Submission to KPMG Regarding the Automobile and Insurance Transparency and Accountability Expert Report: Interim

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July, 2014
Toronto, Ontario

The Ontario Trial Lawyers Association is responding to the recent request by KPMG to provide input regarding the Automobile and Insurance Transparency and Accountability Report (Interim) and to answer a survey which appears loosely related to same. For the reasons set out below, OTLA has significant concerns regarding the survey, the conditions which KPMG has placed on responding to the survey, and in fact, the entire Transparency and Accountability Expert Report process.

The Ontario Trial Lawyers Association (OTLA) was formed in 1991 by lawyers acting for plaintiffs. Our purpose is to promote access to justice for all Ontarians, preserve and improve the civil justice system, and advocate for the rights of those who have suffered injury and losses, while at the same time advocating aggressively for and promoting safety initiatives.

Our mandate is to fearlessly champion, through the pursuit of the highest standards of advocacy, the cause of those who have suffered injury or injustice. Our commitment to the advancement of the civil justice system is unwavering.

Our organization has over 1,500 members who are dedicated to the representation of injured plaintiffs across the province and country. OTLA is comprised of lawyers, law clerks, articling students and law students. OTLA frequently comments on legislative matters, and has appeared on numerous occasions as an intervener before the Court of Appeal for Ontario and the Supreme Court of Canada.

OTLA welcomes the opportunity to participate in a discussion concerning the regulation and structure of auto insurance in Ontario. We take issue, however, with the limited role and the conditions which KPMG put into place to circumscribe our involvement. We were first contacted by KPMG on July 7, and were required to respond within only a few weeks. Attempts to obtain a meaningful extension were rejected. Providing a very short timeframe, during summer vacation for many of our members, limits our ability to make a full and meaningful response. OTLA questions the urgency and timing of this survey. If KPMG is truly interested in our answers to the questions asked and in OTLA's opinions regarding the Transparency and Accountability Expert Report, then more time should have been granted to allow OTLA and other important stakeholders to provide more meaningful feedback regarding this Report. This approach clearly suggests that KPMG wants to be in a position to claim that it consulted with stakeholders, but in reality, has little interest in their input.

OTLA has significant concerns with the structure of the survey itself. We are disappointed that we have never been asked to provide feedback concerning the interim report. It appears that KPMG is attempting to limit stakeholder involvement with this

survey to merely commenting on how *our members* might be able to assist the insurance industry in striving to meet premium reduction goals. The language of the interim report makes it clear that KPMG worked closely with the insurance industry in the research and drafting of the Interim report. Such close co-operation is not surprising given the long-standing business relationship between KPMG, the IBC and the insurance sector generally. However, it does not appear that ANY other stakeholders were consulted during the preparation of the Interim Report, as the July 5, 2014 letter from KPMG to OTLA inviting participation in this survey specifically stated that only "senior executives of the insurance companies" were consulted prior to releasing the 2014 report. Further, the survey itself confirms that no stakeholders representing injured people were consulted prior to the release of the 2014 report. The failure to even solicit input from such key stakeholders undermines the validity and value of this process.

While the survey circulated by KPMG asks us to describe how "***our members"*** might facilitate the cost saving / premium reduction process, as noted above, OTLA's proper role is not primarily to speak for our members, but rather to promote justice for all Ontarians and to advocate for the rights of those who have suffered injury and losses. As such, our response will not focus on our membership, but will instead, in accordance with our mandate, provide a voice to accident victims who continue to see their rights compromised, contractual benefit entitlements reduced, and consequently, quality of life negatively impacted by insurance "reforms."

A key question that neither the interim report nor the KPMG survey appears to even consider, is the fundamental relationship that needs to exist between profits, premiums and protection. The report is entirely focused on profits and premiums. The interim report fails to conduct any meaningful analysis of the devastating consequences that flow from the 2010 cuts to first party accident benefits. The report fails to consider that the majority of claimants have seen their medical and rehabilitation benefits reduced by 96.5% under the new system. Families pay hard earned dollars for auto insurance in the mistaken belief that they are protecting themselves in the event of injury, not realizing the significant limits on automobile insurance coverage that exist in our present system. The all-too-frequent result is that policy holders suffer physical and emotional distress, and considerable financial hardship; yet the interim report frustratingly fails to examine the question of adequacy of protection.

OTLA notes that in previous work done for the insurance industry, KPMG purported to find that up to a billion dollars per year was being drained from the system by fraud. The IBC has argued repeatedly that the only way to purge the system of fraud it to make it so unappealing that the wrong elements will not seek to abuse it. OTLA

wholeheartedly supports the elimination of fraud from the system. Not one dollar should be paid towards a fraudulent claim. But neither the interim report nor the survey appear to consider the ramifications flowing from the KPMG/IBC position. We question why a profitability analysis lacks any meaningful discussion about, or any proposals to combat, a problem that purportedly consumes 10-15% of the auto insurance dollar. Innocent accident victims and premium-paying consumers should not be punished for the failure of the insurance industry to fight fraud in any meaningful way, nor should they be penalized for the fraudulent actions of a tiny minority.

The longstanding close relationship between KPMG, the IBC and the insurance industry leads us to our final and most significant concern relating to process; that is, the fact that as the author of the interim report, KPMG is in a clear and obvious conflict of interest. As part of the 2013 budget process, the Government announced it would be introducing,

> ***"A transparency and accountability mechanism in the form of an <u>independent</u> annual report by <u>outside experts</u> on the impact of auto insurance reforms introduced to date on both costs and premiums. The report will review industry costs and changes to premiums paid by Ontario drivers and make recommendations as to further actions that may be required to meet the government's reduction targets."*** *p. 286 The Budget Papers, 2013 Ontario Budget*

OTLA lauded this initiative as a first for Ontario, and likely Canada. We welcomed the appointment of an independent annual report by outside experts. Unfortunately, given its past close working relationship with the insurance industry, KPMG is rendered incapable of being accepted as a neutral and unbiased evaluator. KPMG's spirited attack of the Government's own GISA analysis is more indicative of an advocate for the insurance industry rather than an "independent … outside expert." It is a fundamental, oft-repeated tenet of law that "justice must not only be done, but must be seen to be done." The appointment of KPMG to act as an outside expert and advisor to the government on this file violates that fundamental principle.

Reducing Automobile Insurance Costs

In its survey, KPMG asked respondents to identify "any further actions that the Government can implement to help…reduce costs that would affect the automobile insurance product". OTLA believes that the most effective way to decrease costs is to

reduce the cost of administering accident benefits claims by implementing controls on insurer-initiated medical examinations.

Data recently released by the Insurance Bureau of Canada (IBC) from Health Claims for Auto Insurance (HCAI), for the period ending in December 2013, makes clear that the accident benefits system is too expensive to administer, particularly due to the number of unnecessary, insurer-initiated medical assessments. The oldest data available, representing accidents which occurred in the first half of 2011, provides a full 3 years of financial information about how insurers have spent premium dollars.

The most striking feature of the HCAI data is that insurers spent an average of 17% more for insurer-initiated medical examinations than they did for treatment for these accident victims. Specifically, insurers paid an average of only $4,045 for treatment, per claim while they paid an average of $4,721 for insurer-initiated examinations per claim. Insurers also ordered medical examinations for almost half of all accident victims. The total cost just for assessing this small group of accident victims was a staggering $65.6 million:

All Claimants Med / Rehab Expense Class	Accident dates January 1 - June 30, 2011 Number of Claimants	Percent of Total Claimants	Insurer Paid	Percent of Total Insurer Paid	Average Insurer Paid per Claimant
Treatment - Subtotal	*26,831*	*92.4%*	*108,528,683*	*49.9%*	*4,045*
Treatment - MIG only	6,646	22.9%	11,062,435	5.1%	1,665
Treatment - non MIG only	6,364	21.9%	47,943,780	22.0%	7,534
Treatment - MIG and non MIG	13,821	47.6%	49,522,468	22.8%	3,583
Insurer initiated exam	13,913	47.9%	65,686,521	30.2%	4,721
Provider initiated exam	12,813	44.1%	16,829,416	7.7%	1,313
Goods and supplies	6,006	20.7%	3,462,568	1.6%	577
Missed/Canceled appointment	6,929	23.9%	9,172,426	4.2%	1,324
Transportation	4,673	16.1%	9,565,560	4.4%	2,047
Others	3,164	10.9%	2,362,355	1.1%	747
Unallocated Amount	0	0.0%	2,017,051	0.9%	0
Total - All Expense Classes	29,036		217,624,580	100.0%	7,495

Treatments by Reported Injury Grouping and Accident Date: IBC HCDB Standard Report 2013 – H2

It is clear from the objective HCAI data that insurers' reliance upon these assessments has become a reflexive action. This level of reliance is one that that our accident benefits system cannot sustain. Considering that benefits were cut dramatically in September 2010 for the explicit purpose of saving money for the insurance industry and reducing premiums, it is unacceptable to permit insurers to spend such a markedly

disproportionate amount of every premium dollar on these assessments. The public was asked to accept drastic reductions in benefits in return for lower auto premiums. However, despite the huge cuts in September of 2010 that ought to have made assessments in most cases totally unnecessary, insurers have simply refused to reduce their reliance upon these assessments by choice; they continue to send almost half of all automobile claimants to insurer examinations. Changes must be made to ensure that this wasteful use of premium dollars does not continue. Once the changes are implemented to the dispute resolution system previously proposed in Bill 171, and recently re-introduced in Bill 15, insurers should not need medical assessments to deal with most claims.

OTLA proposes the following measures to curtail wasteful medical assessments:

- No insurer assessments ought to be permitted for issues that are subject to a paper review Arbitration, such as whether or not someone is in the MIG, or treatment plans under a specified amount. A paper review is sufficient under those circumstances.

- Insurer assessments should not be permitted more than once every 6 months. The assessors should be prepared to comment upon the foreseeable future so that repeated assessments become unnecessary, while maintaining the ability of insurers to provide medical reasons for denials.

- “Multi-disciplinary” assessments, where victims are subjected to multiple assessments within a short period of time, should be eliminated.

- Insurers should not be permitted to spend more than a specified maximum on assessments in a non-catastrophic claim. OTLA submits that there is no reason to spend more than 10 per cent of the available benefit amount (i.e. $5,000) on all assessments.

It should also be noted that insurers spent almost $10,000,000 on missed/cancelled appointments for this small group of accident victims. There must be a way of substantially reducing, or eliminating, these payments that add nothing whatsoever to the recovery of injured accident victims.

SPEAKING FOR ACCIDENT VICTIMS

The “Miscellanea” section of the KPMG survey seeks input from stakeholders on uncertainties in the automobile insurance system and how to mitigate, if possible, these uncertainties.

OTLA has consistently advocated for a balancing of the “3 Ps” of auto insurance – profits, premiums and protection. The interim report and the KPMG survey virtually ignore the “protection” component, while focusing only on premiums and profits. It cannot be overlooked that the Supreme Court of Canada in *Smith v. Co-operators General Insurance Co.* [2002] 2 S.C.R. 129 clearly and unequivocally stated at paragraph 11 that the objective underlying the Statutory Accident Benefits Schedule (SABS) is “consumer protection legislation”. The lack of focus on protection for consumers has created uncertainty for accident victims which must be addressed.

The dramatic cuts to the accident benefits system in September 2010 include the introduction of optional benefits which are seldom purchased by Ontarians, the Minor Injury Guideline (“MIG”), and the new cap of $50,000 for medical and rehabilitation benefits for non-catastrophically injured claimants. These changes have resulted in drastically lower payments for treatment and significantly increased financial hardship and uncertainty to injured people, many of whom do not have recourse to an adequate tort regime to compensate them for their reasonable losses. If victims are unable to work due to injury and the lack of funding for adequate medical treatment, they are only entitled to a maximum income replacement benefit of $400 per week, unless an optional benefit has been purchased for higher coverage. After the reduced medical and rehabilitation limits are exhausted, victims are then forced to pay out of pocket for all health care costs that are not covered by OHIP such as physiotherapy, occupational therapy and psychological counseling.

In this context, it must be remembered that the rights of innocent accident victims to pursue tort claims to recover their reasonable losses have been consistently eroded for decades, with no appreciable restoration of those rights since 1996. At the same time, the availability of Statutory Accident Benefits, already slashed in 2010, was further restricted by the passage of Ontario Regulation 347/13 which came into force on February 1, 2014, reversing *Henry v. Gore Mutual*, and limiting attendant care benefits for family members who provide attendant care services to injured victims. Affordable premiums should be the goal of any insurance system, but premium reductions based solely on the drastic reduction of available protection provides cold comfort to Ontarians when they are seriously injured in a car crash.

OTLA strongly believes that tremendous savings can be found by reducing the significant transactions costs that have crept into our system, eliminating uncertainty in the SABS that fuels unnecessary disputes, and reducing costs related to fraud, towing, storage, etc. that provide no benefit to injured accident victims.

i. Refining the Definition of the MIG

OTLA submits that the scope of injuries covered by the MIG must be refined to permit injured people to obtain proper treatment, and to reduce costly disputes. It is contrary to the proportionality principle to put accident victims in the position of being required to incur the cost of obtaining legal representation when there is a dispute over entitlement to a minimum treatment limit of $3,500.00.

It appears that the MIG was introduced in order to combat rogue treatment clinics, not to address the legitimate treatment needs of injured people. The definition of "minor injury" in the MIG is unduly broad and all-encompassing and, as statistics have shown, it is being applied by the insurance industry to almost 80 per cent of all persons injured in automobile accidents. The MIG was established to cover the average treatment costs for a very simple, uncomplicated whiplash-type injury. As presently worded, insurers are consistently applying the MIG to far more serious injuries, such as tendon and ligament tears, joint dislocations and even serious psychological and brain injuries. These injuries often require significant treatment and result in longer recovery times, and therefore should never have been classified as "minor".

The government needs to refine and narrow the scope of injuries that are covered by the MIG so as to:

a) better permit injured people to obtain proper treatment for their injuries; and

b) reduce uncertainty for accident victims and insurers who don't understand the MIG classification system.

If the MIG was properly re-defined, accident victims who exhaust the treatment limit under the MIG would be less likely to incur the expense of retaining legal representation to assist them in the resolution of these disputes with their first party insurer. Unfortunately, accident victims increasingly have no recourse other than to retain counsel, which not only taxes the insured's already limited financial resources

disproportionately to the amount at stake, but also unnecessarily clogs the dispute resolution system.

ii. Attendant Care

In September 2010, the Ontario government amended the SABS to require that family members providing attendant care services had to prove an economic loss before they could obtain attendant care benefits. The Ontario Court of Appeal in *Henry v. Gore Mutual Insurance Company*, confirmed that proving an economic loss was only a threshold test. If the family member met that test, they could then recover the benefit in accordance with the SABS. However, with absolutely no consultation with stakeholders who speak for accident victims, the government subsequently passed Ontario Regulation 347/13, which drastically limited attendant care benefits for family members. Now, attendant care benefits paid to family members are limited to the amount of the family member's "economic loss". These changes have brought about tremendous uncertainty and stress to accident victims and their family members during a time of crisis. Instead of the benefit being a fixed amount, set by the SABS, family members must now hire lawyers and accountants in order to attempt to prove the exact amount of their loss. The dispute that flows from this uncertainty increases the transactional costs of the system.

The Ontario government has historically recognized the importance of family members being fairly compensated for providing needed attendant care services. Not surprisingly, injured people generally prefer to receive these intimate care services, often required to be provided at odd hours, from family members. As the statutorily prescribed hourly rates in the Form 1 are substantially lower than actual market rates for attendant care services ($23 per hour for market rates versus $10.25 per hour for supervisory care under the Form 1), the only way for an injured person to receive the necessary attendant care is to rely upon friends or family members. The provision of attendant care services by family members is, therefore, something that ought to be encouraged. Regulation 347/13, which demands that family members gather evidence and witnesses to attempt to prove their economic loss, forces victims to rely upon charity from friends and family, or go without this necessary care.

This lack of attendant care services will also have a negative impact on a victim's ability to recover from his or her injuries and return to work. The additional transaction costs created for these family members in order to prove the exact amount of their economic loss adds unnecessary costs and uncertainty to the system. Family members who provide attendant care services should be compensated in accordance with the level of service they provide.

iii. The $50,000.00 Limit

OTLA submits that there is a gap in coverage that must be addressed for those accident victims who have sustained very serious injuries, but who may not meet the definition of "catastrophic impairment" as defined by the SABS. The gap also exists when it is too early under the SABS to assess their catastrophic status, while in the meantime, the non-catastrophic medical and rehabilitation limits (and likely, the attendant care non-catastrophic limits) have been exhausted.

Those accident victims who have recourse to a tort claim, where liability is not an issue, may be able to pursue an advance payment pursuant to section 256 of the *Insurance Act* or bring a motion for partial summary judgment. However, this will not be possible in the vast majority of cases.

Victims who exhaust rehabilitation funding will be unable to pursue vocational rehabilitation and thus less likely to resume productive efforts within the workforce. These victims will also claim income replacement benefits for longer than would otherwise be necessary. They will also make greater claims against at-fault drivers, thereby increasing costs to the tort system. Victims ought to be given every reasonable opportunity to increase their function and return to work, which is not currently the case under the SABS.

iv. Income Replacement Benefits

The maximum available under the SABS for income replacement benefits (IRBs) has remained static at $400 per week since 1996 – over 18 years ago. Although the formula for quantifying the IRBs changed from 80 per cent of net income to 70 per cent of gross income in 2010, the IRB for someone who is unable to work remains capped at $400 per week.

From November 1996 to today, the consumer price index has increased by 37.8% In other words, $400 in November 1996 would be equivalent to $551.20 in 2014, yet, no change has ever been made to the maximum IRB available to motor vehicle accident victims of $400 per week. In fact, this benefit is less than what a minimum wage job would currently pay in Ontario. The maximum weekly entitlement for IRBs ought to be raised from $400 to $600, a level that the benefit was originally set at in 1990. The change would go a long way to help injured persons and their families to subsist at a time of crisis, decrease uncertainty, and give people a better opportunity to improve and return to work, thereby decreasing the potentially longer term costs to the system. Further, those victims who are fairly compensated by the IRB are far less likely to initiate a tort claim, thereby reducing costs to the system.

CONCLUSION

While OTLA appreciates the opportunity to respond to the KPMG survey, insufficient time has been provided to analyze the issues and arrive at a full slate of meaningful recommendations. What has been provided in this submission is really only the tip of the iceberg. OTLA has significant concerns about a process in which a primary stakeholder – the insurance industry – is given preferential access and input into the very process that is intended to result in a neutral, outside analysis of industry practices and costs. Real and meaningful changes to the system that will contain costs, reduce premiums, and provide a fair insurance product for injured victims will only come if all key stakeholders are brought together to work collaboratively on practical and feasible solutions.

The recently released GISA figures, which are considered the 'gold standard' of insurance data reporting, are revealing. The loss ratio for all mandatory coverage is 67%, and an even lower 58% for accident benefits coverage. It is time to stop focusing on further cuts to coverage, or the "protection" aspect of the three Ps, as the way to reduce costs to the system. The long overdue anti-fraud provisions need to be implemented to eliminate, as much as possible, this wasteful and criminal aspect of our system. Huge transaction costs, primarily in the form of insurer initiated assessments, must be brought under control. Uncertainty created by constant changes to the SABS, which inevitably lead to disputes, must be reduced. And direct costs to insurers that do nothing to assist accident victims, such as towing and storage fees, must be reviewed to ensure they are fair in the current marketplace. If costs are contained in this manner, it is a win for insurers, a win for accident victims, and a win for premium-paying Ontarians.