



Ontario's Ailing Auto Insurance

Ontario insurers looked to the Ontario regulator to diagnose and cure the province's ailing auto insurance product. And while they hail the province's diagnosis, the treatment, they say, isn't strong enough to keep insurers from having to raise consumers' auto insurance rates.

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Imagine

a person involved in a car collision getting transported to the local hospital's intensive care unit with serious injuries. The doctors in the room look over the patient's various charts, MRI results, x-rays and correctly diagnose the injuries down to the final detail. In the operating room, a doctor takes out a bottle of regular strength pain reliever and gives the patient two pills and a glass of water. "Take two of these and call me in the morning," says the doctor, and the surgical team leaves the room.

This is a classic case of a treatment not meeting expectations, especially in light of the seriousness of the original diagnosis. The patient's resultant confusion and disappointment is an apt metaphor for how the province's insurance industry is responding to the diagnosis and treatment prescribed by Ontario's insurance regulator, the Financial Services Commission of Ontario (FSCO), to cure the province's ailing auto insurance system.

Overall, the insurance industry believes the regulator lost its focus somewhere between its diagnosis and the treatment it prescribed in a report concluding its five-year review of the auto insurance product. "There was a bit of a dichotomy we saw with respect to the [FSCO] report," said Don Forgeron, president and CEO of the Insurance Bureau of Canada (IBC). "The diagnosis FSCO supplies is very accurate. They clearly recognized the seriousness of the cost problems within the system. But the cure it prescribed is inconsistent with the diagnosis. It's similar to saying, 'You have a migraine headache and you need strong medicine, but just take one aspirin and we'll see what happens.' That's a little unfortunate, from our perspective.

The Illness and Symptoms

Ontario's auto insurance system is ill. On this point, all of the stakeholders and the regulator agree. The patient is a hybrid system that includes both a first-party accident benefits (AB) regime to pay injured claimants and a tort (court) system for delivering accident benefits. The system is too complex, nobody understands or wants to fill out the paperwork, there are too many health professionals' assessments for minor injuries, most of the insurers' money is propping up the system (including cottage industries for assessment) rather than going to the claimants, the system disproportionately caters to minor injury claimants, etc. etc.

For insurers, the claims costs associated with many of the problems mentioned above directly (and negatively) affect their bottom lines. The magnitude of the problems with Ontario's private auto insurance system for the insurance industry is clearly represented in the financial figures the Insurance Bureau of Canada (IBC) presented at the 2009 Swiss Re breakfast in early April. IBC presented the industry's 2008 numbers just one day before FSCO concluded its mandated five-year review of the provinces' auto insurance system. FSCO has since issued its final report to Ontario Finance Minister Dwight Duncan. In its report, FSCO made 39 recommendations to Duncan to reform the auto insurance product, if in fact the minister chooses to make any changes to the system at all.

IBC's numbers suggest some kind of change will be necessary, because the losses the province's auto insurers suffered in 2008 Q4 are quite simply unsustainable. Overall, the industry lost capital in 2008 for only the third time in 33 years, with a total of more than half of the country's primary insurers reporting an underwriting loss of Cdn\$290 million. [The loss was flattered by a Cdn\$1.4-billion release of reserve funds.] Ontario auto was a major driver of the loss, IBC said, noting Ontario auto represents 27.2% of primary insurers' net premiums earned in the entire country. IBC estimated

auto losses in Ontario in 2008 would hit Cdn\$390 million.

In 2007 Q4, insurers' loss ratios in the accident benefits area — roughly translated as the insurers' claims payments divided by the premium they collected, with numbers above 100% representing a loss — were between



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103% and 124%. One year later, in 2008 Q4, Canadian auto insurers posted loss ratios in the AB side on the order of between 130% and 179%. In other words, primary insurers were paying out between \$1.30 and \$1.79 in accident benefits claims costs for each \$1 worth of insurance premium they collected from consumers.

Seen from the perspective of reinsurers (who insure the insurance companies), the system as a whole is suffering. “Most of our exposure [on the reinsurance side] tends to be excess of loss, and what we've seen over the last several years is that the AB claims have really been skyrocketing,” says André Frédette, the vice president and general manager of Caisse Centrale de Reassurance (CCR). “So when you see

\$2-million, \$3-million, \$4-million, \$5-million or \$6-million claims, it's not unusual anymore. I think a lot of companies have big net retentions [i.e. primary companies will choose to pay large claims on their books instead of paying reinsurers a premium to make claims payments on their behalf that exceed a certain threshold] — some \$2 million, \$3 million, and some \$5 million. They're taking it on the nose, big-time.”

As primary insurers' claims costs on the AB side escalated, so, too, did their expectations that the regulator would make recommendations to help reduce their claims costs. “There's a lot of high expectation, because I think there was a general belief that because the results had deteriorated so rapidly, we really needed quite a surgical response to the issue,” said Irene Bianchi, vice president of claims for RSA. “In Ontario, in accident benefits, the loss ratio is running as high as 179%. You just can't sustain that. You can't sustain that for a couple of quarters. There was a huge expectation that FSCO would understand the issues and to come up with recommendations that were pretty prescriptive and address this issue.”

FSCO's diagnosis

And so with the insurance industry's expectations weighing down upon it, not to mention the additional expectations of consumers, trial lawyers and health care providers, FSCO spent the better part of a year looking over the 90 submissions it received during the consultation period of its five-year review. In early April 2009, the regulator submitted to the minister a 72-page report featuring 39 recommendations to reform the system. Its detailed recommendations address a variety of issues raised by all stakeholders represented in the consultation process, including consumers, health care providers, trial lawyers and insurers. The full report is available at FSCO's Web site: www.fSCO.gov.on.ca/.

In terms of a diagnosis, FSCO echoed the concerns of almost everyone that the existing accident benefits system is far too complicated for experts to sort

through, let alone the average layperson. "Virtually every stakeholder commented on the complexity of the existing accident benefits system," FSCO noted, after spending a few pages of its report tracing the origin and evolution of the Statutory Accident Benefits Schedule (SABS), the legislation that governs the accident benefits system in Ontario. "A number of stakeholders compared [SABS] to the *Income Tax Act*. To provide some context to the issue, the current SABS is estimated to be six times the length of the schedule that was introduced under Bill 68 [in 1990]. The current SABS is also estimated to be 40% longer than the Bill 164 SABS [introduced in 1994], which stakeholders used to refer to as 'bloated.' An argument could be made that SABS has increased the regulatory burden on both consumers and the insurance industry."

FSCO's report acknowledges the complexity of the system has led to what the regulator describes as "the overutilization of assessments in the auto insurance system." It then cites 10 examples of abusive assessment situations, including, among others:

- "'assessment mills' operating in the auto insurance system and providing claimants with inappropriate or unnecessary assessments given either the diagnosis and/or the stage of recovery;"
- "multiple requests for assessments being sent to insurers in order to overwhelm company adjusters;"
- "assessments being conducted by facilities not involved in a claimant's treatment;" and
- "costs of these assessments are out of line with the benefit to the claimant or insurer."

FSCO then notes the costs of these assessments to the insurance system, citing IBC statistics for 2007. "The IBC submitted that in 2007, based on incurred losses (paid claims plus reserves), for every dollar spent on treatment, another 60 to 80 cents were spent on assessments," the report says. "For minor claims (between Cdn\$1,000 and Cdn\$20,000) they suggest that assessment costs were

between 70 and 80 cents for every dollar of treatment. This level of assessment activity is reported to be inconsistent with other jurisdictions including the public health care system."

FSCO goes on to recognize the impact of the system's various inefficiencies on insurers' overall AB costs. Citing IBC data,



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the report notes accident benefits loss costs in Ontario went up from Cdn\$331 per vehicle in 2003 to Cdn\$385 per vehicle in 2007. "Loss costs for accident benefits saw the largest relative increases during the past five years," FSCO said. "Accident benefits rose by 16.3% since 2003 but since 2004, the increase has been 34.6%...Rising loss costs have resulted in the upward swing of rate changes approved by FSCO. However, rate increases have not kept pace with rising loss costs and the insurance sector reports significant rate inadequacy in the system. Consumers will likely see their premiums increase significantly in 2009 and 2010 without some structural changes to the auto insurance product to reduce and stabilize costs in the system."

FSCO's treatment plan

So how to cure this ailing system?

Out of FSCO's 39 recommendations, arguably two-thirds of them directly address escalating first-party AB costs. The others deal with tort (third-party bodily injury claims made in court) or other reforms. To help insurers control costs, FSCO in some instances recommended caps on expenses; in others, they recommended converting some of the mandatory AB benefits into optional benefits. In other words, consumers would be given the option to pay a higher premium for additional coverage that is now available to them under the basic, mandatory package. The following of FSCO's suggestions, in no particular order, have generated discussion within the insurance industry:

- Recommendation #10: Further consultation with experts in the field is needed to amend the definition of "catastrophic impairment" (in the defining regulation). The goal for this review should be to ensure that the most seriously injured accident victims are treated fairly.
- Recommendation #11: Expenses related to s. 24 SABS assessments should be subject to the same maximum monetary and time limits that apply to medical and rehabilitation benefits under s. 19 of the SABS.
- Recommendation #12: The fee for completing forms, including any assessment required to complete the form, should be capped at Cdn\$200. The cost of all other assessments should be capped at Cdn\$2,000.
- Recommendation #15: Consider having assessment requests — and treatment plans, if Recommendation #21 were to be adopted — subject to a referral made by the health professional primarily responsible for the claimant's rehabilitation (in most cases a family physician).
- Recommendation #22: Reduce the cap for medical and rehabilitation benefits for non-catastrophic claims to Cdn\$25,000. Introduce a Cdn\$100,000 optional medical and rehabilitation benefit along with the existing Cdn\$1-million optional benefit.

- Recommendation #29: Make housekeeping and home maintenance expenses and caregiver benefits optional.

On the tort side, Recommendation #31, which would open up access to justice for third-party tort claims, is significant to insurers. It addresses comments made by former Ontario associate chief justice Coulter Osborne in his Civil Justice Review completed in November 2007. In his report, Osborne notes two methods used in court to limit insurers' tort liability costs (particularly for minor claims). The first is a set of deductibles — Cdn\$30,000 and Cdn\$15,000 — that are immediately subtracted from any court award for a claimant worth less than Cdn\$100,000. The second is a "verbal threshold" that defines whether a claim is "catastrophic" and therefore not subject to the deductibles. As did Osborne, FSCO viewed the two methods as being redundant, and therefore made the following recommendation:

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

Rehab for the AB system

As far as the specific recommendations related to AB are concerned, two aspects of FSCO's general approach have generated discussion within the industry. To help contain insurers' costs, FSCO has recommended either caps in some areas or converting mandatory benefits to optional benefits. And while the industry predominantly appreciates these efforts to minimize their costs, it's difficult to say whether they will actually transform the system or simply produce cost savings in some areas while increasing costs elsewhere.

Mandatory to optional benefits

George Cooke, president and CEO of The Dominion, said he was happy to see FSCO recommend the conversion of some mandatory benefits to optional benefits. At the same time, however, he believes FSCO should have applied this approach more consistently than it did.



The transfer of some mandatory benefits would put a “tremendous onus of responsibility on brokers and brokers’ errors and omissions... I think it’s going to open that door up [to litigation against brokers], and I think that’s very dangerous.”

Like Cooke, Philippa Samworth, a partner at Dutton Brock, sees an immediate benefit to insurers in terms of reducing their claims costs. “The elimination of housekeeping as a benefit only knocks out \$100/week, but you’ve got to think about the collateral costs that go with that, which is a series of in-home assessments,” says Samworth. “It is a benefit that everybody asks for. It’s a highly abused benefit, because it’s always a family member [who does the housekeeping or caregiving]. Lots of time surveillance is used to look at that type of issue. So some of the costs that

insurers spend to look at that issue and fight that issue would be gone....All of that litigation goes away, and the insurer doesn’t have to worry about that.”

But this cost containment measure doesn’t come without unintended consequences. For instance, how would the broker channel explain these changes to consumers? “It’s going to put a tremendous onus of responsibility on brokers and brokers’ Errors and Omissions,” observes Steve Smith, president and CEO of the Farm Mutual Reinsurance Plan. “I think it’s going to open that door up [to litigation against brokers], and I think that’s very dangerous. This is a very complicated legislation. People are being asked to make decisions on whether or not they want accident benefits in the event of an injury. Basically [brokers] are saying [to consumers]: ‘We can save you money if you don’t want these coverages.’ People will not understand the ramifications of choosing or not choosing that coverage at the time of application. They’ll be simply focused on the premiums. And if they don’t understand the ramifications fully, you’re going to get people saying: ‘Well gee, I didn’t understand that. I didn’t know I’d be faced with those kinds of hardships in the event of a claim.’ Brokers’ Errors and Omissions [insurance] is fully exposed on this. It’s just the wrong way to go.”

Others, like Rocco Neglia, vice president of claims for The Economical Insurance Group, see the recommendation as an opportunity for brokers rather than a liability (so to speak). “I think brokers would welcome the opportunity to provide that extra service to their clients by saying this is a complicated product, it’s not as much of a commodity as you think it is, and these are the reasons why you need a broker to help explain,” he says.

In fact, brokers in Ontario are already explaining the difference between mandatory and optional benefits to consumers as part of the everyday course of their business, says Randy Carroll, the CEO for the Insurance Brokers Association of Ontario (IBAO). Brokers already have workflows and systems

in place to explain the differences between mandatory and optional benefits to consumers. And Carroll implies FSCO's recommendation would in fact save costs for insurers, since consumers often decide not to buy optional benefits. "From a consumer's point of view, it's looked at as an additional cost," he says. "I don't have to have it, so I won't take it. Ninety-nine per cent of the consumers that brokers talk to now about optional accident benefits decline."

The trick for brokers would be in how to explain to consumers who already have housekeeping and caregiving benefits as part of their mandatory coverage, for example, that these benefits are no longer part of their existing coverage. Consumers would have to pay additional premium costs to retain these benefits.

"The concern I would have is: How will it be presented to the consumer who has the benefits now?" says Carroll. "Every time you turn around and change your product, where you are taking things away, that's where the large exposure comes through."

"If I have you come into my office as a new client, I can sit down with you and talk to you in regard to what coverage is available and about what optional coverages you may want to consider. You can then make an informed decision during the process of that conversation. But if I'm...sending out a renewal in which benefits were included before and now they have been taken away, there is a concern in regard to how you actually [help the consumer] make the transition..."

One way out of the dilemma might be for the industry to include the optional coverages upon first renewal, Carroll suggested, thus putting the consumer in a situation in which he or she would actively have to opt out of the coverages that would be converted into optional benefits. "At least it forces the conversation between the consumer and the intermediary, regardless who the intermediary is, so that the consumer understands he or she is making an informed decision to remove something, versus just having it taken away," he said.

Caps

Both Cooke and Samworth, who has worked very closely with the auto insurance reform file in the past, make the point that caps or "ceilings" can have the dual effect of increasing lower costs as well as decreasing higher ones.

"The reduction of the med-rehab cap

Whatever cap you put on [assessment costs] then becomes the new low... While there might be a [cost] decreases initially, I think in some cases... what you're going to see is that most reports will come in at the maximum.

to Cdn\$25,000 in and of itself makes a lot of sense," said Cooke, who noted the industry has argued for such a cap, but didn't get it, in several previous rounds of reform. "But the problem you've got to worry about there is that you don't want to push the cost for the guy that should be at \$5,000 up to a \$25,000 claim.... What you have to do is to accompany it with controls so that you keep the \$5,000 as a \$5,000, and you still have some position for the one that should be at a \$45,000 [claim] to get the incremental \$20,000."

Similarly with the cap on assessment costs at \$2,000, the danger is that lower costs will be scaled upward to meet the \$2,000 cap. "Whatever cap you put on it then becomes the new low," Samworth says. "I do see a lot of insurers' reports come in at \$1,000 and \$1,200, \$1,500 – all of those individuals now know that they can ultimately bill for \$3,000. So now the new report cost will be \$2,000. While there might be a [cost] decrease initially, I think in some cases... what you're going to see is that most reports will come in at the maximum."

Good-bye AB costs, hello tort

Trial lawyers appear to believe FSCO came to the right balance between decreasing insurers' costs on the AB side while simultaneously opening up access to justice for consumers on the tort/bodily injury side. Going into the review, trial lawyers, who represent claimants in court for third-party bodily injury claims, asked FSCO to lower the \$30,000/\$15,000 deductibles applied to court awards less than \$100,000. Their request to FSCO was to reduce them down to \$15,000 or eliminate them entirely. FSCO did not go that far, but Richard Halpern, chair of the Ontario Bar Association's automobile insurance working group, said he could certainly live with FSCO's recommendation to reduce the deductible to \$25,000/\$15,000.

"The important thing about the deductible is to consider what FSCO has proposed for the second stage, which is a closed claims study to whether or not the threshold should be eliminated entirely," said Halpern. "In the face of that, I'm content with the deductible level because there is some prospect that the threshold will be eliminated entirely." The verbal threshold defines what constitutes a "catastrophic" injury, to which the deductibles do not apply.

Insurers aren't as happy with the tort reforms. They see the opening up of tort as increasing their claims costs on the bodily injury side, even while their AB costs are getting capped. "My concern is that the positive side [of what FSCO is recommending] is absolutely destroyed by the negative of the pieces we are starting to see around the tort side," says Bianchi. "There was a meeting of the IBC's industry advisory group [in April 2009] and everybody rated this whole proposition. I think the highest score was between a six and a seven. The lowest was between a two and a four out of 10. So nobody is really happy with it."

Samworth adds the dissatisfaction is rooted in the math: "If every accident claim right now is subject to a \$30,000 deductible, and if you take \$5,000 off of that,

then for every claim [going forward] there's going to be an additional \$5,000 that's going to be paid out. There has to be a cost."

And that cost will be passed onto the consumer in the form of higher auto insurance premiums, which already represent 5% of Ontarians' disposable income — the highest such percentage in the country. "Our current claims trends are on the upward swing and we view the recommendations in the report to be at best neutral in controlling the costs," says Mark Feeney, vice president of personal lines and packaged products for the Co-operators General Insurance Company. "Much will depend on the details and which recommendations are implemented, but our view is that if these are implemented, premiums will continue to rise."

Halpern says he doesn't accept this conclusion. He says insurers' increased costs on the tort side would be balanced out by FSCO's recommendations on the AB side. "What [FSCO] did in terms of saving costs, the most significant thing, would be the reduction of the medical rehabilitation benefit for non-catastrophic cases from \$100,000 to \$25,000 and the introduction of optional coverage," says Halpern. "So you can buy up to \$100,000 or even up to \$1 million, if you choose. But basic coverage will be \$25,000 for med rehab. That alone represents hundreds of millions of dollars in savings to the insurance industry."

Immediate prognosis

The prognosis of all of this remains unclear. IBC says it is unable to cost all of FSCO's recommendations because some of them are based on further study or discussion. Various sources have critiqued the insubstantial nature of some of the reforms as "airy fairy," "lacking in crispness" and "not immediately implementable."

Cooke is especially blunt in his assessment. "Where is this going to go?" he asks. "When you look at the report in total, there's some stuff in here that clearly reduces costs, there's some stuff

in here that clearly increases costs, there's some stuff in here that I don't know what the hell it does, but stuff that needs further study or it's fuzzy. At best, you might say it's cost-neutral. If that's the case, there's an inadequacy in existing rate levels that needs to be dealt with, and quite frankly I believe that this



product currently costs too much... It costs too much because the amount of money going toward low-end injuries, and the transaction costs associated with

managing low-end injuries, are too high. They need to be reduced."

If the end result of the whole exercise is a wash, then don't expect insurers to be rushing to the finance minister to encourage the recommendations to pass. In terms of a lobbying position, the industry is caught between a rock and a hard place — either it can either carry on with an unacceptable status quo, or it can implement future reforms that may not make a difference. Faced with the proverbial 'Sophie's Choice,' IBC has subtly suggested the best action to take in this case might be to take no action. "We have to continue to make the case that the net effect of these changes is no effect," says Forgeron. "We still have a problem, consumers still have a problem, that costs are growing much faster than premiums and costs continue to grow. If the net effect of all of this is to have no effect, the old adage 'to do nothing is to do something' very much applies here."

That would be too bad, Halpern says. "I think quite frankly that it's in the interests of the insurance industry that the minister does [act on FSCO's report]," he said. "The industry doesn't see it that way, but I think the industry is making a mistake in not coming out more in support of this comprehensive package of reform, and working with those who are interested in reform to get this thing done in a way that ensures we get better access to justice, but also that the insurers get a reasonable profit for the risks that they undertake."

The minister's office did not return phone calls requesting an interview. Two insurers who have spoken to the minister have suggested he does plan to act in June; based on these discussions, it appears the minister has some definite ideas in mind. Public notices have been put out saying the minister will seek further comment from stakeholders in May, and will make some type of decision about acting on the report in June.

Assuming he does act quickly on the file, most believe the reform package is not a strong enough remedy for a patient that is in critical care. ☹