's ready to make regulatory changes but he's not releasing the report? Do you think this committee would be—

Mr. Philip Howell: That's a question for you to ask the minister.

Mr. Jeff Yurek: —a good spot to discuss those changes?

With regard to costs in the system, would changes to the territory ratings or giving new drivers a credit affect costs in the insurance system? Aside from premiums, would that affect costs in the whole insurance industry?

Mr. Philip Howell: You can't actually separate costs from premiums, because anything that's a cost is going to be translated to a premium.

Mr. Jeff Yurek: So accident claim costs: Would they be affected by changing territory ratings or in fact giving new drivers a credit on their insurance?

Mr. Philip Howell: Accident claims costs will be determined by the number of accidents that happen and

the benefits that are available to access under the system. Those are independent of territory.

Mr. Jeff Yurek: Claims cost are independent.

Mr. Philip Howell: The issue, I think, around the territory is going to speak to how much individual drivers pay for their own premiums.

Mr. Jeff Yurek: So the total cost stays the same?

Mr. Philip Howell: Total cost is going to be determined by the number of accidents that happen and the amount of dollars that are paid out in the claims to settle those accidents.

Mr. Jeff Yurek: Now, Brampton—I had a figure here that if you add up all the claims costs, 20% of the population would have made a medical claim. Would they have higher rates, then, if their claims costs are higher than the rest of Ontario? Would they have higher premiums?

Mr. Philip Howell: Yes, there is a link between claims accidents and claims costs. So drivers in a certain territory—and as noted by Tom in his comments, these are not singling out individual people. The territories are quite big in terms of the number of drivers that are covered. But if a particular territory is generating a large and high amount of cost, the drivers in that territory are going to see that reflected in their premiums.

Mr. Jeff Yurek: Thank you.

Back to the Auditor General's report on mediation: It's supposed to take within 60 days to go through the process and it's now up to a year.

Mr. Philip Howell: Right.

Mr. Jeff Yurek: What steps have you taken to help ease that backlog?

Mr. Philip Howell: There are a number of steps, and actually I'm going to ask Tom to answer that question. I'll just note that he can talk about the steps that we've taken internally at FSCO to improve productivity, and we've had some good results. In addition, as noted in my remarks, the government is undertaking a review of the whole DR system later this year.

Mr. Tom Golfetto: As Phil mentioned in his remarks, the number of mediations that we received in 2006 was around 13,000, and in 2010 it was almost double that. In fact, in 2011 we received 36,000 cases for mediation. That is actually almost triple the number of mediations that we received in 2006.

So we've undertaken a number of initiatives over the past several years to try to improve the productivity and reduce that backlog. In fact, between 2006 and around 2010, we increased the productivity of our mediators—that is to say, the number of cases that we've been able to close through mediation—by about 50%.

I expect that number will increase in 2012 because of some of the initiatives that we have undertaken more recently. One of those is, in addition to the regular workload that a mediator might handle, we have set up something that's known as blitz settlement mediation days. The purpose behind this is to get insurance companies and applicants and their representatives that have a lot of files in common to come to FSCO one day per week, usually on a Friday, and go through a number of cases—significantly more than they would normally be able to do, so they might bring 50 or 60 files that they have in common—and we provide them with mediation rooms and a mediator. The purpose of that is to try to improve our productivity and get as many cases out the door as we can in one day. We've been fairly successful in that, in that we've conducted mediations in this manner of over 1,000 cases already, which has improved our productivity. So that is one thing that we have done.

Another thing that we have done is we've sent out letters to insurance companies and their representatives prior to their case being assigned to a mediator. The letter asks really two questions.

The first question it asks is, "Has this case already settled?" because, as has been noted, there is a backlog of mediation and therefore there's a fair amount of time that has passed between the time we've received the mediation application and when we've actually been able to assign it to a mediator. During that time, a lot of things can happen, and one of the things that can happen is that the case can settle but FSCO hasn't been notified about it. So we've been able to, with this letter, identify cases that have been previously settled that we can take out of the system.

Secondly, the letter asks whether the parties themselves consent to fail the mediation because there's no point in doing the mediation: Both parties agree that mediation will be unsuccessful; both parties have already tried to settle and there's no way they can. If both parties do agree and fill out a form and send it to us, we will do a quick paper review of the case to ensure that the best efforts have been made to settle the case, and then actually issue a report of mediator to allow the parties to move on.

The third thing that we have done, and perhaps the most effective so far, is we've implemented an electronic calendarization system. In the past, mediators were responsible for scheduling their own mediations, and so what would happen is they would make various calls to either side and actually waste a fair amount of time trying to schedule the mediations. So now what we've done is we've put an electronic calendar on our website where the parties themselves can go and pick a mutually convenient time to do the mediation. The parties pick the time and we provide a mediator.

This became mandatory in February; we started the pilot last July. This has resulted in a significant increase in the number of mediations that we can do, because, frankly, we looked at our business and we decided that our core business was actually doing the mediations, not scheduling the mediations. So that has resulted in a significant increase in the number of mediations that we're able to assign to a mediator.

The Chair (Mr. David Orazietti): Sorry; I'm going to stop you there. I think Mr. Yurek just has one more quick question.

Mr. Tom Golfetto: I do have one more thing to say about what we have done, if I might, because it's very important.

The Chair (Mr. David Orazietti): All right.

Mr. Tom Golfetto: We issued recently an RFP for the contracting out of mediation services to assist with reducing the backlog.

The Chair (Mr. David Orazietti): Okay, fair enough.

Mr. Jeff Yurek: Sorry, just a quick question. I understand you have few investigators to actually investigate fraud, so I'm assuming you don't have the resources necessary to tackle how big an issue it is in Ontario. Just further to that question, how are you using the HCAI information to track and monitor fraud, if at all?

Mr. Philip Howell: There are a number of elements there. We do have investigators as part of FSCO and we do regulate more than auto insurance. However, fraud is a criminal activity, so it has to be pursued, and the laying of criminal charges and so on has to be pursued, through the policing system. We do have some limited authorities, and there are proposals contained in the latest budget, and as you heard from Mr. Gorbet, suggestions that we should perhaps have some enhanced authorities that are being considered to give us more opportunity to deal with abuses in the system.

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As well, our investigators do work very closely with other police forces and with the Insurance Bureau of Canada in terms of sharing information and coordinating prosecutions. Our ability to lay charges is under the Provincial Offences Act. If some of the proposals that are being proposed are passed, we'll have an enhanced ability to deal with a wide variety of market conduct and behaviour issues both on the part of companies and on the part of providers in the health care system.

The Chair (Mr. David Orazietti): I'm going to stop you there. We need to move on.

Mr. Singh, go ahead with questions.

Mr. Jagmeet Singh: Sir, in terms of criteria that can be used in assessing an individual, can status in Canada be used as a risk factor?

Mr. Philip Howell: No.

Mr. Jagmeet Singh: Can income level be used as a risk factor?

Mr. Philip Howell: Tom is in charge of underwriting.

Mr. Tom Golfetto: Are you referring to the risk classifications?

Mr. Jagmeet Singh: Yes. Can income level be used as a risk classification?

Mr. Tom Golfetto: No.

Mr. Jagmeet Singh: Can years of residence in Canada be used as a risk classification factor?

Mr. Tom Golfetto: No. The elements that cannot be used are, as an example, income level, employment status, occupation, credit rating, home ownership, the existence of potential collateral source benefits you might have through another insurance party and not-at-fault accidents.

Mr. Jagmeet Singh: Thank you very much.

I'm going to ask you some questions now about the automobile insurance territorial rating update. I understand that 55 territories can be created in the province of Ontario and 10 in Toronto. Is that correct?

Mr. Tom Golfetto: That is correct.

Mr. Jagmeet Singh: So that's means 45 can be created outside of Toronto. Is that correct?

Mr. Tom Golfetto: Yes, that is correct. That's the maximum number.

Mr. Jagmeet Singh: Thank you. This is a portion of the bulletin. It reads, "One of the concerns from a public policy perspective is that if a territory is based on a small geographical area, even though densely populated, socio-economic factors may be influencing loss costs. In addition, drivers may operate their vehicles all over the city, so narrowly defined territories may not be logical. A limit on the number of territories that may be proposed is reasonable and would minimize rate differences due to socio-economic factors."

I just quoted that portion.

Please confirm that two public policy objectives of this bulletin include that territorial definitions not be rooted in socio-economic factors of the drivers in the territories, and that it doesn't make sense to have small, neighbourhood-based territories.

Mr. Tom Golfetto: In answer to your first question, yes, that's right. Socio-economic cannot be used.

Mr. Jagmeet Singh: Okay.

Mr. Tom Golfetto: Could you please repeat the second question, because I didn't quite get it.

Mr. Jagmeet Singh: For example, in the GTA, if you're likely to drive all over the GTA, does it make sense to have small, neighbourhood-based territories?

Mr. Tom Golfetto: Territories aren't small and neighbourhood-based, although I do understand your point about densely populated areas that could have 2,500 risks. That is the minimum amount that can be used for the definition of a territory by an insurer.

Mr. Jagmeet Singh: Okay. I'll move on to my next question. There's a component that requires contiguous territories. Are you familiar with that?

Mr. Tom Golfetto: That's right.

Mr. Jagmeet Singh: The bulletin reads as follows: "In addition, there is the concern that territories that are based on non-contiguous geographical areas could lead to 'red-lining.'" So is it fair to say that the territory guidelines are to prevent red-lining? Is that correct?

Mr. Tom Golfetto: That is correct.

Mr. Philip Howell: That is correct. Are you reading from the 2005 bulletin or the—

Mr. Jagmeet Singh: Yes, the January 31, 2005, bulletin.

Mr. Philip Howell: Okay.

Mr. Jagmeet Singh: There's a section in that bulletin that indicates that the rate differentials for adjoining territories were initially capped at 10%. You allowed it to evolve over time. I assume it evolves upward. Can you tell me what a typical rate differential for adjoining territories is now in the city of Toronto, if the 10% is no longer accurate?

Mr. Philip Howell: I think we'd have to get back to the committee with that detail.

Mr. Jagmeet Singh: Okay. Would you commit to—

Mr. Philip Howell: We'll see if we can, yes.

Mr. Jagmeet Singh: Okay. What does a typical territory look like in the city of Toronto, just roughly, in terms of how wide east-west and how long north-south?

Mr. Philip Howell: It varies. It's important to understand: Each company—

Mr. Jagmeet Singh: —has its own territories.

Mr. Philip Howell: —can have its own territories. They're not single—

Mr. Jagmeet Singh: Uniform.

Mr. Philip Howell: Yeah, they're not at all uniform. And by the way, not every company needs to have 55 territories; they can have less if they wish, and similarly in Toronto.

As I say, there are 100 companies operating. Realistically, 25 companies account for the market, but you can figure, with a minimum of 2,500 risks in a territory, it's not going to be like a two-block area or something like that; it's going to be a subset of the GTA.

I'm not sure it's possible to answer that question, because each company—

Mr. Jagmeet Singh: —is completely different.

Mr. Philip Howell: —in the GTA can create up to their own 10 territories.

Mr. Jagmeet Singh: Fair enough. I'm going to ask you some questions just about the recent changes that came into effect since September 30, 2010. There were significant changes that were made. Has this impacted the profitability of the companies? The underwriting profitability: Has it increased in terms of the companies that you monitor?

Mr. Philip Howell: We are not engaged in the solvency regulation of the companies. That's the responsibility of OSFI, because they're federally incorporated companies.

I think, though, I will make one comment, which is that the system is a dynamic system. People are always looking for ways to access the system and see what benefits can be paid out. Even if everyone was playing completely above board, there's still going to be variability over time for a specific company's individual results at a point in time, because accidents are accidents. They could be hit with a couple of catastrophic accidents during that period. So that's going to affect a company's financial reporting.

But there isn't really a direct—you can't directly link reforms that are made in September 2010, first of all, which wouldn't have been fully in place until September 2011, because not everyone renews their policies on the same day each year. And then there's also the fact that claims costs play out over several years—

Mr. Jagmeet Singh: That's fair. Just a couple of quick questions, then: Do you have access to the figures in terms of the claims costs and what they are for 2011?

Mr. Philip Howell: No, we don't have full-year 2011 data yet.

Mr. Jagmeet Singh: Do you have partial—

Mr. Philip Howell: There is data that will be collected by the General Insurance Statistical Agency, which would probably be August or September, I think, when that would be available.

Mr. Jagmeet Singh: What data do you have as of now, and can you table that—

Mr. Philip Howell: We don't have 2011 data for the whole year.

Mr. Jagmeet Singh: Any data whatsoever? Or do you have partial data?

Mr. Philip Howell: There is data that anyone can access from GISA—some of which you have to pay a fee for, but it's accessible—that can give you some explanation of trends.

Mr. Jagmeet Singh: And do you have any specific data that FSCO maintains, that you can release to this committee?

Mr. Philip Howell: We don't maintain specific data on the financial performance of individual companies.

Mr. Jagmeet Singh: What about claims costs?

The Chair (Mr. David Orazietti): I'm going to need you to—

Mr. Philip Howell: Sorry?

The Chair (Mr. David Orazietti): I need you to try to wrap it up, here.

Mr. Jagmeet Singh: Sure. And what about claims costs for 2011? Do you have—

Mr. Philip Howell: This will be in the data that will be available later in August or September.

Mr. Jagmeet Singh: And do you have partial data that's available now? For example, first quarter, second quarter—

Mr. Philip Howell: There is some data from the first half of 2011 that's available, but it's fairly incomplete in terms of being useful for assessing the reforms, because you really don't have the experience yet of a full year of the reforms.

Mr. Jagmeet Singh: That's fine.

Mr. Philip Howell: That's why the data that will be available in August or September will actually be the first data on claims performance that can meaningfully be used.

Mr. Jagmeet Singh: Can you table that data? Whether it's meaningful or not, can you table that data that you do have? Yes?

Mr. Philip Howell: Tom?

Mr. Tom Golfetto: I guess that would be when the data is available—

Interjection.

Mr. Tom Golfetto: The first half?

Mr. Philip Howell: I'll look into that, yeah.

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The Chair (Mr. David Orazietti): Mr. Marchese, if you want to ask questions, you have about 30 seconds. We'll move on. So, 30 seconds: Make it quick.

Mr. Rosario Marchese: Very good. I have a quick question. The Auditor General, in the 2011 report, recommended that FSCO review what constitutes a

reasonable level of profit, and you agree with that. The rates were set in 1996 by your department, your office. Have you ever thought of reviewing that on your own without having to agree with the Auditor General that maybe it's a good time to do it?

Mr. Philip Howell: It has been noted in the past in FSCO's statement of priorities. It was noted the year before the auditor's recommendation, yes.

Mr. Rosario Marchese: It was noted, meaning you were going to conduct a review yourselves?

Mr. Philip Howell: It has been noted that a review should be undertaken, yes.

Mr. Rosario Marchese: But you never did.

Mr. Philip Howell: It was not undertaken, primarily because of the amount of work we were engaged in implementing the 2010 report, so it was not undertaken that year.

Mr. Rosario Marchese: Okay. The rate approval process in Alberta includes public hearings. Do you think that's a good idea, if we had that here?

Mr. Philip Howell: I can't comment on their system. It's a different system.

Mr. Rosario Marchese: It's a private-delivery jurisdiction; I understand.

Mr. Philip Howell: Private delivery, yeah.

Mr. Rosario Marchese: Do you think it's a good idea, or you don't want to comment on it, in terms of public hearings on establishing the rate?

Mr. Philip Howell: I think we have a system that's in place that's defined in the legislation and regulations for how approvals are made in Ontario.

The Chair (Mr. David Orazietti): Thank you; that's time.

Mr. Philip Howell: Currently, I'm quite comfortable with that system. If the government directed otherwise, we'd have to consider it.

The Chair (Mr. David Orazietti): Mr. Howell, that's it. That's enough. Thanks.

Mr. Yasir Naqvi: Thank you, Chair. I've been waiting for my turn.

Mr. Howell, Mr. Golfetto, thank you very much for your presentation. Thank you very much for providing a pretty in-depth primer. I know it's a very complicated system, but it's a good primer in terms of how the system works.

I'm going to ask one question on the issue around profitability or the return on equity that we were talking about, and then I'll get into talking a little bit more about the insurance rates and premiums. On ROE, you, in your presentation, on page 7, mention a benchmark of 12%. There is a perception out there that insurance companies are guaranteed 12% profit. Are benchmark guarantees the same thing, or what's the difference here?

Mr. Philip Howell: No, absolutely not. As Tom mentioned earlier, the rate-setting process is a prospective one. It's a process in which companies, in determining the rates they are going to require in a period going forward, need to assess both their estimate of current claims costs, which will include costs maturing from earlier accidents' years—so they'll look at the accident-loss trend. It will also include, in terms of determining the amount of rate that they're going to need or amount of premium, their estimate of expenses in terms of delivering the product. It will also include a return on the capital that's invested in the business.

Let's remember that Ontario auto insurance, for many of these companies, is a relatively small portion of their business. The Ontario auto part is competing with other business opportunities in other parts of Canada and other parts of the world for rate of return. So the company will always—they have to, in order to do the actuarial estimates of the needed rate—include some measure for return on invested capital.

The 12%, as Mr. Marchese noted, was established a number of years ago and has been in use since then. We published that as a benchmark and look to companies to ensure, in their rate application, that they have actually taken account of return on capital. The last thing that we want is companies not taking account of return on capital and going out of business, because ultimately, the more companies that are financially viable and offering insurance, the better it's going to be for the drivers in the province and for holding rates down.

Having said that, the 12% is certainly not guaranteed, and it has been many years since companies have generated a 12% rate of return on their equity in the auto product in Ontario.

Mr. Yasir Naqvi: So you are going to be reviewing that benchmark, I think, that you indicated—

Mr. Philip Howell: We are going to be reviewing the benchmark. I should probably also note that in the other provinces that have privately delivered auto, the benchmark that's used ranges from 10% to 14%. So, depending on the jurisdiction—the 12% does deserve to be reviewed, I think, given what has happened to cost-of-capital trends and interest rates over time. It's certainly not relevant, as some have done in the press in response to the auditor's report, to compare that benchmark to the cost of the Ontario government borrowing funds internationally. That's completely irrelevant in terms of a price of capital for a private business.

Mr. Yasir Naqvi: Okay. I want to talk to you a little bit about insurance rates and premiums. I preface my line of questioning by saying that it might come as a surprise to some people that there is more to this province than the greater Toronto area, and I for one would like to recognize that, coming from Ottawa. So I think we need to have a conversation around what happens in the rest of the province as well as and opposed to just in Toronto, because it's important.

When we're talking about territories, if we remove territories as a ratings factor, what would happen to rates across the province?

Mr. Philip Howell: What would happen to rates across the province is that the total amount of money raised would stay the same. The amount paid by individuals would vary dramatically, depending on where you live. The rates for drivers in Toronto would drop sig-

nificantly. The rates for people in other parts of the province would rise dramatically.

Mr. Yasir Naqvi: So rates in other parts of the province will rise dramatically.

Mr. Philip Howell: If there was a single territory.

Mr. Yasir Naqvi: Do you have any sense of—

Mr. Philip Howell: And that's arithmetic, right? I mean, the costs are determined by the number of the accidents and the administration costs of delivering the insurance. So the total is going to stay the same.

Mr. Yasir Naqvi: So the rest of the province will pay for the sins in Toronto.

Do you have any sense of what kind of differential we're talking about, what kind of variable? What will happen in the north? What will happen in eastern Ontario, in my part of the world? What kind of rates increases are we talking about in—

Mr. Philip Howell: I think in the north and eastern Ontario, they'd be dramatic. I don't—

Mr. Yasir Naqvi: Over a 10%, over a 20%, over a 30% increase?

Mr. Philip Howell: Oh, I would think well over 10%. They'd be quite dramatic. I don't want to be pinned down to a specific number out of context, but again, the arithmetic ensures that that would happen.

Toronto: You mentioned that the population density is much greater, and there are a lot of people in Toronto who are paying high premiums because of the higher claims costs that are generated here. That means that a large volume of that overall number is accounted for by Ontario people. So if their premiums are going to come down dramatically, that has to be dispersed over many fewer people in the rest of the province, where population density is less. Consequently, there will be reductions for people living in Toronto, but dramatic increases for people living in other parts of the province.

Mr. Yasir Naqvi: And you think at least 10%—

Mr. Philip Howell: Oh, at least. And again, it's going to depend from territory to territory, from company to company and individual to individual, which is one reason that I'm reluctant to be pinned down. But again, the arithmetic shows that that would be the case.

Mr. Yasir Naqvi: Mr. Howell, it's my understanding that Bill 45 imposes a rating structure that has a Statistics Canada population measure as a rating variable that is ranked fourth in order. It has been claimed that this measure will help save, for example, the north from the debilitating effects of this particular bill. Do you find the claim to be accurate at all, especially given the overly simplistic and unworkable rating structure that it's placed in?

Mr. Philip Howell: What I will say is that I think the use of that as a rating variable is getting away from what the Insurance Act is looking for in terms of rating variables, i.e., that they be predictive, or reasonably predictive, of risk. That type of a measure is arbitrary in the context of determining risk, so it's inconsistent with the Insurance Act, as it's currently written. That, of course, doesn't mean the Insurance Act couldn't be changed and amended.

I think perhaps, again, more importantly, as a factor that determines the chance of accidents and so on, it is true that density does matter, but population in and of itself is not really a risk factor in the sense that the Insurance Act contemplates.

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Mr. Yasir Naqvi: So let me ask you this: What are the consequences of moving away from a system designed around risk?

Mr. Philip Howell: Well, it stops being insurance, for one thing, and it becomes arbitrary. Essentially, you're into a system where you are just setting prices that don't bear a relationship to what's driving the cost. In other words, it's going to—it becomes arbitrary.

We should be clear about this: All insurance does involve some degree of cross-subsidization; that's the essence of pooling risk. That's what insurance is. But if you take it to the extreme in a large area that has all kinds of risk factors, which Ontario does, that have to do with climate, density of roads, number of roads, types of vehicles used, all that kind of stuff, and just sort of throw that out—

The Chair (Mr. David Orazietti): Mr. Naqvi, I need you to wrap up.

Mr. Philip Howell: —you're going to be disconnecting the pricing of the product from the things that cause the risk.

Mr. Yasir Naqvi: I have one last question.

The Chair (Mr. David Orazietti): Very briefly.

Mr. Yasir Naqvi: A very brief question. I don't know if you're seen the comments that Mothers Against Drunk Driving, MADD, have made in regards to Bill 45. Basically, they said that the bill punishes responsible drivers and rewards dangerous drivers and will increase the risk to Ontario road users. In your analysis of Bill 45, do you agree with that statement made by MADD Canada?

Mr. Philip Howell: I don't think it's appropriate for me to comment on that opinion. And by the way, just so it's clear, I think the analysis of Bill 45 and so on is the responsibility of the legislators and the government. As I indicated in my remarks, we operate within a regulatory environment. If the Legislature passed that, we'd have to figure out a way to deal with it.

What I will say unequivocally is that in a single-territory type of system or a two- or three-territory type of system, there will be really, really large increases for some people in their insurance premiums in parts of the province outside of the GTA.

The Chair (Mr. David Orazietti): Thank you for your time today and thank you for your presentation.

Next presentation—

Mr. Jagmeet Singh: Mr. Chair, this is a document I wanted to table anyways; I'll just table it now. I would gladly give one to the presenters. I have copies for everybody.

The Chair (Mr. David Orazietti): Okay. The clerk will circulate those.

COALITION REPRESENTING
REGULATED HEALTH PROFESSIONALS
IN AUTOMOBILE INSURANCE REFORM

The Chair (Mr. David Orazietti): Okay folks, moving right along, the next presentation is the Coalition Representing Regulated Health Professionals in Automobile Insurance Reform. Come on up. Good afternoon. Welcome to the Standing Committee on General Government. You've got 10 minutes for your presentation.

Just a reminder to members of the committee: If we're going to try and get an opportunity for each caucus to ask a question of every presenter, one person pick your question, keep it brief, and we're going to try and keep things moving.

Mr. Rosario Marchese: Sorry; we're going to rotate the questions, five minutes per—

The Chair (Mr. David Orazietti): Each caucus will get an opportunity. Not five minutes each; five minutes combined. The presentation is 15 minutes. They've got 10 minutes for their presentation; we've got five minutes of balance.

Mr. Rosario Marchese: Chair, I hear you. Can I ask—

The Chair (Mr. David Orazietti): Same way we've been doing it.

Mr. Rosario Marchese: No, I understand that. Sometimes we rotate it so that we all get five minutes with different deputants. We could decide to do how we like it, Mr. Chair.

The Chair (Mr. David Orazietti): Sure, if that's the will of the committee.

Mr. Rosario Marchese: Do people like the idea of a minute and a half each or do you want to rotate with the different presenters?

Mr. Yasir Naqvi: I say we split the time because we may have questions, too. They're different groups and different perspectives.

Mr. Rosario Marchese: The problem is, you're only going to get one question.

Mr. Yasir Naqvi: Well, then, I get one question.

The Chair (Mr. David Orazietti): This way everyone gets a question of the presenter.

Mr. Rosario Marchese: I hear you, but I'm asking—

Mr. Todd Smith: That's a fair way to go about it. I think that's a fair way.

Mr. Rosario Marchese: Okay.

The Chair (Mr. David Orazietti): We just have to try to keep it concise.

Whoever's speaking, please just state your name for the purposes of Hansard, and you can start when you're ready. You've got 10 minutes and we're going to divide the time for questions.

Dr. Moez Rajwani: Thanks, Mr. Chair, for the opportunity. I'll just quickly introduce our group. My name is Moez Rajwani. I am with the Ontario Chiropractic Association and the co-chair of the coalition. To my right is Karen Rucas from the Society of Occupational Therapists. To my left is Jennifer Holstein, director of programming and member services, Ontario Physiotherapy Association, and I have Faith Kaplan, who's with the Ontario Psychological Association. Jen's going to start speaking first and then I will end the conversation.

Ms. Jennifer Holstein: Good afternoon. Thanks very much for having us. I'm going to speak really fast because I know we've got about 10 minutes and we do have questions afterwards, so I won't dawdle.

Just a briefing about who we are. We're comprised of professional associations representing literally thousands of health care professionals working with patients, and particularly those injured in motor vehicle accidents. Over 10 years, we've worked with government and other stakeholders on numerous changes to the auto insurance system. We've provided expertise and advice on SABS reform; development of the original pre-approved framework, which then morphed into the MIG, as you guys may know; development and rehabilitation of the health claims for our auto insurance system; and most recently we've been working with FSCO's HCAI data reports and anti-fraud working groups. We're comprised of plenty of professional associations. We've provided a list for you there; I won't go through them now.

Auto insurance in Ontario has been subject to numerous regulatory overhauls in the past 10 years, all with the intent of stabilizing or lowering premiums paid by Ontarians. The most recent round of reforms, which was implemented in September 2010, addressed many issues that were seen to be affecting costs in the sector. The costs of soft-tissue-injury claims were going up, so the reforms brought us the introduction of the minor-injury guideline and the minor-injury cap that would cover med rehab costs for the majority of soft-tissue injuries. Med rehab costs were capped at a much lower threshold, bringing Ontario in line with benefits in other provinces. The cost of assessments is now included in that cap as well.

Potential claims abuse of the housekeeping and caregiving benefits resulted in their almost complete removal from the system. Also, the attendant care benefit was reduced by 50% and its misuse was handled by reducing the assessors to OTs and RNs, registered nurses.

Insurers have the means and obligation to verify whether an expense has been incurred, and patients are engaged in managing their own expenses—which is fantastic—through the receipt of periodic benefit statements outlining what has been billed under their policy. In addition, FSCO released a guideline on what is allowed to be billed for goods and services, like exercise balls, assistive devices, that kind of thing.

Your committee here has several goals. We'll be focusing on the minor-injury guideline and minor-injury cap, antifraud initiatives and dispute resolution.

The changes in 2010 made a significant impact on available medical rehabilitation benefits in particular. Funds available to those who are catastrophically impaired have not changed; however, those related to non-catastrophic were cut significantly. Basic med rehab benefits were cut in half to $50,000, with the cost of any

assessments now included in that cap. However, the majority of patients will now only be able to access approximately $3,500 in benefits if their injury is considered to be minor under the definition in the statutory accident benefits schedule.

In addition to cuts made to med rehab, other benefits available under the SABS were cut, capped or only available if you purchased optional insurance. Several of these benefits are not accessible if the patient is seen to have a minor injury. Prior to 2010, patients with neck injuries—so whiplash and associated disorders—received treatment under the pre-approved framework guideline. Reforms brought us an expanded version of this guideline that now includes the majority of soft-tissue injuries. Whether the patient has a sprained ankle and some slight neck pain or has multiple soft-tissue injuries, this all goes under the minor-injury cap.

While the majority of people will likely get better under this framework, there's no exemption for those people who require additional treatment once the minor-injury guideline treatment and the total cap of $3,500 has been reached. It should be noted here that the $3,500 is a relatively arbitrary fee. It's not something that was based on—the treatment framework itself is based on scientific evidence, but not the amount. So we may have gone from a program that is a little too narrow in its scope with the pre-approved framework to one that might be a little too broad.

Discretion for insurers was also introduced to limit the insurer need to seek an insurance examination for every dispute, even those where it would be reasonable to deny out of hand; so, for instance, something really ridiculous or somebody resubmitting a treatment plan over and over and over again. However, providers are finding that insurers are using this discretion to deny what could be reasonable treatment without the opportunity for a patient to get a second opinion. Insurers are obligated to identify a medical reason for denial, but provider experience, again, indicates that this isn't happening. So when a patient does get denied, there are no real options for dispute resolution beyond the FSCO mediation and arbitration process, which we've heard is taking significantly longer than it should.

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Dr. Moez Rajwani: So to summarize some of the medical issues that have come up, minor injuries, as you heard in the two presentations before, were a key driver of the escalation in costs. As regulated health professionals, we were supportive of the concept of dealing with soft-tissue injuries in a reasonable fashion. But as we mentioned earlier, now we have a situation where those 15% or 10% or 5%—whatever that number is—do not get better. There really is no opportunity for them to go outside of that cap.

There is a gap between the $50,000 that's available to a serious injury, and that of a catastrophic injury, which is $1 million. Some patients run out of the $50,000 before they're able to go through the application process of $1 million, which can happen at the two-year mark.

As you're looking at this whole area of catastrophic determination, there are two issues, really. There are those who are seriously injured and those who are catastrophically injured. I know the government has tabled something in terms of what the new definition may look like. From a health professional point of view, we want to make sure that access to care is not limited by the complexity of a system. So if the system is going to become more complex to get access to that care, then that's something we're concerned about. The system that exists today only really impacts 2% or 3% of patients who are really catastrophic. So we want to make sure, if there are going to be any regulatory changes, that the whole picture be looked at before the change is made.

There was the introduction of a $2,000 cap on assessments. Again, FSCO mentioned that there was a rising cost in assessments, and we acknowledge that and we realize that that was a concern. For certain remote areas outside of the GTA that require services, the $2,000 can be cumbersome because of travel costs. Some of the more complex assessments required for complex patients can also be a concern.

We, as an organization that represents health professionals, have been very supportive—and our members are also concerned about fraud. One of the big issues for us is identity fraud, where regulated health professionals have been abused themselves by their regulatory numbers being taken advantage of by non-health professionals. So we've been working with the fraud task force in the area of credentialing and looking at how we can make sure that our professions are organized. Some of the measures that Phil Howell talked about in terms of some of the regulatory changes—we've been supportive in those areas.

HCAI was mentioned earlier, and we've been strong supporters of HCAI. We feel HCAI is the opportunity to get some real medical data for some of the questions that all of you are asking, and we've been working with the HCAI working group to come up with data that can be relevant and useful to all of us.

When you're looking at the area of licensing, we want to remind everybody that there are regulatory colleges that exist, that already license us. We understand that sometimes they are not using their full authority in the business practice area, but before you start looking at full licensing in the auto sector, we recommend that you look at the regulatory bodies and ensure that the systems that you already have in place are maximized before you go to the licensing area.

In issues of non-regulated health professionals, we are supportive of a licensing system and we would support any measures that the government put forward.

The Chair (Mr. David Orazietti): Okay. I need you to wrap it up here.

Dr. Moez Rajwani: Okay. So in conclusion, we've been supportive of some of the measures. However, we think that the pendulum has now shifted. Some health professionals feel that everybody thinks that we are all fraudulent somehow and that everything is being double-

and triple-questioned. We want to reassure the standing committee that we're here to make the system work, but we want to make sure there's access to care.

The Chair (Mr. David Orazietti): Thank you very much. In rotation, the NDP caucus is up first for questions. If you've got a question for our presenters, go ahead, Mr. Singh.

Mr. Jagmeet Singh: Certainly. You indicated that some of the issues that arise from putting a cap may differentially impact those who have further distances to travel, and for complex cases. In general, in terms of quality of care that we're receiving, or the quality of the product that we're receiving, in terms of the benefits we're receiving in Ontario, your thoughts on that as compared to other provinces—the amount of care or the amount of benefits that we receive now.

Dr. Moez Rajwani: It's a broad question because there's a spectrum of care. I think that when it comes to complex care issues, where there are multiple injuries that the patient has incurred, and then that framework between the serious and the catastrophic, we do feel that there can be situations where treatment is compromised and that we need to look at those areas.

In the soft-tissue area, as Jennifer mentioned, the majority of patients do get better quickly and require a certain amount of treatment. But, once a minor injury, not always a minor injury. There are circumstances where things that seem very simple and uncomplicated at the beginning, due to multiple reasons, become more complex and there needs to be that transition from soft tissue to something that may require more intervention.

Mr. Jagmeet Singh: Okay. And just one last thing: Have you had any experience with the fact that many claims are now being denied or with the fact that everyone is arbitrarily being funnelled into soft-tissue damage?

Dr. Moez Rajwani: Yes. One of the things that we've identified is that the SABS now asks for a medical reason. Sometimes patients are put into certain boxes, whatever box that is, without a medical reason. We want to ensure that health care providers are making the decisions on health care issues and not non-health care providers. So that's an issue that we do see.

The Chair (Mr. David Orazietti): I appreciate it. Thank you. Next question. Mr. Naqvi, go ahead.

Mr. Yasir Naqvi: Thank you very much. Thank you for your presentation. One thing that's sort of been bothering me that Mr. Howell was talking about too is the statistics that in recent years there has been a significant increase in medical costs even while the number of accidents has been stable. How do you account for these figures? What, in your view, is going on, that we see that differential?

Ms. Karen Rucas: The $56,000 per claim that they're talking about: We have to also be careful what we're talking about there. Is that also the cost of those housekeeping benefits, the attendant care benefit, the RIB benefit, or is it just the cost of treatment and assessment? When we talk about assessment, we also have to look at, is that the assessment for the purposes of determining if somebody needs an income replacement benefit, or is that an assessment before you give treatment? Everyone has to be assessed before we treat you. So we have to look at that $56,000 number and understand really what's inside that number. I don't know that we've gotten any straight answers in terms of what that number represents. Is it benefits plus treatment plus assessment? Is it the insurer assessment? We don't know.

Mr. Yasir Naqvi: Do you have a theory?

Ms. Karen Rucas: I have a theory that it's all-in, but I don't know for sure.

The Chair (Mr. David Orazietti): Thank you. Ms. Scott, go ahead.

Ms. Laurie Scott: Thank you for coming and appearing today. You mentioned the "catastrophic" report. We have certainly asked for that to be tabled, and hopefully the government will allow ample time so the health care professionals can give advice on that report. We just wanted to let you know that we have asked for that.

Back to young professionals: The graduates seem to be a target for fraudulent—you know, their numbers are taken; you get into the new profession, you don't really know the land mine you could be walking into in this insurance climate at the moment. Do you have any ideas how we can stop the identity theft among the professionals?

Dr. Moez Rajwani: One of things that some of the professional associations are now doing is, they're trying to orient new graduates around the realities of business practice. There's a reality in school about health care, and that's really important; that's what you go to school for. But sometimes you graduate and you don't really understand the framework that you're in. As professional associations, that's our job. We're not a regulatory body; we're there to take care of our profession. Many of us have, not even just in that year but in fourth year or their last year of school, started talking about some of these practice issues, talking about jurisprudence, talking about fraud, and just realizing that at the end of the day, with the title of their regulation or their health profession comes a responsibility and accountability and what that's all about.

So we're trying, from our point of view. I know the Financial Services Commission has issued some pamphlets around this area, and we'll continue to work with them. We're looking at a credentialing process where people can check to make sure that if they're working for ABC rehab clinic, then their name's there, and if they're not working for them, then they're not there. So that's what we're working with.

Ms. Laurie Scott: Excellent. Thank you for that. That's fine.

The Chair (Mr. David Orazietti): Thank you very much. That's time for your presentation. I appreciate you coming in today.

ALLSTATE INSURANCE

The Chair (Mr. David Orazietti): Our next presentation: Allstate Insurance. Good afternoon, folks. Welcome

to the Standing Committee on General Government. As you are aware, you've got 10 minutes for your presentation, so simply state your name for our recording purposes and you can start when you're ready.

Just as part of housekeeping, you're aware that the bells are ringing here and we need to be able to get to the House to vote, so start, and at some point I will have to stop you and then I'll let you continue after we come back. I appreciate your co-operation.

Mr. Tony Irwin: Good afternoon, Mr. Chairman and members of the committee. My name is Tony Irwin and I'm manager of external affairs and consumer relations at Allstate. I'm joined today by my colleague Saskia Matheson, our director of risk management for auto and property. On behalf of the Allstate Canada group of companies, we'd like to thank you for the opportunity to address your committee here today.

Over the past several months, we have met with members from all parties in the House, including some from this committee, to discuss issues that we feel are affecting our industry. We think these discussions are vital to ensuring we have an auto insurance system that is fair, accessible, affordable, sustainable and competitive for Ontario consumers. We intend to continue these discussions, moving forward, and applaud the government for recognizing the need for an ongoing dialogue with all stakeholders, FSCO and the Ministry of Finance.

1630

As has been said by other presenters today, auto insurance is a complicated product but nevertheless an essential one in our society. As family budgets continue to be stretched, we recognize that the cost of auto insurance is becoming more difficult for many people to manage, and was an issue heard at many doorsteps during the provincial election last year. There are no easy answers, but Allstate is committed to making improvements to protect consumers and foster a competitive marketplace, enabling our industry to contribute to the provincial economy in a meaningful way, while at the same time providing the best product possible to our customers.

We are here today because we believe these hearings are an important part of the process and because we think we have something to contribute from our own unique perspective and experience. Finding solutions to auto insurance affordability is a daunting task. It is our hope that in addition to increasing awareness, these two days of public hearings will encourage all stakeholders to commit to making the system better for Ontario consumers.

By way of background, Allstate Canada Group includes Allstate Insurance Co. of Canada, Pembridge Insurance Co. and Pafco Insurance Co., and employs over 600 people at our Canadian head office in Markham. We underwrite the personal risk of Ontarians in communities both urban and rural, north and south, east and west throughout the province, and have been providing property and casualty insurance products to Canadians since 1953. Allstate Insurance Co. has 415 exclusive agents in 53 offices across Ontario with $498 million gross written premium in 2011. Pembridge and Pafco are broker channel companies. Pembridge operates in the standard market, while Pafco is an alternative market for high-risk drivers. We work with 169 broker partners in 467 locations across Ontario with $189 million gross written premium in 2011.

I'd now like to turn it over to my colleague Saskia Matheson.

Ms. Saskia Matheson: Good afternoon. Thank you very much for the opportunity to speak to this committee. My name is Saskia Matheson. I'm the director of risk management for Allstate Canada. I've been with Allstate Canada for five years, but I've been involved in the Ontario automobile insurance question for 25 years—I had to count it twice just to make sure it was true.

I began actually with the Osborne inquiry in 1987. In fact, at that point we were looking at very similar questions to what you were looking at today, which is how do you balance the need for fast, efficient, fair, complete benefits and support for people who have been injured in an automobile accident against the need for affordability of all Ontarians? That report became the foundation of what I consider the first reform in 1989—there may have been some before, but they were long, long ago—which was the OMPP reform, which began this conversation. The conversation has continued through a number of reforms since that time, always focused on the same question: How do we balance affordability against the need to help victims of auto accidents?

During that time and all of those reforms, I have seen what I would count as four themes that have evolved, and they seem to remain true through all those years. I'd like to share those themes with the committee.

The first is the basic truth—we've talked a lot about fraud—that the more generous the system of benefits, the more tempting the fraud becomes. So there are perpetrators of fraud who sit on the edges and wait, but when the target is tempting, that's when they move.

There have been a lot of discussions today—and certainly in the press and over the years—about, can we estimate the amount of fraud in the system? Can we put a dollar figure on it? The first point to make is that it is a difficult process, one, because perpetrators of fraud aren't very helpful in supplying data about the money they take out of the system. So we're not going to get nice statistics that come through either Revenue Canada or any other place—

The Chair (Mr. David Orazietti): Sorry, I need to stop you.

Ms. Saskia Matheson: Absolutely.

The Chair (Mr. David Orazietti): Members have to go and vote. We'll be right back to continue. Thanks. We're in recess.

The committee recessed from 1635 to 1643.

The Chair (Mr. David Orazietti): Right, folks, we'll get started. You've got about four more minutes for your presentation, and then we've got some time for questions. So, yeah, go ahead. Thanks.

Ms. Saskia Matheson: As I mentioned earlier, there's been a lot of discussion about fraud, and there are certainly differing estimates of the amount of that fraud.

Interjections.

The Chair (Mr. David Orazietti): Folks, we need quiet so that we can hear the presenter. Thank you.

Ms. Saskia Matheson: Those estimates range from some studies that were done in Quebec in the late 1990s that put those amounts at around 10% of claim amounts and between 10% and 20% of claims dollars, all the way to some US studies that put that number as high as 40%. But the importance isn't the quantum. The importance, in our view, is the fact that these are dollars that are coming out of policyholders' pockets, and they are going to people who are not entitled to them. Those are dollars that are coming out of someone's pocket who is entitled to them, and that's why it's important.

It leads to the corollary, though, that in the same way that generosity of benefits leads to a temptation to fraud perpetrators, it also leads to the danger of administrative cost. The more dollars that are at stake, the more important each side sees the controls and the administrative completion of the forms and the checkpoints, and while these are absolutely crucial to ensure the fairness of the system, they also add cost. So it is truly important that we collaborate in streamlining that process and taking out as much administrative cost from the system as we can. No one ever sets out to create a system that is administratively expensive or cumbersome. It grows as the competing visions of what controls need to be there are in place. So, to our view, collaboration and discussion of these issues becomes crucial to building the long-term solution.

This leaves us with a really important point, which is, we all want the issue and the cost in the system to be fraud, we want it to be administrative waste, but once you've run through, once you've gotten rid of all the fraud, once you've cleaned out all the administrative waste, then you need to make the hard questions about what benefits are you going to give in return for what premium. Those questions are the really, really hard questions. Every round we've done of Ontario automobile product reform has been that balancing act. How can we squeeze more benefits out of a product without raising the price? How can we reduce the price without giving up any of the benefits?

My third point: Did I mention that collaboration is important? I have about, I believe, a minute and a half left, and even if I had all the answers, we couldn't begin to scratch the surface of the work that needs to be done. But one of the important reasons that Allstate is here today, and we are at every table we are invited to in any way participate in on this subject, is because it is so critical that all interested parties—the government, the industry—come together to make the product better.

I do leave you with one final win-win, because there is one win-win in this question, and that is the win of traffic safety. We've seen how there has been a reduction in claims but an increase in expense. Only through a reduction in accidents and a reduction in the severity of the injuries that occur do we end up with less cost and less premium and more benefit to all Ontarians.

We look forward to that collaborative effort. We believe industry has a lot to offer in all of those regards, and we thank you for your time today.

The Chair (Mr. David Orazietti): Thank you very much for your presentation. The government caucus is up first. Mr. Naqvi, go ahead.

Mr. Yasir Naqvi: Thank you very much, Chair.

Let me ask you a question about data on accident rates across the province. I'm sure you have data on accident rates. To what extent does that impact the actual rates, the premiums that people pay?

Ms. Saskia Matheson: Sure. We go through two exercises. Obviously, one is predicting the amount of dollars we will need, which is very much based on what accidents have occurred and, therefore, where they are likely to occur in the future. That sets the amount of dollars that we're going to need in order to pay those claims a year and two and three years down the road. Then we divide that, and I think this is something that the representative from FSCO was mentioning.

The two exercises: The dollars in the end must equal each other, but we do work within certain limitations. For example, there could be accident benefit claims that cause a great deal of expense in one category of claimant, but we do not use accident benefit experience in order to rate customers. So in the end, the numbers have to be equal, but they are different equations.

The Chair (Mr. David Orazietti): Thank you. Mr. Yurek, go ahead.

Mr. Jeff Yurek: Thank you for coming out and speaking at this committee.

Part A and B questions: Can you quickly review what FSCO has in place to prevent insurance agencies from red-lining, or how they say targeting race, income and socio-economic factors? And part two: We've talked earlier, and the reports have come out, that premiums are higher in the GTA as a result of high claim costs. As a business, are your premiums—your customers in the GTA—as a result because you want to charge people in Toronto more, or is it actually the fact that it costs a lot more to do business in Toronto? If you can touch upon those two.

Ms. Saskia Matheson: I'm not sure. Perhaps I can deal with the latter part of that first. We're a business in business to make money. What we want to do is charge people the right premium for the cost at the end of the day. It absolutely has no advantage to any company to charge a group more than it represents, because you'd be chasing away the business to a competitor who would be able to under-price you for that same business. So that's the question of—we charge what we charge in the GTA and in each territory because that is the cost that is represented to us in each territory.

In terms of the rules that are in place for territory from FSCO, they have fairly complete and extensive rules about the number of territories that we can have—a

word, "contiguity," that none of us who work in insurance used to know until FSCO came on to the scene.

But perhaps most importantly, there are rules to stop companies from creating territories out of a piece of street here and a bit of information over there. They must actually be a territory that you can look at on the map and draw a line around. They must have sufficient people in them to be statistically valid.

Ourselves, we use a technique that goes first to personal characteristics in determination of rate. So first, we look at the experience. We take out all of those variables that explain—things that people can control. For ourselves at Allstate and the way we do our rates, territory is the last piece of the puzzle that is there for things that individual characteristics of the driver cannot explain.

The Chair (Mr. David Orazietti): Okay, thank you. We're going to move on. I appreciate it. NDP caucus—questions? Mr. Singh.

Mr. Jagmeet Singh: Since the regulations in 2010, have you noticed a significant decrease in claims costs in 2011?

1650

Ms. Saskia Matheson: We've noticed two things that have happened. First, we have seen a decrease in claims on the medical side. We are also, however, beginning to see an increase in claims on the bodily injury side. Our claims department uses the term "cautiously optimistic" because, as I think was mentioned before, reforms that came in in September 2010 only begin to push that through—

Mr. Jagmeet Singh: Sure. Could you table your claim costs for 2011?

Ms. Saskia Matheson: We can table our—I'm looking at Mr. Irwin. Our data is part of IBC data, and we certainly—it's part of the rate filings that go into FSCO.

Mr. Jagmeet Singh: Thank you. And in terms of profits, have your profits increased substantially in 2011?

Ms. Saskia Matheson: We have three brands. My only hesitation is our three brands have different experiences. In one case, things have improved, and in one case, not so much.

Mr. Jagmeet Singh: Okay, and just a final question: Replacing territories with census metropolitan areas would allow for many divisions across Ontario still. For example, every city in Ontario could represent a CMA if it falls within the population, which is over 10,000, so many of the cities in Ontario would still be subject to being separated and treated differently. Would you agree with me that all it would do is stabilize rates within the CMA as opposed to increasing rates in other CMAs?

Ms. Saskia Matheson: I think you're referring to the provision within the bill that you tabled about using population as opposed to using specific territory. Is that correct?

Mr. Jagmeet Singh: That's right.

Ms. Saskia Matheson: If I can say, first of all, our view is that customers are always better off if companies can compete on a number of rating differentials. That allows companies to bring in new and different ways to benefit customers.

Mr. Jagmeet Singh: Within one region.

Ms. Saskia Matheson: But stabilizing rates within one area, if we're talking about the industry—if we're forced to have one rate in one area, I suppose that's stable. The question is whether or not stable is either fair or equitable to the people both within that area or outside of it.

The Chair (Mr. David Orazietti): Okay, that's time. We appreciate you coming in. Thanks for your presentation today.

INSURANCE BUREAU OF CANADA

The Chair (Mr. David Orazietti): Folks, our next presentation is the Insurance Bureau of Canada. Good afternoon. Welcome to the Standing Committee on General Government. Thanks for coming in today. You've got 10 minutes for your presentation. State your name for the purposes of our recording Hansard, and you can start your presentation when you're ready. Thank you.

Mr. Ralph Palumbo: Thank you. My name is Ralph Palumbo. I'm here from the Insurance Bureau of Canada as the Ontario VP. I'm accompanied today by Barbara Sulzenko-Laurie, our vice-president of policy, and Pete Karageorgos, our manager of consumer and industry relations.

I'm here, basically, to deliver a simple message on behalf of our member companies: Auto insurance rates in Ontario are too high. We know that you hear that from your constituents. While we can't deal with individual cases today, I do want to say that a key service of IBC is helping consumers navigate through the insurance system through our consumer information centre. We've provided that contact information with our presentation today.

Now the facts: The average private passenger auto annual premium in Ontario as of April 2012 was $1,534. That compares with $1,051 in Alberta, $989 in Newfoundland and in the $800s in other Maritime provinces.

While four years ago, Ontario premiums were on average 25% higher than the next-highest province—that's Alberta—today, the average Ontario premium is now more than 45% higher than Alberta and almost twice as high as premiums in the Maritime provinces.

Calculating how much insurance should cost is a complex task, as you've heard today, because insurers must set the price long before they know what the costs are that they're going to incur. Insurers can't know for certain ahead of time how many consumers will make a claim or how much those claims may be. Therefore, the cost of claims must be calculated based on actuarial science. Using information from past experience, insurers determine the price to charge consumers today to protect against claims that they may incur in the future. The rates that insurers charge, as you've heard, must be approved through the FSCO regulatory process.

How did Ontario's insurance rates get so high? This is what we know: Ontarians are not the worst drivers in

Canada. In fact, Ontario has the safest roads in North America. Cars are now better equipped for protecting passengers. There are 12% fewer serious accidents requiring hospital admission. So if the roads are better, cars are safer and accidents are less severe, what is driving up insurance costs? I will answer that question, but first I want to dispel a few myths about the factors at play in terms of the higher premiums.

Let's start with the issue of insurance industry profits. As you've heard, FSCO sets a benchmark for profit of 12% as part of the rate approval process, but this doesn't mean that insurance companies have a guaranteed 12% profit. In reality, the Canada-wide industry return on equity across all insurance lines across the country was 8% in 2011. That compares with levels of 9.8% in mining, 10.6% in manufacturing and 11.8% in retail trade.

Here's another fact: Between 2008 and 2010, the industry lost a total of $2.96 billion on auto. In 2010 alone, the figure was $1.76 billion. I can say without any equivocation that during this period, when premiums were rising significantly, insurance profits were not a factor.

Any reasonable person would ask, "Why do you keep writing here? Why are you in the business when you're losing all that money?" The answer is that insurance profitability is cyclical. Insurers didn't always lose money in Ontario, and they sure hope that they don't in the future. As well, Ontario is a significant market. Nobody wants to leave Ontario. Why would they?

The other issue, of course, is that home, car and business insurers are very conservative and safe investors. They invest in secure bonds that are a lot less vulnerable to stock market fluctuations than other investments. That's why in 2008, when the TSX and mutual fund indices finished in negative territory, the P&C industry investment returns came in at almost 4%.

All right, so what's driving up the costs? You've heard it over and over again today: It's claims—claims costs. If the problem was factors that insurers use to classify risk, like the use of territory, or for that matter, any other factor, then we would see premium increases in other private sector insurance markets, like Alberta. But we don't. Something very unique is happening in this province.

Since 1990, when the concept of no-fault insurance was introduced, the Ontario auto insurance product has offered the highest benefit package in Canada—in fact, in all of North America. Ontarians receive more compensation from insurers than any other Canadians. Why is that? Because the benefit package has been and remains generous, it has been vulnerable to significant inflation. Some of that inflation is the result of fraud, but a large part is due, frankly, to the mentality on the part of too many health care professionals, medical suppliers, claimants and lawyers that essentially goes, "Look, if the money's there, let's use it." Quite simply, the benefit maximums and the auto insurance product have become financial targets.

You've also heard today that Ontario auto claims costs are made up of two components: no-fault accident benefit (AB) injury claims; and bodily injury (BI) claims, where the insured person sues the at-fault driver. Beginning in 2005 and up to the September 2010 reforms, accident benefits costs were spiralling out of control. From 2005 to 2008, the total value of these claims went up 70%. But premiums did not go up right away. Rather, because of competition in the market, insurers took the loss, and average premiums actually fell by 2.6% during that period. Subsequently, however, claims costs continued to rise by another 60% to 2010, so premiums had to catch up, and average premiums rose 12% over that two-year period.

1700

So while claims costs increased by 60%, average premiums rose by 12%. While the September 2010 reforms were a needed first step in reducing pressure on no-fault injury costs, claims costs were still out of control.

Why is that? Well, you've heard that there's in excess of 30,000 unresolved claims cases awaiting dispute resolution at FSCO, and these have undetermined costs. Depending on how those cases are decided, it could very well re-ignite the accident benefits cost spiral. I don't think we can stress strongly enough how this backlog is a major risk to insurance premium stability.

First of all, claimants don't know what their benefits will be, and insurers don't know how much their claims are going to cost.

Second, the number of catastrophic injury claims is rising faster than other claims. From 2004 to 2010, the number of all no-fault injury claims rose 28%, whereas the number of large claims has more than doubled. Acute care for accident victims is covered through OHIP, and insurers reimburse the government over $142 million a year for these services. As I mentioned, hospitalizations for motor vehicle accidents are down 12%. Still—and this is a mystery—auto insurers are being presented with many more catastrophic injury claims.

Third, bodily injury claims costs are increasing rapidly. The latest figures show that the frequency of these claims has been rising, as has the average claim cost. When you consider that BI claims represent more than $2 billion in costs each year, it's very concerning that the volume and average cost of these types of claims appear to be rising so rapidly. Let's be clear: BI is on the same track that accident benefits were before the 2010 reforms, and more needs to be done to assess the causes and what can be done to alter this trend. As one part of the insurance product is reformed, other parts feel the pressure, much like squeezing a balloon.

Fourth, there is a persistence of fraud in the auto insurance system. You may know that just last week, a Scarborough man was sentenced to three and a half years in federal penitentiary in connection with a staged collision ring known as Project 92—this was the 29th conviction in relation to this investigation—that may have cost insurers over $25 million.

Now, we know that the government has taken unprecedented steps to stop fraud and abuse, but so have insurers. Companies have taken significant steps to enhance their claims management process. For some

companies, this has meant wholesale restructuring of their claims departments. As well, we're pleased to say that consumers are becoming more educated. We certainly want this momentum to continue.

The Chair (Mr. David Orazietti): Mr. Palumbo, we need you to wrap up so we can get to questions.

Mr. Ralph Palumbo: Absolutely. I guess I'd just wrap up by saying that the habit of abusing the system has grown up for more than 20 years, and it's going to take a commitment from all of us—industry, government, policyholders, stakeholders, members of the Legislature—to work together to do what's necessary to drive down claims costs.

The Chair (Mr. David Orazietti): Thank you very much for your presentation.

Mr. Smith, go ahead.

Mr. Todd Smith: Thank you very much for the great presentation, Mr. Palumbo. You answered a lot of the questions we had here as to why costs are so high in the province of Ontario.

Would you say that the 30,000 cases that are currently in the backlog are the biggest factor going forward—wiping out those cases in the backlog—and do you think the 2010 reforms are going to result in major decreases in claims across the province?

Mr. Ralph Palumbo: I'll let Barb Sulzenko respond.

Ms. Barbara Sulzenko-Laurie: The 30,000 backlog is very dangerous, because we don't know what the outcome of those claims is going to be. Our feeling is that it's likely there are a number of claimants advised by their representatives who are feeling that if they can get some good arbitration decisions, they can beat the reforms, and if they succeed in beating the reforms, they can undo the savings that are potentially resident within the 2010 reforms. So what's really happening to the mediation process and the backlog is that there's a pull of potential reward if they can get some arbitration decisions which benefit them that overturn aspects of the reforms.

Mr. Todd Smith: So does the IBC then feel confident that the reforms that are in place are going to reduce the number of claims or the cost of claims in the province? Or do we need to go further? What's the silver bullet here?

Mr. Ralph Palumbo: I think we need to give it more time, as Mr. Howell said. I think one of the major issues, as Barb was indicating, is what's going to happen with all those cases at mediation? Depending on how those are adjudicated, we'll know: Either costs will go up or down. I think we remain cautiously optimistic at this point.

Ms. Barbara Sulzenko-Laurie: In the meaning that government put to the reforms, we're going to see the backlog just fall away. It will just fall away. Of course, the other problem that Mr. Palumbo raised as well is that at the same time, to the extent that the 2010 reforms are successful on the AB side, we are seeing a pushover of those claims into the bodily injury side.

The Chair (Mr. David Orazietti): Thank you. Thanks for your question.

NDP caucus: Mr. Singh, go ahead.

Mr. Jagmeet Singh: Sir, I'd like to draw your attention to a letter that was given to you before you sat down today. All the committee members have it. It's written by Mary Hardy, who's a Ph.D., FIA, FSA, CERA, a CIBC professor of financial risk management and an actuarial scientist. She indicates in her letter regarding Bill 45, "In other words, if the bill results in a change from using the insurer-defined territories to using the SA"—or statistical area—"definitions, without any other changes, there is no reason why the premiums outside the major conurbations should change. The major impact would be on premiums charged in and around Toronto."

Do you agree with Ms. Hardy, the CIBC professor of financial risk assessment?

Mr. Ralph Palumbo: First of all, we're very pleased that you decided to seek some actuarial expertise, because you sure didn't do it before you introduced the bill, and that was a problem.

Mr. Jagmeet Singh: That's not what I asked you, sir.

Mr. Ralph Palumbo: Secondly, we received the letter five minutes ago—

Mr. Jagmeet Singh: That's correct.

Mr. Ralph Palumbo: —and, frankly, we haven't had the opportunity to study it. So—

Mr. Jagmeet Singh: Sir, my question is, do you agree with the notion that replacing the territory definition with "statistical area" should not result in any increases outside of the CMA or the statistical area?

Mr. Ralph Palumbo: Mr. Singh, we're going to continue to rely on the actuarial report that we have. Secondly, we will have a look at the report that you provided to us five minutes ago and certainly get back to you about that. We're not prepared to speak to a report that you gave us five minutes ago. Ours was widely distributed and has been for a month and a half.

Mr. Jagmeet Singh: So, sir, you're not able to—do you disagree with Ms. Hardy? Is that your position?

Mr. Ralph Palumbo: Our position is, we haven't read it yet.

The Chair (Mr. David Orazietti): The question has been asked.

Mr. Ralph Palumbo: But we are glad you took that step.

The Chair (Mr. David Orazietti): Liberal caucus, go ahead.

Mr. Yasir Naqvi: Thank you very much.

The Chair (Mr. David Orazietti): If you could be brief. Sorry, Mr. Naqvi. If you can—

Mr. Yasir Naqvi: Do you want to vote first and then come back?

The Chair (Mr. David Orazietti): It's up to you. Okay, let's go vote.

The committee recessed from 1709 to 1716.

The Chair (Mr. David Orazietti): All right, folks, we'll just continue. We've just got a couple of minutes here for the Liberal caucus to ask questions, and then we'll move on to the next presentation. So if I can just get folks' attention back, that would be great. Thank you.

Mr. Naqvi, go ahead.

Mr. Yasir Naqvi: Thank you, Chair. Thank you, Mr. Palumbo. I'll go back to what I was inquiring of Mr. Howell when he was here from FSCO about the impact, in your view, if we eliminate territories, as has been prescribed in Bill 45. What kind of impact do you foresee this having on non-GTA areas, areas outside the GTA?

Mr. Ralph Palumbo: Well, we're adopting the submissions made by Mr. Howell. Mr. Karageorgos will follow up.

Mr. Pete Karageorgos: Thank you. The key issue really is one of costs, as we've heard earlier this afternoon. All that Bill 45 or the proposal would do is shift costs. What we have primarily is a cost issue based on data that we have seen through GISA, where the greater Toronto area currently, as of 2010, has a $706-million deficit. So basically, drivers in this region have paid $600 million less into the system than what they've taken out. They've taken out more, and that cost is what's being spread out and proposed to be spread out beyond the GTA area. To address those cost issues and to recover that cost to ensure that you have the dollars to pay for claims, it's going to require a spreading. Currently, we have territories that are used to determine those rates. When you eliminate that and create larger areas—for example, in the greater Toronto area right now if you take that alone as a CMA, you're going to see rates increase on average about $300 to $400. Now, if you manage that, you still need that money. If you don't want to increase costs in certain parts of the GTA, you need to look beyond that. That's what this bill is going to force insurers to do: look beyond that. In an area such as northern Ontario, as we've said, those drivers there are going to be forced to pay for claims costs in southern Ontario.

Mr. Yasir Naqvi: So do you have any sense of, let's say, in Ottawa or northern Ontario, what kind of percentage we're talking about in terms of cost increase if we move to one or two territories?

Mr. Pete Karageorgos: We have done analysis, and we can provide you with that.

Mr. Yasir Naqvi: Just quickly: Ottawa and the north, what's your analysis?

Mr. Pete Karageorgos: Based on the numbers that I've looked at just today, you're looking at in the neighbourhood of anywhere between 20% and 30%.

Mr. Yasir Naqvi: Increase. Thank you.

The Chair (Mr. David Orazietti): Thank you. That's time for your questions. We appreciate your coming in today.

ONTARIO SPINAL CORD INJURY SOLUTIONS ALLIANCE

The Chair (Mr. David Orazietti): Next presentation: Ontario Spinal Cord Injury Solutions Alliance. Good afternoon. How are you?

Dr. Cathy Craven: Good afternoon. Thank you for the opportunity to present.

The Chair (Mr. David Orazietti): Absolutely. Welcome to the Standing Committee on General Government. As you're aware, you've got 10 minutes for your presentation, and time after that will be divided among members for questions. You can start by simply stating your name and proceed with your presentation.

Dr. Cathy Craven: My name is Dr. Cathy Craven, and I'm presenting today with Mr. Rick Watters and Mr. Peter Athanasopoulos. We're presenting today on behalf of the Ontario Spinal Cord Injury Solutions Alliance, which is a network of key stakeholders related to patients with spinal cord injury. It's comprised of 70 member organizations; that includes clinicians, researchers, service providers, patients and their families, as well as research and health care funders. Our real reason for being here today was to respond to the proposed definition of catastrophic impairment. As I'm sure you're aware, we're representing the people who have valid catastrophic impairment claims the majority of the time, and we wanted to provide some commentary to the position statement that was prepared by the expert panel.

We want to begin by acknowledging the very careful and thoughtful review by the expert panel as it relates to spinal cord injury and spinal cord injury care. One of the things that's in there is the proposed adoption of the international standards for neurologic classification of spinal cord injuries. This is a method of looking at what type of spinal cord injury patients have. It's used internationally, is well validated and would eliminate a lot of the discrepancies and holes in the current classification system. So we do want to strongly endorse the panel's recommendation related to that.

However, there are two provisos in that recommendation that we had some concerns about. The first was that the patient or person must have attended an in-patient rehab facility. As you know, in our complex health care environment there are lots of other reasons why patients don't end up in a tertiary academic spinal cord injury rehab centre that relate to their level or complexity of care. As an example, many high quads, people who have the highest need—those who are ventilator dependent and have no voluntary movement of their arms or legs, like Christopher Reeve—are the people who are often not making it into academic rehab settings and wouldn't fit the catastrophic impairment definition if you included that rehab filter. There are lots of reasons that patients aren't being admitted to in-patient rehab that are system problems that we don't think should be incorporated into the insurance definitions.

The other issue relates to point 4 in the definition. I believe the panel was trying to make sure that patients who have very mild impairments—those are people we call ASIA impairment scale D, who have had good motor recovery and have started to return to walking. I think the panel was concerned that people might be labelled catastrophic and receive a great deal of funding they were not eligible for.

They've put in some filters there, but we believe they are too concrete, and we would propose that the panel

adopt the autonomic standards form, which is again an internationally validated dataset that looks at other impairments the patient might have, other than just their ability to walk or not. For instance, if they have a central cord syndrome, they can return to walking and they're able to void spontaneously, but they have no hand function, so when they get to the toilet, they can't undo their own pants. So it's sort of an interesting challenge for people.

There are also people who have problems with temperature and blood pressure regulation, erectile dysfunction and respiratory function that aren't really addressed in the definition. The autonomic standards, which is in your package, pick up on those and is something that is also an impairment skill. So for patients who are AIS D and there is some controversy about whether they would meet the criteria, we would propose adding the autonomic standards as a way of identifying those people who have a subtle mobility impairment plus maybe other things that would allow them to qualify.

I guess the biggest take-home message we would like to have is not to abandon the international standards, because we think that solves the issue for ASIA impairment scales A, B and C. So this is a really good decision for 75% of patients. There's a small number of patients for which there is some controversy—this ASIA D group that we're talking about—and use of the autonomic standards might eliminate a lot of this controversy.

The other two issues we wanted to comment on are, is it important that the definition of "catastrophic impairment" also look at the health complications and the difficulties of aging with health complications over a person's lifetime. So it's not only their impairment at day zero when they have their assessment—do they meet the insurance threshold or not?—but also what other health complications they're likely to experience over their lifetime.

The other issue is that we thought it was important that the legislation specify who has the appropriate credentials to do the international standards for neurologic classification of spinal cord injury. The American Spinal Injury Association has been responsible for disseminating these standards internationally, and they have a well-established credentialing process which is an online training program where people can go, attend the course and then receive a certificate.

Our recommendation would be to use the well-established training and credentialing process that's already in place. The only proviso we add is that the person doing the assessment would also have at last 1,000 hours of some clinical experience, in order that not only are they trained but they've done it a sufficient number of times that we would believe their data is valid. Those are our main comments.

I brought Rick Watters with me, somebody who has an AIS D impairment, who would be one of the patients who would fall into this category where it's a big controversy about, do they meet the catastrophic impairment criteria or not? I thought Rick could just speak to you from his own personal experience.

Mr. Rick Watters: Thank you. Rick Watters. I had a traumatic injury to my spinal cord when I was 16. That goes back about 34 years now. In the early stages, I was classified as a complete quadriplegic with no possibility of recovery. I was paralyzed from approximately the top of the shoulders down. Over a course of several months and over the course of a year of therapy, very intensive therapy, I managed to get up walking on crutches—not completely independently, not completely safely, but at least enough to improve my function around the home and to get in and out of my vehicle and so forth.

Over the years, I've seen an erosion of that function. When I was young and I was 18, I could do some fairly significant distances with my crutches. Now I've got an accumulation of secondary complications, including arthritic joints, and I've had quite a few falls. I don't feel comfortable walking alone anymore; I have to have some assistance. Even getting up from sitting to standing is a big chore for me.

I'm a big proponent of supporting and assessing people properly, because at this stage of my life I'm very much dependent on other people to assist me with daily living, including my toiletries, getting dressed for the day. Even with mobility, I need a power wheelchair. For any kind of distance around my house or my office, I have to have a manual chair to really be functional. To be able to get around on crutches is great, but when it comes down to functionality, when your hands are tied up with crutches and your concentration is solely on being able to propel yourself forward and to stay stable and not fall over, it becomes a question of whether it's practical for me to use my crutches, many times.

Dr. Cathy Craven: The group that's controversial—they're using the standard that if you can walk 10 metres, you're okay. What we're trying to say is, if you can walk 10 metres, say, from your kitchen to your bathroom, that's not equivalent to community ambulation. On community ambulation, the ability to walk across the street at a traffic light at an appropriate speed is more the threshold that we would be looking for, but I think arguing about a threshold isn't really very valuable. I think using the autonomic standards should pick up some of those other impairments that people have.

In summary, we would like to endorse the recommendation to use the ASIA standards for those with ASIA AIS A through C, and, for those with AIS D who do not clearly meet the threshold for catastrophic impairment, that the autonomic standards be added.

The Chair (Mr. David Orazietti): Thank you very much for coming in, and thanks for your presentation.

First up, NDP caucus. Questions? Mr. Marchese.

Mr. Rosario Marchese: I welcome you here. You might have had a chance to hear many of the presenters, including the Financial Services Commission of Ontario, the two fellows who were here, and you heard from Allstate Insurance, Saskia Matheson. The insurance companies are quite happy with the changes because, as I read it, the profits have been much better in the last year as a result of cuts in benefits. Saskia Matheson was

saying that when you have increased benefits, there's a tendency for people to abuse them. You've heard the health professional response on auto insurance fraud, where they say they are concerned that insurance companies are now treating all HP as fraudulent; too many treatment plans are being denied.

So we've got two sets of problems here, right?

Dr. Cathy Craven: Yes. One of the things I think is a problem in the system, if I can speak as a clinician from my own clinical experience, is that people aren't labelled clearly as having a catastrophic impairment early. If they were labelled early, the insurance game and the plan for care for that patient could be enabled immediately, and it might limit some of the personal injury or bodily injury claims that are going on, because when people are sitting there not knowing if they are going to get their insurance claim, and their family's looking at, "I don't know how I'm going to take care of my family member over their lifetime," then they look for, "Who's going to help me pay for it?" So I think there is a role to enable expedient dealing with people who have a legitimate catastrophic complaint.

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I think for some of the patients who have a spinal cord injury or who have a very severe brain injury and have been in a coma for a long time, there's clearly no question and we need to have a responsive system for those people. And for those who have some sort of more time-limited, you know, "I broke my arm," "I broke my leg," where it's a little bit more controversial, maybe there is a different mechanism. But unfortunately, some people who have robbed the system and been fraudulent are really robbing the people who genuinely need this support.

Mr. Rosario Marchese: Thank you.

The Chair (Mr. David Orazietti): Okay, thank you. Liberal caucus: Mr. Naqvi?

Mr. Yasir Naqvi: Thank you very much. Thank you for coming this afternoon and making the presentation. I appreciate your comments.

I've got one question, and that is around communication. Do you feel that there is sufficient dialogue between insurance, medical and legal professionals around insurance issues, or do you think it needs to improve?

Dr. Cathy Craven: I think the communication can always improve. I think that the quality and volume of communication really depends on the insurer rehab consultant who's in the game. One of the biggest challenges is if people aren't deemed catastrophic right away, then we don't have the rehab consultant and those other people in place right away to help with the communication. So, again, I think that timely designation of people would really help the communication processes.

When it becomes very problematic for people is when they're looking for some third party payer, some additional source. So when people are in in-patient rehab, they have a health care system providing them with their acute resources, but our rehab lengths of stay now are being compressed dramatically. People are being transferred to outpatient services for which there are long waiting lists for therapies. I mean, the true impact if this goes forward and we don't include the AIS D is that we're going to overwhelm our outpatient therapy services by trying to serve those people who are currently attending third party clinics.

Mr. Yasir Naqvi: Quickly, do you have any recommendation as to how we can ensure timely communication?

Dr. Cathy Craven: Timely communication? I don't off the top of my head, but I'd be glad to prepare something and send it, having thought about it.

Mr. Yasir Naqvi: Thank you. I appreciate it.

The Chair (Mr. David Orazietti): Thank you. Conservative caucus: Mr. Yurek, go ahead.

Mr. Jeff Yurek: Thank you. Thank you, Dr. Craven and Mr. Watters, for coming today.

Just a quick question. It seems with this budget coming up the Liberals have full intention of changing the "catastrophic" definition. We heard today the FSCO superintendent has his report due. Minister Duncan, who has kept the report to himself, has not released it for consultation, which I think is questionable there.

If we go by our stats, fraud accounts for 15% of claims costs, whereas catastrophic is 1%, maybe 2%. Do you not agree that maybe we should slow down on the cat change and actually flip it and maybe put our efforts towards fraud? We're taking two or three years to actually do something about fraud, whereas on catastrophic we seem to be rushing as fast as possible. Would you not agree to maybe slow down on the cat changes and take it a little slower and try to up our efforts on fraud to help reduce claims costs?

Dr. Cathy Craven: Okay, I don't know what the SCI Solutions Alliance's position would be on this. I see some need to move forward with the "catastrophic" definitions, even if they're not quite perfect. I think the problem is (1) the definitions and (2) the thresholds. The two thresholds that are available are $100,000 and $1 million. There's a lot of spinal cord care that is above $100,000. I mean, the direct medical costs of a spinal cord injury are $120,000. That's the mean, but in other groups it's much, much higher. So the "catastrophic" issue for me, as a clinician who is trying to serve patients, is about the thresholds.

But designating people in a timely way and allowing the system to move forward is much more helpful, rather than—many people are sitting in limbo and it's becoming a financial hardship for them and their families to manage these people in the hope that there will be a settlement.

Mr. Jeff Yurek: And would you like to see that—

Dr. Cathy Craven: I'm saying the fraud issue, yes, is probably the larger cost. But those 1% of people whom the insurance industry is intended to help are the people who are getting the most delay in helping them.

Mr. Jeff Yurek: So you're in favour of the Liberals making the changes without releasing the report and

having consultation with everyone, or do you think we should—

Dr. Cathy Craven: I think consultation needs to happen. I don't know what's in the report, but I guess—

Mr. Jeff Yurek: Neither do I. I'm hoping it comes out.

Dr. Cathy Craven: I understand you have to pick your priorities, but—

The Chair (Mr. David Orazietti): Thank you. That's time for the presentation. I appreciate the questions. Thank you very much for coming in today.

PROCARE HEALTH GROUP

The Chair (Mr. David Orazietti): Our next presentation: ProCare Health. Good afternoon, and welcome to the Standing Committee on General Government. You have 10 minutes for your presentation. Thank you for being here today. Just simply start by stating your name. You can begin your presentation, and we'll have five minutes for questions at the end, or any time that you don't use in your presentation.

Dr. Saeid Sarrafian: Thank you. My name is Saeid Sarrafian. I'm a chiropractor and a physiotherapist, and presently I own and operate five rehabilitation clinics in Ontario.

In the past 17 years, I've been working at different facilities and had a chain of rehabilitation clinics with 11 locations in the past, and I've seen four changes over the last 17 years in the auto insurance law affecting rehabilitation benefits to patients involved in car accidents. With the last changes, as of September 2010, I've seen a big change in the number of patients as well as in the benefits that these patients receive.

I'm in support of preventing fraud. My submission is that regulating the rehabilitation facilities in Ontario will be a very big help, because as health care practitioners, we have regulations towards our regulatory bodies or colleges, but businessmen don't have any regulation, and they can open any facility at any time, anywhere, under a corporation and hire physiotherapists or chiropractors or other practitioners to see patients. Since these people have no regulation, they can do any kind of fraud, and with any kind of activity that they do, they put regulated health practitioners such as me into very unfair competition. These people pay big referral fees in order to receive clients. They pay referral fees to family doctors, to lawyers, to paralegals, to body shops, to anybody who can guide these clients to their facilities, and since they pay these big referral fees, they pass the costs to other insurance providers by overbilling the treatments.

On the other side, by reducing the cost to $3,500, I can see the big damage has gone to the patients, because I see a lot of clients in the clinic, and the amount of $3,500, the way it has been designed as blocks of treatment over a period of 12 weeks, won't help the majority of clients. The dispute is always between the patient and the insurance companies, and that's why there are 30,000 cases now in FSCO waiting for decisions.

I think if there is a premium for every driver in Ontario, and everybody pays a fee in order to have insurance—if they have an injury, the gap between $3,500 and $50,000 or $100,000 is huge, and the definition of MIG is not that clear. In many cases that we provide a treatment plan to the insurance companies to get their approval, even though there are pre-existing conditions—there have been cases with fractures and there have been cases where there are neurological conditions, and all of these put the patient outside minor injury—the insurance companies deny the treatment. At this time, a lot of these patients do not receive the proper treatment, and the facilities also financially go under a lot of stress and pressure.

Any auto accident in Ontario or anywhere else is big business. From the time that the accident happens, tow trucks, body shops, part makers, mechanics, doctors, lawyers, paralegals and other health providers make money by somehow providing a service. Definitely, by having so many people in the ring, there is the possibility of fraud.

One of my major concerns is that sometimes, in this ring, patients get caught as well, and by getting involved in an accident they receive unfair treatment by the insurance companies as well as by people who are in the loop trying to make some money off them.

One thing that has bothered me also as a health care practitioner is, since I am in this industry—and the industry, even though it's big, it's small—you hear things, and if I want to call, let's say, the College of Chiropractors and complain regarding a chiropractor that I heard is doing something illegal, my report, my letter of complaint, has to have my name, and my name will be disclosed. They do not take any complaint anonymously.

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This has to change. I believe the college should take complaints from anybody and they should investigate, and if a health care practitioner who is regulated is found to be guilty of any professional misconduct, any fraud by the college, and the college revokes or suspends the licence and gives him a penalty, this also should be referred to the police for criminal investigation. I've heard and read some decisions by the college and some practitioners have done fraud, but there has been no police involvement or prosecution of these people who have been involved in these crimes.

Another issue is, a lot of assessments are done by the insurance companies and a lot of them are not justified. A lot of them are a waste of money and are just designed in order to decline claims and to say that this patient does not require any treatment. The cost of any of these assessments sometimes is two or three times more than the actual treatment plan that was proposed for the treatment of the patient. You can see that the treatment can provide benefits, but the assessment does not provide any benefit to the patient.

This was a general submission that I had over the changes that are in effect in Ontario. If any of the members have any questions, I'd be happy to answer.

The Acting Chair (Mr. Michael Coteau): Thank you, sir. I'll start with the Liberal caucus.

Mr. Yasir Naqvi: Thank you very much, sir. I really appreciate it. How do you feel the system can be made fair for the victims? Do you have any suggestions, recommendations?

Dr. Saeid Sarrafian: Well, the amount of $3,500 is one issue, but the duration that the insurance companies or this new legislation proposes is 12 weeks and puts this on a block, and says that for the first week of treatment after injury, the amount payable is $775, regardless of the number of times that patient received treatment. So for a health care facility that wants to provide treatment—it might be five days a week, two days a week, three days a week—it's a cost issue, but to the patient, it's the actual treatment that they receive, and I don't believe patients recover within 12 weeks. There is no research. There is no medical backup with this MIG, and there is a wide range of age between the clients. Somebody aged 10 may recover faster than somebody aged 80 or 70, and you cannot say that somebody with the same type of injury can recover in 12 weeks who is 40 years of age.

It's very unfair because the definition is very vague. It's not clear and, most times, gets abused. My recommendation is either to increase the amount or just make the 12-week period a little shorter for patients who benefit better in the shorter time—maybe eight to 10 weeks. That's a crucial time that patients receive the most amount of support and treatment, and they feel better after six to eight weeks after the injury. Twelve weeks is very open, very broad.

Mr. Yasir Naqvi: Thank you very much.

The Acting Chair (Mr. Michael Coteau): Thank you. PC caucus?

Ms. Laurie Scott: Thank you very much for appearing today. I'll follow up a little bit with some more questions. You said that the college right now does not take complaints about—

Dr. Saeid Sarrafian: That's true.

Ms. Laurie Scott: So bad-performing chiropractors basically, right?

Dr. Saeid Sarrafian: Exactly.

Ms. Laurie Scott: So there's no mechanism to report a chiropractor for not performing at all?

Dr. Saeid Sarrafian: The only way is, I have to have my name at the bottom of the letter, and my name and my letter will be sent to the chiropractor that I make the complaint about. By doing that, my name will be disclosed and open and then nobody's comfortable doing that.

Ms. Laurie Scott: Right. Okay. And has anybody in your college considered changing that regulation—because they're self-regulating, right?

Dr. Saeid Sarrafian: No. I've talked to the College of Physiotherapists and the College of Chiropractors of Ontario. I'm a member of both colleges, and they're saying that they cannot do anything, they cannot send this to the complaints committee unless it is signed and named on the letter. If there is no signature and no name, they would not proceed.

Ms. Laurie Scott: Okay. So that adds more to our fraud problem—right?—with insurance because there is no policing.

Dr. Saeid Sarrafian: Exactly.

Ms. Laurie Scott: Okay; thank you for clarifying that.

Earlier on—I'm not sure if I caught it—you were just talking about regulating the profession; you were not saying there was another regulation that you wanted to see about a business? I don't know if I—

Dr. Saeid Sarrafian: Yes. I would like to see rehabilitation facilities and assessment centres in Ontario be regulated, and by regulation, I mean that only a regulated health care provider in Ontario can own and operate this facility. That eliminates a lot of fraud because a businessman, by regulating his facilities, cannot open and hire other individuals to run this facility.

Ms. Laurie Scott: Okay. Thank you for clarifying that. I appreciate that.

The Acting Chair (Mr. Michael Coteau): Thank you. NDP caucus?

Mr. Jagmeet Singh: Thank you very much for attending.

Remarks in Punjabi.

Dr. Saeid Sarrafian: Very good; thank you.

Mr. Jagmeet Singh: Sir, I just wondered, in your experience with regard to assessments for a plan of treatment: When those assessments are made or when a treatment plan is made, are you aware of what type of resources that insurance companies put towards refuting a claim and how much those refutations can cost?

Dr. Saeid Sarrafian: In, I could say, over 80% of cases, the treatment plans get rejected. In many cases, the reason for rejection is not clear. It says, "not necessary and reasonable." So an insurance adjuster, without any medical education or any more information about this patient, says that it's not necessary and it's not reasonable. They refer the patient to an independent examination or insurance examination. In the majority of times, these reports do not support the patient because these providers are getting paid by the insurance company. Obviously they want the insurance company's business. It's the same system that it was in Ontario as DAC before.

I've been a patient myself. I was hit by somebody back in November. Even though I have a pre-existing back condition—I have a bulge in the lumbar disc area—the insurance company rejected the treatment and sent me to a medical doctor, who examined me for a period of one hour and then later said everything was fine and I was completely normal and this is not, you know, outside me. The cost of that report, surprisingly, was $1,700—for one hour of examination. How do you justify that? The cost of treatment was $800. That was my health care practitioner's proposal. So they paid $1,600 to reject a treatment plan that is $800 that can actually help the patient.

I see these things every day.

Mr. Jagmeet Singh: So in terms of your experience, how often—

The Acting Chair (Mr. Michael Coteau): Last question.

Mr. Jagmeet Singh: Last question; sure.

How often do you see this type of practice? You run a number of clinics, or you see a number of patients on a wide basis. How often is that practice of having an independent assessor charge more or charge about the same price as the actual assessment that you're looking for in the first place?

Dr. Saeid Sarrafian: I believe, in 80% of cases, that's what it is. There are few doctors or practitioners who see the patients, so the cost of the assessment is higher. I know there is a cap of $2,000, but they can perform three assessments and get paid $2,000 each per assessment.

I know why insurance companies do that, because early on in the treatment, after the injury, they get the report from a practitioner saying that this patient is fine; the patient can go back to work; the patient has no need for the treatment. Later, they use these reports in arbitration and mediation, showing to the arbitrator that, "This patient was fine a year ago, two years ago, six months ago, and that's why we're not paying for the cost of treatment, housekeeping or attendant care."

The Acting Chair (Mr. Michael Coteau): Thank you very much. That's it. We appreciate your time. Thanks for coming to present.

ONTARIO PSYCHOLOGICAL ASSOCIATION

The Acting Chair (Mr. Michael Coteau): Next we have the Ontario Psychological Association. If you can just say your name for the record. You've probably heard this a thousand times: It's a 10-minute presentation; five minutes of questions shared by the three parties. Welcome.

Dr. Ronald Kaplan: I'm Dr. Ronald Kaplan and I am the co-chair of the Ontario Psychological Association auto insurance task force. I am here with Dr. Faith Kaplan, a member of the task force; Dr. Amber Smith, a member of the task force; and Dr. Brian Levitt, who is the president of the Canadian Association of Psychologists in Disability Assessment.

We are all psychologists who have been involved in examining and reviewing the auto insurance product for many years and in working as treatment providers. I'd also like to mention that I was on the expert catastrophic impairment panel as the mental health and brain injury expert last year.

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Psychologists are regulated health professionals. All must be members of the College of Psychologists of Ontario. Psychologists are accountable to the college for both their professional and business practices. The college has about 3,600 members, including psychologists and psychological associates. The Ontario Psychological Association has approximately 1,500 members. CAPDA has 150 members who do independent medical examinations and insurance assessments.

Psychologists are highly trained mental health professionals, one of only two professions that can legally diagnose a mental disorder in Ontario, with training in research, diagnosis and treatment. A doctoral degree in psychology involves more than 10 years of post-secondary study and supervised training. Psychologists provide effective and efficient care based on scientific research. The essence of professional psychological practice is its adherence to the scientific stance. We believe this leads to significant cost savings to the individual and the health care system. We believe cost control is necessary and essential, but it has resulted in harm to some injured accident victims. We believe this doesn't have to be the case.

Auto insurance policy must balance maintaining a viable system, affordable premiums and providing benefits to injured accident victims for timely treatment. Multiple measures brought in in September 2010 appear to be controlling costs, reflected in statements regarding increased profits of insurance companies. Achieving cost control is important, but we must consider some of the consequences and determine if some adjustments may be necessary.

First, let's review some of the ways cost control measures are harming some accident victims. Dr. Amber Smith will now speak.

Dr. Amber Smith: First of all, we have to recognize that psychologists usually are seeing a very select proportion of injured victims, but they tend to be the ones with the most problems—the most vulnerable—the greatest disability and creating the greatest burden on the system. In current Ontario data, it's about 2% to 4%.

Auto accidents are the biggest cause of civilian brain injuries and post-traumatic stress. The only way to measure impairments in thinking, feeling and behaviour after a traumatic brain injury is through proper neuropsychological assessment. The most effective treatment for PTSD is psychological treatment.

Depression is the number one reason for disability. Psychological treatment for depression, especially the kind experienced after an accident, is at least as effective as anti-depressants—in some cases, more effective—and costs less than medication in the long run. But our patients, when they can't access this care, are not the ones who will be vocal about the barriers they're facing. They're depressed, stigmatized and dealing with invisible disabilities that other people don't understand. This system is not being kind to them, and they are not getting the care they need.

Adjusters are denying applications without discussing them with the proposing psychologist. We need better communication. There is a failure to provide a medical or other reason as a basis for the denial. We're having difficulty reaching adjusters to ask any questions. Excessive denials cause delay and harm to patient rehab and additional costs to the system that do not contribute to patient rehab.

The application and approval process has become more adversarial. In our data, denials of treatment plans have nearly doubled, but the second-opinion reviewers are approving nearly two thirds of those after the insurer denial. All that does is generate extra costs and delays and barriers for the people who need the care that was proposed in the first place.

Currently, we're being asked by insurers to submit smaller plans even for patients with very complex presentations, when we are clear they're going to need much, much more care. Smaller plans are more likely to be approved—double the larger plans in our data.

Unfortunately, in addition to insurer decision and the number of applications, the number of applications with no response has increased dramatically. While we push for a second review of our denied proposals, we're often unable to reach the adjuster or to find out what's happening, and more applications are being lost to pending status. We generally do not know why our plans are denied, and so we have difficulty shaping future applications.

When they're referred for a second opinion, patients now have to wait months for these appointments, and they have no services while they wait. Insurer response to a proposal is required within 10 days, but if referring for a second opinion, there are no timelines for when the referral must take place and how long the person doing the second opinion can do the report. It's often several months, and then the person is worse when they come back for treatment later.

In addition, insurers don't always obtain an appropriate IE. Sometimes they get other health professionals who don't understand psychology assessment and treatment or the requirements of the SABS, and they don't know about our profession-specific guidelines that are based on scientific research. The examiner may be from another profession.

We also have misapplication of the minor-injury definition and minor-injury guideline. We have a preponderance of cases, unfortunately, that are referred to us with clear concussions and clear post-traumatic stress that have been restricted to the MIG—the minor-injury guideline. These people can't access any care, and they're in severe need.

In addition to that, you have significant delays in dispute resolutions. Accident victims who disagree with the insurer's determination have to wait over a year for mediation prior to arbitration to address the dispute. They're not getting timely access to treatment, even if it's approved later, and then the disability is more chronic.

The reduced $50,000 benefit is insufficient funding for seriously injured accident victims who may not be cat and who haven't yet been determined to be cat. Accident victims with multiple physical injuries, brain injuries and psychological disorders may require intensive treatment, home modifications etc., and $50,000 doesn't cut it.

Dr. Ronald Kaplan: Dr. Levitt?

Dr. Brian Levitt: I'm just going to make a couple of quick points following off what Dr. Smith has just spoken about. The first point I want to make is that catastrophic criteria may be too restrictive, and we've already heard about that today. Complicating this, gaps in coverage are created as a result of having lower standard benefits.

A further restriction occurs by only allowing physicians to complete catastrophic impairment applications—OCF19s—except when there is only a brain injury, and patients with mental and behavioural impairments are restricted because they're unable to have their application completed by psychologists with appropriate expertise in diagnosis and rating. Also, there is a risk of harm to seriously injured patients if the criteria are made even more restrictive.

The second main point I want to leave you with today is that the catastrophic impairment criteria must be fair, reliable and valid. There is particular risk to those needing immediate identification and with less obvious injuries, including brain injuries and mental and behavioural disorders.

You may hear a number of things about combining physical and mental and behavioural impairments with respect to catastrophic. One thing that I want to mention with respect to that is that valid and reliable mental and behavioural ratings can be determined. I have several published articles addressing this that we'll include in our written submission.

I also hear a number of fears that combining mental and behavioural impairments with physical would lead to large numbers of catastrophic claims. Those fears, I believe, are unfounded. When we look at the data from our own clinic—five years of data we collected in our assessment centre, which represents about 250 patients who were assessed for catastrophic over that time—only a couple more patients each year would be deemed catastrophic based on combining mental and behavioural with physical. However, catastrophic impairment was critical to this very small group of accident victims, as it provided an opportunity to apply for funding for required services.

The Acting Chair (Mr. Michael Coteau): You have about a minute left.

Dr. Amber Smith: Psychologists are experts in diagnosis, treatment and rating. They can play a key role in addressing all the issues we're raising today.

Provision of evidence-based psychological services is cost-effective. It provides cost offset to the rest of the system and reduces the cost of other services and disabilities.

We have profession-specific guidelines that are based on internationally accepted science. Psychologists are generally proposing and reviewing based on those guidelines, but there are pressures on both proposers and reviewers to trim and limit so much that patients are not getting the kind of care they need.

We're developing tools to help identify who is appropriately included or excluded from the minor injury guideline. We're trying to reduce inappropriate applications, inappropriate denials and unnecessary disputes.

We're developing guidelines for IEs. We've developed a group to do that and engage a broadly representative group to work on this.

We want to improve the quality of the second-opinion reviews—the credibility—and reduce subsequent disputes.

Dr. Ronald Kaplan: Dr. Faith Kaplan—

The Acting Chair (Mr. Michael Coteau): I think you're a bit past 10 minutes. Do you want to take 30 more seconds and just conclude?

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Dr. Ronald Kaplan: Yes. Dr. Faith Kaplan will conclude.

Mr. Yasir Naqvi: Chair, I'm willing to give my time for my question—for you to finish your presentation.

Dr. Faith Kaplan: Just to go back to where everybody started this afternoon, we absolutely agree that anti-fraud measures are critical. What we would like to see is those funds be able to be used or saved so that there are sufficient funds available for those who actually need them. As a profession, we are into this wholeheartedly because we're very concerned about misuse of health professionals in any way. We have been part of the pilot to look at the professional identity tracker and we are very supportive of any actions we can take as health professionals to help reduce fraud.

We're also very involved in supporting the development of the HCAI database, because we believe that will be a way to provide information that can be used to shape policy decisions as we all go forward in terms of giving us realistic numbers to know the actual incidence of injuries, the utilization of services and also, perhaps, to help identify areas of practice that do need to be looked at more closely.

Dr. Ronald Kaplan: Thank you for the opportunity to meet with you. We appreciate that we covered a lot of ground very quickly. We'd be happy to answer questions today and we'll have more material in our submission.

The Acting Chair (Mr. Michael Coteau): Thank you, doctors. We'll start with the PC caucus.

Mr. Jeff Yurek: Thank you, doctors, for coming out today. It was very quick and I look forward to reading your whole submission.

I just want to make the comment that mental and behavioural conditions that occurred—accidents. I mean, you look across the province of Ontario with our health care system, those are usually the problems that slip through the gaps. I'm glad you guys are working towards that. I urge you, if and when Minister Duncan releases the catastrophic report, to take a good look at that and consult on it before regulations are changed.

Dr. Ronald Kaplan: Thank you, Mr. Yurek.

The Acting Chair (Mr. Michael Coteau): NDP caucus, any questions?

Mr. Jagmeet Singh: Yes. You indicated a couple of points regarding more denials creating more disputes and more delays. In your own experience, how does that drive up costs?

Dr. Amber Smith: There's an administrative burden associated with each denial and chasing each denial and then getting a second assessment opinion that two thirds of the time supports our plan in the first place.

Dr. Faith Kaplan: I think there's another unintended consequence to the degree it causes delay for the patient and added stress. When they are actually seen, their condition may be more difficult and more protracted to treat than it would have been initially.

Mr. Jagmeet Singh: And would you agree with me that treatment is most important right after an accident occurs and any delay in treatment right after an accident occurs could impact future rehabilitation and getting back to the best or the optimal condition you can get back to?

Dr. Ronald Kaplan: Yeah, there's always a best time for treatment, especially with acute stress disorder, post-traumatic stress disorder and brain injury. It's very important to have early intervention.

Mr. Jagmeet Singh: And just one thing, if you could comment on, from FSCO—I'm not going to quote. I'm not sure who it was, but it was a remark that the insurers are partially to blame for some of the costs that have been incurred or some of the costs related to delivering services because they didn't verify if some treatments were required or not. I don't think they mean rejecting or denying, but just verifying if a treatment is required. What's your response to that, if any?

Dr. Faith Kaplan: I think it's a good opportunity to comment on a comment that was made before about the need for communication. We understand there will be some work done on dispute resolution and we would hope that could also move towards including dispute prevention and ways to encourage more dialogue. There is now more time for an adjuster to consider an application.

We would like to see more opportunities for there to be an actual dialogue that would allow the adjuster to weed out and determine which applications actually need that kind of scrutiny of a second opinion, where there's a specific question that can be addressed, and come to some resolutions that might be more efficient and cost-effective.

The Acting Chair (Mr. Michael Coteau): Thank you very much.

Dr. Ronald Kaplan: Thank you.

FAIR

The Acting Chair (Mr. Michael Coteau): Next, we have FAIR. Welcome. I'm sure you've heard: 10 minutes; five minutes for questions. You're okay with that?

Ms. Marianne Reichert: Yes.

The Acting Chair (Mr. Michael Coteau): Okay.

Ms. Marianne Reichert: Good afternoon. Jaisa and I will share the time.

I'm honoured to speak on behalf of FAIR, which stands for Fair Association of Victims for Accident Insurance Reform. Today, I would like to speak not only on behalf of my husband and myself but also the 12,000 adults and children who sustain serious injuries in car accidents in Ontario every year.

My name is Marianne Reichert. My husband, Jörg Reichert, was involved in an automobile accident in October 2007 which left him with serious and permanent personal injuries, including head trauma. Jörg lost his cognitive skills. He has major depressions with personality change.

That day changed our lives. Jörg lost the life he loved the most. He was a brilliant and successful businessman and entrepreneur. Jörg and I had the privilege to build Mövenpick and Marché restaurants when we came to Canada in 1982 until 2004. Jörg worked hard, and with his creative approach and amazing leadership, he changed and impacted on millions of fans of our restaurants. His affiliation with Loblaws, his ability to take our company public and always be on the edge with his ideas made him a leader and known figure in the industry. We have about 80 reference letters from movers and shakers, and previous management will confirm the same.

After we left Mövenpick/Marché in 2004, we opened a large restaurant concept on Highway 400. We had big plans for expansions. Jörg never stopped. His business life was his golf course. He was always a great provider. We have twin daughters who are 16 years old, and we adopted our daughters from China in 1997.

The accident changed our lives drastically. From one day to another, Jörg could not function anymore and changed. It was horrific to see. Over four years later, today, he is still the same, and we are at the end of our rope.

The insurance cut Jörg off all treatments two years after the accident. If they would have not done this, Jörg could have continued with his OT, physical program, counselling and naturopath, along with all of the other recommendations by his medical experts, and he would have had a chance to recover. In no time, the $100,000 plus assessment costs was used up. If he was injured today, he would only have $50,000 for medical and rehab, including assessment costs. This is far not enough, and does not allow victims any chance of getting their lives back.

I am the sole caretaker of Jörg and have not received any attendant care benefits, neither for the past or current. I was not able to create any income because I look after Jörg and our daughters and all of our administrative affairs in our home. Jörg's depression and thoughts that life would be better without him have impacted our two daughters and me tremendously. We do not travel anymore. We do not socialize. We are walking on eggshells around Jörg. Jörg used to be a social butterfly and connected to everyone very easily. Now he does not even call his brother.

The accident also wiped out all of our savings and assets. It is horrific. Even with all of our financial resources, we have not been able to cope. We have lost everything. Jörg had to surrender his life insurances in order to receive cash out of them. If we are not successful with the sale of our last asset and the home we live in, we will lose it to the bank soon.

We both did not generate any income since 2007. This has had a horrific impact on us and others. Ever since Jörg's private disability insurance stopped about two years ago because Jörg became a senior, we have lived from family and friends, and most of our creditors have been very understanding. But it's just a matter of time that they will lose their patience too.

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I have started to sell furniture to support our life. Can you imagine asking family and friends to give you money? Can you imagine being in front of a court trying to reason why you did not pay your credit card bills? No one can. It is beyond any belief what we need to go through, and not to lose our dignity.

Jörg has been deemed catastrophic by medical experts. His medical file is 2,000 pages. When the "catastrophic" submission was made, they insurer sent Jörg to four doctors. All these doctors, three of them, took exactly 45 minutes to assess him. They were curt. They were rude. They handled him and dealt with him like a commoner. All four decided that Jörg is not catastrophic, overriding any other expert reports which we have.

What did the insurer do? The insurer listened just to the four of them and made the decision that Jörg is not catastrophic. With any catastrophic determination, we would have received retroactive payment and would have been able to pay our mortgage and go on with life and try to sell our house in order, which we can't do now because of those four doctors who have treated us very poorly. But the insurer listens only to them. There's nothing you can do. There's only the arbitration process you can do—nothing we can influence or our lawyer. Our lives would have been much easier after the accident if Jörg would have been designated catastrophic much easier and faster. Suffering emotionally and financially is absolutely catastrophic and horrific.

The insurance system is not functioning, and those with serious injuries like my husband and many others are grossly underfunded. The government should increase non-cat funding, at least back to the pre-September 2010 level, and look at increasing that further. This limit has been in place for over 15 years.

It can absolutely not be allowed that the government tries to make it even now harder to become catastrophic. It is not. I am a witness of what can happen to someone in that case and not being looked after. The definition of catastrophic should be expanded on and not contracted.

Take the FSCO system. I know, only through our lawyer, who is an excellent lawyer and who really tries to look after us—I'm learning that it's overworked and backlogged, and any dispute is just not dealt with. All of our benefit claims are backlogged. They're not being dealt with. We have no source of hoping that maybe a few thousands dollars come to us. It's not being dealt with. The arbitration for the catastrophic is the only way, and it will take up to six months. What do we do? My husband always says, "Ma, we can live under the bridge." That's his take on it.

Someone has to take responsibility for the victims and make sure that their well-being is looked after, including their families. The insurance must give their clients the comfort that they will be there when things go wrong. The protection has to be of an appropriate magnitude and barrier-free. The insurance is taking the position that the system is abused. Maybe it is, but every system is. But it cannot be that a group of seriously injured people is being neglected by this thinking. By doing so, they're abusing the victims. We are the victims of the insurance.

The Acting Chair (Mr. Michael Coteau): There's about a minute left in your presentation, the allocated time.

Ms. Marianne Reichert: I'm not sure what will happen—and I will pass on to Jaisa—but I will try to reach out with my experience to help as I can. Thank you very much for listening.

The Acting Chair (Mr. Michael Coteau): How long is your presentation?

Ms. Jaisa Sulit: Three and a half minutes, if that's okay. Thanks.

Good afternoon, everyone. My name is Jaisa Sulit, and last August 2010, I was involved in a motorcycle accident that left me with a burst fracture of T12, a spinal cord injury, and cauda equina syndrome. I was deemed catastrophic.

For the first several months after the accident, I had to use a wheelchair, but with frequent therapy at Toronto Rehab, I was discharged home, walking with a walker.

Now, fortunately for me, I was able to access cat benefits before I was discharged, meaning that I was able to continue with the rehab that I required with no gaps in my care. Almost two years later, after committing myself full-time to physiotherapy four days a week, massage therapy weekly, social work biweekly and physiatry for botox every several months, and a period of time working with an OT and a dietitian, here I am now walking with just one pole and requiring a wheelchair only for long distances. Because of the cat funding for all of the rehab that I've done so far, I have obviously made progress, and I continue to progress. Because I've had access to cat benefits, I've been able to take some professionally related courses so that I not only can one day work productively within my physical limitations, but I can return to a career that I enjoy doing. I have high hopes that I will be able to gradually return to work as an occupational therapist by the end of this year.

So, ironically, yes, I'm not just here as a patient, but I'm here as a health care professional as well. I have eight years of experience in both in-patient and outpatient rehab, but only now, now that I've been able to walk in the shoes of the patients we're talking about today, do I have an understanding of the very complex and long-term care needs of our patients. Even as a health care professional myself, I was never aware of this long journey of recovery that our patients face. Only now, as a patient myself, do I understand that recovering from an injury like mine may take five years, 10 years or even more.

Currently, it is estimated that less than 1% of all accident victims are deemed cat, yet the government is considering changing the definition to make it even more difficult to achieve this designation. That is because it will include individuals like me who have spinal cord injuries but are able to walk, as well as many others with serious injuries, including adults and children with brain injuries. This is happening when in fact the cat definition should be more inclusive, not less, given the cuts in non-cat funding.

Under this proposed new cat definition, I would not be deemed catastrophic, meaning that instead of the cat funding that I still do require today, I would only have had $50,000 in funding and all of that would have been exhausted within the first nine months after my accident.

Without the cat funding, I really would not be here as I am today. It's only because I've had the cat resources that I have been able to commit full-time to my recovery, not just physically but mentally as well.

Catastrophic funding is why I'm able to continue to see a multidisciplinary rehab team that has not only helped me regain physical and functional abilities, but has helped me to adjust to living a life with a disability.

Fortunately, I am learning how to cope with pain, loss of abilities, depression, frustration and irritation, and changes in my relationships. This is not just simply about money; this is about what this money means to the patients who need it the most. Without cat funding, I'd have no more money for any more rehab—not just for physio, massage, social work and physiatry, but also I'd have no money for vocational rehab. But because I was—

The Acting Chair (Mr. Michael Coteau): Can we stop the sidebar conversations on both sides?

Sorry, continue.

Ms. Jaisa Sulit: Thank you. But because I was appropriately deemed catastrophic, I now continue to have the resources that I do require for this long journey of rehab. Because of this cat funding, I have hope that I will be able to run and dance again. I have hope that I will be able to return to a job that I enjoy doing, and I have hope that, in time, I will make enough recovery to do all the things that bring meaning to my life.

So my story of continuing progress because of frequent, ongoing, long-term rehab is what anyone here deserves. It's a chance of returning to a type of life that you actually want to wake up for. So please take a moment right now and just think: If you were to walk out of here today and you or a loved one were to have an accident, whose shoes would you rather be in: those of Mrs. Reichert's husband or mine?

Thank you.

The Acting Chair (Mr. Michael Coteau): Thank you for your presentation, both of you. We appreciate it here at the committee.

We'll start with the NDP caucus. Questions?

Mr. Jagmeet Singh: I just want to thank you very much for taking the time to share your stories. The contrast between the two stories is stark: having abso-

lutely no treatment and being rejected and denied versus having the future prospect of rehabilitation through receiving benefits, as you should. That's a very stark and very clear example of the way it should work and the way it shouldn't work. So thank you for taking the time to share your stories.

The Acting Chair (Mr. Michael Coteau): Thank you. Liberal caucus, anything?

Mr. Yasir Naqvi: I just want to thank both of you for coming in and sharing your personal stories. It makes a big difference in the work we're trying to do here. Thank you.

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The Acting Chair (Mr. Michael Coteau): The PC Caucus.

Mr. Todd Smith: Yes, I would agree. Thank you both for your stories. Startling differences in the two stories, and obviously, there are some gaps that need to be filled in. I appreciate both of you coming here and telling your stories to our committee. It means a lot to us to hear from you and hear your real-life stories.

Ms. Marianne Reichert: Our pleasure

Ms. Jaisa Sulit: Thank you for listening.

BROWN AND KORTE—BARRISTERS

The Acting Chair (Mr. Michael Coteau): Our last presentation is Brown and Korte insurance defence litigation firm. Welcome. So, a 10-minute deputation and five minutes for questions. Thank you very much for being here.

Mr. Harry Brown: My name is Harry Brown. I'm the senior partner of a law firm called Brown and Korte. We do insurance defence work primarily. I specifically do a lot of insurance legislative development.

Just to start the story very quickly, I was here in January 1988 for Bill 2. I don't think any of you know what that was, but Bill 2 was the start of the Ontario Insurance Commission; it was the start of FSCO, the Financial Services Commission of Ontario. From there, I took a year with the hearings on no-fault legislation and other related matters and so forth. I've done about 100 cases at FSCO. I do a lot of the insurance work.

My argument today that I want you to hear—I have no financial interest whatsoever in the outcome; I have no interest with respect to individual parties or with respect to individual ministers. I've dealt with most of them from 1987 to the current time. The problem though, it's my submission to you, is that there is insufficient proactive regulation of the auto insurance product.

I'm going to start by saying that if anybody thinks that the 34/10 changes to the product solved the problems, they're nuts. That's the bottom line here. We see the issues. We see them today. The MIG issue is starting. You've got the new catastrophic issues. You've got many, many different issues. You've got the problems of regulation of not just the fraud issue; you've got the regulation of the health care providers.

You've got situations, for example, that the government—in my submission, there's what I call the disconnect. If this was OHIP, the government would be taking steps on a yearly basis to analyze the problem and solve the problem before it goes cataclysmic.

We saw it back on October 1, 2003. The rates went up 20% in one year. That was only in Ontario. In the GTA, they went up twice that much. Just before the changes on September 1, 2010, we had the same situation. The rates went up hugely in the GTA, approximately 44% in a year. That's because the system was broken.

But the signs of the system breaking were there for four or five years before. You can see, in 2004, rates were going up dramatically for assessment costs. Assessment costs were just pennies, proportionally, of the system. In 2004, SABS costs totally were $1.8 billion, and in 2010, they were $4.5 billion. If that had been the whole year—because really, the problem stopped on September 1, 2010—it would have been $5 billion.

All those cost pressures in the system were there to be seen. But because the government sets the product but they don't have to pay the cost, except for the MVACF, there's no financial incentive for governments to go ahead and try to deal with the system earlier on. I've talked to ministers—I've talked to Conservative, I've talked to Liberal and I've talked to NDP ministers—about changes that could be made on an ongoing basis, on a yearly basis. Many of them say, "Gee, that's a good idea. We'll think about it. Come back later." And they do get implemented. All of them got implemented.

The 42.1—the rebuttals—that's one of the major reasons why at 30,000 FSCO mediation stalled. What happened was the care providers—in 2004, we did a study for RBC. RBC showed that on average you were getting six or seven treatment plans for, say, a $1,500 whiplash. That's $1,500 of a dent to somebody's bumper—a WAD-1 or WAD-2 whiplash. In 2009, you're getting 60 applications for treatments; you're getting 60 applications for assessments. And by August 31, 2010, the cost of assessment was more than the cost of treatment, which in my submission was ridiculous. But all that could be seen going back.

I went to Willie Handler, really the policy guru for FSCO, in 2009 before he issued his white paper on March 30, 2009, and said the rebuttals had to come out. The rebuttals were driving five or 10 of these treatment plans per week, and the reason was because the assessors got $450 for just pressing a button, doing the same rebuttal to the report. If they saw somebody, it was $750 and if you were dealing with their cat, you're dealing with $20,000 to $40,000 for the rebuttal reports. Willie said, "Good idea. Go downtown. Go somewhere else." There was nothing going on.

Back in 1999, I went to see the PA for Mr. Eves who was running the auto insurance reforms at that time and said, "What about taking CPP off the post-104-week disability?" He said, "Good idea. Maybe we'll think about it." Nothing happened. That product blew up, and by October 1, 2003, what he did was he took off CPP, not

just post-104, but for every payment of IRBs, but he made it retroactive to January 1, 2002.

There has to be a proactive approach to the auto issue, because these problems are still here. They're going to fester. I'm not saying which policy should be enacted. That's for you people to figure out. What I'm saying is, there has to be an annual review of the product to put it in balance on a yearly basis.

You do have plans in the legislation that deal with reports on SABS every two years, a huge revision every five years. Let's put it this way: October 1, 2003. They started looking at it in 2008. They finally put out reform 34/10 on September 1, 2010, which was seven years later. I mean, seven years—truly, and no significant change to the product, and everybody could see the explosions coming? Why would you have the people of Ontario, including the people in the GTA, pay ridiculous premiums because the government of the day and FSCO hadn't taken the initiative to try to solve the problem before it blew up? That's really what my belief is here.

I'm going to say this to you: You probably have one of the best insurance commissioners ever in the last 20 years, in my opinion, after dealing with all of them. He's quite proactive. But there has to be something that forms a link between FSCO, the problems it sees and knows about, and the government to take steps to affect these programs before it blows up.

Any questions?

The Acting Chair (Mr. Michael Coteau): Thank you, sir. The Liberal caucus.

Mr. Yasir Naqvi: Thank you for your very succinct presentation and your point.

One of the major works that is going on right now is around anti-fraud. I'd like to hear your views and to what extent you think fraud is a factor in the rates and the premiums that we see right now. Does that fit into your proactive approach that the government and FSCO should be taking to deal with auto insurance?

Mr. Harry Brown: I think FSCO and the government today are taking significant steps to deal with fraud. Fraud is a very real issue. I have a case starting at FSCO on June 11, and I'm calling eight doctors who will say that of the 80 OCF-22s, which is an application for assessment, and the 80 OCF-18s—this is a whiplash case—that they submitted, these eight doctors will say that their signatures were used without their permission, electronic signatures. I'm calling those eight doctors, and they're eager to testify. And I know how they got them.

Fraud is a huge issue. We do a lot of fraud investigation for insurers.

I'm going to say this, too, to put it in balance: One of the problems is there have been so many accident benefit claims combined with tort claims that the insurers simply want to take a cost-effective solution. So they didn't bother using, for example, examinations under oath until recently, in the last couple of years, to really determine if there's a fraud in those cases. To a certain extent, they're the author of their own misfortune. I act for insurers, but I'm saying that. If you take a look at a fraud and you say, "That's fraud in that case. I'm not going to pay anything. I'm going to go through a trial, I'm going to go through an arbitration and expose the mess," you may win, you may lose, but at the end of the day you have to expose it. You have to take a strong stand.

The Acting Chair (Mr. Michael Coteau): PC caucus?

Mr. Jeff Yurek: Thanks for coming today and speaking to us. I like your idea about a yearly review. Through the campaign, I heard from a few brokers the fact that five years is way too long to actually fix problems that do arise.

I just want your thoughts on the mediation. Right now, we have a backlog of 12 to 18 months. If they do make changes just to the catastrophic, I imagine it will shoot up further. Is there a way to streamline the process?

Mr. Harry Brown: The problem has been building up for years. It started off when they took out the DAC system, I'm told, and there was a massive number of treatment plans that were denied in the lead-up to the September 1 changes. You were getting 10 a week and a whiplash case. That's in there, plus the MIGs are in there.

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There is a case—my partner is handling it—from one of the insurers, Aviva, which is going to the Court of Appeal. A judge in Kitchener ruled that 60 days was the valid timeline. I think there has to be access to justice. I think that what's going to happen is, the Court of Appeal will likely uphold the justice in Kitchener, and then you'll see these cases come out.

I got an email from FSCO, I think this week, saying that they're stacking up new arbitrators and new mediators to try and resolve the backlog.

The mediation process is nothing. You can have a mediation in 10 minutes. It's really easy. The problem is: Going into the court system or going into the arbitration system; that's where the backlog is going to be. But it's easily dealt with, really.

The Acting Chair (Mr. Michael Coteau): Mr. Marchese?

Mr. Rosario Marchese: Thank you, Harry, for the presentation. I need to agree with the recommendation you make. I don't know whether you were here when I asked the FSCO people about the rate of return, which was set in 1996.

Mr. Harry Brown: I was at the hearings. The rate of return was set in 1989; 12.5%. I was on the council.

Mr. Rosario Marchese: I was puzzled by the fact that they haven't done any review of their own. Then all of a sudden, the Auditor General said, "You should do a review," and they said, "We agree." So now they have the energy, but a year ago, when they thought about it, they didn't have the energy or the people. But, pressed by the auditor and presumably the government, all of a sudden they have the energy.

Mr. Harry Brown: I think the Auditor General's report really shed a lot of light in a dark corner, and I think that made things happen very quickly. I also think that nobody realistically sees any insurance company in

the last 20 years doing a rate of return of 12.5%. That was based in 1989, when you had high inflation and Bell was doing 8%, 9% and that sort of thing. It's not realistic, and I think most insurers will tell you that.

There have been a few little blips along the way when they announced a new product and the insurance companies said, "Okay, then I don't have to pay tort claims anymore because it's permanent and severe," and then later it turned into a six-month whiplash; it got you over the threshold.

I think the other big problem is—for example, one of my clients lost $1.040 billion two years ago in Ontario. We were all afraid they were going to withdraw—

Mr. Rosario Marchese: Who?

Mr. Harry Brown: State Farm. I can tell you, if I speak to any company in Ontario, I say, "Don't put any business in the GTA. I don't care what the premiums are; it's just a disaster." The biggest problem at FSCO, to answer your question, was that they were worried about loss of capital, not about people making too much money.

Mr. Rosario Marchese: Thank you.

The Acting Chair (Mr. Michael Coteau): Thank you very much.

Mr. Harry Brown: Thank you.

The Acting Chair (Mr. Michael Coteau): Now, MPP Singh, you have a request, I believe.

Mr. Jagmeet Singh: Yes. Just to clarify, I wrote it—it's a bit confusing. It's a request but I put it like a motion. I just wanted to clarify. There were three things that were indicated today that there would be follow-ups on.

FSCO indicated two issues they would follow up with. One was the current rate differential for adjoining territories. The percentage initially was 10%; they weren't sure what it is now, and they wanted to clarify what the current rate is.

Just as an aside, FSCO is well aware of what that is. That's something that they set. So if it was set at 10% before and it's changed now, it's something that they should readily have access to.

Mr. Rosario Marchese: So we're requesting that information.

Mr. Jagmeet Singh: So we're requesting that information and that it be, hopefully, tabled by the next time we're sitting.

The second one is, they also indicated they had claims data for the first half of 2011 and that they would provide that, as well as a comparison with the claims data for 2010.

Those are the two things that FSCO indicated they had. I just wanted to clarify that. I know that Madam Clerk is taking notes on this so that she can follow up.

The last piece was that Allstate indicated that they were prepared to present their claims data for 2011. That's the other clarification.

Those three things, if we could—

The Acting Chair (Mr. Michael Coteau): Those three things are on the record. We'll take it as a staff undertaking, a staff request, to gather that information.

Mr. Jagmeet Singh: Sure.

The Acting Chair (Mr. Michael Coteau): That's fine.

Mr. Jagmeet Singh: That's it. Thank you.

The Acting Chair (Mr. Michael Coteau): No other items on the agenda. This meeting is adjourned.

The committee adjourned at 1835.

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