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# Official Report of Debates (Hansard)

**Tuesday 10 July 2012**

# Journal des débats (Hansard)

**Mardi 10 juillet 2012**

## Standing Committee on Finance and Economic Affairs

Automobile insurance review

## Comité permanent des finances et des affaires économiques

Examen de l'assurance-automobile

Chair: Bob Delaney
Clerk: Valerie Quioc Lim

Président : Bob Delaney
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

# COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 10 July 2012

Mardi 10 juillet 2012

*The committee met at 0930 in the Holiday Inn Toronto-Brampton Conference Centre, Brampton.*

## AUTOMOBILE INSURANCE REVIEW

**The Chair (Mr. Bob Delaney):** Good morning, everyone. We are here to resume our consideration of the auto insurance industry pursuant to an order of the House dated May 31, 2012.

## STRUCTURED SETTLEMENTS GROUP INC.

**The Chair (Mr. Bob Delaney):** Our first deputation of the morning will be Structured Settlements Group Inc., Douglas Mitchell. Please come forward. Take a seat, make yourself comfortable. Introduce yourself for the purposes of Hansard and then proceed. You'll have 20 minutes to make your remarks, followed by up to 10 minutes of questions, which will be divided equally among the parties. Your first questions will come from the PC side.

**Mr. Douglas Mitchell:** Thank you. By way of introduction, I'm Douglas Mitchell. I'm president of Structured Settlements Group Inc. My family has been in the insurance business since 1933. I started in 1970, mainly in claims, and by 1985 was primarily negotiating structured settlements.

If you are unfamiliar, a structured settlement uses a special annuity that enables the defendant insurer to guarantee tax-free future payments to a claimant, saving the defendant insurers in Ontario hundreds of millions of dollars. Defendant insurers lobbied hard to get this benefit and, in return, structured settlements were supposed to be openly available to all claimants.

I've participated in more than 2,000 settlements that involved structures. I have taught structured settlements at over 100 law firms and financial brokerages, and at the Insurance Institute of Ontario. I have been a structured settlement adviser to every level of government in Canada, from local police forces right up to the federal government.

I see two serious problems in the industry: preferred structure brokers and assignments. I will deal with preferred brokers at this time, and you may draw upon my experience for information about assignments causing a massive concentration of risk at a later date, if you wish.

There are four full-time structure brokers in Ontario and all are paid by commission when they place the funds for the annuity with a life insurance company. With the changes to the act in 1996 and subsequent, adjustors and lawyers have increasingly relied upon structure brokers to provide quotes on the cost of buying tax-free annuities to cover each of the types of future needs as a basis from which to start negotiations.

In the last 10 years, a large number of auto insurers have designated preferred brokers. In theory, these are the brokers that they would prefer their own adjustors and lawyers contact to get information about the costs or the value of future payments. In practice, the general insurance companies' lawyers and adjustors demand that the annuity be placed by their preferred broker, resulting in their broker receiving the commissions.

Preferred brokers have refused to split commissions with the claimant's brokers. They say they can represent the best interests of both sides at the same time so the claimant does not need their own expert. The general insurance companies refuse to pay bills submitted as a disbursement by a claimant lawyer for independent structured settlement advice.

This process, over several years, has caused the claimants' lawyers to be unable to consistently secure independent structure calculations and advice, leaving them to accept whatever calculations and technical information the defendants' preferred broker suggests.

There are a multitude of variables that affect the calculation of the cost of future needs and other elements in a structure quote to make it appear to address those future needs. People do make errors and do "forget" elements from time to time. Without the oversight of a claimant's structure expert, the defendant's preferred broker's mistakes go undetected and elements are excluded or included at the discretion of the defendant's preferred broker without question or review.

Some time ago, I undertook to help at least one claimant lawyer each month, even if I knew that I would not be paid. The result was shocking. Out of the scores of cases, there was a mistake on virtually every case, and only once was the mistake in favour of the client. The claimants' preferred brokers are consistently making mistakes and including assumptions that favour their client, the defendant insurance companies. These mistakes have been as large as $600,000 on a single case and would

have gone undetected if it were not for my gratuitous participation in the case.

This situation was prevalent in the United States about 10 years ago and, once exposed, led to many lawsuits against defendant insurance companies. The United States' industry leaders forced a change to the structured settlement practice, acknowledging that each party is entitled to independent expert advice, and if both sides engage structure brokers, those brokers will share the commission equally. This is somewhat similar to our MLS system here in Ontario for real estate.

This practice ended the problems and the abuses in the United States, but this problem needs to be addressed here. Ontario defendant insurance companies have no interest in claimants getting independent structured settlement advice while the errors are in their favour and saving them money.

I've attached in my printed materials, which will be handed out, the relevant portion of the only Canadian textbook about structured settlements. The writer, John Weir, a former superintendent of insurance for the province of Ontario, anticipated this problem and clearly stated that no one broker can represent the best interests of both the claimant and the defendant at the same time. His comments on conflict of interest are quite strong.

In conclusion, if structured settlement costs are going to be used as one of the bases for negotiation, then the claimant needs to have access to independent calculations and technical advice. Somehow, by commissions or fees, that work must be paid for or it will become unavailable. If structured settlement costs are not used during negotiations, then the claimant is receiving a fixed amount of money. If he chooses to structure part of his funds, then the broker's commission is paid out of his settlement funds. For the defendant insurers to demand that their preferred broker receive that money, to the exclusion of the qualified expert that the claimant has chosen, is absurd.

The quick solution is for regulators to confirm that the claimants' costs of securing independent expert advice about structured settlements is a claimable disbursement, which is payable either through a share of the commissions or directly from the defendant insurer. The defendant insurers will not need to pay this bill. They will simply direct their preferred brokers to share the commissions, or find new brokers who will share those commissions.

I'm available for detailed discussions and to provide multiple examples, as recent as last week, of these abuses. I'm also available for more detailed discussion about the problem of concentration of risk at any time you choose. Thank you.

**The Chair (Mr. Bob Delaney):** And thank you very much. Mr. Yurek.

**Mr. Jeff Yurek:** Thank you for coming in today. It's great that you've come in because this is the first I've actually heard of this part of the equation. I would gladly like to meet with you and talk to you about it later on as I digest some of what you've said personally.

Now, this problem: Has it just recently occurred? Has it been growing? When did it really start?

**Mr. Douglas Mitchell:** It started about 10 years ago, and it started with one particular defendant group who found that by offering quotes on a certain basis that favoured them, they could save probably a quarter of the starting price of each negotiation. It spread then, generally, to more and more of the defendant insurers over the years, and I'd say that now, probably 75% of the defendant insurers have picked one or two preferred brokers who will present what should be a fair and neutral assessment very much tilted in their own favour.

**Mr. Jeff Yurek:** So basically you want the system opened up to give fair choice to both the defendant and the plaintiff?

**Mr. Douglas Mitchell:** Yes. Every other expert that you might seek out information from in the course of an injury claim, you'd get an independent expert. First of all, you don't have to go to the lawyer that the insurance company uses to get your legal advice. You hire an independent lawyer and your party-to-party costs are paid. You don't have to use the accountant or the actuary that the defendant insurance company uses; you get to retain a financial expert to crunch your numbers for you, and those bills are paid. You don't rely on the information from the doctor who is giving the report to the insurance company. Although the doctors are supposed to be neutral, the doctors are well known to be tilted to one side or the other.

**0940**

But every claimant gets to retain experts in various fields, and those experts are paid more or less fully on every case except in the case of structured settlements.

**Mr. Jeff Yurek:** Ted has a question.

**Mr. Ted Chudleigh:** Just a brief question: You mentioned life annuities. I understand life annuities are purchased on the basis of a proposed cost-of-living increase. Quite often, those cost-of-living increases are inadequate to provide the claimant with cost-of-living indexes. Are these being manipulated as well by the system?

**Mr. Douglas Mitchell:** First of all, you can buy a life annuity that's level. You can buy a life annuity that's going to increase at 2%, 3% or 4% as a fixed rate of increasing. You can buy life annuities that are guaranteed to increase with the consumer price index, and on those annuities—and as you probably know, in Ontario, interest rates and the consumer price index pretty well run like railroad tracks. If interest rates go up, the consumer price index goes up. Your annuity will go up by the same percentage in the following year, but your annuity will not fall if interest rates or CPI falls. Your annuity will go up with CPI. If CPI goes negative, your annuity remains level at that plateau until CPI is positive again, and then it goes up again.

**Mr. Ted Chudleigh:** So it's more expensive to buy.

**Mr. Douglas Mitchell:** Yes. Now, one company, Canada Life, has come out with CPI plus 1% a year and CPI plus 2% a year, and that's in response to a case called Roberts vs. Morana and the MTO, where a great

deal of actuarial time was spent in court proving that care costs, non-medical care costs, are increasing at the consumer price index plus at least 1% more per year, and medical care costs are increasing at the consumer price index and at least 2% per year. Canada Life responded by developing a product that would pay in either of those two patterns.

**The Chair (Mr. Bob Delaney):** Thank you. I'll have to cut you off there. Mr. Singh.

**Mr. Jagmeet Singh:** If I understand this correctly, the key issue—I mean, if I could break it down, and tell me if you agree, one issue is that insurance brokers or insurance companies are using preferred brokers, which kind of tilts the balance in their favour as opposed to the claimant. The other issue is that claimants don't have access to a lawyer or an independent source of getting advice on how to structure their annuities. Can you touch on those two parts? Am I understanding you correctly?

**Mr. Douglas Mitchell:** Yes, you're understanding correctly. It's like telling every claimant of Dominion of Canada that they have to go to a doctor who happens to be Dominion of Canada's doctor, and they can't go anywhere else. If they do, the doctor's bill won't get paid. As much as I am trying, I can't spend my entire career going and doing work for claimants when I'm not getting paid. The other structure brokers, I think, have found the same thing.

**Ms. Teresa J. Armstrong:** I also have a question. In one of the areas of your deputation, you had said, "People do make errors, and do 'forget,'" but you've put that in quotes. Are you insinuating perhaps that forgetfulness is maybe motivated?

**Mr. Douglas Mitchell:** Yes, I am. With only one exception have I ever seen an error in favour of the claimant.

**Ms. Teresa J. Armstrong:** But the errors where you've got "forget": Are they intentional so that—

**Mr. Douglas Mitchell:** Yes.

**Ms. Teresa J. Armstrong:** You believe they are.

**Mr. Douglas Mitchell:** Yes.

**Ms. Teresa J. Armstrong:** Okay—on the part of the insurance company.

**Mr. Douglas Mitchell:** On the part of the defendant insurance company's preferred broker.

If you want an example, on quite a few cases, what I've found is that the defendant's broker will present a structure number that is supposed to meet the income replacement benefit on a statutory accident benefit file. They regularly "forget" that there is a stage post-65 where you receive a percentage of your pre-65 income for the rest of your life. I've run into that so many times where this is presented as meeting the IRB obligation. They forget about the post-65.

**Ms. Teresa J. Armstrong:** I want to squeeze this question in. FSCO is responsible for the insurance companies' rates and making sure that they don't break the rules, for penalties. Do we know who oversees these companies that perhaps forget, not to the benefit of the client?

**Mr. Douglas Mitchell:** I brought this to the attention of FSCO four years ago and really haven't had any response.

**Mr. Jagmeet Singh:** What would you envision a better system would be, if you can just briefly outline that?

**Mr. Douglas Mitchell:** It's very interesting. Over the course of the time I've been in the business, whenever a recognized official makes a statement about how they would conduct claims business, every lawyer and every adjuster in the province suddenly takes that as a benchmark or a measure of reasonable conduct and very quickly moves to that measure of reasonable conduct to protect themselves from future claims and—

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Naqvi.

**Mr. Yasir Naqvi:** Go ahead, finish your sentence.

**Mr. Douglas Mitchell:** All that has to happen is some regulator or some person in authority has to come out and say, "I firmly believe that claimants are entitled to independent structured settlement advice," and somehow that advice has to be paid for, whether it's by share of commission or by actual receipt of a fee from the defendant insurance company.

**Mr. Yasir Naqvi:** Thank you very much for coming today and—I want to echo Mr. Yurek—bringing a unique issue that we have not heard in these hearings up to now. What are your recommendations to us?

**Mr. Douglas Mitchell:** Just what I was reiterating in the last few moments: You may be able to identify, or, as a body, make a statement or have someone confirm that the cost of securing independent structured settlement advice is a cost that should be recovered from the defendant insurers. The defendant insurers will immediately turn around and force their preferred brokers to split the commissions rather than pay it as an extra cost. The whole process will become transparent again and equal. Right now, it's very unequal.

**Mr. Yasir Naqvi:** Thank you very much for your time.

**The Chair (Mr. Bob Delaney):** Thank you very much, Mr. Mitchell, for having come in this morning to share your thoughts.

**Mr. Douglas Mitchell:** Thanks for your time.

## MR. GERRY KYLIE

## MR. BRYAN YETMAN

**The Chair (Mr. Bob Delaney):** Our next deputation is from Gerry Kylie and Bryan Yetman. Are you in the room?

**Mr. Gerry Kylie:** I don't believe Bryan is here.

**The Chair (Mr. Bob Delaney):** I'm sure he can catch up to you. You'll have 20 minutes to make your presentation here this morning, followed by 10 minutes of questions divided equally among the parties. Your questioning will start with the NDP. Please begin by introducing yourself for Hansard, and then proceed.

**Mr. Gerry Kylie:** My name is Gerry Kylie. I just want to start out by saying welcome to Brampton, or, as former Premier Davis used to say, the centre of the universe. Mr. Davis sometimes stretched the truth a bit, but applied to our current automobile insurance situation in the province, he'd probably be pretty much spot-on.

I'm an insurance broker in Brampton with Heart Lake Insurance Brokers. I've been in the insurance business for 41 years, the last 34 as a broker serving the Brampton community. In the interests of full disclosure, I am a member of the Insurance Brokers Association of Ontario, but I appear here today representing only myself and not the association.

I'm sure that most people here understand the difference between brokers and insurers, but I'd just like to reiterate for those who do not that, as brokers, we need to work closely with insurers, but our mandate is to represent our customers' interests to the insurance companies.

Insurance is a complex product, and I feel, and the law requires, that consumers need and get expert advice tailored to their own individual needs when purchasing the product. My aims and goals will sometimes differ with those of the insurance companies, as my prime responsibility is to advocate on behalf of the public and serve my customers to the best of my abilities.

With respect to the auto insurance fraud and abuse situation, we have to get auto insurance rates under control. I believe the single most important thing that can be done to lower claims costs and thus insurance premiums is to tackle fraud and abuse in Ontario's auto insurance system, particularly in the accident benefits area. I can't tell you exactly how to do this, but I can tell you I'm seeing far too many accident benefit payouts ranging up to $50,000 when total damages to both vehicles involved are less than $1,000. It can happen that someone is that badly injured, and those who are deserve every penny of compensation they are entitled to. But realistically, what has been happening defies all logic.

**0950**

The Auto Insurance Anti-Fraud Task Force recommendations are scheduled to come out later this year, and I want to urge the government to implement those recommendations as quickly as possible. Page 57 of the 2012 budget foreshadowed some of the task force's final report recommendations: regulation of health clinics, various gaps in regulation, the establishment of a dedicated fraud unit, a consumer education and engagement strategy, and a single Web portal for auto insurance claimants.

I'm not political. I'm not a member of any party in the province. And I will tell you that I do not care who gets credit for taking action here, but action must be taken. I'm prepared to support constructive recommendations to combat fraud and abuse from any party. The public deserves nothing less. If we continue to tolerate abuse of the system, it will only get worse. We already pay the highest rates in the country and cannot handle any more increases. Savings must be found in the product design and administration.

I will say it again: Tackling fraud and abuse in auto insurance is probably the most important thing we can do to lower premiums. However, please, let's not get into a major overhaul of the system. I've worked through three different major overhauls of the system in my career, and we don't need a fourth. What we need is to give the 2010 reforms an opportunity to work. They appear to be having some effect, but we do need to proceed with action on the abuse front.

Even with those reforms, don't be deluded into thinking there are excess profits in the auto insurance area. There are no simplistic quick fixes to the system, and it's not a time for aggressive measures on rates. Again, let me be clear: I'm not here to defend insurers, but any aggressive tampering with the system will add expense—both actuarial and systems overhaul—and will threaten market stability.

There is, though, one other measure that can be taken to deal with unfair pricing practices in the property and casualty market. That is to ban the use of credit scoring in personal property insurance.

In 2005, the Ontario government banned the use of credit scoring in the rating of auto insurance. Shortly after that, many insurers began circumventing the ban by refusing to offer quotes to those who refused access to their credit information. This was finally brought under control by the 2010 auto reform package, which defined use of credit as an "unfair and deceptive practice." What the insurers have now done is used credit scoring much more aggressively on their property products, which basically subverts the ban. Many consumers buy both property and auto products from the same carrier to take advantage of multi-policy discounts. We have had situations where companies increased their property premiums dramatically—for example, from $900 to $2,200 for house insurance—due to credit scoring, which forces the client to go elsewhere, and thus they divest themselves of an auto policy they don't want in the process. We have to stop this back-door effect on the automobile consumer. My concern with this is that more and more property insurers are using credit scoring, and soon there won't be an elsewhere to go.

These are not all bad people. They may have a low credit score for all kinds of reasons, but most have always paid their premiums and been good customers who place no claims burden on the industry. Once there is nowhere else to go, we will have an availability crisis. That means you'll be back here with a standing committee on property insurance in the near future. None of us need that when it is so easily avoided.

Both Newfoundland and New Brunswick have seen fit to ban credit scoring, and Bill 108 has been introduced in our Legislature. I urge you to support it. I also believe it will be a simple procedure to amend the "unfair and deceptive practice" regulation currently in the Insurance Act to apply to property, the same approach as was taken with auto.

Thank you for your time.

**The Chair (Mr. Bob Delaney):** And thank you very much. Mr. Singh.

**Mr. Jagmeet Singh:** Thank you, sir, for being here today. You indicate that fraud is the single largest contributor to costs, or it could be the single largest way to save money where it comes to bringing down insurance premiums.

The IBC disagrees with you. The IBC says that claims costs are the number one cause and, of claims costs, fraud may be a portion. The Auditor General has indicated that fraud accounts for between 10% and 15% of the costs. The anti-fraud task force can't give a number; they're not able to say how much fraud actually costs.

We've seen that the cost per vehicle that insurance companies have to pay out—and their largest cost is their claims cost—has gone down by approximately 70%. I don't think we can find that type of savings in terms of reducing fraud, but there's no guarantee that's going to result in any savings in our premiums.

How do you respond to that, and how do you respond to any guarantee that by reducing fraud there will be a savings for consumers, when we've seen one of the largest decreases in cost in the history of insurance but we haven't seen any significant savings in our premiums yet?

**Mr. Gerry Kylie:** I'm sorry. You threw a lot of different percentages and numbers at me there and I'm not sure I caught them all. What were you referring to as the—

**Mr. Jagmeet Singh:** Just in general that the cost per vehicle has gone down significantly, and that's the largest cost. Insurance companies are saying their largest cost is how much they pay out per vehicle—their claims cost per vehicle.

**Mr. Gerry Kylie:** You mean per vehicle to repair a vehicle?

**Mr. Jagmeet Singh:** No, just based on their overall cost, including accident benefits, payouts on vehicles. Their entire costs have gone down significantly, largely because of the 2010 reforms. We've seen that they've gone down by more than half.

**Mr. Gerry Kylie:** I don't believe that's true, as an overall basis.

**Mr. Jagmeet Singh:** We had FSCO just confirm that yesterday. So just assume that that's true. How is that—

**Mr. Gerry Kylie:** I can't assume that's true, because I just can't believe it—and I don't believe it.

**Mr. Jagmeet Singh:** Let's say, as a hypothetical, claims costs have gone down significantly, by more than half. Take that hypothetical; assume that hypothetical. How is that going to relate to our premiums going down when we haven't seen that?

**Mr. Gerry Kylie:** If that were to happen, FSCO would be telling the companies to approve decreases pretty quickly.

**Mr. Jagmeet Singh:** Okay.

**Mr. Gerry Kylie:** They're not going to sit there and let companies make excess profits on the product. It's not going to happen.

**Mr. Jagmeet Singh:** And when would you foresee that that would happen?

**Mr. Gerry Kylie:** I'm not sure exactly when the companies file for their rates, but when they start filing, if they're not filing low enough rates FSCO would tell them to go back to the drawing board and file lower rates.

**Mr. Jagmeet Singh:** Okay. If there were savings of something over 50% in terms of costs, if they went down by that much, you would foresee that there would be some significant reduction in premiums?

**Mr. Gerry Kylie:** Well, yes. They would track pretty closely.

**Mr. Jagmeet Singh:** Okay, that's good. Do you agree with the idea that claims cost is the largest difference or the largest component in terms of premiums?

**Mr. Gerry Kylie:** Claims cost is—I mean, you've really got two things. You've got administration cost and claims cost, and claims cost is certainly the bulk of things. But claims cost includes a lot of different areas. Since the tightening of the 2010 accident benefits, we've started to see a lot more lawsuits starting to arrive on our doorsteps from people trying to get their money from a tort standpoint.

**Mr. Jagmeet Singh:** Right. Thank you.

**The Chair (Mr. Bob Delaney):** Thank you. Ms. Mangat.

**Mrs. Amrit Mangat:** Thank you, Gerry, for your presentation. You spoke in your presentation about the fraud and abuse, that a lot is happening in the greater Toronto area. Can you explain it? What kind of fraud is happening in Brampton?

**Mr. Gerry Kylie:** I don't believe I can specify as to what's going on there without—I mean—

**Mrs. Amrit Mangat:** Because you mentioned—

**Mr. Gerry Kylie:** We see examples on a regular basis of claims that seem to be way over and above what damages are to vehicles. When you see $400 damage to a vehicle and you have accident benefits payouts of $35,000 and $40,000, it doesn't sit right with me. I've been doing this for a lot of years and the last few years we've started to see this, and it doesn't make sense.

**Mrs. Amrit Mangat:** Okay. Is this fraud more than in other parts of the province and Canada? Is it specifically more in Ontario, the GTA and Brampton?

**Mr. Gerry Kylie:** It seems to affect the GTA more so, Brampton being part of the GTA. Brampton has a lot of problems, being that the growth of the population has far exceeded the infrastructure and the roads' ability to handle it, so the roads are very busy. We also have a particular problem with a lot of new drivers, being a lot of people who moved here 15 or 20 years ago. Their children are now driving. They're new drivers on the road. We do have a large immigrant community that arrives here, and they may be experienced drivers and they're not used to Canadian winters and whatnot. So we have a lot of new drivers in our system here in Brampton which is affecting things as well, I think.

**1000**

**Mrs. Amrit Mangat:** Okay. My second question is, is territorial rating the only cause for the increase in auto insurance premiums?

**Mr. Gerry Kylie:** Pardon me?

**Mrs. Amrit Mangat:** Territorial rating: The area where you live in is the only cause that the auto insurance premiums are high?

**Mr. Gerry Kylie:** No, it's one of a number of rate-setting factors—

**Mrs. Amrit Mangat:** Okay. What are the other factors? Can you please throw light on that?

**Mr. Gerry Kylie:** You've got people's individual driving records: how long they've been driving, what their accident record is, what the conviction record is—these things are all part of the rating equation—what their vehicle is, what the accident rating on their vehicle is, as far as the damageability factor. Some of the foreign cars are more expensive to fix than some of the North American cars, these types of things. Some people are injured more in an accident than others, so that's all part of the equation as well.

**Mrs. Amrit Mangat:** So territorial rating is just one factor; it is not "the" factor for increased auto insurance—

**Mr. Gerry Kylie:** No, it's one of a number of factors. I mean, it's—

**The Chair (Mr. Bob Delaney):** And on that note, I'm just going to interrupt you. Mr. Yurek.

**Mr. Jeff Yurek:** Thanks for coming in, guys. My question won't be hypothetical. We know fraud increases claims costs, so therefore that's why claims costs are higher, and premiums going down—we learned from FSCO yesterday that it could take up to a year to actually get a premium change, so there are some problems there.

My question for you: One, what do you see as the broker's role in educating consumers on fraud? Because I think that will be a big help in reducing fraud. Two, who do you think should be on the oversight of fighting fraud? Should it be FSCO? Should it be the Insurance Bureau of Canada? Should it be some other government agency?

**Mr. Gerry Kylie:** I think FSCO and the government may be in the best position to handle it, in conjunction with the insurance brokers. We have a big role to play in this. But the cost of advertising and brochures and these types of things, and getting the information out to the public, I would think the insurance companies should bear a big part of that cost. Now, I'm speaking as an individual here.

**Mr. Jeff Yurek:** Now, with the role of educating the clients, do you see the brokers having a major role in taking that on?

**Mr. Gerry Kylie:** Yes.

**Mr. Jeff Yurek:** And would the insurance brokers of Ontario—I know you probably can't speak for them, on their behalf—

**Mr. Gerry Kylie:** Bryan may be able to.

**Mr. Jeff Yurek:** Bryan probably can. Would they be up to taking a strong part of this role of educating the public?

**Mr. Gerry Kylie:** I would certainly think so.

**Mr. Bryan Yetman:** Apologies for being late. I thought we were starting at 10 this morning.

Yes, certainly, that was—

**The Chair (Mr. Bob Delaney):** I'll need you to just introduce yourself before you start.

**Mr. Bryan Yetman:** Oh, sorry. My name is Bryan Yetman. I've actually driven all the way here from Whitby today. I am a past president, now two years removed, of the Insurance Brokers Association of Ontario.

To that point, Jeff, I know that when the auto reforms had come through in 2010, the one thing that the brokers' association did is we actually sent our education team on the road and actually spoke to over 11,000 people, being out there to sort of inform and educate. We actually created some electronic infrastructure for our brokers to be able to easily print materials and brochures, and encouraging our broker members to send out information to the public.

So, in short, absolutely that's something that I think the association would look at as their responsibility, something that they would be happy to do. They certainly have a track record of being able to get out there and inform the public and also the professionals who are out there servicing the product.

**Mr. Jeff Yurek:** And what body do you feel would be best suited to lead the charge on fraud: IBC, FSCO or a government or a mix?

**Mr. Bryan Yetman:** I think at that stage, at that level, when you're talking about actual regulation and enforcement and things like that, right now, if you're asking me here today, I think the Financial Services Commission of Ontario would be the most logical body, alongside with some police authorities and whatnot as well and the courts. But certainly I wouldn't think they would want to leave the disciplinary action and whatnot to the public—like the insurers or the IBC or the IBAO. The association would certainly be happy to be out there and educate, but at the end of the day, those types of things should be managed at the government level, the regulatory level, and the most logical place, at least given our current infrastructure, would be the Financial Services Commission of Ontario.

**The Chair (Mr. Bob Delaney):** Okay, and thank you very much for coming in today to make your deputation and for sharing your thoughts and your expertise.

## ONTARIO PSYCHOLOGICAL ASSOCIATION

**The Chair (Mr. Bob Delaney):** I am advised that while our next deputant on your schedule has not arrived yet, we do have the 11 o'clock deputation, the Ontario Psychological Association, ready to go. So Dr. Amber Smith, Dr. Brian Levitt, if you're in the room, please come up. Have a seat. Make yourselves comfortable.

You will have 15 minutes to make your deputation this morning, followed by up to 10 minutes of questioning. This round of questioning will begin with the government side. Please begin by stating your names for Hansard and then proceed.

**Dr. Brian Levitt:** We'll be ready in just a moment.

**The Chair (Mr. Bob Delaney):** F5 will get you your slideshow.

**Dr. Brian Levitt:** Thank you.

**Dr. Amber Smith:** All right. I'm Dr. Amber Smith from the Ontario Psychological Association task force on auto insurance and the lead author of our guidelines on assessment and treatment of psychological injuries under auto insurance for Ontario.

**Dr. Brian Levitt:** I'm Dr. Brian Levitt. I am the president of the Canadian Academy of Psychological Disability Assessors. The Canadian academy is basically a group of psychologists who are senior psychologists with expertise in doing disability assessments, with a lot of evidence-based experience that we can bring to bear in terms of looking at the superintendent's report and what we're presenting to you today. Thanks for inviting us.

We thought we'd begin with just a little bit about who psychologists are, because sometimes there's a little bit of confusion around that. We're independent, autonomous, regulated health care providers trained from the bachelor's all the way through to the doctoral level in normal and abnormal mental health, experts in scientific methods applied to health and behaviour, and experts in measurement. We provide scientific, valid and reliable methods for assessing impairments, provide cost-effective, empirically validated, evidence-based treatments, and provide the gold-standard interventions for depression, anxiety, brain injury and chronic pain.

In Ontario, psychologists see patients with traumatic injuries under WSIB, auto insurance, victims' services etc. We're employed in hospital programs for chronic pain, depression, anxiety disorders, schizophrenia, cognitive impairments and brain injuries. Also, we cannot bill OHIP directly.

With respect to auto insurance, car accidents are the single biggest cause of civilian post-traumatic stress and brain injuries. Psychologists provide the most effective treatments for post-traumatic stress. Psychology is the only profession able to measure and diagnose cognitive impairments due to brain injury.

For accident victims, psychologists assess and treat post-traumatic stress disorder, depression, chronic pain and traumatic grief. We assess and rehabilitate brain injuries, assist in school and work re-entry, and assess and measure disability.

Furthermore, for accident victims, we tend to be involved with the most seriously injured and vulnerable, we work with high-need victims who have brain injuries and psychological disorders, and we provide services that are critical for recovery and disability prevention. Historically, in terms of the data in Ontario, that's 2% to 4% of accident victims.

As you all, I imagine, already know, mental health is often misunderstood. Services are often underfunded. Many studies across the country tell this story again and again; auto is no different. MVA victims with psychological conditions are among the most vulnerable of accident victims. Psychological disorders and brain injuries are invisible—this is an important point that I think bears underscoring—and they're easy targets for stigma, misunderstanding and discrimination.

MVA victims with psychological conditions tend to have higher levels of disability. It's the burden of comorbid conditions, when you combine mental and behavioural with physical impairments. Co-occurring mental and physical disorders create a greater burden on the system, suffer due to shortages of services for mental illness and brain injuries, and then there's often offloading to the public system, such as CPP, Ontario Works, public housing, prisons, etc.

**1010**

Obviously, cost control is essential. It's something that keeps coming up, and the 2010 reforms appear to be working. We included—we don't have it in our PowerPoints, I guess because we couldn't quite figure out a way to get this into the slides—an article from the Canadian Underwriter. It's in the packets that we had handed out. The graph in this article underscores this point that cost control appears to be working since the 2010 reforms. The June 2012 statistical issue shows a significant decrease in AB costs for insurers in Ontario since 2010. If you look at that blue line, that's the significant drop in the AB costs. Then coincident with that is an increase in the tort costs; that's the red line. So when you're seeing the significant drop in the benefits, you're also seeing the increase in the expense with tort.

So even though we're seeing this cost control, we see that this has created unintended consequences. Reforms have resulted in harm to some injured accident victims, and this is part of what we want to talk about today, because this does not have to be the case.

**Dr. Amber Smith:** We need solutions that continue to control costs, that reduce fraud, but that rehabilitate, prevent disability and protect the most vulnerable, and avoid harming people inadvertently. What we're seeing in the current 2010 reforms is that they're too blunt. They are hurting vulnerable people. They are controlling costs, but there's more there.

What we have currently is evidence-based guidelines for assessment and treatment services that are billable under auto insurance in Ontario. They were developed by more than 20 psychologists from around the province and passed by the Ontario Psychological Association board of directors. They have been published in an international peer-reviewed journal. They are accepted by our psychological community and are based on science.

They are not accepted by the insurance industry. We see consistent denials of everything that's consistent with these guidelines. So that's going to be part of our proposed solutions, that we need some acceptance of these guidelines.

What is working: The anti-fraud task force is working. The OPA is participating with that. The college of psychology is part of the professional identity tracker. Many psychologists are now able to track who is billing in their name for whom they're not working, so we're really glad for that. Let's keep that.

What is working: our electronic submission service, HCAI. This centralized invoicing and form submission system provides utilization and cost data. It should be able to identify outliers that can be investigated. It should make transactions more efficient and reduce transaction costs. So in terms of solutions, let's keep improving HCAI—there are some problems with it, some bugs that need to be worked out, but we think it's going to be good—and continue the anti-fraud task force. Let's keep those.

Now, what's not working: Our assessment and treatment plan approval process is not working. We're having more denials, more disputes, more delays. There are no reasons given for the denials, no communication with the providers, and the whole process has become far more adversarial. We have data from some reputable clinics outside the GTA, clinics that follow the Ontario association guidelines for assessment and treatment, and you can see the significant drop in approvals and increase in denials. This is seen and reported by other very reputable clinics that employ only regulated providers that are very ethical and that follow the guidelines.

The next slide is tracking from 2008 to the end of May in 2012. You can see the change in the full approval rate from pre September 1 to post September 1, and the increase in the denial rate, how actually it's increasing. If you look at the very bottom number, 29%, 32%, 42%, it's going up.

The problem is also that more of these are supposed to go to IEs, to second opinion. They don't always go; they're getting stuck in pending status. Two thirds of our IEs—I didn't include this on the slide; it's too much—are still being approved, the same rate as before, so all you're getting is lack of timely rehab, increased patient distress, frustration, increased disputes and transaction costs, increased disability. All of that means increased tort and BI costs and offloading to public systems.

What do we need to do? Let's reinstate timelines for decisions so people aren't lost in this grey zone. Reinstate deemed approval provisions. Improve adjuster education. Ensure approval for plans that are consistent with our evidence-based guidelines. Require communication between insurer and patient or provider prior to denial of service. These numbers are from clinics that call the adjusters. Call when they're submitting a plan. Ask for feedback from the adjusters—they don't get it. Require a reason for the denial. Too often it just says "denied": There's no reason given, the patient is denied service, and we can't do anything.

What else is not working? I referred to insurer examinations. In addition to having more referred and actually being stuck in the referral process for months, we also have no timelines. We're getting IEs by other professions. As psychologists, it's weird to get a second opinion from a GP or a nurse. Decisions that don't make sense: They don't understand our guidelines; they're approving and denying things that we can't do. Then we're getting repeat IEs for the same questions: patients who are sent for an IE before they come for assessment. The assessment says they need treatment, we do the assessment, submit a plan for treatment, and then they're sent back to the same IE to ask about the treatment that they already approved. There's no communication with providers, even when we try.

Let's ensure we have appropriate experts for IEs. Let's reinstate the timelines again. Let's develop joint guidelines for IEs. CAPDA and OPA are doing this, but again, if we develop another guideline, we need some assurance of acceptance by the industry.

I don't want to take up too much time. Also, the minor injury definition is too blunt an instrument. Cost control is obviously working and there is greater buy-in. We are seeing more people using it. The problem is, it's being used indiscriminately. There are high levels of utilization, which was a problem with the PAF, but it's being misapplied. We have patients every day with clearly documented concussions, brain injury and post-traumatic stress being restricted to the minor injury guideline. This is inappropriate. It's supposed to be for sprains and strains. They're getting denied services, and obviously that creates greater disability, more mediations and arbitrations, more lineups at FSCO, more BI and tort claims.

Our solution: Let's develop tools to identify who is supposed to be included and excluded from the definition and restricted to the MIG. We're doing this together, OPA and CAPDA. We're developing guidelines again. We want to reduce the inappropriate applications, denials and disputes. Again, we need some understanding that if it's science-, if it's evidence-based, it should be acceptable.

Back to Brian.

**Dr. Brian Levitt:** I'm just going to be spending a little bit of time now talking about the cat recommendations in the superintendent's report.

First, we support the intention in the report to introduce elements of evidence-based medicine to the Ontario automobile insurance system. We think this is a fantastic idea.

One of the recommendations we have is a simple change in the language in the report from "psychiatric" to "mental and behavioural." This is most consistent with current research, evidence and practice, to refer to disorders as "mental and behavioural," not as "psychiatric," which is a professional designation as opposed to a description of a disorder.

Also, we would like to see a more appropriate threshold for mental and behavioural impairments as comparable to physical impairments. I raise this because in the superintendent's report, the threshold appears to have been increased or the bar appears to have been raised for mental and behavioural in relation to physical and is discriminatory in that sense. If the government is

intending to have mental and behavioural impairments have a higher threshold, then the report actually does support that quite well, but we think that's not comparable and is discriminatory. We think there should be a shift in the GAF from 40 or less to 50 or less, which would be much more consistent with the other catastrophic definitions.

We also are looking at—

**The Chair (Mr. Bob Delaney):** Just to advise you, you've got about two minutes to go.

**Dr. Brian Levitt:** Perfect. Thank you.

Another recommendation is to include mental and behavioural impairments in an overall whole-person impairment rating; in other words, to combine all impairments of the whole person, not just physical but mental and behavioural, and that this can be done very easily with a conversion table, that is evidence-based, in the California workers' comp system.

We'd like to see the removal of the requirement of a restrictive list of specific diagnoses from the mental and behavioural criteria, because this is discriminatory. However, if a specific list is required, we'd like to be included in the process of generating a guideline for it.

**1020**

Also, allow psychologists to conduct—that is, as lead examiners—examinations for determination of catastrophic mental and behavioural impairments: This is what we've done since the inception of the SABS catastrophic, but have been excluded since the 2010 reform.

Then include psychologists among those who may complete applications for catastrophic mental and behavioural impairments and sign the OCF-19s, which, again, we have been able to do since the inception of the SABS and since 2010 have been excluded.

Continue to recognize our autonomy, competence and authority to independently certify treatment plans relevant to goods and services for patients with catastrophic mental and behavioural impairments. Also, continue to recognize neuropsychologists to independently certify plans for patients with catastrophic brain injuries.

Improve timeliness of access to catastrophic determination and address details of interim identification. There are a number of bulleted points here about our proposals to do that. In the time I have, I won't go through all that.

Also, remove the language in terms of any requirements for publicly funded or community-funded services from the definitions, because this does not fully incorporate the reality that there is private funding being used for rehabilitation services.

In conclusion, we want to thank you for the opportunity to meet with you, and we welcome any questions that you have. Thank you very much.

**The Chair (Mr. Bob Delaney):** Nice timing. Ms. Wong.

**Ms. Soo Wong:** Thank you for your presentation. I want to ask you—yesterday we had a presentation from FSCO, and very clearly from the chart it showed to the committee, there are concerns with respect to the rise of examination and assessment from 2006 to 2010. From the chart I'm seeing in front of me, there's an increase of 228% in terms of examination and assessment. I want to ask both of you from your association, what are you doing about this increase, and how are you going to address the fraud? Very clearly, this increase is not acceptable—and your association in reducing it, and your accountability through your college. I want to hear some solutions about this increase.

**Dr. Brian Levitt:** Absolutely. It's a very serious point and well understood.

The data going to 2010 unfortunately leaves out the rest of the story, which is 2010 up to now. Since the reform, we've actually seen a precipitous drop in terms of the number of examinations. When we look, for example, at the catastrophic assessments through our own clinic, there has been a return to levels of around 2007—before 2008, actually, since the reforms came in in 2010.

When you've removed the rebuttal system, for example, which really saw a huge spike in the number of assessments, we're now seeing our number of assessments drop down to what they had been around 2007. I think a lot of this actually has to do with legislative markers as opposed to fraud or overuse of the system in that sense.

**Ms. Soo Wong:** But I didn't get an answer from you with regard to accountability by your members in terms of fraud, okay? I want to know, has your regulatory body been proactive in disciplining or revoking the licence of your colleagues who have not been ethical in their practice?

**Dr. Amber Smith:** I think part of what's difficult is that the colleagues are not always reported to the colleges, and the colleges are complaint-based. What the college is doing is, the OPA and the college are among the first participants partnering with the anti-fraud task force to ensure that psychologists can actually see who's billing in their name. What has happened is we have had complaints by our members that they sometimes are doing IEs on OCF-18s that have been submitted in their own names, and they didn't do the work.

**Ms. Soo Wong:** Okay.

**Dr. Amber Smith:** Everybody's very pleased that OPA is one of the first, and the college has signed on to be—I think we're the second college with the anti-fraud task force to be able to track that.

In terms of being able to bring any kind of sanctions against members who have been fraudulent, the college needs people to report that. They're report-based. If it's not reported, they can't do anything.

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Yurek.

**Mr. Jeff Yurek:** A couple of quick questions here. How important is it to initiate treatment when somebody is starting to go through a mental condition due to an auto accident? You're saying they get delayed. How important is that?

**Dr. Amber Smith:** As with most things, it's very important to try to catch it early because it's not as en-

trenched and it's not as severe. If we can catch it early, we can have a much bigger effect and prevent more difficulties later. The problem with the delays is that not only does it increase the patient's distress but it entrenches the condition and then it takes longer, it takes more to try to straighten it out.

**Mr. Jeff Yurek:** Would it be more cost-effective to treat earlier than to wait?

**Dr. Amber Smith:** For sure.

**Mr. Jeff Yurek:** Assessment costs were brought up. They were skyrocketing through the roof and then they got capped to $2,000—your comments on that? Has the pendulum swung too much to the other side? And number two, your northern members: Is there trouble to access professionals in the northern parts or the rural parts of Ontario due to these assessment caps?

**Dr. Amber Smith:** I think access is difficult in rural and northern areas regardless, assessment caps or no assessment caps, particularly in a system with limited access to experts.

In terms of the assessment costs, I think my colleague, Dr. Levitt, addressed that, that in general the assessment costs were going through the roof with regard to rebuttals. However, those were capped in 2010, and we've seen a precipitous drop.

**Mr. Jeff Yurek:** Professionally, how accurately can you diagnose a mental condition after an accident with regard to pre-existing conditions? How accurate are you at determining what was there before the accident and after?

**Dr. Amber Smith:** That's an excellent question. Do you want to—

**Dr. Brian Levitt:** In terms of the issue of pre-existing—and this is something we spend a great deal of time on. First of all, with respect to diagnosing, we can be very accurate, valid and reliable with our diagnosis without looking at cause. We can diagnose very accurately.

Parsing through with the idea of causation, we need to have time to look at the complete medical file to do a complete workup in terms of the clinical interview, get our collateral sources, so that we can get all of the aspects of the picture to figure out where things fall out. So when we have the time to do a proper assessment, we're able to parse out causality rather accurately.

**Dr. Amber Smith:** It goes back to our scientific methods. In psychology, we call it multi-trait, multi-method assessment. It means you get your information from multiple sources and try to see how it all hangs together so you can be more accurate.

**Mr. Jeff Yurek:** Okay. And a personal opinion, I guess—not your answer, it's just that the next question is personal. The $3,500 limit on the MIGs, is that a fair amount? Should it be higher, should it be lower? Do you have any thoughts on that?

**Dr. Amber Smith:** For the minor injury, you mean?

**Mr. Jeff Yurek:** Yes.

**Dr. Amber Smith:** Frankly, we don't see people who have minor injuries, so it's a bit difficult for us to speak to. Certainly any of our patients who are trapped within that, it's clearly insufficient. It doesn't even pay for our services.

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Singh.

**Mr. Jagmeet Singh:** You touch on something that has come up a couple of times now, that some of the changes that we've seen in the 2010 reforms are shifting the costs from the private sector to the public sector. I'm just wondering if you could comment on that with more specificity.

**Dr. Amber Smith:** I think that's especially true with regard to the assessment and treatment of injuries. Frankly, when people are trapped within a system that isn't looking after their needs, they get offloaded. In the Hamilton area, most of our physicians participate in—what's it called?

**Dr. Brian Levitt:** Family health teams.

**Dr. Amber Smith:** Family health teams. They have access to mental health counsellors who look after a lot of their patients. A lot of our referrals really are the really, really, really injured people for whom the mental health counsellors and the family physician's office aren't enough. But they get offloaded back because they can't come see us because the system isn't looking after them and is restricting them too much. Sometimes, when they lose their homes, they go to Ontario Works, and sometimes, when they can't get access to higher levels of benefits, they go on CPP.

**Mr. Jagmeet Singh:** One of the things that I think is a targeted approach—sometimes the word "fraud" is used as a blanket and it's just this shotgun approach to a problem but it doesn't really provide any real solutions. One of the things I noticed that I think is a positive step is the issue of tracking the psychologists and who's billing in their own name as a way of specifically targeting one area that was an improper practice. Are there other areas where there can be a strategic kind of targeted approach to looking at avoiding excess costs that's not such a blanket thing as just throwing out the word "fraud," but using something more thought-out and more thoughtful in terms of an approach?

**1030**

**Dr. Amber Smith:** I think OPA and CAPDA would love that. I think we're really pleased that OPA is at the table with the anti-fraud task force and that the college has jumped on board immediately to try to help us.

I'm not sure we're the right people to answer that question.

**Dr. Brian Levitt:** Probably not in that sense, but still, we're very much on board with that. The idea of OPA and CAPDA working together, for example, on joint guidelines in terms of how we do the MIG assessments, how we would do IEs, so developing guidelines that we hope the profession will follow and to get the buy-in from the insurance industry so we're all working together on the same page, would be hugely beneficial, I think.

**Dr. Amber Smith:** One of the things we did do in developing the assessment and treatment guidelines was

ensure that we had psychologists working who provide second opinions, who do IEs, as well as who do assessment and treatment. They came up with several measures—it was a large group of psychologists—that should limit fraud, that should limit who can apply and who can participate in this and who can be funded. I would hope that uptake of those guidelines by industry would help to reduce fraud.

**Mr. Jagmeet Singh:** The last thing I wanted to quickly touch on is, I agree with you that HCAI is a very powerful tool in tracking and could prevent some other excess charges. You mentioned improving HCAI. What specifically could we do to improve HCAI?

**Dr. Amber Smith:** There are some features right now whereby things like—they're just bugs, where the dates don't necessarily match. The date that the provider considers the date of the form to be is not the same as the date the insurer considers the form to be. Therefore, even though it's a pre-approved service, the invoice gets denied and doesn't get paid, and there are actually more transaction costs, plus the fact that insurers tend to print everything out. Adjusters still have printed matter and are not viewing things electronically.

The system should work if we can get it there, but these are things we need to work out.

**The Chair (Mr. Bob Delaney):** Thank you very much for having come in and shared your insight this morning.

## ONTARIO BRAIN INJURY ASSOCIATION

**The Chair (Mr. Bob Delaney):** Our next deputation is the Ontario Brain Injury Association: Tammy Dumas, Steve Noyes. I think you're in the room. Please come forward and take a seat. Make yourself comfortable. All of the mikes work. Just pick any seat you wish.

You'll have 20 minutes to make your remarks this morning. Please start by introducing yourselves for Hansard. In this round of questioning, which will be up to 10 minutes, the questioning will begin with the official opposition. So please begin with your introduction for Hansard and proceed.

**Ms. Tammy Dumas:** Thank you. Good morning. My name is Tammy Dumas, and I'm the associate director of the Ontario Brain Injury Association, or OBIA, as we are commonly known. I'm here today with my colleague Steve Noyes, who is a survivor of brain injury and our IT consultant.

On behalf of the board of directors of the Ontario Brain Injury Association, we thank you for the opportunity to make a submission to this committee for input on this study of the auto insurance industry's practices and current trends. OBIA applauds this committee for seeking further input, and again we thank you for the opportunity for Steve and I to share our concerns.

OBIA is a provincial not-for-profit charity which speaks on behalf of survivors of brain injury, of which there are approximately 500,000 in Ontario. Since 1986, we have been working to enhance the lives of Ontarians living with the effects of acquired brain injury through education, awareness and support.

OBIA does not provide direct rehabilitation services to people. Therefore, as an organization, we are not directly impacted by the proposed insurance changes. However, our main priority is to advocate on behalf of people living with brain injury to ensure that they receive the reasonable and necessary services that they are entitled to in order for them to achieve the best possible quality of life given their circumstances.

As part of our support to Ontarians who have experienced brain injury, we offer a toll-free provincial helpline where we receive calls from both survivors of brain injury and their family members. Many of these calls are from people who have been injured in motor vehicle collisions. As a result, we have an abundance of opportunity to hear the consumer's perspectives on and experiences with auto insurance.

Furthermore, we receive calls from family members whose loved ones have never been diagnosed with a brain injury following a motor vehicle collision, but suffer severe neurological impairments and difficulties with functioning following a motor vehicle collision. One of the services that we often provide is helping families navigate through the systems and the necessary steps required to access the appropriate assessments needed to in fact determine if they have a brain injury. These calls come to us sometimes months or even years following a motor vehicle collision.

OBIA recently conducted a study with over 600 participants, and in that study, nearly 16% of respondents indicated it took them longer than six months to learn of their acquired brain injury; 4% stated it took them longer than five years to learn of their injury.

Therefore, given OBIA's mandate, our services and the compilation of our membership, we believe we are in a unique position to comment on some of the specific aspects of auto insurance, particularly as it relates to catastrophic brain injury. I will note that my presentation is a bit of an abridged version from the presentation that you have in order for us to meet our time.

We know that the financial costs of ABI in Ontario are indeed great and are measured in the hundreds of millions of dollars for rehab and lifelong support. The public health care system does not have the financial dollars required to cover all of these costs. Thus, it's legislated by the provincial government that all individuals who drive must have auto insurance to ensure that the health care system does not become burdened with the cost of serious injuries related to motor vehicle collisions.

OBIA is very concerned with the proposed changes in the superintendent's report on the definition of "catastrophic impairment." It is our position that the proposed changes from the current definition will be detrimental not only to the severely injured, but to the general population, as services previously covered by insurance will fall to the taxpayer and those utilizing OHIP will be on a longer wait-list for required services.

I would like to highlight some of our concerns regarding the proposed changes to the definition of "catastrophic impairment," the first being the proposed changes to the definition of "traumatic brain injury" in adults. In the initial report, the expert panel recommended that a person who sustained a brain injury must be accepted for admission to a program at an in-patient neurological rehab centre. This was changed to state that the eligibility criterion is now admission to an in-patient facility or an outpatient or day-rehab program.

Although OBIA is pleased with the modification in this criterion, we still see the proposed change as being prohibitive in receiving treatment. Even within our current system, we know that people are falling through the cracks, and under the proposed change, this will become an even wider crevice for several reasons.

OBIA has many members who have never spent a day in an in-patient rehab facility, outpatient or day program, but do have severe brain injuries that meet the current definition of catastrophic brain injury. One example is a person named Gerry. Gerry was proceeding through an intersection when a driver ran a red light and T-boned him. Gerry was unconscious for only a few moments prior to the ambulance arriving. The ambulance took him to the hospital and he was later released.

Gerry began to experience problems with headaches and cognitive difficulties. He went to his doctor, who told him to go home and rest. Long story short, Gerry never spent a day in a rehab centre or an outpatient or day program.

Gerry attempted to return to work as a primary school teacher. However, due to his difficulties with memory, sequencing and fatigue, among others, the school asked him to step down. Gerry will never return to the classroom as a teacher, nor is he currently capable of other full-time employment.

Gerry did go through rigorous testing and later was, in fact, deemed catastrophically injured. Gerry had a good experience with his insurance company and they were very helpful through this difficult process. Further, the insurance dollars that were available to Gerry allowed him to put a rehabilitation team in place. This team enabled Gerry to get some of his life back, and he is now able to live at home with his family.

Under the proposed changes, we are not sure what would have happened to Gerry. More than likely, Gerry, like others, would have been forced to utilize the Ontario Disability Support Program or Ontario Works simply to keep a roof over his family's head, with little quality of life because of the deficits because of his injury. OBIA is concerned that newly injured Gerrys will fall through the cracks with some of the proposed changes.

**1040**

There are long wait-lists. There are already long wait-lists for in-patient, outpatient and day programs, and by adding this criterion, the proposed changes will only increase the long waiting times for treatment on an already significantly stressed system.

There's a shortage of recognized neurological rehabilitation centres, outpatient and day programs, creating regional disparity for treatment. Rural brain injury survivors specifically are at a disadvantage under this definition. For some in the very rural north, there are no outpatient or day programs at all for them to access. However, across Ontario, even where they do exist, there are still tremendous barriers, transportation being the primary difficulty. For example, there are programs available in Hamilton, but for individuals in the Niagara region or Niagara Falls, that trek may simply be impossible. This could be due to not having the availability of a friend or a family member or another support person to provide them with that transportation, and there is no direct public transit to a lot of these programs.

Additionally, for those with severe brain injuries, often they have a window of a few good hours in a day where they have the energy and the stamina, and this would be used up by simply the transportation alone—getting there.

Another concern is the onus on front-line medical personnel to facilitate the admission to outpatient and day programs. The matter to consider is that the requirement for admission to a neurological in-patient centre, outpatient or day program puts the onus on front-line personnel—ER doctors, family doctors etc.—to recognize and diagnose a brain injury but also to facilitate admission into a facility.

In OBIA's experience, brain injuries are often missed right at the time of trauma, especially when there are other injuries that need immediate attending-to or are immediately recognized. It is our experience that it is often at the point when a brain injury survivor attempts to return to their normal life—for example, returning to work or returning to school—that the true deficits from their brain injury are realized. These deficits can include memory loss, inability to organize and sequence, lack of physical and mental stamina. Again, these people, under the proposed changes, would fall through those cracks.

The exclusion of community-based rehabilitation programs: The proposed definition completely leaves out the numerous brain injury survivors who seek assistance only through community-based rehab programs. In many cases, these programs are just as valuable and are more cost-effective. Under the proposed definition, these brain injury survivors seeking that type of support would be left out.

In regard to the physical and psychiatric impairments not being combined for the purposes of the cat definition, the proposed changes to this definition would require any impairment or impairments arising from traumatic brain injury that could be classified as psychiatric to be evaluated using the adult definition of cat and not the whole-person impairment. From OBIA's perspective, we need to look at the overall outcome for the individual and their success or, sadly, lack of success in resuming their life that they had prior to their brain injury. Therefore, we believe that a brain injury survivor who sustains a mild or moderate brain injury, resulting in psychiatric symptoms

along with the physical impairment, should not be excluded from being able to combine impairments.

The report also indicated it did not have the resources to conduct a comprehensive review of the literature to determine whether valid and reliable methods of combining physical and psychological impairments exist. Therefore, OBIA feels it's premature to remove this from the definition, as it presents a barrier for access to funds for possible rehabilitative supports.

Family doctors as the gatekeepers of treatment and assessment plans: A final concern OBIA has is making family doctors as gatekeepers on treatment and assessment plans. Currently in Ontario, there are almost one million people who do not have a family doctor and will not be able to access any care. Furthermore, in our experience, there are many times, when supporting our clients and our members, that we have had to educate their family doctors about their brain injury and their symptoms, and their recovery. Understandably, they are general practitioners and not specialists. OBIA has grave concerns about putting them in a specialist role.

In summary, OBIA has concerns regarding the changes being proposed to the cat definition and the impact it will have on those who are seriously injured in motor vehicle collisions. Furthermore, those who are seriously injured will be forced to turn to the public health care system, putting even more pressure on an already stressed system.

I thank you again for the opportunity to share OBIA's concerns, and I'd like to introduce my colleague Steve Noyes.

**Mr. Steve Noyes:** Good morning. My name is Steve Noyes. I have a brain injury. Let me tell you a little bit about myself.

It was June 2007. I was working as director of information and communication technology at Mount Sinai Hospital. With the support of a staff of over 80 individuals, I had the full responsibility for all computer systems and the entire phone system and network infrastructure for the hospital. I also spent a considerable amount of time working with the Ministry of Health and the LHIN on major hospital integration projects.

On June 6, 2007, after a typical busy day at the office, I left the hospital to start my trip home. As I was crossing the street at a crosswalk, a bus made a left-hand turn and ran over me. I sustained a severe traumatic brain injury as well as orthopedic injuries.

I spent a few months at St. Michael's Hospital recovering and waiting for a bed in rehab. In September, I was transferred to the Chedoke rehab in-patient unit. While in this program, I was always doing something to rehabilitate my mind and body. My belief was that I was working hard enough that when I went home, I would just pick up my life where I left off: back to my career, my family, my friends. Was I in for a surprise. What I came home to was my wife learning to live as a caregiver, my daughter needing to behave more like a parent than a new high school graduate, and a son who was just lost.

One day, while at an appointment in Hamilton with my wife, I received a text message from my son saying, "I love you." There was no response to further text messages I sent. We discovered when we returned home that he was taken to the hospital after taking a bottle of my sleeping pills. Fortunately, he had called friends after taking them, and I will always be grateful to those friends and the paramedics who saved his life. My point here for this committee is that brain injury not only affects individuals; it affects everyone in a family.

Coming home was a huge dose of reality. In my mind, I had lost everything that was familiar to me: my job and its prestige, my role in my family, my ability to be independent. I didn't even know myself. My behaviour was out of control: angry mood swings, impulsive spending and, not surprisingly, depression. How does one move ahead under such circumstances? The answer is: community-based rehabilitation.

My brain injury was unfortunate. However, I was fortunate to have been deemed catastrophic and, as a result, gained access to resources that allowed me to work with a specialized team in my own home. You see, the hard work of recovery is learning how to live again and that can only happen at home, but it takes enormous funding resources. In my case, my rehabilitation team consisted of a speech-language pathologist, an occupational therapist, a neuropsychologist, multiple rehabilitation therapists, attendant-care support workers so that I could be safe at home, and a case manager to coordinate everything.

For me, my brain injury also caused severe vision loss, so I also have with me today my service dog, Tonka. He is my best friend and gets me safely from point A to point B.

With all the help I received, I'm learning to live a new life. I'm still not working, but I obtain meaning and satisfaction from my role as computer consultant with the Ontario Brain Injury Association. My family is still adjusting to the new me, but thankfully they are not suffering like they were. My daughter has finished university and is engaged to be married. My son has found his passion in helping others as he was helped, and is training to be a paramedic. I still meet weekly with my neuropsychologist and work with a rehabilitation therapist three days a week so that I can be healthy, productive and not depressed.

So, five years after my injury, that is where I've travelled. But without the financial resources that my catastrophic designation brought, I'd be in a very different place, perhaps even becoming a long-term psychiatric patient, because, ladies and gentlemen, without resources, that's where many individuals with my kind of injury end up.

I thank you for your time today. I am passionate to see that others who sustain brain injuries receive the support they need to make the best possible recovery. I hope you have heard my message and will consider the benefits of being deemed catastrophic. Remember, what we are

talking about here is only the eligibility to access what is needed to recover; that access is everything. Thank you.

**1050**

**The Chair (Mr. Bob Delaney):** Thank you very much. Mr. Yurek?

**Mr. Jeff Yurek:** Thanks for coming in today. It was great to have your presentation.

A couple of questions. Since the 2010 changes, what percentage of your association, dealing with auto insurance, is not getting deemed catastrophic and therefore having to deal with the $50,000 threshold?

**Ms. Tammy Dumas:** That's a good question. It's not something that we're currently able to track, but we've put those plans in place to start to track those calls that come in partly because many people were not aware that that's even an issue, without education and understanding the changes that occurred in 2010.

But from OBIA's perspective, it is something that we're tracking currently in the calls that come in to our helpline and through other requests for service. We don't have any concrete numbers yet around that difference, but we have just recently started to notice an incline in those types of calls and those requests for information.

**Mr. Jeff Yurek:** And on average, what's the wait time between—you've given us a couple of times, but what's the average wait time for being deemed catastrophic from the time of the accident?

**Ms. Tammy Dumas:** You know what? Not being a clinician, I'm not sure that I can answer that question in a clinical way.

We can speak to it from the context in which we get the phone calls around how often people have waited to receive any diagnosis at all related to a brain injury. And I mean that we receive hundreds of calls every month for people who have a brain injury but haven't yet been diagnosed.

**Mr. Jeff Yurek:** And there's been a lot of talk about fraud over the last few months—sorry if you can't hear me. I'm light-talking again.

**Ms. Tammy Dumas:** That's okay, thanks.

**Mr. Jeff Yurek:** There's a lot of talk about fraud in the system. We feel that a lot of the fraud that's going on is actually taking the money away from helping people in your association, which is therefore causing massive changes in the system. Do you have any thoughts on fraud at all or any examples coming through your association?

**Ms. Tammy Dumas:** I honestly can't speak to any examples that would come through our association or through our helpline related to fraud. Is there a question that it exists? No. Our concern, from OBIA's perspective, however, again goes to simply that the resources are available to those who do need it so that serious consideration is given to the information of the context around how it's going to affect survivors or potential brain injury victims and their families moving forward.

I can't speak definitively about the fraud issue, but I can speak to how the changes would affect people having not received the cat designation. I think Steve is a perfect example of that, as is Gerry. Those are just two people of the hundreds we could probably talk about.

**Mr. Jeff Yurek:** And do you feel these new proposed definition changes to catastrophic are going to possibly increase the likelihood of people being denied catastrophic coverage?

**Ms. Tammy Dumas:** Yes.

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Singh.

**Mr. Jagmeet Singh:** Yes, thank you. One of the recurring themes, I think, that is occurring—I think you touched on it very well and I'd like you maybe to address it again—is that money or funding or resources that are put up front—and I think this also speaks to Mr. Noyes's story as well. I thank you for sharing that with us. It's always difficult to share and relive those experiences, so thank you so much for sharing that, and thank you for your advocacy work, as well, as a part of OBIA.

**Ms. Tammy Dumas:** Thank you.

**Mr. Jagmeet Singh:** What I'm seeing is that resources up front, in terms of rehabilitation and reintegration, prevent cost down the road that if you can put resources in the front end, you save in the long end with chronic psychiatric patients or other things of that nature. Is that something that you're advocating? Am I understanding you correctly on that?

**Ms. Tammy Dumas:** I'll speak to that quickly if you want to. Absolutely, and I think we would advocate for sure that we work with people all the time around—immediate rehabilitation is important for an individual with brain injuries recovery. We do see the demand on the health care system down the road around the future services that are required, in particular related to mental health services, as Steve mentioned, issues related to depression, anxiety. A lot of that can be related to the breakdown of the family as a unit because, as Steve said, brain injury does not just affect one person; it does affect the family as a unit. A lot of those future costs are if the family caregiver is unable to work. Outside of the medical community, we start to see people relying on welfare, ODSP, Ontario Works, those kinds of things.

It's a big picture that we need to look at, in the context of not just the individual who sustained the injury but the family that's surrounding them. Down the road, if immediate supports for everybody are not provided, particularly for the individual to make the best possible recovery, then what's that long-term effect going to look like, and who's going to pay for that?

**Mr. Jagmeet Singh:** Ms. Dumas, I also want to thank you so much for your advocacy. One of the things that's really concerning to me, that I think I didn't really turn my mind to and you've really drawn this out very well, is that the definition requires someone to be admitted to an in-patient neurological rehabilitation centre. There's a series of problems with that. I didn't realize that, inherently, there are already long waiting lists, and if you are required to be an in-patient, then you're inherently going to have to wait on that same long waiting list, which will

severely impact those who are able to access brain injury treatment. Is that what you're talking about?

**Mr. Steve Noyes:** If I can actually comment on that from experience: I spent a month and a half sitting, waiting, in a bed at St. Michael's, waiting for an in-patient rehab bed, when I could have been served from home in a better way with outpatient rehab and the community-based rehab. But that wasn't offered at the beginning, not until after my in-patient stay.

**Mr. Jagmeet Singh:** So essentially—and you touched on this, Mr. Noyes—at the end of the day, to be reintegrated into society, you need to be able to learn to live at home.

**Mr. Steve Noyes:** Right.

**Mr. Jagmeet Singh:** And as much in-patient treatment as possible will never replace the outpatient, and being able to reintegrate into your family life.

**Mr. Steve Noyes:** No. If you ask me for my opinion now, the outpatient at-home rehab is three times better than what you would receive from an in-patient rehab perspective.

**The Chair (Mr. Bob Delaney):** Thank you. Ms. Mangat.

**Mrs. Amrit Mangat:** Thank you, Tammy and Steve, for your presentation. Steve, thank you very much for sharing your story with us. It's really heartbreaking.

My question is to Tammy. Tammy, in your presentation, you spoke about your concern that newly injured Gerrys don't fall through the cracks. In your opinion, what do you recommend so that those people don't fall through the cracks?

**Ms. Tammy Dumas:** I think it's with some of the changes where people—I'm thinking about Gerry as an individual specifically, and the struggle that he endured because he wasn't deemed as being catastrophically injured initially, because the doctor sent him home. What we're saying is, sometimes severe brain injury is not immediately recognizable. But he was living with a catastrophic brain injury. He was unable to function in all of his roles that he had prior to his brain injury. Receiving those services, getting those assessments early on and starting to receive some of those rehab services would have prevented some of the difficulties that Gerry had down the road.

Again, Gerry's story is a positive one in that he's one who ended up receiving that designation and thus the resources that are attached to it, and was able to put the team in place that he needed, to get the help that he needed. But without all of that, without the designation, those resources don't come, people don't get the help that they require, and there's a breakdown of many things.

**Mrs. Amrit Mangat:** Thank you.

**The Chair (Mr. Bob Delaney):** Okay, we're done?

**Ms. Tammy Dumas:** Thank you very much for having us.

**The Chair (Mr. Bob Delaney):** Thank you very much for having come in and for having shared your thoughts and opinions this morning.

**Mr. Steve Noyes:** Thank you very much for having us.

## HEALTH SERVICE MANAGEMENT

**The Chair (Mr. Bob Delaney):** Our final deputation this morning comes from Health Service Management: Viivi Riis, if you're in the room. Please take a seat anywhere. Make yourself comfortable. You'll have 15 minutes to share your thoughts and opinions with us this morning. This round of questioning will begin with the NDP. There will be up to 10 minutes of questions. Please begin by stating your name for Hansard and proceed.

**1100**

**Ms. Viivi Riis:** My name is Viivi Riis. As a physical therapist with more than 30 years of professional practice experience, I've treated many people with injuries suffered in automobile collisions. My experience includes services provided at the request of insurers as well as by plaintiff lawyers who represent victims of injuries caused through another party's negligence. I have obtained a master's degree in rehabilitation science, with a focus on health services research, and I've published three peer-reviewed articles related to the delivery of health services in the private and auto insurance health sectors.

I have experience with auto claims issues in Ontario, Alberta and the Atlantic provinces, including knowledge of issues pertaining to what are often termed "minor" injuries. I'm recognized by the Nova Scotia Supreme Court as an expert in physical therapy and rehabilitation matters, in the context of a constitutional challenge on their definition of minor injury.

Last year, I represented the Insurance Bureau of Canada on the New Brunswick working group on minor personal injury convened by the Minister of Justice. This is a very familiar forum for me.

Recently, I've been invited to be a member of the Ontario minor injury guideline expert panel, and I'll assist in the development of a new minor injury guideline for Ontario.

Finally, as a health consultant, I work with health care businesses, auto insurers and the Insurance Bureau of Canada, IBC, to facilitate policies and procedures that strive to improve health services to those injured in automobile collisions. I think I'm in a unique position because I have insight into the challenges faced not only by my colleagues—health professionals—but also by the insurers who work with persons injured in automobile collisions.

My experience in this field has confirmed to me that claimants, or patients, who can access the right resources at the right time to recover maximally have a better quality of life and tend to participate more fully with their families, the labour market and society at large. I think our previous presenter spoke to that as well.

It follows that maximal recovery is the common goal of both the health care industry and the insurance industry because costs to the insurance industry and society are reduced when individuals can resume partici-

pation as fully as possible. At the same time—and this is a very critical point to remember—it's axiomatic that demand for health care funding will always exceed supply. You will never have enough health care, and I think that has to be something on the Rolodex in your brain as you consider these problems.

The government is faced with a delicate balancing act to weigh the need of injured persons for effective health care with the need of drivers in Ontario for affordable and available auto insurance.

My submission will draw your attention to three topics that, in my view, don't get enough attention. I think these are important if the government wants injured Ontarians to receive evidence-based health services that promote a return to the individual's pre-accident activities and reintegration into their families, the labour market and society at large.

The first is accountability for health outcomes. It's my opinion that most health professionals are very well-intentioned and want to do the right thing for injured persons. But the system is very complex. It has taken me a good 10 years to truly come to understand the nuances of first party benefits, third party benefits and all of the gymnastics that have to happen for those processes to go forth.

This complexity and the influence of other stakeholders such as insurers and lawyers has created confusion and misguided behaviours. Much attention is paid to how much and what kind of treatment is available to injured persons, but very little attention has been placed on whether all that treatment in fact helps the injured person to reach the goal of returning to their pre-injury life, and that includes work, family, societal roles. There's much frustration in the system. I'm sure if you've heard from injured people, they will tell you about their frustration. The previous presenter from OBIA said that they get frequent calls from injured people trying to figure out how to navigate the system. I think this is a very big issue.

It's also confusing because, in my experience, claimants involved in legal proceedings arising from an injury must typically submit to various medical examinations and questioning by representatives of all the parties involved in the case. Generally, there are two insurance adjusters involved, often from different companies. These processes, in spite of the efforts by health professionals, lawyers and insurers to explain each step, can be confusing and often result in frustration or anger.

Another source of irritation for injured victims is when two medico-legal reports come to conflicting opinions, something that has also been cited by presenters in these hearings and others. This is a very common problem when we have an adversarial system.

The Australian Attorney General in 1996 said at a public seminar on their motor accident system, "One important basis upon which any compensation is determined is, of course, the medical report. Trial judges have remarked to the Motor Accidents Authority that in some cases, the differences between medico-legal reports tendered by the parties are so great as to cast doubt as to whether they are related to the same person." I can assure you this is a very common occurrence in Ontario as well.

There is an absence of consequences for poor health outcomes, and part of the reason for this is that there are no consequences for health professionals if the treatment they deliver doesn't actually help to improve the injured person's functioning. In my experience, many treatment plans are submitted because the first two or three rounds of treatment didn't help, so yet another round of treatment is requested. In other words, "The treatment didn't work like I thought it would, so let's just do more treatment." It's very difficult for insurers to comprehend why more treatment is a good idea when previous treatment didn't work. It's also very difficult for insurers to deny treatment if the patient hasn't recovered yet.

The next topic is conflicting incentives. Our system provides conflicting incentives to injured persons, which, in my opinion, has also influenced the behaviour of health professionals. On the one hand, first party benefits, or accident benefits, pay health providers to promote recovery, but on the other hand, third party benefits, bodily injury benefits and pain-and-suffering awards increase in size only if recovery does not happen and if treatment is required for prolonged periods.

As a physical therapist, I can tell you it's very easy to find reasons to treat anyone. If I were to assess everyone in this room, I guarantee you I would find a legitimate cause for treatment for each of you. While not always driven by fraud, it's naive to ignore the financial—

*Interjection.*

**Ms. Viivi Riis:** Are there people who need help?

*Laughter.*

**Ms. Viivi Riis:** I don't think a lot of this is driven by fraud. I think there are certainly pockets of very intensive fraud, but I think that the general health care professional is trying to do a good job. But it's naive to ignore that there are financial incentives built into the system, and these incentives reward prolonged or unnecessary treatment. For example, colleagues of mine, health professionals, have told me of cases where plaintiff lawyers have instructed them to continue treatment, even when that professional has recommended discharge. I personally have experienced that kind of instruction, working with people who have been injured in automobile collisions.

Health practitioners are able to assess patients and prescribe the type, amount and duration of treatment for the patient. The same health practitioner who prescribed the treatment will typically, if approved by the insurer, deliver that same treatment. An analogy would be a physician prescribing medication or devices and then also selling those prescriptions or those devices.

Recently, I've also heard from my colleagues that plaintiff lawyers are guaranteeing payment of treatment, even if the auto insurer has not approved the treatment plan. Again, I'm not saying that all health professionals engage in such practices, but it would be naive to ignore

the architecture of the system and how it might influence the behaviour of health care professionals.

Return to work and its usual activities is in fact an excellent treatment strategy for most persons with strains, sprains and mild-to-moderate whiplash. We often refer to these as "minor injuries." I don't like the term "minor injuries" because any injury that happens to you is never minor to the person who is injured, so I'd rather use "strains, sprains and mild-to-moderate whiplash."

We know from the health care science that returning to usual activities is one of the best treatments possible. But again, my clients often told me that they were instructed by their lawyer not to return to work until they were 100% better. Now, as a physical therapist, I can tell you that without doing the activity you need to be competent in, you're not going to become 100% in that activity. I use the analogy of an athlete. If an athlete injuries himself, imagine if he had to return to his activity only when he was 100%. You have to do the activity. You have to practise the activity you need to do in order to recover from the injury.

The factors I've discussed here, I think, have encouraged submission of unnecessary or excessive treatment plans for persons injured in auto collisions. This leads to higher costs, and it also stimulates the insurer to do more assessments to obtain medical backup that will allow the insurer to deny unnecessary or excessive treatment.

**1110**

There has also been an expanding definition of reasonable and necessary, and I think this language has been problematic, because it's not concisely defined anywhere for medical professionals. Since I began practising in the auto insurance environment in 1992, there has been a dramatic change in how health professionals perceive the concept of reasonable and necessary. In response, insurers have become cynical and they lack trust in the health and rehabilitation industry as a whole. I think this is a problem, because insurers and health professionals really need to work as a team if the injured person is going to get a streamlined path through the rehabilitation process. These shifts in attitude can only be negative for the injured person.

A colleague of mine, who is an occupational therapist, recently shared a case study with me that illustrates this new culture. The injured person—and this individual has catastrophic injuries, and everybody agreed very early on that his injuries were catastrophic, so that was not an issue—lives in a remote area where all of the health practitioners on the team come from about two hours away. Two OTs from the same company were planning to visit the client to have lunch with him. My colleague, who was the case manager on the file, was invited by the OT to join them for lunch. My colleague asks, "What goals are served by the exercise of having lunch with the client?" The response is, "Community reintegration," although the evidence pointed to the injured person being quite social and well integrated into community. The individual had a brain injury and an amputation, and he had participated in fundraising efforts that had been very successful, and he had done media interviews and so on.

So my colleague declined to have lunch and commented to the OT that, from a boundary and financial perspective, lunch with a client is not appropriate, nor is double-billing—two OTs going for lunch. My colleague was assured that double-billing would not take place and that the second OT is the supervisor to the first OT, who plans to see each client in the company on a monthly basis. My colleague then informed the lawyer of what was, in her opinion, unnecessary treatment. Now, I don't know what has happened, but it appears that my colleague, the case manager, will be removed from this case because the lawyer didn't agree with her interpretation of reasonable and necessary. This treatment, if it did occur, may have resulted in a cost of over $1,000 for lunch for this client, who had a questionable need for this type of intervention.

My recommendation is that while treatment of injured persons must be individualized, the system requires a mechanism whereby health professionals are held accountable to demonstrate the degree to which their treatment actually achieves the goals that are identified in their treatment plan. If you can figure out how to do it, I will be very happy.

The next topic is evidence-based funding. We often hear—

**The Chair (Mr. Bob Delaney):** I'd just like to remind you you've got about two minutes.

**Ms. Viivi Riis:** No kidding.

We often hear that after the first few months after injury, more treatment is important, but in fact, the science tells us that this is not the case. There is new evidence that suggests that in the early stages after minor injuries, less treatment tends to be more effective, so I think it's very important to consider funding models.

I've also supplied you an illustration of how people who are injured in automobile collisions are, in a perverse sense, more fortunate than people who sustain the same injury in non-auto collisions. You've got three tables that show the additional benefits auto-injury victims have that people who have a fall in their backyard or a sports injury don't have access to. It's important to put things into perspective and recognize that OHIP services continue to be available. The insurance industry does pay a levy to support those services.

I do have a recommendation about scientific evidence used to support treatment type, dose and duration, and to examine fee-for-service models. I think fee-for-service models tend to reward health providers for a lot of treatment, but they don't reward health providers for achieving good health outcomes, so if we can look at a shift in funding models, I think that could be valuable.

The final point is consumer education. Consumers have been very much pushed to the side when it comes to the cost of the system. The last part of my submission talks about providing education to consumers so they can understand the system, that they are fully cognizant of what is being spent on their behalf and what the goals of

the treatment are supposed to be. I think if consumers were more aware of their role in the system, if they were more aware that it is their benefits that are being spent for a lunch, they would serve as a better gatekeeper to their funds, and I think they have the right to do that.

So I will wrap up—

**The Chair (Mr. Bob Delaney):** And on that note, I'm sure that we can explore some more of this in questions. Mr. Singh.

**Mr. Jagmeet Singh:** Thank you very much. You've presented a very interesting idea. I like the idea of an alternative model for how we approach health care and how it's funded.

One of the obstacles to the idea—and I think the idea has a lot of merit—is that more and more we're seeing that there's a shift towards a bias in favour of the insurance companies in terms of disputes; there seems to be that shift occurring. What would be some strategies to ensure—I mean, this funding model that you're suggesting wouldn't work in a climate where there is a disparity in power between one group that has all the resources, that can withhold those resources from another group that's trying to claim the resources, unless there was a little bit more protection perhaps for the claimants.

If you agree with that comment or not—maybe you don't. What would you see that would need to take place to create that better funding model, and do you agree that there needs to be more equity between the two parties, that one party has all the resources and they can choose to withhold it?

**Ms. Viivi Riis:** I can't say that I'm aware that there's a shift in arbitration decisions and court decisions for the insurer. I would think that if that were the case, insurers would be paying less in med rehab benefits and not more, but med rehab benefits are still exponentially increasing when compared to any other kind of health care system, so I'm not sure about that statement.

I think what I would like to see—and I don't have the answer for it. I just think there needs to be a way of compensating providers for doing a good job, not compensating for just delivering treatment. It probably needs to be some sort of a blended model, because certainly there are some patients who just won't respond to treatment. I don't think providers should be penalized if they're working with a patient with extra needs, but maybe a blended model where there is some payment for treatment services, but also some sort of incentive to achieve the reintegration, functional improvement; looking at requiring goals of return-to-work using standard outcome measures. I think that's another no-brainer, really, to implement standard outcome measures into the system so all providers have to collect the same standardized measures that are accepted scientifically internationally, and reporting on those and having some aspect of compensation for outcomes.

**Mr. Jagmeet Singh:** Thank you very much. You talked about allowing the idea that the actual claimant or the person receiving the treatment would probably be in the best position to be a gatekeeper of their own funds. I think there's a lot of merit to that argument because it's their funds at the end of the day, and if they're spent appropriately, that would give them more care or less care, depending on how it's spent. I think that makes a lot of sense. How do you see—just maybe some suggestions on what that program would look like.

**Ms. Viivi Riis:** Yes, I've got a whole plan. I just think that there needs to be plain-language consumer education about what auto insurance is. Many consumers think it's like a pension plan: You contribute so much money and you get so much money out. But the concept of risk pooling is not well understood by the average consumer, and it took me a good five to 10 years to sort of figure it out. The concept that the benefits are there if you happen to be unfortunate enough to be injured—and a lot of people do pay into the system and never take a cent out—

**The Chair (Mr. Bob Delaney):** I'm going to have to just stop you there. The rotation moves. Ms. Mangat.

**Mrs. Amrit Mangat:** Thank you, Chair. Viivi, can you explain why the treatment costs, examination costs, benefit costs are so high in the greater Toronto area compared to the other parts of Ontario and other parts of Canada? Isn't whiplash the same in Windsor and Thunder Bay as it is in Brampton, Mississauga and Toronto?

**Ms. Viivi Riis:** In my opinion, it is. But certainly when we look at the data—I participated in a MIG survey for IBC where we looked at minor injuries in the GTA and outside the GTA, and certainly there are higher costs and different provider behaviours in the GTA. I don't know enough to tell you why that happens.

**Mrs. Amrit Mangat:** So what do you suggest can be done?

**Ms. Viivi Riis:** I think the system rewards health providers for delivering treatment, and I think there are incentives to continue to treat in the system, incentives from various angles. If we can try to bring more accountability to the health professional groups to deliver health outcomes, that might help.

**1120**

Certainly fraud is a piece of it as well, and I hope the fraud task force will be speaking to the hearing as well. They certainly know more about that than I do.

**The Chair (Mr. Bob Delaney):** Ms. Wong, you had a question.

**Ms. Soo Wong:** Thank you very much. It's quite refreshing to hear the word "accountability." I have one question specifically. With your comments about accountability—because I asked the previous deputant about the word "accountability"—what can we do more as a government, as this committee, on this whole issue of fraud among health professionals?

**Ms. Viivi Riis:** When you say "fraud," that's a big umbrella. What I've spoken about in my presentation is more opportunistic practices. I think when you look at fraud per se, one problem is that in the system, any one of you around this table can hang up a shingle and open up "The Whiplash Clinic" and you can bring patients in. You just need a physiotherapist or a chiropractor who's

prepared to sign off on these forms. It's very easy to start a business in this health care industry.

I think attaching a health care business in auto insurance to a regulated health professional is a good strategy, and I think there's some work under way examining that possibility. If you do that—

**The Chair (Mr. Bob Delaney):** I'm just going to stop you there. Mr. Yurek.

**Mr. Jeff Yurek:** Thanks for coming in today. A couple of questions for you.

I'm a pharmacist, and recently the government started MedChecks, which means we review medications. I'll tell you, every time I do a med review, I eliminate treatment because it's never been re-looked at, and I like your thought on having treatment re-evaluated after a certain amount of days. I think that's a great idea.

My question is, do you think there should be some sort of carrot dangled in front of health care providers to actually look at ending treatment? And second, do you think it should be possibly enforced by either FSCO or the regulatory body of that specific health discipline?

**Ms. Viivi Riis:** I'm not sure I want a carrot to end treatment, because it's easy to end treatment, collect the money and then have the patient go to another clinic. I still think it has to be meaningful outcomes, so sustained return to work, return to usual activity—some sort of carrot to achieve successful health outcomes. I think that probably is a good idea.

I've also considered this: For people with strains, sprains and whiplash, if they go through the minor injury guideline and at 12 weeks there's a request for more treatment, I think at that point an independent review that's binding could be useful.

**Mr. Jeff Yurek:** Further to questioning, with claims there have been a lot of denials, apparently an increase in denials, so—

**Ms. Viivi Riis:** Oh, I can speak to that, actually.

**Mr. Jeff Yurek:** Good. After I'm done, you can speak to it.

**Ms. Viivi Riis:** It appears that there are a lot of denials, but in fact, when one examines the data—and this is a process that I'm working with IBC on—most of the denials are in fact administrative denials. It's because duplicate forms were submitted, it's because the statement of claim hasn't been submitted, documentation is required or they're waiting for a medical report. So when we look at the actual denials, something like 11% of denials were true denials based on "This is not reasonable and necessary." There's another 12% that were denied because the insurer felt that the patient should be treated and receive benefits, but in the context of the minor injury guideline.

So I think that the denial number that we heard about is an appearance of denial, but I'm not convinced they're true denials.

**Mr. Jeff Yurek:** You don't think there's a problem, then, with increased denials from the 2010 changes?

**Ms. Viivi Riis:** No. I'm not aware of any real evidence that would show that.

**Mr. Jeff Yurek:** Okay. My other question: Your charts here are going on a catastrophic funding model, someone falling from a ladder. Do you want to go over that last chart and maybe talk about the avenues, the differences, I guess? I'd like to read more about appendix 3 there.

**Ms. Viivi Riis:** Okay. Appendix 3 looks at two people who have what we think of as catastrophic injury. I've used a spinal cord injury; that's where I did my graduate work. On the right-hand side you'll see what benefits are available. If somebody falls off a ladder and sustains a spinal cord injury, they have access to OHIP, in-patient services and outpatient services. If they have extended health services through work or private insurance, they would access that as well. Then there's also March of Dimes and various organizations that help support people with spinal cord injury.

Somebody with a spinal cord injury in an automobile collision gets all of that, plus the additional benefits. So we have first party benefits, which is the accident benefits, a million dollars of med rehab; attendant care of $6,000 a month, up to a million dollars; income replacement benefits of $400 a week and more, if optional benefits have been purchased; housekeeping and homemaking, $100 a week for life, and I believe that's indexed; caregiving benefits, if they're unable to engage in caregiving, for two years; plus, if they were the innocent victim of an at-fault party, they can also sue for any additional health care expenses that they might need for the rest of their life, and they can also get what's called "general damages" or a pain-and-suffering award.

What's interesting—

**The Chair (Mr. Bob Delaney):** I'm going to stop you there. I want to thank you very much for your thoughts and insight this morning and for taking the time to come in and address the committee.

If anybody wishes to sit and chat with any of our deputants that remain, they're perfectly welcome to do so.

I also want to acknowledge our host riding and MPP Jagmeet Singh for having brought in some nice masala chai tea and some Indian sweets. I would recommend for staff and members to help themselves to the masala chai while it's still warm.

We are now in recess. We will pick up our deputations this afternoon. I would like to ask members to be back here by 12:45. Our first deputation is at 12:50. The committee is in recess now.

*The committee recessed from 1126 to 1250.*

**The Chair (Mr. Bob Delaney):** Good afternoon, everyone. We are here to resume our study of the auto insurance industry.

## COLLISION INDUSTRY INFORMATION ASSISTANCE

**The Chair (Mr. Bob Delaney):** Our first deputation of the afternoon is going to be the Collision Industry Information Assistance. John Norris, if you're present,

come on up and start us off. Pick any chair; they're all the same. Make yourself comfortable. You'll have 15 minutes to present your thoughts and opinions, followed by up to 10 minutes of questioning. The rotation will begin this time with the government side. Please begin by identifying yourself for Hansard and then proceed.

**Mr. John Norris:** Mr. Chairman, thank you very much. Good afternoon, members of the committee. My name is John Norris. I'm the executive director for the collision repair trade association in Ontario, and have been since 1988.

I should tell you a little interesting story. Just as I was leaving my office this morning for this meeting, I had a call from a shop in Toronto, and they had a customer in there with a collision repair being towed there. They were very upset.

I said, "What happened?"

They said, "Well, they just had an accident in the Dufferin-Lawrence area of Toronto, and the first thing that happened was someone showed up at their window saying, 'How would you like to make money? How would you like to make a lot of money?' The lady didn't know what this person was talking about. He just said, 'Listen, when the police get here, tell them you have a neck injury and you have to go to the hospital. When you get to the hospital, don't worry about it. I'll be there to meet you.'"

So they prep the customer and off they go, long before the police arrive. That type of solicitation at accident scenes, whether it's for tow or whether it's for clinical assessment or rehabilitation, is happening every day, every hour, all over the province of Ontario.

I am one of the contractors that helped design the Ontario Ministry of Transportation's stolen and salvage inspection program for shops in Ontario. We have over 500 collision repair shops that are inspection stations that are inspecting rebuilt vehicles to ensure their safety and legitimacy—i.e. they are not stolen—going on the roads of Ontario.

I'm also the administrator for the Vehicle Security Professional Program in Canada this year. It just started in Canada after four years in the US, on behalf of the 18 car companies in Canada that import and manufacture in this country, and the after-market technicians. That program provides security data from the manufacturers directly to a qualified tech to fix the car. Why am I mentioning that here? Because those security data include CAT, collision avoidance technology. As we have more and more vehicles in the system and being able to repair more vehicles, it's not a surprise to anyone in this room to see the Volvo S60 commercials of the car stopping itself before it hits something; the Lexus SUV that stops itself before you actually back over something in the driveway; the new Cadillac SVT programs, where the car's steering wheel shakes to warn the driver they're getting too close to another vehicle. If this program is successful, our US program identifies through NHTSA that in 25 years we'll have an 81% decrease in motor vehicle accidents, and we'll hopefully have a similar decrease in the amount of problems that you have on the insurance claims side and the problems you have on the health care side. So there's a light at the end of the tunnel. The technology may solve us all a lot of problems and a lot of headaches in the future.

In the interest of full disclosure, I should tell you that when I was a teenager and I saved for my first dream car—it was a used sports car—I had my first insurance experience. My used sports car was appreciating, not depreciating, in value, so I asked my insurer about it. I was told to see an appraisal firm that he recommended and obtain an appraisal. I did that. The appraisal showed the car had increased in value. I paid for the appraisal and the insurer's invoice for the additional premiums that my insurer required to cover the new replacement price. Sure enough, the car got stolen. After 30 days with no recovery, I asked the insurer for the money they had appraised the car for and I had paid additional premiums for. The answer: "Not a chance," said the insurer. They'll pay only what they think is fair, and their idea of fair was significantly below the appraisal price they had previous accepted. Did I want to complain? Sure, I did. I was told, "You either take the lower amount cheque now, Mr. Norris, or we'll see you in three to four years in court." So I took the cheque. That was my first experience as a kid in the auto insurance business.

However, with 300 members in our association, we hear and live with the complaints from our members, that I want to highlight to you today, that show the level of abuse that takes place immediately after that physical collision on the road, abuse that costs us all millions of dollars a year and can often be used to justify higher premiums for motorists. Please remember that in all the discussions you've heard of treatment plans and bodily injury claim costs, it's the collision repair shops who are the first to see the car and often the customer. We can tell if the vehicle was damaged now or earlier. We can tell if an accident may not have happened or had been staged. We know if the tow operator tried to sell the collision. We know if the tow operator obtained personal and private customer information so they could sell that information to a treatment clinic.

These are professional, Ontario-licensed, trained techs who can spot a fraud when they see it. As an industry, we can be the first line of defence against fraudulent claims. Yet we're never mentioned in the FSCO report. We were never asked to help with the Ministry of Finance report on auto insurance abuse. We were ignored. We're disappointed that, with our wide range of grassroots and repair knowledge, and our past work with IBC on towing abuse and with the province on theft claim issues, we were left out of that discussion.

Every day we hear from our members the tales of kickbacks, payoffs, towing abuse, medical treatment clinic sales techniques and aggressiveness, all while trying to calm down and protect that poor car owner, who soon will be exposed to the high-pressure sales tactics used on today's accident victim. And we wonder why premiums are high. Well, more importantly, I will high-

light the options for you today that are already available to the government to handle this and stop much of that costly abuse.

I can tell you, in collision repair in Ontario, the average insurance cost for a car repair was lower in December 2011 than it was in December 2004. I can guarantee you that clinics and medical costs are up 300% or more while our costs have actually gone down.

Shops tell us of abuse details, of tow truck operators selling collision work for a kickback and selling private, personal information of the car accident victim to get their $2,000 commission from the treatment clinic all the way to demands for kickbacks that shops must pay to keep repair work in their shop. Even the parts companies that supply the parts to repair your accident collision damage must pay in kickbacks.

"Kickbacks" is not a nice word. Many will appear before you after my presentation today to contradict me and explain that they're really just business transactions in cash; they're really just referral fees for business; they're really discounts, or offered freely in order to obtain a thank you for business volume. For the next few minutes, let's just call those new definitions on an old game what they are and just talk about kickbacks—some in cash, some under a contract, many because of the fear of what will happen to their future business if the kickback isn't paid.

Those business threats are rarely entailing violence, although I had death threats when we were working with Toronto licensing to clean up an endemic towing overcharge problem. By the way, we solved that problem and saved the insurance companies in Toronto alone $8 million each year on their towing bills. Usually the threats are to blacklist your business. Usually the threats are that no cars will ever be towed to your shop, or every effort possible will be made to steer customers away from your business.

I'll tell you today that there are none of our shop members here with me. I'm here alone. Not a single shop owner would come with me today because they're too scared to appear with you and be seen in public. They believe that any testimony or presentation to you today on what actually happens after a car accident—what they go through, what they see every day—would be used to shut down and isolate their businesses to the point of business failure, and they simply cannot afford to be blacklisted.

So let's have a quick look at what goes on with kickbacks and why it costs so much money to the insurers in the claims process.

There are treatment clinics that issue commissions of $2,000 to tow drivers who will transfer private, confidential data on accident victims to them. We interviewed a tow driver who makes two calls a week and he gets $125,000 a year. All the rest of that is kickbacks.

The clinic then immediately contacts the accident victims. They advise them that they are an insurance-preferred supplier or an insurance industry provider. Then they'll set up an expensive treatment plan. They haven't met the victim yet.

There are tow truck drivers and operators who push for their kickback as they sell the collision-damaged car to a body shop. Those repairs across Ontario now cost the shop, because the shop now seeks to recover the extra dollars paid to the tow operator. Our association receives calls from homeowners living behind a mall: "Why is a tow truck bashing a car into the wall at the back of the mall parking lot?" Well, by raising the damage level, the repair becomes more costly for the insurer and the tow operator gets a percentage of the damage appraisal.

In order for a shop to generate the extra revenue to pay back that chaser, the insurer gets billed for work that wasn't done; repairs with used or stolen parts that were billed as new; outrageous bills for storage; environmental fees; drop-offs; moving fee; $300 to move the car on the lot; $500 for a piece of cardboard under the vehicle to catch any oil drips; $35 to allow the customer one phone call. If the customer decides to take the car somewhere else for repair: days of frustration, thousands of dollars having to be paid in release fees because that kickback has to be paid somehow.

**1300**

Car repair costs have remained consistent for the last eight years, despite rapid increases in labour costs, facilities management, equipment, more costly supplies, and, frankly, shops are not in a position to pay any more of a fair wage. Insurers insist on sometimes using untested after-market parts that the car manufacturers recommend against using and may not respond the same as automakers' original equipment parts in any new collision after repair in order to lower the price insurers pay out for an accident. These accidents may come back to haunt us in the form of increased injury after a second accident.

This only delays the inevitable when these new accidents occur after the initial repair and the car occupant is badly injured with a huge claims injury cost because of a faulty repair, having used parts stipulated by the insurer but not recommended by the carmaker. New high-tech and safety-biased parts needed to repair newer cars are being refused for replacement with demands by insurers that after-market or cheaper, used parts be put on.

Members, the kickbacks are on both sides of the table. Kickbacks are demanded by insurers, who often have a huge marketplace dominance and make decisions that determine whether your shop is going to survive or not for up to 10% of the price of the repair as a commission charged to send them their own customers' business. This is after paying them a labour hourly rate that's not sustainable to pay for equipment or new technologies. We are not aware that this kickback is being reported to FSCO. This is a business kickback that may not have been identified in the figures supplied to FSCO as claims revenue. It may be money that's being kept by the insurer that's used for other purposes.

Similarly, if a kickback is received by the insurer for a repair that was through a no-fault system billed internally to the insurer that covered the at-fault driver, we worry the bill will be charged for the full retail amount and not the actual amount the insurer paid. This may mean higher

insurance premium levels are being based on artificially higher claims costs than what actually happens.

We also worry about what happens in a dominant marketplace because it means insurers, not competent repair shops, are ordering repair parts now for your car—often not the parts recommended by the car company, and from vendors the shop doesn't know or are even close to the repair shop. When these parts are dropped to the shop by the insurer, the insurance company demands a 3% kickback from the parts company.

Insurers demand that parts be ordered based on a list of suppliers given to the repair shop. No longer can the repair shop deal with suppliers they built up a long-standing relationship with, but they must deal, instead, only with the supply firms that provide a kickback to the insurer. We've asked the Competition Bureau to have a look. We're worried that this is going to lead to higher injury costs in the future and that our shops might be responsible or deemed responsible.

All kickbacks should be prohibited. If identified—and currently the Insurance Act, regulation 7/00, on deceptive and unfair practices, should apply—enforcement action should take place. We worry that insurance companies in Ontario may no longer be concentrating on the insurance business but instead on parts procurement, the collection of fees and kickbacks. Why, to our never-ending frustration, do insurers issue cheques for thousands of dollars a day for massively inflated tow bills—we viewed a $16,000 tow bill; a $64,000 tow bill—for services clearly and identifiably not rendered—

**The Chair (Mr. Bob Delaney):** It's almost disappointing for me to inform you that you've only about a minute to go.

**Mr. John Norris:** Let me just do a few highlights and a summary, if that's fine, Mr. Chairman?

**The Chair (Mr. Bob Delaney):** Please.

**Mr. John Norris:** Why are insurance companies paying for collision repairs in the back of an oil-lube shop, to the point where the repair paid for those unlicensed, non-equipped open bays is so bad, the insurer must buy back the repaired vehicle and scrap it? We've seen cheques for $12,000, $48,000, $65,000 to buy back vehicles that have been repaired so badly with insurance money at illegal and underground garages that no car can safely be driven; they're scrapped after being repaired. The easiest way to solve abuse, ladies and gentlemen, is don't pay for it.

The summary is that one option available—and it would be a rather surprising option, perhaps, that would have a huge impact immediately reducing insurance premiums—is to reduce the customers' insurance premiums by the amount the insurance company received in kickbacks on his repair. How's that for different?

**The Chair (Mr. Bob Delaney):** And on that note, I'm going to have to ask that the questioning begin with the government side. Ms. Piruzza.

**Mrs. Teresa Piruzza:** Thank you very much, and thank you so much for coming in and presenting to us quite a bit of information there. Unfortunately, we weren't able to get through it all. Would you be able to provide us with the written copy? You have them there. Perfect. Okay. We can read through that.

Now just with respect to some of the comments that you've made as well, because I remember some time ago—I'm going back a number of years now—there was quite an outcry in the industry with respect to preferred auto shops and insurance companies telling people, "No, you must go to this." I recall there was quite a consumer education awareness process that we went through. I'm going back probably about 15 years now with that. Is that coming back in terms of having the preferred auto shops or is it better than it was years ago?

**Mr. John Norris:** That's a very good question. It started in 1991 with the demand of Allstate Insurance for a 10% kickback on parts sold. Preferred programs are institutionalized across Ontario; they're not going to change. The intent of the preferred program was to protect the customer. So a customer who didn't know whether they were going to be treated fairly, honestly, legitimately with qualified people would have an idea of where to go. In itself, that's a valid representation. The insurance industry would then, using those types of standards of compliance, training and equipment, determine which shops could be on that list and be able to offer those to the customer.

What's happened, unfortunately, is that it has modified and now, because of the number of vehicles—if you recall, we didn't get a winter and our shops were wondering if they could even survive that. But we have so little cars coming in now and will in the next little while—for as long as we can see, certainly, we'll have less vehicles. What's happening is the insurance company wants to drop the number of facilities. So they dropped the number of facilities—one company will go from 400 preferred shops to 150.

Where the challenge shows up is when the insurance company—and there are some in Ontario that are very dominant that have bought up other insurance companies. Because of that they have now changed their dynamics. So you have insurers in Ontario who are saying, "We now have marketplace dominance," sometimes 40% or 45% of all policies written in this general area. "We're going to tell you, as a shop, what you're going to do. We're not interested in your quality of work. We're not interested in your competence or compliance. We just want the 10% off."

We have one shop the other day that got notified by an insurer they'd been with for 20 years that they were leaving tomorrow—30% of their business would disappear; he'd have 30% less business. It was going to a shop down the road that offered them a 5% cheaper price. That shop did not have a licensed tech or any equipment to fix the car, but they still got the work from the insurer.

So the demands by the insurer now are different. The insurer sets the rules and says to the shop, "You're going to do this or we will blacklist you. You will never get work from us unless you do these things."

**Mrs. Teresa Piruzza:** In terms of some of the elements or some of the issues that you brought forward

in your presentation as well, do you have recommendations in terms of how to enforce? Because I think in a number of those elements that you brought forward there is currently legislation to prevent it from happening. But how does one enforce that? Secondarily to that as well, are those individual cases reported?

**Mr. John Norris:** All those are good issues. I can tell you that we have taken individual cases of quarter-million-dollar accident frauds to the insurance company. The insurance company has told us, "Don't bother us. We're not interested at looking at stuff at a quarter-million dollars. It's not within our threshold. We have other things to do."

Why on earth won't you take this? We've given you all the documentation showing this is a claims injury fraud—it was actually five accidents that were staged. The answer I got from the insurance company was, "Why would we bother if we can get 12.5% return from Ontario? Why would we bother looking at our claims issues and our fraud issues when FSCO will guarantee us a 12.5% return?"

**The Chair (Mr. Bob Delaney):** And on that note, I have to move the rotation. Mr. Yurek.

**Mr. Jeff Yurek:** Thank you. Thanks for coming in today. Just further to that question, have you ever taken the fraud cases to FSCO?

**Mr. John Norris:** We had groups take it to FSCO. In fact, those comments I made were to a government agency that took it to FSCO. We provided the data to them and they took it to them.

**Mr. Jeff Yurek:** And then what did FSCO say—

**Mr. John Norris:** Oh, to FSCO? I'm sorry, no. That was a government agency that took it to the insurers. The only time we've met with FSCO was in regard to setting up a standard for what should be the level of shop payment—in other words, only legitimate facilities should be getting paid, not backyard oil-lube shops underground. That's the only discussion we've had with them.

**1310**

**Mr. Jeff Yurek:** They've never offered to say, "Bring us your fraudulent claims. We can actually deal with it"?

**Mr. John Norris:** No. We've asked to help them with their current auto insurance fraud issues, and we haven't heard any comment back.

**Mr. Jeff Yurek:** Nothing on that. Do you know what per cent cost to the total claims cost in the insurance business right now is due to the fraud part of your collisions schemes?

**Mr. John Norris:** That's a difficult—and IBC has the same problem in determining a number. They use a number of $2 billion and have for I think four years now on a consistent basis. So it' s very difficult to say. It's certainly in excess of $100,000 a day.

**Mr. Jeff Yurek:** And finally, is there anything else from your deputation that you didn't say that you'd like to add?

**Mr. John Norris:** We did have a process set up—in fact, we presented it to Queen's Park in 2001—to set standards for facilities. Those things can still work. I think the real, simple, easy things right now—I'm just floored that insurance companies seem to have no qualms with just issuing a cheque for no reason whatsoever to a facility that doesn't exist.

**Mr. Ted Chudleigh:** If I might, a short question: The premiums in the personal automobile business are about $10 billion a year. You suggested that they're using a number of $2 billion a year; that's 20%. So 20% of the insurance business is fraud? Do you find that number acceptable—not acceptable; I'm sure you don't find it acceptable—but in the realm of reasonable? Is that something that you would think is reasonable? Is that how big this fraud in this industry is, 20% of $10 billion?

**Mr. John Norris:** I think it's not unreasonable to suggest 20%. We used to think that only 15% of the people in Ontario drove without car insurance, and now we find out it's significantly higher than that.

I think we're looking at a significant fraud issue. I think all you need to do is go into heavy urban centres, have an accident and watch who shows up. That will tell you right away that there's so much money in this that the tow-chasers are there trying to get to your car; they'll fight. We just had one shot in Mississauga at an accident right in the middle of the intersection.

**Mr. Ted Chudleigh:** There was one shot in Milton about three years ago.

**Mr. John Norris:** It's a very aggressive, cash-rich business, and they're in it for the dollars. They're not in it for the consumer, they're not in it for the motorists; they are there to take as much money out of the insurance industry as they can.

**Mr. Ted Chudleigh:** Thanks for coming in.

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Singh.

**Mr. Jagmeet Singh:** Thank you very much, Mr. Norris. You've shed a lot of light on an issue here.

I just want to ask you— I think a lot of times when we look at the fraud equation, a lot of the blame seems to be put on to the citizens of Ontario or the people in the communities. From what you're recounting, and I think it's more to what the anti-fraud task force is saying, organized crime and these types of fraud rings are the true culprits. At the same time, what you've touched on, which I think is very important, is that the insurance companies themselves have a large part to play in this. In simply ignoring the situation that they can easily take some steps on their own, or by ignoring people approaching them with valid claims, the insurance companies themselves are also a part of the puzzle.

If you could just touch on that, what we could do to ensure that the insurance companies themselves who provide the resources, who are the source of the billions of dollars—how they can be monitored and there can be some oversight on the way they conduct their business.

**Mr. John Norris:** That's fair enough. There's a variety of answers to that. One is that you make sure that all the facilities that they pay to are in fact legitimate and meet legal compliance requirements in Ontario for equipment, people, taxes, environment. So you make sure that

you're not issuing a cheque to Joe's Oil Change. When the Ministry of Labour did a blitz inspection in Barrie, we found six collision shops that were in the back of oil and lube shops, all of which were closed. They actually had seizure orders by the ministry because they were so dramatically in health and safety violation. So there are ample opportunities for insurers to simply say, "We're not going to pay those people."

I will tell you that the easiest way to stop fraud is simply don't pay it. As soon as you stop issuing that cheque to an illegitimate facility, as soon as you stop issuing that $2,000 commission cheque from the treatment centre, as soon as you stop issuing the kickback that either an insurer is getting or the tower is getting for selling that car, then you start to have an impact in the marketplace. You can do that through the Insurance Act, through deceptive practices; you can do that through towing regulations with municipalities; you can do it with police licensing programs with tow trucks; you can do it through audit programs where you have to identify where those monies are coming from. There are a variety of ways to do it.

From the insurance side, I'm not convinced that insurance companies—and I'm sure someone is going to write me up in the media—are serious about the fraud issues. I'm convinced that they're serious about getting their 12.5% return, but I'm not convinced that they're serious on fighting the fraud issues—because they're going to get paid for this one way or another. They're going to get their money back without having to investigate those fraud issues.

**Mr. Jagmeet Singh:** So what you're saying is that in large part, insurance companies themselves are turning a blind eye to this when they should be playing an active role in preventing a lot of the waste that's going on.

**Mr. John Norris:** They're turning a blind eye to this. I see this every day and I wonder why no one complains about this. I'm probably the first coming to you and saying, "This is so bizarre."

**Mr. Jagmeet Singh:** My colleague has a quick question.

**The Chair (Mr. Bob Delaney):** Mr. Norris, I am so sorry. I have to pull the plug on this one. On behalf of all of the members here, I'd like to thank you for having come in today and delivering what I guess I could describe, in an understated fashion, as a breathtaking presentation. We greatly appreciate your time and the insight that you have provided. Thank you again.

**Mr. John Norris:** Thank you, members of the committee.

## MR. EDWARD ROMANIUK

**The Chair (Mr. Bob Delaney):** Our next deputant is Edward Romaniuk. Take a seat; anywhere is fine. Make yourself comfortable.

**Mr. Edward Romaniuk:** Ladies and gentlemen—

**The Chair (Mr. Bob Delaney):** Just before you start, you'll have 15 minutes to make your remarks, followed by up to 10 minutes of questioning. This rotation will begin with the official opposition. Please begin by introducing yourself for Hansard and then proceed.

**Mr. Edward Romaniuk:** My name is Edward Romaniuk, R-O-M-A-N-I-U-K, just to correct the agenda spelling of my surname, which has a double N, incorrectly.

I'm appearing here as an individual, a private citizen, if you will. I'm going to give an introduction, basically, of myself, first of all, and my recent experience with insurers. I'm going to follow that with more detail, and then a set of recommendations. Finally, I have one big question to present to one of the industry associations, which I will come to right at the very end.

First of all, I'm a retired professional engineer, and a general management consultant as well. I've been driving continuously since I was 16 years of age and have had no claims; I have a perfect driving record, eight-star rating. I've been with the current insurance company for over 10 years. Recently I received a premium notice, and my insurance rate had gone up by 14.5%, which kind of staggered me.

Just to make sure and for the record to show that I'm accurate in what I'm saying, or at least make sure that it's been recorded correctly, I'll read a little bit of a prepared statement that I have. I'll leave a copy with the Hansard clerk there.

There was no good, substantial justification for this increase, given the inflation rate in Canada being in the order of 2%. To base premium calculations partly on the postal code residence of the insured is completely without merit, and instead should be strictly based on claims history and driving record.

An example—

*Interjection.*

**Mr. Edward Romaniuk:** Sorry. Is that better? Can you all hear me okay? It's probably too loud.

An example: One year ago—July 4, 2011—at 10 a.m., I was patiently waiting at a red light for the light to change. The weather was clear; no precipitation; light traffic in a quiet residential area of Etobicoke. My vehicle was struck from behind by the car behind me, which in turn had been also struck from behind and so on. Four cars were involved in this chain collision.

I, being in the lead car, quite probably would have settled for a small cash settlement with the driver if it were a one-on-one collision since the extent of the damage on my vehicle I considered to be minimal. But since three other cars were involved, it was considered prudent to allow the insurance industry to handle the incident, particularly since a police report was issued.

The police report indicated that the tail-end driver who caused the entire chain of events was charged with "following too close." I was subpoenaed as a court witness for the prosecution exactly one year later, namely July 4, 2012. The defendant pleaded guilty to a lesser charge and my presence in court was, in fact, unnecessary according to the reporting officer from 22 Division. Nonetheless, I appeared in court, much to my own

inconvenience and unnecessary expense, and was not required to say or do anything in court.

**1320**

The defendant received a slap on the wrist and quite possibly received demerit points, or certainly fewer demerit points than he would likely have received otherwise. Since I was not at fault in any way whatsoever, my rate was unaffected by the claim I made. I was told by the collision repair company—which incidentally appeared suddenly on the scene without my calling anybody; he was there, Johnny-on-the-spot—that because I was driving an older vehicle, a 1993 Buick with only 80,000 kilometres on the odometer, it would likely be impossible to properly colour match and obtain identical parts for the repair job. Repair was not a good option, I was advised.

In addition, if a repair was to be performed, I would also have to have another emission test and recertification of the car's roadworthiness, all of which combined to make the recommendation to take a cash settlement and buy another car with the proceeds as the best option. This was done. Believing this was the only sensible course of action to take, I opted for a $1,200 settlement and I bought a car for about the same amount of the cash outlay. This was my mistake, but I was under some time pressure to make a decision quickly.

The car I bought had 275,000 kilometres on the odometer, and appeared to be in reasonable condition and was certified roadworthy. A short time later, within two weeks of the purchase, I faced two major repair jobs which cost me in total well over another $1,200, much to my personal dismay, and I still had an older car, namely a 2003 Mazda.

Under insurance surprises: I also learned that, having obtained another vehicle, the comprehensive insurance coverage that I had on my previous car would no longer apply under the grandfather clause which provided for only a $ 50 deductible. As you well know, the current deductibles on comprehensive are in the order of $300 to $500, but since I was grandfathered in on the previous car, I assumed that this would be a carry-over onto the next car. I was told this would not happen, and therefore I cancelled the comprehensive insurance simply because it wasn't worth it given the value of the car, which is far, far less than what the deductible would probably even be. Certainly, I was willing to take the risk. The likelihood of my car being stolen was probably quite minimal and would not justify the comprehensive fee premium and the deductible.

Through no fault of my own, I was now deprived of a favourable comprehensive coverage because it was now a different car. I would have been better off to repair the first car, or at least taking a cash settlement and performing a minimal amount of repair and continuing to drive the old car, but that option was no longer available to me.

To further add insult to my experience, after closely scrutinizing my recent premium notice/policy agreement, I noted there was a 3% surcharge if one paid the insurance on a monthly basis instead of one lump sum annual payment. This was introduced, without my being made aware of it except in the fine print of the policy, some four years earlier. This practice I considered to be a sneaky way of introducing an escalation of cost without making it obvious to the policyholder, since for the previous six years or so there was no surcharge for monthly payments versus lump-sum annual payment.

Auto valuation: It would seem to me that the insurance premium should bear some relationship to the value of the car. For example, a $200,000 Ferrari would not carry an insurance premium of $200,000, and yet my car, a 2003 Mazda valued at much less than $1,200, has a premium of $1,136 with no comprehensive and no collision coverage, and having only the minimum of PL and PD coverage of $1 million. This incongruity seems grossly unfair given the way the insurance industry establishes the formula for premium increases and given that home insurance and property taxes are based on market valuations. In like manner, insurance premiums should be priced similarly.

Insurance Bureau of Canada: While the bureau makes a show of its commitments to lowering insurance premiums, I personally have seen little or no evidence of any significant improvement of coverage or reduction in premium costs, despite the public relations attempt, as evidenced by the bureau's "Open Letter to Ontario Drivers" in yesterday's issue of the Toronto Star. I understand it also appeared in a number of other local newspapers. This lobby group seems to be very successful in appearing to be greatly concerned with "exorbitant legal fees," to use their words, for profit medical treatments, fraud etc. Scant attention seems to have been paid to improprieties in the collision-repair industry—and I certainly agree with everything that Mr. Norris said earlier—and real attention to fraud in its variety of forms.

User pay: A more equitable formula for premium establishment would be for all moving violations, infractions, fines and the like normally paid to the provincial Attorney General's coffers—such payments should be made directly into a pool fund to keep insurance premiums at a lower level for the safe, no-points, no-claims driver. All costs, including court fees, should go to this fund. For example, toll Highway 407 late or non-payments are enforced by the Ministry of Transportation by withholding drivers' licences, yet the revenue derived from this enforcement—that is to say, the toll charges—goes directly to a private company, the owner of Highway 407. In other words, the government is enforcing the rules, but the 407 owners are receiving the benefit.

My recommendations:

(1) Sharply increase the rates for poor drivers with poor claims history.

(2) Reduce premiums significantly for claims-free drivers.

(3) Do not allow plea bargains to be entered into to obtain convictions to lesser charges, thus reducing points records of such drivers.

(4) Apply all fines for—this is repetition—infractions to a pool of the insurance industry to reduce fees for those deserving because of a zero-claims history.

(5) Abandon the practice of determining premiums based on postal codes.

(6) Correlate the premiums to the valuation of vehicles. As I mentioned earlier, where a car is valued at $800, the premium should not be $1,200. Conversely, a $200,000 auto should not carry a premium of $200,000 or more. Of course, we know that that does not happen, at least for the higher-value car—a Ferrari, for example.

(7) Increase competition between insurance companies, even though my premium is lower than other quotes I received. There appears to be an element of collusion, much like the setting of gasoline pump prices.

(8) Reward good drivers and severely penalize poor drivers—harshly! And I say that with exclamation marks.

(9) Locate all offenders who are driving while licences are under suspension or driving while uninsured. The number of such people driving under suspension—we don't know, really, and it's only on a random basis that we discover these particular people doing so. For example, the driver who struck my car, as described above—fortunately, the police were called, and I learned that his driver's licence was under suspension. Otherwise, if it had been done privately, I wouldn't have known.

(10) Tighten quality standard pricing policies of body repair shops where they are known to charge excessively if the claim is going through an insurance company as compared to a private, billable transaction. Body shops notoriously ask, prior to the work being performed, "Is this repair going through insurance or privately?" If privately, the price is always lower.

(11) Consider legislation for mandatory coverage through provincial mandate, as in BC and Manitoba, where rates, I understand, are considerably lower.

(12) Establish an insurance industry ombudsman or an oversight body with real teeth to enforce rules and severely punish those individuals guilty of bad and/or illegal practices of staged accidents—which has been discussed earlier—wherein perpetrators are awarded large settlement amounts for bogus injury claims, repair of damage, work interruption etc.

**1330**

The advertisement in the newspaper, by the way, as you all are well aware—the Insurance Bureau of Canada makes a very loud noise in terms of what they are doing in this regard, yet I don't see too much real action.

**The Chair (Mr. Bob Delaney):** Just to remind you, you've got about a minute and a half.

**Mr. Edward Romaniuk:** Okay. I'm just about finished.

(13) This usually involves collusion between body shops, tow truck operators, unethical medical practitioners—few in number—and fake victims, injuries etc. My insurance company already has an ombudsman and ensures fair treatment. This position title should be in general use by all insurance companies.

(14) Hold the Insurance Bureau of Canada strictly to account by demonstrating how they have been effective in reducing premiums for good drivers and truly punishing bad drivers. Further, government should pool revenues derived from fines, levies etc. towards the lowering of insurance premiums, which is the emphasis of what I said earlier.

The last question I have—and I've learned this just this morning from a friend in the gym where I work out. She has a sister in Montreal. She drives a 2012 Audi, a $60,000 car. Her premium for full coverage is $500, which is less than half of what mine is. I say, are Montreal drivers better drivers than there are in Toronto? I hardly think so. There is some reason for this, and I don't know what it is, and I think the committee should take some investigative action to determine what and why this is occurring.

I'd be pleased to answer any questions.

**The Chair (Mr. Bob Delaney):** Thank you, Mr. Romanuk.

**Mr. Edward Romaniuk:** Romaniuk.

**The Chair (Mr. Bob Delaney):** Romaniuk. Our rotation will begin with Mr. Arnott—and I got my licence in Montreal; I'm on the same page you are.

**Mr. Edward Romaniuk:** Good.

**Mr. Ted Arnott:** Mr. Romaniuk, thank you for coming in today and offering this committee your experience: your years of driving and the experience you've had with insurance companies. Your thoughtful recommendations—I don't recall anybody else coming in with this many. I was trying to keep notes as I went along. Obviously, the record of what you said will be available to all of us through Hansard.

**Mr. Edward Romaniuk:** I have a statement here.

**Mr. Ted Arnott:** If you have it, that's helpful too.

In your first recommendation, you said increase the rates for poor drivers and reduce rates for better drivers. Later on, you said that insurance companies should correlate the premiums with a greater relationship to the value of the vehicle, and that there needs to be an ombudsman for each company—or I guess an ombudsman for the whole province. I think if the insurance industry were here, they would argue that they're doing some of this already, but obviously, your perspective is it's not going far enough, not even close.

**Mr. Edward Romaniuk:** That's right.

**Mr. Ted Arnott:** Many of the insurance companies do have their individual ombudsmen, though. Is that not the case?

**Mr. Edward Romaniuk:** Well, I don't know about other insurance companies because I didn't contact them with regard to whether they have or have not an ombudsman, but my insurance company did, and I had a great deal of time on the telephone with them—they were in another province, by the way—and they were helpful, but they couldn't do anything with respect to justification with regard to the 14.5% increase of the premium. I spent a considerable amount of time with the agent who was

handling all of this, and there's nothing. I have no other way of reducing the premium.

**Mr. Ted Arnott:** Would it be appropriate for me to ask if your agent is a broker dealing with a number of companies or representing just the one company?

**Mr. Edward Romaniuk:** I went on insurancehotline.com—which, by the way, you may or may not know, and even a lot of the people in the industry do not know this. Insurancehotline.com is run by a lady called Lee Romanov, and the only reason I remembered it is because her surname has the first two syllables of my name. I wondered, "Why is it and how is it that they can run a full-page ad in the Toronto Star?" I found out through a little bit of research that the Toronto Star has a majority interest in the company.

Yes, I did go through insurancehotline.com and, yes, I did find quotes, but the lowest quote I found was probably $25 lower than my present quote. I feel satisfied that my company—and I've been with them for over 10 years—is probably the lowest, but that doesn't mean that it's the best, what it should be, given the situation and so forth. I mean, where's the 14.5% coming from?

**Mr. Ted Arnott:** Thank you.

**The Chair (Mr. Bob Delaney):** Thank you very much. Mr. Singh.

**Mr. Jagmeet Singh:** Thank you very much for your deputation. You have, as my colleague indicated, provided a lot of thoughtful suggestions and recommendations, and I appreciate that. Thank you for your time.

You indicated in your list of concerns to increase the premiums for poor drivers sharply and harshly, and you also suggested removing the postal code discrimination or that type of practice. Can you talk about those two pieces and why you thought to add those specifically?

**Mr. Edward Romaniuk:** Well, I feel, most importantly, that the driving record is how a person should be judged, rather than where he lives. For example, I know of a fellow, who has since passed on for other reasons—nothing to do with insurance or cars. For some reason or other, don't ask me how—he's with the same insurance company that I'm with, and yet, somehow, he was referred to as having an address in, or at least rated as living in, Orillia, and therefore his insurance premium was far less than mine. Yet he lives at St. Clair and Yonge. I thought, "Well, good luck on you. I won't report this to the insurance company," because I felt that it's not my business to—I mean, he wasn't cheating, but somehow or other—maybe it was a mistake in their paperwork; I don't know—but they told me that he was covered under an Orillia location.

But to base it on postal code, with the mobility of people in their cars, you could live in a low-rated postal code area and create accidents and havoc in another area. It makes no sense at all. If you live in Churchill, Manitoba, or some place, I suppose the accident frequency is probably quite low, since there are probably few roads and vehicles—I'm from Manitoba originally—but making it by way of postal code makes no sense to me whatsoever.

**Mr. Jagmeet Singh:** In terms of policy, moving forward, where it comes to insurance companies and the way they conduct themselves, what part do you think insurance companies should play in terms of bringing down premiums, addressing some of the fraud concerns that you brought up, particularly when it comes to the excessive costs of collisions and other things of that nature?

**Mr. Edward Romaniuk:** I think the insurance company, through the Insurance Bureau of Canada or some other government association of some sort, should provide an audited and detailed financial statement comparatively—I don't know whether it would only be available for publicly listed companies or all companies, but there should be some way of comparing their financial record against others, and what the premium history is and why they all seem to be congregated in a very narrow band as being the same premium, and yet I'm sure they're not having all the same claims history, the same profit history and the same personnel efficiencies, shall we say.

**The Chair (Mr. Bob Delaney):** Thank you. Ms. Mangat.

**Mrs. Amrit Mangat:** Thank you, Mr. Ramaniuk—

**Mr. Edward Romaniuk:** Romaniuk.

**Mrs. Amrit Mangat:** Thank you for your presentation. You have expressed a list of concerns; you spoke about postal codes as one of them. Do you think postal codes are the only factor for the higher insurance rates?

**Mr. Edward Romaniuk:** No, of course not.

**Mrs. Amrit Mangat:** No. What are the other factors?

**Mr. Edward Romaniuk:** It would be the driving record, the number of points a person has and so forth. But I think that the penalty for having a poor driving record should be the most important of all because they are the causative factor in all of this, and they should be made to pay dearly—far more dearly—than they do. After three years or five years or whatever it is, your record is dismissed, written off. I think it should be a lot longer and the infraction should carry heavy fines, and those fines should go into a pool to support the insurance industry and good drivers.

**Mrs. Amrit Mangat:** Okay. You spoke about fraud as well in your presentation—fraud?

**Mr. Edward Romaniuk:** Yes.

**Mrs. Amrit Mangat:** Yes. How can we eliminate fraud? What do you think?

**Mr. Edward Romaniuk:** I think I would ask the people in Montreal about that question, because they don't seem to have the same problem—or maybe they do, but how are they justifying the lower—this is not the only case that I learned of today of the lower premium.

How to determine fraud? I think Mr. Norris probably has more definitive ideas on this. I'm not familiar enough with the process involved, but I have read in the paper, the Toronto Star, about the staged accidents. Every once in a while, they'll stage an accident and the supposed victim in fact does get hurt, and deservedly so. There should be some independent witnesses somehow, either video or whatever.

**1340**

But as to how to determine fraud, I think it's probably fairly easy at the collision reporting level to determine fraud. As Mr. Norris said, some of his people are very good at identifying what is a staged type of an accident and what is a real accident, and similarly whiplash.

In fact, one of the questions asked of me—because I was sitting stationary at the red light, waiting, when I got hit. The first question I was asked—and I'm not sure who asked me this question, but maybe it was the police—was: "Do you have any whiplash, any pain?" I said, "No, not at all." In fact, it was not even a mosquito bite.

**Mrs. Amrit Mangat:** Do you think that—

**The Chair (Mr. Bob Delaney):** Mr. Romaniuk, thank you very much for having offered your thoughts and feelings here today.

## MR. HARJIT JASWAL

**The Chair (Mr. Bob Delaney):** Our next presentation will be from Harjit Jaswal. Mr. Jaswal, just take a seat anywhere.

*Interjection.*

**The Chair (Mr. Bob Delaney):** That would be fine. Good afternoon. Sat sri akal je.

**Mr. Harjit Jaswal:** Good afternoon, everybody.

**The Chair (Mr. Bob Delaney):** You'll have 15 minutes to make your presentation to the committee, followed by up to 10 minutes of questioning. This round of questioning will begin with the New Democrats. Please begin by stating your name for Hansard, and proceed.

**Mr. Harjit Jaswal:** My name is Harjit Jaswal and I'm a realtor in Brampton. I've lived for a long time in this area, I work in this area and I surely know the insurance problems of the area too.

First of all, I thank all of you for giving me the opportunity to speak to you regarding the insurance concerns I have. I wanted to give a presentation, but I didn't know I had to bring my own laptop, so I will do it just with paper.

As we all know, insurance companies are a for-profit business, on the side that it is a service industry too.

Over the past few years, we have seen that auto insurance costs have gone really, really up and the premiums have gone up too. Insurance premiums, if you see the graph I gave to you all—I hope everybody has that—we see that they have an upward trend. Since 1985 until 2010, the trend is upward. This graph is inflation-adjusted, so inflation is not playing any part in there, but when we see this graph closely, we see the cyclic pattern in between the reforms. Whenever there was reform of the insurance premiums there was a dip, but after a few years they came back again. That tells us very clearly that major reforms are stop-gap solutions. They don't offer any permanent solution.

When we see the next graph, we see that the accident benefit costs, which go to the insurance, have gone very much higher. With the increases, the premiums are going up too. That case is very much true for Toronto. It is a very large portion of that that goes in the GTA area.

If we see the other graph, we see that expected GTA costs, based on private health care expenditures, was 22%—I took these graphs from the anti-fraud task force interim report, with which you might be all very familiar—but the accident benefit costs grew 185%, which is $1.7 billion more than the expected one, and all GTA drivers are paying $700 per vehicle just to cover that cost because insurance companies are not going to pay from their pocket, and they pass it on to us.

If we see the auditor's report, we know that accident benefit claims frequency has increased while injuries have decreased, so that tells us that there is fraudulent activity going on. Accident benefits is the only area where the insurance company is losing. I have seen the data from the general insurance statistical agency, which shows that in all areas, insurance is making money. There is only one area where insurance is losing money, and that is the accident benefit claims.

Severe injuries from collisions decreased, while the claim severity increased. That again shows us that there is some kind of activity going on.

The backlog of disputes requiring mediators has grown at an alarming rate. In November 2008, wait time was only 3.3 months, and now it is 9.6 months.

Drivers, in the GTA particularly and in the whole of Ontario, feel that they are at the mercy of insurance companies because insurance is mandatory. Drivers have the perception that the regulators are not doing enough of what should be done.

I want to bring a few scenarios in front of you where you will see how the insurance problems occur. Scenario one is uninsured drivers. They can make the claim, or they are making the claims. The driver goes to the insurance broker, asks for the insurance. The insurance broker gives him a one-month slip. That is never reported to the insurance. After one month, they tear up the slip. They get a new slip. They can keep on doing it month after month, not reporting or paying anything to the insurance company, and just bribing the insurance broker, until they are involved in an accident. Normal people who are paying the insurance are paying for that fraud.

Suggestion: Temporary insurance slips should be stopped. Insurance companies should be giving the temporary insurance slips, not the insurance brokers, and only when they get the payment.

I would like to bring another scenario. Whenever there is an accident, a tow truck driver comes to you and says, "Oh, you will not have to pay this deductible. I will take you to a body shop where you will not have to pay the deductible." Now, insurance companies who are trying to stop the fraud are bothering normal drivers too much. Fraudsters get away with those laws or complexities of the policy, but the normal drivers who are involved in an accident get caught and they are denied the claim. Drivers want to see what works, because they know that they have been paying high insurance, so they go with that route, going with the tow truck. Many of them do

that, and when they go to the body shop, either the body shop works with the appraiser or they do more damage to the vehicle so that the claim can be enlarged. The insurance company ends up paying thousands more in damages just because the driver is trying to save $500 or $1,000 of deductible.

I have a suggestion for that. At the collision centres, all the staff are paid by insurance companies. They can have some appraisers over there who can appraise the vehicle right there, and insurance companies can pay. That way, the additional storage charges and car rental charges for the additional days until the appraiser is coming can be saved, and it can be done right at the collision centre. That will save a lot of money for the insurance companies.

The government should consider creating an equivalent to the Better Business Bureau for auto body shops in which complaint submissions are just by the insurance companies if they have any proof against a body shop, not just by saying that they want to deny. If they have any proof, they can just report over there. The insurance companies should have some kind of right to deny any claim if people want to go to those shops which are crooked or are doing fraud.

Insurance companies should consider some incentives to mitigate this problem. They can start some kind of discount if a person commits that they will go to their recommended body shop. In the case of accident, they can offer some kind of discounts in the beginning of the writing of the policy, or they can offer a discount by lowering the deductible at that time if the claimant goes to the body shop which is recommended by the insurance company.

**1350**

There is another scenario where accident benefit claims for minor collisions occur. A person involved in a minor collision with either no or minimal injuries submits a large claim indicating that they are severely injured. Costs of the physiotherapy and any medical aids are covered by the insurance company because it is mandatory for the insurance to cover them. These types of claims often lead to disputes. Because there are no injuries and there are big claims, they lead to disputes. There are so many cases like this that the time to appoint the mediator has gone up and more and more time delays are there that cost insurance more because a claimant uses their time for advantage to prolong the physiotherapy or something—they want to keep the thing alive until they have gone in front of the mediator.

I would like to see that insurance companies should have the right to request a second opinion from a different doctor at any point during the claim. If there is a big discrepancy, corrective action should be taken.

Cost of the medical aids is another thing. Cost of medical aids should be limited to their retail value. If somebody is paying cash, it is different, and if an insurance company is paying, it is very much different.

FSCO should work to clear the backlog of disputes requiring a mediator to reduce the settlement times. They should work quicker.

Injuries—this is the most important, I feel. Injuries can be broken into two categories—minor injuries and major injuries—and mandatory insurance should be only for the major injuries. Minor injuries can be taken off the mandatory list and put as an optional endorsement. The pool for the premium for minor injuries can be separate, and whosoever wants to take the minor injury claims, they are most welcome to take them and pay for that premium. Everybody in Ontario should not be suffering because some people want to go eight months because they have muscle pain. However, these minor injuries can be big for some people. Minor injuries can be small for a young person; they can be too much for little kids or an elderly person. Doctors' assessments should be used to determine which should fall under minor and which should fall under major.

I have another scenario. There is definitely fraud going on against insurance, but insurance is not doing all well either. They are denying legitimate claims because their policies are so complex and a person who is telling the truth gets caught in there, because most of the insurance companies' money is going to fraudsters and they try to recover it by denying legitimate claims.

I will bring this personal case which I personally know. A driver was going on a highway. He did not have collision coverage; he had only third party. He was hit on the windshield by a big piece of rubber which came from the tire of a truck. The vehicle was going on the 400 series, so both the vehicles were in high speed. Once that windshield is broken, the driver cannot see anything, and the car spun. It spun and hit another car, then bounced back, hit the median wall, bounced back again, hit another truck, and then bounced back to the median wall again, and it was totally damaged. Luckily, the driver of the car did not get hurt. The truck driver did not stop because he did not realize that something was happening behind.

There were multiple witnesses over there. The police were called on the scene. The insurance company denied that claim to repair that car for an insured motorist, using the technicalities of the policy that the driver did not provide the licence plate number of the other vehicle.

**The Chair (Mr. Bob Delaney):** Mr. Jaswal, you have about two minutes to go.

**Mr. Harjit Jaswal:** Okay, thank you.

I say that insurance companies should treat their clients fairly.

In conclusion, I would say that insurance is a service industry but ordinary people aren't always getting the benefit of the service, despite paying higher rates. People currently feel intimidated by the complexity of their policies and the attitude of the insurance companies, resulting in legal disputes. The problem is on both sides and has led us to a downward spiral.

It started off with a small group of people who committed insurance fraud, costing insurance companies

heavily. Insurance companies raised rates to cover the cost and became very cautious to stop the fraud, and the general population, with genuine claims, were not always treated fairly because they got caught in this stopping the fraud thing.

Major reforms have helped in the past, but they are temporary fixes. Ideally, government should monitor the situation on an ongoing basis and introduce changes. Government should work in parallel with the insurance companies to come to a happy medium.

Thank you.

**The Chair (Mr. Bob Delaney):** Thank you. Mr. Singh.

**Mr. Jagmeet Singh:** Thank you very much. In your deputation you took a very balanced approach and looked at all the different players, the insurance companies as well as people who bring claims that don't have merit to them, claims that aren't worthy. You've looked at all the different components and I appreciate that and thank you for giving a thoughtful recommendation.

I wanted to ask your opinion on this. If we look at the overall claims costs—and that's essentially the largest component of what an insurance company pays out: the actual cost of each claim. If the claims costs drop significantly—and there's some evidence now that because of the 2010 reforms, we're seeing that there have been significant drops in how much it costs an insurance company on a year-by-year basis. So far, the data is showing that the costs have come down well over 50%. If the cost of insurance is going to decrease so much, the cost in terms of what insurance companies are paying out, as a citizen here in Ontario, what do you feel should happen with premiums?

**Mr. Harjit Jaswal:** I think the FSCO should interfere over there. When insurance companies go to the FSCO for the increase, then FSCO should monitor that too; the costs have gone down, the premiums should be coming down.

**Mr. Jagmeet Singh:** That's fair. In terms of the picture, what do you think insurance companies should be doing in terms of their role in helping to bring down insurance costs or premium costs?

**Mr. Harjit Jaswal:** I think insurance companies have an advantage. Insurance is mandatory for drivers. They are using that portion for their advantage because they are not actively playing the role which they should be playing to stop the fraud. Insurance companies should be working with the people, they should be working with the government to stop fraud.

At the same time, they should be generous to the general public. When somebody is involved, they should not be using all those technicalities to deny the claim.

**Mr. Jagmeet Singh:** My colleague has a question for you.

**Ms. Teresa J. Armstrong:** Hi. Thank you very much for your presentation.

I just want to kind of wrap up with you—your conclusion about how you're saying insurance is a service, that even though it's mandatory it's still a service, and that ordinary people aren't always getting the benefit of that service, despite paying higher rates.

You talk about people feeling intimidated by the complexity of their policies. Is there a way that you think that could be helped? I certainly wouldn't want people to feel, when they're buying something that's mandatory, that they're not understanding or getting the service that they are expecting. How would you think that could help—the communication between that and the broker or the insurance industry?

**Mr. Harjit Jaswal:** What insurance companies are doing is they are trying to stop the fraud, because they have big law companies, and they are making things harder and harder to prove that it was a genuine claim. On the other hand, a normal person will not read the whole policy when they are getting their insurance. Then when the accident happens, they know that anything they say, anything they talk to the insurance company, is not going to help to solve their insurance case; they are going to have to get the insurance out of this thing, and they deny the claim. That's why they want the mediators. They want it disputed so that they know that—whatever is working, they want to do that.

**1400**

**Ms. Teresa J. Armstrong:** So would it be fair to say that, ultimately, people who buy insurance feel they have to fight for things that they're paying for under the policy, as opposed to it being delivered to them so that when they're in a time of need, they can be helped through their claim?

**Mr. Harjit Jaswal:** They can definitely fight, but making the whole thing a fight is going to cost more and more, because it is going to be a lengthy procedure, it is going to cost more, and at the end of the day, it is going to cost more to the driver, so premiums are going to go high.

They should try to make it simpler and a way that ordinary people should not be intimidated.

**The Chair (Mr. Bob Delaney):** Thank you.

**Mr. Harjit Jaswal:** You're welcome.

**The Chair (Mr. Bob Delaney):** Ms. Mangat.

**Mrs. Amrit Mangat:** Thank you, Mr. Jaswal, for your presentation. In your presentation, if I look at it, you spoke about different scenarios, scenario 1 to 4. All those scenarios, they reflect about fraud. Some kind of fraud is going on. Do you think that by eliminating fraud, we would be able to lower the premiums?

**Mr. Harjit Jaswal:** Definitely, definitely. As I say, it might not readjust without the interference of the government. We might have to have government interference, where they can put some more controls that the insurance premium—because the insurance industry is controlled by the financial services commission. The financial services commission can check from time to time what it is costing them, so they can definitely interfere—or they can be mandated like this so that they can interfere. These kinds of reforms can be done.

**Mrs. Amrit Mangat:** Do you think dedicated fraud units would help in lowering fraud—a dedicated fraud unit would help in eliminating fraud?

**Mr. Harjit Jaswal:** Dedicated fraud units might, they might not, depending on how seriously they are working on it. But fraud—people should be aware about that, too. The insurance companies should have seminars with people. They should make the people know that when you save $500 in deductibles, you are paying a lot more in premiums. They should come out to educate the people. They should support the people. There should be a little better bond between the seller of the policy and the user of the policy.

**Mrs. Amrit Mangat:** Do you think that would be a permanent solution to lower premiums?

**Mr. Harjit Jaswal:** That should be.

**Mrs. Amrit Mangat:** Thank you.

**Mr. Harjit Jaswal:** You're welcome.

**The Chair (Mr. Bob Delaney):** Mr. Yurek.

**Mr. Jeff Yurek:** Thank you for coming in today. It's great. You sound like you've done your homework. I've got a few questions for you.

It's interesting how you kind of put the fraud cycle into this, where people commit fraud and the insurance companies are losing money, so therefore they get a rate increase; then they increase their rates and then fraud occurs more. They go back to FSCO to increase rates.

**Mr. Harjit Jaswal:** Yes, it is a cycle.

**Mr. Jeff Yurek:** A lot has been said about the insurance companies dealing with fraud, and I have no problem with that dealing with fraud. But where do you see the government, as the regulator of the whole industry, fitting in in how they should be dealing with the fraud issue?

**Mr. Harjit Jaswal:** Regulators can make stricter laws, and as soon as the fraud goes down, regulators should make sure that the insurance goes down. If people have this kind of insurance from the regulators, that is going to work for their benefit, it might be that people will do better.

**Mr. Jeff Yurek:** Right. And the next point: You talked about the complexity of the insurance, the fine print that you read. I'm much like you: I don't think I've ever read past "sign here," and I really have no idea what I'm signing for. Now that I'm on Hansard as saying so, my insurance company is probably going to do something to me.

I find that more red tape, regulation and bureaucracy that grows from the industry tend to add to those fine-print pages, and that might in itself be its problem. You didn't touch on it here, but with premium rates going down—we learned yesterday in committee that FSCO could take up to a year to actually approve a rate decrease for insurance companies. I don't know if you've got much information about regulations or red tape that you wanted to speak upon at all.

**Mr. Harjit Jaswal:** Not about the red tape. I didn't go into that detail. But I did inquire quite a bit about the insurance, and I checked the letter—how it is working.

**Mr. Jeff Yurek:** Okay. My third question, since you've done a lot of research—and this is a way-out-there question I like to throw in, every now and then: What are your thoughts on no-fault insurance as the way Ontario is run now as compared to the tort-run system?

**Mr. Harjit Jaswal:** As for no-fault insurance, I think that minor injuries should be taken out of that, because minor injuries is the one which is—because we don't want our citizens to be sitting in the hospital all summer with pain and not treating them. We don't want that. That's what the insurance is for. But with the minor injuries like having muscle pain, somebody driving the car, or they are involved in the accident—if there are minor injuries which are simple muscle pain or something for a few days, it shouldn't be—it goes for years or months just to raise the claim, not because there is actual pain for that long time. We know that, all of us. Otherwise, this graph shows that private health expenditure has not gone up in the whole of Ontario; it is just the accident benefit claims which have gone up.

**Mr. Jeff Yurek:** Thank you very much.

**The Chair (Mr. Bob Delaney):** Mr. Jaswal, shukriya ji. I think we very much appreciate you coming in to share your thoughts and feelings with us today.

I'm not sure our next deputant has arrived. Is William Axworthy in the room?

The committee will take a short recess. Nobody go too far away.

*The committee recessed from 1407 to 1422.*

**The Chair (Mr. Bob Delaney):** The committee will briefly come back to order. It being the agreed-upon time of 2:22, with the absence of the final deputant, we are adjourned until 9 a.m. tomorrow in Windsor.

For those of you travelling with the committee, we are going to be leaving the hotel in about half an hour to take the coach bus to the airport. Jagmeet, make sure you check with the clerk, and make sure you know where you're bringing the car; we don't want to be leaving without you.

Okay. We're adjourned.

*The committee adjourned at 1422.*

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Tuesday 10 July 2012



**STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS**

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Mr. Jeff Yurek (Elgin–Middlesex–London PC)

**Also taking part / Autres participants et participantes**
Mrs. Amrit Mangat (Mississauga–Brampton South / Mississauga–Brampton-Sud L)

**Clerk / Greffière**
Ms. Valerie Quioc Lim

**Staff / Personnel**
Mr. Andrew McNaught, research officer,
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