Aviva Canada Response to the Ontario Automobile Insurance Dispute Resolution System Review - Interim Report

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Aviva Canada Inc. ("Aviva") appreciates the opportunity to provide comments and recommendations on the Ontario Automobile Insurance Dispute Resolution System Review- Interim Report dated October 2013. The purpose of the Interim Report was to consider whether mediation should remain mandatory for Ontario auto insurance disputes, and how best to deliver auto insurance dispute resolution in Ontario- through government, the private sector or a combination of both. We commend Justice Cunningham, Mr. Murray Segal and Mr. Willie Handler for delivering an Interim Report that thoroughly considers all issues relating to this mandate.

The Government has given Justice Cunningham the following mandate for the final report:

> "Recommendations regarding systemic causes of and solutions to the mediation backlog, potential changes to the current structure, a delivery model and process, the addition of a dispute prevention process for the system and other issues related to the viability of the DRS".

The mandate does not make any explicit reference to cost reductions. Aviva respectfully requests that the mandate be reviewed and amended to include cost reduction as a specific goal. The Government has imposed a 15% mandatory rate reduction upon insurers through the *Automobile Insurance Rate Stabilization Act*. The mandate, as stated, may lead to cost reduction but Aviva believes that an explicit goal to reduce costs is in order given the explicit rate reduction goal given to insurers. In order to reduce costs, both the average cost of a dispute and the total number of disputes need to be reduced.

Aviva agrees with many of the recommendations made in the Interim Report. These recommendations will reduce the average cost of a dispute. However, Aviva does not believe that the report goes far enough in addressing the systemic causes of dispute and therefore it is uncertain whether the actual number of disputes will be reduced.

I. Recommendations that Aviva Supports

Aviva agrees with the following recommendations:

1. Establish statutory time limits for dispute resolution. (Timeliness).

2. The system should accommodate different processes based on the complexity of the case. (Pproportionality).

3. Costs should be introduced at the back end of the process instead of the front end, in order to provide some balance to the system by penalizing those who abuse it. (Accessibility)

4. Separate policy and adjudication by adopting a provision similar to s.126 of the *Workplace Safety and Insurance Act* that sets out how WSIAT is to apply WSIB policy in the appeal process and the procedure in the event clarification is needed. (Predictability)

5. Eliminate mandatory mediation and replace it with a merged mediation-arbitration model providing evaluative input to the parties when warranted early in the process. (Streamlining)

6. Eliminate appeals to the Director's Delegate. Appeals would go directly to a single judge of the Superior Court. (Streamlining)

7. The current cost structure ($500 mediation and $3,000 arbitration) is too high. Costs should be similar to those charged in other jurisdictions. Costs should be graduated based on the services that are provided. Costs should be assigned to a claimant following an unsuccessful arbitration. (Costs)

8. Dispute Resolution Services should be delivered external to FSCO.

9. Aviva prefers a contracted service delivery model over a tribunal. Aviva agrees that expertise and quality issues could be addressed through oversight, training, quality control and meaningful standards. A contracted service delivery model would provide more flexibility to respond to varying demand. (Private vs. Public)

II. Recommendations that Aviva Supports in Principle

Aviva agrees in principle with the following recommendations and offers additional comments:

a. Advocacy Office

In principle, Aviva likes the idea of an advocacy office as an alternative to legal reps. It remains to be seen whether consumers would use an Advocacy Office instead of lawyers or paralegals. The cost of establishing and operating an Advocacy Office may outweigh the benefit if claimants do not access the Advocacy Office. The Advocacy Office will in effect be competing for business with lawyers and paralegals. The latter two have already established referral networks and mastered the art of advertising. In order for an Advocacy Office to succeed, the individuals and entities that have early contact with car accident victims should be mandated to pass along information regarding the Advocacy Office. This would include tow truck drivers, auto repair shops, hospital personnel, insurers, lawyers and paralegals.

b. Cash for Treatment

Aviva agrees that the current culture in the SABs must change. Aviva has long been a proponent of providing treatment not cash to claimants. Aviva was a driving force behind the original one year no-cash settlement provision. However, extending the no-cash settlement provision alone without adjusting the overall timelines and rules associated with medical and rehabilitation benefits will not change the current culture. The rules surrounding medical and rehabilitation treatment are still too loose and the limits are still too high. There is too much incentive for overtreatment and overutilization.

Under the current system, a claimant who sustains an injury, other than a minor injury, is entitled to medical and rehab benefits for **10 years** or until the financial limit[1] is reached, whichever occurs first. Claims can be open for 10 years and this creates significant workload and expense issues for insurers. Settlement is the only option to close down a file to gain certainty of the outcome. Even then, settlements have been frequently challenged. Claims need to exit the system quicker. Treatment needs to be limited to a time period that is supported by medical evidence. Claimants need to be encouraged to get on with their lives. Claimants' legal representatives need to focus on their files and move claims along. Shorter timelines will drive this and have a direct positive impact on cost reduction.

Ontario is the only province that makes med/rehab benefits available for 10 years as part of its mandatory coverage. In Alberta, claimants are entitled to $50,000 in med/rehab for 2 years. In Nova Scotia and New Brunswick, med/rehab limits have recently been increased to $50,000 for 4 years. There is no medical evidence to support a 10 year med/rehab period for non-catastrophic injuries. The culture would change significantly if the timeline was reduced to 2 or 4 years and a no settlement provision was imposed. This would force treatment not settlements. Alternatively, the culture would also change if medical and rehabilitation treatment was prescribed according to Programs of Care. Programs of Care combined with a no settlement provision would also drive a culture change.

c. Proposed Legislative Framework

Aviva supports the Proposed Legislative Framework. The dispute resolution system needs shorter timelines but those timelines need to be enforced. Currently, the delays in the system allow claimants' legal representatives to ignore their files to the detriment of the claimants.

i. Mandatory Internal Review

The Interim Report recommends a mandated "second set of eyes" review for benefit denials. Philosophically, Aviva agrees that a "sit down" with the claimant is a good idea. Most insurers have either implemented this or some other type of review procedure. A mandatory internal review will add further costs and therefore again, it is critical that the benefits outweigh the costs. The Mandatory Internal Review must be designed to prevent and limit disputes. Aviva believes that this can be achieved as follows:

- The claimant must be responsible for requesting a review meeting.
- The review meeting must occur within a well defined short timeline. We agree with the 30 day proposed timeline. There can be no exceptions to this timeline.
- If the meeting does not occur within the time limit, the claimant cannot initiate a dispute nor can the benefit denial be added to a subsequent dispute.
- An in-person meeting between insurer and claimant would be more effective than a telephone meeting. However, if the goal is to complete the process within 30 days, it would be prudent to

[1] $50,000 for non-Minor Injury/ non-CAT claims and $1 million for CAT claims.

offer a choice of telephone or in-person meeting. However, the in-person meeting should be encouraged.

- In cases where the claimant has legal representation, the attendance of the legal representative is optional. The claimant must attend.

ii. Access to Courts

- Claimants may choose to access the courts if they (or their legal reps) perceive the DRS system to be more restrictive than the Court system. This will compound an already overburdened Court system. The review team may wish to consider limiting access to the Courts to certain specified disputes only.

iii. Case Manager/ Gatekeeper Role

- The case manager/ gatekeeper role will be a key role. It will be important to ensure that the gatekeeper is provided with the appropriate authority to address jurisdictional and other procedural issues. The gatekeeper's decisions should be final; otherwise these decisions will spawn a separate set of disputes.

iv. Mediation/ Pre-Arbitration Process

- Aviva agrees that the mediation/ pre-arbitration process should be more evaluative. Pre-trials in the Court system are also supposed to be evaluative but in Aviva's experience, they often are not. Providing an evaluation must be mandatory.
- Aviva also agrees with a differentiated hearing process based on the complexity of the dispute. A full adversarial process is not needed for all disputes. However, there should still be a mechanism whereby the truthfulness of the evidence can be tested. Full hearings will permit this. On paper hearings and expedited hearings, consideration should be given to a limited cross-examination of witnesses or experts that an opposing party intends to rely on. The right to cross-examination would be available only by order of the pre-hearing arbitrator. The cross-examination would take place outside of the hearing. The pre-hearing arbitrator could set time limits for the length of cross-examination and the timelines for completion. This process would be similar to the civil rules that allow for cross-examination on affidavit evidence in advance of a motion or Simplified Trial.

III. Recommendations that Aviva Does Not Support

Aviva disagrees with the following recommendations:

a. Assignment of Disputes to Health Care Providers

Aviva does not support the recommendation that a health care provider be allowed to dispute a denial of benefits as long as the claimant has assigned the benefits to the provider. Aviva believes that this recommendation will drive up the number of disputes and ultimately costs. Providers have an inherent conflict or self-interest when it comes to treating claimants in the SABs. There is more financial gain for providers to continue treatments. The Ontario system has high average treatment costs which suggest overutilization. The Ontario system has also been plagued with fraud especially around the use of electronic signatures on assessments and treatments. Aviva currently has difficulty engaging claimants in the claims process. Quite often, Aviva's claimants are unaware that a particular treatment or assessment has been recommended for them. We need claimants to be more involved in and accountable for their care and recovery. This was one of the objectives of introducing the health care spending account in 2010. Accountability would be undermined if claimants were allowed to turn their denials over to providers for dispute. Providers should not become claimants' advocates. Claimants are already well represented by lawyers and paralegals.

The Interim Report cites the fact that some U.S. jurisdictions allow for the assignment of benefits to health care providers. It is dangerous to borrow bits and pieces from other jurisdictions without fully understanding the entire product and the checks and balances inherent in the system. Our research confirms that New Jersey and New York allow for the assignment of benefits to health care providers. However, a number of significant differences exist between those jurisdictions and Ontario:

- Ontario claimants have access to publicly funded medical treatment. This may or may not be the case for claimants in New York or New Jersey. The ability to access the auto insurance medical and rehabilitation benefits becomes more important when there is no access to public healthcare.
- Benefit limits are much lower in New York and New Jersey. In New York, the basic PIP limit is $50,000 with optional buy-up. The $50,000 limit applies to **all** benefits including medical, rehabilitation, housekeeping and disability income replacement**.** In New Jersey, the basic policy offers $15,000 in PIP personal injury protection coverage and includes up to $250,000 of medical benefits coverage for CAT type injuries. These limits stand in stark contrast to Ontario's $50,000 med/rehab and $1,000,000 CAT med/rehab limits. The low limits provide protection against fraud and overutilization and also limit the scope of disputes. Ontario's high limits and lack of general controls have contributed to fraud and overutilization.
- New Jersey has enacted the *Automobile Insurance Cost Reduction Act (*AICRA) and imposed a tight set of rules on medical providers that must be followed in order to obtain compensation. Most notably, the rules include Medical Protocols (Care Plans) and tight timelines. Ontario only has one program of care, the Minor Injury Guideline. There are no guidelines to dictate how the $50,000 med/rehab or $1,000,000 CAT med/rehab limits are spent.

b. Establishing Case Law and Publishing Decisions

The report recommends that arbitration decisions be published and also that arbitration decisions address each individual case. It is not clear to Aviva whether this means that arbitration decisions are or are not binding. It should be clearly stated that arbitration decisions are not binding on other disputes. Arbitrators

should be responsible for adjudicating individual disputes but should not be responsible for creating a body of law. Case law should be established only by the Ontario Court.

Aviva strongly recommends that arbitration decisions not be published. Disputes should be between the claimants and their insurers. Arbitrators should be resolving individual disputes and not establishing case law. Disputes are usually fact specific and if there is no legal precedent set, there is no need to publish arbitration decisions. Currently, arbitration decisions are carefully studied by all parties including health care providers creating an underlying, in-direct influence on behaviour. Aviva has already observed deterioration in Minor Injury due to clinics and IE assessors interpreting and following the *Scarlett v. Belair*[2]decision despite the fact that the case is not binding and it is under appeal. The list of diagnoses that clinics are including in minor injury assessments is markedly different after the *Scarlett* decision was released. Aviva suspects that assessors are trying to fit claimants into the *Scarlett* decision.

There has also been a tendency of FSCO arbitrators to adopt other arbitration decisions as if the e original decision was binding. This is particularly dangerous when done in obiter and the point followed may be erroneous. A good example of this is seen in the recently released decision of *Augustin v. Unifund*[3]. The issue before the arbitrator was whether the claimant was precluded from proceeding with the mediation because she did not attend her IE. Arbitrator Sapin provides a wide ranging, and arguably out-of-scope analysis of many sections of the Minor Injury Guideline. She adopts the *Scarlett* definition of "compelling evidence" which is one of the issues under appeal. This practice of FSCO arbitrators "blessing" each other's arbitration decisions has led to the creation of a troubling body of law.

c. Attacking the Systemic Cause of Disputes

The number of disputes has more than doubled from 2007 to 2012.[4] Changes are needed to reduce the total number of disputes. More clarity and certainty is required. In addition, there needs to be finality to some decisions. Currently, almost every decision that is made by an insurer can be disputed. While it may be outside of the scope of this review, Aviva feels compelled to comment on ways to increase certainty and clarity.

- The Minor Injury definition and Guidelines are currently the subject of 25% of Aviva's disputes. These disputes generally do not pertain to treatment within the Minor Injury Guideline. Rather, the dispute is over whether a claimant can escape the "Minor Injury" category and access the higher med/rehab limits. Tightening the definition of "Minor Injury would eliminate a large number of these disputes.
- The definition of Catastrophic Impairment has been subject of much arbitration and litigation over the years. A new definition is needed that is far less complex than the current definition. The Expert Panel drafted a new definition. It is time now to implement it.

[2] *Scarlett and Belair Insurance Company Inc.* (FSCO A12-001079, March 26, 2013)

[3] *Augustin v. Unifund Assurance Company* (FSCO A12-000452, November 13, 2013).

[4] In 2007, there were 17,028 total mediation and arbitration applications. This number increased to 38.899 in 2012.

- Reducing the med/rehab timelines from 10 years to 4 years or 2 years would reduce the number of disputes.
- Programs of care that clearly define treatment protocols for common auto accident injuries would eliminate disputes over medical benefits (noted in the Interim Report as the most common dispute). Programs of care exist in many other jurisdictions and at the WSIB. These could easily be imported into Ontario SABs.

Introducing tighter definitions and programs of care would alleviate the need of an expert medical panel that would support adjudicators. Aviva would be pleased to provide further recommendations on this topic.

Aviva thanks the Government for the opportunity to provide feedback on the Interim Report. It is important that changes to the DRS reduce the number of disputes and the cost of disputes and contribute towards more certainty in the system. Aviva would be pleased to discuss any aspects of submission.