Financial Services Commission of Ontario

Auto Insurance Regulatory Oversight

Background

The Financial Services Commission of Ontario (FSCO) is an arm's-length agency of the Ministry of Finance responsible for regulating the province's insurance sector, including auto insurance. FSCO also regulates pension plans, mortgage brokers, credit unions, caisses populaires, loan and trust companies, and co-operative corporations in Ontario.

FSCO's mandate is to provide regulatory services that protect the public interest and enhance public confidence in the regulated sectors through licensing, monitoring, and enforcement. FSCO's senior official, the Superintendent of Financial Services, is responsible for the general supervision of the regulated sectors as well as the administration and enforcement of the *Financial Services Commission of Ontario Act* and other related statutes.

The most significant piece of legislation for auto insurance is the *Insurance Act,* which establishes standards for the auto insurance industry and empowers FSCO to regulate insurer behaviour and investigate complaints about unfair practices.

FSCO's high-profile activities include ruling on applications for premium-rate changes by Ontario's 100 or so private-sector insurance companies. About 20 of these companies hold about 75% of the market. Commission rulings must ensure that the proposed premiums are justified based on factors such as an insurance company's past and expected claim costs, its operating expenses, and what would be a reasonable profit.

In addition, FSCO periodically reviews the statutory accident benefits available to people injured in automobile accidents. It provides dispute resolution services, such as mediation, to settle disagreements between insurers and injured persons about the entitlement to and amount of statutory accident benefits. FSCO also administers the Motor Vehicle Accident Claims Fund, which compensates people injured in automobile accidents when there is no insurer to cover the claim. The Fund is mainly financed by revenues from fees for drivers' licence registrations and renewals.

In the 2010/11 fiscal year, FSCO spent a total of $59 million. Expenditures for FSCO's Auto Insurance Division were approximately $14 million, with 95% of that amount going to salaries and benefits. FSCO recovers all of its costs relating to the regulation of auto insurance from insurance companies operating in Ontario.

Auto Insurance in Ontario

Ontario has about 9 million licensed drivers and 7.5 million passenger cars and trucks. In the past

10 years, the number of people killed or injured in motor vehicle accidents in the province has declined by about 25%. In 2009, the latest year for which a breakdown exists, 535 people were killed in accidents and another 61,975 were injured. Approximately 60% of injuries were minor, including sprains, strains, and minor or moderate whiplash, while 39% were moderate to major, including fractures or internal organ damage. The remaining 1%—about 800 people—suffered catastrophic injuries, such as severe brain impairment or paraplegia, or required amputation.

Auto insurance has been compulsory in Ontario since 1979. In 1990, the province introduced a mixed no-fault/tort insurance system, requiring the payment of injury and property-damage claims by the insurance company of each vehicle involved in an accident, regardless of fault. Coverage levels for different types of injuries and death claims are set out in the Statutory Accident Benefits Schedule (SABS) under the *Insurance Act*. However, people experiencing serious injuries can also sue at-fault drivers for damage in excess of SABS benefits for economic loss and/or pain and suffering.

Despite the no-fault rules, Ontario law requires insurers to assign "fault" to a driver in an accident as set out in regulations to the Act, which can lead to increases in that driver's premiums.

Ontario motorists are required to purchase insurance that includes:

- standard SABS coverage for medical benefits, attendant care, and disability income for people injured in an automobile accident as well as death and funeral benefits for those killed in an accident regardless of who was at fault;
- a minimum of $200,000 in third-party liability coverage for personal and property claims as a result of lawsuits against the insured;
- direct compensation coverage for damage to a vehicle owned by the insured caused by another driver (no fault); and
- uninsured automobile coverage to protect against injuries and damage to a vehicle caused by an uninsured motorist.

Consumers can increase their third-party liability and SABS coverage and also purchase other optional insurance, such as caregiver coverage. Additional voluntary insurance coverage for the vehicle is also available, including collision coverage for damage to vehicles and comprehensive coverage for theft, vandalism, and other perils such as fire, flood, or hail. For example, FSCO informed us that 99% of Ontario drivers in the five years ending in 2010 purchased more than the mandatory $200,000 minimum third-party liability coverage.

In the 2010 calendar year, Ontario drivers paid $9.8 billion in auto insurance premiums. The total number of claims in 2010 was approximately 584,000, with claims costs totalling $8.7 billion, broken down as follows:

- $4.5 billion in SABS benefits;
- $2 billion for third-party liability;
- $900 million in direct compensation for property damage caused by other drivers; and
- $1.3 billion for other property claims such as collision and comprehensive damage.

Audit Objective and Scope

Our audit objective was to assess whether FSCO had adequate systems and procedures in place with respect to its auto insurance responsibilities to:

- ensure compliance with relevant legislation and its own policies established to protect the public interest and to enhance public confidence in the auto insurance sector;
- administer the Motor Vehicle Accident Claims Fund in the public interest; and
- measure and report on the effectiveness of its regulatory oversight.

Prior to our fieldwork, we identified criteria to be used to address our audit objective. Senior

management at FSCO reviewed these criteria and agreed to them.

The scope of our audit included a review and analysis of FSCO's relevant files, policies, and procedures, as well as interviews with the appropriate staff. We also held discussions with, and obtained information from, a variety of organizations, including insurance companies, the Insurance Bureau of Canada (the national industry association representing some 90% of the private insurance market), and other stakeholders such as health-care providers, consumers, and lawyers with an interest in auto insurance.

We researched auto insurance regulatory legislation and operations in several other North American jurisdictions and visited the Manitoba Public Insurance Corporation, the Insurance Corporation of British Columbia, the Alberta Superintendent of Insurance, and the Alberta Automobile Insurance Rate Board to discuss their perspectives on regulating the auto insurance sector and the administration of insurance operations. We also engaged on an advisory basis the services of an independent expert with senior management experience in the insurance sector.

We also reviewed recent audit reports issued by the government's Finance and Revenue Audit Services Team related to FSCO and, as a result, we were able to reduce the scope of our examination over the Motor Vehicle Accident Claims Fund's contract with an independent claims adjuster.

Summary

The responsibility of the government includes balancing the need for a financially stable auto insurance sector with the need to ensure that consumers pay affordable and reasonable premiums and receive fair and timely benefits and compensation when they are involved in accidents. The Superintendent of Financial Services (Superintendent) is responsible for administering the legislation and regulations that the government establishes to achieve these objectives. Claims payments are the largest driver of the cost of auto insurance premiums, and with the average injury claim in Ontario of about $56,000 being five times more than the average claim in other provinces, Ontario drivers generally pay much higher premiums than other Canadian drivers do. Another reason claims costs in Ontario are higher is because Ontario's coverage provides for one of the most comprehensive and highest benefit levels in Canada.

Although the government has begun taking action to address the high cost of claims in Ontario, the following observations outline some of the challenges the Financial Services Commission of Ontario (FSCO) faces if it is to be more successful in proactively fulfilling its role of protecting the public interest and enhancing public confidence in the auto insurance industry.

- From 2005 to 2010, the total cost of injury claims under the Statutory Accident Benefits Schedule (SABS) rose 150% even though the number of injury claims in the same period increased only about 30%. Moreover, the number of injury claims in 2009, at almost 75,000, was 20% higher than the number of people reported by the Ministry of Transportation as having been injured in automobile accidents that year and FSCO had not analyzed the reasons for this significant difference.
- Between 2008 and 2009, SABS benefits payments rose 37% in the Greater Toronto Area (GTA), compared to 23% in other Ontario cities and just 14% in rural areas. According to FSCO this may be attributable in part to the concentration of plaintiff representor and health-care provider communities in the GTA. Accordingly, GTA vehicle owners pay higher premiums than motorists in other parts of Ontario.
- FSCO had not routinely obtained assurances from insurance companies—nor had it conducted any regular on-site compliance

reviews to ensure—that they have paid the proper amounts for claims or that they have handled claims judiciously. Without such assurances, the risk exists that consumers will not be treated fairly. There is also a risk that unnecessarily high claims costs could result in the need for insurers to raise premiums and may also help insurers obtain approval from FSCO for higher premium increases. FSCO has recently initiated action to address this.

- Industry estimates peg the value of auto insurance fraud in Ontario at between 10% and 15% of the value of 2010 premiums, or as much as $1.3 billion. Unlike many other provinces and American states, Ontario does not have significant measures in place to combat fraud. The government and FSCO are awaiting the recommendations of a government-appointed anti-fraud task force expected in fall 2012.
- In approving premium rates for individual insurance companies, FSCO allows insurers a reasonable rate of return, which was originally set at 12.5% in 1988, based on the benchmark long-term bond rate of 10%, and revised to 12% in 1996. However, that profit margin has not been adjusted downward since that time, even though the long-term bond rate has been about 3% for the last couple of years and is projected to remain at a relatively low level for some time. Furthermore, FSCO needs to improve its documentation supporting its premium-rate-change decisions and approvals to ensure that it can demonstrate that it treats all insurers' requests consistently and that premium-rate changes approved are just and reasonable.
- Increasing demand and restraints on resources have caused significant backlogs in FSCO's mediation services for claimants in dispute with insurers, with resolutions taking 10 to 12 months rather than the legislated 60 days. It also did not capture information that would allow it to assess the reasons why the number of applications for mediation has sharply risen—by 135% over the last five years, with about half of all injury claims ending up in mediation. Demand for mediation is highest in the GTA, where 80% of all mediation applications originate, even though the GTA accounts for just 45% of automobile accidents involving injuries.
- FSCO does not yet have any meaningful measures of its success in meeting its mandate to oversee auto insurance or of its customer service performance that could be publicly reported in its annual report and on its website.

We considered FSCO's first comprehensive review of the statutory accident benefits, which was completed in 2009, to have been a good measure to assess automobile injury claims, although we believe that such reviews should be conducted when circumstances warrant doing so rather than only at the legislated five-year frequency. As a result of the first review, the SABS was changed by the government in September 2010. FSCO advised us that it was too early to determine if the changes had mitigated the significant recent growth in the average claim cost and stabilized premiums.

Related areas that the government and FSCO needed to address include the following:

- The Motor Vehicle Accident Claims Fund had $109 million less in assets as of March 31, 2011, than it needs to satisfy the estimated lifetime costs of all claims currently in the system. This unfunded liability is expected to triple by the 2021/22 fiscal year unless the revenues are significantly increased. For instance, the government would have to double the $15 fee currently added to every driver's licence renewal to eliminate the unfunded liability.
- All provinces, including Ontario, require that insurers, rather than taxpayers, pay for the health-care-system costs of automobile-accident victims. The amount of assessment FSCO collects annually from insurers on behalf

of the Ministry of Health and Long-Term Care to cover these costs has not increased since 2006, even though health-care spending in Ontario has increased by about 25% and medically-related statutory accident benefit costs have increased by almost 120% over the same period. If Ontario's health-care assessment per registered vehicle were raised to the average of other provinces, the cost to the taxpayers of covering these health-care expenses would be reduced by more than $70 million, but such a move would likely add almost $10 to the annual insurance premium for each vehicle in Ontario.

OVERALL FSCO RESPONSE

FSCO welcomes the Auditor General's recommendations. While the effectiveness and administration of Ontario's auto insurance regulatory regime by FSCO is generally sound, the audit recommendations will strengthen the oversight of the auto insurance system.

The government has a challenging task in balancing the need for a financially stable auto insurance sector with the needs of consumers. FSCO supports the government in meeting this challenge by administering auto insurance legislation and regulations. FSCO plays an important role in ensuring that the pricing of auto insurance in Ontario remains reasonable through its rate regulation process and that individuals injured in auto accidents are treated fairly.

In 2009, FSCO completed its first comprehensive five-year review of Ontario's auto insurance system, which it presented to the government. The review assessed several systemic problems and, as a result of the first review, the government made significant regulatory changes in September 2010. FSCO continues to work on implementing a range of additional longer term projects announced by the government as part of its 2010 reforms.

Detailed Audit Observations

STATUTORY ACCIDENT BENEFITS CLAIMS COSTS

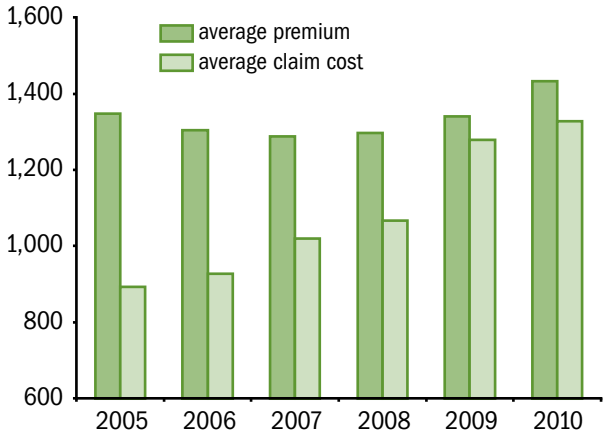
Past Reforms

Ontario's auto insurance program has undergone numerous changes since the introduction of a mixed no-fault/tort insurance system in 1990, with legislative reforms enacted in 1994, 1996, 2003, 2006, and 2010. These changes were made largely to address both the significant growth in the cost of Statutory Accident Benefits Schedule (SABS) payouts and the resulting increase in insurance premiums. In each case, however, the legislative reforms provided only temporary relief from higher premiums. As a result, we noted that Ontario's auto insurance system has a history of increasing claims costs, which insurance providers ultimately pass on to drivers through higher premiums. In our view, more timely changes could have been made and are still needed to control claims costs and premiums.

In 2003, the government amended the *Insurance Act* to require the Superintendent of Financial Services (Superintendent) to undertake a review of the effectiveness and administration of auto insurance at least every five years and make recommendations for improvement to the Minister of Finance. In 2008, FSCO undertook the first statutory five-year review, which led to a report to the Minister of Finance and to legislative changes in the SABS in September 2010. By that time, however, claims costs had already risen rapidly between 2005 and 2010, as shown in Figure 1. From 2005 to 2010, total claims costs in Ontario increased by 61%, from $5.4 billion to $8.7 billion. FSCO informed us that the primary cause for this escalating trend was increased SABS benefits costs, not the increase in the number of accident claims. Indeed, the injuries claim costs rose 150%, even though the number of injury claims increased by only 30% over the same period.

Figure 1: Ontario Average Premium and Claim Cost, 2005–2010 ($ per insured private passenger vehicle)

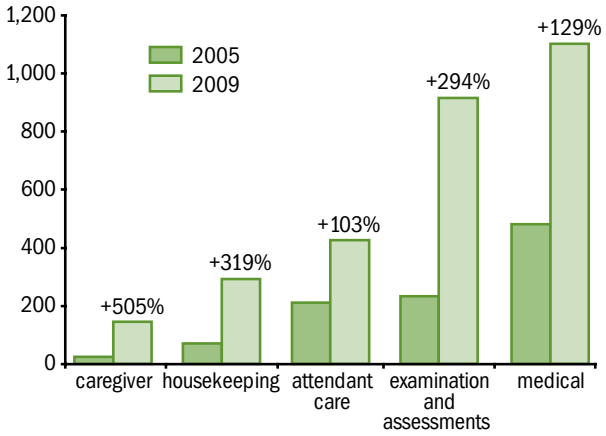
Source of data: General Insurance Statistical Agency*



* The General Insurance Statistical Agency is a not-for-profit corporation established to compile auto insurance statistics on behalf of Superintendents in provinces where there is private-insurer delivery of auto insurance. Statistics reported include private passenger vehicles and exclude commercial vehicles.

Figure 2: Increases in Ontario's Statutory Accident Benefits Costs by Type of Benefit, 2005 and 2009 ($ million)

Source of data: Financial Services Commission of Ontario



When we analyzed the $8.7 billion in total claims costs for 2010, we found that SABS benefits costs accounted for $4.5 billion, or more than half the total. That compares with 2005 SABS benefits costs of $1.8 billion, or one-third of the total. Compared to the 150% increase in the SABS portion of total claims costs between 2005 and 2010, the other claims-costs components, including third-party liability and collision, rose by a more modest 16%, to $4.2 billion from $3.6 billion.

Over the same five-year period, the average SABS benefits cost per claim rose 92%, to $56,092 from $29,189. In its statutory five-year review, FSCO identified significant cost increases of between 103% and 505% in the key benefit components of the SABS, as illustrated in Figure 2.

FSCO attributed the cost increases of SABS benefits to what it called "over-utilization," especially before the reforms of September 2010. Previously, there were few limits on treatment and assessment expenses, and those that existed were higher than needed. We were informed that providers of legal and health-care services may have benefited from the lack of properly defined limits by over-treating and over-assessing patients.

For example, the Insurance Bureau of Canada reported that as much as 30% to 40% of every dollar spent in 2007 to treat automobile-accident claimants in Ontario went to examinations and assessments by regulated health professionals prior to initiating benefits and treatment. According to FSCO, this level of assessment activity was inconsistent with that being incurred by the other provinces.

FSCO further informed us that a dramatic cost increase in SABS benefits in the Greater Toronto Area (GTA) was a major contributor to the overall increase in accident benefit costs in the province between 2008 and 2009. Over that single year, SABS benefits costs rose 37% in the GTA, compared to 23% in other Ontario cities and just 14% in rural areas. Accordingly, GTA drivers on average pay significantly higher premiums than motorists in rural Ontario.

2010 Auto Insurance Reforms

SABS benefits increase for more severe injuries. As a result, the government and FSCO need to ensure that the definitions of injuries are clear, so that insurance companies and claimants can agree on the associated benefits for the level of health care and amount of compensation to which claimants

are legally entitled. Where uncertainty exists, claimants may seek, typically with the assistance of legal professionals and health-care providers, to categorize their injuries as more severe to maximize benefits and compensation.

Following FSCO's statutory review of the SABS, which included public consultations, the government announced in November 2009 a package of 41 reforms that it said would provide more consumer choice and premium stability. The reforms would achieve these goals by controlling claims costs, responding to medical over-assessments and over-treatment of minor injuries, and simplifying the administration of the SABS, as well as making certain enhanced benefits optional at additional premiums. The reforms aimed at controlling claims costs included:

- introduction of a broader definition of minor injuries, called the interim Minor Injury Guideline, to replace the existing minor-injury guideline, called the Pre-approved Framework;
- introduction of an overall $2,000 limit on the cost of all automobile-accident-injury assessments and a $3,500 minor-injuries-benefits limit on the cost of all treatment services and assessments combined;
- lower standard medical and rehabilitation benefits for moderate to major injuries, along with lower coverage for attendant care and income replacement benefits; and
- elimination of housekeeping, home maintenance, and care-giving benefits for all but catastrophic claims.

No significant changes were made for claimants with catastrophic injuries, who continue to be eligible for a lifetime maximum of $1 million for medical treatment and rehabilitation, and another lifetime maximum of $1 million for attendant care.

Regulations to implement the new reforms took effect on September 1, 2010. At the time of our audit, FSCO and insurance industry representatives told us it was too soon to say if the reforms had been effective in limiting claims costs and stabilizing premiums. Most insurers we spoke with said it would take at least two years to determine the impact of the reforms.

However, FSCO said that it expected some of the reforms to lead to lower claims costs. For example, before 2010, under the Pre-approved Framework, only whiplash and whiplash-associated injuries were classified as minor injuries. As a result, fewer than 20% of injuries fell within this lower-cost framework. Under the new interim Minor Injury Guideline, minor injuries now include sprain, abrasion, laceration, strain, or minor whiplash. FSCO informed us that it expects 50% to 60% of all SABS benefits claims to fall under this new definition, which caps total payouts for minor injuries at $3,500.

Some insurance companies have publicly voiced concerns about claimants seeking benefits to which they are not entitled. A common insurer complaint was that some health-care providers repeatedly sought for their clients approval from the insurer for treatment plans exceeding the $3,500 limit for defined minor injuries under the interim Minor Injury Guideline. FSCO informed us that it was not surprised by this development, because it expected consumers and their representatives to test both the system and the resolve of the insurance companies.

If an insurance company suspects that a claimant's condition meets the definition of minor injuries, it can ask the claimant to undergo examination by the insurer's health-care professional. For example, one insurer said in an industry publication that it tracked approximately 500 claimants injured after the September 2010 rule changes and found that one-third of those who initially requested higher treatment benefits were placed under the $3,500 limit because an insurer-requested examination determined that their injuries met the definition of a minor injury. Another insurer reported that medical examinations undertaken at its request determined that 80% of claimants who initially sought compensation beyond the $3,500 cap were in fact not entitled to it.

FSCO informed us during our audit that it will monitor how all stakeholders, including insurers and health-care providers, apply the interim Minor Injury Guideline, and that their compliance with the new guideline is essential to lower the cost of accident benefits and ultimately stabilize premiums.

According to FSCO, consumers need a better understanding about treatment and rehabilitation options, as well as the risks of over-treatment. Although the Ministry of Finance recommended that health-care providers and insurance companies work together to improve consumer awareness and expectations regarding treatment and outcomes as part of the reforms to the SABS, no such action had been taken at the time of our audit.

FSCO also indicated that it expects to replace the interim Minor Injury Guideline in 2013 or 2014 with a more comprehensive evidence-based treatment protocol for such injuries, which will focus on more efficient and effective treatment outcomes.

Ongoing Due Diligence Claims Management

The insurance industry assesses its financial health in large part by a measure it calls the "incurred loss ratio." The ratio is determined by dividing average claims costs per vehicle by average premiums. According to FSCO, any ratio with a value higher than 80% of total claims expenses compared to total premium revenues may well result in a loss for an insurance company when other administrative and overhead costs (minus investment income) are factored in—a situation that probably cannot continue for an extended period. Ontario's incurred loss ratio has recently worsened, rising to 93% in 2010 from 66% in 2005.

In addition, according to FSCO's records, the incurred loss ratios among the top 40 Ontario automobile insurers ranged from 65% to 176% in 2010. This may indicate that some insurers are better able to manage and limit their claims costs and insurance risks than others. Indeed, several stakeholders we interviewed said that insurance companies did not always apply standard due diligence in adjusting or questioning benefit claims under the SABS.

FSCO informed us that it had expected the insurance companies to respond to its September 2010 reforms by more proactively challenging questionable claims. However, FSCO advised us that it soon identified actions by certain insurers as well as health-care providers that were inconsistent with the intent of the reforms. As a result, FSCO issued a bulletin in March 2011 reminding insurers of their responsibility to challenge questionable or inappropriate claims. According to the bulletin, FSCO was "aware that a small group of service providers and representatives were continuing to abuse the system." The bulletin goes on to say that "insurers are expected to have and use policies and procedures that comply with best practices and legislative requirements when adjusting all claims."

Following a government announcement in the March 2011 Budget, FSCO made it a strategic priority in June 2011 to assess how well insurance companies implemented the September 2010 reforms to ensure that consumers are being treated fairly and in accordance with the Act. FSCO intends in future to conduct compliance audits of insurance companies that appear higher-risk, although no dates have been set. FSCO last assessed insurance companies' compliance with the SABS benefits using a self-assessment questionnaire to all insurance companies in 2006. On the basis of the responses, it made field visits to some insurers and reported on its findings in September 2007.

Auto Insurance in Other Provinces

All Canadian provinces have laws requiring mandatory auto insurance. Three of them (British Columbia, Saskatchewan, and Manitoba) deliver insurance through government-owned insurance corporations. In Quebec, the government insures against injuries and death while private insurers cover property damage, liability, and personal injury in accidents outside the province. Private-sector insurance companies serve the remaining six

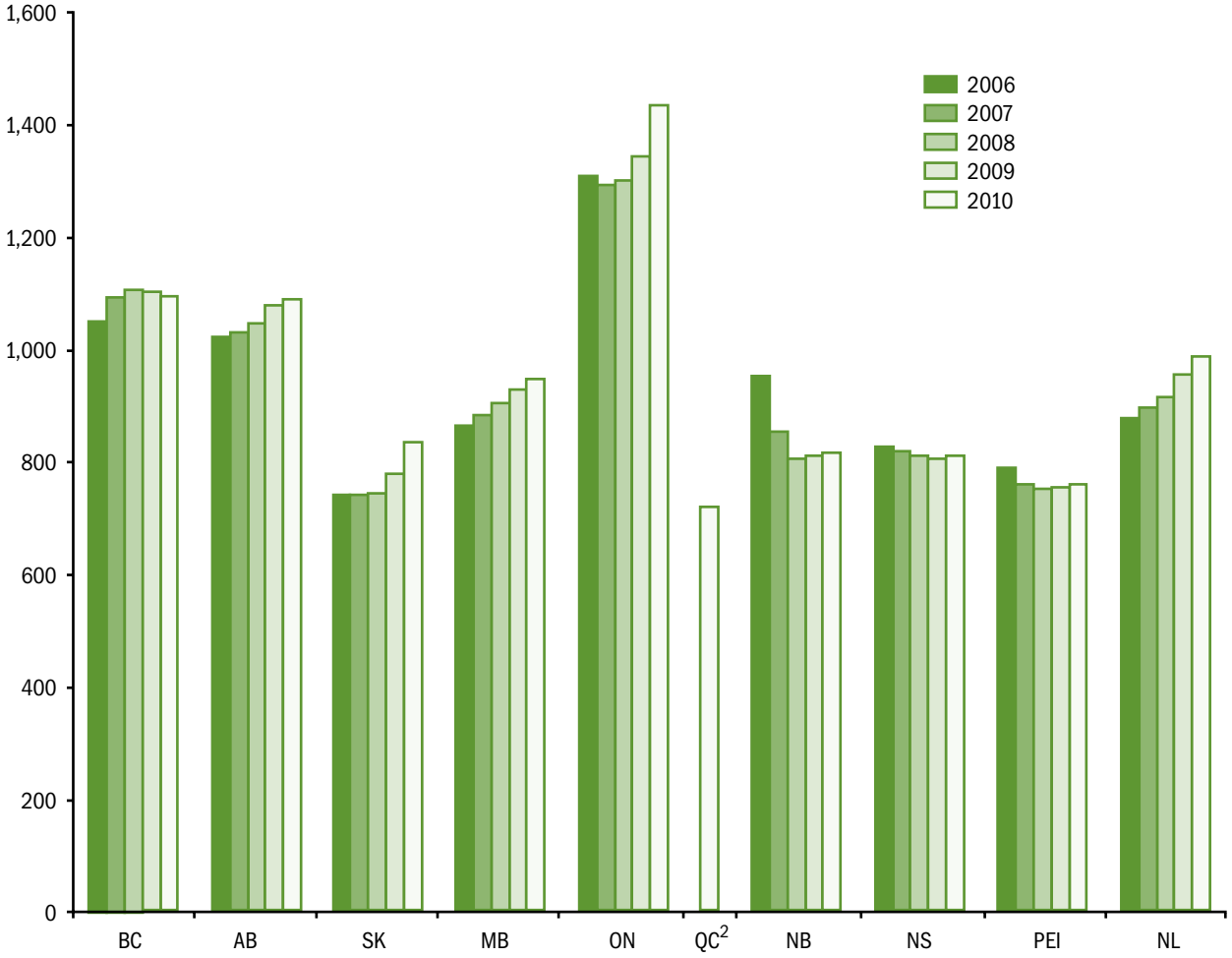
provinces, including Ontario. Manitoba, Saskatchewan, and Quebec have no-fault insurance systems. Ontario and the six other provinces have a mixed no-fault/tort system in which benefits are available to injured accident victims from their own insurer regardless of fault, and people have the right to sue responsible parties for further damages.

Although Ontario has one of the lowest per-capita rates of automobile-accident deaths and injuries in the country, it also has the highest average premium in Canada, as illustrated in Figure 3, which also shows that most other provinces generally experienced lower premium increases over the last five years—and some actually had premiums decrease. Claims costs are another key comparison because they constitute the largest cost of any auto insurance system. Figure 4 shows that Ontario has the highest average total claim cost per insured vehicle of any province.

Although health-care costs and income replacement and standard accident benefits levels vary somewhat across Canada, it could also be argued that the average benefit claim cost for automobile-accident injuries should be reasonably similar regardless of whether the comparison is made between the GTA and other cities or between Ontario and other provinces. However, although in 2005 accident benefits cost the same (about

Figure 3: Provincial Comparison of Average Premiums, 2006–2010[1] ($ per insured private passenger vehicle)

Source of data: General Insurance Statistical Agency and provincial insurance corporations

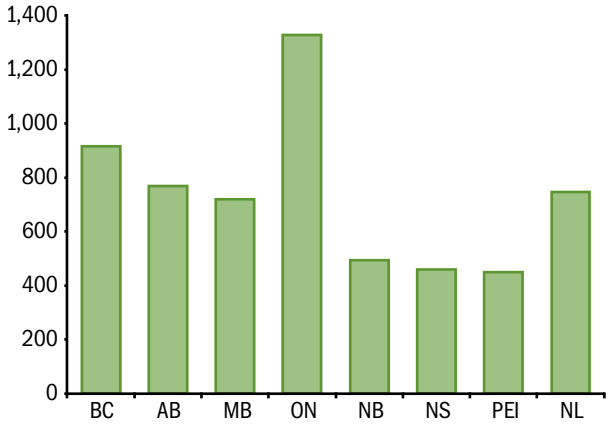


1. Differences in each province's auto insurance coverage and other factors will impact premiums. This comparison does not attempt to adjust for any of these differences.
2. Quebec not available 2006–2009.

$30,000 per claim on average) in the GTA and the rest of the province, by 2009 the GTA cost per claim had risen to $60,500—about one-third higher than the $45,900 cost per claim for the rest of the province. In addition, as Figure 5 indicates, on average Ontario's claims costs under the SABS are significantly higher than the statutory accident benefits claims costs incurred by other provinces, with most provinces paying out less than 25% of Ontario's benefits. This is at least partly due to Ontario accident benefits and the limits on payouts under the SABS, which are generally as high as or higher than most other provinces, as illustrated in Figure 6.

Figure 4: Provincial Comparison of Average Total Claim Costs, 2010*($ per insured private passenger vehicle)

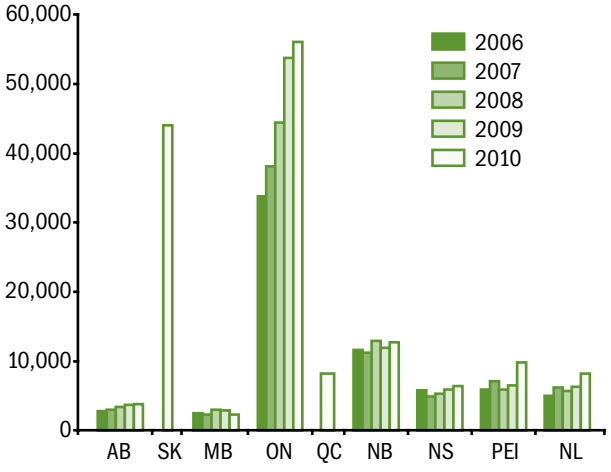
Source of data: General Insurance Statistical Agency and provincial insurance corporations



* Saskatchewan and Quebec not available.

Figure 5: Provincial Comparison of Average Costs per Claim for Statutory Accident Benefits, 2006–2010* ($)

Source of data: General Insurance Statistical Agency and provincial insurance corporations



* British Columbia not available; Saskatchewan and Quebec 2006–2009 not available.

RECOMMENDATION 1

In order to ensure that the Financial Services Commission of Ontario (FSCO) can effectively monitor Ontario's auto insurance industry, particularly claims costs and premiums, and recommend timely corrective action to the Minister of Finance when warranted, FSCO should:

- implement regular interim reviews of the Statutory Accident Benefits Schedule to monitor trends such as unexpected escalating claims costs and premiums between the legislated five-year reviews, in order to take appropriate action earlier, if warranted;
- monitor ongoing compliance with the interim Minor Injury Guideline, expedite the work to develop evidence-based treatment protocols for minor injuries, and identify and address any lack of clarity in its definitions of injuries;
- implement its plans as soon as possible to obtain assurance that insurance companies are judiciously administering accident claims in a fair and timely manner; and
- examine cost-containment strategies and benefit levels in other provinces to determine which could be applied in Ontario to control this province's relatively high claims costs and premiums.

FSCO RESPONSE

Ontario's auto insurance system is complex and FSCO agrees that the system would benefit from more frequent reviews.

In addition to the five-year review, FSCO conducts a legislated review every three years of the risk-classification and rate-determination

Figure 6: Provincial Comparison of Maximum Statutory Accident Benefits, as of June 2011 *

Source of data: Financial Services Commission of Ontario and each province's auto insurance provider or regulator

Benefit Type	Ontario Maximum Benefits with Private Insurers	Range of Maximum Benefits—Other Provinces with Private Insurers	Range of Maximum Benefits—Other Provinces with Publicly Operated Insurance
medical	$50,000 for 10 years ($1 million over lifetime for catastrophic injury)	$25,000 for four years to $50,000 for four years	$150,000 over lifetime to unlimited benefit over lifetime
attendant care	$36,000 for two years ($1 million over lifetime for catastrophic injury)	included under medical benefits	included under medical benefits to $4,142 per month with no lifetime limit
income replacement —partial disability	70% of gross income to a maximum of $400/week, maximum 104 weeks	$0 to $250/week for up to 104 weeks	between 75% of gross income (to a maximum of $300/week for 104 weeks) and 90% of net income (up to $83,000)
income replacement —full disability	partial disability payments continued for lifetime	$400/week for up to 104 weeks to $250/week continued for lifetime	partial disability payments continued for lifetime
death benefit	$25,000 to spouse and $10,000 to each dependent	spouse: $10,000–$50,000 each dependent: $1,000–$6,000	spouse: between $5,000 plus $145/week for 104 weeks and $415,000 each dependent: between $1,000 plus $35/week for 104 weeks and $54,817

* Includes lowest and highest maximum statutory accident benefits provided by the group. Only Ontario and provinces with publicly operated no-fault insurance have catastrophic injuries benefits; however, tort compensation is available in B.C. and the provinces with private insurers, as well as in Ontario.

regulations. As well, FSCO participates in a review of the adequacy of the Statutory Accident Benefits every two years. FSCO believes these three statutory reviews could be combined into one comprehensive review that takes place on a more frequent basis than every five years and will communicate this to the Ministry of Finance. As part of a more comprehensive and frequent review, FSCO would also examine cost containment strategies and benefit levels in other provinces and would provide this analysis to the government.

FSCO believes that the development of an evidence-based treatment protocol for minor injuries is an important step in ensuring that the treatment provided to individuals injured in auto accidents in Ontario reflects the current medical science. FSCO will be issuing a Request for Proposal for consulting services to develop a new treatment protocol and will be requiring that this work be completed in two years instead of the planned three-year time frame.

FSCO also recognizes the importance of making insurance companies more accountable for the administration of statutory accident benefits claims in a fair and timely manner. During the summer of 2011, FSCO introduced a new requirement that insurance companies provide CEO attestations that they have controls, procedures, and processes in place to ensure compliance with legislative requirements around the payment of such claims.

FRAUD IN AUTO INSURANCE

Ontario's Experience

It is a federal Criminal Code offence to defraud or attempt to defraud an insurance company, with conviction carrying large fines and/or a prison term

of up to 10 years. Auto insurance fraud can involve claimants in a legitimate minor accident who misrepresent the injury or damage to get higher compensation; service providers who claim for unnecessary services or for services not rendered; and staged accidents and faked injuries. According to the Insurance Bureau of Canada and FSCO, a significant amount of fraud involves false claims for physical injury and accident benefits authorized by health-care service providers.

It is impossible to give a precise figure for the value of auto insurance fraud in Ontario, but recent insurance industry estimates indicate that the problem is serious and suggest that fraud-related costs may have accounted for between 10% and 15% of auto insurance premiums in 2010, or up to $1.3 billion. Stated another way, fraud-related costs account for up to 15 cents of every dollar of premiums paid.

Another indicator of possible fraud in the system is the recent significant discrepancy in the number of injury claims reported by the General Insurance Statistical Agency compared to the number of injuries reported by the Ministry of Transportation. Over a one-year period in 2009, the number of injury claims increased 13% and the average cost of claims rose 32%, although the number of reported injuries in Ontario from automobile accidents decreased by 1%. Moreover, there were almost 75,000 injury claims filed—20% more than the 62,000 injuries from automobile accidents actually reported at the time of the accidents. Before 2009, the number of injury claims was below or slightly above the Ministry of Transportation reported injuries. FSCO has not analyzed the reason for these significant discrepancies and increases, and whether they may be partly attributable to fraud.

Our discussions with insurance industry representatives in Ontario and other provinces indicated that the problem of fraud is worse in Ontario than elsewhere in Canada, and it has been growing since the mid-1990s. Even a decade ago, the Insurance Bureau of Canada reported that Ontario had the highest fraud rate of the nine provinces that participated in a 2001 study.

Insurers and their customers are the victims through increased premiums when auto insurance fraud is perpetrated. However, the decision to investigate fraud is left to each insurer. Most, if not all, insurers as well as the Insurance Bureau of Canada have their own investigators. FSCO, on the other hand, has had a minimal role in fraud identification, investigations, and prosecutions.

If an insurance company decides to take action against someone it suspects of fraud, it may contact FSCO directly or pass information on to the Insurance Bureau of Canada for further review and analysis. The Insurance Bureau of Canada may in turn forward the case to FSCO.

FSCO's Investigations Unit, which comprises nine investigators who are primarily former police officers, is responsible for investigating all financial-services companies and individuals regulated by FSCO and not just automobile insurers. As a result, the unit's investigation of fraud against individual auto insurance companies is not its primary activity. FSCO relies on the Insurance Bureau of Canada or insurance companies to provide the information and evidence necessary to launch an auto insurance fraud investigation and win a successful conviction. FSCO itself has no jurisdictional authority to prosecute fraud under the Criminal Code; that authority belongs to the Ministry of the Attorney General. FSCO does have the authority under the *Insurance Act* to prosecute provincial offences such as health-care fraud in the auto insurance sector through the *Provincial Offences Act*. It may take action on any of the following offences:

- charging for services not provided;
- charging, paying, and/or accepting referral fees; and
- making a false or misleading statement to an insurer in order to obtain payment for goods and services.

Fines range from a maximum $100,000 on a first conviction to a maximum $200,000 for subsequent convictions. FSCO investigators have limited

ability to collect information from a health-care professional or clinic owner. Therefore, FSCO relies on insurance companies to provide the evidence that is needed to prosecute. In contrast, FSCO has significant authority over insurance companies, which are required by law to furnish FSCO with full information. FSCO advised us that because the burden of proof is high and its investigative powers are limited, its chances of winning a prosecution against a clinic owner are relatively low.

We noted that despite the recent increase in public awareness of health-care fraud, there has been no increase in the number of cases being forwarded to FSCO. FSCO received 16 complaints against health-care professionals and clinic owners between 2008 and the first half of 2011 but had obtained convictions only against three health-care clinic owners between 2007 and 2010, resulting in fines totalling $202,000.

More recently, insurance companies have begun to deal with fraud in civil rather than criminal court. In 2010, several insurers sued selected health clinics over alleged fraud related to auto insurance claims. One insurance company alleged it paid out at least $1.2 million to three clinics owned by the same individual for medical services that were never provided. Other legal action alleged that invoices were submitted from health-care clinics totalling over $1 million for treatment allegedly provided by persons who did not work at the clinic or who had left prior to the treatment being billed. At the time of our audits, these suits, some seeking restitution for several million dollars, were still pending.

Anti-fraud Measures outside Ontario

The Insurance Bureau of Canada issued a report in February 2011 on "Preventing Auto Insurance Fraud in Ontario" to the Ontario Minister of Finance. In it, the Insurance Bureau concluded that fraud is a "serious" problem in Ontario and recommended several measures to help address the issue and reduce claims costs. We noted that the majority of these recommendations reflected actions taken by U.S. jurisdictions over the past decade to curb fraud. The recommendations included:

- establishment of a bureau of insurance fraud investigations and prosecutions under the *Insurance Act* that would be administered by FSCO;
- increased criminal and civil penalties for fraud;
- civil immunity for persons or organizations reporting suspicious activity;
- mandatory notification of health-care fraud convictions to relevant professional colleges and the Ministry of Health and Long-Term Care;
- creation of a joint Ontario government-insurance industry fund to finance fraud investigations and prosecutions, and to provide cash rewards to people providing information leading to a conviction of insurance fraud;
- mandatory criminal background checks for any director, officer, or owner of an independent health clinic before granting a license to operate; and
- establishment of a public-education campaign on insurance fraud.

All 50 U.S. states have enacted laws defining insurance fraud as a specific crime, and 41 have established Insurance Fraud Bureaus. Insurers in these jurisdictions must comply with fraud-reporting requirements before regulators will consider their applications for premium increases. Twenty states require insurers to forward all suspicious claims to a state Insurance Fraud Bureau. Other anti-fraud measures taken by one or more U.S. states include:

- rewards of up to $25,000 for information about fraudulent acts;
- public education and advertising campaigns such as Virginia's fraud awareness website **www.stampoutfraud.com** and Pennsylvania's **www.helpstopfraud.org**.
- a requirement that accident reports list all passengers involved in an accident and not just the driver; and

- withholding benefits from anyone convicted of insurance fraud.

We found in our discussions with two government-operated insurance corporations in other provinces that their monopoly offered several distinct advantages in the fight against fraud, including:

- their ability to publish an annual top-10 list of auto insurance frauds in their province;
- operation of a special unit composed of former police officers to investigate alleged fraudulent claims, along with funding for Crown prosecutors dedicated to handling insurance fraud; and
- employment of extensive data-mining techniques and fraud analytics of claims data to identify potential fraud. Each corporation maintains a central database of all claims in the province, making it possible to identify unusual claims or trends that require further investigation.

FSCO, by contrast, is a regulator rather than an insurer and thus has no first-hand knowledge of auto insurance fraud in this province. Information about the occurrence and extent of fraud in the auto insurance sector is proprietary information belonging to insurance companies. Insurers in Ontario have historically been reluctant to acknowledge publicly any incidences of fraud, or to share this information with government organizations, including FSCO. Most of the recommendations in the Insurance Bureau of Canada's report are beyond FSCO's ability to implement without government approval. In its 2011 Budget, the government announced measures to address auto insurance fraud. One measure included the establishment of an auto insurance anti-fraud task force. Task-force members were appointed in July 2011 with a deadline to issue a final report with recommendations by fall 2012. In addition, the government announced the recently-created Health Claims for Auto Insurance (HCAI) system will be used to detect potential fraud. FSCO and insurance companies established HCAI on February 1, 2011, an online database and billing portal requiring health-care providers to submit billings for injury claims centrally before they are forwarded to insurers for payment.

RECOMMENDATION 2

To reduce the number of fraudulent claims in Ontario's auto insurance industry and thereby protect the public from unduly high insurance premiums, the Financial Services Commission of Ontario (FSCO) should use its regulatory and oversight powers to:

- help identify potential measures to combat fraud, including those recommended by the Insurance Bureau of Canada and those in effect in other jurisdictions, assess their applicability and relevance to Ontario, and, when appropriate, provide advice and assistance to the government for their timely implementation; and
- ensure development as soon as possible of an overall anti-fraud strategy that spells out the roles and responsibilities of all stakeholders—the government, FSCO, and insurance companies—in combatting auto insurance fraud.

FSCO RESPONSE

FSCO shares the Auditor General's concerns about fraudulent auto insurance claims. The Ministry of Finance's Auto Insurance Anti-Fraud Task Force will identify measures to combat fraud. FSCO supports and is working with the Task Force's steering committee and working groups. FSCO will implement any changes in regulatory responsibilities arising from the Task Force's recommendations.

RATES FILINGS AND APPROVALS

All automobile insurers are required under the *Insurance Act* and the *Auto Insurance Rate Stabilization Act* to obtain approval from FSCO's Superintendent

of Financial Services for the premiums they charge and for any changes to the authorized rates. The Superintendent is required to reject any application where rates:

- are not just and reasonable in the circumstances; or
- would impair the financial solvency of the insurer; or
- are excessive in relation to the financial circumstances of the insurer.

Proposed premium rate changes by insurers are ultimately a business decision based on factors that include past and anticipated claims costs, operating costs, and profit levels. Insurance companies are not required to submit rate applications at any specific interval; instead, they submit when they determine that an adjustment, increase, or decrease is appropriate. The main type of filing, a major filing for private passenger auto insurance, must be certified by a qualified actuary, a business professional who uses mathematics to provide expert assessments of the financial impact of risk and uncertainty as it relates to insurance premiums, expected claims, and reserves.

Approval of Rates

In order to determine whether the proposed rate is justified, FSCO conducts its own actuarial reviews using benchmark assumptions. FSCO informed us that, in so doing, it recognizes that actuaries use a degree of acceptable professional judgment in determining assumptions in their assessments and may come to different conclusions. FSCO also considers other factors, such as the actuaries' assumptions that cause differences, rate stability for consumers, and the actual rates charged in the market compared to other insurers, in determining whether the proposed rate is justified and reasonable. As a result, FSCO may approve an insurer's proposed rate increase even if it is up to three percentage points higher than FSCO's calculated rate. During the audit, we noted that this practice of permitting a three-percentage-point margin was not documented in FSCO's filing policies, although it subsequently added this practice to its rates approval policies when we brought this to FSCO staff's attention.

Between 2006 and 2010, FSCO reviewed and approved 293 major filings, as follows:

- approval of the full request in 65% of filings submitted by automobile insurers;
- approval of a lower-than-requested rate in 25% of filings; and
- approval of a higher-than-initially-requested rate in 10% of filings.

It is important that FSCO be consistent in its granting of approvals; otherwise, it may provide a competitive advantage to one insurer over another or may be seen as providing unequal treatment to companies and consumers. It is also important, particularly when FSCO's conclusions are significantly different from those of the insurers' actuaries, that FSCO clearly document the rationale for its decisions in order to demonstrate fairness and consistency. We noted that for approvals granted for a lower-than-requested rate, in some instances the rate approved still exceeded FSCO's calculated rate by more than 3% and the reasons for the approvals were not adequately documented. In one case, the file did not clearly indicate why an insurer received permission for an increase that was eight percentage points higher than indicated by FSCO's own actuarial determination. In this case, we estimate that the additional percentage increase allowed could result in additional annual premium income of $25 million for the insurer.

In the cases where FSCO authorized a higher-than-initially-requested rate, we also generally found inadequate documentation to justify FSCO's decision to grant a higher-than-initially-requested increase. For example, we were informed that FSCO approved a rate higher than initially proposed by an insurer on grounds that the insurer had or could have financial solvency issues, and it was important to protect the company's clients over the long term by granting a higher premium than had initially been requested. However, we noted that FSCO

requested the insurer to increase its rates even though there were no financial solvency concerns identified by the Office of the Superintendent of Financial Institutions, a federal regulator. The insurer agreed to the request. FSCO had no formal policy on approving the rates of companies with financial solvency concerns or on providing guidance on if and when companies should be asked to resubmit their filings for a higher rate increase than initially requested.

We acknowledge, however, that according to FSCO, no auto insurance companies operating in Ontario have declared bankruptcy since 2002 or defaulted for financial reasons on their claims payouts.

Review of the Profit Provision

When determining whether to approve a rate filing, FSCO conducts its assessment by factoring in a reasonable profit for the insurance company based on a 12% return on equity (ROE). A study conducted in 1988 set the ROE at 12.5% based on its relationship to the long-term Canada Bond rate, which was 10% at the time. The ROE was last changed to 12% in 1996, and we were advised that FSCO has not since conducted a comprehensive review of what it considers a reasonable profit for insurance companies operating in Ontario. Given that long-term Canada Bond interest rates were substantially lower at the time of our audit, standing at about 3%, have been low for some time, and are forecasted to stay low for some time, the current 12% ROE could be higher than appropriate, assuming that FSCO still considers the long-term bond rate to be an appropriate benchmark. In any case, given that it has been 15 years since the 12% ROE was established, we believe that a reassessment is long overdue.

Approved Premium Rate Implementation

To inform consumers of approved premium rate changes, FSCO publicly reports on a quarterly basis all insurers' rate filing approvals, listing the overall average percentage rate change to the authorized rates. Consumers renewing their auto insurance at the same time might attempt to compare their actual rate change to their insurer's approved rate change as published by FSCO, but it is unlikely that the overall average approved rate change would be exactly the same because premiums also reflect such variables as the claims experience of the group classification and location. As a result, consumers are unsure if the new rate they are paying is in keeping with that insurer's overall rate approval.

Consumers can complain to FSCO if they are paying an incorrect rate, and FSCO will follow up with a review of the complaint and the approved rates on file. An investigation will take place where warranted. FSCO informed us that between the 2005/06 and 2009/10 fiscal years, only five of the 22 incorrect rate application cases that it investigated were initiated by the public and other sources, while the remaining 17 were self-reported by insurers. We were advised that when FSCO establishes that there has been an error, it follows up to ensure that the consumer has received a refund and any applicable interest, and may conduct an on-site review of the insurer to assess procedures and the accuracy of approved rates.

In the four-year period from 2005/06 through 2009/10, FSCO levied four fines against insurance companies totalling approximately $250,000 for rate errors. Such errors can have a significant financial impact on consumers—we noted examples of overbilling that totalled between $1 million and $11 million.

For all rate approvals, FSCO requires insurers to update their rate manuals and provide FSCO with a certificate signed by a senior officer attesting that they will charge the approved rates and change their information systems accordingly. However, FSCO did not have any procedures for periodically checking that insurers were charging the approved rates. FSCO had not considered the option of requiring insurance companies to provide attestations from third parties, such as their auditors, that the approved rates were actually being applied correctly.

RECOMMENDATION 3

To ensure that the Financial Services Commission of Ontario (FSCO) fairly and consistently authorizes auto insurance company premium rate changes while protecting consumers, FSCO should:

- update and document its policies and procedures for making rate decisions—particularly for applications that differ from its own assessments—and for properly assessing rate changes in light of actual financial solvency concerns of insurance companies;
- review what constitutes a reasonable profit margin for insurance companies when approving rate changes, and periodically revise its current assessment to reflect significant changes; and
- establish processes for verifying or obtaining assurance that insurers actually charge only the authorized rates.

FSCO RESPONSE

FSCO operates one of the most robust premium rate approval processes in North America and fully supports further strengthening of its process. In particular, FSCO acknowledges the need to update policies and procedures to support decisions regarding rate filings.

As part of deciding if rates are "just and reasonable," FSCO determines whether the rate charged is adequate to cover all claims costs and expenses. In addition, case law requires a balancing of interests in the interpretation of "just and reasonable."

Last year, FSCO also identified the need to complete a review of an appropriate profit provision. It will finalize the process and retain a consultant to provide expert analysis on this issue.

FSCO ensures that consumers are issued refunds where an insurer has charged the incorrect rate. FSCO plans to enhance its current processes for verifying or obtaining assurances from insurers that they are charging only authorized rates.

DISPUTE RESOLUTION SERVICES

According to FSCO, the mandate of its Dispute Resolution Services Branch is to provide a fair, timely, accessible, and cost-effective process for resolving claimant disputes with insurers involving the entitlement to and/or the amount of statutory accident benefits. Common examples of disputes mediated include those in which applicants seek greater medical benefits, higher income-replacement compensation, more in housekeeping and/or home-maintenance costs, or attendant care benefits.

Mediation through FSCO is a legislated mandatory first step under the *Insurance Act*, and neither party can proceed to FSCO's arbitration process or court unless mediation occurs first. Mediation services are free for consumers, but the insurance companies pay $500 for each hearing.

The *Insurance Act* requires that mediation be completed within 60 days of the filing of the application unless both parties agree to an extension. FSCO's internal service standards require that a mediation application be assigned to a mediator within three weeks of receipt and that a mediator file within seven days following the mediation process a report that lists issues settled and any that remain in dispute. These services are intended to help insurance companies and claimants resolve disputes quickly and cost-effectively and to ensure that entitled claimants receive any medical benefits and compensation owing within a reasonable time.

We found that FSCO was unable to meet its service standards due to the large volumes of mediation applications filed and its limited staff resources. In the 2010/11 fiscal year, no mediations were completed within 60 days of filing, and most applications were dealt with between 10 and 12 months after the date of filing. It also took approximately 15 weeks—instead of three—to assign an application to a mediator. However, once the mediation process was completed, the mediators met the requirement of issuing a report within seven days in 95% of cases.

FSCO attributed the delays to the dramatic increase in mediation applications over the last five fiscal years. Figure 7 shows that the number of mediation case hearings increased by 135% during this period, while the number of mediation applications pending increased by 645%. FSCO informed us that it expected the mediation backlog would continue to increase, because it was projecting more than 36,000 new applications in the 20011/12 fiscal year, up 18% from 2010/11.

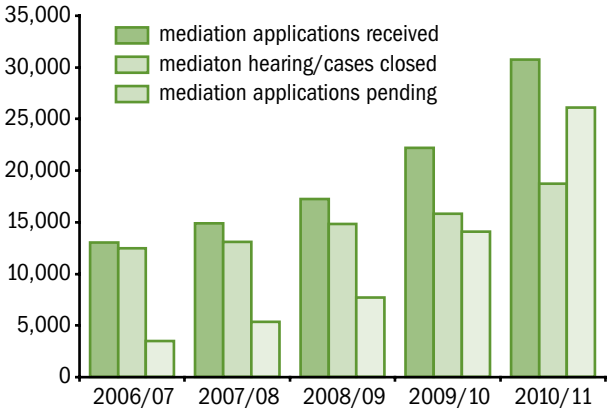
FSCO has implemented measures over the last five years to improve its productivity and help address the growing backlog of mediation applications, and it is now completing 50% more cases with no staff increases. In addition, changes to the regulations under the Act imposed a new requirement in September 2010 stipulating that an applicant may not file for mediation if he or she failed to attend an insurer's medical assessment (40% of applicants have historically failed to attend such assessments).

At the end of our fieldwork, FSCO informed us that it was seeking approval to hire external mediation service providers to supplement its own workforce and help address the existing and anticipated backlog caused by government hiring restrictions which do not allow it to take on more staff.

The current rate of injury claims that result in mediation stands at about 50% of all claims. We believe that this high rate could indicate significant dissatisfaction by claimants with the handling of claims by insurers and/or lack of clarity from FSCO in the guidance and manner in which statutory accident benefits are administered. It could also suggest, in part, that a burgeoning industry providing legal consulting services to claimants is encouraging them to challenge insurers for increased benefits and compensation through the mediation process. This may be the case particularly in the Greater Toronto Area, where about 80% of all mediation applications originate, even though only 45% of automobile accidents involving injuries occur in the GTA.

Figure 7: Growth in Mediation Applications, 2006/07–2010/11

Source of data: Financial Services Commission of Ontario



FSCO and the insurance companies we spoke to cited several factors they said led to the increasing demand for mediation, including over-utilization of benefits, the impact of recent legislative changes, people seeking more compensation during tough economic times, and the fact that 99% of claimants who dispute their insurer's decision about their claim use a legal service and seek monetary settlements instead of health-care and support benefits. It is also possible that insurance companies are being tougher in assessing claims as they respond to their growing incurred loss ratios and declining revenues from interest-bearing investments during this recent economic downturn, and to pressure from FSCO on insurers to fight fraud.

The actual reasons for the higher number of mediation cases cannot be determined from the information FSCO captures. Although FSCO captures mediation details in individual reports, there is no attempt to evaluate and summarize this information because it is considered to be confidential. Therefore, FSCO does not regularly assess the nature of the disputes, the initial positions of the parties, the details of solutions to resolved matters, and the details of those that were not resolved. This information would help FSCO identify matters of frequent dispute and systemic issues.

We found that FSCO tracks the disputed issues at mediation only by benefit type. From 2006 to

2010, FSCO's records indicated that the top issues in dispute were medical benefits, cost of examinations, housekeeping and/or home maintenance, attendant care, and income replacement. However, this information is not sufficiently detailed to permit an investigation of the root causes of cases that go to mediation. We were advised that FSCO consulted with its mediators on possible improvements to the system, policies, and guidelines to reduce backlogs in 2007 and 2009, but no regular process existed at the time of our audit to obtain mediators' opinions on possible systemic problems and possible improvements and clarifications to SABS guidelines and policies to reduce the demand for mediation.

RECOMMENDATION 4

To ensure that the Financial Services Commission of Ontario meets its mandate to provide fair, timely, accessible, and cost-effective processes for resolving disputes over statutory accident benefits, it should:

- improve its information-gathering to help explain why almost half of all injury claimants seek mediation, as well as how disputes are resolved, and to identify possible systemic problems with its SABS benefits policies that can be changed or clarified to help prevent disputes; and
- establish an action plan and timetable for reducing its current and growing backlog to a point where it can provide mediation services in a timely manner in accordance with legislation and established service standards.

FSCO RESPONSE

FSCO captures information about disputes submitted for mediation, collects aggregate statistical information, and compiles reports on profiles of applications received, types of benefits mediated, workload analysis, processing time, and whether mediation fully or partially settled disputes, or failed to settle them. FSCO will look at additional data collection that might assist in identifying ways to reduce the high demand for dispute resolution services.

FSCO has implemented a number of measures and initiatives that have increased productivity and has managed to close 50% more files during the last five years. Since completion of the audit field work, additional initiatives have been developed and will be implemented through the fall and winter. FSCO has engaged the Ministry of Finance in developing an action plan to address the backlog.

PERFORMANCE MEASURES

In its annual business plan submitted to the Minister of Finance, FSCO established three performance measures for its regulatory responsibilities over the auto insurance industry, as follows:

- average number of days taken to approve private automobile premium-rate applications, compared to its target of 45 days;
- percentage of mediation reports completed within seven days of conclusion of mediation, compared to its target of 94%; and
- weighted ratio of administrative costs to dollars paid out of the Motor Vehicle Accident Claims Fund, compared to its target of 28%.

In the five fiscal years ending in 2010/11, FSCO generally met these publicly stated targets. However, in our view, these targets do not report on its success in protecting the public interest with respect to auto insurance or provide useful insight into its regulatory oversight responsibilities and activities. As well, there are no performance targets regarding the financial health of insurance companies. In particular, the targets include no benchmarking of the cost-effectiveness of auto insurance in Ontario. In addition, the target established for mediation services does not reflect the overall timeliness of service levels. As discussed in a previous section, FSCO generally meets the seven-day

target for issuing a report following a mediation. However, it is of greater importance to consumers to note that FSCO takes between 10 to 12 months to complete a mediation hearing once an application has been received, instead of the legislated requirement of 60 days.

The *Financial Services Commission of Ontario Act* requires FSCO to file its annual report within a reasonable time after the close of each fiscal year to the Minister, who then tables it in the Legislative Assembly. As of July 2011, however, FSCO's annual report for the year ending March 31, 2010, had not been tabled by the Minister of Finance and thus had not been made public. We also noted that FSCO does not report publicly on its performance. For example, it does not make public its annual business plan, and its latest annual report does not include objective and outcome-based performance measures, targets, or details about its accomplishments in meeting stated goals and targets.

We did note, however, that FSCO does make public its Statement of Priorities as required under the *Financial Services Commission of Ontario Act*. In it, FSCO sets out its proposed priorities and initiatives to meet changing economic and marketplace conditions in the coming year as well as its accomplishments from the previous year.

RECOMMENDATION 5

In order to provide the public, consumers, stakeholders, and insurers with meaningful information on its auto insurance oversight and regulatory activities, the Financial Services Commission of Ontario should report timely information on its performance, including outcome-based measures and targets that more appropriately represent its key regulatory activities and results.

FSCO RESPONSE

FSCO agrees that the public, consumers, and stakeholders should be provided with more meaningful information on its performance in the oversight of the auto insurance system. In its 2011 Statement of Priorities, published in June 2011, FSCO indicated that it will develop improved performance measures and establish standards against which it can be judged in all of the sectors it regulates. The existing measures will be reviewed and updated.

MOTOR VEHICLE ACCIDENT CLAIMS FUND UNFUNDED LIABILITY

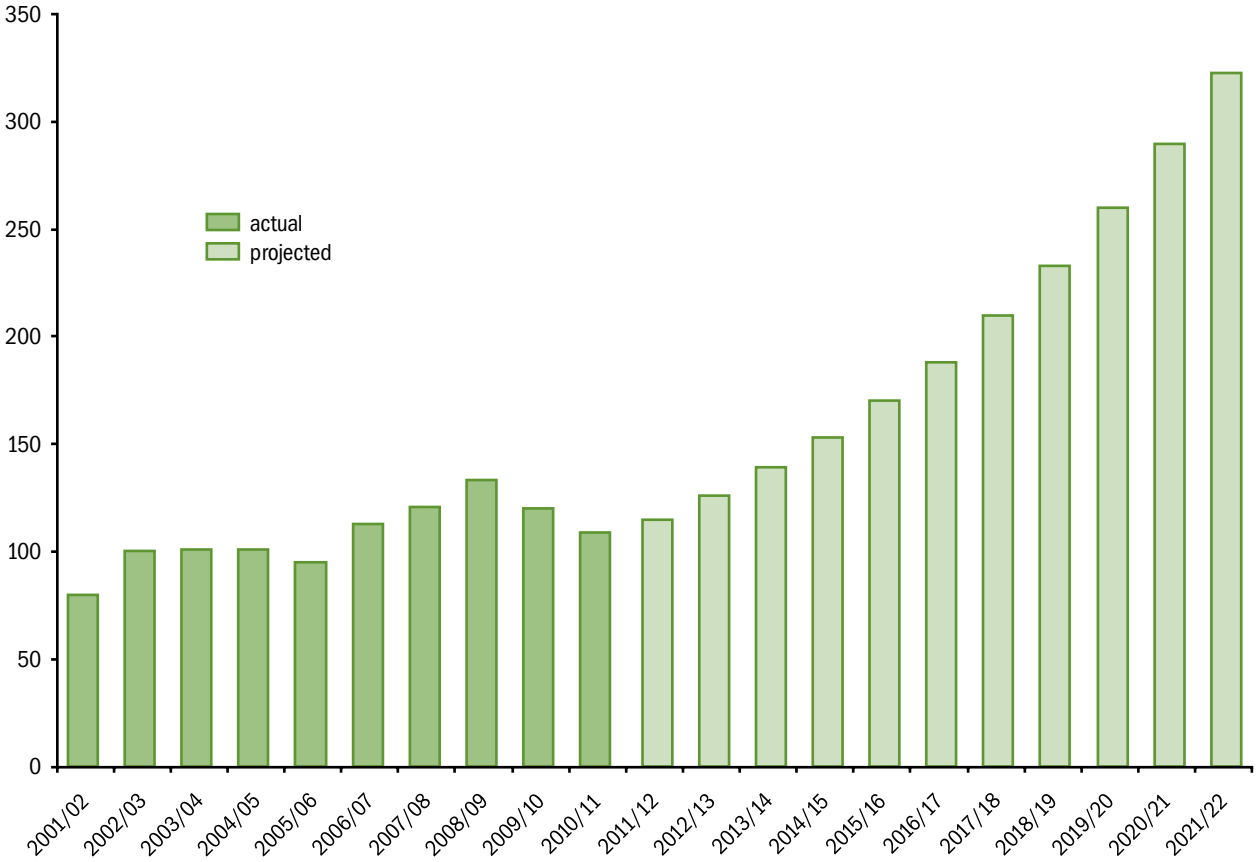
The Motor Vehicle Accident Claims Fund (Fund) is generally considered the "payer of last resort." It compensates victims of automobile accidents caused by uninsured motorists, drivers of stolen vehicles, or hit-and-run drivers, when no other automobile or liability insurance is available to pay a claim. Victims can apply to the Fund, which pays statutory accident benefits and any tort judgments. The Fund operates under the authority of the *Motor Vehicle Accident Claims Act* and is administered by FSCO. The Fund also contracts with an independent adjuster to investigate claims and handle statutory accident benefit claims payments. Payments by the Fund rose from $17.9 million for 553 claims in the 2006/07 fiscal year to $21 million for 585 claims in 2010/11.

According to FSCO's consulting actuary, as of March 31, 2011, the Fund's assets were substantially less than what is needed to satisfy the estimated lifetime costs of all claims currently in the system, resulting in an unfunded liability. As Figure 8 indicates, the Fund's unfunded liability was $109 million as of March 31, 2011, but FSCO forecasts that it will grow to $323 million by the 2021/22 fiscal year unless the Fund receives significant additional revenue.

The Fund is supported primarily by a fee on the issuance or renewal of each Ontario driver's licence, which works out to be $15 paid every five years. In 2010/11, the Fund received $28.7 million in fees.

Figure 8: Motor Vehicle Accident Claims Fund Actual and Projected Unfunded Liability, 2000/01–2021/22 ($ million)

Source of data: Financial Services Commission of Ontario



The fee was last increased in September 2004 by $10 on a driver's licence five-year renewal. Our discussion with management noted that there is no plan or timetable in place to eliminate the unfunded liability in a reasonable amount of time. We estimate that the Fund would need an additional $30 million per year—that is, double the current annual fee revenue—for the next 10 years to eliminate the existing and projected unfunded liability. This could require FSCO to seek Ministry of Finance approval for doubling the current $15 driver's licence renewal fee.

RECOMMENDATION 6

To ensure that the Motor Vehicle Accident Claims Fund (Fund) is sustainable over the long term and able to meet its future financial obligations, the Financial Services Commission of Ontario should establish a strategy and timetable for eliminating the Fund's growing unfunded liability over a reasonable time period and seek government approval to implement this plan.

FSCO RESPONSE

We acknowledge the Auditor General's findings regarding the unfunded liability of the Motor Vehicle Accident Claims Fund (Fund). FSCO's current 10-year projections suggest that the current positive cash balance should adequately provide for the Fund's statutory payment obligations to claimants for at least the next eight years through to the 2019/2020 fiscal year. Cash flow studies are done annually and the next

one will be done in August 2012 to re-assess the 10-year cash flow projections.

In the past, the government has taken appropriate and timely steps to address the Fund's needs. FSCO will continue its regular engagement with the Ministry of Finance on the Fund's evolving financial status to ensure that statutory payment obligations to Fund claimants are met.

OTHER MATTER

Assessment of Health-system Costs

The *Insurance Act* was amended in 1996 to require all automobile insurers operating in Ontario to pay an annual "assessment of health-system costs" to recover the costs to the province of providing medical care to people injured through someone else's fault. The government of the day initially set the assessment at about $80 million a year for the entire industry to help defray costs incurred by the Ministry of Health and Long-Term Care that ought to be paid by insurers. FSCO is responsible for collecting the assessment from insurers, with each insurer paying a pro-rated share of the total.

In 2005, our audit of the recovery of health costs resulting from accidents led us to conclude that the Ministries of Health and Finance did not have satisfactory policies and procedures in place to monitor the adequacy of the initial $80-million annual assessment. Subsequently, the government increased the annual assessment in September 2006 to about $142 million.

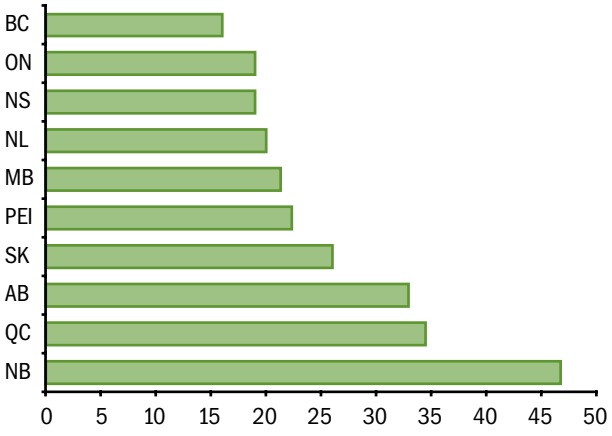
The Health and Finance Ministries reported in our 2007 follow-up that they had established a joint working group that year to conduct further analysis to ensure that future assessment amounts adequately cover the cost of health care provided to individuals injured in automobile accidents. The ministries also said at the time that it would take some time to develop the appropriate mechanism. However, the Ministry of Finance informed us that no progress had been made in this area as of July 2011 and that the government was not considering any increase in the assessment.

We also noted that overall health-care spending by the Ministry of Health and Long-Term Care has increased by about 25% since the assessment was last adjusted in the 2006/07 fiscal year. In addition, medically-related SABS benefits costs have increased by almost 120% over the same period, although some of the medical costs, such as physiotherapy and massage therapy, may be unrelated since they may not normally be covered by the Ministry of Health and Long-Term Care.

We compared Ontario's assessment of health-system costs to those of other jurisdictions and found that Ontario's is among the lowest in Canada when measured on a per-registered-vehicle basis, as illustrated in Figure 9. If Ontario's assessment per registered vehicle were raised to the average of other provinces, the assessment would increase by 50%, or about $70 million, to $214 million. Assuming that the insurance industry was successful in passing this cost on to vehicle owners, this change would likely add almost $10 to the insurance premium for each vehicle in Ontario.

Figure 9: Provincial Comparison of Assessments of Health-system Costs on Auto Insurance Industry, 2011 ($ per registered vehicle)

Source of data: Office of the Auditor General of Ontario, provincial finance ministries, and Public Accounts



RECOMMENDATION 7

In view of the fact that it has been five years since the last review of the assessment of health-system costs owed by the auto insurance sector despite the significant increase in health-care costs related to automobile accidents over the same period, the Financial Services Commission of Ontario should work with the Ministry of Finance, the Ministry of Health and Long-Term Care, and the insurance industry to review the adequacy of the current assessment amount.

FSCO RESPONSE

FSCO agrees with the Auditor General's recommendation that health-care assessments paid to the government by auto insurance companies would benefit from more regular review. The responsibility for initiating the review rests with the government. FSCO will ensure that the Ministry of Finance is aware of the auditor's recommendation and will support the Ministry of Finance in any future review as requested.